

Monday, 21 July 2025

(10.30 am)

(Proceedings delayed)

(10.45 am)

LADY HALLETT: Apologies for the delay. Transport problems.

MS CAREY: My Lady, good morning. May I call, please, Mr Sean Holland.

PROFESSOR SEAN HOLLAND (sworn)

LADY HALLETT: Sorry for keeping you waiting, Professor Holland. You've probably travelled much further and got here quicker.

THE WITNESS: Delays, I think, are inevitable at this time of the year, my Lady.

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

MS CAREY: Mr Holland, your full name, please.

A. Sean William Holland.

Q. You were, during the pandemic, the Chief Social Work Officer in the Department of Health in Northern Ireland, is that correct, taking up that role, I think, in July 2010?

A. That's correct.

Q. And moving on to pastures new in October 2022?

A. Yes.

Q. Just so that we can orientate ourselves in Northern Ireland and the position there, we know that it's the

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a 2018 Department of Health report called the Health and Social Care Workforce Strategy, and that 2018 report outlined that there was an estimated 1,400 care workers needed every year to meet the growing demand on the adult social care sector. And the report noted that domiciliary care workforce needs and should be an early priority in recognition of the particular vulnerabilities we faced in social care.

Can you help us, Mr Holland, with what was done to try and increase the numbers of workers in the domiciliary care workforce as a result of that 2018 report?

A. I think the demand for domiciliary care workers, it's helpful to understand, there are a couple of different components to it. One is demographics, and I'm sure a lot of people will be aware that the demographic profile of the population is changing, and it's changing in that we have a growing population of older people. Within the population of older people we have a growing number of people who are older old people, that would be people over the age of 85, and they particularly drive demand because they're much more likely to have health and social care needs.

The other aspect of the demographic challenges is that we have fewer young people and so that's

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health and social care trusts who contract with the care home providers and, indeed, the domiciliary care agencies; is that correct?

A. That is correct.

Q. But as at the start and during the pandemic, I think there were 482 or 483 care homes in Northern Ireland --

A. (Witness nodded).

Q. -- numbers vary slightly. 16,000 beds, 93% occupancy rate within care homes in Northern Ireland, which I think is one of the highest across the UK.

Would you mind just saying "yes" or "no" for the stenographer.

A. Oh sorry, yes, yes, yes.

Q. Thank you.

And I think there were something like nearly 21,500 individuals in receipt of domiciliary care and 300 domiciliary care agencies registered with the RQIA?

A. Yes, all of that's correct.

Q. And I think in terms of workforce, as at March 2020, there were 36,855 social care workers who were registered.

A. Yes.

Q. Can I ask you about the workforce though, please, in the run-up to the pandemic. In your statement, which is INQ000613603, you make reference there, Mr Holland, to

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restricting workforce supply. There are fewer people in the labour market available for supply.

And then the other side to the workforce challenge is that social care, particularly at the point of being a social care worker, a care assistant, or a domiciliary care worker, is a service that's largely delivered by the private sector subject to market forces, and the market has settled at a place where those are often low-wage, indeed minimum wage, jobs, and zero-contract-hour jobs, which then leads to a churn within that workforce.

So there are a few different elements all of which combined to give a fragility to the social care workforce.

In terms of what was done, each year the contracting of services would have tried to respond to the demand increase, and so that would be a case of we would find ourselves spending -- trying to allocate more money and sometimes that would be in-year monitoring money, other times it would be more planned, but you were trying to expand the capacity to contracting services, but then we also took other actions to try and make the sector more appealing.

So for example, the department would have funded the Northern Ireland Social Care Council to promote the

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career and the sector as a rewarding place to work in. They also, again funded by the department, would have created employment frameworks which would outline how your career could develop within social care, and they also outlined practice learning requirements, ie, a qualification framework. But all of those efforts are fundamentally challenged by the fact it still remained largely a very low-wage sector.

That said, I'd have to say that that's a variable picture. There are some employers who do much better than others in terms of both being able to recruit and retain staff, and that's reflected, they tend to make decisions about taking a smaller profit margin, investigating more in staff, that sort of thing.

Q. And from the department's perspective, do you know whether there -- the 1,400 estimate was actually met? Were you increasing by 1,000 care work -- or only 500? Do you have any idea about how, if at all, the workforce was expanded to the estimated 1,400 care workers needed every year?

A. I don't have that information available to me at the moment but we would have information about the registered numbers of social care workers which, broadly speaking, has shown a trajectory of increase, and had increased dramatically during the later parts of --

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relating to the lack of capacity for Domiciliary Care was recorded as follows:

"The capacity of Domiciliary Care Services, both Trust and Independent Sector services are unable to meet increasing demand."

It sets out there the implications of that.

And at the bottom of that italicised section:

"The risk has recently been exacerbated by Independent Sector providers handing back cases to the Trust to source alternative care provision."

Two things about that, please. Was the department made aware of the fact that there were trusts out there that were struggling to meet increasing demand?

A. Yes.

Q. And do you know, was this a position common across the other trusts, or was it particular to the Northern HSC Trust?

A. The position would vary in trusts, and indeed in some cases it would vary within different geographical sectors of trusts.

So, for example, in the Western Trust, the area of -- what we would call Fermanagh and Lakelands, which is a very low population density, very rural area, would have had particular difficulties delivering domiciliary care services. Other areas wouldn't have had the same

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well, from the beginning of Covid it was a very volatile figure but it did increase.

But there are limitations to that number because that is a record of people who have joined the register.

Q. Yes.

A. People may join the register, and you're registered for a period of three years, but then you may leave the job after three months.

Q. Yes, understood. All right.

Do we take it, though, that as a general proposition there was the fragility in the workforce entering the pandemic in sort of January, February and into March 2020?

A. There would have been a fragility in the workforce and there would have been pressure on budgets, because -- the relationship is: the budget buys the service, which drives the workforce. And there were pressures that were evident through a mixture of waiting times and thresholding of those services.

Q. Can I ask you about one particular trust and can I have up on screen, please, INQ000582513_11.

Mr Holland, this is an extract from, I think, the Belfast -- sorry, the Northern Health and Social Care Trust, and can we see there:

"[In] January ... the Trust's Corporate Risk

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difficulty. So it was a problem across the sector.

This quote specifically is looking at the capacity of domiciliary care and it's important to draw a slight distinction here between different parts of the adult social care sector.

So, care home provision nearly exclusively, but not completely exclusively, has ended up -- and it was never the policy intention explicitly for this to happen, but it has ended up nearly exclusively being delivered by independent providers.

Q. Yes.

A. Domiciliary care, about 70% of the services are provided by independent service providers, but there would be a capacity retained within all of the trusts for in-house domiciliary care. And so one of the actions that we were talking to the trusts about in relation to the issue of handbacks was expanding their in-house capacity.

Q. Right. And does that then relate to the final paragraph on this italicised section:

"The risk has ... been exacerbated by [the] Independent Sector providers handing back cases", ie, we can't look after them in the independent sector so the trust is going to have to meet their needs? Is that what it means, in short?

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1 A. Yes, although it's slightly more nuanced in that you
 2 could have a provider saying "We can't meet this need"
 3 and you might find another independent sector provider
 4 who could. But you would also be looking to your
 5 in-house provision. The net effect was that trusts were
 6 reporting a drift of complex high-need cases coming to
 7 their in-service provision. So independent sector
 8 providers -- I mean, it's a pejorative phrase and it's
 9 one I wouldn't necessarily choose to use, but I would
 10 have trusts saying "The independent sector are
 11 cherry-picking the cases that they want to deal with."
 12 Q. Yes.
 13 I ask because obviously we're going to look in
 14 a moment at the discharge policy in March 2020, but does
 15 the department know how many or the proportion of
 16 patients that were discharged to care homes and those
 17 discharged to domiciliary care? We've heard in other
 18 countries it's a much higher proportion are discharged
 19 to domiciliary care. Was that the same in Northern
 20 Ireland?
 21 A. I don't have the figure with me but we would be able to
 22 access that.
 23 Q. Because the reason for asking about the lack of
 24 workforce in domiciliary care is if you're discharging
 25 many patients from hospitals into the domiciliary care

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1 soon as possible, but the safeguard being that you knew
 2 they weren't barred.
 3 So that was one step we took.
 4 Another step we took was, unlike the situation, say,
 5 for example in England, our social care workers are
 6 registered. So that's a statutory registration, it's
 7 not a voluntary scheme, there's legislation requiring it
 8 to be the case, and we have a regulatory, a workforce
 9 regulatory body, the Northern Ireland Social Care
 10 Council, who register. As is common practice with
 11 registered professions, there's a fee associated with
 12 registration. Now, the Northern Ireland Social Care
 13 Council registers both social workers and social care
 14 workers. The fee is low for social care workers, it's
 15 £30, but recognising that people might join the
 16 workforce for a short period of time and then leave
 17 again, we suspended the collection of fees --
 18 Q. The waiver fee?
 19 A. -- so that people weren't going to be put off by having
 20 to pay a fee.
 21 And then thirdly, we funded the NISCC to increase
 22 their efforts to promote people coming into the sector
 23 to work.
 24 Q. You mentioned there the register, and I'll deal with it
 25 now, perhaps, if I may. We know that the Northern

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1 sector, what steps were taken by the department to
 2 increase the capacity, given that there was going to the
 3 expedited discharges?
 4 A. A few things -- and this is increasing the capacity,
 5 specifically in the domiciliary care?
 6 Q. Yes.
 7 A. Some of the measures apply to both the care sector and
 8 the domiciliary care sector. We sought to make it
 9 easier to recruit people so, so we entered into a new
 10 arrangement in relation to police checks, pre-employment
 11 checks for care workers. Ordinarily for care workers,
 12 you would have a check that encompassed two components:
 13 one would have been to check a barred list because there
 14 are people who would be barred because of previous
 15 conduct from ever working in that sector. The other
 16 would be an enhanced disclosure check, which would be
 17 a more general check of police records. And for some
 18 posts you could also consider non-adjudicated
 19 intelligence the police may have held on someone.
 20 Now, what we said was that to speed up the process,
 21 we'll check the barred list, you can employ someone on
 22 the basis of them not being on the barred list, but
 23 there are conditions associated with what they can do.
 24 They have to be closely supervised. You will pursue the
 25 enhanced disclosure check and you will obtain that as

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1 Ireland Social Care Council maintains the register and
 2 it includes adult residential care workers, daycare
 3 workers, domiciliary care workers, supported living care
 4 workers. And you have rightly drawn our attention to
 5 the fact that there is no such register in England.
 6 From your perspective, Mr Holland, what were the
 7 benefits of having this register in Northern Ireland
 8 during the pandemic?
 9 A. I think there are a few different benefits. Firstly, it
 10 gives you some, albeit slightly flawed intelligence
 11 about the workforce. You know how many people at least
 12 are registered to work in social care. So that gives
 13 you that information. The other benefit, I think, is
 14 that it gives you some assurance, and it's probably
 15 particularly important if you're doing things like
 16 expanding the workforce rapidly under less than ideal
 17 conditions. It gives you some quality assurances
 18 because the registrants have some requirements placed on
 19 them. So they are expected to complete what we call
 20 PRTL, which is post-registration learning and
 21 training (sic). They're meant to do 90 hours per
 22 registration period, which they're meant to document, or
 23 be able to document that they've done 90 hours of
 24 training.
 25 It also means that they are subject to fitness to

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1 practise regulations. So if someone, someone's conduct
 2 is such that it's deemed necessary or it reaches
 3 a threshold for a fitness to practise, that takes you
 4 beyond the situation in England where --
 5 **Q.** Can I pause you there, because I understand that that's
 6 a general benefit of the register but what I was trying
 7 to ascertain was, was there any particular
 8 pandemic-related benefit?
 9 **A.** We could communicate with the workforce. So on a number
 10 of occasions we both issued email messages and we also
 11 directed people through their accounts to social media
 12 messages that we were issuing in relation to the
 13 pandemic.
 14 And NISCC also produced some very targeted learning
 15 resources for the workforce which people would be able
 16 to access, the registrants would be alerted to, and they
 17 could access those. I think it was a suite of four
 18 learning packages. One related to infection prevention
 19 and control; one was advice actually targeted to the
 20 general public about shielding and isolation; there was
 21 another package on resilience and emotional wellbeing.
 22 And I'm sorry, I've forgotten what the fourth package
 23 was.
 24 **Q.** Don't worry.
 25 **A.** But they were, I have to give credit to the Northern

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1 accommodation. That would have an impact on the
 2 workforce. But the -- now, and I think I'm right in
 3 this, that one of the things that we were concerned with
 4 was that the surge plans didn't take into account the
 5 potential impact of any measures that might have
 6 impacted on those figures.
 7 **Q.** Yes. Right. Can I just ask, ordinarily, surge
 8 planning, is that something that should be done at trust
 9 level? Does the department ordinarily have oversight of
 10 the quality and content of the surge plans? Can you
 11 help us?
 12 **A.** Normally, the equivalent, I would say to surge planning
 13 would be winter pressure planning where -- and not
 14 unlike the pandemic, you have pressures arising from
 15 communicable illnesses circulating in the community.
 16 The trusts will produce their own individual winter
 17 pressures plans. The quality assurance and coordination
 18 of those would be done by the Health and Social Care
 19 Board although they would then be shared with the
 20 department, but ordinarily most of the activity would
 21 have been between board and trust in relation to that
 22 kind of planning activity.
 23 The responsibility in legislation for the board
 24 would have related to planning and commissioning
 25 services, whereas the primary responsibility of the

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1 Ireland Social Care Council, they actually won
 2 a European social services award for that suite of --
 3 and it was specifically for those Covid resources that
 4 they won the award for. But we were able to communicate
 5 and direct the workforce towards resources.
 6 **Q.** Thank you.
 7 Can I just take a step back, then, and ask you some
 8 questions, please, about surge planning. And in your
 9 statement you say that the Chief Medical Officer
 10 commissioned work on -- to quality assure and address
 11 gaps in the initial surge plans, recognising obviously
 12 that there were going to be pressures coming to both
 13 health and social care. And I think in your statement
 14 you set out that there were gaps in the plans as far as
 15 adult social care was concerned. Obviously the plans
 16 were predicated on staff absence being the most
 17 significant risk factor. Were there any other gaps
 18 identified in the plans as far as you were aware,
 19 Mr Holland?
 20 **A.** I think that the workforce was probably the main gap
 21 that we saw, but also there was a lack of account taken
 22 for the impact of mitigating measures. So the surge
 23 plans were initially developed on information that
 24 indicated that up to 80% of the population could fall
 25 ill, a proportion of those would require hospital

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1 department is about policy and legislation.
 2 **Q.** Right. So it sits at sort of one level down from you,
 3 if I can put it like that, but can I ask you about,
 4 please, the mid-March plan, and can I have up on screen,
 5 please, INQ000103714,_10. This was the initial,
 6 I think, it was mid-March to mid-April plan dated
 7 19 March, Mr Holland. It was a 12-page document and in
 8 it the plan predicted a 21% absence from the health and
 9 social care workforce.
 10 I appreciate, obviously, then there may be
 11 mitigations that might mean there are fewer absences
 12 than had been predicted.
 13 **A.** That would have been the case.
 14 **Q.** I understand that. But the planned discharge
 15 planning for patients in hospital is set out on screen.
 16 Clearly they're talking about there the importance of
 17 discharge arrangements; the trust to activate their
 18 emergency discharge plans; reference there to expediting
 19 discharges; trusts working to maximise all spare
 20 capacity in residential nursing and domiciliary home
 21 care; and then potentially, as a contingency plan,
 22 needing to redistribute domiciliary care hours as is set
 23 out.
 24 And pages 10 to 11, if you'll forgive me for making
 25 the comment, don't actually mention very much the adult

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1 social care sector at all in this plan. Can you help
2 with how practical or otherwise this plan was meant to
3 be, knowing that there was likely to be a large number
4 of people discharged from hospital at a relatively quick
5 pace?

6 **A.** This set of actions, although you're looking at them in
7 the context of a surge plan created during the pandemic,
8 aren't that different from actions that would be
9 undertaken each year in relation to winter pressures.
10 I suppose the question was, the degree of focus and
11 energy placed into these different areas, but each year,
12 part of the contingencies that you would adopt facing
13 into winter pressures would include most of these. Some
14 I don't think we'd activated before, so the choice
15 protocols, although each year we talked about it, this
16 was the first time we actively said no, people would be
17 discharged regardless of first preference choice.

18 But things like prioritising resources, maximising
19 capacity, and speeding up discharge, all were measures
20 that would have been in previous plans.

21 I think the important thing is that there was no
22 change to the issue about medically fit for discharge.
23 So that wasn't compromised. It was more about the
24 process that's associated.

25 Discharge is always a point of pressure when the

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1 **A.** I think that there were processes happening at different
2 parts of the system that would have different levels of
3 granularity. So this is a high-level statement of what
4 people should be doing. The how they're doing it would
5 appear in processes at a lower level.

6 I think it is also probably important to note that
7 the capacity challenge that this anticipated was never
8 realised. And the first quarter of 2020, although we
9 were slightly up in the number of discharges into social
10 care, it wasn't particularly high. And if you took as
11 an average between the first and second quarter, we were
12 quite significantly down in terms of the numbers of
13 people being discharged into social care. There are
14 a lot of reasons I could go into if you want for that,
15 but maybe that's a later point.

16 **Q.** Not right now, but -- I mean, I'm taking that as your
17 point, but of course you didn't know that as of 19 March
18 when this discharge -- sorry, this guidance came out.

19 **A.** No, we didn't. This was in anticipation of pressures
20 that never realised to the extent that we were preparing
21 for.

22 **Q.** All right. Now, in, I think, early August, the
23 department established the Adult Social Care Surge
24 Working Group, and I just would like to understand why
25 it was established then, and what practical benefits, if

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1 system is under pressure, and there's a tension between
2 social care and the acute hospitals with -- and
3 apologies for characterising it in this way -- you'll
4 have the acute sector saying: beds are being blocked
5 because social care can't deliver, and you'll have
6 social care saying patients are being delayed because
7 the acute hospitals aren't operating effectively with
8 their processes for discharge.

9 And actually, research has indicated that I think
10 when people say "Oh, it's a delayed discharge, it's
11 a social care problem", normally 60% of the time it's
12 actually relating to the processes in the hospital as
13 opposed to in the social care sector.

14 But what this plan is saying, make sure everyone's
15 focused, everyone's working together, and that delays
16 are minimised. It wasn't saying people should be
17 discharged at a lower threshold.

18 **Q.** No, and I understand that and forgive me, looking at
19 this plan, one might say it's rather generic and not
20 hugely helpful to the trusts who are then having to try
21 to find the spare capacity or -- can you help with --
22 it's relatively high level, isn't it, Mr Holland?

23 **A.** Mm.

24 **Q.** I just wonder how practically useful it was thought to
25 be.

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1 any, did it bring when we came into winter 2020 into
2 2021?

3 **A.** There was an evolution of various working arrangements
4 from the very early days, when the Chief Medical Officer
5 initiated the gold, silver, bronze strategic command
6 response, where there were then a number of strategic
7 cells incorporated within that, particularly focusing on
8 things like infection prevention and control, testing,
9 at one point in vaccinations.

10 But as we moved on, we recognised that while those
11 had been an appropriate immediate response, we needed
12 slightly different structures and we decided that there
13 should be a broader coming together of focus on social
14 care. It's not that social care wasn't being
15 considered; it was the framework that we were using to
16 do it we felt evolved once we got through that first
17 wave, and that's the structure that you're referring to.

18 In terms of the benefit of it, it became where
19 a number of different threads that might have been going
20 through different cells were brought together and
21 considered in relation to social care. It also was used
22 to monitor progress against different initiatives or
23 reports that were generated as we went through the
24 pandemic.

25 So, for example, there were two rapid learning

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1 initiatives, one in relation to nursing homes, the other
2 in relation to domiciliary care. They made
3 recommendations. That structure would have tracked
4 progress against those recommendations. It also would
5 have tracked other pieces of work in progress that were
6 happening.

7 **Q.** Can I come on to the discharge policy, then, and we're
8 familiar with the arguments for and against it and the
9 pressures that were certainly predicted to exist at the
10 time.

11 **A.** Yeah.

12 **Q.** And in due course I think there were various changes to
13 the testing regimes pre-discharge. We may look at some
14 of those in a moment. But in terms of isolation and the
15 ability of care homes to isolate, I think certainly that
16 there was -- care homes were not expected to have
17 dedicated isolation facilities but isolation precautions
18 were to be taken when someone was being discharged from
19 hospital into a care home.

20 And certainly isolation requirements were approved
21 by the minister on 24 April -- I'm at your paragraph 598
22 if it helps you, Mr Holland -- and communicated to the
23 sector at the end of April.

24 Can I ask you this, firstly: do you know why there
25 wasn't a requirement put in place for isolation prior to

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1 "... (... a small number of homes still used some
2 double occupancy rooms)."

3 Does the department know how many care homes there
4 were that still had a double occupancy room?

5 **A.** We may have that information but I don't have it to call
6 to memory.

7 **Q.** And I think certainly the -- some care homes were
8 assessed by the RQIA as not being able to appropriately
9 isolate individuals because of the configuration of the
10 care home itself. It was considered to be a very small
11 number of homes that wouldn't be able to isolate.

12 Discharges to those homes, said the RQIA, should not
13 take place from hospital. But was there a band, do you
14 know, as far as the department was concerned, in saying
15 "Well, if you can't isolate, you must not accept them"?
16 Or did it not work like that, Mr Holland?

17 **A.** No, the guidance issued was quite clear to say that if
18 a care home couldn't appropriately accommodate someone
19 or isolate someone on discharge, alternative
20 arrangements would be made. And that was also the case
21 when it came to the point when people were being tested.
22 If a test result wasn't known, alternative accommodation
23 could be arranged.

24 So -- and that would have been in a step-down
25 facility. There were a number of step-down

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1 the end of April 2020?

2 **A.** I think this was a developing scenario, and there were
3 a number of points at which we adopted positions which
4 were changes from previous positions, and I think in
5 almost every instance, and again, I'm probably echoing
6 the comments of my counterpart in Wales, it would have
7 been better if these were done at an earlier stage than
8 they were, but it was the progress under pressure with
9 resources that there was always a lag to some of these
10 things.

11 Sorry, I'm not sure -- did you ask me something else
12 in that question?

13 **Q.** No, no, no, it was why it hadn't come in before, and
14 effectively you said, well, with hindsight now --
15 I think in short you're saying you wish it had.

16 But -- (overspeaking) --

17 **A.** Yeah, and I'd also need to reference it against the
18 infection prevention and control advice that was coming
19 from the Public Health Agency, because that changed
20 a number of times as we went through.

21 **Q.** You do say, however, in your statement, though, that:
22 "The Department worked closely with the RQIA ... to
23 assess the different care homes to implement isolation
24 policies ..."

25 And indeed, it was noted that:

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1 arrangements. And there would have been some step-down
2 facilities that preceded the pandemic and they would
3 have been used under those circumstances.

4 But at no time were we seeking people to accommodate
5 people that they couldn't accept within the extant
6 guidance.

7 **Q.** Right.

8 **A.** And that -- that is relevant to the previous point about
9 the fact that we never faced the capacity pressures that
10 we had anticipated as well.

11 **Q.** I ask you that because I think there was
12 a Northern Ireland Assembly committee for the Health
13 Inquiry report from April 2021, and in the findings of
14 that report the committee noted that many homes
15 struggled to isolate individuals, either for reasons of
16 facilities or adequate staff resources, or, equally
17 importantly, residents' wellbeing and issues of
18 understanding amongst the significant numbers of
19 residents with cognitive decline who presumably weren't
20 able to isolate themselves, and the department noted
21 this was an area of policy the department continued to
22 keep under active consideration.

23 In what way did the department keep under active
24 consideration the ability or otherwise for a care home
25 to isolate individuals?

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1 **A.** Well, one of the things we did do is when we heard
 2 suggestions that people maybe had had to do something
 3 that they felt was outwith the arrangements, was we
 4 tried to pursue actual cases to find evidence of them,
 5 and this was true in relation to a number of things. It
 6 would have included, for example, PPE at one stage. The
 7 independent healthcare providers association were saying
 8 to us, you know, a number of homes aren't receiving PPE.
 9 We asked for a list of those homes and followed them up.
 10 And when we did, we found that they actually were
 11 reporting that they received PPE. So that would have
 12 been one response.

13 The other response would have been developing
 14 guidance to support care homes on an ongoing basis
 15 around the requirements for isolation and compliance
 16 with it.

17 **Q.** And are you able to give us a practical example of the
 18 guidance that supported the care homes around
 19 requirements for isolation?

