

Wednesday, 23 July 2025

(10.00 am)

LADY HALLETT: Ms Cecil.

MS CECIL: Good morning, my Lady. May I please call Professor Sube Banerjee.

PROFESSOR SUBE BANERJEE (affirmed)

Questions from COUNSEL TO THE INQUIRY

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

THE WITNESS: Thank you.

MS CECIL: Professor, you have helpfully prepared an expert report on the impact of the Covid-19 pandemic on the care and treatment of people with dementia and their families, and for those that are following, that's INQ000546956, helpfully brought up on the screen.

If I may very briefly just go through your professional background insofar as it is relevant to the matters we will be discussing today. You are currently the Pro-Vice Chancellor at the Faculty of Medicine and Health Sciences, and Professor of Dementia at the University of Nottingham; is that right?

A. I am.

Q. In relation to your experience, you have both considerable clinical and academic experience.

A. Yes, I'm a clinical academic doing both research and clinical work with people with dementia.

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course.

A. Yes, I did see some of the evidence was from Kate Lee who is the former Chief Executive of the Alzheimer's Society.

Q. And alongside your expertise, the report also draws upon the expertise of Dr Nicolas Farina and Dr Ben Hicks.

A. It does.

Q. Thank you.

If I may begin, then, at the very start, what is dementia?

A. Well, dementia is one of the most serious and one of the most common disorders that we face. It's a major public health and social care challenge. Dementia is a term that is used for a collection of disorders, so dementia is a thing that is caused by various illnesses, the most common of which is Alzheimer's disease. I'll come back to that.

But dementia is a syndrome which is characterised by two things, mainly. Firstly, a progressive decline in one's cognitive abilities, that's your abilities to be able to think and to remember and to do all the things your brain does, so a progressive cognitive decline. But, also, alongside that, there is a functional decline. So that then stops you from being able to do things that you were able to do in terms of activities

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Q. And helpfully for our purposes, you were also, at various points, seconded to the Department of Health and Social Care in relation to policy.

A. Yes, on two occasions I was seconded for four to five years, the first as senior medical officer in the research and development division of the Department of Health, as it was then, basically responsible for all mental health research for people of all ages, including older people, and second, I was -- and second, in 2005 to 2010, I was seconded as the senior professional adviser in older people's mental health and dementia at the Department of Health, as it was at the time, and helped prepare the National Dementia Strategy.

Q. Thank you. I just want to flag, for transparency, one aspect if I may; you also hold number of trusteeships, non-executive directorships, memberships, and so on.

A. I do.

Q. One of those was as a trustee of the Alzheimer's Association; is that right?

A. Alzheimer's Society.

Q. Society, my apologies.

A. Yes, I am a trustee of the Alzheimer's Society.

Q. Alzheimer's Society, my apologies. Thank you, and I flag that just for transparency because you may be asked about some of their work or policies papers in due

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of daily living, so -- as that becomes more -- as dementia becomes more severe, there is more impairment that comes from that, and that includes social communication as well as dressing, cooking, eating, those sorts of things.

Q. So we see both cognitive decline and also functional decline?

A. That's correct, and dementia also has two other aspects which are part of the syndrome and are particularly complex and difficult. So the first of those is the social impairments that happen in dementia, which may be a function of the cognition or maybe a function of other brain changes that are there, but that social -- the social problems that happen in dementia are either withdrawal or agitation, and compromising one's ability to be able to be do the things that we're used to, not because of physical reasons, but because of the way we socially interact.

And very importantly, and a very major driver of poor quality of life for people with dementia, and also their family carers, are the development of neuropsychiatric syndromes, which are a part of the syndrome almost everybody dementia -- everybody with dementia, at some stage in dementia, will develop either anxiety or agitation, sometimes even aggression, and

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1 resisting help giving, at times, but things which can
 2 also include hallucinations and delusions, beliefs that
 3 things aren't real, seeing things that other people
 4 can't see, and these in and of themselves are
 5 distressing for the people with dementia and for carers
 6 and are unfortunately part of the syndrome of dementia,
 7 and they can happen either early in the illness, in the
 8 middle of the illness, or later in the illness.

9 **Q.** Thank you. And is it a terminal illness?

10 **A.** Dementia is a terminal illness. A third of people in
 11 the United Kingdom die with dementia, and dementia is,
 12 as I said, a neurodegenerative disorder, it affects all
 13 parts of the brain, essentially, and our brain
 14 essentially allows us to do everything that we do,
 15 including, you know, breathing and eating and those
 16 sorts of things, so dementia is a terminal disorder,
 17 though people may well die of other illnesses before
 18 they die of dementia.

19 **Q.** In terms of life expectancy you describe that as
 20 typically being between seven to 12 years
 21 post-diagnosis, obviously dependent upon when diagnosis
 22 is made and a range of other factors?

23 **A.** Yes, absolutely. So it depends upon the age at which
 24 one is diagnosed, the earlier one is diagnosed, then
 25 potentially the longer one might live. But vitally, it

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1 So if you have small strokes or you have blocked blood
 2 vessels, then that itself can be a cause of dementia,
 3 and that's often called vascular dementia. So that
 4 would be the second most common specific type of
 5 dementia.

6 What complicates things in dementia, of course, is
 7 that almost everybody as they grow older has some
 8 element of vascular illness; so people with Alzheimer's
 9 disease also have vascular illness, some of that affects
 10 their brain and those cases can then be called mixed
 11 dementias.

12 And there's a different pattern that one gets with
 13 vascular dementias and with -- because it depends on
 14 where the problems are in the vascular system compared
 15 to Alzheimer's disease.

16 There are also a group of dimensions that are
 17 associated with Parkinson's disease. Again, that's
 18 a different pathology than Alzheimer's disease and we
 19 know a little bit more about that. But people with
 20 Parkinson's disease are more likely to develop dementia.
 21 And there are people who develop Lewy body dementia that
 22 can happen before the symptoms of Parkinson's disease
 23 happen.

24 **Q.** Thank you.

25 **A.** There are a lot of other different causes of dementia.

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1 depends upon comorbidities, other physical disorders,
 2 but yes, within seven to 12 years you can expect
 3 somebody who is diagnosed early will die.

4 **Q.** And you have spoken about a number of different
 5 illnesses or causes of dementia, and you touched upon
 6 Alzheimer's.

7 **A.** Yes.

8 **Q.** Just to be clear about that, that is often used, isn't
 9 it, as a shorthand for dementia but it is but one type
 10 of dementia?

11 **A.** Yes. It is the most common form of dementia, followed
 12 closely by Alzheimer's disease with other -- mixed in
 13 with other forms of dementia.

14 Yeah, I mean, we have an imperfect understanding of
 15 the etiology of dementia as a whole and also of the
 16 causes of dementia.

17 But if I could just -- so the main causes are
 18 Alzheimer's disease. And Alzheimer's disease, there is
 19 degeneration -- there is a characteristic degeneration of nerve
 20 cells that leads to those nerve cells' death and
 21 a characteristic pattern of that degeneration in
 22 different parts of the brain.

23 The second most common aetiology form of dementia
 24 will be things that are to do with your vascular
 25 make-up. So cerebrovascular health is really important.

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1 **Q.** Of course.

2 If I can just touch upon specific risk factors, age
 3 is obviously the predominant risk factor for dementia?

4 **A.** It is.

5 **Q.** Women also have a higher prevalence of dementia than
 6 men?

7 **A.** They do.

8 **Q.** Fairly comprehensive studies by The Lancet have
 9 considered that up to half of dementia syndromes might
 10 be attributable to potentially modifiable risk factors.
 11 You set those out within the report. They deal with
 12 things such as less education, hearing loss, physical
 13 inactivity, diabetes, traumatic brain injuries,
 14 pollution, all sorts of other matters; and many of
 15 those, you say, are more common in deprived and
 16 marginalised groups?

17 **A.** They are.

18 **Q.** So there's a potential connection there with
 19 socioeconomic deprivation.

20 You also set out that there is a disproportionate
 21 impact among minority ethnic groups, with a 20% higher
 22 likelihood of dementia; is that correct?

23 **A.** That's correct, and that is likely -- there may be
 24 elements of that that have a complex genetic basis, but
 25 a lot of it depends upon social and behavioural

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1 characteristics. So, for example, if you -- if there's
 2 greater deprivation and your diet is worse, if there is
 3 a higher level of obesity, if you have more diabetes, as
 4 some groups do, then those are more likely, and your
 5 risk of dementia increases with those comorbidities.

6 **Q.** Thank you. And the other group for which there is
 7 a significant risk profile are those with learning
 8 disabilities?

9 **A.** Yes, there are particular groups at risk of dementia.
 10 People with learning disabilities form a high-risk group
 11 in and of themselves, particularly people with Down
 12 syndrome.

13 **Q.** Thank you. And what dementia is not, however, is an
 14 inevitable consequence of aging; that's a misconception?

15 **A.** No, there are a number of misconceptions about dementia
 16 and, absolutely, dementia is not a natural and normal
 17 part of aging. It is -- and it's -- as I said, it's
 18 caused by several illnesses. But all of those are
 19 specific disorders.

20 So the prevalence of dementia, the number of -- the
 21 proportion of individuals at any age group with dementia
 22 does increase with age. So at about 65 it's about 7% of
 23 people, at about 85 it's about 20% of people, at about
 24 95 it's about 33% of people. But that still means that
 25 two-thirds of people do not have dementia, and we have

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1 **A.** The vast majority of care is provided by family carers.
 2 That's the term that I use because that's the one that
 3 family carers have preferred in the research that we
 4 carried out. But family carers also includes friends
 5 that support individuals as well, in the terms
 6 that I use.

7 But the vast amount of care is provided by families
 8 of people with dementia, unpaid family members who
 9 support those individuals. If you look -- if you look
 10 within that at about who provides most care, it is
 11 generally women. Women provide most of the care. The
 12 predominant group will be those people that are spouses
 13 of those individuals, so that if you are living -- if
 14 you're co-resident and live with the person with
 15 dementia and that person develops dementia, then you
 16 will be very likely -- you will be that main family
 17 carer and you will be providing those. And those are
 18 very largely spouses. Some of them are -- are the next
 19 generation, are sons and daughters, who may or may not
 20 move in to do that.

21 But there are also non-co-resident caregivers, and
 22 those are generally sons and daughters or
 23 daughters-in-law who are providing that main family
 24 caring responsibility.

25 Another thing about family caring is that it doesn't

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1 good evidence to suggest that it's not that they -- it's
 2 not that if you live until you're 120 you get it.
 3 Dementia is not a natural and normal part of growing
 4 old; it is an illness in and of itself.

5 **Q.** Just to turn to population demographics for a moment,
 6 across the UK, in terms of the over 65 population, it's
 7 around 7.1% of those individuals have dementia?

8 **A.** Yes, there are different -- there are different
 9 estimates from different studies using different
 10 criteria but it's about that. So we have about -- it's
 11 about 7% of the people over 65, if you take that whole
 12 population again. If you go to higher age groups, you
 13 get a higher proportion.

14 **Q.** So, as I say, 7% over 65s and around 2% across the
 15 entirety of the population?

16 **A.** Yes, about 2% of the people in the UK. That's of all
 17 ages, including children.

18 **Q.** Thank you.

19 Care is obviously an important issue for those with
 20 dementia. You've described that it's a degenerative
 21 disease.

22 **A.** Yes.

23 **Q.** What follows from that is that there are greater care
 24 needs as the illness progresses, as the syndrome
 25 progresses. Who provides care in the majority of cases?

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1 fall evenly in families. So there is generally one
 2 individual who takes most of the role on. And, you
 3 know, there are positive things about caring for people
 4 that you love and know, that are part of your family,
 5 and there are also negative consequences of looking
 6 after people with dementia.

7 **Q.** And we'll come on to some of those in terms of some of
 8 the pandemic impact in due course.

9 Just dealing then with the proportion of those with
 10 dementia that live in care homes, that's approximately
 11 a third; is that right?

12 **A.** Yeah, a third of all people in the UK who have dementia
 13 live in care homes, yes, that's our best estimate.

14 **Q.** And then when looking at the care home population,
 15 it's -- the estimates are around 80-90% of those in
 16 older people's care homes have dementia?

17 **A.** Yes. So if you look at care homes, the normal care
 18 homes, not care homes that are specifically for people
 19 with schizophrenia or people with learning disabilities,
 20 if you look at, you know, the 95% of those standard care
 21 homes, between 85% and 90% of those individuals have
 22 dementia. Care home care in the United Kingdom,
 23 long-term social care, is essentially dementia care.
 24 Because that is the reason why individuals cannot
 25 continue to live in their own homes.

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1 People with dementia also, when they are admitted,
2 live longer, so they live longer in those homes. People
3 who are admitted to care homes with an acute physical
4 problem out of hospital, and no cognitive impairment,
5 they will often die within the first six months of being
6 in the care home.

7 So you end up with a care home population being
8 80-90% made up of people with dementia.

9 **Q.** Thank you. I'd like to move, then, to the initial
10 pre-pandemic position in terms of governmental policy
11 and strategy. If I can summarise what you have to say
12 in your report like this: what you explain is that
13 across the four nations, dementia had emerged as
14 a priority over the past 15 years.

15 **A.** Mm.

16 **Q.** However, for the years immediately prior to the
17 pandemic, that had waned, effectively, the interest and
18 the will had waned in respect of those, there were
19 concerns about a lack of delivery. The question I have
20 is a very specific one, which is: what implications did
21 that have for the pandemic?

22 **A.** So the waning was particularly clear in England, but the
23 level of delivery was unclear in all of the countries of
24 the UK, in terms of what was being done. The specific
25 question as to what did that do, it means that we were

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1 self-reporting symptoms.

2 Were the risks to those with dementia foreseeable?
3 Ought they to have been included in those policy
4 documents on the basis of what is known?

5 **A.** Yes, and yes, they were foreseeable and they should have
6 been included in those documents. People with dementia
7 are almost by definition old and frail with complex
8 comorbidities. They are also, as we've heard, more
9 likely to be living in care homes, so congregate
10 households. It is entirely predictable that almost any
11 pandemic would affect older people and people with
12 dementia disproportionately. And it's very clear that
13 that's what happened within this pandemic. There are
14 few pandemics that would be isolated to children, or
15 whatever, but these are the most vulnerable, physically,
16 in our society, and it is likely that the most
17 vulnerable in society are most likely to be vulnerable
18 to infectious diseases.

19 So yes, I think that any pandemic, any pandemic
20 planning should have explicitly included those people
21 that were most at risk of being harmed, and I think that
22 any future pandemic planning must attend proportionately
23 to those people who are most likely to be harmed by
24 those pandemics.

25 **Q.** If I may pick up on the disproportionality that you've

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1 less prepared, we had less good care and support for
2 people with dementia than we could have, and that we
3 should have. And that put people with the dementia
4 certainly less in the eye of policymakers, it was less
5 of a priority for the Department of Health, or the
6 Department of Health and Social Care, as it became,
7 because it wasn't -- didn't have the policy priority it
8 once had, and I -- and it meant that the services that
9 were being provided to support people were often
10 fragmented and often -- and that there was major
11 variation across the country in terms of what one might
12 be provided with in terms of both diagnostic and
13 post-diagnostic care.

14 **Q.** Thank you.

15 If I can turn, then, to the guidance at the outset
16 of the pandemic, in England, dementia was not explicitly
17 mentioned with regard to shielding or social distancing,
18 in terms of the March guidance --

19 **A.** Yes.

20 **Q.** -- the April unpaid care guidance or, indeed, the list
21 of clinically extremely vulnerable that was later
22 published in winter of 2020. It was similar in Northern
23 Ireland, and again, in England and Wales, when it came
24 to guidance in relation to dementia, it was not in
25 relation to risks but with regard to difficulty in

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1 just mentioned.

2 **A.** Yes.

3 **Q.** One of the headline messages from your report is that
4 people with dementia were disproportionately impacted in
5 terms of mortality --

6 **A.** Yes.

7 **Q.** -- death, in short. And that overall, a quarter of all
8 deaths occurred with people with dementia?

9 **A.** Yes, and what we've tried very hard to do in our report
10 is to look, as dispassionately as we can, at the various
11 sources of data that are out there. And the data
12 sources are not unequivocal. We have looked at a lot of
13 research from a lot of different places and a lot of
14 routinely collected data. What we also tried to do was
15 to boil it down into understandable messages, which had
16 the weight of the evidence behind them. And yes, we
17 found that 25% of the deaths of people with Covid were
18 in people with dementia, so a quarter of all people who
19 died of Covid were people who had dementia.

20 And as we said earlier, that's a quarter of all the
21 deaths happening in 2% of the population. That is
22 disproportionate.

23 **Q.** Thank you. And I'm not going to take you to the
24 statistics that you set out within your report, but in
25 terms of the four nations, what is clear is that the

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1 same pattern emerged in terms of that, broadly speaking,
2 a quarter figure.
3 **A.** I mean, there are variations, there are minor
4 variations, but it's pretty clear that the same
5 experiences were had by people with dementia across the
6 United Kingdom. There are variations in the way that
7 dementia is recorded, there are variations in the way
8 that death may be recorded and other things, which means
9 that there will be variations, but yes, it appeared to
10 us that the same things were happening across the United
11 Kingdom.

12 **Q.** And deaths in hospitals, a similar disproportionality,
13 with people with dementia being 38% more likely to die
14 in hospital during wave 1 to those without dementia, and
15 in wave 2, still 34% more likely, comparatively?

16 **A.** Yeah, and all of the information holds together.
17 Clearly a lot of people with Covid died in hospitals,
18 and that, you know, that is -- that -- and many of those
19 people were people with dementia, who died in hospital
20 with Covid. There were people who died in hospital,
21 people who died at home, and people who died in care
22 homes, and in all of those settings, if you had
23 dementia, you were much more likely to die than those
24 without.

25 **Q.** Indeed. And in terms of excess mortality, similarly,

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1 dementia?

2 **A.** Yes, that's the thing, so the 85-90% estimate is based
3 upon those studies that have gone into care homes and
4 actually diagnosed people using research methods. If
5 you simply rely on the GP records for dementia, then
6 only two-thirds of people are diagnosed at any time, so
7 many people in care homes may not have a formal
8 diagnosis but will have dementia.

9 **Q.** And you provide a number of potential explanations for
10 these disparities that arose in relation to the
11 pandemic. One aspect of that, in your words, is
12 deprioritisation and differential management of care
13 home residents and people with dementia. Can you just,
14 very briefly, explain a little bit further as to what
15 you mean by that.

16 **A.** Specifically in care homes?

17 **Q.** Yes.

18 **A.** Yeah. So I think that it's very clear that there was
19 worse care provided by the NHS and by the system as
20 a whole to care homes than there was to acute hospitals.
21 There was a prioritisation of acute hospitals over care
22 homes, and that included the sending people back to care
23 homes that had -- without testing, who were Covid -- who
24 were positive for Covid and who therefore spread those
25 things.

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1 people with dementia had the highest levels of excess
2 mortality in 2020?

3 **A.** They did.

4 **Q.** Just to be clear, these disparities were seen even when
5 accounting and adjusting for comorbidities and other
6 potentials causes of death; is that right?

7 **A.** That's right. I mean, the data here become, you know,
8 a little more uncertain, but those studies that have
9 been done, that have attempted to control for the
10 effects of, you know, other physical illnesses and other
11 situations, do suggest that that even when you take
12 those into account, that there was an increased
13 mortality in people with dementia, and part of that, of
14 course, will be the effect of care homes that we've
15 talked about, as well, in terms of determining higher
16 mortality rates.

17 **Q.** Indeed. And just dealing with -- picking up the point
18 about deaths in care homes, if I may. Obviously, there
19 are a large number of individuals that are not formally
20 diagnosed with dementia.

21 **A.** Yes.

22 **Q.** But is it right that in your view and, indeed, the
23 research that you've considered, that notwithstanding
24 that, the overwhelming majority of those that died
25 without formal diagnosis were likely to have also had

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1 So there's a set of reasons why those sorts of
2 things might happen, but they are all based on a lack of
3 priority given to care in -- social care, compared to
4 care in healthcare. There is talk of the, is it the
5 steel boundary, or the ring of steel --

6 **Q.** The ring --

7 **A.** -- that was put around care homes and just looking at
8 the evidence, you wonder whether that -- well, firstly,
9 there's very little evidence of it, but you wonder if
10 its effect was to protect the NHS from people in social
11 care, rather than to protect those people in social care
12 from Covid.

13 **Q.** If I can ask you, please, just in relation to one other
14 aspect, within your report you explain that obviously
15 lots of individual decisions are taken --

16 **A.** Yeah.

17 **Q.** -- and there are systemic issues then that come into
18 play, as a consequence of that. And one aspect of that
19 are beliefs and misconceptions. Can I just ask in
20 relation to that, what concrete steps should and could
21 have been taken to recognise and address that
22 disproportionate impact during the pandemic?

23 **A.** So I think clearer guidance would have been very
24 helpful. I think guidance that made specific reference
25 to older people and to people with dementia, criteria

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that were more explicit would have been helpful. I think that -- and this is absolutely not seeking to make any statement of blame, but it is seeking to understand why one group of people appears to get a worse set of care than another group of people.

And if we look again at the research-based evidence, we see that the general population and healthcare professionals have lower expectations and lower positivity about older people and older people's health than they do about people in -- middle-aged and younger people. And so you have a set of potential biases that enter into clinical decision making, but also enter into the management of hospitals, and also enter into the generation of health policy and delivery of health policy because these misconceptions and negative attitudes towards older people are held by the general population and also by people in healthcare.

So presented with extraordinarily difficult and complex situations, you're, you know, and you are asked to make decisions and you make those decisions according to your internal compass. If your internal compass faces away from people who are old, then you may be more likely to decide that individuals don't get a test, are sent back to their care homes or sent back home, rather than afforded the care that might -- the extra care that

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A. So people with dementia rely on -- they rely on health systems, social care systems, to have their support. But they also rely on those systems being available to be able to tell them they've got dementia. Nobody knows that they've got dementia until you've been through a diagnostic process. And it's complicated, because many people who are developing dementia -- and this is different from other disorders -- do not recognise that they have the symptoms. There's a lack of insight that is one of the features of dementia.

So an individual with a pain in a particular place might come forward and say, "Hi, I've got this pain."

Someone with dementia will not -- is not likely to come forward and say, "Hello, I've got a problem with my memory."

What happened during the pandemic was that the diagnostic services that existed were largely shut down and stopped working.

Q. Those are the -- (overspeaking) --

A. They were largely -- so diagnosis happens in a two-stage process in the UK. The first is that, in primary care, there is a suspicion that something is wrong, and that might be a family carer come and say -- coming to say, "I'm worried about my partner."

It might be an individual saying that themselves.

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be provided in a general hospital, for example.

LADY HALLETT: Can I just interrupt?

A. Of course.

LADY HALLETT: Ms Cecil asked you about the guidance, and you said clearer guidance with specific reference to older people and people with dementia would have been helpful, and you said, "more explicit criteria". What did you mean by more explicit criteria?

A. I think that decision -- and one can understand why, but clinical decision making was largely left to individuals to make their own decisions in those without guidance. I think that the lack of ... the lack -- so there were a number of conditions that were identified as particular high-risk groups quite early, and dementia wasn't one of those. And I think that that then frames those high-risk groups as ones where you should do things and the rest as ones where you might -- there might be less of a reason to do things. That's the sort of thing I was talking about there.

LADY HALLETT: Thank you.

MS CAREY: If I may turn to other impacts, you also explain that diagnostic services and post-diagnostic care, so effectively people being diagnosed, those services were seriously disrupted during the pandemic. What does that mean in practice?

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Or it could be that memory problems were noticed as part of another -- as part of a routine consultation.

Now, all of those things didn't happen. That's that first stage. The second stage is you then refer that person to a specialist memory service, and that memory service then does the more detailed assessment, and not only makes the diagnosis of dementia, ascertains that they have that, but also works out what condition is causing the dementia and what other problems people have. So you can formulate a proper care plan.

So what happened in the pandemic was that both elements of that were shut down. So primary care services essentially became an online service, and online services don't really provide that sort of -- you can't pick something up in a consultation --

Q. In the same way?

A. -- in the same way. And they were perceived as being a scarce resource that shouldn't be disturbed, and so older people are much less likely, in those circumstances, to seek care.

But even if individuals were noticed as having memory problems, the memory services that exist, which are, you know, hard pressed through the country anyway, and of variable quality, they were essentially closed down, because the normal way of assessing people with

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dementia is to see them face-to-face and take a collateral history from a family carer, and it's a careful and multidisciplinary assessment that's done face-to-face.

And face-to-face services stopped.

There was some pivoting towards online services, but the volume of people being seen was very much lower. So what it ended up with, was a cohort of people who were less likely -- who either had their -- the opportunity for diagnosis missed, or it happened late, with the consequent problems that come from not knowing you've got dementia. Because the next piece of information is in this -- and it's another misconception, people believe there's nothing you can do about dementia -- there's a lot that you can do about dementia, but you have to know that you've got it in order to be able to do that. And systems and services have to know you've got it.

So there was a cohort of individuals who were -- whose diagnosis was missed, and we still are reaping the problems that come from that, and a cohort of people whose diagnosis was delayed.

It is also likely that those diagnoses that were made were of lower quality and lower accuracy than diagnoses made in the normal way.

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on those needs assessments during the pandemic, with far fewer, and certainly not at that level, in short; is that correct?

A. That is correct. One of the challenges that dementia and complex care, like dementia, raises, is that it's not a simple mechanistic process to make a diagnosis. So it's not like you do a blood test and you know that someone's got something. And it's also not that if that blood test is positive you then provide a particular tablet and everything goes away. That's really not what you get in dementia.

So all of the quality, all of the ability to live well with dementia, comes from these sorts of comprehensive assessments, this careful multidisciplinary work that then ends up with people's psychological and social needs being met as well, as their physical needs.

Q. Indeed.

A. And that was compromised during the pandemic.

Q. And you go on to speak about the importance of non-pharmacological care, but what you also then go on to state is that almost all of those modalities of care and support were stopped or curtailed in the pandemic.

A. Yes.

Q. And what impact did that have, briefly?

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Q. In terms of any future pandemic is there anything that you would recommend, for example, where face-to-face appointments cannot be maintained for whatever reason?

A. Yes, there's learning that we can take from the pandemic in terms of how to do it well and how to do it badly.

It was -- it was local, local innovation that happened within the pandemic. And there are things that one can do online. There are things that you can do to try to improve both the quality and the penetrance of people with -- of diagnostic services. So, yes, there are things that one can do differently.

Q. Thank you.

If I can just turn now to needs assessment and care planning, if I can just call up paragraph 73, please, of your statement INQ000546956, that's at page 34, what you explain there is that:

"Comprehensive needs assessment and care planning is core to providing good quality care ..."

It's much more than giving medication.

You explain that it involves a holistic person-centred approach, considering the person as a whole, the family, and the social context in which they live, also considerations of history, preferences, lifestyles.

Again, similarly, you describe a significant impact

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A. So people with dementia and the -- and their family carers had, and also people with dementia in care homes, had really very major negative impacts in terms of their quality of life and quality of care being provided to those individuals.

It's a complex picture when you have a co-resident person with dementia and a family carer because the consequences -- because family -- again, there's good and clear evidence now, I think, from multiple sources that suggest that if you were lucky enough to be living with somebody, then that person would -- then the person with dementia, in that situation, was more likely to have their life quality maintained, but that would be at the expense of the quality of life and the mental health of the carer of that person with dementia.

Q. Indeed.

If I can then also ask you, if I may, to look at this particular experience, this really deals with the experience of those with dementia.

It's INQ000474426, it's at page 26, and it goes over the page, please, to 27, at paragraph 5.6 to 5.8.

What we have here are the experiences of Cilla Merryweather and her parents Rosemary and Ronald Brown. They sadly died during the second wave of the pandemic in November 2020 and January 2021. What

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1 she explains there is that when the first lockdown was
2 announced -- she recalls that all the additional
3 supports that her parents had begun to rely on started
4 to disappear, chiropody services, but also visits from
5 the dementia nurses, an overworked and
6 under/inexperienced domiciliary care service was
7 utilised which sadly, for obvious reasons, resulted in
8 Ronald rarely being seen by the same care worker.

9 So the continuity of care that you speak to, the
10 familiarity of routines, and the like, were obviously
11 not present.

12 It continues that after Rosemary had passed away,
13 his health also then declined. And due to his decline
14 in his health and his needs not being able to be met by
15 those levels of domiciliary care, he was moved into
16 a care home.

17 How common were those types of experiences, in terms
18 of the research that you've undertaken?

19 A. So, it's a very familiar story. It's a familiar story,
20 it's actually a familiar story out of pandemics as well
21 as within the pandemics, but clearly these sorts of
22 things became much more common within the pandemics in
23 terms of the, you know, the very difficult circumstances
24 that both carers and people with dementia found.

25 So the networks that support people, that we put
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1 likely to settle into the care home and you're less
2 likely to be -- to have a good care plan generated and
3 less likely to be properly supported in that
4 environment.

5 So I think these normal stories of tragedy were very
6 much exacerbated and increased during the pandemic.

7 Q. Thank you. Turning, then, to medications that were
8 utilised, so pharmaceutical issues. You explain in your
9 report that up until 2020, levels of medication
10 prescribed for the treatment of dementia, so
11 dementia-specific medications --

12 A. Yeah.

13 Q. -- were rising year on year, but in 2020 there was
14 a significant decrease in those prescriptions. Set
15 against that, you explain that there was an increased
16 use of antipsychotics during the pandemic.

17 A. Yes.

18 Q. So firstly, turning, if I may, to the dementia-specific
19 medication, in a nutshell, why would that have been?

20 A. So just a word, I think, before about what I mean by
21 those two sets of medication. There are a set of
22 medications that were licensed some time ago for
23 dementia, that kind of make the best of what you've got.
24 They do not stop the dementia, they do not slow the
25 dementia, but they give people the best function they

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1 together, that families put together, that services put
2 together, to support people with dementia in the
3 community to enable them to live well with their family
4 members, we talked about the assessment process, but
5 they are fragile and they require attention to keep them
6 working, and they do work better when there is
7 continuity of care and understanding. That's why family
8 carers are so important, because they don't change in
9 the middle of that care framework, and they require --
10 they require management.

11 In the pandemic, those sorts of things broke down,
12 and when you -- and if your main and your most important
13 support is your family carer, co-resident carer that
14 lives with you, the loss of that individual will often
15 destabilise someone living within their own homes and
16 then it becomes difficult to provide the care that's
17 needed within that home, and so there may need to be
18 a transition to a care home.

19 Now, what's important is to do that really
20 carefully, because it's one of the most, you know, it's
21 one of the biggest changes anyone will have. If you've
22 got dementia, it's very difficult to learn to be in
23 a new place. There's a need for support that wraps
24 around that happening, and in the pandemic that support
25 and wraparound wasn't there which means that you're less

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1 can have at that time, and those are the anti-dementia
2 medications that I've mentioned in the report, including
3 donepezil is one of those.

4 There are very few quality markers for care of
5 people with the dementia because there's been no
6 investment in quality care markers, so we simply use
7 things that are available and one of those is the
8 prescription of anti-dementia medication because, you
9 know, it is a good thing to receive these medications if
10 you have dementia, and we had -- and this had been
11 monitored since the medications were introduced, and
12 there had been a really heartening increase in the
13 prescription of those medications since the publication
14 of the National Dementia Strategy, that's very nicely --
15 that's a very good increase that happens there. So this
16 is a positive thing that we were doing across the United
17 Kingdom in terms of providing these medications.

18 It's a marker of a diagnosis having been made, and
19 that having been made in secondary care, made well
20 enough for the medication to be prescribed.

21 During the pandemic what we see is that number drops
22 off markedly, so the numbers of people with -- receiving
23 anti-dementia medication decreases markedly. Part of
24 that will be to do with the mortality of people with
25 dementia during the pandemic that we talked about, and

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1 part of it will have been that the services that people
2 were receiving, the diagnostic services stopped so new
3 people were not being initiated on anti-dementia
4 medication.

5 **Q.** Thank you.

6 **LADY HALLETT:** Can I ask you to slow down, Professor.

7 **A.** Oh, sorry.

8 **LADY HALLETT:** A lot of us are responsible for speaking too
9 quickly, including me.

10 **A.** Sorry, would you like me to say that again?

11 **LADY HALLETT:** No, no, not at all, I'm just thinking I don't
12 want the stenographer putting down the pen in protest.

13 **A.** Yes, sorry. So I will much more slowly talk about
14 antipsychotics.

15 **MS CECIL:** Indeed, and perhaps I can summarise it in this
16 way: the dispensation of antipsychotics is another
17 indicator of quality in terms -- (overspeaking) --

18 **A.** But of poor quality --

19 **Q.** -- but an indicator of poor care quality in relation to
20 dementia patients, and you explain that over a decade or
21 so the use of those medications had decreased by half,
22 but in your words, when presented with the stress of the
23 pandemic and the removal of non-drug options for care,
24 the system fell back into its old ways.

25 You describe within your report why antipsychotics
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1 take those medications, so it's a big risk. And also
2 the effectiveness of these medications is low.

3 And we had a good news story in the United Kingdom,
4 which was that we had -- we had identified it as
5 a problem, there'd been great work done in primary care
6 and in general hospitals, and in mental health services,
7 and we've driven down the prescription of these drugs,
8 we've halved the level of prescription of these drugs.

9 Now, some people will require them because it is so
10 difficult and complicated, and because there are no
11 other treatments, drug treatments, for these behavioural
12 problems. So we'd managed to drive this down really
13 well. But presented with the -- and replaced them with
14 non-drug treatments, with sensible monitoring, with care
15 and support that enables people to live well without
16 those drugs.

17 But presented with the problems of the pandemic,
18 people fell back, I believe, on the old ways, that --
19 firstly, there was more agitation and more problems for
20 people in homes and in care homes. So there's a greater
21 need. And then, secondly, there were a lack of other
22 options, or a perception of the lack of other options,
23 and so the level of prescribing of these medications
24 increased. And that, again, will have contributed to
25 the increased mortality seen in people with dementia in
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1 are inappropriate and that certainly for certain types
2 of dementia, they can significantly exacerbate or cause
3 different or new symptoms such as hallucinations, have
4 the opposite effect, in short, and mask actual need; is
5 that correct?

6 **A.** So that's correct, apart from the causing
7 hallucinations. As I said before, hallucinations can be
8 part of dementia, and delusions can be part of dementia,
9 and behavioural disturbance like aggression and
10 agitation can be part of dementia, and they're immensely
11 distressing for the person with the dementia themselves
12 and for carers. So it's entirely legitimate that we
13 should wish to treat those symptoms.

14 The most common drug that was used -- set of drugs
15 that was used in order to do that were antipsychotic
16 medications, and antipsychotic medications unfortunately
17 have been proven over the last two decades to have some
18 really important negative effects in a lot of groups,
19 but positive effects. In people with dementia it's been
20 shown to have even more of a negative effect than you'd
21 expect.

22 So there is an excess mortality associated with
23 antipsychotic medications being taken if you have people
24 with dementia, and that's of the order of a 1-2%
25 increase in mortality for every three months that you
34

1 the pandemic.

2 **Q.** Indeed. And if I may then turn to other aspects, the
3 Inquiry has heard significant evidence in relation to
4 there being a decline in cognitive function?

5 **A.** Yeah.

6 **Q.** And -- in terms of -- following from lockdown or from --
7 in relation to visiting restrictions, isolation and the
8 various restrictions that were put in place. Is that
9 something that is -- that also arises from your
10 research?

11 **A.** So we looked carefully at this, and there is no
12 definitive research because there is no control group of
13 people that didn't have a -- that weren't exposed to the
14 pandemic at this time. But actually, there is good
15 evidence, from different sources, that during the
16 pandemic, people with dementia experienced greater
17 cognitive decline than you would have expected outside
18 of that. So greater cognitive decline. Greater
19 functional decline as well, so that people's abilities
20 to look after themselves and do things for themselves
21 decreased in the pandemic more than we would have
22 expected over that period of time had there not been
23 a pandemic.

24 And there are a lot of plausible reasons why that
25 might be, which include the virus itself, in some cases,
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1 but also includes decreased social stimulation and
2 decreased encouragement of people to actually do things
3 for themselves and the social limitations that came from
4 the pandemic and the lack of stimulation that came from
5 the pandemic.

6 **Q.** And similarly, in relation to the Every Story Matters
7 report that's been prepared for this module and for the
8 Inquiry, there were also themes emerging that the lack
9 of visits or care by a loved one would have physical
10 consequences too, such as drinking less water, which is
11 obviously an important factor for individuals of that
12 age with that condition.

13 From one care worker, who says:

14 "I'd say those residents with advanced dementia ...
15 [for those] loved ones used to come in, and it would
16 prompt them to eat ... they knew that person ... [and as
17 a consequence there was] weight loss through lack of
18 stimulation ..."

19 Would that accord with what you would expect?

20 **A.** It would indeed.

21 **Q.** Thank you.

22 **A.** You can't underestimate the value to a person with
23 dementia in a care home or in their own home, but
24 particularly in a care home, of visits from people that
25 they know and love, because people that they have known

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1 It explains -- and this is one example:

2 "I feel extreme guilt that I can't visit my mother
3 properly, she can't understand why I won't enter her
4 care home. I feel distraught watching her cry or refuse
5 to come to the window to see me."

6 Similarly, staff members describe individuals within
7 the care home wanting a hug or to sit with them, to hold
8 their hands. They couldn't do that, and it was very
9 distressing. And further, that the consequence of that
10 for some was that actually those residents no longer
11 recognised their loved ones where they were unable to
12 visit over a period of time.

13 **A.** Yes.

14 **Q.** Is that something that was predictable?

15 **A.** It's entirely predictable in that -- and again, one of
16 the reasons why one might pay particular attention to
17 the -- there are a million people with dementia in
18 the UK at the moment. It's that kind of number that
19 we're talking about.

20 So, one of the reasons why you might pay particular
21 attention to people with dementia is that, you know,
22 people with dementia have a disorder of memory, they
23 cannot remember things, which means that if you tell
24 people that they need to wear a mask, they will not
25 remember they need to wear a mask. If you tell people

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1 their own lives and who they continue to recognise,
2 people who spend time with those individuals, you know,
3 social time talking about things, going through things,
4 you know, encouraging people to eat and drink, as you
5 say, but also enabling people to be socially stimulated
6 and to continue to, you know, use the memories that they
7 have and enjoy those moments with those individuals.

8 There is something, you know, very specific and very
9 special about the care and support that can be given by
10 family carers in that way.

11 **Q.** Indeed.

12 **A.** And the loss of that is one of the things that will
13 cause a deterioration in those individuals, either
14 through things like prompting people to eat and drink,
15 or through people developing depression, or through
16 people's dementia itself progressing more quickly and
17 therefore people losing skills that they had beforehand.

18 **Q.** Indeed.

19 And with regard to those restrictions that were put
20 in place, the Inquiry similarly has heard evidence of
21 confusion in people with dementia in relation to why an
22 individual, their loved one, could not visit or could
23 not come into a room, had to stay outside, those sorts
24 of issues.

25 If I can just call up INQ000109754, page 2, please.

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1 that you can't come in because there's a bug around and
2 that's why your relatives are not visiting, then they
3 will not remember that. It will be, you know,
4 continually being in a state of wanting to see a person
5 that's not coming or wondering why they're not coming
6 any more. And not being able to, you know, do the
7 things they used to, be that a hug or whatever.

8 You know, it is not possible for many people with
9 dementia -- it will not have been possible for them to
10 understand the rules and not possible for them to comply
11 with the rules, though they would be potentially
12 sanctioned for not complying with those rules.

13 And there are heartbreaking -- there's heartbreaking
14 testimony that one reads from care homes and from people
15 in their own homes about, you know, the difficulties
16 caused by the entirely predictable cognitive impairment
17 that people with dementia have, and a lack of ability to
18 understand that on the part of the general public and
19 respond to it on the part of services.

20 **Q.** One of the innovations that was put in place during the
21 pandemic was the greater use of digital technology to
22 try to compensate for some of these issues, and for many
23 it was a very good innovation, but for others, and in
24 particular those with dementia, you describe it as being
25 a weak mitigation.

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1 If I could just call up INQ000474426, page 20,
2 paragraph 4.40, please.

3 This speaks to the experience of Arthur Argyle,
4 a gentleman with dementia, who was described by his
5 daughter Sarah as being visibly scared when using
6 Facetime.

7 **A.** A cardinal element of having a dementia is the inability
8 to learn how to do new things. You can remember stuff
9 from ages ago, which means you can still have a great
10 conversation about those sorts of things, but you can't
11 learn new things. One understands why there was this
12 switch to digital, and there were digital solutions, but
13 actually, you need a lot of human help to be able to use
14 a technology that you've never seen or used before. And
15 that the sad reality is that -- you'd mentioned a weak
16 mitigation, I think what we created is a set of digital,
17 digitally-excluded people and that's not just people who
18 can't afford the stuff, it's actually people who can't
19 learn to use it. It's about people who are frightened
20 by -- they don't know what these images are about or
21 what they're for, they can't understand why there's
22 somebody in that.

23 There are so many ways in which digital technologies
24 can be really helpful for all sorts of people in all
25 sorts of situations, and for some people with dementia,

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1 Roy Staples, an elderly gentleman, spritely nonetheless,
2 who took up dancing, having been inspired by Strictly,
3 at the age of 84, was in a care home, his family had
4 concerns about patients being discharged from hospital
5 and in particular a new resident who had dementia and
6 wandered into his room.

7 In terms of that wandering, does that pose
8 particular challenge within this cohort and demographic
9 of people?

10 **A.** So it does. Wandering is one of the behavioural
11 problems that can develop within dementia, so it's not
12 that people are, you know, purposefully seeking to
13 invade other people's space or seeking to leave the home
14 in a way that is dangerous. That is part of what
15 happens in dementia, both wandering and getting lost, as
16 well. And I mentioned earlier that it's quite difficult
17 for people with dementia to learn the geography of a new
18 home, if they are moved in their homes. So you would
19 also have the confusion that comes from having no idea
20 where anything is, and not being able to learn where
21 anything is.

22 Now, of course, the way to mitigate this is to have
23 sufficient staff around to be able to help individuals
24 and to be able to divert people and to, you know, try
25 and stop these things from happening. But again, it is

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1 there's some, you know, there's some nice examples of
2 things that worked very well for certain people, but for
3 a very large number of people with dementia,
4 particularly those with more severe dementia,
5 particularly those within care homes, you know, the
6 answer to every problem being "Well, there's an app" is
7 not an answer that actually helps individuals.

8 **Q.** And if I may turn to other challenges that care homes
9 were facing, an English care home manager described
10 residents with dementia as not understanding the need to
11 stay in their rooms, for example --

12 **A.** Yes.

13 **Q.** -- but wandering. And that's also a theme that
14 similarly comes through the Every Story Matters
15 report --

16 **A.** Yes.

17 **Q.** -- with residents becoming very upset, explaining that:
18 they did inform infection prevention control, who just
19 basically said, well observe and what will be, will be.

20 Another account from Every Story Matters, a resident
21 admitted with Covid in a dementia ward where everybody
22 is mobile, everybody is moving around, and it spread
23 through the home like wildfire.

24 And similarly in the corporate witness statement of
25 Covid Bereaved Families for Justice, the experience of

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1 predictable that there will be such things and what you
2 can't rely on is an individual understanding the rules
3 and therefore complying with them, and it's not a wilful
4 act, it's an act of -- (overspeaking) --

5 **Q.** It's a consequences of the illness.

6 **A.** -- and a consequence of the disorder. And if you feel
7 agitated, then you may wander. If there are, kind of,
8 wander pathways for you to go around outside the care
9 home, that can be quite helpful. If all you can do is
10 walk the corridors of the care home, that's more of
11 a difficulty.

12 And a final issue with that is that quite often, the
13 wandering happens at inconvenient times. There's
14 a phenomenon called sundowning whereby people are more
15 likely to be agitated or to wander at night rather than
16 during the day when there is traditionally lower levels
17 of staffing and therefore lower levels of being able to
18 deal with that.

19 So yes, it's absolutely part of -- it's an absolute
20 part of managing people with dementia and a predictable
21 risk.

22 **Q.** Thank you.

23 Another aspect was the use of face masks. Just
24 very, very briefly, it revealed that many people,
25 actually, with dementia relied on lipreading but there

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1 are also the lack of social cues, communication, and one
2 recommendation you make is to consider the use of
3 transparent masks in any future pandemic and indeed,
4 that's something that's been acknowledged by the
5 UK Government in guidance.

6 **A.** Yes, a lot of the cues that individuals will get are
7 lost when you cover a substantial amount of the face,
8 particularly the bit that smiles and has emotion
9 associated with it.

10 **Q.** Thank you, Professor Banerjee.

11 You set out at length within your witness statement
12 the impact on family carers and, indeed, you've covered
13 it to some extent already today, so I don't propose to
14 deal with that, save as to say that the impacts were, as
15 you have already described, profound.

16 **A.** Profound and negative.

17 **Q.** Thank you. Then finally, in terms of recommendations,
18 you similarly set out at the end of your statement
19 a comprehensive list of practical and focused
20 recommendations in relation to the pandemic. If I may,
21 just because of the limitations that we have, just draw
22 on one in particular, which would you say is the most
23 significant and most important message to take away?

24 **A.** So if I may steal two, the first would be that we really
25 do need clarity and specificity in communication that is

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1 and training that would change that and it would change
2 the system for the better for older people who are the
3 main people who use health systems wherever, and would
4 be the main people who are affected in any plausible
5 forthcoming pandemic.