20 **A.** I'm trying to recall, did ... no, I think the PHA
 21 probably issued guidance at some point. We included it
 22 in the departmental guidance. We also would have been
 23 providing advice and support to care homes on an
 24 individual basis about how they could meet those
 25 requirements through the service support team that we

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1 looking at them and saying "Oh, this home could only
 2 isolate three people" or "This home couldn't isolate
 3 anyone at all."

4 This was a desktop exercise that was only ever meant
 5 to be used at a system level. So they were simply
 6 reviewing things like what was the home registered for?
 7 How many single-use bedrooms did they have? How many of
 8 them were en suite? And they were coming up with an
 9 estimate.

10 This wouldn't be a document that would have been
 11 used to guide individual decisions to discharge a person
 12 into a care home. They would have been done on
 13 a case-by-case basis and the two sides of the equation
 14 would have been the medical side, fitness to discharge,
 15 and on the care home side, ability to accommodate in
 16 line with the guidance.

17 And there would have been a fluidity to that that
 18 wouldn't be reflected in this exercise. So, for
 19 example, you might have had a much lower level of
 20 occupancy in the care home for a variety of reasons, and
 21 there was a decline in occupancy in care homes through
 22 this period, which would have enabled them to enact
 23 isolation that wouldn't have been obvious from the
 24 desktop exercise that the RQIA had done.

25 **Q.** Right. So if I understand you correctly, the desktop

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1 established, and I'm assuming you might want to talk
 2 about that at a later point. That was the repurposing
 3 of the RQIA staff.

4 And we also gave them links with the PHA who would
 5 have provided direct advice to them on infection
 6 prevention and control including isolation.

7 **Q.** Can I ask you to turn up, perhaps in your statement,
 8 paragraph 624 onwards, just sticking with the issue of
 9 isolation, because the RQIA did an assessment of care
 10 homes' ability to provide isolation facilities, and
 11 I think the result was that there was about 80 care
 12 homes that were available and able to isolate, and
 13 I don't want us to misunderstand the figures, and there
 14 were various ways that the RQIA worked it out, but if
 15 there's 480-odd care homes across Northern Ireland but
 16 only 80 of which could isolate, I want -- there's
 17 potentially quite a large disconnect there and a large
 18 number of homes that were physically unable to isolate
 19 notwithstanding the importance of it by the end of April
 20 when it was written into the guidance.

21 Do you know why that number is so low, and does it
 22 cause you any concern on behalf of the department,
 23 Mr Holland?

24 **A.** I think this exercise needs to be put into context.
 25 This wasn't the RQIA going out and inspecting homes and

26

1 exercise may in fact be an underestimate of the number
 2 of homes --

3 **A.** I would imagine it is.

4 **Q.** Right. Put that figure to one side, one can foresee
 5 that in a future pandemic the need for isolation may be
 6 particularly uppermost now in people's minds if there's
 7 delays to testing capacity and the like. Does the
 8 department know now or has it asked for there to be any
 9 work done to actually ascertain which care homes could
 10 isolate an individual in their own home with en suite
 11 facilities for 14 days, as was envisaged by the
 12 guidance?

13 **A.** I would have to note that I'm coming up on three years
 14 from having left the department --

15 **Q.** Yes.

16 **A.** -- so I can't really give an up-to-date position on the
 17 department. A few points I would make, and you may come
 18 on to data at a later point. I think that while we did
 19 hold information on social care at the point at the
 20 beginning of the pandemic, we very rapidly evolved a far
 21 more detailed level of data collection, both in terms of
 22 what we were getting information on, and the timeframe
 23 within which we were getting it. I think that's a point
 24 for future learning, that we should make sure we have
 25 that data, or better data available on the sector.

28

1 The second point is, I think, that isolation is
2 something that probably should be thought about in
3 a much more anticipatory way in terms of pre-pandemic
4 planning for a future pandemic and that then takes you
5 to looking at the actual configuration of care homes.

6 I think that building of care homes over the years
7 has always been subject to standards, but those may
8 benefit from being revisited to consider how the
9 infrastructure would support a positive response to
10 a future pandemic. And I mean, an example of this --
11 and it's a tension that's been there before -- would be
12 there's been a movement over the past 20, 30 years, to
13 try and make care homes as homely an environment as
14 possible, and sometimes that creates a tension with IPC
15 requirements. So I remember at the beginning of my
16 career, if I went into a facility, a home, like a care
17 home, they all would have had lino floors, and over the
18 years there's been a dynamic between trying to create
19 a more caring, homely environment, and one that's
20 suitable for IPC.

21 Now, isolation is probably one of the areas where
22 the two coincide because I think increase in
23 single-occupancy rooms is something that both sides of
24 that argument would have agreed to. But there are other
25 elements, like considering air flow and ventilation,

29

1 consideration as to how you would build and configure
2 something like that are different to the types of homes
3 that are receiving very frail, elderly people, whose
4 expectancy of residency is much shorter because they're
5 at a different life stage. And I think that you would
6 need to have very close engagement with the sector to
7 make sure that you had differentiated standards
8 reflecting the different needs and requirements.

9 But certainly for those people who, I think on the
10 back of the experience of this pandemic, we really know
11 will be particularly vulnerable, there are things about
12 building control regulations, and maybe even size of
13 facility, that are going to be relevant. I mean, size
14 of facility is probably one of the most significant --

15 Q. I'm going to come on to size. All right.

16 Can I just, finally, dealing with isolation, you,
17 say in your statement that:

18 "The 14-day isolation did have an impact on
19 discharge and patient flow; however, the Department does
20 not hold specific information regarding acute discharge
21 delays ..."

22 Can you just help us, are we there saying that
23 actually it did inhibit and delay the output of patients
24 by the need to isolate them for 14 days?

25 A. Yes, I'm sure it did because inevitably you will have

31

1 I don't think that that --

2 Q. Can I ask you about that?

3 A. Yes.

4 Q. You argue there quite strongly for more work to be done
5 and to think about this pre-pandemic. Is that something
6 that sits at the department's level? With the RQIA?
7 With the PHA? Who is it that would be responsible for
8 trying to ensure that some thought -- more thought had
9 been given to the need to isolate?

10 A. I think giving more thought to it probably rests across
11 a number of bodies. So the PHA would be the experts in
12 disease transmission and infection prevention and
13 control. The department would be the source of the
14 standards and regulations that would determine
15 eligibility for registration. So those two would need
16 to come together.

17 I also think that you need to engage the actual
18 sector in that discussion as well, and recognise that
19 "care homes" is a very generic term, and it's probably
20 not doing a service to the diversity of needs which are
21 met by care homes.

22 There are care homes which are homes for life for
23 people for a long period of time. There are places
24 where people with physical disabilities and learning
25 disabilities may live for decades, and I think that the

30

1 had occasions where people were medically fit for
2 discharge and sourcing a bed that could accommodate them
3 appropriately would take -- it wouldn't instantly be
4 available. I'd have to say that is not an uncommon
5 problem. I mean, that is one of the challenges in
6 normal times for discharge. You're relying on
7 a turnover and a churn in beds. So there's sometimes
8 a delay while you have to wait for the suitable
9 placement for the needs of an individual.

10 Q. Can I ask you about a different aspect of the discharge
11 policy and I think the position in relation to residents
12 with dementia. I think prior to the pandemic, residents
13 with dementia could only be placed in
14 a dementia-registered bed but that on 18 March in 2020,
15 the Health and Social Care Board confirmed they were
16 content, if necessary, dementia patients could be placed
17 in beds registered for other purposes. And there were
18 various conditions put on that, if a dementia patient
19 was going into a non-dementia-registered based.

20 A. Yes.

21 Q. Does the department know how many individuals with
22 dementia were affected by this decision and sent to
23 non-dementia-registered beds?

24 A. I don't have that information, but I would refer you to
25 the statements that have been submitted to the Inquiry

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1 from the trusts, who have indicated that this wasn't
 2 a facility that was significantly used. I could
 3 elaborate a little bit about this if it's helpful --
 4 **Q.** Well, I can help you to this extent: certainly we have
 5 a statement from the Belfast Health and Social Care
 6 Trust who said that that change in policy had a limited
 7 impact on discharges because it was dependent on the
 8 care home being agreeable to take --
 9 **A.** Yes.
 10 **Q.** -- the dementia patient and, indeed, it was met with
 11 resistance from the care home.
 12 **A.** Yes, and I think a similar point was made by the
 13 Southern Trust or the South Eastern Trust and the
 14 informal feedback I was receiving was that this wasn't
 15 having any impact on increasing supply because it was
 16 dependent on, and quite rightly, dependent on the care
 17 home agreeing. Because we were setting out conditions
 18 that had to be met if you were to do this, and if a care
 19 home was saying "Well, we can't meet these conditions",
 20 they were absolutely right to then refuse that
 21 discharge.
 22 **Q.** I think that change in the policy was not rescinded
 23 until 10 September 2021. Do you know why the policy was
 24 in place for such a long time, particularly if it wasn't
 25 in fact being really taken up?

33

1 paragraph 655.
 2 Now, the Herity report I think came out in
 3 November 2020, and the links or otherwise between
 4 discharges and outbreaks in care homes was one of the
 5 matters that Dr Herity, I think, looked at and we can
 6 see there that the study examined two specific weeks in
 7 2020, week 11, which started 8 March, and week 13, which
 8 started 22 March, where the number of people discharged
 9 to care homes after an unscheduled hospital admission
 10 was slightly higher than the typical week. 465 patients
 11 were discharged to care homes in those two weeks; five
 12 people tested positive within two weeks of discharge and
 13 460 did not. It did not support the hypothesis that
 14 this group of people was a substantial cause of Covid-19
 15 outbreaks in care homes.

16 Now, I think it's right that certainly there was no
 17 discharge in -- testing in week 11, but the first
 18 interim protocol on testing came out just before the
 19 week 13 testing. So clearly we need to bear in mind
 20 there was limited testing capacity at this time.

21 Do you know whether the department did any other
 22 work to try to establish whether there was a link
 23 between discharges and the seeding of infection in care
 24 homes once testing was up and running?

25 **A.** I'm not aware specifically of additional work that the

35

1 **A.** I think pressures on the system were an issue through
 2 that period which is why it wouldn't have been
 3 rescinded, although it wasn't having a significant
 4 impact. And when it was rescinded, I have to be frank
 5 about this, I think it was based about the fact that
 6 there had been a change in the -- well, rescinded is the
 7 wrong way of putting it and I think we used that
 8 language so I apologise for that --
 9 **Q.** You did. It's all right.
 10 **A.** -- but the RQIA, there had been a change in personnel at
 11 the RQIA and when we were seeking to renew this
 12 provision, they said, "Actually, we think that in terms
 13 of our standards, you don't have that flexibility."
 14 Previously they'd been happy to accommodate that
 15 flexibility, I think they were saying "Now we're not so
 16 sure we have that flexibility", so although we describe
 17 it as being rescinded, what we actually said was if we
 18 are going to do this you need to get a temporary
 19 variation in your registration from the RQIA, but
 20 I don't think that was ever sought then subsequently.
 21 **Q.** Right. Can I just stand back a little and ask you,
 22 please, about the Herity report that was conducted, and
 23 it might be easier if I call up on screen an actual
 24 paragraph in your statement, Mr Holland.

25 Could I have on screen INQ000613603_194, and

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1 department did. I mean, the decision to discharge
 2 people at a point before testing would have been
 3 informed by the existing advice from the PHA and other
 4 experts at the time, and that's not part of my
 5 professional competence.

6 **Q.** No.

7 **A.** This report -- I suppose it's a point I would make about
 8 a few different sources. A number of reports have
 9 looked at this.

10 **Q.** Yes.

11 **A.** I think there has been the Vivaldi Study, there's also
 12 been studies in Scotland and Wales, and they've all
 13 concluded more or less the same thing.

14 Now, I'm not a scientist and I'm not qualified to
 15 adjudicate the merits of each of those reports, but in
 16 a sense, these are all post hoc. They're useful in
 17 terms of contributing to our knowledge for how we might
 18 respond to a future pandemic. And actually, I think
 19 that's -- if I was to ask you to do something, I think
 20 one of the things that would be -- that we would invest
 21 a lot more in researching, understanding about the
 22 differences that occurred between countries and regions
 23 and services.

24 I mean, currently we know -- and, please, when I say
 25 this, this is not in any way to minimise the experience

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1 of people who died in care homes in Northern Ireland,
 2 and it's not to suggest anything positive about the
 3 system -- we know that you were least likely to die in
 4 a care home in Northern Ireland compared to England,
 5 Scotland and Wales. Compared to England by quite
 6 a margin. Many European countries did much better than
 7 Northern Ireland so it's not a point -- but one thing,
 8 I think, for future learning is we need to understand
 9 that better because, currently, we don't really know
 10 why. I mean, there are hypotheses about it, but we
 11 don't really understand that.

12 Was it just purely about community transmission
 13 levels being different in countries? Or was it that the
 14 infrastructure of the systems was different in
 15 countries? Or was it individual Covid-specific
 16 interventions had an impact?

17 And I think that's something that's really
 18 important.

19 And this falls into that -- it's after the fact.
 20 The point at which the people were being discharged, we
 21 didn't have this information.

22 Q. Just picking up on that point, then, you are not the
 23 first, and I dare say you may not be the last, witness
 24 to suggest there should be more work done in this area.
 25 Do you know whether any work is being undertaken in

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1 Clearly, I think the suggestion is that homes run by
 2 a larger provider had more outbreaks. That's how I read
 3 it. Am I right in that?

4 A. Yes.

5 Q. With 50% plus homes affected by Covid-19 outbreaks.

6 A "larger provider" -- can you give us an idea, what
 7 is a larger provider? 10 beds, 20 beds, 100 beds?

8 A. 50 beds I think is what was being used. I mean, this
 9 piece of work was as a result of a conversation I had
 10 with the then interim chief executive of the RQIA,
 11 Dermot Parsons. And, I mean, the -- at an early point,
 12 we were looking for any source of information that might
 13 be of assistance, and so I just contacted Dermot and
 14 said "Listen, maybe you're already doing this or maybe
 15 it's not valid" -- because I've no scientific
 16 expertise -- "but", I said, you know, "might there be
 17 benefit in looking at the intelligence that you hold on
 18 care homes and seeing if you can find any correlation
 19 with either outbreaks or how well or otherwise they cope
 20 with outbreaks?"

21 And so they did this piece of work.

22 It's not research standard. I mean, it was really
 23 that. And I think the RQIA produced a leaflet and they
 24 make the point, you know, correlation isn't the same
 25 thing and, I mean, you shouldn't use correlation purely

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1 Northern Ireland to understand how the infections get
 2 into the care homes, whether it's the community
 3 transmission. And if you don't know, who, in your
 4 opinion, would be the right body, organisation,
 5 department, to further that research?

6 A. I don't know, currently. I think that there are a range
 7 of bodies ranging from academic institutions through to
 8 government ALBs who have a role in commissioning,
 9 conducting and funding research.

10 I think at a governmental level you can set
 11 a priority, particularly with funding bodies, to direct
 12 future research. And I really think that this is an
 13 area that merits that focus, because there were quite
 14 significant differences, and we don't properly
 15 understand why.

16 Q. Well, perhaps can we have a look at some work that was
 17 done in relation to characteristics of a home that was
 18 affected by an outbreak.

19 And could I have up on screen, please,
 20 INQ000103683_7.

21 This is an RQIA document, Mr Holland, I think dated
 22 May 2020, and they looked at some of the care homes that
 23 had outbreaks and then came up with these six
 24 characteristics, but it might require a little bit of
 25 elucidation through you, if you're able to.

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1 as a way to target individual intervention.

2 But it was just a thought to say: well, you know,
 3 from what you know, can you link anything? Can you
 4 learn anything?

5 And so that's what they came up with.

6 Q. So if the home was run by a larger provider, then they
 7 were potentially more likely to have had an outbreak.

8 If the service had two manager changes. Is this,
 9 presumably, care homes again?

10 A. Yes, it was --

11 Q. So if the manager changed twice, they were more likely
 12 to have an outbreak. And does the department have any
 13 observations on why the managerial changes has maybe led
 14 to a link in increased outbreaks?

15 A. This would echo with some work I was aware of
 16 pre-pandemic. I think John Kennedy did some work for
 17 the residential care forum in England, which was
 18 looking -- and obviously he wasn't looking at Covid at
 19 that stage; he was looking at regulatory failure and
 20 trying to identify factors that were indicators of an
 21 increased likelihood of regulatory failure, and I think
 22 he pointed to frequent changes of manager.

23 I think the understanding is that leadership is
 24 very, very important, and that if you have frequent
 25 changes in leadership, (a) it's a discontinuity in

40

1 leadership, but it may also reflect good leaders not
 2 wanting to stay and work in a particular place.
 3 **Q.** And just briefly, then, characteristics 3, 4 5 and 6:
 4 larger homes with 40 plus registered beds were more --
 5 **A.** Sorry, I said 50 plus --
 6 **Q.** You did, it's all right, don't worry.
 7 40 plus were more likely to have in outbreak. We've
 8 heard other evidence that's -- I think from Scotland,
 9 where a similar finding was.
 10 "Less than 10 year[s] since [the] 1st Registration."
 11 What was the thinking as to why if they had not
 12 been -- sorry, if they'd been registered in the last
 13 10 years, they were more likely to have had an outbreak?
 14 Am I reading that the right way round?
 15 **A.** Yes, I think you are, and I never really understood why
 16 there would be a correlation there --
 17 **Q.** No.
 18 **A.** -- but that's what Dermot came up with.
 19 **Q.** All right. And are you able to help us with
 20 characteristic 5:
 21 "More than 10 requirements and recommendations ..."
 22 Is that that they were required to improve by
 23 the RQIA?
 24 **A.** Yes, that would reflect the level of previous regulatory
 25 direction they'd received. Now, it's important to say

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1 it's a logic that footfall of any description -- I mean,
 2 we'd already modified the RQIA inspection methodology to
 3 reduce footfall. So recognising that having large
 4 numbers of people going into a home who may work in
 5 other places, it was something that we recognised.
 6 So, from early on, we'd recommended minimising the
 7 use of bank and agency staff. I think we also gave,
 8 within the financial packages, the flexibility and
 9 suggested that care homes use some of the financial
 10 support that we were providing to block book agency
 11 staff, so that agency staff were being paid to go to
 12 them and they knew they could rely -- that they'd
 13 been -- would be paid to go to them rather than going to
 14 multiple providers.
 15 Post-Vivaldi, I think it was a case of really
 16 just -- it was a continued area of emphasis. So,
 17 subsequently, the PHA, at a later point after, it was
 18 after Vivaldi -- I think it was quite a bit after
 19 Vivaldi -- issued a leaflet which was specifically about
 20 highlighting the risks of bank and agency staff.
 21 But that was, I think, from the very beginning,
 22 something that we were emphasising in our guidance to
 23 care homes.
 24 **Q.** Yes, you're right, the March guidance said that homes
 25 should seek to limit turnover in staff they use and seek

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1 that doesn't mean that they necessarily have been
 2 subject to enforcement notices, but they may have been
 3 noted having areas of improvement. And I suppose that
 4 isn't surprising.
 5 **Q.** And characteristic 6:
 6 "High risk Local Government District ... defined as
 7 over 60% of Nursing Homes affected."
 8 Can you help?
 9 **A.** That's community transmission.
 10 **Q.** Right, thank you.
 11 So they're potentially some ways which might explain
 12 why there were outbreaks in some care homes and not
 13 others.
 14 You mentioned a moment ago Vivaldi, and we know that
 15 Vivaldi found that the use of bank staff in particular
 16 was a risk factor. And Vivaldi came out in July 2020,
 17 I believe. Do you know what was done to restrict staff
 18 movement or the use of bank or agency staff prior to
 19 Vivaldi? And then, again, what was done post-Vivaldi?
 20 **A.** I think we had identified the use of bank staff and
 21 agency staff at an early stage in the guidance that we
 22 issued that predated Vivaldi.
 23 **Q.** Yes.
 24 **A.** So we -- from very early on, we were saying that you
 25 should minimise staff movement, because we've -- I mean,

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1 to limit the number of staff moving between different
 2 homes. A relatively uncontroversial but high-level
 3 statement.
 4 But given that there was the workforce shortages
 5 that we discussed, how realistic was it, in the
 6 department's view, to have fewer staff available because
 7 of (a) you're going in without a strong workforce, (b)
 8 you've now got ill staff and or those who are isolating,
 9 and now you're telling care homes to restrict staff
 10 movement. One might be forgiven for thinking that those
 11 things don't sit very comfortably together. And so how
 12 was the care homes going to limit the number of staff if
 13 they didn't have enough staff in the first place?
 14 **A.** That's why we didn't issue a direction saying "Don't do
 15 it."
 16 **Q.** Right.
 17 **A.** What we did was say "You should strive to avoid doing
 18 this", and I think, as we went through, guidance became
 19 more granular and it was saying, you know: go through
 20 these steps before you look to engage agency or bank
 21 staff. So look at how you can manage your rotas, look
 22 at how you can cohort staff to particular units.
 23 But we recognised the tension that you're
 24 highlighting.
 25 **Q.** Yes.

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1 A. So I suppose the balance was that you have the potential
 2 risk materialising from bringing someone from one
 3 setting in to another setting, versus the immediate risk
 4 materialising of not being able to provide the care
 5 someone needs at that point in time and that's why it
 6 was about saying "Try very hard, make this your last
 7 resort", but we never said "You can't do it".

8 Q. Right. You've mentioned there a one-page document.
 9 Can I have up on screen, please, INQ000508442. This
 10 was the document which we think was published in
 11 January, according to your statement, although it may
 12 have been actually written in November 2020.

13 A. Over the weekend I've been trying to track down the
 14 exact date and I've come up with both of those dates and
 15 I can't stand over which one was the actual date it was
 16 published.

17 Q. Well, it's not going to stop me asking this question: if
 18 Vivaldi came out in July 2020, whether it's November or
 19 January 2021, certainly a number of Core Participants
 20 think that this guidance came out too late, given the
 21 importance of the Vivaldi findings from the summer of
 22 2020. Do you know why there wasn't guidance put out
 23 before either November 2020 or January 2021?

24 A. Well, there was guidance put out, but this is the PHA
 25 guidance. So I mean, in every iteration of our guidance

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1 A. The block booking, we specifically said that you can
 2 block book staff.

3 Q. One other matter in relation to limiting staff movement,
 4 was any thought given in Northern Ireland to bringing in
 5 legislation to mandate staff not being able to move
 6 between care home settings?

7 A. I don't recall it being an issue. I think before we got
 8 to the point where we might have thought about
 9 legislation, we were recognising this is a system that
 10 is fragile and, as with a number of things with the care
 11 home sectors, we thought encouragement, education,
 12 support, advice, was better than direction and
 13 legislation.

14 Q. And do you know if there's any thought being given to
 15 whether there should be legislation in the event of
 16 a future pandemic?

17 A. I don't have that information.

18 Q. All right. The -- you mentioned there perhaps
 19 potentially some cohorting of staff and I think trusts
 20 were asked in October 2020 to consider how to cohort
 21 staff to limit the risks of infections, and there was
 22 a meeting, I think you say in your statement at
 23 paragraph 369, that on 16 October, there was a meeting.
 24 "During that meeting it was confirmed that working
 25 in one care home was not always an option for agency

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1 we, I think, were emphasising the importance of
 2 minimising movement of staff, so there was guidance
 3 put out.

4 Q. Right.

5 A. I can't answer for the PHA as to why they put this out
 6 at that point in time.

7 Q. We can see there from the PHA document that:
 8 "Agency staff must not work in more than one setting
 9 on the same day.
 10 "Agency staff should choose to work in either
 11 a hospital setting or a community setting and not both."
 12 But do I understand it from you that this is not
 13 mandatory?

14 A. Well, there's no --

15 Q. Or there's no sanction if you don't do it --

16 A. No.

17 Q. -- may be a better way of putting it?

18 A. Yes.

19 Q. Right. And just more generally on the topic of limiting
 20 staff movement, did the department put in place any
 21 funds or measures to try to recompense staff who could
 22 only now work in one setting or now had to do limited
 23 hours? We're aware of the Infection Control Fund in
 24 England but was there any similar funding put in place
 25 in Northern Ireland that was ring-fenced for this?

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1 staff as they were trying to assist shortages throughout
 2 all homes and Trusts."

3 Did the department do anything to try to encourage
 4 cohorting, either by way of funding, additional guidance
 5 or anything of that nature?

6 A. I keep coming back to the block booking. That is a form
 7 of cohorting and so that's what we were doing. And then
 8 the advice that I've referred to previously. But
 9 nothing in addition to those things.

10 Q. And in relation to funding, I think financial support
 11 was provided in April 2020, June 2020 and October 2020.
 12 And there was various different funds then in '21 and
 13 into '22.

14 The department became aware of some instances where
 15 care home staff refused to take a Covid test. Can you
 16 help us about that, Mr Holland? Do you have any idea
 17 about the scale of that problem, the numbers, where this
 18 was happening, when it was happening?

19 A. I think we do have numbers on the uptake of vaccines by
 20 different occupational group and setting. I can't
 21 recall --

22 Q. Oh, that's vaccines, but I was talking about --
 23 (overspeaking) --

24 A. Testing?

25 Q. Yes.

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1 A. I don't think we've got the information on testing, I
2 don't think that was collected. Sorry, your original
3 question?
4 Q. That's all right, let me help you. You were aware of
5 the problem of some instances where care home staff were
6 refusing to take a test?
7 A. Yes.
8 Q. You've not been able to give us any detail about the
9 scale of that but I think the department understood that
10 part of the reason for refusing to take a test was
11 because staff would have to rely on Statutory Sick Pay.
12 Does that ring --
13 A. Oh yes, no, that's absolutely the case. We were --
14 I mean, it wasn't simply the issue of taking a test; it
15 was that people might turn up, even before, I think, the
16 testing would have been available, that they might turn
17 up for work when they were feeling unwell. So very
18 early on, we said that we would fund an increase of
19 people's salary from Statutory Sick Pay up to 60% of
20 their salary.
21 Q. Yes.
22 A. And that -- we just didn't want people -- testing
23 probably became relevant to that later but it was before
24 then, before the testing issue, it was just we didn't
25 want people who were symptomatic coming in to work

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1 started the seven-day shift.
2 Can you help with what was the rationale and the
3 thinking between exploring this model?
4 A. There were two sources of rationale, I suppose. One was
5 there were people talking about putting a ring of steel
6 or a protective ring around care homes, and they weren't
7 defining what that meant. And then I was also aware --
8 a lot of people were aware -- but there were reports in
9 the media where some homes where, on a voluntary basis,
10 staff had chosen to move in and they seemed to be doing
11 better at avoiding outbreaks. Particularly there was
12 a home, I think it was called White House or the White
13 House --
14 Q. It doesn't matter but --
15 A. -- in Devon.
16 Q. Anyway --
17 A. -- I mention it because --
18 Q. Thank you --
19 A. -- we were able to look at that as being a starting
20 point. And so we just thought: well, would this work?
21 And so we did some work to develop a proposal. We did
22 a very quick high-level outline about how you might do
23 this, having staff living in, enhanced testing, and what
24 have you. We circulated it and got the views of Chief
25 Medical Officer, Chief Nursing Officer. I'm not sure if

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1 because they were worried about losing their pay.
2 Q. And so the department put in place some measures,
3 I think, to fund independent sector employees up to 80%
4 of the salary --
5 A. Yes.
6 Q. -- including those on zero hours.
7 A. Yes.
8 Q. So there was some financial recompense --
9 A. Yes.
10 Q. -- if the staff member had to stay at home.
11 A. And that was also, I think, extended to staff who were
12 shielding and I think to staff who might have been
13 pregnant, because there was early advice, I think, about
14 members of the workforce who were pregnant being kept
15 away from face-to-face practice, I think.
16 Q. Right. Can I turn to IPC as one of the other measures
17 and ways in which to try and keep residents and, indeed,
18 people living in domiciliary care safe. And I think --
19 I know that the guidance was primarily led by Public
20 Health Agency. Understood. But one of the things that
21 the department did explore was what was called the Safe
22 at Home model and can I ask you about that, please.
23 I think the department explored the possibility of
24 staff living in care homes for seven days on, seven days
25 off, with an isolation period of 48 hours before they

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1 the Chief Scientific Officer was there at that stage,
2 but we circulated it round. And I think the view back
3 was it was worth a look at. So we then moved into
4 trying to develop it in a more practical basis.
5 Conversations were opened up with Four Seasons, as
6 was, Carol Cousins would have been the regional
7 director. We had a very good relationship with Carol,
8 we would have consulted with her a lot.
9 Q. I think, though, that in due course, notwithstanding the
10 conversations that were going on with Four Seasons to
11 potentially pilot the Safe at Home model, there was
12 concerns raised by the unions about the supply of and
13 guidance on PPE, particularly whether staff might feel
14 compelled to live in --
15 A. Yes.
16 Q. -- and the unions were not supportive of the Safe at
17 Home model?
18 A. No. We got to the stage with Four Seasons of
19 identifying two potential pilot sites. Then they
20 received communication from the trade unions and the RCN
21 where those points that you've just referenced were
22 raised. There was a meeting held with the unions. The
23 department tried to address their concerns. They were
24 concerned, I think, about recompense, they were
25 concerned about being pressured, as you say. And we

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1 made it absolutely clear: no, this would be an entirely
 2 voluntary scheme; no one would lose out financially if
 3 they chose not to participate. We went through testing
 4 and PPE and tried to address their concerns.
 5 But subsequent to that meeting, Four Seasons came
 6 back to us and said: the unions still are not convinced,
 7 we can't proceed with that.
 8 **Q.** All right. And I think in due course you and the Chief
 9 Nursing Officer issued a letter inviting expressions of
 10 interest wider than Four Seasons but received no
 11 positive response?
 12 **A.** Yes. Well, basically we just went out to the sector and
 13 said: listen, if anyone is interested, we will work with
 14 you to try to implement this model.
 15 **Q.** Yes.
 16 **A.** And no one came forward.
 17 **Q.** No.
 18 **A.** I'd have to say, looking back, it was not something that
 19 we ever could have ramped up to scale.
 20 **Q.** No.
 21 **A.** But it was --
 22 **Q.** Presumably because there wouldn't be enough staff who
 23 would want to sleep in for seven days on --
 24 **A.** A whole range of factors. I mean, you know, the layout
 25 of care homes where -- you know, I mean, it just
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1 most acute in March into April 2020 but thereafter,
 2 thankfully, access to PPE supplies generally began to
 3 resolve?
 4 **A.** Yes, I think that's a fair comment.
 5 **Q.** I just want to ask you about one example, please.
 6 Can I have up on screen, please, INQ000397065.
 7 At the time -- this is an email from 18 March, and
 8 just to help you, IPC guidance for domiciliary care was
 9 issued the day before, the 17th, and it said that the
 10 trusts should help support independent providers if the
 11 independent provider could not get PPE from their usual
 12 sources.
 13 So that's where we were at and that was the guidance
 14 that came from the department, and here is an email from
 15 the chief exec of the IHCP to the department, that says:
 16 "... I have been taking calls this evening from
 17 a distressed domiciliary care provider who has had no
 18 support from the Trust -- they have a client presenting
 19 with coronavirus symptoms and have been told by the
 20 Trust they must provide the care even without the
 21 required PPE and that no test will be carried out to
 22 determine if it is [in fact] coronavirus -- this is
 23 wholly unacceptable! They have doubled up on their
 24 normal protective equipment and provided the care rather
 25 than leave the client with nothing -- the risks
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1 wouldn't have been some -- but we did think it might
 2 have been worth to run a pilot just to see if there were
 3 elements of it that could have been transferred to the
 4 wider sector.
 5 **Q.** Do I take it then that -- do you know if there is any
 6 future plan to try to do a pilot like this, perhaps in
 7 peacetime, or to see if there's any merit in the Safe at
 8 Home model being rolled out if needed in future?
 9 **A.** I'm not aware of any plans in relation to that.
 10 **MS CAREY:** My Lady, I'm moving on to a slightly different
 11 topic. Would that be a convenient moment for
 12 a mid-morning break?
 13 **LADY HALLETT:** Certainly. I shall return -- I'm going to go
 14 by the Internet time rather than by the clocks. I shall
 15 return at quarter past.
 16 **MS CAREY:** Thank you.
 17 (11.57 am)
 18 (A short break)
 19 (12.15 pm)
 20 **LADY HALLETT:** Ms Carey.
 21 **MS CAREY:** Thank you, my Lady.
 22 Mr Holland, can I ask you, please, about PPE. And
 23 when looking at all the documents and reading your
 24 statement, would you agree with this general
 25 proposition, that the problems with access to PPE were
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1 associated with this are totally negligent."
 2 Then Ms Shepherd goes on to say -- she was asking
 3 for a number of questions: she would like a 24/7
 4 response as "Coronavirus does not work on an office
 5 hours basis", and clearly she has been taking a number
 6 of calls, she says, "for 10 days now with the
 7 communication not aligned through Trusts ..."
 8 And you can sense her frustration at being told
 9 things that are not been delivered.
 10 "In the time of doing this email I have taken 2 more
 11 calls from Care Home providers -- Southern Trust --
 12 having been advised that there is no PPE for care
 13 homes."
 14 It's not a council of perfection, Mr Holland, I hope
 15 we can acknowledge that sensibly, but here you have, the
 16 day before, guidance going out to domiciliary care
 17 sector saying the trusts will help support independent
 18 providers and 24 hours later clearly still issues with
 19 providers getting the support they needed.
 20 Do you have any sense of the scale of the problem --
 21 here we are in mid-March -- where domiciliary care
 22 providers were not being supported by the trusts? And
 23 if so, what did the department do about it?
 24 **A.** The first thing I'd say -- I obviously can't comment in
 25 any detail about an individual example that's been
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1 presented.

2 **Q.** No.

3 **A.** The first thing I would say is that I think it was
4 actually from 12 March we first said that trusts needed
5 to support the independent sector with PPE. And in
6 addition to the guidance statements, I phoned each trust
7 executive and made it very clear that there should be no
8 organisational boundary in terms of the use of PPE
9 between trusts and the independent sector. And
10 I remember someone saying "Are you saying we have to
11 share our PPE?" And I said "It's not your PPE, this is
12 a resource for Northern Ireland."

13 So that was the advice. And that message was
14 repeated several times.

15 Now, I think, inevitably -- this was new.
16 Previously, independent providers were responsible for
17 sourcing their own PPE. So you're introducing a new
18 logistics arrangement. So it wasn't going to be smooth,
19 from the get-go. And, I mean, I know -- I have
20 a relative who was working as a care assistant in
21 a care home and she told me of, you know, a car pulling
22 up outside the care home, ringing the bell, and then
23 throwing a box of PPE to the door. And it wasn't
24 a smooth, you know, "We need, you know, 100 gowns and
25 30 masks", or whatever. You know, they got a box from

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1 "Well, trusts aren't giving us what we need", or
2 whatever. I think I mentioned before we took the break,
3 we did ask the IHCP "Tell us who's having trouble and
4 we'll pursue this."

5 Now, I'm not saying that the list they gave us,
6 those weren't people who didn't have trouble, but when
7 she gave us the list and we started contacting them,
8 they'd say "No, we're getting supplies now. It's
9 working."

10 **Q.** Okay.

11 **A.** I think one other thing I'd mention, because I think
12 it's referenced in one of the statements I've seen from
13 the IHCP, was that she referenced "We couldn't get FFP3
14 masks anywhere", and there wasn't any guidance --

15 **Q.** No.

16 **A.** -- that would have required them to have used --

17 **Q.** We understand.

18 **A.** Now, I am not saying the guidance was right or wrong,
19 but we were only supplying to the guidance. And,
20 I mean, people were scared and they were very, very
21 anxious, so I understand that, but the fact that they
22 couldn't source FFP3 masks isn't an indication that the
23 arrangements weren't working.

24 **Q.** Right. Let me pause you there, because the Chief
25 Medical Officer in his witness statement suggests three

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1 the trust. But it did rapidly improve.

2 **Q.** And what did the department do to try to aid its
3 improvement?

4 **A.** We reinforced the messaging. We also clarified things
5 like the single point of contact in trusts. I mean,
6 I know Pauline was looking for a point of contact in the
7 department 24/7. We weren't suppliers of PPE. We
8 didn't hold stocks. So the place for them to have
9 a point of contact was within trusts.

10 **Q.** Yes.

11 **A.** And that was the way the supply chain worked. We
12 instructed trusts to modify their ordering through
13 BSO PaLS to include the care home needs that would be
14 presented to them. So it was BSO PaLS to trusts, to
15 care homes. That was the chain.

16 So, I mean, a single point of contact for -- in the
17 department would have added an extra link in that chain.

18 And --

19 **Q.** Although I think -- sorry, go on.

20 **A.** And the other thing I would say is that -- I mean, the
21 IHCP had the direct phone number of me, my director, and
22 actually the minister. You know, she was able to and
23 did directly phone the minister.

24 What we did, as well, was we -- in the early days,
25 we were getting reports that were saying, you know,

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1 things that might assist with PPE supply. He
2 says: greater resilience of supply lines, including
3 scale-up for local manufacture.

4 What, if anything, has the department done to
5 increase the resilience and maybe even do some work in
6 relation to local manufacture?

7 **A.** I'm afraid I couldn't answer that.

8 **Q.** He also suggested there should be a greater supply of
9 stock to be held by health and social care trusts.

10 Do you know, as at the time certainly when you left
11 the department, was there a greater stock being held and
12 was there any plan in place for the amount of stock that
13 should be held? How long it should be held for?

14 **A.** I know that the -- I think it's called the PIPP, the
15 pre -- the pandemic influenza planning whatever, did
16 allow for a strategic supply of stock, and at one point
17 I know that -- I think the minister announced that he'd
18 released 30% of that --

19 **Q.** Yes.

20 **A.** -- pending more ordering.

21 I don't know and nor would I have been involved in
22 those discussions. It wouldn't have been part of my
23 responsibility. But just specifically on stock, I do
24 know, quite quickly, because there was anxiety in the
25 care homes. They were getting PPE but they were anxious

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1 they were going to run out. And I could understand that
2 because at the early stages of us telling the trusts to
3 supply them, it was a challenge in terms of supply and
4 there were a lot of fears about supply.

5 So they wouldn't have been being over-supplied, but
6 at a fairly early opportunity the minister directed that
7 a buffer stock, a two weeks' buffer stock, should be
8 issued to care homes, and that happened.

9 **Q.** Yeah, I think that came out sometime in mid to late
10 April of 2020?

11 **A.** Yeah, I mean, that was -- take it -- I mean, I'm sure
12 you remember the stories of planes arriving from China
13 and stuff being useless and all the rest of it. A lot
14 of anxiety in the early days. But by -- we were getting
15 into April, the position hadn't eased but there was more
16 confidence, and so a buffer stock could be released, and
17 so care homes were -- well, trusts were instructed to
18 give care homes two weeks.

19 **Q.** Can I ask you about one other aspect of the department's
20 work which is the Department of Health's PPE mailbox
21 which was set up, I think, in late March when the Chief
22 Nursing Officer and the Top Management Group, as I think
23 it was then called, became aware of reports of concerns
24 about lack of PPE and the mailbox was set up not as an
25 advisory service but to forward the queries to the most

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1 they would have been providing advice in relation to
2 queries about PPE.

3 In addition, there was the point of contact within
4 trusts and the PHA were also providing support to the
5 independent sector on PPE.

6 So the helpline was, kind of, like, just to be sure
7 to be sure to be sure, make sure that we've as many
8 arrangements in place as possible that could address
9 the --

10 **Q.** You've just mentioned there the SST that was set up,
11 services support team, and I'm going to deal with that
12 topic mainly with the Chief Medical Officer, Mr Holland,
13 but just from the department's perspective do you think
14 there's a role in the future for the services support
15 team in the event of a future pandemic?

16 **A.** I'd have to say I think it was -- and again, I'm
17 cautious about saying things worked well, because --
18 well, anyway. I think it was a positive experience.
19 The service support team became operational very
20 quickly, it provided ongoing support from qualified and
21 experienced people who knew that -- these were people
22 who would have inspected and regulated this sector and
23 they were all health and social care professionals.
24 Social workers, nurses, physiotherapists, and that was
25 a source of advice directly to providers.

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1 other appropriate, either person, sector, department,
2 organisation, to respond to them?

3 And it only received 95 queries as at the end of
4 December 2020 across health and social care. Do you
5 know, Mr Holland, why, on any view, that seems to be
6 quite a low number of queries into the department's PPE
7 mailbox?

8 **A.** I would hope that it was a reflection on the fact that
9 the other arrangements that were in place were working
10 well. So we had reconfigured or repurposed the RQIA to
11 provide service support teams.

12 **Q.** Yes.

13 **A.** And they were providing advice and support to care
14 homes. And I think it's important, because I think most
15 of the countries did something around repurposing
16 regulators to provide an advice service, but there are
17 differences. I mean, in England, for example, the CQC
18 had the policy for years of having, I think they call
19 them generalist inspectors and specialist inspectors,
20 and the generalist inspectors weren't health and social
21 care professionals. The RQIA was never like that. All
22 of its regulatory staff were either social workers,
23 doctors, nurses, physiotherapists, what have you.

24 So the service support team providing that service
25 were people who could give a high quality of advice and

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1 And it was -- I was pleased to see, I think in the
2 UK Homecare Association's evidence, they noted the
3 experience of the service support team positively in
4 contrast to other arrangements in other countries ... so
5 yes, I do think it's something -- I mean, in terms of
6 planning for a future pandemic there has to be a degree
7 of realism. You can't have a mirror system sitting for
8 decades waiting potentially to be used. You know, but
9 you can have plans in place to how you can quickly work
10 up supports, and I think something like the service
11 support team should be incorporated into future planning
12 arrangements.

13 **Q.** New topic, please, and visiting, and in particular I'd
14 like to ask you some questions about the Care Partner
15 scheme. But just to put it in some context, the
16 guidance for care homes on 17 March 2020 did not impose
17 a blanket ban but we are aware that, I think, certainly
18 about 82% of care homes were restricting visits prior to
19 that date anyway.

20 Come forward to September 2020, and I think there
21 was a move for one face-to-face visit per week by one
22 person, and there was the Care Partner scheme. I just
23 want to be clear, was the care partner in addition to
24 the one-to-one face visit?

25 **A.** The Care Partner scheme was intended to be something

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1 quite different from the regular visiting arrangements,
 2 and we were getting a lot of correspondence and we also
 3 would have had engagement with people. As restrictions
 4 were lifted for wider society, there was growing
 5 frustration, absolutely understandable frustration, from
 6 families, although it wasn't always straightforward,
 7 there were families who didn't want visitors coming in,
 8 but there were a growing number of people who did want
 9 to visit, and I can't remember exactly the genesis of it
 10 but the proposal for care partners was slightly
 11 different to increasing regular visiting in that it was
 12 recognising -- and I would have had experience of this
 13 from my own family with relatives in care homes, that
 14 sometimes you'll have a member of your family who plays
 15 a particular role, and actually, the idea was you
 16 could -- you'd be able to treat that person more like
 17 a member of staff, because I mean, I can think back to
 18 relatives who were in care homes pre-pandemic, and I can
 19 think of a relative of mine, and another relative, and
 20 the relative would have gone in and fed them every day,
 21 would have done sort of some physio with them and stuff
 22 like that.

23 So the Care Partner scheme was trying to say that
 24 where you have needs that pre-pandemic were being met in
 25 that way, can we start to bring that back in and treat

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1 were important, they were an organisation who
 2 represented the business interests of care homes,
 3 whereas we had a lot of relationships directly with care
 4 homes where, if you were looking to discuss practice and
 5 develop practice, if we went through the IHCP they would
 6 simply have had to have gone to their members to get
 7 feedback whereas we would have just gone directly, and
 8 we had very good relationships with certain providers.

9 **Q.** Let's just look at the definition of a care partner,
 10 please, and have up on screen INQ000256450_30.

11 This is taken, Mr Holland, from the actual
 12 23 September guidance. It says there at paragraph 4.1:

13 "Care partners are more than visitors. [They] will
 14 have previously played a role in supporting and
 15 attending to their relative's physical and mental
 16 health, and/or provided specific support and assistance
 17 to ensure that communication or other health and social
 18 care needs are met due to a pre-existing condition.
 19 Without this input, a resident is likely to experience
 20 significant and/or continued distress."

21 It's a fairly broad definition there, if I may say,
 22 but how was it actually going to help the care homes
 23 decide who was or was not a care partner?

24 **A.** I don't know the detail of the discussions as they
 25 developed, but I don't think that would be necessarily

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1 the person as if they were a member of staff? Because
 2 it wouldn't have been a significant additional risk if
 3 you put the right arrangements around it. If you're
 4 letting staff in, why not let a designated person in who
 5 actually would be a support to the care home because
 6 they would be undertaking some of the burden that the
 7 staff would normally have to meet.

8 **Q.** Let me just pause you there, because we're going to look
 9 at a little bit of the guidance in a moment, but the
 10 guidance came out on 23 September and it was to be
 11 implemented by 5 November to give care homes time to
 12 make the arrangements, identify the care partner, and
 13 the like. But prior to 23 September had there been any
 14 engagement with the sector about the practicalities
 15 surrounding the Care Partner scheme? Or did that come
 16 after the guidance had come out, but before it was due
 17 to be implemented?

18 **A.** My understanding, and this work was led by the Chief
 19 Nursing Officer's group, was both. There was
 20 engagement. I know that the IHCP said that they hadn't
 21 been engaged --

22 **Q.** Yes.

23 **A.** -- prior to the announcement but there had been
 24 engagement with people in the sector and I suppose that
 25 reflects the fact that while conversations with the IHCP

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1 that difficult, because as I said, this was building on
 2 arrangements normally that had been in place prior to
 3 the pandemic. Before the pandemic, we didn't call them
 4 care partners, but it wasn't uncommon for there to be
 5 visitors who played a much more active role in the care
 6 of someone in a care home beyond a wider range of
 7 visitors.

8 **Q.** Let me put it another way, then. From the perspective
 9 of the loved one or the relative, how did they prove to
 10 the care home that they were a care partner and not just
 11 someone who was coming in once a week to see their loved
 12 one?

13 **A.** I think that the notion that they would just be coming
 14 in once a week, well ... people want to provide care for
 15 people they love. I don't -- I wasn't aware of
 16 a challenge with people putting themselves forward
 17 unsuitably for the role, and I'm not sure I understand
 18 why anyone would unsuitably put themselves forward for
 19 that role.

20 **Q.** The care home guidance -- sorry, the guidance that came
 21 out on 23 September said nothing at all about testing
 22 arrangements for care partners. Do you know why the
 23 guidance didn't say either they're not going to bring in
 24 testing or they're going to bring in it in due course
 25 when there's more capacity? Why is the guidance totally

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1 silent on whether care partners should or should not be
 2 tested before coming into the care home?
 3 **A.** I have to be honest, the detail of this was dealt with
 4 by the Chief Nursing Officer. I think that the
 5 initial -- there was some preparatory work before the
 6 September announcement. I mean, these weren't just
 7 ideas that came out of the blue, but they were announced
 8 in a draft state, it was acknowledged there was going to
 9 be ongoing work to refine and develop them as
 10 implementation moved forward.
 11 **Q.** Okay. And as I understand it, it was not underpinned by
 12 legislation, the Care Partner regime, but the
 13 expectation was that it would be followed.
 14 **A.** Yes.
 15 **Q.** And Minister Swann states that it should be put on
 16 a statutory footing. Do you know what the department's
 17 view is on whether care partners should be made subject
 18 to statutory legislation?
 19 **A.** I wouldn't have current awareness of what the
 20 department's position on it is, so this is a slightly
 21 speculative answer but I'd offer a few views.
 22 I think both the RQIA standards and the fact that
 23 these are contracted services provide some levers that
 24 can be used to shape the nature of a service, and that
 25 could include care partners.