6 **MS CECIL:** Thank you, Professor Banerjee. Those are my
7 questions.

8 **LADY HALLETT:** Thank you, Ms Cecil.

9 Mr Weatherby.

10 Mr Weatherby is just there, Professor

11 **Questions from MR WEATHERBY KC**

12 **MR WEATHERBY:** Good morning, Professor. I represent Covid
13 Bereaved Families for Justice UK which represents
14 bereaved families, including some of the families whose
15 accounts were very helpfully put to you earlier.

16 I've got four very short and, I hope, very
17 straightforward points to put to you.

18 At page 81 of your report, you refer to both
19 inequality and inequity in the section dealing with care
20 and outcomes. In Module 1, the Inquiry heard from
21 Professor Marmot, who told the Inquiry that the word
22 "inequity" was used to describe, and I quote "avoidable
23 differences in health which are judged to be avoidable
24 and are not avoided, are unfair, hence inequitable."

25 Am I right that you've drawn the distinction between

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1 inclusive of dementia and that acknowledges the care
2 home system as being, you know, of profound importance
3 in dementia care and therefore having particular
4 challenges. We needed that before the pandemic, we
5 certainly need it now, moving into any future pandemic.

6 So clarity and specificity of communications is
7 absolutely there. And that includes public messaging
8 during pandemics. And that can be prepared beforehand.

9 **Q.** Yes.

10 **A.** And I think the other thing that I would say is that
11 we've really got to have better, improved understanding
12 and improving health and care professional attitudes and
13 beliefs about dementia. We are running systems and
14 services that fundamentally believe -- happily believe
15 things that are not true about dementia, that it's an
16 inevitable part of aging, that there's nothing you can
17 do about it, that having dementia is worse than being
18 dead in some ways. So what is the problem with all of
19 this?

20 Those are the sorts of things that underpin the
21 problems that we had in planning for the last pandemic,
22 in dealing with -- with that pandemic and that continue
23 to be a problem in the way that we provide services and
24 would be a problem in the next pandemic. And there are
25 good, clear, simple things that we can do in education

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1 inequality and inequity in the same way?

2 **A.** I have drawn a difference between inequality and
3 inequity. Professor Marmot has clearly been working on
4 this his whole life. I have a more simple way of
5 looking at it, which is that inequalities happen because
6 there are differences and there are all sorts of reasons
7 why there may be differences. Inequities are where
8 there are difference that are not fair. Now, whether or
9 not they can be addressed by different changes and
10 addressed by that is a different matter but they are
11 things there are not fair.

12 In dementia we have profound inequalities but we
13 also have profound inequities also.

14 **Q.** Which can be changed or challenged?

15 **A.** There are things that one could do to address a number
16 of those -- (overspeaking) --

17 **Q.** And is that why it is important to examine the care and
18 outcomes for people living with dementia through the
19 lens of both inequity and inequality?

20 **A.** Yes, it is. I mean, one of the major research projects
21 that I lead is called DETERMIND and that is all about
22 the outcomes of care and inequalities and equities in
23 dementia care and outcomes. So yes, it is absolutely
24 important to look at it through both of those lenses.

25 **Q.** Yes. In Module 2, experts on discrimination highlighted

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1 a lack of research and data on the impacts of
2 discrimination on particular groups, including
3 minoritised ethnic communities and the LGBTQ+ community.
4 Is this an issue with respect to dementia research
5 also?

6 **A.** It absolutely is. We've got far, far, far less research
7 on people from minority ethnic groups and from LGBTQ+
8 groups. One of the -- that's one of the reasons why in
9 my DETERMIND project, that I was talking about, has
10 recently been funded to look specifically at those
11 groups.

12 **Q.** Yes. Now, earlier you mentioned the statement of
13 Katherine Lee from the Alzheimer's Society. I'm not
14 going to go to that, the Inquiry has that, but do you
15 agree with the Alzheimer's Society's recommendation for
16 dementia-specific planning for future pandemics?

17 **A.** So I need to just reiterate my potential conflict of
18 interest, as a trustee of the Alzheimer's Society, but
19 yes, I do agree with that, there should be
20 dementia-specific planning and that was one of the two
21 things that I chose as the recommendation.

22 **Q.** Yes, indeed, I'm not going to go to them but I think
23 there were six specific recommendations. But the bottom
24 line is there needs to be proper pandemic planning
25 for -- that includes -- specifically includes dementia.

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1 specifically at the Northern Irish context, and enabled
2 us to be able to care between places. But if you look
3 at an indicator like mortality, there's very little
4 variation across that, and certainly there are -- there
5 is evidence of people in each of those areas having
6 difficulties and problems.

7 Integration is a problem, and also a set of --
8 really an -- interesting possibilities for improvement,
9 across our health and care systems.

10 **MR WEATHERBY:** Indeed.

11 Thank you very much, Professor.

12 **LADY HALLETT:** Thank you very much, Mr Weatherby.

13 Mr Stanton.

14 He is right over there, Professor.

15 **Questions from MR STANTON**

16 **MR STANTON:** Thank you, my Lady.

17 Good morning, Professor.

18 **A.** Hello.

19 **Q.** I ask questions on behalf of the Covid Bereaved Families
20 for Justice Cymru. I just have one question. It
21 relates to one of the recommendations with your --
22 within your report, that the care home sector needs to
23 be involved in emergency planning in the future.

24 **A.** Absolutely.

25 **Q.** Something which you've just touched on in your answer

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1 **A.** People with dementia are predictably a group that will
2 be disproportionately -- that could be
3 disproportionately affected by any future pandemic, and
4 are certainly a very high-risk group, and so you would
5 expect that group to be part of planning.

6 **Q.** Yes.

7 Final point. In a footnote on page 15 of your
8 report you say:

9 "... it is remarkable how little things varied
10 across the UK for people with dementia and their family
11 carers. Wherever one lived things were very difficult
12 indeed."

13 And I think you've repeated that in evidence this
14 morning.

15 In Northern Ireland, the system is one of integrated
16 health and social care, and this is sometimes held up as
17 an advantage because the particular position and
18 vulnerabilities of people in social care can be
19 integrated into decision making.

20 Given your evidence, would you agree that you've
21 found no evidence that the integrated nature of the
22 health and social care system in Northern Ireland had an
23 appreciable difference in terms of outcomes for people
24 with dementia and their families?

25 **A.** So there's relatively little research that looked

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1 with Mr Weatherby.

2 Given it was well known that care homes -- care home
3 residents are particularly vulnerable to a pandemic
4 event, again as you described fully earlier, are you
5 able to offer a view as to why the sector was not
6 properly engaged prior to the Covid-19 pandemic? It
7 seems such a glaring and obvious omission.

8 **A.** Well, I can think of at least two things. The first is
9 that health systems very often forget care systems, and
10 that is a major problem and they're often seen as
11 a lower priority, and as different. And we need to
12 be -- we need to get rid of that distinction. It's
13 a system -- one bit cannot live without the other bit,
14 and we're seeing that in the pressures in general
15 hospitals today.

16 I think the second reason, a second reason is
17 potentially that the -- the care system is often
18 perceived as being provided by independent companies,
19 and therefore you can't deal with it because it's lots
20 of different little bits and it's very difficult for
21 you, therefore, to get information or whatever. And
22 I think one of the papers submitted on Operation Cygnet
23 or whatever suggests that.

24 I agree that it is difficult, potentially, to get
25 information, but it's such a critical part of the system

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1 that actually just because it's difficult should not be
2 a reason not to do it.

3 And a third -- sorry, half of the money that care
4 homes are provided with in the UK is money that comes
5 from local government. It is essentially governmental
6 money that gets paid to them. The ability to stipulate
7 that information should be given should be part of that
8 process, and therefore one could more meaningfully
9 involve care homes.

10 **MR STANTON:** Thank you very much.

11 **LADY HALLETT:** Thank you, Mr Stanton.

12 Ms Jones, who is just over there. Sorry to point to
13 everybody.

14 **Questions from MS JONES**

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

16 Thank you, Professor Banerjee. I ask questions on
17 behalf of John's Campaign, The Patients Association, and
18 Care Rights UK, all of whom work extensively with people
19 with dementia and their family carers.

20 You've said in your evidence today and in your
21 report that government guidance was confusing and
22 clearly not prepared with people with dementia in mind.

23 **A.** Yes.

24 **Q.** I'm sure that links to the recommendation you
25 highlighted about the need for clearer communication in

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1 care settings.

2 You may be aware of the ongoing campaign for
3 a statutory right to an essential care supporter,
4 sometimes known as Gloria's Law, through which people
5 would, in all circumstances, have a legal right to the
6 presence of a chosen care supporter who could be with
7 them, advocate for them, and provide them with
8 individualised care and support, regardless of the care
9 setting that they live in.

10 In your view, what difference would a legal right of
11 this sort of have made for people with dementia during
12 the pandemic?

13 **A.** That's a difficult -- I mean, so, firstly, there is no
14 data that I have available for me to be able to make
15 that, so it would simply be an opinion that I would be
16 giving on that.

17 I think that if people with -- if people during the
18 pandemic had had more access to their main family carer
19 and had been able to see those individuals, then their
20 quality of life would have been better, and it is likely
21 that their -- that the progress, the negative progress
22 of their illnesses may have been mitigated. So it would
23 have been better for the person with dementia.

24 If those individuals were in care homes, for
25 example, it is likely that those individuals would have

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1 future.

2 In your view, what difference might it have made if
3 government had consulted with people with dementia or
4 their family carers or representative organisations
5 before producing the guidance?

6 **A.** Well, had they done that, they would have had a better
7 idea of what the potential challenges are, and you would
8 have hoped that the information would have been more
9 comprehensive and also more inclusive of people with
10 dementia.

11 One of the main problems is that people with
12 dementia were not mentioned in any way in anything for
13 quite a while in the pandemic. And had they been
14 included, it is likely that there would have been
15 a better and more effective advice in terms of helping
16 people with dementia.

17 **Q.** Thank you.

18 You've also said in your evidence today that you
19 can't underestimate the value to a person with dementia
20 of visits from a person they know and love, and I know
21 that's a position that those I represent would strongly
22 endorse.

23 And you've also addressed the many negative impacts
24 that people with dementia and their family carers
25 suffered by the exclusion of visitors and carers from

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1 been more easily managed and more happy and contented
2 within the care homes, and therefore required less care.
3 So it would have been good for those care homes. And
4 one could imagine the same things pertaining within
5 general hospitals also.

6 **MS JONES:** Thank you very much, Professor.

7 Thank you, my Lady.

8 **LADY HALLETT:** Thank you, Ms Jones.

9 That completes the questions we have for you,
10 Professor. I'm sure there are many very distressing
11 aspects of medicine, but yours, I suspect your specialty
12 is particularly distressing for some, who aren't used
13 to it.

14 Do you find any difficulties in recruiting people to
15 your specialty?

16 **THE WITNESS:** So, yes. And we do because -- and that's one
17 of the problems about there being societal and
18 professional prejudices against older people. When
19 people come into medical training and nursing training
20 and other things, they have quite a low level of
21 enthusiasm and positivity and knowledge and -- about
22 working with older people and working with people with
23 dementia. When they leave training, they have even
24 lower levels of positivity, even though 75% of the
25 people that they're going to be dealing with are old and

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1 frail, because that's the nature of the hospital
2 population.
3 The thing that -- it can be depressing and
4 difficult, but it can be immensely exciting working out
5 how you can try to deal with these things in order to
6 make things better. So one of the things that I refer
7 to in the report is a programme that we generated, which
8 is now being rolled out across the whole of the south of
9 England, which basically -- it's called Time for
10 Dementia. People -- students meet a family with
11 dementia. They work with that family, they are taught
12 by that family what it's like to have dementia, over
13 a two-year period. They start to identify with that
14 family, and they end up with much more positive ideas
15 about older people, much more positive ideas about what
16 family carers do, and they end up as little
17 change makers who want to make sure that the system is
18 not -- the system is changed so it is more positive for
19 people like their family.
20 So that relational learning can make a big
21 difference. There's things that we can do to make this
22 better. They're not being done at the moment; they need
23 to be.
24 **LADY HALLETT:** Thank you very much indeed, Professor.
25 By the sounds of it, they may be little

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1 about your professional background and then I'll give
2 you a moment to give some preliminary remarks.
3 So you were previously the chief executive of the
4 Association of Directors of Adult Social Services.
5 **A.** Yes.
6 **Q.** And you held this position between January 2015 --
7 **A.** Mm.
8 **Q.** -- until June 2024.
9 **A.** (Witness nodded)
10 **Q.** You have previously worked for the Local Government
11 Association, as well, haven't you?
12 **A.** Yes.
13 **Q.** And prior to that, you worked as a director of social
14 services?
15 **A.** Yes.
16 **Q.** So therefore, in terms of your chief executive role in
17 ADASS, which is what I'll call it from now on, you were
18 in post at the time of the pandemic.
19 **A.** Yes.
20 **Q.** Now, I understand there are some brief preliminary
21 remarks that you would like to make. Please feel free
22 to do so now.
23 **A.** Thank you. So first of all, I'd like to express sorrow
24 for everyone who died needing social care and support
25 during the pandemic. There were tragic mortality rates.

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1 change makers but if you have your way you're going to
2 be a big change maker, so I wish you luck.
3 **THE WITNESS:** There's a lot of change that needs to be made,
4 but thank you.
5 **LADY HALLETT:** Thank you very much for the help that you've
6 given to the Inquiry and for the work you're doing so
7 far as dementia sufferers and their families are
8 concerned. Thank you.
9 **THE WITNESS:** Thank you very much.
10 **LADY HALLETT:** Very well, I shall return at half past.
11 (11.15 am)
12 (A short break)
13 (11.31 am)
14 **LADY HALLETT:** Ms Shotunde.
15 **MS SHOTUNDE:** My Lady, please may I call Cathryn Williams.
16 **MS CATHRYN WILLIAMS (sworn)**
17 **Questions from COUNSEL TO THE INQUIRY**
18 **LADY HALLETT:** Thank you for coming to help. I hope we
19 haven't kept you waiting for too long.
20 **MS SHOTUNDE:** Can you please confirm your full name.
21 **A.** My name is Cathryn Williams.
22 **Q.** And thank you for providing the Inquiry with your
23 witness statement dated 16 August 2024. And for the
24 record, that's INQ000571608.
25 I'm going to just briefly ask you some questions

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1 I also want to pay tribute to the paid and unpaid
2 carers who did so much, and again, there were
3 disproportionate mortality rates amongst care staff and
4 social workers. And finally, I want to pay tribute to
5 everyone who worked excessively long working days for
6 months on end trying to address the issues that were
7 before them.
8 **Q.** Thank you.
9 So the Association of Directors of Adult Social
10 Services, it's a charity whose members are current and
11 former local government directors of adult social
12 services; is that correct?
13 **A.** Yes.
14 **Q.** And its objectives include furthering comprehensive
15 equitable social policies and plans which reflect and
16 shape the economic and social environment of the time,
17 furthering the interests of those who need social care
18 services, regardless of their background and status, and
19 promoting high standards of social care services; is
20 that correct?
21 **A.** Yes.
22 **Q.** In terms of the role of directors of adult social
23 services, am I right in saying that they are responsible
24 for leading, commissioning and delivering adult social
25 care work and social care in local authorities?

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1 A. Yes, in England.
 2 Q. Thank you. Their remit includes older and disabled
 3 people, people with learning disabilities, unpaid
 4 carers, people with mental ill health, and those needing
 5 care and support who are experiencing abuse and neglect;
 6 is that right?
 7 A. Yes.
 8 Q. And state-funded adult social care services support over
 9 1.1 million people in England; is that right?
 10 A. Yes.
 11 Q. I'm going to ask you some questions about pre-pandemic
 12 planning. Now, there was some work undertaken by ADASS,
 13 commissioned by the UK Government on future pandemic
 14 planning.
 15 If we could just turn to your witness statement,
 16 that's INQ000571608, page 25, paragraphs 7.2. If we
 17 could just scroll up a bit please. Thank you.
 18 So for that work that was commissioned, there were
 19 a number of reports that were produced by ADASS prior to
 20 the pandemic, and I've got them listed up here, such as:
 21 "Key message from the survey of Directors of Adult
 22 Social Services ...
 23 "Critical information and data needed for [Directors
 24 of Adult Social Services] and local partnership decision
 25 makers to plan for and make timely and rational
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1 particularly, were unsure what use the Department of
 2 Health and Social Care had for
 3 these -- (overspeaking) --
 4 A. No, we do know that during the pandemic, for instance,
 5 when we were talking about Care Act easements, that
 6 Department of Health civil servants mentioned that
 7 they'd been looking at the plans, but whether they'd
 8 looked at them prior to the pandemic, I couldn't say.
 9 Q. Do you think some of the work on easements may then have
 10 been used in the pandemic in this instance?
 11 A. I think it was. I think the fact that there were
 12 easements probably demonstrated that. But I'm very
 13 conscious that, whilst we were doing the pandemic flu
 14 work, we had anticipated that social care wouldn't be
 15 able to deliver all of its responsibilities because of
 16 staff shortages, and we were working on there being 20%
 17 of staff not being -- not functioning.
 18 But we hadn't really anticipated that other sectors,
 19 like hospitals and schools, also wouldn't be able to
 20 fulfil all their duties.
 21 Q. So essentially you were looking at it from one
 22 perspective --
 23 A. Yes.
 24 Q. -- but you weren't considering all the other sort of
 25 services, public services, that went down as well?
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1 decisions about the reprioritisation of services ...
 2 "The Communications and Support Infrastructure ...
 3 "Recommendations on regulatory and process easements
 4 that Directors of Social Services require ..."
 5 And:
 6 "Proposals to support local areas to prepare now for
 7 a future pandemic."
 8 Did the work identify any gaps in pandemic planning
 9 for the adult social care sector?
 10 A. So we produced reports for each of those sections that
 11 you have in front of you. And we also produced a guide
 12 for directors of social services, and I will refer to
 13 them as DASSs from now on. Apart from the guide for
 14 directors, which we distributed to our members across
 15 England, the other reports all went into the Department
 16 of Health and were, in effect, private reports.
 17 Q. Did -- sorry, go on, please.
 18 A. So we did, in our guide for directors, identify a number
 19 of recommendations for people locally, our members, and
 20 we also identified a number of recommendations for the
 21 Department of Health, many of which were in the separate
 22 private reports.
 23 Q. And I understand from your witness statement that, other
 24 than the guide for pandemic flu planning for directors
 25 of adult social services, ADASS, and yourself
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1 A. Yes.
 2 Q. In terms of pandemic planning, who or which organisation
 3 was previously responsible for checking the adequacy of
 4 pre-pandemic planning in the adult social care sector?
 5 A. So, to the best of my knowledge, there wasn't anybody,
 6 either nationally, regionally or locally.
 7 Q. And just so I'm clear on this, this is also -- this is
 8 including all planning, so planning on the local
 9 authority level and also planning on the provider level;
 10 is that right?
 11 A. Yes. To an extent, the work that we'd done on Brexit,
 12 which was led and closely monitored by DHSC, had looked
 13 at things like staffing, supplies, fuel, transport, but
 14 it hadn't looked at the infectious nature of a pandemic.
 15 Q. Do you think there was a role for local authorities in
 16 respect of pre-pandemic planning, other than of course
 17 its own plans?
 18 A. Well, local authorities and social care providers have
 19 the unique knowledge about how care works on the ground.
 20 So certainly, pandemic planning is necessary, whether
 21 that's for tomorrow or 20 years' time. Whether --
 22 I can't answer the question solely in relation to local
 23 authorities. It's -- clearly involves many more people.
 24 Q. And prior to this pandemic, other than the work that was
 25 commissioned by DHSC, was there any other role that
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1 ADASS had in pre-pandemic planning at all? Guidance
2 that was provided for local authorities, for example, or
3 anything like that?

4 **A.** We weren't part of Operation Cygnus, if that's -- if
5 that's what you're asking me.

6 **Q.** So, in evidence last week, Michelle Dyson told us that
7 in February 2020 there was a plan to revise local
8 authority plans and that the Minister for Social
9 Services wanted to see a copy of a good local authority
10 plan so that it could possibly be replicated across
11 other local authorities.

12 And in evidence, it was noted that at a meeting,
13 that the Local Government Association and ADASS did not
14 have the assurance skills to do -- to review plans, but
15 that they might be able to help make a checklist with
16 questions to ask when checking the plans are fit for
17 purpose, so that local resilience forums can be
18 confident.

19 Is there a greater role that you think ADASS could
20 undertake regarding pre-pandemic planning to assist
21 local authorities?

22 **A.** Well, I think that we can certainly contribute the
23 experience of ADASS members of the pandemic to future
24 pandemic planning, definitely. And certainly with our
25 partners in -- care providers and others, I think that

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1 for purpose? If you think there is any. If you think
2 they should be done at all.

3 **A.** So possibly a combination of CQC with social care
4 expertise, public health, and some representation from
5 an organisation like ADASS in a sort of panel system.
6 Perhaps not every single plan, but some kind of
7 selective process.

8 **Q.** Do you think there were any other organisations that
9 should be consulted or involved in planning? So, for
10 example, representative bodies of care providers,
11 recipients of care or unpaid carers.

12 **A.** Definitely. I think the interface with local resilience
13 forums is a critical one as well, and it was -- the
14 juxtaposition of local resilience forum, NHS structures
15 and local authorities, together with national
16 organisations, was -- worked sometimes very well,
17 particularly where there was coterminosity, like in
18 London, but was inherently problematic for some other
19 DASSs.

20 **Q.** Other than regulations, how else do you think pandemic
21 planning can be embedded into care providers? Is there
22 a role that you think the local authority could or
23 should play in respect of that, and in particular in
24 respect of the services that they're commissioning?

25 **A.** So, prior to the pandemic, I think none of us had an

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1 would be essential.

2 **Q.** And in evidence last week Helen Whately suggested that
3 the CQC could check whether providers have got pandemic
4 plans. Do you agree with that suggestion, that that's
5 something that the CQC could check?

6 **A.** So I have consulted with someone from the CQC about
7 that, and apparently in the regulations there's no
8 explicit requirement for providers to have pandemic
9 plans, although they do have to have contingency plans.

10 I think the view is that there could be a case -- it
11 might be possible to do it at the point of registration,
12 and at the point of inspection, but to ask the
13 organisation to assure 18,000-odd pan flu plans would
14 be -- in one go would be unrealistic.

15 **Q.** Just so I've got it correct, there was no requirement in
16 the regulations for care providers to have specific
17 pandemic plans, just contingency plans?

18 **A.** There's a requirement for them to provide safe care,
19 which might incorporate that, but not specific pandemic
20 plans, to the best of my understanding.

21 **LADY HALLETT:** Well, that depends on one's definition of
22 contingency, doesn't it?

23 **A.** Of course.

24 **MS SHOTUNDE:** Which body do you think should be responsible
25 for assuring the plans, making sure that they are fit

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1 idea of how difficult a pandemic and how disastrous
2 a pandemic could be. Now we do. And it's probably
3 important, while there is still a degree of freshness in
4 people's minds, to look. And certainly local
5 authorities and others would have roles in that.