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1 Can I have up on screen, please, INQ000256455_3.
 2 This is a letter co-written by you and the Chief
 3 Nursing Officer, and we can see at the top of the page
 4 there that you've annexed a copy of the guidance that
 5 had gone out. You said:
 6 "Since that time we have been engaging with ...
 7 stakeholders, including representatives of families and
 8 of care homes, [IHP], Trust staff, including those
 9 providing support to care homes [et cetera], to listen
 10 to concerns regarding the implementation of the care
 11 partner and to provide a supplementary description
 12 around the concept."
 13 What was the supplementary description that you
 14 provided?
 15 **A.** I think it was just more information and more
 16 granularity as to how it would work. But I'm not --
 17 I can't recollect exactly. I mean, we were trying -- we
 18 were getting a lot of feedback from families about
 19 visiting in general and the care partner concept. Once
 20 people became aware of it, they were very interested and
 21 wanted to engage in that. And myself and the Chief
 22 Nursing Officer held a few virtual meetings with
 23 relatives, and they were very emotional and fraught
 24 meetings for very obvious reasons, but they were very
 25 keen on relaxing and increasing access to visiting

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1 I think that there has been a reluctance on the part
 2 of trusts to use the contract with a care home to
 3 influence practice, and I think that's been a failing.
 4 And if that was something that were more developed,
 5 I don't know if you would need to think about
 6 a statutory footing for care partners.
 7 I mean, I was struck very much in talking to trusts
 8 that I couldn't find any instance where there had been
 9 deficits in service provided by a provider. And I'm not
 10 talking about minor deficits, I'm talking about where
 11 there had been significant problems that had resulted in
 12 a withholding of a payment for a service.
 13 Now, that always struck me as strange, because -- in
 14 most areas of life if you pay for something and you
 15 don't get what you pay for, you know, sort of
 16 withholding future payments is an accepted practice.
 17 But there seemed to be a very strong reluctance. Maybe
 18 if that was explored.
 19 Although, if you take care partners as being part of
 20 an expression of Article 8 rights, then maybe it is
 21 appropriate for it to go on a statutory footing.
 22 I mean ...
 23 **Q.** Can I just move on a few weeks in time to 12 November,
 24 and, in theory, this Care Partner guidance should have
 25 been implemented by the week before.

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1 generally and the Care Partner scheme.
 2 On the other hand, we had care homes who,
 3 understandably, were nervous, because of their
 4 experiences earlier on in the pandemic, and particularly
 5 if they hadn't experienced it themselves, they will have
 6 seen other homes where there had been a significant
 7 number of deaths. So I think they were scared.
 8 And, you know, in other contexts we've given
 9 a message out about absolutely minimising the number of
 10 people going into a care home, as a preventative
 11 measure, and now we're trying to relax that arrangement
 12 specifically in relation to visiting and the care
 13 partner.
 14 **Q.** Should we take it, though, that if there was need for
 15 a supplementary description and work, perhaps that the
 16 original guidance wasn't as helpful as it might
 17 otherwise have been had there been that stakeholder
 18 engagement? Do you think that's a fair criticism
 19 Mr Holland?
 20 **A.** No, I don't. I think that it was always recognised --
 21 I mean, this occurred with some other issues where
 22 people -- I mean, I can think -- going back all the way
 23 to the March 17th guidance, where the IHCP were critical
 24 of the fact that we'd issued guidance without what they
 25 would have considered full consultation. Full

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consultation normally for a department could stretch anything from 6 to 12 weeks, involve very extensive engagement with a range of stakeholders.

I think there were points where it would have been negligent to have withheld what was available at a point in time to wait for full consultation. I think in the case of the Care Partner scheme, we wanted to give hope to relatives as early as we could to say: look, we're looking at your concerns, we've got some plans, you know, that we are bringing forward. This is what they look like.

But those plans weren't fully developed, and I think that's okay. And then you then work through the issues with providers as you go.

Q. I think in due course there was clearly always that tension between reducing footfall, particularly in the autumn of 2020 as numbers began to rise into that winter?

A. Yes.

Q. And here you are, potentially -- I think it was two -- potentially two people could be named as care partners, plus the face-to-face visitor, so you've got three people potentially going into a care home without the professionals that are going in, without the staff going in.

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As more time went by, if you had people who wanted to be care partners and there was still resistance from a care home, we started -- and I think it might have been referenced in the letter you had up a few moments ago -- reference to if you're receiving funding, you know, we'll need to consider whether, if you're not complying -- and we also, I think, referenced the fact that compliance with visiting guidance and -- I can't remember if it was also the Care Partner -- certainly with the visiting guidance -- might be considered by the regulator when inspecting against the relevant standards about maintaining contact with families.

So it was, as far as possible, a softly, softly encouragement, sort of, nurturing approach but there was a little bit of an edge as you went on.

As to the answer to the second part of your question, it was always recognised that not all families and maybe not all care homes would require a Care Partner scheme. The profile of people living in some care homes is very, very different. You know, we have homes and supported living arrangements and non-nursing homes, for example, where people are there on a respite basis, so it's short-term, and indeed, normally that's to give a break from the people who are primary carers so you wouldn't have them there. You

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Was any thought being given to increasing the amount of testing available to the care partners? We know it came in over the Christmas period, where there was one test a week for one visitor over, I think, about a three or four-week span, but do you know why that wasn't done back in November when the Care Partner scheme should have been implemented?

A. I'm assuming, and it is an assumption because I wasn't involved in the detail of the discussion, that as testing capacity became available, it was used for extensively. But that's an assumption on my part.

Q. And just finally on this topic, you say in your statement that by mid-December, 182 care homes had implemented the scheme, and by September 2021, 289 had, which rather begs the question what about the other 200-odd care homes that hadn't implemented the scheme? What, if anything, did the department do to find out why they hadn't and maybe to encourage compliance with the scheme?

A. There were steps taken to encourage compliance with the scheme from it being first announced in the September on a continuous basis. I think that the steps that were taken to encourage compliance started in a very supportive way. It was about trying to explain, reassure, provide more information, answer questions.

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also have mental health facilities which would have a different -- I mean, while I'm not saying visiting and relationships aren't important, you wouldn't have the need for support and assistance with direct personal care tasks. So there could be a lot of reasons as to why you would never reach the full 482 number.

Q. Understood. Right.

Can I just ask you one other topic on visiting, please. Certainly the department's position was that necessary healthcare visits should always continue throughout the pandemic, and I think you have seen reference in the Care Homes 10,000 Voices report from September 2020 where 58% of respondents said that their healthcare professionals did meet their needs but 22% stated healthcare professionals met their needs some of the time and 20% said they were never met. So 42-ish% are either not met at all or only met some of the time?

Was the department aware that there were problems with getting healthcare professionals to pay the necessary visits into care homes and if so, what did the department do about it?

A. That would have been a relationship between the trusts and the care homes. The trusts were contractors with the care homes. They were employees of the staff who needed to get access to care homes. We would have been

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1 aware, because trust would have flagged up that there
2 were sometimes issues about getting access. We may have
3 intervened directly in cases although I don't recall it.
4 I think that it was a case of the trusts working with
5 the care homes to ensure that there was access.

6 What we did do was probably increase the capacity to
7 provide in-reach support to care homes to meet
8 healthcare needs. So there would have been, in trusts,
9 acute care at home services, a hospital at
10 home services, enhanced care in the community services.
11 Different names, all of which related to the drive over
12 the previous decade, probably, of trying to shift
13 services that traditionally were provided in hospital
14 into the community. The Chief Nursing Officer's group
15 and the Chief Medical Officer's group had worked
16 basically directing to say there should be a focus from
17 these services during this pandemic on where we know
18 there are concentrations of people with high
19 vulnerability, so they would have been increasing the
20 amount of service of that nature going into care homes,
21 and I think, again, the statements you have from trusts
22 reference the role of trust staff going in to deliver
23 those kinds of services.

24 **Q.** New topic, please. And just briefly some observations
25 from you, please, Mr Holland on data.

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1 survey. There was a survey week in relation to
2 domiciliary care where we took all the information that
3 was available about who was receiving domiciliary care,
4 what for, how many packages, who were providing. And
5 that was the survey week. And that provided
6 information. But it was an annual survey. That's not
7 the same as live-time data.

8 We also had market information from the analysis
9 provided by commercial consultancies, and that's
10 a source I know NHS England also use. There's --
11 I mean, I can think of two consultancies, I think it's
12 Knight Frank or Frank Knight, I can't remember which,
13 and LaingBuisson, who were noted providers of market
14 information. So they'll tell you how many providers
15 there are, profitability, how many business failures
16 there have been, types of bed. But again, it's not
17 real-time information.

18 **Q.** Can I just pause you there?

19 **A.** Yes.

20 **Q.** I think you said in your statement there was, at your
21 behest, a design of a template for there was one single
22 return being made. I just want to have a look at it.

23 It's INQ000560995.

24 Because clearly there were demands being placed on
25 care providers and domiciliary care agencies to provide

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1 In your statement, you say that prior to the
2 pandemic, the Department did not collect data on care
3 homes. You make reference -- it's at your
4 paragraphs 831 and 832, you said:

5 "... NHS England were recording some social care
6 data in respect of care homes ..."

7 Including number of beds registered; number of beds
8 that were available, vacant beds, the percentage of
9 residents tested for Covid, and the like.

10 And we know that data collection improved over the
11 course of the pandemic. But didn't Northern Ireland
12 have none of that data as at January or February of
13 2020? And if not, do you know who did?

14 **A.** Sorry, I'm just looking for --

15 **Q.** 831 onwards in your witness statement.

16 **A.** Yeah. It's maybe a definitional thing but I apologise
17 if the statement is misleading by saying we didn't have
18 data. We had information about the sector but the type
19 of information and the time frames within which it were
20 supplied were not what we needed in the pandemic. And
21 you could make a case and a criticism to say we needed
22 it before the pandemic and I wouldn't argue with that
23 criticism. But we did have information.

24 So we had a lot of market information but not in
25 real time. So the market information, we did an annual

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1 data to lots of people, PHA, RQIA, trusts and
2 potentially the department, and I think your plan was to
3 have it all in one place.

4 And is this a mock-up of the template that you
5 devised or that was devised?

6 **A.** It was -- well, firstly, I can't take credit for this
7 solely. I think there were a number of people who would
8 have been expressing the view: can we streamline this?

9 **Q.** Yes.

10 **A.** And the idea was, as you say, to try to ease the burden
11 on care homes, because a lot of people were asking them
12 for information. And so we did two things. One, we
13 made -- I mean, we made a lot of financial provision to
14 care homes. We guaranteed their income at one stage,
15 very early in the pandemic, when -- I mean, I know a lot
16 of the talk has been about the sector being flooded, we
17 were concerned about vacancies, so we guaranteed income.

18 But we also at a point said we recognised there are
19 administrative burdens associated with data, so we paid
20 a management premium to help people be able to make the
21 returns. But the other thing was trying to simplify the
22 process.

23 **Q.** Yes.

24 **A.** And this was our attempt. And I think we were nearly
25 successful entirely, but not entirely, in that the PHA

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1 wanted to retain some of their own data collection. But
2 everyone else accepted the single point.

3 And in defence of the PHA, I'm not sure but I think
4 that might have been in relation to statutory duties,
5 because Covid is a registered disease.

6 Q. Understood.

7 A. But we wanted to simplify it, so -- and it did change.
8 I think the big leap was being able to move to it being
9 submitted by app.

10 Q. Yes.

11 A. So we got to the point where your returns could be made
12 by an app. There were some additions made to it over
13 time as to information that was being sought, but the
14 idea was that we would start getting real-time data, not
15 the sort of data that you get from a survey once
16 a year --

17 Q. No, I understand that --

18 A. -- but you will get a daily return, I think before 10.15
19 in the morning or 10.30.

20 Q. I think you said in your statement, though, it was
21 supposed to be mandatory but not everyone completed the
22 form due to either staff absence or they were off caring
23 for sick residents and the like.

24 Do you know if there's any position now where data
25 returns like this are mandatory and, indeed, monitored

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1 available, how many were occupied, you might know
2 something about them. You would maybe know about what
3 the staffing pressures were.

4 Now, certainly going into the pandemic we had
5 nothing like that.

6 Q. No.

7 A. Now, partly -- it's the private sector, there were, you
8 know, 482 homes, 300 domiciliary care providers. You
9 know, we're not talking about a single unified system.
10 This had been outsourced, in effect, and that made it
11 complex. But certainly in the pandemic, it became
12 really important that we knew, day-to-day, how the
13 system was doing. And we didn't know that before and
14 I don't know what the current position is.

15 Q. There's other people, I suspect, I can ask about that.

16 Just finally from me, please, Mr Holland, I'm not
17 going to ask you about the RLIs and all of the other
18 work done by the department, but there is one aspect of
19 Minister Swann's evidence that I'd like the department's
20 views on. He recommended a central registry of unpaid
21 carers to be maintained either centrally by the
22 department or at trust level, he wasn't sure which might
23 be more practical, but what's the department's view on
24 is that necessary, and if so, how would it help in the
25 event of a future pandemic?

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1 for non-compliance?

2 A. I don't know what the current position is. I think we
3 did get up to 99% return at one stage, but that was very
4 late on, and there was a law of diminishing returns
5 where, you know, you got big gains, big gains, large
6 gains, less gains, and there's a sort of small bit at
7 the end. And we got to 99%.

8 I don't know what the current position is, but
9 I think, again, it's one of the lessons for the system
10 about the care sector. I would say one of the biggest
11 failings pre-pandemic, and I would like to say it's not
12 a failing now, but quite often the health sector views
13 the care sector as being something that's there to
14 support its effective functioning. And that's wrong.

15 Certainly, without a -- if you have a dysfunctional
16 care sector, it's going to add to burdens on the health
17 sector and potentially collapse, theoretically, the
18 health sector, but it should be seen as something that
19 is important in its own right. People live there. Many
20 people spend their last days there. So it shouldn't
21 just be viewed in terms of how it supports discharge or
22 whatever. It needs to be something in its own right.

23 Now, in the healthcare sector, on any given morning
24 in the department, with a few phone calls, I suspect
25 that you could find out how many ICU beds were

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1 A. I can't give you a current answer to whether the
2 department feels it is necessary or not, but what
3 I would say is that it is challenging to have
4 a statutory register, but there were deficits in the
5 fact that we didn't have a comprehensive register. We
6 were able to identify people who were in receipt of
7 a service but not all unpaid carers are. We were able
8 to identify people who were in receipt of direct
9 payments, but not all unpaid carers are. And we were
10 also able to identify people who were in receipt of
11 independent living fund payments and thalidomide grant
12 payments.

13 But that's a much smaller number than people who
14 are -- who were carers and not necessarily in receipt of
15 a service, but who you might want to communicate with or
16 you might want to reach out to at a time like this.

17 Q. Yes.

18 A. So I can see where Robin is coming from and I can
19 understand why he's asking it.

20 Now, I don't think you could force carers to put
21 their names on a register they don't want -- when they
22 don't want to. But I suspect that it is an area where,
23 with focus, we could improve our knowledge and ability
24 to communicate with the sector. I mean --

25 Q. Can I ask you this, then, because clearly you're no

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1 longer in the department, but would it have helped you
 2 in your role as Chief Social Worker had there been such
 3 an unpaid carers register during the pandemic?
 4 **A.** There are some things it would have helped with but
 5 I wouldn't overstate it.
 6 **Q.** Okay.
 7 **A.** So resources and services were already significantly
 8 under pressure and we were already thresholding
 9 services. So simply having the identification of unpaid
 10 carers wouldn't necessarily have added to us being able
 11 to provide them with lots of services. We wouldn't have
 12 been able to. But it would have meant we would have had
 13 a channel of communication with them and that would have
 14 meant things ranging from providing them with --
 15 directly, when we published advice, but directly
 16 providing them, maybe through an email link or whatever,
 17 advice on shielding, isolation, maintaining your own
 18 wellbeing, access to other supports. I mean, one
 19 example -- I mean, and I know that you're aware of
 20 this -- we made available a carer's recognition card.
 21 **Q.** Yes.
 22 **A.** So people could access protected shopping time. If the
 23 police stopped them during lockdown, they could say, you
 24 know, they could produce this card and the police would
 25 accept it. Now, I don't think we were very strict on

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1 questions.
 2 **LADY HALLETT:** There are.
 3 Thank you, Ms Carey.
 4 Ms Campbell, who is just over there.
 5 **Questions from MS CAMPBELL KC**
 6 **MS CAMPBELL:** Thank you, my Lady.
 7 Mr Holland, you may know I represent the Northern
 8 Ireland Covid Bereaved Families for Justice, and we have
 9 questions across three topics, revisiting in fact some
 10 of the evidence that you leave already given this
 11 morning with the assistance of Ms Carey.
 12 I want to focus, please, first on a correspondence
 13 that came to you and the Chief Nursing Officer from the
 14 IHCP on 16 November 2020.
 15 I won't put it on screen, but you'll immediately
 16 notice it's just a number of days after the letter that
 17 we've looked at recently from you and the Chief Nursing
 18 Officer in relation to Care Partner guidance, and the
 19 implementation of Care Partner guidance.
 20 And the IHCP write are you that they had provided
 21 constructive feedback at the end of October 2020 on the
 22 documents issued regarding the care partner role and has
 23 offered to engage fully on, and I emphasise, shaping the
 24 concept of that care partner role, and they observe that
 25 they have yet received no response or feedback to their

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1 issuing those, to be honest. I think more or less
 2 anyone who asked for one got one, but it still, at its
 3 height, reached 42,000. The estimate is there are
 4 220,000 people.
 5 Another area, I think, would have been advice on
 6 IPC, infection prevention and control.
 7 **Q.** Quite.
 8 **A.** Now, we did promote that advice very strongly. There
 9 was a web-based -- the one, I mentioned earlier,
 10 provided by NISCC which was deemed suitable for family
 11 carers to use to improve their practice in relation to
 12 infection prevention and control, but you're sticking
 13 things out through social media and we did put a leaflet
 14 drop to everyone, but that's not the same as maybe
 15 people knowing there was a portal they could go to for
 16 updated advice, where you could directly email them if
 17 you wanted to with information.
 18 So yeah, there would be benefits but I wouldn't
 19 overstate them.
 20 **Q.** Understood.
 21 **A.** It wouldn't lead to loads of new services being
 22 available.
 23 **MS CAREY:** Understood. Thank you very much.
 24 Mr Holland, that's all the questions I have for you.
 25 My Lady, I think there are some Core Participant

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1 questions and, instead, there appears to be a delay in
 2 meeting to discuss the matter or to develop
 3 a supplementary description of the care partner role,
 4 with a shift from the Department of Health to the Public
 5 Health Agency to take the lead.
 6 So we're 16 November 2020 and this is from the IHCP.
 7 And you have observed in your evidence that, of
 8 course, the IHCP represent the business interests of the
 9 independent care sector, and that's correct, but it's
 10 the business interests of some 50% of the independent
 11 care sector, and well in excess of 200 care homes, both
 12 nursing and residential; you'll acknowledge that, is
 13 that right?
 14 **A.** Mm-hm.
 15 **Q.** And I'm afraid I'll have to ask for a --
 16 **A.** Yes.
 17 **Q.** Thank you. It's just for the purposes of the
 18 transcript.
 19 And you'll also recognise that behind those figures
 20 are many hundreds of residents and many thousands of
 21 family members being impacted by potential failures to
 22 implement Care Partner guidance.
 23 **A.** Yes.
 24 **Q.** You understand that?
 25 **A.** Yes.

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1 Q. And the question, really, on behalf of the Northern
2 Ireland Covid Bereaved is this: here we are on
3 16 November 2020, almost two months after the guidance
4 was issued, why is it that the representatives of 50% of
5 the independent care sector appear to believe that the
6 care partner role was, as yet, a concept and one that
7 could be shaped or given a supplementary description?

8 A. Again, I have to caveat this by saying that the lead
9 role in developing this work was done by the Chief
10 Nursing Officer in our group. But I do know that both
11 prior to the announcement in September, and certainly on
12 an ongoing basis from September, there was ongoing
13 engagement with actual providers in developing the
14 concept.

15 I mean, the IHCP is one person and maybe some
16 administrative staff, and the one person is not someone
17 who has experience of running care services. And that
18 doesn't mean they're not an important voice and on some
19 instances they are absolutely the right voice, but if
20 you're looking to engage -- and we found this around
21 a number of areas -- if we were looking to engage on
22 a practice issue that -- sometimes if you went to the
23 IHCP, you were adding a layer into the chain that caused
24 delay, because they in themselves were not experts in
25 this. So they were going to members and then coming

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1 A. I recognise that there was a tension between encouraging
2 and supporting, and providing advice and information to
3 care homes to enable them to be confident enough to
4 engage with the Care Partner scheme, and reluctance on
5 the part of some providers which, as time went on,
6 became less reasonable, given the understandable fears
7 that were there.

8 I think I indicated earlier that we had a graduated
9 approach in that as we rolled out and there was still
10 some resistance, from a diminishing number of providers,
11 we started to reference that we would use regulatory
12 standards and potentially contracting to encourage more
13 firmly participation.

14 Whether we got that balance right or not, I can't
15 judge, but I do know that it was a risk if we were to
16 alienate people, and our preferred choice was try,
17 I mean, mainly carrot, a little bit of stick, but mainly
18 carrot. If that was a misjudgment, it was one, but
19 I don't know if it was.

20 Q. Well, you in your evidence, with the assistance of
21 Ms Carey, talked about an approach of a softly, softly
22 nurturing approach --

23 A. Yeah.

24 Q. -- in the first instance. But ultimately you had to
25 address this impasse in part at a business level because

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1 back to you.

2 We had a lot of links with a number of
3 organisations, both in the IHCP and not in the IHCP.
4 And those contacts would have been used particularly
5 around some practical issues. So it would have been
6 more appropriate for the nursing team to engage directly
7 with care homes than with a representative organisation
8 which in itself was not -- and had limited capacity.
9 I mean, at one stage I'm fairly certain to say the IHCP
10 approached us for funding to increase their capacity
11 because they said they had limited capacity to engage
12 with us. And that was something we considered and we
13 didn't provide funding to them at that point. But we
14 would have engaged directly with providers.

15 Q. You see, because there are concerns, and there remain
16 concerns on the part of the bereaved, many of whom you
17 know either engaged with the development of the guidance
18 or were desperate to see it implemented at this point in
19 November 2020, that the department was insufficiently
20 clear or robust with the sector, and that might well
21 include the sector representatives, as to the
22 expectations that had existed since, we know,
23 23 September 2020, that every effort should be made to
24 implement the guidance. Do you recognise the legitimacy
25 of those concerns?

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1 in your statement you indicate that on 16 December 2020,
2 recognising the concerns felt by many care homes about
3 visiting and Care Partner arrangements, the department
4 announced further support, and I think that included
5 financial support to be available to all care home
6 providers in Northern Ireland to facilitate visiting, in
7 line with the guidance, particularly over the festive
8 season.

9 Now, you talked about getting the balance right.
10 Really, if we might focus on how quickly measures were
11 taken at this particularly stressful time for families.
12 Why did it take until 16 December, bearing in mind the
13 23 September announcement of the Care Partner guidance
14 in particular, to announce a package that might be
15 capable of achieving some resolution?

16 A. I'm fairly certain financial assistance to support
17 visiting predated that by quite a significant time.

18 Q. Well, we can look at that through your evidence and the
19 evidence of others.

20 Moving on, then, to reporting of Covid outbreaks.
21 And it's a fairly discrete question. You've been asked
22 a number of questions in relation to domiciliary care
23 because we know how many people in Northern Ireland rely
24 on it and how many families value it. In your
25 statement, you indicate that there are over 21,000

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1 individuals in Northern Ireland in receipt of
2 domiciliary care, of which nearly 9,000 required six or
3 more visits and ten or more contact hours per week. So
4 that's a lot of people going in and out of people's
5 homes on a very regular basis, and yet we know that
6 there's no statutory requirement for domiciliary care
7 agencies to report Covid outbreaks to the RQIA or,
8 indeed, anywhere else, and no legislative or regulatory
9 amendments were made at any point to impose such a duty.

10 Do you accept the concerns of the bereaved that
11 relying on domiciliary care agencies to self-report --
12 and we know it came through a voluntary app --
13 particularly when those individuals and agencies were
14 operating under significant time and financial
15 constraints, and you've told us some of that this
16 morning? Do you accept that that was neither an
17 adequate nor a robust mechanism to ensure proper
18 monitoring and oversight of Covid outbreaks in
19 domiciliary care?

20 **A.** I'm not absolutely sure, but the -- I mean, the
21 emergency legislation made Covid a notifiable disease.

22 **Q.** Yes.

23 **A.** And I'm not sure the extent of which, I mean, that
24 wouldn't have discriminated against -- I mean, it was
25 a notifiable disease. The app was separate to that and

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1 tested every four weeks. And again to revisit some of
2 the concerns that the IHCP raised with you, when they
3 brought the views of care homes about the practical
4 impact of that decision, which they again complained was
5 made without consultation with them. I don't expect you
6 to remember the specific examples, Mr Holland, but
7 I imagine you'll remember some of the sentiment.

8 One care home provider wrote:

9 [As read] "I'd be keen to hear other providers'
10 thoughts on the Department passing over complete
11 responsibility for administering, ordering, testing,
12 data collection, regular Covid-19 testing for staff and
13 residents to the care providers. I'm also keen to hear
14 opinions about the timescale from implementation of
15 3 August. My opinion [writes the author] is
16 unprintable."

17 And within the same correspondence there were
18 further, similar concerns being raised.

19 Is this is an example of the Department again
20 failing to sufficiently engage with the sector when, in
21 August 2020, it made significant changes to the testing
22 regime?

23 **A.** No, I don't believe it is. And indeed, the statement
24 that you've just quoted doesn't reflect the reality of
25 the situation. There was significant support being

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1 that's probably why the PHA didn't -- wanted to maintain
2 the separate reporting on Covid from the app. I don't
3 think that the app was intended to be the main route by
4 which public health surveillance would be notified
5 through for outbreaks of Covid.

6 **Q.** Particularly in relation to domiciliary care, is --

7 **A.** No -- (overspeaking) -- I'm just saying I don't think
8 that would be the case. I mean, there are public health
9 requirements about notifying a notifiable disease. The
10 app wasn't replacing those. The app was about us
11 collecting information about circumstances. I mean,
12 I stand to be corrected on this, it's not an area of
13 expertise, but I don't think that you can conflate the
14 request for returns through an app with statutory
15 requirements in relation to a notifiable disease and
16 it's not an area of my expertise.

17 **Q.** That's fair and, in fact, we've already touched on it
18 through the RQIA, as well, so I should perhaps leave it
19 at that.

20 Finally, testing in care homes, and particularly
21 focusing on the period from August 2020. You indicate
22 at paragraph 505 of your statement that a regular
23 programme of PCR testing commenced on 3 August, so
24 almost five years ago, 2020, with asymptomatic staff to
25 be tested every two weeks and residents were to be

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1 provided in relation to testing, both direct support and
2 financial support to facilitate testing. And it was
3 a very, very significant level of support.

4 Now, I understand that peoples' individual
5 experience at a time of pressure, when they're scared,
6 when things are very difficult, can lead them to
7 represent things in a certain way, but that statement
8 wouldn't be an accurate description of the situation.

9 **MS CAMPBELL:** Thank you. Those are all my questions.

10 **LADY HALLETT:** Thank you very much indeed, Ms Campbell.

11 That completes the questions that we have for you,
12 Mr Holland. I do understand how distressing it can be
13 to have to relive those very difficult times. So thank
14 you very much for the help that you've given to the
15 Inquiry. I don't know how many people were involved in
16 preparing your statement, but thank you to everybody who
17 helped with that and thank you for coming here today.

18 **THE WITNESS:** Thank you very much, my Lady.

19 **LADY HALLETT:** Thank you.

20 Very well, I shall return at 2.15.

21 **(1.13 pm)**

22 **(The Short Adjournment)**

23 **(2.16 pm)**

24 **LADY HALLETT:** Yes, Ms Shotunde.

25 **MS SHOTUNDE:** My Lady, please may I call Nicola Dickie.

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MS NICOLA DICKIE (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Good afternoon.

MS SHOTUNDE: Please provide us with your full name.

A. Nicola Dickie.

Q. Thank you for coming back to provide evidence for this Inquiry. And thank you for your witness statement dated 14 April 2025.

If I can just start with your role during the pandemic, you were the health and social care chief officer for the Convention of Scottish Local Authorities from February 2020 until September 2021; is that correct?

A. That's correct.

Q. And I'm going to refer to the convention as COSLA throughout.

A. (Witness nodded).

Q. What was your responsibility in that role?

A. So I delivered policy as it related to health and social care, so that included adult social care, mental health policy, National Care Home Contract, all of the stuff as it related to health and social care for the organisation on behalf of our 32 member councils.

Q. And in October 2021 you became Director of People Policy in COSLA. What was your responsibility in respect of

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Q. What was the role of COSLA in the context of the adult social care sector during the pandemic?

A. So during the pandemic we provided leadership from our sector. As an organisation we fed into national discussions. We provided political representation at all of the various meetings that were set up to guide us through the period of the pandemic. We were also responsible for agreeing and delivering the sustainability payments for the adult social care sector.

Q. In terms of the adult social care sector in Scotland, it's my understanding that local authorities have statutory responsibility to provide adult social care services, and local authorities and NHS boards are integrated or work together in order to achieve that; is that correct?

A. That's correct.

Q. How is this done? Through what organisations?

A. So local authorities will agree what services they wish to delegate to their IJB, which then governs those services. So all of the local authorities in Scotland have delegated in some way their adult social care, so we've got 31 health and social care partnerships. The services are delegated and therefore it's up to the health and social care partnerships to agree and plan

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the adult social care sector in that role?

A. So the chief officer role that, I had someone else took on that role and then they reported to me as a director alongside chief officer who was dealing with children and young people, and COSLA's strategic migration partnership which is asylum and migration.

LADY HALLETT: I'm terribly sorry to interrupt, can you slow down.

THE WITNESS: Yes.

LADY HALLETT: Otherwise, I'm going to have a stenographer --

THE WITNESS: I will try my very best.

LADY HALLETT: -- complaining. Thank you.

MS SHOTUNDE: What is your role currently?

A. I'm the Director of People Policy now.

Q. Thank you. I'm going to ask you some brief questions about COSLA. My understanding is that it's a councillor-led cross-party organisation with all 32 unitary authorities as members; is that correct?

A. That's correct.

Q. It also has a Health and Social Care Board which leads on all aspects of policy development and political lobbying in relation to health and adult social care for COSLA; is that right?

A. Correct.

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for the types of services that should be provided.

That includes health services but it also, importantly, includes adult social care services, and in some instances children's services and justice.

Q. And you mentioned IJB. Could you just tell us the full --

A. So, integrated joint boards are the governance mechanisms, so that's the decision-making body, and the health and social care partnership is, if you like, the delivery arm. So that's where you've got your paid officials who will take forward the work.

Q. And were there any advantages or disadvantages to this model during the pandemic?

A. So I think the advantages were that we were already used to working in partnership to deliver services at a local level across Scotland.

It meant that there was a degree of integration already there in kind of peacetime, if you were, and many of our services and service users were used to getting services from both health services and social care services as we went into the pandemic.

Q. So in Scotland would you say that, for example, the NHS, the health side, had a good understanding of the adult social care sector because of these integrated models?

A. I think the NHS had a good understanding of community

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1 services as they are provided in Scotland. I think the
 2 acute services that set outwith our community provision
 3 were perhaps not as integrated as they could have been
 4 just by nature of the very fact that they're taking
 5 place inside hospitals as opposed to community provision
 6 that's provided across communities in Scotland.

7 **Q.** I'm going to ask you some questions about the
 8 pre-pandemic capacity of the adult social care sector.
 9 And if I could pull up INQ000147362, page 5.
 10 Now, this is the adult social care winter
 11 preparedness plan which was dated 6 November 2020, but
 12 it kind of gives an overview of the adult social care
 13 sector in Scotland.
 14 "Around 245,000 ... people receive social care and
 15 support in Scotland.
 16 "Around 60,000 people in Scotland are receiving home
 17 care at any one point.
 18 "The majority (77%) of people requiring social care
 19 services or support are aged 65 or over.
 20 "People residing in a care home tend to be older,
 21 with around 90% of residents aged 65 and over, and
 22 1 in 2 aged 85 plus."
 23 However it acknowledges that not everybody receiving
 24 adult social care is older, there are younger adults as
 25 well.

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1 You'd stated in your witness statement at
 2 paragraph 2.25 that:
 3 "Issues relating to the sustainability of the care
 4 sector in Scotland, specifically in relation to
 5 capacity, were largely as a result of funding and
 6 workforce issues that COSLA has raised consistently with
 7 the Scottish Government."
 8 How did these capacity-funding workforce issues
 9 affect preparedness of the social care sector in
 10 Scotland when the Covid-19 pandemic hit?

11 **A.** The capacity issues meant that, already, most areas of
 12 Scotland were only providing support through adult
 13 social care to those with high or severe support needs.
 14 Those on low to medium support needs were probably not
 15 featuring in terms of access to support.

16 **Q.** And in terms of pre-pandemic planning, who or which
 17 organisation was responsible for pre-pandemic planning?

18 **A.** So health and social care partnerships were responsible
 19 for the day-to-day planning. If we got into a situation
 20 where we needed to step into a resilience situation,
 21 then local authorities and health boards would step in
 22 as category 1 responders at that point. But the
 23 day-to-day planning and therefore annual winter planning
 24 was the auspices of the health and social care
 25 partnerships.

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1 And if you go down -- thank you -- and have a look
 2 at the numbers employed. As at December 2019 there were
 3 206,400 people employed in the social service sector.
 4 There is a COSLA survey that was undertaken for this
 5 Inquiry, and in it, some of the local authorities
 6 answered the questions on preparedness.
 7 And if I can pull that up, please, it's
 8 INQ000587789, slide 6. Sorry, slide 5.
 9 As you can see, on preparedness, of the 29 local
 10 authorities which responded to this question, 52% said
 11 that the preparedness of the sector was not very good,
 12 and 3% said not good at all. So that's a total of 55%.
 13 And capacity of the care sector, 41% said not very
 14 good. Ability to increase capacity, 55% said not very
 15 good.
 16 However, when it comes to the resilience of the care
 17 sector, 72% of the local authorities that answered said
 18 it was very good or fairly good.
 19 And if we can turn to slide 6, of the 14 local
 20 authorities that reported that capacity or resilience
 21 were not good, many of the reasons why are listed there.
 22 All 14 mentioned workforce recruitment difficulties,
 23 rising demand for adult social care services, funding
 24 pressures, et cetera, going down in a sliding scale in
 25 terms of the numbers.

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1 **Q.** And were there any requirements for care providers
 2 themselves to have plans in respect of emergencies?

3 **A.** So there would be contractual obligations on recipients
 4 of the care home contract so there would be expectations
 5 in terms of, you know, access to PPE should there be an
 6 infection or an outbreak, et cetera. So there were that
 7 type of expectation on individual care homes to make
 8 sure that they had access to that. And then they would
 9 all be feeding up in to the overall planning that was
 10 being done through the -- through the local area plans.

11 **Q.** And then to zoom out and look at it on a more macro
 12 level, in terms of the Scottish Government's, et cetera,
 13 more national planning, I understand that there was the
 14 Scottish Government Resilience Room, and under it the
 15 national incident management group and the National
 16 Contingency Planning Group, which, in your statement,
 17 you state:
 18 "Both groups were established prior to the relevant
 19 period and were constituted in such a way as to ensure
 20 that there was a coordinated public sector response to
 21 emergency or critical incident situations in Scotland."
 22 Were either of those organisations responsible for
 23 pre-pandemic planning on a national level for the adult
 24 social care sector?

25 **A.** So the SCOR arrangements are normally stood up in

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response to an emergency. So they're not standing arrangements that sit all of the time, so if we'd perhaps had a cluster of outbreaks of some infection we might have been in a situation where SCOR would have been stood up. The National Contingency Planning Group is group that COSLA would bring together in normal times, if, for example, we had a large care home that was faced with closure and a lot of residents that we needed to move out, or a string of care homes across Scotland that were needing coordinated arrangements to make sure that residents were being moved into alternative provision, so the National Contingency Planning Group was one that we would bring together as and when required. So whilst it was a standing group, it didn't meet all of the time.

We started off with the National Contingency Planning Group but as the scale, and it was clear just how much of a difference Covid-19 was going to make, that was where we transitioned from almost kind of one issue, National Contingency Planning Group, or one site, into the arrangements that we had that took us through the period of the pandemic.

Q. Is there any national pre-pandemic planning sort of organisation that exists now or before the pandemic that COSLA was involved in?

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future pandemics?

A. I think, given the differences in areas across Scotland, you do need to start local. I think there are a number of things that it would be useful to almost have sitting to the side that you would consider as things that could be taken over nationally very quickly in the event of a pandemic, and I'm sure we're going to come on and talk about PPE and provider sustainability payments, you know, who is classified as a key worker, for example. These are things that a local level it would be very difficult during a pandemic or in the run-up to a pandemic, for an individual local level to do.

So I think the local planning and the pushing it up the way is right, but it feels to me that we need a suite of things that we can kind of regularly go back and review in terms of that, nationally.

Q. Thank you.

I'm going to ask you some questions now about your liaison with the Scottish Government and other stakeholders during the pandemic. We briefly touched upon the National Contingency Planning Group a moment ago. There were some other groups or subgroups that COSLA was involved in, one of which was the Workforce Issues Group, which I understand was constituted in May 2020; is that correct?

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A. So what we do have is each of the health and social care partnerships will provide an annual plan where they will plan for peaks and troughs throughout the year, given that winter is always a particularly pressurised time in the health and social care partnerships. Those plans are written at a local level, and then they are fed into colleagues in government, and colleagues in government will check those plans and make sure that they after sitting in and against any national planning that they have done for the NHS or the social care system. So I suppose it's a kind of averaging up, if you like, in terms of the 31 plans come in, colleagues in government will look at them, and then they'll provide feedback to a particular area to say, "That doesn't look strong enough in terms of planning", or "Can we support you with that?" That type of thing.

So I don't know that it's pandemic planning in that respect, in terms of its -- it's the day-to-day way in which we deliver services in Scotland.

Q. Do you think, let's say there was a future pandemic that is coming into the fore in the horizon, do you think the current set-up for pre-pandemic planning which sounds like it's more on a local level and then fed up nationally, do you think that is an adequate way for Scotland to prepare the adult social care sector for

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A. Yes.

Q. What was the purpose of the group?

A. So that group's purpose was an area where we could consider workforce issues as they applied to the local government workforce, so not specific to just adult social care. So it was everyone who worked for local government, and that was across, as you can imagine, you know, waste operatives, teachers, adult social care. So that was where we discussed all of the workforce issues as they were arranging -- arising from the local government workforce. Obviously there are some staff in Scotland who provide adult social care that are employed by local government, but we had the separate forums where we were having conversations about the adult social care workforce that didn't work in local government.

There were times when some of the issues were the same and there were times when some of the issues were very different. For example, access to sick pay between local government, adult social care staff, and those who don't work in local government.

Q. Okay. So the Workforce Issues Group, as you just said, was in respect of people who were employed by the local government.

A. Right.

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- 1 Q. So would that group have dealt with adult social care
2 staff that were not directly employed by the local
3 government, but were employed by private providers?
4 A. No. That stuff would have come up with the pandemic
5 response, because that's where we had representatives
6 from the third and independent sectors.
7 Q. So that's the Pandemic Response in Adult Social Care
8 Group which was set up in September 2020; is that right?
9 A. Yes, and it was a follow-on to some of the work that was
10 being done through the Care Home Rapid Action Group and
11 the regular meetings that we had stood up.
12 Q. So was it that group, that Pandemic Response in Adult
13 Social Care Group that just started to deal with the
14 specific issues that members of staff in the adult
15 social care sector were facing?
16 A. So I think that the Pandemic Response in Adult Social
17 Care was when it became formally constituted. There
18 were regular meetings before that. They were titled
19 "gold" sometimes, they were "silver" commands other
20 times, but there was regular dialogue and I think you
21 can see that with some of the exhibits that we've
22 provided. There was regular dialogue with those
23 providing adult social care.
24 Q. Prior to September 2020?
25 A. Yes.

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- 1 social care elements to make sure that what was there
2 worked for the infection prevention and control measures
3 that were required, but also that didn't turn care homes
4 into hospitals.
5 Q. So you mentioned time needed to understand that care
6 homes weren't like hospitals and therefore IPC measures
7 needed to be different for them. Do you have any
8 examples of the differences and why IPC measures needed
9 to be different for care homes?
10 A. So I suppose we've referenced one example in the
11 statement around about Christmas decorations, and, do
12 you know, recognising that these are people's homes and
13 the concept of saying to someone they can't put up
14 a Christmas decoration is probably not going to land
15 that well.
16 I think another example is, do you know, in many
17 cases, residents in care homes are free to move around
18 the care home. So when you were starting to say, do you
19 know, infection prevention measures mean you've got to
20 be confined to the one area, we had to make sure -- I
21 suppose it's different in a hospital because to an
22 extent doctors and nurses and other professionals are
23 controlling the flow of movements but in modern care
24 homes, people don't necessarily have their movements
25 restricted.

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- 1 Q. Okay. And you mentioned the Care Home Rapid Action
2 Group, that was established in April 2020 to address the
3 urgent needs and challenges faced by care homes during
4 the pandemic; is that right?
5 A. Yes.
6 Q. How effective was that group, in your view?
7 A. So I think the group was effective in that it looked at
8 issues of infection prevention and control. I think
9 that the fact that the group was set up around about
10 infection and prevention control meant that we were
11 bringing, if you like, the existing doctorate that had
12 come from how things worked in our hospitals and I think
13 we took a while to get our heads around about the fact
14 that care homes are not hospitals, they're not -- the
15 physical location is not like a hospital and, indeed,
16 the way they are actually used by people who are living
17 in care homes.
18 So we were relying very much on the infection
19 prevention control specialists to bring that type of
20 expertise but we were working hard from a COSLA
21 perspective to make sure we were bringing in the
22 expertise of our chief social work officers, of our own
23 health and social care chief officers who were used to
24 providing services in these areas. So we were trying
25 to, kind of, match up the health elements with the

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- 1 So there was a lot of time having to be spent to
2 make sure that what was coming through in the guidance,
3 that absolutely, the infection prevention control
4 guidance was there but it needed to come with a degree
5 of additional explanation because people were going to
6 have to explain to residents and their families why, do
7 you know, a relative, potentially, was going to be kept
8 in their own room when they had been used to moving out,
9 for example, do you know, into communal day rooms where
10 they could sit and be with other residents.
11 Q. Before I move on from this point, you've mentioned
12 staff, you've also mentioned care homes in respect of
13 groups that were set up. What about domiciliary care?
14 A. So both Scottish Care and CCPS, who we were engaging
15 with, represented those who were providing home care,
16 not just care homes, although they mixed across the two
17 organisations, and we also had our own workforce who
18 were providing domiciliary care. So there was still the
19 same ability to have that conversation with those
20 representing the workforce that were providing
21 domiciliary care.
22 Q. Was that happening early in the pandemic or do you think
23 it took some time before?
24 A. So I think it was happening early in the pandemic to an
25 extent. I think the issues that we were starting to see

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1 in care homes meant that there was a lot of focus went
2 on to that. But I can remember conversations early in
3 the pandemic about what was the guidance for domiciliary
4 staff when they were, as we were talking about donning
5 and doffing their PPE and how did you do that, do you
6 know, potentially in a rural location in the dark and in
7 the wet?

8 So there were certainly conversations going on at
9 that point, again, to make sure that people could be
10 clear what was the guidance that they were being asked
11 to follow, and importantly, how could they implement
12 that?

13 **Q.** I'm going to move on to discuss isolation. When it
14 comes to hospital discharge, I will leave those
15 questions for Core Participants once I've finished, but
16 I do have a question in respect of designated settings
17 in England and Wales -- sorry, in England, and also the
18 step-down facilities in Wales.

19 In England the UK Government created designated
20 settings which were specific care homes that had
21 isolation facilities to house Covid-19-positive people,
22 and in Wales they implemented a step-down and step-up
23 policy where people who were Covid-19 positive, still
24 displaying symptoms, and/or still within the 14-day
25 isolation facility would be transferred to an NHS

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1 visit, would have been miles. But I would need to
2 understand exactly how they worked in England to give
3 a more definitive answer on that, but the geography
4 would certainly have been a consideration, I suspect,
5 for us.

6 **Q.** Speaking of visiting, I'm not going to ask you
7 any questions about visiting restrictions, because,
8 again, I'm going to leave that to the other Core
9 Participants, but I am going to ask you a question about
10 Anne's Law.

11 At paragraph 3.9 of your witness statement you
12 mention the "distress and upset caused by restrictions
13 placed on care home visiting". You also state that
14 the -- then:

15 "The Care Reform (Scotland) Bill [had] been
16 introduced [in] Scottish Parliament. ... [which]
17 introduces 'Anne's Law' which would give visitation
18 rights in the event of another such [pandemic]. [And
19 that] COSLA fully supports [that] legislation."

20 To help the UK Covid Inquiry understand Anne's Law,
21 could you please inform us what stage the piece of
22 proposed legislation is at in Scotland?

23 **A.** So as far as I'm aware, the concept of Anne's Law is in
24 the amended Bill that the Scottish Parliament still
25 currently has on its statute books, which should

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1 facility to recover before then being returned to, let's
2 say, their care home or their own home.

3 Was a similar policy adopted in Scotland?

4 **A.** So I can't recall COSLA being engaged in conversations
5 around about anything that would have worked in that way
6 at a Scotland level, and it's certainly not referenced
7 in any of the submissions that have come in from the
8 member authorities.

9 **Q.** Do you think something like that would have been useful
10 or needed in Scotland?

11 **A.** I think it might have worked in areas that there was
12 a lot of access to care homes. I suspect that might
13 have been more problematic in more remote and rural
14 areas, where you're already travelling large distances,
15 potentially, to access a care home. And we certainly
16 had quite a bit of upset from residents and indeed
17 relatives where they were not potentially getting their
18 first choice, as it were, for care homes because we had
19 care homes that were closed to admissions.

20 So it might have worked on a more highly populated
21 areas where you had three or four care homes in a maybe
22 five-mile radius. I'm not so sure it would have worked
23 in big, remote areas of Scotland where, do you know, the
24 distance between care homes, and therefore the distance
25 that relatives might have been asked to be moved -- to

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1 hopefully be seeing its passage before the end of this
2 Parliamentary term in Scotland.

3 **Q.** In respect of Anne's Law, my understanding is that it
4 would provide rights for a visitor to see a loved one in
5 a care home.

6 May I just confirm from you whether that would be
7 during a pandemic as well?

8 **A.** As far as I'm aware, it would be in only the most
9 extreme cases that you wouldn't be permitted to have
10 a relative access you in a care home. So I would assume
11 that that would mean for the period of any future
12 pandemic, and indeed where we've got outbreaks of
13 infection prevention control over the winter period.

14 **Q.** Thank you.

15 I'm going to move on and ask some questions about
16 the management of the pandemic generally, and in
17 particular the enhanced professional clinical and care
18 oversight of care homes.

19 Now, as previously stated, in Scotland, the delivery
20 of adult social care is more integrated than some of the
21 other nations in the UK, with this enhanced professional
22 clinical and care oversight of care homes. Could you
23 please just explain to us what that was.

24 **A.** So that entailed clinicians and, more often than not,
25 nurses, taking a more hands-on approach, as it were, to

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1 how things were being run in care homes.
 2 So, from a COSLA perspective, we obviously didn't
 3 have the expertise to go in and do that, but we were in
 4 a situation where we were able to make sure that the
 5 balance of that clinical oversight we were still feeding
 6 through what were potentially implementation issues with
 7 whatever might be being suggested, because we were
 8 picking that up from our member councils and indeed
 9 professional associations that are associated with adult
 10 social care.

11 **Q.** So my understanding is that it included
 12 multidisciplinary teams comprising of the NHS director
 13 of public health, an executive nurse lead, medical
 14 director, chief social work officer, and others, who
 15 would have assisted the oversight of care homes and,
 16 I would presume, also providing advice in respect of,
 17 like, IPC measures and things like that?

18 Sorry, that was a nod?

19 **A.** That's my understanding, yes.

20 **Q.** Thank you.

21 And my understanding is that they would also
 22 undertake visits to the care homes if, for example, the
 23 patients had tested positive and things like that?

24 **A.** Yes.

25 **Q.** Would you say that this was beneficial during the

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1 provide.
 2 **Q.** And from your statement I've noted two potential data
 3 gathering tools or mechanisms. One is the Safety Huddle
 4 Tool.

5 **A.** Mm.

6 **Q.** And the other is the data dashboard. Am I right in
 7 understanding that they're both two separate systems, as
 8 it were?

9 **A.** Yes.

10 **Q.** And in respect of the Safety Huddle Tool, my
 11 understanding was that this was in force from
 12 14 August 2020; is that right?

13 **A.** Yes.

14 **Q.** Do you know when the data dashboard came into force?
 15 Was that earlier or after?

16 **A.** So the data dashboard was somewhat iterative in terms of
 17 as we were going through, so the data dashboard was
 18 a kind of melting pot, if you like, of -- as we started
 19 to see, you know, testing coming on board, we were
 20 adding that information into it. So -- so you got to
 21 the national level where you could look and see, do you
 22 know, how many tests had been done, how many had been
 23 undertaken, et cetera, et cetera.

24 But it kind of started off with a few things on the
 25 dashboard, and as we went forward and we got more

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1 pandemic for care homes?

2 **A.** I think it was beneficial for care homes during the
 3 pandemic, even if that was just to have a bit of
 4 reassurance that someone else was coming in and was kind
 5 of looking at what you were doing and checking you were
 6 complying.

7 **Q.** Would you recommend the same system in a future
 8 pandemic?

9 **A.** Yes.