6 **Q.** Do you think that providers' pandemic preparedness
7 should be a factor that influences local authorities in
8 respect of which providers they should be commissioning
9 services from?

10 **A.** So, local authorities will want to take a number of
11 things into account, and that could be one of them.
12 However, I think the real challenge is marrying up the
13 underlying fragility of providers in terms of their
14 ongoing work with requirements to make robust plans for
15 the future, and there is a significant gap in many
16 instances between that.

17 **Q.** Thank you.

18 In respect of key decisions that were made by
19 the UK Government, you've stated in your statement that
20 acute and intensive healthcare needs were the focus of
21 decision making during the pandemic.

22 Was there any focus on the adult social care sector
23 at all? And if so, when do you think that focus
24 started?

25 **A.** So in my witness statement I describe social care as

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1 being an afterthought. I think that there was
 2 probably -- there could have been a degree of knowledge
 3 that we weren't aware of, and it was a deliberate
 4 decision, as the then Secretary of State has said, to
 5 make the least worst decision making, and I couldn't
 6 comment on that, but it certainly felt as though
 7 decision making for social care came afterwards and once
 8 we, with all our partners in the sector, were alerting
 9 DHSC and senior politicians to the actual impact of the
 10 pandemic on people needing and working in social care.

11 **Q.** In your statement you mentioned that there was a lack of
 12 understanding by the UK Government of the adult social
 13 care sector in England. How do you think the lack of
 14 understanding impacted the UK Government's response to
 15 the pandemic?

16 **A.** So, the hospital discharge decisions were an obvious
 17 one. Decisions around testing for social care coming
 18 afterwards. PPE, more or less all of the protections
 19 were secondary, and more complex for social care across
 20 such a diverse sector. I think there were also issues
 21 about status, inequalities, the care workforce being
 22 very low paid and account not having been taken of the
 23 complexity of giving them time to get PPE, tests,
 24 vaccinations, and the fact that if you work in
 25 a hospital it's relatively easy to go to a room and get

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1 acute hospitals, in particular the 30,000 discharges,
 2 not for reasons of politics but because it is health
 3 collapse, that is what is killing people in Italy."

4 At the time do you think that was the right approach
 5 by the UK Government, the focus on hospital discharges,
 6 because it's a health collapse, and this is what they
 7 saw in Italy?

8 **A.** So I completely understand the anxiety about acute
 9 hospitals and intensive care, and recognise that, but in
 10 other parts of my submission in the witness statement,
 11 I did make representation that, actually, you can't just
 12 look at acute hospitals; you have to look at the whole
 13 health and social care system and its capacity and
 14 resilience, and I also felt very strongly and mentioned
 15 that it was necessary, it should be looked at, the NHS
 16 community, primary, and mental health capacity, as well,
 17 because they sit so closely with social care.

18 **Q.** On that point, I'm going to ask for your statement to be
 19 pulled up on screen.

20 That is INQ000571608, paragraph -- so page 51,
 21 paragraph 12.14. Just take a moment because I'm
 22 skipping. Okay.

23 At this paragraph you've stated that:

24 "In the afternoon of 16 March ... [NHS England]
 25 (with DHSC copied in) asked ADASS to comment, within an

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1 a vaccination, whereas you're talking about thousands
 2 and thousands of people sometimes travelling two hours.

3 I think that there was very little understanding of
 4 the size and the number of people working and needing
 5 social care, and actually the workforce was larger than
 6 that of the NHS. And the complexity and wonderfulness,
 7 really, of what family and unpaid carers contribute to
 8 keeping us all alive and working and living.

9 **Q.** An example you used was the decision to discharge
 10 patients from hospitals into care homes without testing.

11 I want to ask you some questions about the Prime
 12 Ministerial meeting on 18 March 2020, and for your
 13 reference, in your statement it's paragraph 8.2.

14 In your statement you note that there was a Prime
 15 Ministerial meeting on 18 March at which ADASS attended,
 16 and you state that:

17 "... the principal discussion in relation to social
 18 care was its role in assisting the NHS with discharges,
 19 but which did not address social care concerns about the
 20 safety and resilience of its main services, and its
 21 capacity to undertake the discharge task."

22 And in an email, which I won't pull up on screen,
 23 but it was from James Bullion to you and others,
 24 summarising the meeting, he states:

25 [As read] "Complete focus on assisting the NHS and

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1 hour and a half, on the draft hospital discharge
 2 guidance," and that it was shared that evening with
 3 ADASS trustees, and on the morning of the 17th, you
 4 returned initial comments.

5 And those comments include that it:

6 "... only looks at discharge and unless you look at
 7 the capacity of the whole system -- including primary,
 8 community health care, social care and the inevitable
 9 additional needs if unpaid carers cannot function, then
 10 there is a serious potential to make things worse."

11 You also state that:

12 "There were ... a range of comments about increasing
 13 care in the community, for rehabilitation and reablement
 14 ... [and] that care homes might not be the best place,
 15 in a pandemic due to [the] risks to others ..."

16 And you emphasise that people needed information.

17 You also state you don't believe that many of the
 18 comments were incorporated into that discharge guidance.
 19 Did you receive any feedback from the UK Government
 20 about this?

21 **A.** I received feedback from one civil servant in DHSC who
 22 stated that social care would be looked at at a later
 23 date.

24 **Q.** Do you think that, with time, there was any work done by
 25 the UK Government to mitigate or alleviate any of the

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1 concerns that you raised?

2 **A.** Well, certainly around that period there was an
3 intensive amount of work undertaken, not just in
4 relation to hospital discharge, but the growing
5 awareness of transmission and its impact. And
6 certainly, the work that was going on across DHSC,
7 ourselves, care providers, the Care and Support
8 Alliance, which included carers and Age UK and
9 organisations like that, started to ramp up very, very
10 significantly.

11 **Q.** So the response that I've read out in the
12 paragraph 12.14 was actually from an email, and I'm
13 going to pull that email up now, please.
14 It's INQ000103763, page 2.
15 The last substantive paragraph, which starts with
16 "Secondly", you state that:
17 "... this is ostensibly a 'systems' message --
18 though actually it reads as a directive from
19 NHS [England] to social care. Social care is part of
20 the system. It hasn't been co-produced. I have already
21 had email heat from people alerted to at least one
22 webinar for NHS staff. There are 22,000 social care
23 providers. Communication in this form is like to cause
24 chaos which is the absolute last thing we need right now
25 for local systems."

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1 care sector could deal with that, with the lack of PPE,
2 testing, et cetera.
3 If I could pull up your statement.
4 That's INQ000571608, page 53, paragraph 2.21,
5 please.
6 I just want to ask you about a particular point that
7 is here. You state that:
8 "On 31st May we responded to an enquiry from a DLUHC
9 civil servant about rapid hospital discharge."
10 And your response in the email chain includes the
11 first paragraph, but on the second paragraph you state:
12 "As hospitals emptied, many to 55% occupancy at one
13 point, some local systems made their own local
14 arrangements not to further discharge people to care
15 homes that couldn't isolate and didn't have PPE. We
16 heard of other hospitals continuing to discharge
17 rapidly."
18 So, as I've mentioned previously, at the beginning
19 of the pandemic there were concerns regarding the
20 ability of care homes to be able to look after
21 residents, both coming in from hospital and also their
22 current residents, due to lack of PPE, testing,
23 et cetera.
24 In this context, do you think that rapid discharges
25 from hospitals to care homes should have continued to

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1 Do you feel that that was the overall culture when
2 it came to hospital discharges during the pandemic? Did
3 it feel like it was a directive from the NHS to the
4 adult social care sector?

5 **A.** So, yes, the systems were there for the NHS, and they
6 weren't there in terms of systems and infrastructure for
7 social care.
8 There was also a habit of NHSE sending out letters
9 that were addressed to trust chief executives or primary
10 care, and also to either directors of social services or
11 to chief executives of the councils. But there were no
12 addresses. So we often heard from our members that
13 they'd been shown an email from NHSE by one of their
14 NHS colleagues locally, but we weren't aware of it.
15 And we'd offered to NHSE to distribute such
16 communications if they'd wanted us to.
17 And that email was rather more abrupt than I would
18 normally have been, but it was done in great haste.

19 **Q.** It was. In a note here, you say:
20 "Unfortunately we couldn't meet your (unreasonable)
21 requests for comments within [the time]", et cetera,
22 et cetera.
23 Now, we've heard numbers of concerns from various
24 witnesses about the hospital discharge policy and, in
25 particular, issues in respect of how the adult social

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1 take place when occupancy rates in hospitals were low?

2 **A.** So I understand the anxieties, and work closely with
3 people in acute hospitals, so I completely understand
4 their anxieties about treating people and retaining
5 capacity. But certainly, rapid discharge without
6 consideration about whether the environment that people
7 are going to is suitable, whether it's safe, whether
8 they actually wanted to go there, and certainly our work
9 on discharge to assess, as the following paragraph
10 highlights, had worked on the model that 95% of people
11 would go home, that there'd be reablement and
12 rehabilitation to enable people to get back on their
13 feet, and at least that people, even if they needed
14 long-term care, would have had the time to consider
15 which options were right for them and whether they could
16 afford them, whether they were suitable, and so on.

17 **Q.** And before we go on to that paragraph 3, which I will
18 ask you a question about, do you think that
19 consideration of the ability for local care homes to
20 safely care for residents should be factored into
21 decisions on discharge and especially when occupancy
22 rates in local hospitals are low?

23 **A.** Absolutely. And their capability and whether they're
24 the right place for people, because one care home is
25 very different from another, and there are other

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1 options, as well as care homes.
 2 **Q.** Now, you mentioned the discharge to assess model, and
 3 the fact that the discharge plan describes 95% of people
 4 going home, 4% of people to reablement, and 1% of people
 5 to nursing care, and you state in this email that you've
 6 heard of 30% going to nursing homes in one area, but you
 7 state that that might not be at all typical.

8 Overall, do you think that this particular aspect of
 9 the discharge plan, the amounts of people that are
 10 supposed to be going to their home, nursing home, and
 11 reablement, do you think that was largely followed
 12 during the pandemic or do you think it was a bit of
 13 a mixed picture?

14 **A.** I don't think we had evidence that it was and certainly
 15 we raised that concern with DHSC and with NHSE. I think
 16 the function that social workers had in hospital was to
 17 have a conversation with individuals about what would be
 18 right for them on discharge from hospital so -- or their
 19 representative, if they lacked capacity to make such
 20 decisions.

21 I think the anxiety about getting people out quickly
 22 and the fact that Capacity Tracker was a model whereby
 23 -- and was advertised by NHSE as a model whereby trusts
 24 could discharge people to care homes and, indeed, care
 25 homes were invited to advertise vacancies, made that

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1 two recommendations which we communicated with our
 2 members. One was around using data in relation to
 3 quality, and the other was in relation to not taking up
 4 new contracts for people with services that were rated
 5 inadequate. And particularly in the context of hospital
 6 discharge, clearly many of the people discharged from
 7 hospital had more intensive needs than they might have
 8 had otherwise, and we had a point of view that
 9 "inadequate" might indicate that providers might be
 10 unable care for the people they were caring for already.

11 **Q.** I'm going to ask you a question about the designated
 12 settings policy.

13 If I could just pull up a document. It's

14 INQ000514882, page 4.

15 I believe these are minutes of a meeting, and in
 16 respect of designated settings, the second bullet point:

17 "... there were challenges in finding suitable
 18 premises/providers, getting CQC approval in a timely
 19 [manner], and a difficulty for providers in obtaining
 20 insurance. The scheme to support this was cumbersome
 21 and often not used. Designated settings were expensive,
 22 late in the process, and not all capacity was used."

23 Did ADASS support the designated settings scheme and
 24 if so, why?

25 **A.** We contributed and were present at meetings where it was

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1 a route for people that was more convenient for
 2 hospitals than was necessarily right for the individuals
 3 concerned, and their families.

4 **Q.** In Michelle Dyson's evidence session on 16 July, she was
 5 asked questions about discharge into care homes that
 6 were rated as inadequate and specifically whether the
 7 Department of Health and Social Care knew how many
 8 people were discharged into care homes, that were
 9 considered inadequate.

10 She confirmed that the UK Government did not know
 11 how many people had been discharged into care homes
 12 rated as inadequate. However, she also said that in
 13 this regard, local authorities have an important role as
 14 they have statutory duties regarding their local care
 15 markets, there might be issues that local authorities
 16 are aware of, but the CQC are not, and that where the
 17 CQC is aware of the issues, local authorities may have
 18 undertaken their own assurance checks to make sure that
 19 those issues have been resolved.

20 Do you think there is a role for local authorities
 21 in either ensuring or monitoring the people discharged
 22 to care homes rated as inadequate by the CQC?

23 **A.** So prior to the pandemic, we had worked with CQC and
 24 DHSC, and organisations of people with disabilities and
 25 older people on quality matters. In that, we took away

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1 discussed. I remember personally asking Jenny Harries
 2 more than once whether there was evidence that this
 3 would provide better outcomes by way of infection
 4 control. I don't think that she was able to respond
 5 then and I don't know whether that's -- any research has
 6 been done since.

7 I do think that the principle of asking people
 8 whether they think that the risk of getting an infection
 9 during a pandemic is more important to them than the
 10 risk of not having contact is very important, and I know
 11 providers bent over backwards to try to make safe areas,
 12 such as they could within care homes, and that homecare
 13 providers did absolutely the utmost they could in
 14 relation to going to home to home.

15 I think in principle, to refer back to what you were
 16 asking originally about the discharge plans, our
 17 understanding in the early meetings was that NHS would
 18 be supporting people who had tested positive, and that
 19 clearly didn't take shape in the actual discharge
 20 guidance that was produced, and was challenged later.

21 As I say, I think there is a notion of trying to
 22 introduce some form of choice for people and if that
 23 needs to be in a separate establishment then I can see
 24 the justification for it, but of course another pandemic
 25 might be transmitted in very different ways. So, yes.

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1 Q. And just on your point on your understanding on the
 2 early meetings that the NHS would be supporting people
 3 who had tested positive, how were they supposed to, or,
 4 you know, suggested to have been supporting people or
 5 should have been supporting people at the time?
 6 A. So the original suggestion, I think, was in community
 7 hospitals or in the Nightingale hospitals.
 8 Q. Yes. So, in respect of the designated settings policy,
 9 and in particular, where local authorities had to
 10 provide a list of care homes that had the ability to
 11 take on Covid positive patients, would you support
 12 a similar scheme in the future?
 13 A. If the context is right.
 14 Q. You may not be able to answer this, but do you think
 15 that that scheme, when it was up and running, was
 16 successful?
 17 A. It's difficult for me to say, because it was up and
 18 running quite late in the progress of the pandemic.
 19 Perhaps, if it had been up and running sooner.
 20 But of course, if you were to establish something
 21 from scratch, unless the country has addressed the issue
 22 about workforce, that would be very difficult to set up.
 23 Q. So do you think, in respect of pandemic planning, the
 24 concept of designated settings should be included in
 25 that, so that if there was a future pandemic, it could

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1 Q. I'm going to move on to ask you questions about
 2 restriction of staff movement between care settings.
 3 What did ADASS think about the concept of restricting
 4 staff movement between care settings?
 5 A. It makes absolute sense in an ideal world. In the world
 6 we were living in, care staff were, as you know, low
 7 paid and often dependent on more than one job to put
 8 food on the table.
 9 So issues like staff pay, furlough, or compensation
 10 for not doing more than one job was absolutely
 11 necessary, as well.
 12 Q. Do you have a view, or does ADASS have a view, on
 13 whether there should be legislation restricting staff
 14 movement?
 15 A. Well, it should certainly be discouraged, and could be
 16 part of a new deal for care staff, positively. Whether
 17 it should be legislation, I'd need to consider more, and
 18 I would need to be in discussion with more people about
 19 that.
 20 Q. And I presume from what you've said previously, you'd
 21 also want to ensure that proper remuneration is in place
 22 for the care staff? Is that a yes?
 23 A. Yes, that's a yes.
 24 Q. Thank you.
 25 If I could ask you some questions about Care Act

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1 be started up quite quickly?
 2 A. The concept where there is a place for people to go who
 3 need care and support, that minimises the risk of
 4 infection, is definitely a sound one.
 5 Q. I'm going to ask you some questions about visiting
 6 restrictions, and I'm going to just hone in on the issue
 7 of blanket bans, on restrictions of visiting by local
 8 authorities and other organisations.
 9 Were you aware of those taking place?
 10 A. I wasn't aware of blanket bans by local authorities.
 11 I'm aware of some localised bans where there were local
 12 outbreaks by health protection and public health teams
 13 because of community and other issues or local outbreaks
 14 in homes.
 15 Q. Do you know if directors of adult social services were
 16 involved in decisions on blanket bans?
 17 A. Not to my knowledge.
 18 Q. So you think it was more of a public health sort of
 19 decision but on a localised level?
 20 A. So I think that some care homes took their own decisions
 21 to ban visitors based on anxieties about transmission.
 22 But as I say, I'm not aware of directors being involved
 23 in those decisions. Though no doubt their local
 24 director of public health would have been in dialogue
 25 with them.

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1 easements. What, if anything, did ADASS or the -- oh,
 2 gosh, I can't remember the name of it, give me one
 3 second -- the National Advisory Coronavirus Group --
 4 what, if anything, did ADASS or the National Advisory
 5 Coronavirus Group do to assess the impact of Care Act
 6 easements on people in need or in receipt of care and
 7 their family members?
 8 A. So NCAG, as we referred to it as, commissioned Think
 9 Local Act Personal to do a review of the Care Act
 10 easements, and they talked to those who had enacted
 11 them, and people involved in their local areas,
 12 including disabled people's organisations.
 13 We had also decided that we would ask our members
 14 more about the impact they'd had, both those DASSs who
 15 had enacted them but also a wider group of directors.
 16 Q. And I believe that ADASS produced a document called
 17 *'Themes and Learning from ADASS Members on the Local
 18 Response to COVID-19 in Spring and Early Summer 2020'*,
 19 which discussed the use of Care Act easements. And it's
 20 clear from that document that they were not used to
 21 a great extent. My understanding is around eight out of
 22 151 local authorities used Care Act easements during the
 23 pandemic.

24 Do you think Care Act easements would be necessary
 25 in a future pandemic, given that they were not used to

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1 a great extent in this pandemic?

2 **A.** So I think that the fact that there were amendments to

3 legislation in relation to social care and not in the

4 same way to schools or hospitals or other public

5 services meant that it was possible that disabled and

6 older people needing care and support felt that they

7 were unfairly singled out in terms of their rights

8 having been reduced.

9 I think that the -- there is a very painful

10 juxtaposition for us as an organisation in relation to

11 the easements, because we had been reporting via our

12 members surveys for many years on the lack of confidence

13 that our members felt in delivering their statutory

14 duties, and that continued, and worsened, during the

15 pandemic.

16 So I think that it caused a great deal of distress

17 for directors not to be able to deliver the Care Act and

18 Mental Capacity Act, because they were felt to be good

19 legislation.

20 I think there would be -- need to be a -- I think

21 what I'm saying, briefly, is there would need to be

22 a broader look at how public services function rather

23 than just social care in the context of another

24 pandemic.

25 **Q.** And the Inquiry has heard some evidence where people

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1 nobody did that maliciously or in an underhand way.

2 They were simply trying to juggle the staffing and the

3 resources that they had.

4 **Q.** What, if anything, did ADASS do to ensure that the

5 system of easements were being used correctly by local

6 authorities?

7 **A.** Sorry I didn't hear the middle bit of that.

8 **Q.** What, if anything, did ADASS do to ensure that the

9 system of easements were being used correctly by local

10 authorities?

11 **A.** So we had regional structures and met with our regional

12 chairs regularly, and within our regions there was

13 a degree of both support and challenge for each other.

14 And we regularly communicated with our members but it

15 wasn't an assurance process.

16 **Q.** If we have a future pandemic and if we have Care Act

17 easements in it, would you agree with the suggestion

18 that the CQC should monitor the use of Care Act

19 easements in a future pandemic?

20 **A.** It's possible. I think the people who did use the

21 easements were intensely scrutinised both by DHSC and

22 rights groups, and locally, and some described it as

23 bombardment when they were trying to juggle the actual

24 impact of the pandemic, as well.

25 Again, there's a context, isn't there, about do you

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1 have, and organisations have, alleged that local

2 authorities -- some local authorities did not invoke

3 Care Act easements but reduced services or acted in

4 a manner with which they should have declared that they

5 were invoking Care Act easements.

6 The Inquiry has also heard that some local

7 authorities were using flexibilities in the Care Act to

8 provide less services without turning on easements. Was

9 ADASS aware of this, and if so, how widespread was this

10 issue?

11 **A.** So to answer you, I think that councils and DASSs had

12 for many years been considering how they were able to

13 enact the Care Act and deliver rights to people, and

14 that they had, certainly our members had an impossible,

15 in my view, job to do in terms of balancing the number

16 of people to whom they provide care and unmet needs, the

17 price that they paid to providers, the quality and the

18 choice that they were able to fund and facilitate, and

19 to balance as part of councils, to meet their legal

20 requirement to balance their budgets. I think that's

21 a very difficult equation to make the right decisions

22 on, and I think that people were having to flex over

23 a number of years, and the pandemic certainly made that

24 worse.

25 I don't -- I'm a hundred per cent confident that

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1 do this just for social care or do you do this

2 elsewhere? And certainly there's a role for all public

3 services to be challenged in crisis.

4 **Q.** But during this pandemic was there a mechanism where

5 recipients of care and their family members could

6 complain about the use and impact of easements during

7 the pandemic?

8 **A.** So there wasn't a single process but certainly the

9 existing procedures remained in place, and certainly

10 locally, I know there was a lot of discussion with

11 Disabled People's Organisations. But I'm also very

12 conscious, having worked in social work and social care,

13 that it's extremely difficult for people who are frail,

14 isolated, excluded, or, as -- not everybody clearly in

15 receipt of, drawing on social care, is in that position.

16 Some are very much not. But it's very difficult to

17 engage with complaining.

18 **Q.** So my next question is, do you think there should be

19 a specific mechanism for recipients of care or their

20 families to be able to complain about the use of

21 easements in a future pandemic?

22 **A.** It's difficult for me to answer that one specifically.

23 People should always be able to make representation, of

24 course.

25 **LADY HALLETT:** It's also another possible way of draining

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1 the local authority resources in responding to
2 individual complaints at a time when everyone is under
3 enormous pressure. It's a really difficult balance,
4 isn't it?

5 **A.** Yes.

6 **MS SHOTUNDE:** I'm going to ask you some questions about
7 infection prevention and control and in particular PPE.
8 And I'm just going to hone in to the initial, sort of,
9 drops of PPE.