10 **Q.** I'm going to ask some questions on data. What were the
 11 issues regarding data in Scotland at the start of the
 12 pandemic for the adult social care sector?

13 **A.** So, as I've said in the witness statement, we had no
 14 national oversight of what occupancy rates were like,
 15 what workforce statistics were like. So local systems,
 16 so health and social care partnerships and those tasked
 17 with delivering it at a local level, had that oversight.
 18 They could tell you where they had vacancies, where they
 19 potentially had outbreaks of other issues and, indeed,
 20 where they had any pinch points in the workforce.

21 But we didn't have access to that at a national
 22 level, which goes back to the point I was making earlier
 23 about you have to deliver it -- design it and deliver it
 24 locally, but you need the ability to push things up if
 25 we need more support than what the local system can

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1 information from the Safety Huddle Tool, we kind of
 2 grossed that up.

3 **Q.** Have the improvements in collecting national data
 4 continued to date?

5 **A.** Yes.

6 **Q.** If there was a future pandemic, do you think that the
 7 data currently collected would be sufficient for -- on
 8 a national level to support care homes and home care?

9 **A.** Yes, I would. And we use it for winter planning
 10 purposes as we move forward.

11 **Q.** Do those mechanisms include data in respect of unpaid
 12 carers?

13 **A.** No.

14 **Q.** No. Is that data being collected by local authorities
 15 or at a national level?

16 **A.** So one of the, kind of, lessons learned or
 17 recommendations I think is about data sharing, and
 18 unpaid carers is a really good example.

19 So there would be three or four different systems in
 20 local government where somebody might be classified as
 21 an unpaid carer because of things they're accessing.
 22 That may well be on their GP record. That may well be
 23 somewhere else. But it's quite difficult to get
 24 a collective list of our unpaid carers. So I think
 25 that's an area where we need to work to join up the

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1 various bits of information that would be useful.
 2 **Q.** Thank you.
 3 If I could just pull up a statement from the Care
 4 Inspectorate Wales on screen. It's INQ000475130. And
 5 we're looking at paragraph 92.

6 In this paragraph, the Care Inspectorate state that
 7 the new Safety Huddle Tool which captured daily data for
 8 care homes existed. But then if you go to the second
 9 page, the first sentence, it says:

10 "However, I understand we did raise strong concerns
 11 from the outset that this [the Safety Huddle Tool]
 12 involved duplication of data provision which would
 13 impact on care service providers who would experience it
 14 as a duplication of effort on their part."

15 Did you hear similar concerns regarding data
 16 collection from care providers?

17 **A.** I don't recall, but, to be honest, there were -- there
 18 was a lot going on.

19 I wonder if the reason why we went for the Safety
 20 Huddle Tool is that it was a continual record as opposed
 21 to a snapshot in time, but I don't recollect the exact
 22 issue that's being raised there.

23 **Q.** Do you think perhaps, in the context of considering
 24 a future pandemic, trying to find ways in which the data
 25 can be collected which aren't too much of a burden for

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1 system.

2 **Q.** And in terms of attempts to increase capacity during
 3 the pandemic, the national recruitment portal was
 4 established in April 2020; is that right?

5 **A.** Yes.

6 **Q.** How useful was it?

7 **A.** I think it was useful to an extent. I think it allowed
 8 us to bring people, who had perhaps not long left the
 9 adult social care system, back. We did something
 10 similar across the NHS workforce, of course.

11 I don't know that it necessarily got us any new
 12 recruits who maybe hadn't considered social care as
 13 a career up until that point. What I would say is COSLA
 14 is an organisation that also runs myjobscotland, which
 15 is where we put all of the vacancies for local
 16 government, and we've extended that so we now put
 17 vacancies for independent and third sector providers for
 18 adult social care on that website.

19 So there was an opportunity there.

20 The other thing I would say about it is that we
 21 maybe didn't get, do you know, hundreds and hundreds of
 22 applications, but there was a really strong signal that
 23 colleagues in the NHS board, through NES, were willing
 24 to work through the adult social care sector to try to
 25 support us with our recruitment challenges. So I think

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1 care providers is something to be looked at in Scotland?

2 **A.** Yes.

3 **Q.** Thank you.

4 I'm going to move on to workforce issues.

5 And if I can ask for the COSLA survey to come back
 6 up on screen. That's INQ000587789, slide 7.

7 This is a bit similar to the previous that we looked
 8 at but it's about the care sector during the pandemic.
 9 As you can see, of the 29 local authorities who
 10 responded to this question, of capacity, 31% said that
 11 it was not very good and 3% said it was not good at all.

12 And on the ability of the care sector to increase
 13 capacity during the pandemic, 45% of local authorities
 14 said not very good, and 7% said not good at all.

15 And if we can turn to slide 8 quickly, please.

16 Again, it's similar issues that were raised
 17 previously in terms of pre-pandemic preparedness
 18 workforce recruitment issues, retention difficulties,
 19 et cetera.

20 Since the pandemic, has capacity in the care sector,
 21 adult social care sector, improved in Scotland?

22 **A.** I would say it's probably about the same.

23 **Q.** About the same?

24 **A.** I think we still have workforce challenges in terms of
 25 recruiting and retaining staff in the social care

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1 that was -- that shows and demonstrates the
 2 collaboration and partnership that we've alluded to
 3 throughout the statement.

4 **Q.** And just on that, if you could just give us a little bit
 5 more information. How did the -- sort of NHS assist
 6 with this -- this increasing of capacity?

7 **A.** So I think the Cabinet Secretary asking an NHS board in
 8 the time of a pandemic to help us deliver on recruitment
 9 challenges in social care was a pretty strong signal
 10 that it wasn't over at the social care system of --
 11 of -- on its own to fix the recruitment challenges, so
 12 I think that's -- it was a pretty strong -- they could
 13 have been off doing something else, I'm sure, but there
 14 was a recognition there that the social care workforce
 15 needed to be augmented in the same way that the NHS did.

16 **Q.** Thank you.

17 I'm going to ask you some questions in respect of
 18 PPE, personal protective equipment.

19 If I could just pull up the Scottish Trades Union
 20 Congress statement, INQ000569884, and paragraph 75.

21 This a quote, I believe, from the GMB union where it
 22 states that:

23 "There was a shortage of PPE in private care homes,
 24 and there wasn't enough PPE for everyone who was
 25 providing direct care. Generally speaking, there was an

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overall shortage of PPE in the country, so initially the PPE was so scarce that it was being directed towards the NHS, where people who were contracting COVID-19 were being taken. People working in care homes or in community care therefore weren't getting access to PPE, or the equipment that was coming in wasn't the proper equipment that [it should have been]."

They also go on to talk about concerns about the quality of PPE, stating that:

"... [they] felt our members, overwhelmingly low-paid, working class, women, were being provided with the cheapest possible masks or really low-quality plastic gowns."

Was COSLA aware of the concerns regarding access to PPE at the beginning of the pandemic?

A. So I think we provided the Inquiry with our risks and issues log and PPE was raised very early on in the pandemic. So COSLA were aware from both conversations on our own workforce, those that were employed by local government and indeed those that were commissioned to provide services.

Q. And I understand from your statement that there were near daily calls with trade unions and COSLA, and PPE was also raised in some of those calls.

Now, in respect of PPE provision, what was the role

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Q. And that memorandum of understanding, the MoU, commenced on 27 April 2020; is that right?

A. Yeah.

Q. I understand there were 50 PPE hubs that were put up into existence?

A. Yes.

Q. And they were managed and operated by the 31 health and social care partnerships.

A. Yes.

Q. How successful would you say the distribution of PPE was through the PPE hubs?

A. I think the distribution was successful. I think there were always pockets of best practice that could have been better. I suspect the fact that you're dealing with 1,200 disparate social care providers across 50 hubs in a time of a pandemic meant that there were some confused messages but for the most part, we heard a lot less, in terms of access to PPE, once the hubs were up and running. And I suppose those weekly calls that we were having with social care providers was an opportunity for people to say, do you know, it's working really well in that area but there's something not quite right in that area, and that would allow us as a membership organisation to reach out to that individual local authority and say, "Is there something

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of local authorities in Scotland in providing PPE, distributing it to the adult social care sector?

A. Before the pandemic or during the pandemic?

Q. During the pandemic.

A. During the pandemic. So as I said earlier on, the National Care Home Contract provides that providers supply their own PPE for their day-to-day running. It became clear that the scale of the PPE that was required was not going to be useful for individual providers to be trying to source that. I'm sure you've heard elsewhere about, do you know, the market all -- there's no point everybody bidding in the same market. So using our existing procurement systems in Scotland through both the National Health Service and, indeed, Scotland Excel who procure on behalf of local government, we were able to source PPE and then local government signed up to a memorandum of understanding with Scottish Government and colleagues elsewhere and we then provided hubs for access to PPE. So individual care homes and domiciliary care could come forward and draw down some of that PPE.

We also opened access to unpaid carers, and they were either coming in, individually through local government routes, or they were coming in through carer centres to access PPE.

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we can help you with? Is there something that's -- you're confused about?" Or whatever.

Q. If we could pull up the COSLA survey again, INQ000587789, slide 12, please.

This is about accessibility of PPE in the first six months of the pandemic:

"Overall, in the first six months ... how easy or difficult was it for care providers within your local authority area finding it to access PPE?"

Of the 29 local authorities that responded, 45% said providers found it either very or fairly difficult in the first six months of the pandemic, and 38% said they found it very or fairly easy.

If we could pull up the Local Government Association survey, that is INQ000400522, page 45, table 25. As you can see here, the local authority counterparts in England and in Wales have also answered that question. 87% of local authorities in England said that they found it very difficult or fairly difficult to obtain PPE in the first six months of the pandemic. And in Wales, 55% said that they found it very difficult or fairly difficult, both of which are higher than the 45% of providers that was mentioned by the local authorities in Scotland.

Do you think there was anything in particular that

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1 was particularly going well, in terms of PPE
 2 distribution?
 3 **A.** I suspect the fact that we utilised the existing
 4 procurement routes, so we already had contracts that
 5 were up and running and we didn't have to step outside
 6 those. So Scotland Excel always had and always
 7 continued to be able to procure on behalf of all 32 and,
 8 similarly, our NHS procurement arm were in a similar
 9 situation. So I suspect that in itself meant that
 10 because we had those tried and tested routes, it was
 11 a bit simpler. But again, I don't know why our
 12 colleagues in LGA and Welsh LGA, I don't necessarily
 13 know their systems as well as I know the Scottish
 14 system.
 15 **Q.** I'm going to move on to ask questions about testing for
 16 Covid-19. Some other local authorities in other nations
 17 were involved in some way in respect of providing tests
 18 to either staff and/or residents during the pandemic.
 19 What role did local authorities in Scotland play in
 20 respect of testing?
 21 **A.** So we had no formal role in the testing regime, in terms
 22 of actually performing the tests. Where local
 23 government did support our colleagues in the NHS was in
 24 access to infrastructure. So knowing where was the
 25 right place to put a local testing system, knowing what
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1 73%.
 2 Obviously, you do not work in the other nations and
 3 I'm not going to be asking you what went badly there
 4 versus what went well in Scotland. However, I would
 5 just like to know, from your perspective, what went well
 6 in respect of testing in Scotland? Was there anything
 7 that needed to have been improved going forward or do
 8 you think it just -- it went swimmingly?
 9 **A.** I think it went as well as it could have done, given
 10 that we were waiting on tests being developed and other
 11 bits and pieces. But I think the integrated nature of
 12 the system in Scotland meant that we never had
 13 a situation where we were potentially having to
 14 prioritise one part of the system against the other
 15 because there was a recognition that, do you know, that
 16 the integrated system means that we need to know across
 17 all of the workforce, where we needed access to testing.
 18 And I think the fact that we did put that into the PPE
 19 hubs meant that there was a tried and tested method of
 20 getting that out.
 21 **Q.** Thank you. I'm going to move on to ask you some
 22 questions about funding and I'm actually going to start
 23 with the provider sustainability payments. Similarly to
 24 the other nations, there were concerns in Scotland about
 25 the sustainability of social care providers which
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1 the transport links were like, accessing some of our
 2 buildings that were closed, et cetera, et cetera, and
 3 then the other support that we provided in response to
 4 testing was support for shielding individuals and,
 5 indeed, access to support for people who were having to
 6 isolate and needed access to some income.
 7 **Q.** And my understanding is that when it came to lateral
 8 flow tests, those were made available through the PPE
 9 hubs; is that right?
 10 **A.** Yes, and importantly that included for unpaid carers.
 11 **Q.** For unpaid carers, as well. Do you remember when that
 12 started?
 13 **A.** As far as I'm aware, the lateral flow tests were
 14 available from the get-go, as it were, in terms of once
 15 we had the hubs up and running, they were there as soon
 16 as we had them in any scale.
 17 **Q.** I won't take us to the surveys again but I will read the
 18 responses. In respect of COSLA's survey, of the 29
 19 local authorities that responded to the question in
 20 respect of access and testing for care providers in the
 21 first six months of the pandemic, 45% found it very or
 22 fairly difficult. In respect of England, local
 23 authorities in England, 84% of local authorities said
 24 that care providers found it very or fairly difficult to
 25 access testing in the first six months; and in Wales,
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1 existed during the pandemic. And this was due to the
 2 impact of additional costs, because of the pandemic,
 3 such as staffing, sickness, PPE and also a decline in
 4 care home occupancy; is that right?
 5 **A.** Yes.
 6 **Q.** And the Scottish Government introduced provider
 7 sustainability payments to cover the additional costs in
 8 May 2020; is that right?
 9 **A.** Yes.
 10 **Q.** My understanding is that the provider sustainability
 11 payments were distributed by local authorities; is that
 12 right?
 13 **A.** That's correct, yes.
 14 **Q.** If I could pull up the Scottish Care witness statement,
 15 that's INQ000509530, paragraphs 113 to 114.
 16 Here they talk about issues in respect of provider
 17 sustainability payments. And they state that:
 18 "There were inconsistencies in the approach being
 19 taken to applications for under-occupancy and
 20 sustainability payments by local authorities. Local
 21 authorities did not have sufficient resources to process
 22 the applications and at times did not explain why
 23 applications were refused or partially granted."
 24 Scottish Care also say that they:
 25 "... liaised with COSLA to highlight the pressures
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1 that the sector was under and the challenges that
2 applicants were having when attempting to access
3 sustainability funds."

4 And if we could stick on the statement but go to
5 page 33, paragraph 125 and 126. They also state that:

6 "... social care providers had to apply
7 retroactively for sustainability payments and
8 accordingly had to incur increased costs or providing
9 services without any certainty as to whether such costs
10 would be reimbursed."

11 They also mentioned substantial delays between
12 applications being submitted, being granted, and
13 payments being received, which compounded this
14 uncertainty.

15 Now, in respect of the first point that was
16 mentioned, which was inconsistencies in approach being
17 undertaken to applications for under-occupancy and
18 sustainability payments by local authorities, was COSLA
19 aware of those issues at the time?

20 A. Yes.

21 Q. What, if anything, was undertaken to try to make things
22 easier or to try to alleviate those inconsistencies?

23 A. So what we did was we looked to see if there was
24 a fundamental issue with the process, so was it
25 something that was wrong in the guidance or something

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1 authorities.

2 Q. And do you think that those issues were improved on
3 during the pandemic?

4 A. I think we got better as we were going, but again, we
5 spent a lot of time trying to get to the bottom of, was
6 it relationships in a particular area that were causing
7 issues? Was it the way the applications were coming in?
8 Was it the way the applications were being assessed? So
9 I would love to say we fixed it in the first week and it
10 was once and done, but that was not how things played
11 out, as pressures came back in, in a fresh winter
12 period, you would potentially have to reach out to
13 individual areas and say, "Can we help? Is there
14 something with the process that you're not sure of?"

15 Q. And if there was a future pandemic, would you state that
16 that kind of funding should remain being funnelled
17 through local authorities or do you think it should be
18 done on more of a, sort of, national level down?

19 A. I think it's right that local authorities will
20 understand the providers in their area, and there's an
21 element of, if you try to do it nationally, it would
22 have to be checked by the local system anyway, and
23 colleagues in government didn't have the capacity to
24 deliver payments directly at that point.

25 So it's not unusual for my organisation to say that

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1 that was unclear in the guidance? And we made that as
2 clear as we possibly could and made sure that that was
3 then reissued to individual local authorities. We then
4 worked with Scottish Care, I think twice weekly, if
5 there were particular issues in a particular area, that
6 could be to do with the fact that there was a lot of
7 staff who were off sick with Covid themselves in
8 a particular team. It could be to do with the fact that
9 there was -- perhaps people were approaching the way in
10 which they were looking through applications as if we
11 were in non-Covid times and, do you know, at the end of
12 the day, our finance officers always have to be able to
13 prove good use of public money but I suppose we were
14 working with individuals. So we were looking at: is
15 there a problem across the piece, is it a problem with
16 an individual area? Taking it right down to, is it, do
17 you know, is there something we can do with individual
18 teams?

19 What I would say is that in many cases the teams
20 that were processing the grants for social care
21 providers were the same teams that were then being asked
22 to issue payments for other sectors that had potentially
23 come through. So there was definitely an issue around
24 about capacity and the ability, do you know, deliver for
25 different sectors -- particularly in the smaller local

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1 things should be done local by default, and national by
2 agreement. I didn't see that it would have been any
3 better a process had it been done at a national level
4 because there would still have been the need to check
5 with the local system about occupancy rates, et cetera.

6 Q. And similarly, there was an enhanced Statutory Sick pay
7 scheme --

8 A. Yes.

9 Q. -- or the social care staff support fund, which was
10 introduced because of concerns about care staff having
11 to self-isolate because they'd only be entitled to
12 Statutory Sick Pay. Those are also funnelled through
13 local authorities in a similar way.

14 I'm not going to pull it up on screen but Scottish
15 Care also mention that there were long delays in
16 payments being reimbursed. Do you think that those
17 payments should also remain funnelled through local
18 authorities, or do you think they should go directly to
19 staff during a future pandemic to ensure that they get
20 their Statutory Sick Pay, or enhanced sick pay, I should
21 say?

22 A. I suspect we would build in a different type of delay if
23 we were moving halfway through to some -- a completely
24 new organisation, potentially making a payment to staff,
25 we had all the bank details, we'd done all the due

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1 diligence, we knew who these care providers were.
 2 I think if we could have got the capacity up and running
 3 quickly, we wouldn't have seen some of the delays that
 4 we saw.

5 **Q.** Thank you. I've got one question in respect of changes
 6 to the regulatory inspection regime. I'm not going to
 7 pull the COSLA survey up again, but 38% of local
 8 authorities felt that the suspension of inspections of
 9 care homes had a negative impact on safeguarding.

10 What, if anything, did local authorities do to
 11 mitigate this?

12 **A.** So I think we had our chief social work officers who
 13 were meeting regularly to think about and discuss what
 14 were the areas that were potentially being missed with
 15 the fact that we had stood down those visits. And
 16 I think if you take the enhanced clinical governance for
 17 care homes, there was a bit of a safeguarding there,
 18 that other teams that were going in that were
 19 multidisciplinary. But I think as we move forward it's
 20 one of the things that we should be agreeing in --
 21 agreeing in extremis: if -- if we get to a situation
 22 where we do that as a minimum, what are we doing over
 23 here to make sure that those safeguards were there?

24 **Q.** Thank you. And my last area to ask you questions on is
 25 in respect of easements, and these were -- basically

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1 **Q.** If I can pull up my final document on screen, please,
 2 it's the Inclusion Scotland witness statement.
 3 That's INQ000520202, paragraphs 85 and 86, in which
 4 Inclusion Scotland state:

5 "The emergency legislation allowed local authorities
 6 to relax certain duties, but the duty to provide support
 7 still applied under section 12 of the Social Work
 8 (Scotland) Act. Despite this, Glasgow Disability
 9 Alliance found that approximately 2000 Disabled people
 10 in Glasgow had their care reduced or completely
 11 withdrawn from March 2020 onwards and many were forced
 12 to rely on family members or neighbours or to go without
 13 care."

14 On paragraph 86 they state:

15 "The easements which allowed care assessments to be
 16 put on hold had an immediate impact on care users as
 17 well as raising questions about whether support would be
 18 available in the longer time, with social workers in
 19 Scotland reporting that some of their service users were
 20 'left in limbo'."

21 What are your views on the reduction of care and
 22 also the pausing of assessments during the pandemic?

23 **A.** So I think the statement there from Inclusion Scotland
 24 talks to some of the survey results that you've gone
 25 over. We did have difficulties in accessing workforce.

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1 section 16 and 17 of the Coronavirus Act allowed for
 2 local authorities to dispense with particular social
 3 care assessment duties covering social care for adults,
 4 children and support for carers. This was, I understand
 5 it, removed on 30 November 2020 in Scotland; is that
 6 right?

7 **A.** Yes.

8 **Q.** My understanding is that COSLA and Solace were consulted
 9 on developing a survey for local authorities to complete
 10 on a monthly basis regarding the use of easements?

11 **A.** Yes.

12 **Q.** But you state that the results were collected by the
 13 Scottish Government. As such, you were unaware of how
 14 many local authorities enacted easements during the
 15 pandemic.

16 Do you think COSLA could have had a greater role in
 17 respect of easements?

18 **A.** So I think, from memory, we probably thought about
 19 a third had, but in many respects, for some, that was
 20 for a two-week period or something like that. So
 21 I think the fact that Scottish Government were
 22 collecting the data didn't mean that we were absolutely
 23 unaware of what was happening. But obviously we're not
 24 an improvement organisation; we're a membership
 25 organisation. So we don't perform that function.

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1 I think it's difficult to understand, of the 2,000
 2 people who had their care reduced, what were their
 3 support needs. Were they in the low and the medium
 4 category? We moved to a system using the easements or
 5 where we were looking at people who had high support or
 6 extremely high support needs. It's difficult to know,
 7 but I think the pausing of assessments was something
 8 that we were really, really keen to limit the amount of
 9 time that we did that, least not because we had people
 10 who, because of Covid, their support needs had gone up,
 11 but we also had people on the other side who -- they
 12 potentially didn't want access to the social care that
 13 they were getting before and they wanted to have their
 14 changes there.

15 So we did try to narrow the amount of time that the
 16 assessments were put on hold, and then I think
 17 I remember in 2021 we did a kind of go-through in terms
 18 of how many assessments needed to be redone.

19 **Q.** My final question: if there was a future pandemic, do
 20 you think that easements should be enacted in order to
 21 allow local authorities to reduce some of their
 22 services?

23 **A.** I think it would be an option that nearer the time that
 24 we would need to think about. And I say that because --
 25 we're going to come on to lessons learned I hope,

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1 because I think the fact that -- if you don't have your
 2 social care system running so hot, I don't know that you
 3 would be in a system -- and you would be in a situation
 4 where you would need easements. I think the problem is,
 5 is that the system has been running too hot. As you can
 6 see from the local authority surveys, so when the
 7 easements came in, I suspect there were -- not a lot of
 8 local authorities put easements in because they were
 9 already providing support to the people who were in the
 10 most need, there probably wasn't any higher you could
 11 go.
 12 **Q.** Just to clarify, when you say so "hot", what do you mean
 13 by that?
 14 **A.** So we were already in a situation in Scotland where most
 15 local areas were only providing support through adult
 16 social care to those who were in desperate need, if you
 17 like, or, do you know, at the higher end of the needs
 18 threshold.
 19 **Q.** Pre-pandemic?
 20 **A.** Pre-pandemic. So when the easements come in, if you're
 21 only providing those who are at the most extreme -- I'm
 22 not sure that easements make that any different if
 23 people are already accessing it at that level.
 24 **MS SHOTUNDE:** My Lady, those are my questions.
 25 **LADY HALLETT:** Thank you very much.

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1 be: if we were in a situation where people weren't being
 2 tested, were we clear that the infection prevention and
 3 control measures that we've discussed were such that we
 4 could prevent it?
 5 **Q.** Yes, right.
 6 Were these concerns that COSLA itself had, and was
 7 raising? Or were they the concerns of others that you
 8 were aware of and put forward?
 9 **A.** So we were gathering feedback from our member
 10 authorities, be that from paid officials in those local
 11 authorities or indeed from our own elected members. It
 12 was 1,200 -- just over 1,200 elected members in Scotland
 13 who were obviously getting feedback from their
 14 constituents.
 15 **Q.** Yes.
 16 **A.** But as well we were also getting information from the
 17 social care providers through the weekly meetings.
 18 **Q.** And so far as you're concerned, were the concerns that
 19 you raised with the Scottish Government or the Cabinet
 20 Secretary for Health and Sport, were they acted upon,
 21 and if so, to what effect?
 22 **A.** So I think the fact that you can see that we set up the
 23 care home action group and we had specifically, on
 24 infection prevention and control -- I think as we've
 25 alluded to in terms of why did local authorities in

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1 Mr Weatherby, who is just there.
 2 **Questions from MR WEATHERBY KC**
 3 **MR WEATHERBY:** Thank you, my Lady.
 4 Good afternoon. I ask just a few questions on
 5 behalf of the Covid Bereaved Families for Justice UK.
 6 Two topics: hospital discharges to care homes or
 7 care settings without testing, and visitation.
 8 So hospital discharges first. So paragraph 3.10 of
 9 your statement, in respect of hospital discharge, is you
 10 say, and I quote:
 11 "... this is a matter that will have come up at the
 12 weekly meetings between the COSLA Spokesperson and the
 13 Cabinet Secretary for Health and Sport, given the
 14 concerns connected with this ..."
 15 Can you help us what the nature of those concerns
 16 was?
 17 **A.** Sorry, was that in terms of visiting restrictions
 18 or ...?
 19 **Q.** No, in terms of the hospital discharges into the social
 20 care settings without testing.
 21 **A.** So I think as we alluded to elsewhere in our statement,
 22 and indeed if you look at some of the minutes from those
 23 earlier meetings, there were two concerns. One was
 24 there wasn't access to testing, so the actual physical
 25 capacity to test wasn't there. And the other would

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1 Scotland have a difference in access to testing that we
 2 saw elsewhere in the UK, I suggest that -- that suggests
 3 to me that the social care provision was understood by
 4 the Cabinet Secretary, and we acted upon those concerns.
 5 **Q.** Yes. Okay. I think you may have answered my next
 6 question but, just for clarity, I'll ask you again.
 7 Were members of COSLA raising concerns about the
 8 hospital discharges without routine testing, and also
 9 the adequacy of IPC measures at this time?
 10 **A.** Very early in the pandemic?
 11 **Q.** Yes.
 12 **A.** I suspect a lot of it was potentially coming through
 13 word of mouth, as it were, because not necessarily all
 14 of our elected members would have been in care homes or
 15 hospitals given the fact that we had restrictions.
 16 **Q.** Yes.
 17 Now, paragraph 2.27 of your statement you say that:
 18 "COSLA's role is to represent the views of its
 19 member councils and to ensure that any strategic
 20 decisions that are capable of being operationalised by
 21 local authorities [were]."
 22 Were you aware of any barriers to operationalising
 23 guidance put out by the Scottish Government in
 24 March 2020, which noted that facilities would be advised
 25 of IPC measures when hospital patients were discharged

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1 to care settings without testing?

2 **A.** No.

3 **Q.** Not. And again, I think, to round off this subject,

4 this topic, I think you have probably covered this

5 already but just for clarity, is it your evidence that

6 all care homes did have appropriate isolation facilities

7 and sufficient resources, beds, PPE, staffing, to have

8 undertaken a precautionary approach in every instance of

9 hospital discharges prior to May of 2020?

10 **A.** I think the guidance that was drafted was drafted with

11 support from professionals who were working in the

12 system. Can I say that every single care home in

13 Scotland was in a position to apply that? No, I can't.

14 **Q.** Yes.

15 **A.** What I can say is that the guidance was drafted with

16 those who could say to a degree of certainty, in terms

17 of representatives of the workforce from across the

18 sectors.

19 **Q.** Yes -- that wasn't quite the point. Did they have the

20 appropriate isolation facilities and sufficient

21 resources to carry through on that guidance and in terms

22 of taking a precautionary approach?

23 **A.** As far as I'm aware. But that would be for the Care

24 Inspectorate, potentially.

25 **Q.** In terms of visitation, paragraph 4.2, you state that:

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1 told the Inquiry in his witness statement that you were

2 briefly referred to earlier -- and just for the record

3 it's paragraph 295 of that statement -- that guidance

4 issued on 26 March of 2020 suspending routine visits in

5 care homes:

6 [As read] "... did not achieve the correct balance

7 of managing risks with the rights of individuals and did

8 not sufficiently consider the unintended consequences of

9 the visiting restrictions."

10 Were you and COSLA aware of those concerns from the

11 inspectorate?

12 **A.** Yes.

13 **Q.** And did COSLA respond to that guidance or raise those

14 concerns with the Scottish Government?

15 **A.** So again, I think if you go back and look at the

16 minutes, we were having those ongoing conversations in

17 terms of the balance between the two, two things.

18 **Q.** So you raised those concerns. What was the outcome of

19 raising those concerns with the Scottish Government?

20 **A.** So I think the outcomes took a lot -- a bit longer than

21 we would have expected to see, but we were absolutely

22 clear as we came out of the first lockdown that visiting

23 restrictions needed to be one of the first areas that we

24 looked at.

25 **MR WEATHERBY:** Thank you very much.

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1 "... COSLA officers had to remind officials and

2 clinicians that care homes are not purely clinical

3 settings but the homes of the residents. Ensuring that

4 they continued to feel like that, even in the midst of

5 lockdowns, was of vital importance to the overall

6 wellbeing of the residents."

7 Firstly, do you agree that relatives being able to

8 visit their loved ones is an example of this, what you

9 say the vital importance to the overall wellbeing of the

10 residents?

11 **A.** Yes.

12 **Q.** And secondly, the Inquiry has heard evidence that

13 visiting policies were inconsistently applied between

14 care homes. Was that an issue in Scotland, so far as

15 you're aware?

16 **A.** So again, I think if you look at the minutes of the

17 meetings that were taking place, I think that was

18 raised, in terms of different care homes applying

19 different visiting restrictions.

20 **Q.** So that was a --

21 **A.** Some of that was later on in the pandemic where we had

22 different tiers though, as well, so it's important to

23 tie it to the right timeline.

24 **Q.** Yes. Thank you.

25 Now, Kevin Mitchell from the Care Inspectorate has

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1 **LADY HALLETT:** Thank you, Mr Weatherby.

2 Mr Straw. Mr Straw is over there.

Questions from MR STRAW KC

4 **MR STRAW:** Good afternoon. I represent John's Campaign, The

5 Patients Association, and Care Rights UK.

6 You say at paragraph 4.24 of your witness statement

7 that the Scottish Government's emphasis was on stopping

8 the spread of the virus. And you also say in your

9 statement that COSLA is fully supportive of the proposed

10 Anne's Law, which will ensure that in the future there

11 will be a different approach as to how restrictions on

12 visits will be managed in care settings.

13 You appear from this to consider that the government

14 focused too narrowly on infection control and neglected

15 to properly consider and address indirect harms. Is

16 that correct?

17 **A.** I think the four harms we -- Scotland approached the

18 pandemic was -- was useful. I think in terms of

19 visiting restrictions, it's an area where we perhaps

20 allowed the infection prevention control to be given

21 a higher weighting than potentially of the outcomes for

22 people.

23 **Q.** And do you know why that balance wasn't correctly struck

24 and what can be done to ensure that it is correctly

25 struck in future?

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1 **A.** I think the difficulty we had was anecdotally we knew
 2 what it was going to mean, not least because my own
 3 grandmother was in a similar situation, but we didn't
 4 have the evidence necessarily about how visitors were or
 5 were not transferring the virus in care homes. So
 6 there's something for me about us understanding that as
 7 we move forward, because if we're going to implement
 8 Anne's Law in Scotland, which we are, we need to
 9 understand what are the -- do you know, what are the
 10 practical ways in which we can make visiting during
 11 a pandemic or any other outbreak safe.
 12 **Q.** So is this right: getting better data and information on
 13 both the indirect harms --
 14 **A.** Yes.
 15 **Q.** -- of restrictions and then also understanding how they
 16 can be managed?
 17 **A.** Yes.
 18 **Q.** Thank you.
 19 A different topic. In your statement you mention
 20 a range of engagement that COSLA undertook, but none of
 21 the organisations that you actually mention in your
 22 statement include people living in care homes and their
 23 chosen supporters. Could or should COSLA have done more
 24 to listen to and learn from lived experience from people
 25 like that?

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1 **LADY HALLETT:** And thank you for travelling down to see us.
 2 **THE WITNESS:** Thank you.
 3 **LADY HALLETT:** Very well, I shall return at 3.40.
 4 (3.27 pm)
 5 (A short break)
 6 (3.40 pm)
 7 **LADY HALLETT:** Ms Hands.
 8 **MS HANDS:** My Lady, good afternoon. If I may call
 9 Ms Nadra Ahmed.
 10 **MS NADRA AHMED (sworn)**
 11 **LADY HALLETT:** Ms Ahmed, I'm sorry you've been kept waiting.
 12 I hope you haven't, but you're our last witness of the
 13 day, that's why.
 14 **THE WITNESS:** That's all right.
 15 **LADY HALLETT:** I don't know if that's a privilege or
 16 a disaster.
 17 **Questions from COUNSEL TO THE INQUIRY**
 18 **MS HANDS:** Thank you.
 19 Ms Ahmed, good afternoon. You are here today as the
 20 executive co-chair of the National Care Association, or
 21 NCA for short, to tell the Inquiry about your members'
 22 experiences during the pandemic. And you have produced
 23 a statement which, for those following, is at
 24 INQ000515683.
 25 **A.** I have.

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1 **A.** So I think COSLA as a membership organisation were
 2 working at a national level. We're probably one stage
 3 removed. But what we were doing was taking regular
 4 feedback from our 1,200 elected members, who live and
 5 work in the communities that they represent, or
 6 professionals that were working in those systems and
 7 indeed speaking daily with people who had lived and
 8 living experience. So I think at a national level, it
 9 is something that COSLA have reflected on and will
 10 continue to reflect on, but we were absolutely taking
 11 feedback from our member councils on what they were
 12 picking up from the ground, and therefore from relatives
 13 and residents of care homes.
 14 **Q.** Okay, so you consider that was an important thing to do
 15 and you have -- (overspeaking) --
 16 **A.** Absolutely.
 17 **MR STRAW:** Okay, thank you very much.
 18 **LADY HALLETT:** Thank you, Mr Straw.
 19 That completes the questions we have for you,
 20 Ms Dickie. Thank you very much for your help for the
 21 second time.
 22 I haven't checked, I'm not sure whether I can say
 23 that's it. But if it is it, thank you so much for all
 24 the help you have provided to date. Very grateful.
 25 **THE WITNESS:** Thank you.

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1 **Q.** Thank you. And just starting with some of the work of
 2 the NCA, is it right that it represents and supports
 3 small and medium-sized care independent -- sorry, care
 4 providers in England --
 5 **A.** Yes.
 6 **Q.** -- and has approximately a thousand members?
 7 **A.** Yes.
 8 **Q.** The majority of your membership are nursing or
 9 residential homes?
 10 **A.** Yes, it is.
 11 **Q.** And the remainder are home care, but essentially 92% of
 12 care in residential homes?
 13 **A.** Yes, and learning disability services.
 14 **Q.** Thank you. You have told the Inquiry that smaller care
 15 homes have around 20 to 40 beds and medium-sized
 16 providers have 50 to 150 beds; is that right?
 17 **A.** Yes.
 18 **Q.** And is that in England?
 19 **A.** Yes, it is.
 20 **Q.** You have described the pivotal contribution of the SME
 21 sector, as you refer to it, in your statement, and how
 22 it is the backbone of care provision. Can you briefly
 23 explain why it is so important?
 24 **A.** Yes, thank you. We use that quite a lot because over
 25 80 -- I think it's 83.4% of the sector is made up of

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1 small to medium-sized care providers across the country,
2 and they are set in all sorts of different areas. So
3 accessible through most communities, and that's how they
4 are located.

5 But they're also owned primarily, either
6 individually or with small boards, so there's not
7 private equity in the people that we were work with. It
8 is investments that are made by the providers
9 themselves.

10 **Q.** And you have told the Inquiry that during the pandemic
11 you had almost daily contact with civil servants about
12 issues in the care sector. We're going to come on to
13 more detail with those issues but what were some of the
14 issues that you raised?

15 **A.** I think it was primarily because information was so
16 slow, and actually very, very inconsistent. So as from
17 the perspective of how we were going to handle it,
18 because initially, when the pandemic was talked about,
19 there was -- late February, we were still kind of
20 talking about Brexit, and we were talking about the
21 challenges for the sector from that perspective. And
22 that included shortages of staffing. And so we were
23 very concerned when the pandemic was kind of announced
24 as being there. We were told that it wouldn't have an
25 impact on our bit of the sector initially.

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1 quite -- it was downplayed, that, you know, this was not
2 something that was going to impact on our piece of the
3 sector, and we didn't need to worry about it. We needed
4 to support the NHS. That was primarily what we kept
5 being told.

6 I think families were beginning to see some
7 challenges, as well. We didn't really get -- I guess,
8 the shortest answer is no, we didn't get what we were
9 looking for. We were given explanations that actually
10 were not consistent.

11 **Q.** And is that at the start to the pandemic?

12 **A.** Yes.

13 **Q.** Did it improve?

14 **A.** It started to improve with more regular meetings.

15 **Q.** Can you remember when that was?

16 **A.** It was probably the second week of March or so, sort of
17 13, 14, 15, something like that, that we suddenly
18 started to get a lot of meetings appearing in our
19 diaries from departmental colleagues, and a little bit
20 from -- we had very little contact, as the National Care
21 Association, we have never been seen as the organisation
22 that kind of really needed to be talking to the NHS, for
23 example. You know, very little contact with the NHS
24 except at local levels where our members did that.

25 Certainly we were beginning to get that sort of

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1 There was very little information coming. There was
2 a little bit of a panic amongst our members because we
3 have things like norovirus that are around, we have all
4 those kinds of issues that come into our settings and
5 we've always managed, through infection prevention and
6 control mechanisms, to keep our residents safe. But of
7 course, the pictures that were coming out from across
8 Europe were quite challenging, and the smaller
9 providers, you know, weren't, for example, there was
10 something that came across from a care home in Spain and
11 all those issues, they were causing people quite deep
12 concerns.

13 And as small providers, what we have to remember is
14 they are it. There isn't an HR department. There isn't
15 anyone else there from a regional office, generally
16 speaking, able to deal with the challenges that they
17 were facing.

18 So we started to get a slow trickle of concerns that
19 were coming through to our membership. So we were
20 pointing it out on a regular basis, asking for
21 information, mostly about the virus, mostly about what,
22 you know, the symptoms might be, what people needed to
23 be looking out for. All of those kinds of things.

24 **Q.** And did you get that information when you asked for it?

25 **A.** I think initially it was, initially it was really

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1 linkage.

2 So we were trying to work quite dynamically with the
3 kind of messages that were coming through, and I think
4 the issue was there was quite generic information that
5 was really much more suited to larger establishments
6 because it was coming down from the NHS kind of
7 perspective.

8 Smaller providers, where you've only got ten
9 residents, or you might only have 20, or you've got
10 a learning disability service with four or five, there
11 was no tailoring towards that messaging.

12 **Q.** Did you have the opportunity at those meetings, or
13 perhaps in email correspondence outside of the meetings,
14 to provide any feedback on the guidance or decisions
15 that were being made to represent the views of the
16 providers that you represent?

17 **A.** Yes, yes, we did. And we worked with colleagues in the
18 sector, also representatives, and we worked really hard
19 to try to make sure that our views were being reflected
20 and we were getting real intelligence from people on the
21 ground, you know, when somebody rings you up, and says,
22 you know, "I've just taken somebody back from the
23 hospital, and now we've got five -- five of our
24 residents are poorly, you know, what do we do? How do
25 we deal with this?" People were kind of doing this, it

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1 was a fast-moving scenario, so by the time you actually
2 went back to a meeting to talk about the challenges, the
3 provider would already have to have made some decisions.

4 And I think there was a lot of clash on the way that
5 we were being told to look at things. I think one of
6 the problems that was really clear to me was that there
7 were people who were being asked to write guidance, to
8 talk about these things, who had no experience of either
9 the social care sector, or certainly not smaller
10 providers. So they were quite new into these roles,
11 they were being brought in, they were having to do quite
12 a lot of research. And I think picking up so many
13 different messages for them was difficult.

14 But for us, on the ground, for our members, it was
15 becoming quite impossible, because we also had
16 a workforce that was really worried, you know. What we
17 have to remember is our workforce were the ones that
18 were on the ground. They didn't have any kind of
19 support except us trying to support our members.

20 **Q.** And I'm going to come on to ask you about that, but two
21 things, please, if I may on what you've just said.

22 The first is around the staff structures within the
23 smaller providers. And I think you've said in your
24 statement that the lack of administrative staff in some
25 of those care providers made it more difficult to

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1 at the national level and talking to colleagues in the
2 department or, indeed, in the NHS, it took time because
3 it had to be signed off, you know, and sometimes that
4 would take a long time. We'd get all sorts of things
5 coming through which contradicted each other. Sign-offs
6 were taking a long time. But that particular WhatsApp
7 group suddenly got momentum and it also had doctors on
8 it that would come on and give -- geriatricians who were
9 actually giving really good advice, as well.

10 So they were able to -- so a lot of them are care
11 home providers or staff, but they were also people that
12 were happy to do some of the research behind some of the
13 guidance to try and interpret it into simple English,
14 into plain English, and get it back.

15 **Q.** I'd like to just ask you now about the hospital
16 discharge policy that was introduced in March 2020 in
17 which care homes were asked to take patients that were
18 in hospital.

19 To your knowledge, what were some of the practical
20 difficulties for small and medium care providers in
21 following the discharge requirements, for example,
22 around isolation or cohorting of staff?

23 **A.** I think the difficulty -- there were various issues
24 around this, because obviously by then there was more
25 concern. People weren't very keen on taking people out

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1 implement and communicate changes in guidance in
2 a timely manner.

3 So what support do you think could have been
4 provided to them to have helped with that?

5 **A.** Well, I think with that, I think plain English would
6 have been really good, as well, you know, just being
7 able to pass things through in a timely manner. You
8 know, for our administrative staff who were used to
9 dealing with rostering and residents and, you know,
10 making sure the files were right to suddenly have to
11 deal with quite medical terms, you know, quick
12 implementation methodology, I think it was really
13 beginning to -- I think it was challenging because their
14 roles were changing so quickly, as well.

15 **Q.** Okay. And is it right that you set up a WhatsApp group,
16 or the NCA board set up a WhatsApp group for managers
17 and owners to help with interpretation and dissemination
18 of information and guidance?

19 **A.** Yes. One of our colleagues on the board who is a nurse
20 herself, Anita Astle, she set up the WhatsApp group and
21 very quickly, it picked up momentum and we had people --
22 it wasn't just NCA members; it was -- just everybody was
23 joining it.

24 It was the only -- it was the only mode at that
25 point that was immediate. So everything we were doing

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1 of hospital, but I think we were being vilified by
2 everybody if we didn't take them. And some providers
3 chose not to take them and kept the virus out of their
4 services. But those that did, to try to support the
5 NHS, because that was the mantra, were then having to
6 look at the way that they were isolating.

7 So initially you could isolate in a room, and the
8 other residents were able to kind of go mingle. And
9 then, you know, very quickly that began to change
10 because the more people that were becoming infected,
11 you'd have to cohort them, create zones where only
12 certain people worked.

13 So that -- it had an implication on the staffing as
14 well, because you'd have the people who were working in
15 a red zone and -- you know, all of those things.

16 But the other channel for our providers, SME
17 providers, were -- you know, we had converted buildings,
18 and those converted buildings created challenges. You
19 know, narrow corridors, potentially. Room access being
20 very different to a purpose-built building.

21 So providers and their workforce were doing the very
22 best they could, quite quickly, to accommodate people
23 who had come out of hospital. You know, we were told
24 that they didn't need to be tested initially, they could
25 just be discharged, because if they didn't show

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1 symptoms, they didn't need to be tested. Which was --
 2 you know, it was a bit crazy at the time, because of
 3 course if they were -- and, you know, we have examples
 4 where a provider who has only 20 beds had to get
 5 somebody -- you know, had somebody come back from the
 6 hospital, and they brought Covid with them, and within
 7 three or four days, he was -- he messaged me to say that
 8 15 of his residents now had Covid, he didn't know how to
 9 deal with it, half of his staff were now isolating. And
 10 he was in a really, really challenging position.

11 And so we were trying to pick up these messages and
 12 see what we could do. There was no local authority
 13 support that was coming through. There was nothing that
 14 was actually -- there was nothing present in mind or in
 15 soul or in word that made us feel that we were being
 16 looked at or supported.

17 So, you know, that particular individual, he -- you
 18 know, he phoned me -- the last time that he phoned me
 19 was at about 11 o'clock one night because he was on his
 20 own in the home trying to deal with Covid-positive
 21 patients.

22 So it was really challenging, you know, to try --
 23 what do you say to somebody at that time of night? How
 24 do we kind of translate some of this really late stuff
 25 that was coming through to us to say "It'll be fine,

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1 know, being transferred into a service, I wasn't sure
 2 about the wellbeing side of it for those people as well.

3 Did I support it? I think I supported it because it
 4 was a potential solution to a very, very chaotic period.
 5 I was extremely concerned about the insurance
 6 implications for people. I was worried about families,
 7 and how they would feel if loved ones were being
 8 transferred into a Covid-positive environment, and how
 9 that visiting might -- you know, how that might impact
 10 on them.

11 So my honest answer is I wasn't sure about it. But
 12 I think, in the position that we were in, it was
 13 a solution.

14 And not -- initially, there was a lot of interest in
 15 it but I'm not sure how many people eventually did take
 16 the option to open them.

17 **Q.** Okay. Moving on, then, to the suspension of routine
 18 inspections by the CQC, so a letter was written by the
 19 CQC in the middle of March 2020 which your organisation
 20 were invited to consider and to look at with, I think,
 21 one day's notice.

22 In your feedback you asked whether care providers
 23 needed to notify the CQC of Covid-19 deaths, and the
 24 response from them was that they would come back to the
 25 sector shortly.

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1 you'll be fine"? How were we going to translate that
 2 into helping that individual?

3 **Q.** And you attended meetings later in 2020 regarding the
 4 development of designated settings. That's alternative
 5 accommodation, facilitated by local authorities to
 6 receive discharge from hospital, if the patients
 7 couldn't be isolated in the care home. You raised some
 8 concerns at those meetings about the policy, so I want
 9 to ask you whether, overall, the NCA supported the
 10 development of designated settings?

11 **A.** I think we were concerned. I think it was something
 12 that was evolving and providers were willing to provide
 13 it. So that's the position statement, if you like. If
 14 providers were willing to provide it, because it would
 15 support the NHS at the time.

16 I think our concerns were very much as to how it was
 17 going to be managed. This wasn't something a smaller
 18 provider could have done. This was going to be
 19 something that had to be invested in a very different
 20 way.

21 Where were the staff going to come from? Because we
 22 were already having challenges around staffing. And
 23 I think, for -- for me, there was an issue about putting
 24 everybody who's Covid positive and the mental health of
 25 those individuals that were getting better and, you

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1 Can you recall why the NCA was asking that in
 2 particular?

3 **A.** Because they are required to give notifications of death
 4 when that occurs in a service. And of course providers,
 5 by the very nature of the role that they do and the way
 6 that they're regulated, do not want to fall out of
 7 regulation with the CQC. And there seemed to be this
 8 kind of -- the CQC went AWOL. There was no support for
 9 the sector. They were basically shutting down, although
 10 they were telling us that they would be around.

11 Calling them became quite an issue. So how were we
 12 going to deal with this? Because we knew that in
 13 certain environments there would be more deaths. You
 14 know, how did they want to be notified of them? You
 15 know, the timely way in the way -- because these are all
 16 things that were happening -- you could have two deaths
 17 in a day. You know, you've got to sit down. You've got
 18 to be dealing with other people who might be Covid
 19 positive.

20 You know, we needed better -- we needed more
 21 clarity. I think CQC was very remiss in that they just
 22 shut the doors and decided that's how they were going to
 23 implement it.