10 If I could just pull up your statement, that's
11 INQ000571608, page 63, and paragraph 14.3.

12 You state here that:

13 "The initial drop to [local resilience forums] was
14 inadequate; they were the wrong mechanism for social
15 care in a period of prolonged emergency, though possibly
16 the only option at the time."

17 What would have been a better option, do you think?

18 **A.** So I think in conclusion to my thinking in relation to
19 pandemic, not just in relation to PPE, but also in
20 relation to testing and planning and responding, that
21 there needs to be a significant review of how LRFs sit
22 alongside NHS structures and government infrastructures,
23 and the Inquiry's report to the first module, which set
24 out what I think you called the spaghetti diagram, just
25 demonstrates absolutely how well and how disconnected

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1 to support them in such ways as they were able, but I'm
2 also aware that many carers were behind closed doors and
3 unknown. So I think the issues were similar to other
4 forms of support and protections.

5 By the time of vaccinations, we and carers
6 organisations had managed to imprint the significance of
7 unpaid carers, such that we were able to advocate for,
8 and contribute to, the standard operating procedure for
9 vaccinations for unpaid carers. But again, that took
10 a while to get under way.

11 **Q.** My understanding is that data in respect of unpaid
12 carers, who they are, where they are, is not complete.
13 Is there sufficient information today -- because I know
14 there wasn't enough in the pandemic -- for local
15 authorities to be confident that they know as many
16 unpaid carers in their areas as possible? And would be
17 able to provide PPE for them in the future?

18 **A.** I'm reasonably confident, though I'm speculating, to say
19 that they wouldn't know who all unpaid carers are, and
20 I'm also reasonably confident that there are people in
21 this room and listening to this who wouldn't identify
22 themselves as an unpaid carer, and some people would be
23 very grateful to be identified in one form or another.
24 Another would feel -- others would feel that it's an
25 intrusion.

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1 social care was from that, compared to the direct lines
2 of the NHS.

3 So I would suggest that there's a review of that,
4 and how national systems, regional and local systems,
5 work together, because LRFs are composed of individuals
6 who have big full-time jobs and can respond to
7 short-term emergencies but clearly it was an unrealistic
8 expectation that they could do that over a long period
9 of time.

10 **Q.** And later on in your statement you state that work was
11 undertaken to address the issues in respect of PPE
12 provision. How successful was the national supply
13 mechanism of PPE during the pandemic, in your view?

14 **A.** Eventually, when it became functional, I think that it
15 was extremely appreciated by directors, by care
16 providers, by unpaid carers and by personal assistants
17 but it took a long time to get established --
18 understandably, because part of the challenge, of
19 course, at that point of time, was global supply.

20 **Q.** And speaking of unpaid carers, what efforts did local
21 authorities undertake to ensure that they had access to
22 PPE?

23 **A.** So the supply of PPE to unpaid carers came later in the
24 day, in line with guidance. And I know that councils
25 made very big efforts to remain in touch with carers and

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1 So, in terms of data, I know that ADASS members did
2 an awful lot of work to put together the data that GPs
3 had, which was patchy, their own data about where carers
4 had been in contact, and data from local carers'
5 organisations, but again, that would only be
6 a proportion of the numbers of people caring in the
7 community.

8 **Q.** I'm going to ask you some questions about funding during
9 the pandemic and in particular the Infection Control
10 Fund and other funding that the government gave to
11 support local authorities and care providers.

12 We have heard evidence from witnesses, including the
13 National Care Forum, who have stated that there were
14 difficulties in the funds reaching the front line,
15 reaching the care providers, and that happened not just
16 at the beginning, but it also happened with the second
17 tranche of funding.

18 Was this is an issue that you were made aware of
19 during the pandemic?

20 **A.** So we were working closely with the Care Providers
21 Alliance association and others right the way through
22 and prior to the pandemic, and so we were aware of the
23 context. Of course the initial funding for councils was
24 to spend at their discretion, albeit that care provision
25 was expected to be a part of that, that councils were at

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1 that point in time covering shielding and rough sleeping
2 and various other initiatives as well.

3 Certainly we heard from our members and from our
4 care provider colleagues that the requirements of the
5 grants were making things slower than they might
6 otherwise have been.

7 **Q.** And if I could just pull up on the screen INQ000587670,
8 page 76 -- sorry, page 86, paragraph 361.

9 This is a statement from the Homecare Association
10 for Module 6 in which they state that:

11 "75% of the Infection Control Fund went to care
12 homes. Local authorities distributed the remaining 25%
13 based at their discretion. Homecare services received
14 roughly half of the remaining 25%. Some local
15 authorities gave none of this funding to homecare.
16 Others gave it only to providers who contracted with
17 them."

18 Were you aware of issues with domiciliary care
19 providers receiving funds during the pandemic?

20 **A.** So we were very conscious of domiciliary care providers
21 generally, in that there was a major focus on care
22 homes.

23 In relation to funds, we, alongside other
24 colleagues, advocated for the 25% to be at the
25 discretion, to enable at least some funding to go to
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1 focus?

2 **A.** Yes, I understand that focus, and I think you're right
3 about that, but I think that the issue around community
4 infection and the impact on people who were behind their
5 own closed front doors was less recognised, as well.

6 **LADY HALLETT:** Now that I understand, but that's a different
7 point from whether the proportions should have been
8 different, isn't it?

9 **A. (Witness nodded)**

10 **MS SHOTUNDE:** I'm just going to move on to ask some final
11 questions on the enhanced sick pay scheme.

12 The Inquiry was informed that the money was not
13 reaching staff and we've heard that from various
14 different witnesses.

15 Was ADASS aware of this at the time?

16 **A.** So we were aware that most providers were making
17 significant efforts to ensure that their staff were able
18 to take time off sick with pay or to isolate with pay.
19 But we were also aware that there were small -- much,
20 much smaller proportions of providers who weren't paying
21 their staff sick pay, or an equivalent to their normal
22 wages.

23 **Q.** And what, if anything, did ADASS do about it at the
24 time?

25 **A.** So we contributed to discussions about it, we raised it
95

1 domiciliary care as well as to care homes.

2 I can't answer for local authority variation and
3 MHCLG or LGA may be able to give you more information on
4 that. We didn't keep that data specifically.

5 **Q.** Do you think that the split, so 75% of the funds going
6 to care homes and 25% to home care, was proportionate?

7 **A.** So I think no, it wasn't, but there was an anxiety about
8 how infection had impacted on people living and working
9 in care homes that was visible in a way that people in
10 their own homes wasn't visible, but clearly, the impact
11 on people receiving home care, the impact on unpaid
12 carers, and people who had employed their own personal
13 assistants was very significant.

14 So starting again with experience, I think the split
15 should have been different, but that was the decision
16 that was made.

17 **LADY HALLETT:** Can I press you on that? Basically, it was
18 the care homes where you had -- they'd become hotspots
19 of infection where you had the problems with staff
20 movement, you had a lot of people in the closed
21 community. Surely the considerations for care homes
22 were very different? I appreciate the problems that
23 people caring had at home, please don't get me wrong,
24 I'm not underplaying that, but doesn't that explain why,
25 at the beginning, the care homes were the particular
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1 with our regions, but we were not close enough to, or
2 would have been appropriate to address it with
3 necessarily individual local authorities, but I am
4 conscious that through the data that DHSC had in their
5 regional assurance people, together with our regional
6 staff, they were making enquiries of those employers.

7 **Q.** Thank you. And then my final question is: are there any
8 recommendations that we haven't covered in our evidence
9 today that you want to raise today?

10 **A.** So firstly, I think I've implied this but I think there
11 needs to be, for a future pandemic, a consideration
12 about the infrastructure for social care, including
13 nationally, regionally and locally, and the engagement
14 of social care from the very beginning at the very
15 highest level, in the same way that Secretaries of
16 State, for instance, regularly engage with the chief
17 executive of -- or NHS England, or whatever succeeds
18 that body, because certainly we would have been able to
19 complement something to those decisions, and there were
20 discussions that we now know, partly as a result of this
21 Inquiry, of considerations, for example of asymptomatic
22 transmission, even if it wasn't likely, that we weren't
23 aware of at all and might have been -- behaved
24 differently as a result.

25 I don't expect the Inquiry to be able to resolve the
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1 underlying fragility of social care, but certainly,
2 I think that had a very significant impact on the
3 pandemic itself.

4 So I would personally suggest that there is
5 something akin of a reservist taskforce that meets
6 perhaps annually to review pandemic preparedness, and to
7 challenge plans and operational issues of the time.

8 **Q.** Would that -- sorry, if I could just ask a question on
9 that -- would that be a national taskforce, or would it
10 be like a taskforce in each local authority?

11 **A.** My comments were in relation to the taskforce that
12 Sir David Pearson chaired, for example, that can be
13 stood up rapidly at a point of it looking like there's
14 an emergency.

15 And finally, I would recommend that in a future
16 pandemic, there is an equal consideration given to both
17 our social and psychological needs as well as our
18 medical and clinical needs, and that any view of
19 capacity is closely aligned with quality, safety,
20 safeguarding, and other issues in relation to people
21 needing care and support. And particularly that we
22 don't just look at the closed doors of a care home, but
23 also people behind their own closed doors, who were
24 experiencing more domestic abuse.

25 And I think that of the people I've spoken to,
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1 through the draft action plan?

2 **A.** So, to put that in context, we had been invited, again
3 with very short notice, to a meeting to discuss the
4 phrasing in the action plan particularly --

5 **Q.** By short notice, I think you say 20 minutes in your
6 statement.

7 **A.** Yes, and then we'd been given the opportunity to comment
8 on it. So it clearly wasn't enough, but everybody was
9 working at great pace, and at least we were engaged in
10 that, and we were cognisant of the content of the plan,
11 whereas we hadn't been cognisant of the discharge
12 guidance.

13 **Q.** No, indeed. Just picking up from that, then, looking
14 forward and appreciating, as you've just adverted to,
15 that guidance may need to be produced at speed, what can
16 be done, in your view, to ensure that important
17 stakeholders like ADASS are given sufficient time to
18 properly consider and contribute to guidance in an
19 emergency?

20 **A.** So I think first, let's not lose the guidance we have so
21 that we're not starting always from scratch.

22 **Q.** Yes.

23 **A.** And it might need to be significantly adapted, but at
24 least we're not starting from the beginning as we were
25 then.

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1 there's a collective hope that the Inquiry might make
2 a mark in recognising just how essential social care is
3 for all of our lives, and to start to build towards
4 a new social contract so that we can all live and work
5 and care.

6 **MS SHOTUNDE:** Thank you, Ms Williams.

7 My Lady, those are my questions.

8 **LADY HALLETT:** Thank you very much, just a few more
9 questions.

10 Mr Weatherby is first. He's just there.

11 **Questions from MR WEATHERBY KC**

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

13 Ms Williams, good afternoon. I ask a few questions
14 on behalf of the Covid Bereaved Families for Justice UK.
15 Can I return to consultation, first of all. You've
16 touched on this before.

17 In your statement -- and just for the record, it's
18 paragraph 9.1 -- you describe being given an hour to
19 comment on a near-final document in relation to the
20 hospital discharge policy, and you describe that as
21 "derisory".

22 And on 14 April, you were given 25 minutes to
23 comment on the draft adult social care action plan.

24 That's your paragraph 12.18.

25 So, firstly, was 25 minutes long enough even to read
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1 Secondly, I think the contribution that we can make
2 but also that care providers and other people engaged in
3 the taskforce is more significant, and there needs to be
4 a wide range of people attempting to contribute to it.
5 But I guess preparation rather than trying to make it up
6 as you go along is the key message, really.

7 **Q.** Yes, and what about --

8 **A.** -- despite the best efforts of everybody involved.

9 **Q.** Sure. And what about being embedded within government
10 or having a closer relationship with government so that
11 you don't get 20 minutes, you get a proper period to
12 look at things?

13 **A.** Well, I think in fairness, we have always valued
14 a degree of independence such that we can serve our
15 members and make statements but we've always worked very
16 collaboratively with government, so I think, having
17 social care expertise within government, which there has
18 been in the past, and maybe in the future, but there
19 wasn't to that extent at the time, and by expertise,
20 I mean operational expertise as opposed to policy
21 expertise, would be valuable.

22 **Q.** Yes. Sure.

23 Now, guidance on the requirements for the hospital
24 discharge policy was issued on 19 March, and then
25 sector-specific guidance on admissions was published on

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1 2 April.
 2 Bearing in mind the email that you referred to
 3 earlier, throughout this period, was there a sense that
 4 care homes were being pressured or forced to admit
 5 patients from hospitals?
 6 **A.** I don't think that was the intention, though they were
 7 very strongly encouraged to.
 8 **Q.** Yes.
 9 **A.** But certainly, I know there were parts of the country
 10 and parts of the national system where the pressure was
 11 intense to make what was phrased as their "contribution"
 12 to the pandemic.
 13 **Q.** Yes, so maybe not the intention, but it was certainly
 14 the perception?
 15 **A.** I'm sure that perception was real.
 16 **Q.** Yes. And was there a point at which providers felt less
 17 pressure in that sense? And if so, can you give us some
 18 kind of time frame?
 19 **A.** So I can't describe to you actually having any specific
 20 direct national feedback on that, but I think that as
 21 the social care action plan and then the taskforce
 22 report, and then the subsequent winter plan progressed,
 23 there was a degree of extra recognition.
 24 **Q.** Right, so it got progressively better?
 25 **A.** So -- yes, I think so. But the second year of the
 101

1 most competent and committed staff."
 2 And you go on to expand that later in your statement
 3 at 13.7.
 4 In your view, was an increase in the risk of neglect
 5 an obvious risk at the outset of a pandemic or emergency
 6 such as this?
 7 **A.** It certainly appeared so to me and to ADASS members in
 8 every conversation that we had.
 9 **Q.** And were sufficient measures put in place by central
 10 government, and specifically the CQC, to mitigate this
 11 risk?
 12 **A.** So I think that the emergency framework that CQC
 13 introduced was perceived as difficult for our members,
 14 because they'd relied on CQC data complementing their
 15 own contracts, information, and safeguarding work, and
 16 we certainly said so to CQC at the time.
 17 I'm not sure -- we did try very hard to get safety
 18 and safeguarding on the government agenda on a number of
 19 occasions, but I'm not sure that we -- that we either
 20 articulated it clearly enough or that it was heard.
 21 **Q.** Yes. And do you think there should have been additional
 22 funding provided earlier, as it was perhaps later in the
 23 pandemic, to ensure that safeguarding was instituted
 24 earlier?
 25 **A.** Yes. And I think the issue is just as acute in terms of
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1 pandemic, when there was Omicron, there were different
 2 challenges --
 3 **Q.** Sure.
 4 **A.** -- because of staffing.
 5 **Q.** Yes. Now turning to the hospital discharge policy, but
 6 still in the area of consultation, you weren't consulted
 7 before the announcement of the hospital discharge policy
 8 that was made on 17 March 2020. If you had been, and
 9 you'd known how little information ministers had about
 10 what was going on on the ground, what would you have
 11 advised, in one sentence or as shortly as you can?
 12 **A.** Some greater safeguards for people needing care and
 13 support. I think by then the bandwagon was rolling, so
 14 actions in relation to social care would have needed to
 15 have taken place in the -- I think it was in the middle
 16 of February when people were starting to seriously alert
 17 to the pandemic.
 18 **Q.** Yes. And finally, changing the subject, quality,
 19 safeguarding and regulation, at your paragraph 2.2(i) in
 20 your statement you say this:
 21 "Lockdowns in care homes effectively resulted in
 22 a seismic increase in the number of closed institutions
 23 which coupled with pre-existing staff shortages and
 24 staff sickness significantly increased the risk of
 25 neglect, even in the best run establishments with the
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1 people at home, because --
 2 **Q.** Yes.
 3 **A.** -- in a care home at least you know there's a building
 4 with people in it, whereas we know from previous
 5 safeguarding concerns that it's very possible, for any
 6 reason, for a care -- home carer not to be able to turn
 7 up to somebody who is not able to articulate their
 8 concerns, and that can have as -- catastrophic
 9 consequences.
 10 **Q.** Yes. Finally, does it -- is it a concern that the CQC
 11 apparently didn't collect data during the pandemic on
 12 the number of patients discharged to residential
 13 settings, that were judged to be inadequate before the
 14 introduction of designated settings?
 15 **A.** So I think the whole discharge process, as I've
 16 mentioned, could have been better managed. And yes,
 17 a CQC measure would have contributed to that, perhaps,
 18 but I would need to engage in discussion about that.
 19 **MR WEATHERBY:** Thank you very much.
 20 **LADY HALLETT:** Thank you, Mr Weatherby.
 21 Ms Jones, she's over that way.
 22 **Questions from MS JONES**
 23 **MS JONES:** Thank you, my Lady.
 24 Good morning, Ms Williams. I ask questions on
 25 behalf of John's Campaign, The Patients Association, and
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1 Care Rights UK. I have two questions for you today.
 2 They're both on the topic of the under-recognition of
 3 the adult social care system during the pandemic.
 4 Firstly, you described adult social care as being an
 5 afterthought, with the NHS prioritised and there being
 6 inadequate coordination between the two systems.
 7 What, in your experience, was the overall impact of
 8 this context on adult social care and its ability to
 9 perform the role it needed to during the pandemic?
 10 **A.** So, just to clarify, you are asking me to comment on the
 11 lack of recognition?
 12 **Q.** And the prioritisation of the NHS. What were the
 13 practical impacts on that of the adult social care
 14 sector's ability to do its work?
 15 **A.** Yes, so I think the lack of recognition demonstrated
 16 itself in numerous ways but particularly in the public
 17 messaging. So, if you recall, the 5 o'clock
 18 Prime Minister and/or Secretary of State broadcast every
 19 day. I think, and I may be wrong, but I only recollect
 20 seeing care -- the care lozenge alongside the NHS
 21 lozenge on one occasion, and the messaging was very
 22 much: protect the NHS, save lives, and 'Stay at Home'.
 23 And we did communicate as often as we could with
 24 civil servants about trying to encourage more
 25 constructive messaging around the value that care staff

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1 this day in -- a disproportionate incidence of
 2 Long Covid in care workers.
 3 **Q.** And finally, if I may, do you think there's been any
 4 improvement in recognition of the social care system,
 5 given the important role that it played during the
 6 pandemic?
 7 **A.** So I think that there was recognition during the
 8 pandemic, thanks, partly, to some conscientious
 9 journalists who made the public more aware. There was
 10 also, very unfortunately, some negative recognition when
 11 the message about care staff spreading the virus
 12 occurred, which led to some vilification of care staff
 13 and some even needing protection from the public. Has
 14 that continued? I'm not sure that I see evidence of
 15 that yet, and I'm not sure that contributors to this
 16 Inquiry would say that things are better now.
 17 Certainly the underlying issues about long-term
 18 funding, recognition and reform haven't been addressed
 19 for, I'm sure, a range of reasons.
 20 **MS JONES:** Thank you very much.
 21 **LADY HALLETT:** Thank you very much, Ms Jones.
 22 That completes the questions we have for you
 23 Ms Williams, I'm really grateful to you for the help
 24 you've given to the Inquiry and if you want to reassure
 25 your members, if I've got one message during the course

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1 and people needing care and support have.
 2 I think we had limited success in that, but
 3 certainly, there wasn't the recognition and thanks, and
 4 if you will also recall, what was originally "clap for
 5 carers" became "clap for the NHS", and I think that led
 6 to everybody feeling less valued. And as a consequence,
 7 I think the strong messaging about the NHS possibly
 8 countered what I believe to be -- can only believe --
 9 it's absolutely true -- that there were no direct
 10 messages, for instance, that PPE was to be diverted to
 11 the NHS by suppliers or border control, but I think that
 12 that message was so strong that the NHS was the
 13 priority, that actually, people needing care and support
 14 and working in it were a secondary consideration.
 15 **Q.** And can I just ask in respect of that, what were the
 16 consequences for them, of being a secondary
 17 consideration? How did you see that manifest in how
 18 people were able to perform their work and the care that
 19 was provided?
 20 **A.** So the action plan was produced, in effect, after the
 21 first month of that instant initial transmission rather
 22 than prior to it. It meant that care staff and carers
 23 were secondary in relation to the supply of PPE,
 24 secondary in relation to testing, and the ultimate
 25 impact of that was on morbidity and mortality and to

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1 of this module, it is the importance of recognising
 2 social care. So you've helped, with others, to get that
 3 message very firmly across.
 4 **THE WITNESS:** Thank you.
 5 **LADY HALLETT:** So thank you very much for your help.
 6 I shall return at 1.45 pm.
 7 **(12.47 pm)**
 8 **(The Short Adjournment)**
 9 **(1.45 pm)**
 10 **LADY HALLETT:** Ms Shotunde.
 11 **MS SHOTUNDE:** My Lady, please may I call Alwyn Jones.
 12 **MR ALWYN JONES (affirmed)**
 13 **LADY HALLETT:** I hope you were warned that we wouldn't get
 14 to you until this afternoon. I hope you weren't waiting
 15 too long.
 16 **THE WITNESS:** That's fine, thank you.
 17 **Questions from COUNSEL TO THE INQUIRY**
 18 **MS SHOTUNDE:** Could you please tell us your full name.
 19 **A.** My name is Mr Alwyn Rhys Jones.
 20 **Q.** Thank you for your witness statement for Module 6, dated
 21 17 December 2024.
 22 You are the immediate past president of the
 23 Association of Directors of Social Services Cymru; is
 24 that correct?
 25 **A.** Yes. I mean, there is a new president now, so I'm --

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1 yeah, there's been a further president since we came to
 2 this stage, so, yes.
 3 **Q.** And I will refer to it as ADSS Cymru throughout.
 4 **A.** ADSS Cymru, yes, okay.
 5 **Q.** Your substantive role is as chief officer of social care
 6 for Wrexham County Borough Council; is that right?
 7 **A.** Yes, that's correct.
 8 **Q.** And in respect of ADSS Cymru, you took up your role as
 9 president in December 2022?
 10 **A.** That's correct.
 11 **Q.** And your term of office ended in March 2024; is that
 12 correct?
 13 **A.** That's correct.
 14 **Q.** And I understand that you have some preliminary remarks
 15 that you would wish to make today?
 16 **A.** Yes, if that's okay.
 17 On behalf of ADSS Cymru, I would just like to note
 18 our sincerest condolences to any families that were
 19 affected by bereavements during the pandemic, and commit
 20 to doing all we can in terms of supporting and
 21 understand.
 22 **[Welsh spoken]**
 23 Diolch. Thank you.
 24 **Q.** Thank you.
 25 ADSS Cymru is the national professional leadership

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1 **Q.** In terms of the role of ADSS Cymru during the pandemic,
 2 I understand that you worked closely with the Welsh
 3 Government and other stakeholders and you also were
 4 involved in communication, for example disseminating key
 5 messages to stakeholders and other matters; is that
 6 right?
 7 **A.** Yes, we did play that role.
 8 **Q.** I'm going to ask you some questions about pre-pandemic
 9 capacity of the adult social care sector in Wales and in
 10 particular, resilience.
 11 If I could pull up your witness statement on screen,
 12 please. That's INQ000528094, page 20, paragraph 3.13.
 13 In your statement you mentioned that:
 14 "Issues about the resilience of the independent care
 15 sector also surfaced. Unlike England, Wales has few
 16 large care home chains where staff can be redeployed
 17 between homes. Many are family-owned and their capacity
 18 to manage during the pandemic was severely limited.
 19 Some local authorities did what they could to help, [for
 20 example] in one area, the local authority's catering
 21 department provided cooked food for residents of an
 22 independent care home because the home's catering staff
 23 were absent due to illness."
 24 In terms of Wales having few large care homes
 25 compared to England, how did that affect care homes in

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1 organisation for social services in Wales; is that
 2 correct?
 3 **A.** Yes, that's correct.
 4 **Q.** And my understanding is that it represents the
 5 collective view of all 22 local authorities, social
 6 services departments; is that right?
 7 **A.** Yes, that's correct.
 8 **Q.** And the aims of the organisation are to ensure that
 9 adults, as well as children, in need, experience
 10 wellbeing and achieve what matters to them by accessing
 11 the right care and support; is that right?
 12 **A.** Yes, that's correct.
 13 **Q.** And just to confirm, in Wales, adult social care and
 14 children's social care are dealt with by one person
 15 essentially?
 16 **A.** Yes, generally there is a director for social care, who
 17 covers both adults' and children's services.
 18 **Q.** Thank you. And speaking of that, it's a statutory
 19 appointment in each of the 22 local authorities and my
 20 understanding is that it is responsible -- sorry,
 21 directors of social services are responsible for
 22 services quality and driving delivery of improved
 23 outcomes, safeguarding service and performance
 24 management, et cetera; is that right?
 25 **A.** Yes.