24 **Q.** So it wasn't until 9 April that providers were informed
 25 that when making a notification, they should use

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1 a revised form to notify the CQC if the death of an
 2 individual was as a result of confirmed or suspected
 3 Covid-19. So do you think that was introduced soon
 4 enough or confirmed soon enough?
 5 **A.** No, I don't think so because it was really difficult.
 6 We also, you know, we must remember that GPs had stopped
 7 coming to care homes, as well. We were in a state where
 8 confirming death had become an issue, as well. All of
 9 those things. I think it should have been done quite
 10 quickly, because the deaths had already started, so
 11 a month later is a long time for a provider to be
 12 wondering how they were going to, you know, make sure
 13 that they were doing the right thing and they were
 14 staying within their regulatory responsibilities.
 15 **Q.** And I think in your feedback in the middle of March you
 16 actually asked that any information the CQC provides is
 17 unambiguous and provides clarity to avoid adding to
 18 mixed messaging. So did the messaging from the CQC do
 19 that?
 20 **A.** To a degree. I think we were making -- we were being
 21 stronger by then to make sure that we were making the
 22 rules in a way that was going to suit the providers.
 23 And I think you know. For example, when you -- you're
 24 getting something from CQC that's saying "You must close
 25 your doors" and then you're getting something that you

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1 or three different answers.
 2 **Q.** Moving on now to a slightly different topic and that's
 3 around the implementation of IPC measures. What issues
 4 or barriers, if any, did you hear from some of the
 5 providers that they were having around implementing IPC
 6 measures particularly, perhaps, those providers that
 7 care for people with dementia or learning disabilities?
 8 **A.** I think that the challenges -- what we have to remember
 9 is that we, as a sector, we deal with infection
 10 prevention control as a norm, you know, there is
 11 training for our staff. This was a completely different
 12 thing. This was a completely different beast that we
 13 were trying to come to terms with. So it was becoming
 14 very evident that we needed more, you know, hand gels,
 15 gloves. We have gloves and aprons and things in our
 16 services but then, of course, the mask thing was
 17 coming in.
 18 One of the difficulties around the masks -- we had
 19 to have -- we had long conversations about this -- is,
 20 if you've got somebody with dementia and you've got
 21 members of staff wearing masks, you know, how do we make
 22 sure that we can safely be talking to them, helping them
 23 understand things, all of those things? Because that's
 24 quite challenging. But, of course, from our workforce
 25 perspective, we needed to keep them safe, as well.

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1 must enable visiting. You know, all of those kinds of
 2 things. We needed much more clarity about how and where
 3 we sat.
 4 I think we were -- I think we were really trying
 5 hard to get CQC to work with us in a way that would
 6 support the smaller providers with limited admin
 7 support.
 8 What we got were ambiguous answers which really
 9 didn't make it any easier for us to be clear that we
 10 were doing the right thing.
 11 **Q.** Did that improve as the pandemic progressed?
 12 **A.** I think it improved slightly. It did improve slightly.
 13 But there was always a massive pushback to us, you know.
 14 Whenever we asked questions about something. I think
 15 one provider actually sent me a note saying he'd
 16 notified his CQC inspector about something or other, and
 17 said, "How do you think I should deal with this?" And
 18 the note he got back was, "Well, you're the
 19 professional. You should know how to deal with it",
 20 which really, you know.
 21 So I guess the best anyway to answer this is the
 22 challenges were that we had inconsistent inspectors
 23 giving responses. So the responses were not, they were
 24 not consistent in different areas. So if you've got
 25 homes in two or three different areas you would get two

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1 Dementia was really difficult because people didn't
 2 understand why we were walking around in that kind of
 3 way, as well, trying to keep people calm about, you
 4 know, about the methodology that every home was having
 5 to adopt in its own way.
 6 If you were cohorting people with dementia, you
 7 know, what did that -- the impact on them, how do you
 8 keep them safe in a particular area? We know lots of
 9 providers were putting up those kind of baby gates,
 10 almost, so that people didn't venture forth, and -- or
 11 keeping, trying to keep everybody safe in the
 12 environment they were in.
 13 I think staff found it quite different because when
 14 they were talking -- masks were a premium anyway -- that
 15 created quite a lot of challenge because -- and we
 16 talked about transparent masks, we talked about -- the
 17 trouble was, if I'm absolutely honest, there was a huge
 18 amount of talk. When it came to action, we had to
 19 actually take our best guess as what we could do to make
 20 sure that we could keep the 20, 30, 40 people that were
 21 in our care in the best way that we could.
 22 So there were lots of conversations.
 23 **Q.** And in fact you did raise the issue of the need for
 24 training on infection prevention and control with the
 25 Department of Health and Social Care very early in March

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1 in email correspondence.

2 So, in your view, was there sufficient training on
3 IPC, either at the start of the pandemic, and for staff,
4 or did it develop later on?

5 **A.** No, there wasn't. There was no -- there was no resource
6 put into it, and it was quite piecemeal.

7 **Q.** And on a slightly different topic but still around IPC
8 is testing. You were involved in attending meetings
9 alongside the Local Government Association, and ADASS,
10 around kind of September 2020 where testing was
11 discussed. And one of the issues that arose in early
12 September was that just under 400 homes had not yet done
13 any testing. So what were your members' experiences
14 around accessing testing and why do you think perhaps
15 they weren't testing?

16 **A.** Access to testing came very, very late for our bit of
17 the sector. We had -- deliveries were delayed, really
18 badly delayed, to small and medium sized providers. We
19 were getting regular emails from providers who were
20 telling us that they had not received anything. I think
21 they felt quite isolated. They felt like they had been
22 forgotten. They were -- there was some very angry
23 emails, very long emails from people who were desperate.
24 From the very outset, where -- as soon as we heard about
25 testing, we knew it was one of the ways that we might be

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1 **Q.** I'd like to ask you now about one of the
2 recommendations, in fact, in your statement, and that is
3 for there to be clear guidelines and protocols for care
4 providers to minimise staff movement.

5 So can you describe for us what the experience was
6 for providers of staff movement or restrictions on staff
7 movement during the pandemic?

8 **A.** Well, we were short staffed, of course, and we were
9 working under quite -- very difficult circumstances. We
10 had staff that were living in homes, in gardens, in
11 tents. You know, we had staff that were trying to --
12 were actually keeping away from their own loved ones in
13 order to keep the people that they looked after safe,
14 and they weren't going home.

15 So we had all of that.

16 What we also, you know, we -- the use of agency
17 staff became very difficult, because we couldn't -- we
18 couldn't be very clear about having agencies coming in
19 to our services. Everybody was trying to create
20 a bubble so that we didn't create the challenges.
21 Movement of staff was -- by that I'm assuming what
22 you're meaning is them going from one home to another?

23 **Q.** Yes, indeed, yes.

24 **A.** Yes, so there was always a risk attached to that. And
25 so that would be something that you wouldn't do unless

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1 able to support people and keep more and more people
2 safe. But we were very much an afterthought.

3 You know, we know that it was all about keeping the
4 NHS safe, but it was our workforce that was on the
5 ground. It was -- you know, we were the ones doing that
6 sort of caring responsibility for one of the most
7 vulnerable groups.

8 So the 400 -- you know, I've got no specific idea of
9 why they didn't, but every provider that contacted our
10 offices was just desperate for tests. We also had some
11 tests that were not working, they were giving wrong
12 readings. We had tests that, when they were sent back,
13 didn't arrive in a timely manner, and we were told that
14 they weren't right.

15 So the whole testing scenario, until quite late on,
16 until later on into October, November time, when we
17 started to really get what we needed, the initial
18 stages, people were desperate. You know, providers
19 wanted to be the test sites for it.

20 So we were -- we were finding that -- we knew that
21 this was the way that we needed to work to get people
22 tested. It also had implications for the home itself,
23 obviously, because there was a routine, and there is
24 a regime that has to be put in, but we -- we were
25 certainly not prioritised.

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1 you were absolutely desperate. But most providers did
2 not want to be doing that either. They were trying to
3 keep -- create -- you know, it was creating bubbles.
4 Home care, you know, we had, again, the guidance was
5 really difficult. There were some people who were
6 sharing cars and we were being told that, you know, you
7 had to sit in the back seat and the front -- you know,
8 you can't keep changing the rules. You either do it or
9 don't. If you're sitting in a car and there is
10 infection there, then surely that infection will spread
11 if you're sitting in a car. It just didn't make sense.

12 So movement was always an issue. We were trying to
13 make sure that people understood to limit it and not
14 have people going into too many different services.

15 **Q.** And it's been suggested to the Inquiry that one
16 potential way to achieve that in future would be for
17 a care home to take a fewer number of staff, but who are
18 employed to work full time, or that the worker could
19 continue on a zero-hours contract and take up another
20 job if they didn't have any hours from that care home.
21 Do you think that would be practical for the providers
22 that you represent?

23 **A.** I think that's a really strange -- it's a very strange
24 suggestion. We have to remember that the workforce
25 chooses how they work and where they work. We can't

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1 just make assumptions that they'll be happy to do what
 2 we want them to do, you know. The duty of a care
 3 provider is to try and keep their home fully staffed in
 4 order to meet the needs of the people that they support,
 5 and so to try to tinker around the edges with how you
 6 might get it round in a different way to, you know.
 7 I honestly don't know how to answer that question, you
 8 know. For example, zero-hour contracts, some of our
 9 workforce choose to go on zero-hour contracts because it
 10 suits their working -- their work-life balance.

11 I'm not sure a methodology, that one you've
 12 described, kind of sits with me as being a solution.

13 **Q.** Just briefly in terms of PPE which you've touched on
 14 already, how practical would it be for small and medium
 15 care providers to have, say, a month's worth of
 16 emergency supply of PPE, and would that be helpful in
 17 a future pandemic, do you think?

18 **A.** I think access to PPE has to be one of the
 19 recommendations if we came to something like this again.
 20 With the stock, I mean, I've thought about this quite
 21 a lot because I think one of the challenges we faced
 22 when we were given a drop of PPE was that it was out of
 23 date, you know, that the care providers were sent PPE
 24 that was out of date. And we had providers sending us
 25 pictures of this. I think there has to be a stock.

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1 doing it.

2 So actually, in answer to Mr Hancock on his point,
 3 had we known that we might be hitting something like
 4 that, I think providers would have done that, you know.
 5 But they did have sufficient for their daily use, and
 6 had the government not told us not to worry about it, we
 7 may have been a slightly different situation, because
 8 accessing that PPE became an enormous challenge for us
 9 straight away, especially when we started to hear from
 10 our suppliers that they could no longer supply to the
 11 social care sector because it was being rerouted to
 12 the NHS. So if we -- you know, how much would have been
 13 recruited if it was due to come to us for a stockpile?

14 I think those things are the reality that was on the
 15 ground, and that's -- and we ought to speak the truth
 16 about it. We ought to be telling the truth about this.
 17 That PPE was diverted away from the social care sector
 18 in the early stages to go to the NHS. And that is
 19 a fact.

20 **MS HANDS:** Ms Ahmed, you mentioned in your previous answer
 21 funding, so if I may ask you briefly about that.

22 You have included in your statement some evidence
 23 from a survey that you conducted with your providers
 24 around whether they'd had access or been able to access
 25 the government funding that had been made available.

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1 I think what we have to be really, really clear about is
 2 that social care looks after some of the most vulnerable
 3 people, and it has to be treated as a priority, not as
 4 a secondary. It has to be moved in a way that the
 5 public and those that are making decisions understand
 6 the importance of us having access to resource, for us
 7 to be funded appropriately in order to make sure that we
 8 have that resource, when we need it. And we need it in
 9 a timely manner. We don't need it three weeks down the
 10 road when somebody suddenly thinks, "Oh, actually, it is
 11 going to affect the social care sector, better do
 12 something about it." It doesn't work.

13 **LADY HALLETT:** Forgive my interrupting, I think the point of
 14 Ms Hands' question was an answer from Mr Hancock, which
 15 was that the care homes should have -- I think he put it
 16 as a cupboard in which they could store a month's worth
 17 of PPE. In other words, it wasn't getting access to the
 18 emergency stockpile or supplies, it was having a month's
 19 supply in a cupboard.

20 **A.** Well, most providers would have a reasonable amount
 21 of -- thank you for clarifying that for me. Most homes
 22 would have a supply because that's what you do. You
 23 have a month or six weeks' supply, just in case
 24 something goes wrong. We didn't have that supply of
 25 masks, though. So, you know, this was a new, new way of

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1 Could you briefly just describe some of their
 2 experiences of accessing the government funding.

3 **A.** I think it wasn't the easiest methodology, but actually,
 4 you know, I have to say that it was the only bit of
 5 money that came to the front line, and was really
 6 helpful to the sector. So from that perspective, it --
 7 I -- you know, we're grateful for that.

8 But it wasn't an easy -- it was routed through local
 9 authorities. We understand that -- I think it was 30%
 10 from our -- from memory, from the survey, of people who
 11 said they didn't get it, and it was held back. Which is
 12 quite worrying, why it was so inconsistently
 13 distributed. So certain local authorities didn't
 14 distribute it in the way that they did. Others did
 15 really well.

16 And I think that inconsistency, god forbid we have
 17 anything like this in the future, must be ironed out.
 18 It has to be. If it's ring-fenced, it needs to come to
 19 our sector.

20 **Q.** You have also provided some examples of the types of
 21 additional costs that were incurred by providers, such
 22 as reconfiguration of care settings, buildings,
 23 specialised equipment and increased staffing costs as
 24 well. Were small and medium providers
 25 disproportionately affected by that?

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1 **A.** I believe so. I think we were. We were having to --
 2 the adaptability of our services were quite challenging.
 3 Our insurance costs went up, I don't know, tenfold.
 4 People tell me a hundredfold. Insurance companies
 5 weren't willing to insurance our service because they
 6 wouldn't do the Covid, so reinsurance became really
 7 difficult. That hit us quite quickly. And providers
 8 were paying -- I think where somebody -- one of the
 9 examples I remember was somebody who had paid £1,800 for
 10 their insurance the previous year were being asked for
 11 8,000, 9,000, and then the following year it went to
 12 about 20,000 or 30,000. So that was an enormous cost.

13 Food costs were affecting us as well. Of course,
 14 you know, the delivery chain impacted on us as well.

15 There were -- the reconfiguration, you know, for
 16 example, putting out pods and things, that all came in
 17 for the visiting -- people were already starting to look
 18 at window visits, putting up perspex in between. So all
 19 these were additional costs that we weren't supported
 20 with.

21 **Q.** And at the end of your statement you have provided
 22 a very helpful list of recommendations which the Inquiry
 23 will publish in full but I'd like to ask you about one
 24 of those, if I may, and that's that the NCA would
 25 support a database of all adult social services,

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1 there, and not be vaccinated. Why would they come back
 2 to social care, where that -- other mandatory things
 3 could be thrown at them?

4 **Q.** And just finally, how do you think that would help in
 5 a future pandemic if there were such a register?

6 **A.** I think we'd know where people were and how we could
 7 access -- the data could be used in so many different
 8 ways of making sure that some of the things that
 9 happened didn't happen again. I think having that --
 10 I mean, data collection has become a big thing. It's
 11 great to collect data but it's how you use it that makes
 12 the difference, and if we have it, then we must have
 13 a methodology that goes with it. So we prevent the
 14 challenges that we faced at that point.

15 **MS HANDS:** Ms Ahmed, made thank you.

16 My Lady, those are my questions.

17 **LADY HALLETT:** Thank you very much, Ms Hands.

18 Mr Weatherby.

19 Mr Weatherby is just there, just a few more
 20 questions.

21 **Questions from MR WEATHERBY KC**

22 **MR WEATHERBY:** Thank you very much and good afternoon,
 23 Ms Ahmed. I ask questions on behalf of the Covid
 24 Bereaved Families for Justice UK group.

25 Continuing with the theme of data, in terms of data

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1 including those that are not registered with the CQC.

2 Is that right?

3 **A.** Yes.

4 **Q.** And in regards to that register, would that also include
 5 social care workers?

6 **A.** Yes.

7 **Q.** And do you have a view as to who would be best placed to
 8 collect that data?

9 **A.** I don't have a view on that. Not a strong view, no.
 10 I think there are various people, various bodies out
 11 there who could do the job.

12 **Q.** And do you have a view as to whether it should be
 13 mandatory or a choice, voluntary?

14 **A.** I think that's a much more difficult question. I think,
 15 thinking back to mandatory vaccinations, I wouldn't want
 16 to lose 40,000 staff because of something that we were
 17 mandating which wasn't mandated anywhere else. I think,
 18 if we showed the benefits of it being a useful
 19 collection of data, and then people move towards it,
 20 that might be a better way. I don't like -- since the
 21 mandatory vaccination scenario and the fiasco that that
 22 was, with social care being deliberately targeted to
 23 have that inflicted on them, and the loss of a very good
 24 workforce that we had who are never going to come back
 25 because they could go into the NHS and they could work

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1 and ethnicity, the Public Health England report beyond
 2 the data published in June of 2020 noted that there was
 3 only one study which reported mortality in health care
 4 workers in the UK by ethnicity, and that further
 5 analysis was urgently needed to understand the morbidity
 6 and mortality of health and social care workers due to
 7 Covid, with a particular focus on BAME groups.

8 Was there, in your experience, a general lack of
 9 recording of the ethnicity of not only healthcare but
 10 also social care workers at the start of the pandemic?

11 **A.** Well, it was never mentioned. It was never -- it never
 12 figured; it never factored in any discussions or debates
 13 that we were having in any meaningful way.

14 I think it became much more apparent when the
 15 mandatory vaccination thing came into place, because
 16 there was a lot of concern that a lot of people from
 17 ethnic backgrounds were not willing to take. And that
 18 was the first time that data was starting to be produced
 19 about how Covid would impact people from ethnicity more.

20 **Q.** Yes. In terms of further analysis recommended by PHE,
 21 did the NCA involve itself with that?

22 **A.** We've always -- yes, we did.

23 **Q.** Yes. The PHE report recommended the routine collecting
 24 and recording of ethnicity data as part of routine NHS
 25 and social care data collection systems, and the sharing

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1 of data across local health and care partners to inform
2 and mitigate the impact of Covid-19 on BAME communities.
3 And do you know if that recommendation was actually
4 carried through?

5 **A.** No, I don't.

6 **Q.** Would you have supported that recommendation at the time
7 or going forward?

8 **A.** I think I would have. I am always concerned about --
9 again, I repeat what I just said, data collection is
10 important. But it's why it's used.

11 **Q.** It's what you use it for.

12 **A.** And that's where you've got to be very clear and careful
13 that data is not misused.

14 **Q.** Yes. Finally, in terms of PPE, the Inquiry has heard
15 evidence in previous modules of healthcare workers from
16 ethnic minority backgrounds not having culturally
17 competent PPE, particularly at the start, in the first
18 wave. Was this, to your knowledge, addressed across the
19 care sector?

20 **A.** No.

21 **MR WEATHERBY:** Thank you very much. That's all I ask.

22 **LADY HALLETT:** Thank you, Mr Weatherby.

23 And then I think Mr Straw, who is over there.

24 **Questions from MR STRAW KC**

25 **MR STRAW:** Good afternoon, I act on behalf of John's
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1 part of the sector, were trying their best to try to
2 facilitate visiting for people, because we could see the
3 difference it made. Suddenly, you know, you've got the
4 staff are being all things to everybody, and so the
5 pressure on our staff group was also great, but being
6 able to have people coming in was seen as a benefit. It
7 was always seen as a benefit.

8 But then some of the consultations put barriers in
9 the way. There was such negativity around it in some
10 cases. So I think it wasn't -- I don't think the
11 consultation was carried out to the best -- in the best
12 way that it could have been.

13 **Q.** Okay, thank you. Then coming on to visiting and, you've
14 just touched on it, some of the benefits of visiting, do
15 you consider that the visiting restrictions struck the
16 right balance? And I'm particularly interested in the
17 exclusion of essential carers, family carers, for people
18 who had significant care needs, like dementia sufferers;
19 did those visiting restrictions strike the right
20 balance, in your view?

21 **A.** I'm sorry, as you taper off, I didn't hear the final
22 bit.

23 **LADY HALLETT:** Did the visiting restrictions strike the
24 right balance? So, for example, with essential carers
25 not being allowed to care for their loved ones when they
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1 Campaign, The Patients Association and Care Rights UK.

2 At paragraph 72 of your witness statement you state
3 that the consultations and guidance regarding the
4 reintroduction of visits by loved ones were consistently
5 behind the reality on the ground. Is one reason for
6 this that there was no mechanism which ensured that
7 organisations who represent social care users and their
8 carers were speedily consulted for changes to the
9 guidance?

10 **A.** I'm kind of missing a few words that you said there,
11 sorry, at the end. Was the consultation?

12 **Q.** Was the reason why that guidance didn't reflect the
13 reality on the ground that speedy consultation didn't
14 happen with organisations who represent care users and
15 also carers?

16 **A.** I think the visitation consultations were very
17 haphazard, and certain parts of the sector were
18 potentially talking to interested parties and certain
19 bits of the sector weren't.

20 What was very evident for us was that some of that
21 was contradicting each other. Some of the -- you know,
22 some of the recommendations were challenging each other.

23 And one of the things that kind of is really
24 important, I think, in all of this, is that we were
25 concerned that providers, certainly my members, the SME
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1 had experience of doing so at home?

2 **A.** Well, I think it would have been -- it would have always
3 been beneficial for people to be able to visit their
4 loved ones had they been caring for them at home. It
5 was a risk to their own health that was causing the
6 issues for people.

7 But actually, we had -- a lot of the smaller
8 providers were telling us they were being told that they
9 were in breach because of -- they were allowing people
10 to come in -- tested. You know, by the time the testing
11 had come in, I do believe that if somebody has been
12 caring for somebody in their own homes and they then
13 find them in a care setting, that they should be
14 enabled, if, God forbid, this all happens again, they
15 should be enabled to be -- able to support their loved
16 one.

17 **MR STRAW:** And this may be obvious but you touched earlier
18 on the importance for staff of a family or other carers
19 being allowed in. It takes the burden off staff. And
20 I think you were also pointing there to the benefit for
21 the individual themselves, if they have that essential
22 or family carer support. Are those two of the reasons
23 why it's important to have access to essential carers?

24 **A.** Yes, I mean I lived through it. My father was in a care
25 home. He was there, and I remember the visits to him.
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1 I remember the visits when he was at home, and trying to
2 get food through the door for him, and then going into
3 the care home and not being able to go in to see him.
4 So absolutely, I think -- I think it's quite -- it is
5 quite difficult to argue against having -- taking the
6 pressure off some of the workforce, as well, but also
7 taking -- enabling people who are willing and able.

8 And one of the things that, you know, I think it
9 would be prudent to mention is that some of the people
10 who initially were coming to visit, in care homes, their
11 loved ones, were of an age that was considered to be at
12 risk, and so they had to be, you know -- so the rules
13 were that they needed to isolate or whatever. And it
14 did have -- it has a detrimental impact on the person.
15 You know, I know what my dad felt like because he would
16 stand at the window and keep shouting to me to come up
17 because he couldn't understand why I couldn't come up.

18 So those are the challenges that we were facing, but
19 absolutely, we've got to get it right. We've got to get
20 it right if this happens again, and people benefit from
21 seeing their loved ones. I don't know whether that
22 fully answers your question. I'm kind of probably
23 repeating myself.

24 **Q.** It does. Thank you very much. And I'll move on to the
25 final topic, and I'll try and speak directly into the

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1 particularly people with dementia?

2 **A.** Absolutely.

3 **MR STRAW:** Okay, thank you very much.

4 **LADY HALLETT:** Thank you, Mr Straw.

5 That completes the questions we for you, Ms Ahmed.
6 I'm really grateful to you. I appreciate how
7 distressing it must be for a lot of witnesses who have
8 to think back through those really difficult times, and
9 I'm sure that all the people that you represent had
10 a really tough time, as did their residents and their
11 loved ones. So thank you very much for all your help,
12 and I'm sure there will be some support for you when you
13 leave the hearing room.

14 **THE WITNESS:** Thank you, my Lady, for the opportunity.

15 **LADY HALLETT:** Thank you. I shall return at 10.00 tomorrow.

16 (4.35 pm)

17 (The hearing adjourned until 10.00 am the following day)

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1 microphone in the hope that helps.

2 **A.** I'm sorry, I'm also hard of hearing, so -- but I have
3 got hearing aids in, but it's not picking it up, so it's
4 partially my fault.

5 **Q.** I'm going to shout. Earlier you mentioned -- earlier
6 today in your evidence and also in your statement you
7 mentioned innovations such as visiting pods to
8 facilitate visits. Were you aware that these pods were
9 considered to have major disadvantages for some people,
10 people with cognitive hearing or visual impairments,
11 such as dementia, and people considered that they didn't
12 enable carers to provide care in an effective way?

13 **A.** I wasn't aware of that. I wasn't aware that the pods
14 were considered to be not a good way of facilitating
15 visiting, no. It was something that was certainly used
16 quite a lot throughout the sector, especially in SMEs
17 where space was limited. It was creating additional
18 space so that people could also not have to come in
19 through the building. They were going from outside in
20 order to make that happen. And I wasn't aware of the
21 study that you've -- potentially the study that you've
22 just spoken of.

23 **Q.** Just one broader and final question, then. Would you
24 agree that face-to-face or in-person care is really
25 important for certain types of people needing care,

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