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1 practice during the pandemic?
 2 **A.** I think how that affected care homes during the course
 3 of the pandemic is they were -- they had smaller units
 4 in terms of resilience, in terms of being able to depend
 5 upon during periods of staff sickness, isolation. They
 6 also had a different sort of models in terms of the
 7 buildings they operated from. Generally they were from
 8 different types of buildings, generally older buildings
 9 that had become care homes. So I think it made them
 10 less resilient in terms of that ability to move staff
 11 and that they had very little additional capacity to
 12 move into.
 13 **Q.** How would you describe the level of consultation with
 14 the Welsh Government on the adult social care sector
 15 during the pandemic?
 16 **A.** During the course of the pandemic, we had regular
 17 consultation with Welsh Government during the course of
 18 the pandemic, very, very strongly in early days, and
 19 then depending upon the stage of the pandemic, it would
 20 vary depending upon the level of intensity in terms of
 21 lockdown decisions made at Welsh Government level, but
 22 certainly in the early days we had very regular
 23 meetings, weekly and some colleagues were meeting more
 24 than once a week. We had directors' meetings which then
 25 fed into those meetings with the Welsh Government, and

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1 we were involved in a number of key groups.
 2 **Q.** And from paragraph 2.20 of your witness statement, my
 3 understanding is that the first prime contact that
 4 ADSS Cymru had with the Welsh Government about the
 5 pandemic was in February 2020, and that was a meeting
 6 with Albert Heaney and Sue Cooper who was the then
 7 president of ADSS Cymru.

8 Do you think that was the right time, in terms of
 9 communication with the Welsh Government about the adult
 10 social care sector, or do you think it should have
 11 happened sooner?

12 **A.** It's difficult for me to comment in terms of the science
 13 of the pandemic. Clearly, sooner rather than later
 14 would have been the best. Clearly, that's the first
 15 opportunity Welsh Government felt they had to start
 16 having that conversation about the pandemic with us, and
 17 obviously the level of seriousness with which it was
 18 being considered.

19 **Q.** In your witness statement you described the social care
 20 sector as the "Cinderella service", like several other
 21 witnesses that we've had for this module. You mentioned
 22 discharge and lack of medicine support in care homes as
 23 an example of how it was shown to be the Cinderella
 24 service during the pandemic.

25 Are there any other ways in which you think the NHS
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1 consultation in that regard.

2 **Q.** And in your statement you set out the overall view of
 3 ADSS Cymru, which was that discharge without testing was
 4 irresponsible. At the time, at the beginning of the
 5 pandemic, as I'm sure you're aware, there was a lack of
 6 testing capacity. Then. Do you think that in a future
 7 pandemic, there should any be discharge into care homes
 8 after a negative Covid test, or if there is a positive
 9 Covid test, that the person be put in step-down
 10 facilities before being discharged into a care home?

11 **A.** Clearly in the case of Covid, and given the restrictions
 12 that was put on society, clearly the natural
 13 indication -- the natural place to take this to is that
 14 there should have been testing prior to discharge.

15 I can't comment on the nature of a future pandemic
 16 because it could well be a very different nature to
 17 Covid. But in terms of the pandemic which we faced,
 18 should there have been negative testing prior to
 19 discharge, my answer, simply, is yes.

20 **Q.** What about testing before discharge for people who are
 21 going to be discharged back into their own homes in need
 22 of domiciliary care or care by unpaid carers? Do you
 23 think the need for a negative test before discharge is
 24 perhaps maybe slightly less acute than in care homes?

25 **A.** I think there needed to be testing. I think potentially
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1 was prioritised over the adult social care sector in key
 2 decisions by the Welsh Government during the pandemic?
 3 **A.** I think consideration of social care in the context of
 4 a number of decisions was always later than the NHS. So
 5 when discharge was considered, it was clearly considered
 6 initially with a focus upon supporting the NHS and
 7 having a platform within which they could cope with it
 8 with the pandemic.

9 Similar areas around when decisions were made around
 10 testing and decisions were made around protective
 11 equipment, it always felt that actually social care was
 12 considered slightly later. It was considered, but it
 13 was not immediate. It felt like the initial narrative
 14 was around the challenge within the NHS.

15 **Q.** On the discharge of residents from hospitals to
 16 care homes, ADSS Cymru were consulted on the discharge
 17 guidance at the beginning of April 2020 and I presume
 18 that the decision to discharge without testing had
 19 already been made by the Welsh Government at the point
 20 where ADSS Cymru were consulted; is that right?

21 **A.** I mean, I think there was some initial -- there was
 22 a period of time where there was not clarity around the
 23 testing and discharging. I mean, clearly the guidance
 24 referred to needing to be tested prior to discharge.
 25 So, yes, it would have been better to have immediate
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1 as long as domiciliary care agencies had the required
 2 protective equipment to support their staff, and we have
 3 to recognise that, that maybe it could have been
 4 slightly different. But clearly, there are lots of
 5 conditions that needed to be in place for that to be
 6 different at all. Clearly in a care home it's in
 7 a restricted environment with lots of other people
 8 around, and actually I think it's important that there
 9 were negative tests.

10 **LADY HALLETT:** If you had a shortage of tests -- forgive my
 11 interrupting -- if you had a shortage of tests and
 12 therefore couldn't test before discharge and you had
 13 to -- or you had decided you had to make space in
 14 hospitals, is the alternative to ensure that anyone
 15 discharged is put into isolation in their own room --

16 **A.** Yes.

17 **LADY HALLETT:** -- or in special isolation facilities?

18 **A.** Would that have been the ideal?

19 **LADY HALLETT:** Yes.

20 **A.** Yes, I think it would have been. But it does make the
 21 assumptions about care homes having the right protective
 22 equipment in terms of supporting them. But yes, agreed.

23 **LADY HALLETT:** So it's not just isolation; it would have to
 24 be on the basis there was PPE as well?

25 **A.** Correct.
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1 **LADY HALLETT:** Thank you.

2 **A.** Because I think you put staff in a very difficult
3 position in terms of caring should you not have that PPE
4 in place.

5 **LADY HALLETT:** Then the staff get infected, and --

6 **A.** Correct.

7 **LADY HALLETT:** -- circle of infection, right. Thank you.

8 **A.** Right.

9 **MS SHOTUNDE:** In your statement you've mentioned various
10 issues in respect of discharges that did not take place
11 in a manner in which it was in conformity with the
12 guidance.

13 If I could just bring up your statement on screen.

14 That's INQ000528094, page 22, paragraph 4.6, please.

15 You've stated that concerns -- this is the middle of
16 the paragraph:

17 "Concerns for the health and wellbeing of existing
18 residents and staff meant many directors were not
19 prepared to sanction ... discharges without testing.
20 This resulted in tension and confrontation, and in many
21 parts of Wales, a significant breakdown of trust between
22 care homes and hospitals. The situation was exacerbated
23 by the delay in the Welsh Government publishing its
24 discharge guidance, was some two weeks after the UK
25 published its guidance for England ..."

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1 You state that:

2 "The overwhelming focus on protecting the NHS did on
3 occasions dismiss any notion of the safety and wellbeing
4 of staff and residents in adult social care. For
5 example, a doctor in an emergency department sending
6 a patient to a residential care home without testing for
7 Covid-19 and demanding that the home takes them. This
8 resulted in a heated argument with the Director of
9 Social Services who backed the home's refusal to take
10 the person into care."

11 How common or widespread was this issue in the
12 pandemic?

13 **A.** I think in the early days of the pandemic it was
14 reasonably common. Once the discharge guidance came
15 out, it was less common, although still happened at
16 periods of high pressure, and there are a number of
17 anecdotal examples here, there are others which are not
18 listed here, as well.

19 So in terms of beyond when the discharge guidance,
20 as I say, it was significantly less common, but still
21 happened on occasion.

22 **Q.** We are going to look at one of the other examples which
23 is in an email.

24 Can I pull up INQ000511731, page 1, please.

25 This is an email from a Director of Social Services

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1 What was the role of directors of social services in
2 sanctioning discharges during the pandemic?

3 **A.** I think what you'll find is that the directors of social
4 services, through their commissioning teams, have quite
5 a good relationship with care homes. And where there
6 was concern around admissions either being expected from
7 residential homes, they drew in the director of social
8 services in terms of that conversations, and directors
9 of social services gave that clear guidance: no
10 discharges without a negative test.

11 **Q.** Is this a role that existed prior to the pandemic, so,
12 for example, would directors of social services be
13 involved in the decision of discharge or not discharge?

14 **A.** On an ongoing day-by-day basis today is that happening?
15 No. But obviously were there to be an outbreak of
16 diarrhoea and vomiting within a hospital ward or some
17 issue, they may be drawn into things where things become
18 acutely difficult in terms of those discharges coming
19 out. So, on an operational day-to-day basis, no,
20 ordinarily a director of social services is not involved
21 in that, but they will be drawn in where there are acute
22 problems.

23 **Q.** If I could turn to page 32 of your witness statement --
24 that's INQ000528094 -- you give an example of an issue
25 with discharges in this part of your witness statement.

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1 saying that:

2 "Swansea has experienced discharge to dom care where
3 we weren't informed that [the] patient had been tested.
4 Subsequent result of test was positive. Was back before
5 we had much of a grip on PPE. Risked infection of
6 a number of staff and other care recipients. 8 staff
7 ended up in isolation."

8 Do you think there was a widespread issue of
9 discharge without testing into domiciliary care?

10 **A.** In the same regard, early in the pandemic, yes, I think
11 there was.

12 **Q.** Do you think that issue of discharge without testing
13 into domiciliary care was adequately considered during
14 the pandemic?

15 **A.** I think, actually, early in the pandemic, the health
16 partners tended to see residential care as the main area
17 of discharge and therefore the wider economy of care was
18 not considered adequately, no. There was a perception
19 that you had hospitals, and you had care homes, and that
20 wider economy which is large in terms of the amount of
21 people we delivered care for in the community was not
22 adequately considered, no.

23 **Q.** And just sticking on this email, point 2:

24 "Patient discharged to a care home. Were tested as
25 positive. Not symptomatic. Care home weren't aware

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1 until after the individual died and GP turned up in
2 spacesuit saying that they could see on the records that
3 the individual was positive for Covid infection."

4 Was there a widespread issue of care homes not being
5 told of the Covid status of the person discharged?

6 **A.** I think, again, we go back to the earlier of the stages
7 of the pandemic, prior to some of the discharge guidance
8 coming out. It became significantly less frequent after
9 that point.

10 **Q.** And there was another example I wanted to pull up on
11 screen. It's INQ000511732, page 2.

12 This is from another local authority, where it says:

13 "Please advise. We have received a referral ... for
14 a gentleman ... where the home are not willing to accept
15 [them] back as no Covid status [was] confirmed. However
16 it seems following various calls to the ward, the home
17 and social services that regardless of the results, they
18 are unable to carry out the 14 days isolation
19 precautions post discharge within the home as the
20 gentleman is cognitively impaired and walks about and
21 they do not have the staffing to carry out '1:1' as they
22 do not want to bring in agency cover."

23 And then underneath, there's another example:

24 "I have now received a call from ED ... about
25 another resident from the same home admitted today due

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1 The hospital then insisted that as the person had
2 'technically' not been admitted, they should be able to
3 return to the care home without isolation or without the
4 use of a step-down facility. There also seemed to be
5 inconsistencies between some hospitals with different
6 timescales applied ..."

7 How often did this occur, hospitals using
8 technicalities, as it were?

9 **A.** How often did it occur? I think there were instances in
10 every council across Wales. They were not regular but
11 it did happen in most areas of Wales.

12 **Q.** On 29 April 2020, the Welsh Government issued updated
13 guidance on the step-up and step-down care arrangements
14 during Covid, and in it they described two options as
15 regards to discharge, with the first being discharge
16 back to an existing placement or care package where the
17 individual has received a negative Covid-19 test prior
18 to discharge, or a step-down or step-up within
19 a designated NHS facility where an individual has
20 received a positive test for Covid-19 prior to
21 discharge, are still symptomatic, or within the 14-day
22 initial isolation period.

23 What are your views on how useful the step-up,
24 step-down arrangements were in Wales?

25 **A.** I think in practice -- I think, listen, it would be

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1 to not eating and drinking. Prior to today, they had
2 been [somewhere] and have since tested [Covid positive].
3 All tests carried out in ED today, ie, chest X-ray and
4 bloods are normal. I have been informed that she has
5 taken fluids for them without concern and there is no
6 clinical reason to stay in hospital. Again this patient
7 has cognitive impairment and is wandering. The home has
8 refused to have this resident back as well."

9 Do you think consideration of residents who are
10 cognitively impaired and the ability to implement IPC
11 measures on discharge was adequately considered by the
12 Welsh Government during the pandemic?

13 **A.** No, I don't think it was. I think we were ill prepared
14 for individuals such as those two noted here, because,
15 and the nature of the care homes, and the fact that
16 there were not good isolation facilities within those
17 care homes for individuals such as these.

18 **Q.** And in your statement -- I'm not going to ask to pull it
19 up on screen -- you mentioned that:

20 "... there were incidences of health boards trying
21 to use what might be termed 'technicalities' to bend or
22 to work around the rules. For example, a care home
23 resident taken into hospital might have spent time,
24 often a lengthy period such as overnight, in a hospital
25 assessment unit as opposed to being admitted to a ward.

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1 useful to give guidance. I think you referred there to
2 the second option of a specific step-down facility.
3 I think in practice very few of those came into being in
4 Wales. So the idea of the Nightingale wards were
5 floated in all areas of the country and a couple of
6 locations agreed upon. I don't believe they were
7 significantly used and I think partially -- that was
8 partially because there was not enough resilience in
9 terms of the staffing required to do that, so I don't
10 believe that happened to a great extent.

11 **Q.** So, just to clarify, do you think it's more of a -- that
12 there's a lack of staff rather than a lack of need?

13 **A.** I would say, in terms of those sort of Nightingale
14 facilities, yes, it would have been very difficult to
15 staff them.

16 **Q.** Now, in England, the UK Government create a designated
17 settings policy where local authorities had to list care
18 homes that were capable of taking on Covid-positive
19 patients before -- residents before moving them into
20 their facilities or home that they ordinarily live in --

21 **LADY HALLETT:** I'm sorry, I missed that last bit.

22 **MS SHOTUNDE:** Sorry, that they ordinarily would live in. In
23 terms of designated settings, it's like a step-down sort
24 of facility but it's in respect of care homes.

25 Seeing that you've stated that the step-down

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1 facilities weren't really used that much in Wales, do
 2 you think a similar policy like designated settings
 3 would be useful in Wales or do you think the step-down
 4 would be sufficient in a future pandemic?
 5 **A.** No, I think they would be useful in Wales, so long as
 6 we've considered how we staff and resource them in terms
 7 of them being able to be practical. I think as
 8 a concept and an idea it's really, really good. There
 9 does have to be some practicality to it around how we
 10 staff, how we make sure that they actually work.
 11 **Q.** And in terms of pre-pandemic planning, do you think that
 12 this is something that should be considered?
 13 **A.** Yes, I do.
 14 **Q.** In terms of visiting restrictions, I'm going to pull up
 15 your witness statement on screen again.
 16 It's INQ000528094, page 24, paragraph 4.13.
 17 And in it you state that there were some
 18 inconsistencies in visiting restrictions across Wales
 19 because of questions about the guidance, differences in
 20 local interpretation and application, and who was
 21 responsible for decision making. And you state:
 22 "For example, the managers of care homes asking for
 23 advice on what they should do whereas the Responsible
 24 Individual, it was their responsibility to decide."
 25 We heard evidence from the Older People's
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1 which went against government guidance. How do you
 2 think this could be improved in a future pandemic?
 3 **A.** I think the way that could be improved in a future
 4 pandemic is having good solutions but for how people can
 5 visit safely. There are examples, I think, within my
 6 statement of where some homes had particular
 7 arrangements to meet outside, specific ways of doing
 8 that. I think what we need to do is define what is
 9 a safe area to meet so that even in the worst of
 10 circumstances, a person who is in a care home can have
 11 contact with their family and friends in a way that is
 12 safe.
 13 **Q.** We heard evidence from Albert Heaney for Module 6 where
 14 he had been asked about there being at least two local
 15 authorities who had imposed bans on visits without the
 16 incident management team input or any input at all. And
 17 he was asked whether he had written to local authorities
 18 and he said he did make it very clear what was supposed
 19 to happen.
 20 In your view, do you think, if there are going to be
 21 any local decisions in respect of visiting bans, let's
 22 say because there's an outbreak in a local area, do you
 23 think that incident management teams are the ones that
 24 should be the ones making the decision?
 25 **A.** Yeah, I think working alongside the care home
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1 Commissioner for Wales, who also mentioned difficulties
 2 when it comes to visiting restrictions because of a lack
 3 of understanding of who was responsible for decision
 4 making.
 5 Who do you think should be responsible for decision
 6 making when it comes to visiting restrictions in
 7 a future pandemic?
 8 **A.** My general view here is there should be some general
 9 principles that should sit above this in terms of end of
 10 life and ability to see your relative. And I think
 11 then, depending on the local situation, ultimately the
 12 care home and registered individual has that
 13 responsibility.
 14 However, I would see it as local authorities and
 15 in -- and local partners being able to give some
 16 guidance in terms of actually what is our view around --
 17 for example, in Wrexham, what is the current position in
 18 terms of spread, what's our current view in terms of --
 19 and collectively that that is agreed.
 20 So I think there should be some general principles
 21 nationally with some local interpretation based upon the
 22 situation going on.
 23 **Q.** Now I understand it from some evidence in the Inquiry,
 24 there were some blanket bans imposed in Wales on
 25 visiting restrictions by incident management teams,
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1 ultimately, the care home -- the registered individual
 2 has to have a role because I suspect their insurance
 3 says they have to have a very key role in it, but
 4 I think they should be advised by the local incident
 5 management team, yes.
 6 **Q.** On PPE, you said in your statement, which I'm not going
 7 to pull up on screen:
 8 "Initially, there appeared to be questions whether
 9 care homes should have PPE as care homes are not
 10 hospitals."
 11 Who was making that question? Was it the Welsh
 12 Government? Was it Public Health Wales?
 13 **A.** I think that question emanated from the fact that there
 14 were poor supplies at first, and somewhere in the order
 15 of priority, care homes were not quite as high priority
 16 as the NHS.
 17 So I'm not sure that was ever verbalised or
 18 officially said, but it was something that was the
 19 feeling that we had, those of us who were linking in
 20 with care homes, that they were not given the same level
 21 of priority.
 22 **Q.** If we could pull up an email exchange INQ000511730,
 23 page 1.
 24 I think this is where examples of issues, when it
 25 comes to discharge were asked about:
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1 "The clearest cut example is someone who was
2 discharged from hospital (no PPE), became ill, and was
3 readmitted a few days later and then was found to have
4 Covid-19. Even when the diagnosis came through it took
5 a couple of days to provide PPE. More generally, the
6 issue, is that people are discharged to care homes
7 untested and it is not clear if they have the virus or
8 not."

9 Do you think that in a future pandemic, PPE should
10 be one of the main focuses in ensuring that care homes
11 have PPE before discharges take place?

12 A. Yes, I think it should be one of the main focuses.

13 Q. In Albert Heaney's evidence, he was asked a question
14 about PPE shortages, and in answer he said there was
15 always enough PPE in the system. Do you agree with
16 that?

17 A. In the early period of the pandemic, no, I don't
18 entirely agree with that. The situation did become
19 better and Welsh Government supported us significantly,
20 and we -- supplies were passed down to local authorities
21 to pass to their providers, but in the early period of
22 the pandemic, no. I recall being in Anglesey at the
23 start of the pandemic when we were doing everything we
24 possibly could to source PPE, and it simply was not
25 available. So no, I wouldn't agree that there was

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1 Q. Do you have any ideas of how that could be strengthened?

2 A. I think there are efforts being made for people to
3 self-register as carers and I know that Carers Wales are
4 making efforts to increase that awareness of carers as
5 to why it's important to register as a carer, but
6 I think there are still some people who prefer to remain
7 private as carers and obviously in a period like
8 a pandemic, that makes it more difficult, does it not?
9 Q. I just want to see if you can help me with this.
10 Testing was initially not very widely available for the
11 adult social care sector, but then it became available
12 to social care staff and there was a scheme developed
13 between the Welsh Government, the WLGA, ADSS Cymru, and
14 Data Cymru for local authorities to identify 15 members
15 of staff per council to be tested. Are you familiar
16 with that scheme?

17 A. Yeah, I think when we say -- from the council, I think
18 we mean from the council services, probably care homes
19 and domiciliary care, if I've got that correct. They
20 weren't just -- they weren't just local authority staff,
21 were they?

22 Q. In terms of that scheme, we heard from the WLGA that it
23 covered both local authorities, social care staff and
24 staff employed by commissioned providers. What about
25 providers that were not commissioned by local

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1 sufficient PPE initially.

2 Q. In your witness statement, I won't put it up on screen,
3 but paragraph 6.17(iv), there was an email that you
4 mentioned from the Welsh Government about issue reported
5 by an independent care home in Cardiff where existing
6 PPE suppliers appeared to be restricting supplies to
7 providers in England, and there's questions about
8 actions done by Public Health Wales. Was it a common
9 occurrence that there were providers of PPE that decided
10 to restrict their PPE provision to other nations other
11 than Wales?

12 A. I think there was -- it was clear at first that there
13 was a priority being associated with providing certain
14 sectors with PPE, yes.

15 Q. In terms of PPE and unpaid carers, what, if anything,
16 did ADSS Cymru do to support unpaid carers and access
17 to PPE?

18 A. My recollection is this isn't significant but I do think
19 that we did make PPE available to unpaid carers in due
20 course.

21 Q. Do you think they have enough data in Wales on unpaid
22 carers to be able to ensure that they receive PPE in
23 a future pandemic?

24 A. No, I think our data about unpaid carers needs to be
25 strengthened.

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1 authorities? Do you know how they maybe had access to
2 testing at that point?

3 A. I don't, no.

4 Q. In a future pandemic, where there are limited, let's
5 assume there are limited numbers of tests, for whatever
6 the pathogen is, at the beginning, do you have any
7 recommendations on how testing in the adult social care
8 sector could be implemented?

9 A. I think, however limited they are, those tests do need
10 to be made available and I guess we need to co-produce
11 how we're actually going to prioritise who receives
12 those tests, and that there is at least that early
13 dialogue around, actually, how do we work within this
14 limited number of tests?

15 Q. And my final question on this point: from the WLGA, we
16 had heard that the process of identifying social care
17 staff able to be tested was complex and time consuming
18 during that 15 members of staff per day period.
19 I understand that there is currently now a register for
20 adult social care workers held by Social Care Wales. Do
21 you think that would assist in terms of identifying
22 social care staff in a future pandemic?

23 A. I think it would and it will also help in terms of
24 records as to who has been tested, yes.

25 Q. In your statement, you state that when testing became

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1 available to social care, the focus was on care home
 2 staff and that there was concern about a lack of access
 3 to testing for domiciliary care workers. Do you think,
 4 in a time there may be a shortage of testing, priority
 5 should be given to care homes or do you think it should
 6 be looked at differently?
 7 **A.** I think it probably needs to be looked at differently,
 8 and we need to consider how the priority works across
 9 both care homes and domiciliary care, as well. Listen,
 10 I mean, also in terms of social care, it's not just
 11 domiciliary care. We've also got a network of people
 12 who go out to see people within social care, both
 13 visiting -- you know, we have staff within supported
 14 living environments, and others, so I think there needs
 15 to be an exercise to prioritise across the sector.
 16 **Q.** May I pull up the Care Forum Wales -- no, I don't need
 17 to pull up the statement, actually, I'm going to read it
 18 instead because it will be quicker.
 19 **A.** Okay.
 20 **Q.** We've heard evidence, in the Inquiry, of issues in
 21 respect of funding, funding provided to care providers
 22 in order to cover the costs, the associated costs of the
 23 Covid-19 pandemic. We've heard from Care Forum Wales in
 24 their witness statement that there were issues in
 25 respect of the funding going to care providers, that

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1 to the correct places.
 2 I don't deny, though, that it maybe shouldn't be
 3 done -- we should ensure that it goes faster.
 4 **Q.** In terms of data, we've heard evidence that there was
 5 insufficient data on matters for the pandemic, but just
 6 to focus on ethnic minority groups, you stated in your
 7 statement that there was insufficient data on
 8 transmission and mortality rates for ethnic minority
 9 groups and other protected characteristics. When you
 10 were referring to that, were you referring to recipients
 11 of care, care staff, or both?
 12 **A.** I think both, and the population more generally, as
 13 well.
 14 **Q.** Has the situation improved to date in respect of data?
 15 **A.** I'm not sure, is the answer to that. I'm not sure.
 16 **Q.** If it hasn't, do you think that's a potential work
 17 programme that --
 18 **A.** Yes.
 19 **Q.** -- the Welsh Government should -- (overspeaking) --
 20 **A.** Yes, absolutely, where there are vulnerabilities for
 21 particular parts of society, we need to make sure we've
 22 got good data all round.
 23 **Q.** In terms of the changes to the regulatory inspection
 24 regime, and in particular Care Inspectorate Wales'
 25 decision to pause routine inspections, at paragraph 9.1

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1 there was a lot of delay in it reaching the sector. Do
 2 you think that there's anything that could be done to
 3 rectify this in a future pandemic?
 4 **A.** Yeah, I think probably some relaxation of the ...
 5 I guess, being able to provide money in advance to
 6 support care homes while they're right in the crux of
 7 the financial difficulties, with some accounting which
 8 happens afterwards, would probably make it easier in
 9 terms of passing those funds down. We as a local
 10 authority, we obviously have to have an audit trail in
 11 terms of this is where we're passing it to, this is the
 12 evidence in terms of actually that provision.
 13 I think -- I would suggest some relaxation of that would
 14 make things easier, yes.
 15 **Q.** Do you think that the additional funding should be paid
 16 directly from the Welsh Government to care providers or
 17 do you think it should still be funnelled through local
 18 authorities in a future pandemic?
 19 **A.** I think the reasoning behind funnelling through local
 20 authorities is -- the nature of provisioning in every
 21 local authority is different, so the nature of
 22 provision, and whether it's across the independent
 23 sector, voluntary sector, the nature of the care home
 24 provision and the domiciliary care is different. And in
 25 actual fact, that allows local authorities to target it

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1 of your statement, you state that you think the decision
 2 to pause routine inspections for registered social care
 3 providers was appropriate.
 4 As you're aware, at certain points in the pandemic,
 5 especially when there were outbreaks, et cetera, care
 6 homes almost became what people call closed
 7 institutions. There was no visitors from loved ones,
 8 hardly any visits from other professionals, so for
 9 example medical staff or social workers, and then now no
 10 routine inspections by Care Inspectorate Wales. What
 11 about safeguarding for residents in the care homes?
 12 Were there any concerns about safeguarding for them?
 13 **A.** Okay. Clearly that level of inspection means that there
 14 was less oversight in terms of safeguarding. I think
 15 it's really important to note, though, that safeguarding
 16 structures within the local authorities continued to
 17 work, meaning if we did receive concerns, whether that
 18 be from a staff member or others around safeguarding
 19 within a particular establishment, we did make
 20 enquiries. We did work with a care home to address
 21 whether there'd been a safeguarding issue, and those
 22 things continued to happen.
 23 So whilst oversight will have been less, I do
 24 inherently believe in the good -- that, actually, most
 25 staff go into care for the right reasons and if they

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1 observe anything that they have concerns around from
2 a safeguarding perspective, they do, and will report
3 that, and we then still have the structures in place to
4 actually investigate and do the work.

5 So was there less oversight? Yes.

6 Was there still a level of oversight and support in
7 event of safeguarding concerns? Yes, there was.

8 **Q.** I'm just going to pull up your statement in respect of
9 the impact of the pandemic on unpaid carers.

10 It's INQ000528094, page 69. Thank you.

11 As I understand it, ADSS Cymru conducted their own
12 research into the Covid-19 experience for unpaid carers
13 in a study commissioned by the Welsh Government, and the
14 findings captured the lived experiences of unpaid carers
15 during the pandemic.

16 If we turn to the next page, we have a list of harms
17 that unpaid carers said they faced: social isolation and
18 loneliness, mental health concerns, financial and
19 economic impacts, deterioration in conditions on the
20 cared-for people, and other matters as well, including
21 delays in assessments.

22 What did ADDS Cymru or local authorities do to
23 alleviate the impact of the pandemic on unpaid carers?

24 **A.** On an individual basis, we tended to work with our
25 voluntary sector in terms of how they could support

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1 any business continuity-type plans that care homes have.

2 **Q.** And plans for local authorities, are they reviewed by
3 the Care Inspectorate Wales as well?

4 **A.** Yes, they -- we do get reviewed by Care Inspectorate
5 Wales. I can't remember them focusing on those, but
6 yes, Care Inspectorate Wales do review their business
7 continuity plans we have in place for services.

8 **MS SHOTUNDE:** My Lady, those are my questions.

9 **LADY HALLETT:** Thank you very much, Ms Shotunde.

10 It's now Mr Stanton, who is that way.

11 **Questions from MR STANTON**

12 **MR STANTON:** Thank you, my Lady.

13 Good afternoon, Mr Jones.

14 **A.** Good afternoon.

15 **Q.** I ask questions on behalf of the Covid Bereaved Families
16 for Justice Cymru. I just have two topics to cover with
17 you. The first relates to the issue of PPE. And at
18 paragraph 6.15 of your statement, you refer to a letter
19 that ADSS Cymru sent to the Welsh Government on
20 31 March 2020 which raised a number of concerns, one of
21 which was that the PPE guidance for the social care
22 sector was tailored to supply constraints rather than
23 the risks to staff and vulnerable people. And I should
24 say the client I represent shares the view expressed in
25 that letter.

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1 unpaid carers, whether that be through getting them
2 medications, supporting them in terms of getting food,
3 and that was the main actions we took to liaise with the
4 voluntary sector in terms of that work.

5 **Q.** Thank you.

6 And a final point that I just wanted to ask you some
7 questions about is pre-pandemic planning. In respect of
8 local authorities in Wales and just the Welsh methods
9 generally on planning, who's responsible for plans in
10 the event of a pandemic?

11 **A.** Ultimately I think the responsibility should lie with
12 Welsh Government but then devolve down to local
13 authorities and local health boards in terms of
14 individual plans in terms of responses. Clearly that
15 overall strategic needs to come from Welsh Government,
16 then the operational practice that we need to put in
17 place is by those very key institutions of health and
18 local authorities.

19 **Q.** And currently is there any requirement for care
20 providers in Wales to have pandemic plans?

21 **A.** I believe they do have to have business continuity
22 plans. How specific that is about pandemics, I'm not
23 sure.

24 **Q.** Do you know if they are reviewed by anybody?

25 **A.** Yes, CIW and our contracts teams would go in and review

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1 Please could you explain and expand on the
2 particular aspects of the guidance that you say was
3 tailored to supply considerations rather than safety?

4 **A.** I think it's -- in looking specifically at it, I'm not
5 sure I can, but the overall feeling that local
6 authorities had was that the level of PPE that was being
7 diverted towards the care homes sector was insufficient
8 towards the start of the pandemic, and that clearly our
9 calls to Welsh Government was to address that.

10 Caring for an individual who had Covid in a care
11 home was actually not that much different to caring for
12 them in a hospital, and actually, in some care homes,
13 they were in more difficult environments, where maybe
14 infection control space was at a premium, and therefore
15 the overall view was that it didn't cater sufficiently
16 for that.

17 **Q.** You may not be able to answer this question, but could
18 I ask, were your concerns around the quantity of PPE, or
19 was it more around the type and adequacy of the PPE
20 being provided?

21 **A.** Certainly in the early stages some of the PPE was not
22 adequate. As supplies got better as time passed, that
23 became less of an issue. We do refer in the statement
24 to a couple of examples -- you know, there were some
25 issues with quality. Over time, that became better.

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1 Q. Thank you.

2 My next topic concerns testing on discharge. You

3 dealt with that already at length in your evidence, but

4 my question concerns the situation in December 2020.

5 A. Yes.

6 Q. At paragraph 4.28 of your statement you refer to the

7 Welsh Government's changes to hospital discharge

8 guidance, which included the ability to discharge

9 patients who were testing positive, albeit at a low

10 level.

11 A. Yeah.

12 Q. And you set out the concerns of some of your members in

13 connection with this change, including that the guidance

14 was written purely from a hospital discharge

15 perspective, and did not reference the risk for the care

16 homes.

17 Immediately following this change, in January 2021,

18 there was an alarming increase in Covid-19 infections

19 and, sadly, deaths in care homes in Wales. At this

20 point, were you able to revisit the concerns that you'd

21 expressed in December? And if so, are you able to

22 indicate the response from the Welsh Government?

23 A. I don't think we did particularly revisit. It was seen

24 that the science was indicating that there needed to be

25 a change in the discharge and I don't believe we did

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1 A. Yes, I think we could have minimised the risks, yes.

2 Q. Thank you.

3 My next question is about the problems with data

4 relating to the adult social care sector, problems which

5 you identified and talked about in your statement, for

6 example that the data on registered care settings in

7 Wales held by the Office for National Statistics is

8 woefully out of step with data held by Care Inspectorate

9 Wales, and you also talked earlier today about the need

10 for data on unpaid carers to be strengthened.

11 Do you agree that it would be helpful in this regard

12 for a centralised database of care sector data to be

13 established which could be accessed to support

14 understanding of the care sector and inform decisions

15 that are made about it?

16 A. I think that would be really good. I think obviously

17 you'd have lots of sources coming into that central

18 database but I think one central database would be

19 really, really valuable and useful, yes.

20 Q. Thank you. Then my last question. At paragraph 4.10 of

21 your witness statement you say that:

22 "The Welsh Government shared its thinking with

23 ADSS Cymru in advance of lockdowns, but that care

24 recipients and care workers heard about them when the

25 public announcements were made."

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1 revisit them significantly, no.

2 MR STANTON: Thank you.

3 Thank you, my Lady.

4 LADY HALLETT: Thank you, Mr Stanton.

5 And then it's Ms Jones, who's that way.

6 Questions from MS JONES

7 MS JONES: Thank you, my Lady.

8 Good afternoon, Mr Jones. I ask questions on behalf

9 of John's Campaign, The Patients Association and

10 Care Rights UK.

11 My first question in fact is on the same topic that

12 Mr Stanton was just asking you about: your observation

13 that the guidance on hospital discharge was written

14 purely from the hospital perspective, but it did not

15 reference the risks for the care homes and residents.

16 And in fact earlier, in response to a question from

17 Counsel to the Inquiry, you said that the hospital

18 discharge policy was an example of the NHS being

19 prioritised over social care.

20 In respect of that, do you agree that the

21 government's failure to take account of the risks of the

22 hospital discharge policy on adult social care settings

23 could have been avoided if you or other key stakeholders

24 had been consulted about that policy before it was

25 introduced?

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1 Do you agree it would have been helpful for those

2 two cohorts, care recipients and care workers, or the

3 stakeholder groups that represent their interests, to

4 have also been consulted or given advance notice of such

5 decisions?

6 A. I think it would have been helpful. I think it would

7 have had to be done in a managed way so that that -- so

8 that any spreading of the message wider to the public

9 was managed, but yes, I do think it would have been

10 helpful to have that level of consultation, yes.

11 MS JONES: Thank you very much, Mr Jones, those are all my

12 questions.

13 LADY HALLETT: Thank you, Ms Jones.

14 That completes the questions we have for you. Thank

15 you very much indeed for your help, we are really

16 grateful, I appreciate with all your other

17 responsibilities -- you said you had two successors,

18 since you -- is it a year or two yearly post.

19 THE WITNESS: No, we tend to do a year as the president of

20 ADSS, so I think I finished in 2024, there was one

21 person in '24-'25, and there's one person now. So I am

22 two back.

23 LADY HALLETT: So you have got to go back to your day job?

24 THE WITNESS: Yes, indeed.

25 LADY HALLETT: Which you were doing anyway, I'm sure, at the

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1 same time as running the association.

2 Thank you very much indeed for your help. I am
3 really grateful, and safe journey back to Wales.

4 **THE WITNESS:** Thank you.

5 **LADY HALLETT:** I have been asked if we could break now
6 before the next witness because I think counsel may be
7 meeting the witness. So if I return at quarter to or
8 ten to, let me know. Let's say 2.50. Thank you.

9 (2.37 pm)

10 (A short break)

11 (2.50 pm)

12 **LADY HALLETT:** Mr Beech.

13 **MR BEECH:** Yes, good afternoon, my Lady. Thank you for your
14 forbearance.

15 Please may we call Mr Eddie Lynch.

16 **MR EDDIE LYNCH (sworn)**

17 **LADY HALLETT:** Thank you for coming back to help, Mr Lynch.

18 **THE WITNESS:** You are welcome.

19 **LADY HALLETT:** Coming here to help, as opposed to last time.

20 **Questions from COUNSEL TO THE INQUIRY**

21 **MR BEECH:** Thank you.

22 Good afternoon, Mr Lynch, I'm going to ask you some
23 questions today arising out of your witness statement
24 which is dated 17 February 2025, and for everyone's
25 reference, that's INQ000474926.

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1 Northern Ireland had an over-60s population of
2 approximately some 439,000 and roughly 23% of the
3 population?

4 **A.** Yes, that's correct, too.

5 **Q.** If I could just then move towards the subject matter of
6 this module which is the impact of the pandemic on the
7 adult social care sector. And again, you set out in
8 your statement that approximately 60% of the requests
9 for individual assistance to your office relate to
10 health and social care, the highest proportion of issues
11 raised relate to care homes and that during the
12 pandemic, the government's response dominated your
13 engagement on behalf of older people; is that correct?

14 **A.** Yes, it is.

15 **Q.** If I could pull up, please, on the screen INQ000237831,
16 and this is taken from a briefing which you prepared in
17 October 2020. And just if we could look at the first
18 bullet point under paragraph 5. In October 2020 you
19 felt it important to emphasise that:

20 "When considering care homes we are talking about
21 the homes of around 14,000 older people in Northern
22 Ireland. These settings are their homes."

23 And then, again, at the final bullet point there,
24 you state that:

25 "Northern Ireland needs to stop talking about Care

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1 You took up your role as Commissioner for Older
2 People for Northern Ireland on 13 June 2016, being
3 appointed for an initial four years and was subsequently
4 reappointed for another four-year term on 13 June 2020,
5 and then filled that role in a caretaker capacity until
6 12 December 2024 before moving on to pastures new; is
7 that correct?

8 **A.** That's correct, yes.

9 **Q.** And the Inquiry is familiar with the role of the office
10 but just very briefly, the commissioner is an
11 independent statutory role set up under legislation from
12 2011, and you set out at paragraph 11 of your witness
13 statement that:

14 "The Act affords me promotional, advisory,
15 educational, and general investigatory duties and
16 powers. Their purpose is to enable me to champion the
17 rights and interests of older people [in] Northern
18 Ireland."

19 Is that an albeit high-level summary of the role?

20 **A.** That's correct, yes.

21 **Q.** And just, if I may, in terms of your remit, the 2011 Act
22 defines an older person as normally being aged 60 years
23 or over; is that right?

24 **A.** That's correct, yes.

25 **Q.** And that in line with census data from March 2021,

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1 Homes as buildings and care home residents as numbers.
2 [They] are our parents and grandparents who remain part
3 of our society."

4 As I say, that was October 2020. Why did you think
5 it was important to emphasise those points at that time?

6 **A.** I think it was important to emphasise that because
7 sometimes we do lose the fact that care homes are
8 people's homes, and that is something that needs to be
9 considered when decisions are being taken that affect
10 care homes, particularly in the instance of a global
11 pandemic. And I think it's really important that
12 they're at the forefront when we're talking about older
13 people, we're not seeing them as being placed in a care
14 home for the end of their lives but, actually, that is
15 their place where they are entitled to family visits, to
16 live as happy and as fulfilling a life as possible. And
17 I think that, you know, it is important to have that at
18 the forefront of some of these discussions in relation
19 to actions taken during the pandemic.

20 **Q.** Thank you.

21 If I could have up on screen, then, your witness
22 statement which is INQ000474926, page 17 and
23 paragraph 56, you state there that:

24 "The pre-existing structural weaknesses in the
25 system for delivering adult social care in Northern

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Ireland were horribly exposed at the outset of the pandemic."

I'm well aware and the Inquiry is well aware that you've done an awful lot of work in this area, and perhaps we don't need to delve into the full nature of those pre-existing concerns, but in terms of the impact on the adult social care sector during the pandemic, how did these pre-existing concerns impact?

A. Well, my office had released a series of reports over many years, both preceding my time as commissioner and since then, as well as a number of other reports into the health and social care system in Northern Ireland over the last ten years and beyond, which -- report after report highlighted some of the key weaknesses in our system: issues around recruitment, staff shortages, terms and conditions of staff, and also linkages between how the health system and the social care system would link up and link together, and I think what Covid exposed in early 2020 was some of these problems that were in the system led to a serious impact, unfortunately, in many of the older people who were living in those homes.

Q. The former Health Minister, who is quoted quite a bit in this Inquiry, described the adult social care sector as the "Cinderella service, undervalued and

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unfortunately, many people lost their lives and many older people spent their last months of their lives in dreadful circumstances.

It also affected the wider social care system, where older people were locked down, where people, you know, reliant on domiciliary care packages, became a big problem in many areas as well.

So these were all issues that were being brought on a regular basis to my office. And I think it was -- you know, devastating is the word, when you look at the loss of life and the experience that many older people and their families had over those few years.

Q. If we could start, then, a bit of an exploration of what happened in Northern Ireland, and if we could start with what became the 17 March 2020 guidance entitled "*COVID-19: Guidance for nursing and residential care homes in Northern Ireland*".

And for everyone's note, the final version of that guidance appears at INQ000120717.

I understand that you were invited to attend the meeting on 16 March 2020, but it was ultimately attended by your chief executive; is that correct?

A. That's correct, yes.

Q. Prior to that meeting, a draft copy of the guidance was shared with your office, and in your witness statement

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under-recognised". Is that a description which you recognise?

A. Yes, it is, and I think it's worth pointing out, as well, that sometimes Northern Ireland is held up as an exemplar in discussions within the UK as having an integrated health and social care system. But both myself, my office and many others organisations have, for some years now, been raising concerns about how those two parts of the system link up together and work up.

Q. And before we descend, perhaps, into some specifics of policies or guidance during the pandemic, in terms of a brief overview from your perspective of the impact of the pandemic on older people in receipt of adult social care.

A. Well, it was devastating. Unfortunately, Covid-19, the main -- the people at risk were older people and people with underlying health conditions, and that has swept through Northern Ireland, as it swept through many countries before it reached our shores.

Unfortunately, in relation to the likes of care homes, the nature of the virus was just extremely difficult to control once it got into those settings, and the system and the sector was ill equipped to deal with what Covid brought. And as a result of that,

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at paragraph 102 you describe how it was viewed as unrealistic and impractical.

I'd just like to explore first of all, is that the view of COPNI, and how did that -- how was that view formed, that it was unrealistic and impractical.

A. I think that whilst we did receive consultation on some of the guidance that was produced in those first six months and beyond, the timescale for receiving that guidance was very limited. We believed, as did other organisations that were consulted upon, felt that there was very little opportunity to influence the guidance.

We saw issues in terms of the implementation of the guidance that we felt needed to be talked through, particularly in terms of the care home sector.

And, you know, that meeting that was held on 16 March, I clearly remember my chief executive coming back and reporting back to me on some of the concerns within that guidance, but also reporting that the department was very clear that they wanted to issue it the next day.

Q. If I may pick up that point, then, the department, you say, were keen to issue it the next day, and this is obviously reported back from your chief executive.

In your opinion, was there a need to urgently issue guidance to the adult social care sector?

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1 **A.** I appreciate that it was an urgent and an emergency
 2 situation, and we were looking for quick and decisive
 3 action on all of these issues. However, the strong
 4 feeling of myself and colleagues and others within other
 5 organisations was it would have been better to take more
 6 time to consider the real implications of that guidance.
 7 There was clearly concerns being raised from the care
 8 home sector in particular about the practicality of some
 9 of the guidance that was being introduced.

10 And also, concerns about -- from the sector, in
 11 terms of their resources, about their ability to
 12 actually implement the guidance. So, in my view, it
 13 would have been better to take some more time to try to
 14 get the guidance right, and also pave the way for its
 15 introduction. And I think that would have led to a more
 16 effective implementation of it.

17 **Q.** I appreciate that you represent older people, you don't
 18 represent the care providers, but you've mentioned at
 19 least twice there that they flagged issues with
 20 implementation. Can you recall at this juncture what
 21 the issues they were raising were?

22 **A.** A lot of them was down to resources. You know, there
 23 was a lot of new issues that were coming on the scene
 24 very quickly as a result of the pandemic. So a huge
 25 level of increased, you know, infection control

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1 of representative bodies. If the consultation relied on
 2 was that meeting on the 16th, does COPNI think that
 3 was -- or does the Commissioner for Older People think
 4 that was sufficient?

5 **A.** No, it clearly wasn't.

6 **Q.** I appreciate that you weren't at the meeting on
 7 16 March 2020, but you report that your chief executive
 8 formed the opinion that there was an air of unreality
 9 expressed on the part of either officials of the
 10 Department of Health or the Public Health Agency that
 11 what was seen on the TVs happening in Italy wouldn't
 12 happen in Northern Ireland. Is that a general
 13 impression that you picked up during those times in
 14 March 2020?

15 **A.** Yes, I have to say it was. We had several conversations
 16 raising concerns about care homes. We had seen, on the
 17 news, what had happened in places like Italy and Spain
 18 weeks before, and there were some horror stories that
 19 had emerged. So I had major concern about -- with my
 20 limited knowledge of Covid at this stage, I was no
 21 expert in it, but it was clear from hearing and
 22 listening to the experts that this was a virus that
 23 spread widely. It was a virus that was targeting older
 24 people, particularly. So those conditions alone made me
 25 very, very worried about protecting care homes, and to

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1 measures, for example, was being asked. How the new
 2 arrangements were going to be managed in terms of
 3 actually running a care home. How, you know, the social
 4 distancing was going to be managed.

5 This was also the time when the homes was raising
 6 major concerns around PPE provision as well. So there
 7 was real concerns that they were having about their
 8 ability to care for their residents as effectively and
 9 safely as possible.

10 And obviously that concerned me as the
 11 Commissioner for Older People, that it felt that this
 12 guidance, whilst it may have looked good on paper, if it
 13 wasn't going to be implemented on the ground, then
 14 I didn't have much confident that it was going to be
 15 effective in what it was set out to do.

16 **Q.** For the avoidance of doubt, I raised with you the draft
 17 guidance you viewed as impractical and unrealistic. The
 18 final guidance was then issued on 17 March. Were those
 19 issues addressed between the draft and the final
 20 version?

21 **A.** No, I don't believe so. There was very little, if
 22 anything, changed, which was frustrating for both
 23 myself, my wider team, and also other organisations.

24 **Q.** The first page of the guidance, the final version,
 25 states it's been developed in consultation with a number

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1 liaising with the authorities to see what steps could be
 2 taken to better protect people.

3 And whilst I appreciate this all came at breakneck
 4 speed to the department, I do think more could have been
 5 done in consultation to try to get that guidance better
 6 and more realistic, in terms of its implementation.

7 **Q.** You state, then, perhaps a more general point, that is
 8 at paragraph 100 of your statement that:

9 "There ... seemed to be a high level of reliance on
 10 what was being published in England in relation to the
 11 NHS, and I was concerned that insufficient time and
 12 opportunity was being provided to consider the
 13 implications of its effectiveness when applied to
 14 Northern Ireland's very different system ..."

15 Can I ask you for an example or a specific. How did
 16 this reliance on English guidance impact on what was
 17 happening in Northern Ireland?

18 **A.** Well, we didn't have the exact same system, as I said,
 19 we had, you know, albeit an imperfect integrated health
 20 and social care system, so we were different in terms of
 21 the set-up, the linkages between the NHS and the social
 22 care sector. I think there was also a difference in the
 23 size and scale of the operation. I think Northern
 24 Ireland, being a much smaller place, we probably did
 25 have opportunities to work together, and in

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collaboration more effectively in those early weeks.

And in my view there was a great willingness from the different organisations to do that and it's just a regret that we didn't have some of those conversations earlier on, and I think if we had the opportunity to feed into that at an earlier stage, we may have got the guidance in place more effectively earlier on, as well.

Q. We're talking about guidance at the very outset of the pandemic here, so it's 16 and 17 March. Did the picture improve at all over the coming months and years?

A. I think there was a gradual improvement but I think there was still a feeling that new plans that were being drafted within the government came to us at a fairly late stage. So when they developed, for example, the Care Partner scheme later that summer, I still think there could have been a more early engagement on the details of that scheme, both with my office, but again, with the providers, because there were a lot of concerns raised by them, a lot of care homes were contacting my office at that time, saying that whilst in theory they were in favour of the scheme, they felt that in practice it was going to be very hard to implement, given the lack of resources.

So again, I think there would have been an opportunity to feed in and have a more collaborative

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something that put extra stress on the care homes themselves.

Q. Specifically, then, in March 2020, what alternative should or could have been put in place to ensure that providers received the PPE they needed?

A. Some of this was happening really when, you know, the hospitals were pretty empty. You know, in those early stages we didn't get a surge on the NHS for quite a number of weeks. There was a lot of reports back at that stage, you know, of a lot of the facilities not being under any pressure. So I think more could have been done in those earlier stages.

I think it was clear that the care homes particularly were more vulnerable in those early weeks than the hospitals. The hospitals at that stage seemed to be well stocked, seemed to have plenty of free beds, but the care homes were the ones really in the firing line in those early weeks. And despite the pleas of many homes to get that equipment through, it did take some time for that to happen, and I think that could have been delivered to them more quickly.

Q. You said it took some time. So the guidance was amended on 26 April to ensure that providers would have a buffer stock provided to keep them going, and in a briefing which you provided on October to the Health Committee,

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approach at an earlier stage, because the feeling was that certainly my organisation and others wanted to work constructively with government. As commissioner, one of my statutory duties was to provide advice to government, and I felt, you know, that that could have been taken on board at an earlier stage.

Q. If we could just delve into, then, some of the more specifics. In relation to PPE, the 17 March guidance set out the trusts will continue to work with nursing and residential homes on the provisions of appropriate PPE where they're unable to source their own supplies.

So the position was that where private providers couldn't source supplies, they were to go to the trusts. In your opinion, was that an appropriate position?

A. I don't think it was -- in those early -- early stages, it was very clear that the PPE stocks were being held for the hospitals and the NHS. We were inundated with many care homes coming to us in those early weeks who, despite receiving assurances from the minister and officials in the Department of Health who said homes can go to the trusts and get that equipment, homes were reporting to me that that wasn't the case on the ground: that they had been contacting the authorities and getting nowhere in terms of getting PPE stock. So that was a major issue in the early weeks and it was

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which again we've already looked at, you talk about how these issues continued into late April or May. Is it fair to say that the PPE position improved after that change to the guidance and the requirement to provide the buffer stock?

A. Yes, it did gradually improve. You know, I know there was several conversations that both myself and my team had with Department of Health officials where we went back a couple of times saying that we were still hearing problems on the ground. I know the department issued -- agreed to issue a statement again to the trusts reminding them that they should be providing this equipment to the social care sector, but it was clear from what we were hearing on the ground that still took some time. It did improve but it did take several weeks before we seemed to have that sector being properly supplied.

Q. If I may move on, then, to just briefly discuss the discharge policy, and this was the policy of patients being discharged from hospital without testing in the early months of the pandemic to care homes. And you set out in your statement that concerns were being raised with your office both by families of residents in care homes and by providers, both through the independent health and care provider organisation, and also

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1 individual providers.

2 What concerns were being raised with the
3 commissioner in, say, March, April 2020?

4 **A.** Well, exactly that: there was a number of people had
5 contacted our office directly, and also had contacted
6 the independent healthcare providers raising concerns
7 about the discharge of older people from hospitals back
8 into care home settings without evidence of -- that they
9 were tested for Covid-19.

10 Now, that raised real alarm bells, both for myself
11 and for a lot of the providers, because there was no way
12 of knowing if that person was positive or negative. And
13 obviously at that stage we knew the vulnerability of
14 care homes. So it was very difficult for them to manage
15 that situation not knowing if somebody had could have or
16 not, and what, you know, what actions they could take.

17 So that was an area of concern. There was family
18 members also contacting my office at the time raising
19 concerns about that as well. They had been aware that
20 people had been discharged from hospital.

21 And this -- obviously, you know, in these early
22 stages, this was the time when everyone living in care
23 homes -- there was no vaccine, so people were extremely
24 vulnerable, and a lot of care homes were managing the
25 situation as best they could, but they did feel that it

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1 if any, alternative could there be to this situation
2 which arose regarding testing, especially whenever the
3 Department of Health would say that the capacity was so
4 severely limited that these people couldn't be tested?

5 **A.** Well, I think there was still -- it was, I think, a very
6 grey area, the testing in the early stages. It was
7 something that concerned me quite a lot. You know, as
8 I spoke to some of the experts, the virologists, the
9 epidemiologists, to try to get a better understanding of
10 this disease, and, you know, the implications and how
11 quickly it would spread, it was very clear to me when
12 I asked them in several meetings around, you know, test
13 and trace, whether that was -- should be part of the
14 strategy to try to monitor the virus and control it, and
15 all the experts I spoke to in those early months were
16 very clear that that had to be part of the approach.

17 Now, I think it took a while for testing capability
18 to be ramped up, but there still was some initial
19 testing in those early stages and I think there could
20 have been more testing done for those people being
21 discharged.

22 **Q.** Just for everyone's note, you said it took a while.
23 The -- version 3 of the interim protocol on testing from
24 19 April and that's reflected in the 26 April 2020
25 guidance, basically mandated or required testing prior

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1 was unfair that they were having to take people in
2 without getting that reassurance around the testing of
3 them.

4 **Q.** And what do you think caused or contributed to this
5 issue where people were being discharged without
6 testing?

7 **A.** Well, it seemed to be that this -- that the focus on the
8 NHS was -- there was a major concern that there was
9 going to be a surge in Covid cases to hospitals. It
10 seemed at that time to me that, you know, the NHS was
11 trying to clear out as many beds as possible to create
12 space for that expected surge.

13 However, you know, at the time, you know, you would
14 have to question: did all of those people have to be
15 discharged as quickly as that or could there have been
16 tests done on more people at those early stages when the
17 NHS wasn't under siege? It would seem to have made
18 sense that people would have -- there would have been
19 extra steps taken to try to prevent the unnecessary
20 spread of Covid back into care homes.

21 **Q.** You say there, did all of those people have to be
22 discharged? I think we're going to come on to visiting
23 shortly and, in the context of visiting, I think you
24 accept that ultimately a visiting restriction was
25 necessary in the early stage of the pandemic. But what,

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1 to discharge. It's your position, however, that that
2 intervention or change in policy was too late?

3 **A.** I think it could have been brought in earlier, yes.

4 **Q.** A couple of discrete points then around the discharge
5 policy. To what extent do you understand that
6 individual care homes can safely isolate residents who
7 have been discharged?

8 **A.** I think that was a real difficulty for a lot of the care
9 homes. Certainly many of the care homes that were
10 coming to my office were being very open and honest
11 about their capability. They hadn't dealt with anything
12 like this before, albeit they had experience of
13 infection control but not on this scale. So some of
14 these actions, like the discharge, were extremely hard
15 for many of the care homes managers who were trying to
16 manage the situation, an already very difficult
17 situation within the home, and I think the fact that
18 there was already people being brought in back from
19 hospital not being tested at that stage, they struggled
20 to know about what sort of steps and actions they needed
21 to put in place.

22 And I think that was something again, until we got
23 more of a proper testing programme in place, that
24 continued to be a constant worry for the providers and
25 the families.

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1 **Q.** And is there anything that could be done in the future,
 2 apart from, as you say, perhaps greater capacity or
 3 prioritisation of testing to avoid this situation
 4 happening again?

5 **A.** Well, I would like to think that some of the learnings
 6 of this will be that we need to be better prepared for
 7 a future pandemic. We need to be planning the resources
 8 that we have in place. We need to be able to put that
 9 in place a lot more quickly than previously. And
 10 I accept it was new to everybody and people didn't know,
 11 and a future pandemic could be different, but I think
 12 there are basic steps that can be taken and resourced
 13 that can at least put you in a better position if you're
 14 faced with something like this again -- not just in PPE,
 15 but testing and, certainly, a better plan to facilitate
 16 visiting and human contact with people in those
 17 situations.

18 **Q.** Can I just explore perhaps one of the basic steps, then,
 19 in that briefing to the Health Committee you say that
 20 "it is imperative that any lessons which can be learned
 21 from [the use of step-down facilities] are applied".
 22 What lessons could have been learnt from the use of
 23 step-down facilities in Northern Ireland?

24 **A.** I think the whole -- the health service can be reviewing
 25 all the steps and all the decisions it took at the time,
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1 June 2020?

2 **A.** It was just the programme of testing didn't go far
 3 enough. I thought it was too slow to get up and
 4 running. Again, I was no expert in this, but I had had
 5 several meetings with experts at this stage and a very
 6 clear picture emerging of how this needed to be tackled.
 7 The care home situation by this stage, we knew in the
 8 first couple of months just the devastating impact it
 9 was having, and all the experts were saying the same
 10 thing to me: that, you know, testing and tracing the
 11 virus was absolutely critical for homes to get a handle
 12 on it.

13 So, for me, it was far too slow in coming in in the
 14 first place. In fact there was several statements made
 15 that seemed to say that a testing system in care homes
 16 wasn't needed, which was of deep concern to me at the
 17 time. And I thought -- you know, eventually the
 18 department did come up with a testing programme.
 19 Initially I welcomed its introduction, but I also pushed
 20 to ramp it up as well, so that the amount of testing
 21 happening could be increased as it went along.

22 So I think eventually we got to that stage where
 23 there was regular testing but, again, I had deep
 24 frustration at the speed of that, and what I saw as
 25 maybe a lack of urgency about how important that was in
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1 and look at how effective they were. They will know
 2 better than me how their different areas that they put
 3 in place, how well utilised they were, how effective
 4 they were. But I think, for me, it's about putting
 5 those resources in place and putting enough emphasis on
 6 preparing for a situation like this again.

7 Obviously, we all hope that this doesn't happen, but
 8 a lot of the experts predict that it could well happen,
 9 well within our lifetimes again, so I think there just
 10 needs to be more of a focus. I think the Covid-19
 11 pandemic just identified how ill prepared we were as
 12 a society for something like this, and I think, you
 13 know, it would be terrible if we didn't learn those
 14 lessons and at least put in place an action plan and
 15 resources that would allow a swifter response if we're
 16 faced with this again.

17 **Q.** If I could move on, then, to the issue of testing, and
 18 I appreciate the two are heavily connected.

19 We've perhaps discussed testing policy in March and
 20 April, however you set out in your statement that you
 21 issued a briefing on 4 June 2020, and your primary focus
 22 was to obtain a rollout of a proper testing programme
 23 for the adult social care sector. So that's 4 June.

24 What was lacking, in your opinion, in terms of
 25 testing for adult social care as of the start of
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1 the response to the pandemic.

2 **Q.** Northern Ireland reached then August 2020 and the
 3 position was that there'd be a rolling programme of
 4 testing with residents to be tested 28 days, and staff
 5 every 14. Do you consider that that was appropriate?

6 **A.** Again, speaking to experts, it was clear that it wasn't
 7 sufficient. It was an improvement, it certainly was
 8 something, but it wasn't going to be enough to give the
 9 level of protection that I was seeking at the time.

10 I realise that there was limitations on the number
 11 of tests, and the programme had to be ramped up, and
 12 that's what -- some of the feedback that I was getting.
 13 But I was getting clear expert guidance that the testing
 14 system should have been testing staff and residents on
 15 a more regular basis and that's what I was pushing for
 16 at the time.

17 **Q.** Perhaps if we could call up on screen some
 18 correspondence from yourself from 8 October to the
 19 Minister of Health.

20 If we could have INQ000250250, on the second page,
 21 please. I think it's the third paragraph, you say, and
 22 this is again October:

23 "I am very concerned to see the rising number of
 24 care homes recording outbreaks in Covid19 infections,
 25 and while this may point to the testing system working,
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1 I believe we are now at a stage where the testing must
2 be increased to weekly if we are to identify more
3 positive cases before they have time to spread."

4 So on 8 October, then, you're calling for weekly
5 testing, and you feel that's important in order to
6 identify more cases before they spread further?

7 **A.** Yes, that was the case, and again, as I've said, that
8 was based on several meetings I had with experts,
9 virologists and epidemiologists, and it was clear their
10 advice to me was that, you know, really the more regular
11 testing programme that you have, the more you can catch
12 the virus at an earlier stage. You can identify
13 outbreaks at an earlier stage, and then hopefully put in
14 measures that can contain those outbreaks. So at that
15 stage, I was very keen that the minister consider that,
16 and, you know, introduced that as a matter of priority.

17 **Q.** Thank you.

18 Now, in fact, weekly testing of staff was introduced
19 on 3 November 2020, so roughly a month later. What do
20 you consider about the timing of that change? Was it
21 sufficient or appropriate?

22 **A.** Well, I think in all of these, I think we were playing
23 catch-up. You know, I think all of these things could
24 have been introduced at an earlier stage with testing.

25 It did feel -- it did feel that, for quite a while,

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1 **A.** Again, I think this was an area that, you know, was
2 behind the care homes, I think, in terms of being looked
3 at.

4 I think it's fair to say we were still receiving
5 some concerns raised from family members and older
6 people about domiciliary care workers not being tested.
7 But not on the same scale as the care home setting,
8 because I think the feeling was that the risk was less
9 in those settings, whereas just the nature of a care
10 home and the number of people living under one roof that
11 the focus was on trying to ramp the testing up on to
12 that because they felt -- it -- it seemed like they were
13 under a much higher level of risk.

14 However, we had conversations and obviously that
15 letter was raising the issue about ramping up the number
16 of domiciliary care workers to be tested as well,
17 because the concern there as well was obviously these
18 care workers were going into many different people's
19 houses on a daily basis. So anyone who was positive for
20 Covid was a danger of exposing quite a number of older
21 people to that if that hadn't been picked up in
22 a testing regime.

23 So again, yes, it seemed to come after, it seemed to
24 be further down the line in terms of urgency, but it was
25 certainly an issue of concern.

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1 there was quite a bit of pushback on this, and I just
2 felt that throughout the testing programme it could have
3 been introduced earlier, it could have been ramped up
4 earlier, and that was my frustration. And I think, you
5 know, whilst resources may have been one of the issues,
6 I don't believe it was entirely about resources.

7 I think, you know, in the early stages there was
8 certainly -- there didn't seem to be a huge appetite for
9 testing and particularly in care home settings.

10 So I think that set everything back and I think all
11 of this rolling out of the testing system could have
12 been done weeks earlier.

13 **Q.** As you say, we're primarily discussing care home
14 settings, but that same correspondence goes on, please,
15 if we have a look at the final paragraph:

16 "I have also raised with you and officials on
17 a number of occasions about the need for domiciliary
18 care workers (home care workers) to be included in the
19 regular programme of testing. It is not reasonable to
20 expect these workers to go and arrange tests for
21 themselves, in the same way as a member of the public
22 does."

23 Was there any meaningful engagement from the
24 Department of Health on your suggestion that domiciliary
25 care workers required testing?

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1 **Q.** While the intricacies of exactly when testing for
2 domiciliary care workers can perhaps be worked through
3 with other witnesses, it would appear it was not until
4 at least early 2021 that tests were available, and
5 perhaps even as late as August 2021, until regular
6 testing was extended to all independent providers of
7 domiciliary care. In your opinion, what was the impact
8 of that not being introduced until 2021?

9 **A.** Again, I mean, it's obvious that, you know, Covid was
10 widespread in the community. You were always going to
11 have some of those domiciliary care workers who would
12 have been infected, and the lack of testing for them
13 means that wasn't identified. You know, particularly
14 with the nature of Covid, you know, if somebody had
15 obvious symptoms, that was one thing, they could take
16 action. But the nature of this virus obviously was that
17 you could have no symptoms at all and still be positive.

18 So that was certainly a risk to the people that they
19 were going to visit every day, and the longer it took to
20 introduce that testing, the more people were exposed to
21 that restrictions.

22 **Q.** If I may move on to the issue of visiting of residents
23 in care homes. I did allude to this a couple of moments
24 ago, but I believe it's your position that at the outset
25 in March 2020, there was a need for some form of

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1 visiting restrictions in care homes. Is that correct?
 2 And can you explain why you think that?
 3 A. That was correct. I took a position at the time, it was
 4 a very, it was a very difficult decision, one of the
 5 most difficult decisions, I have to say, throughout the
 6 pandemic. And there was no good decision to take here.
 7 It was clear from the outset that, you know, I was aware
 8 of the impact that this was going to have on people, but
 9 at that stage, it seemed like the right -- people's
 10 right to protect their lives trumped everything else.

11 So at that stage it was seen as the best way to
 12 protect people's lives was to create what was called
 13 a ring of steel, you know, that it was -- that we
 14 restricted access to the care homes as much as possible.
 15 The experts had advised me, you know, the less people
 16 going in and out from the community, you know, the less
 17 risk for people in those care home settings.

18 So, you know, certainly in the early stages,
 19 I supported that the policy. I think over a period of
 20 time, you know, I realised that the negative side of
 21 that policy was very serious and probably more serious
 22 than we initially expected.

23 I think also the other reasoning behind taking that
 24 approach in the early stages was we didn't know how long
 25 this was going to take. We didn't know what -- how the

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1 "... in the future, decisions will have to be taken
 2 for cohorting those older residents of care homes who
 3 choose to live with the risk of infection, with all the
 4 potentially tragic corollaries, but who value daily
 5 contact with loved ones above the risk to their
 6 longevity. And conversely providing more rigidly
 7 isolated care homes for those whose preference is to
 8 protect themselves."

9 If you just expand on that, are you proposing, in
 10 effect, more resident choice going forward in how this
 11 would all apply to them?

12 A. Yes, I am. I think, from reflecting on this issue
 13 particularly over the last few years, I think measures
 14 need to be introduced into care home contracts that make
 15 care homes have, whatever you want to call them,
 16 isolation rooms, visiting pods, but some sort of
 17 physical capacity to enable face-to-face visiting that
 18 reduces the chances of wider infection.

19 I believe something could be done on that front. At
 20 the time, the minister announced some funding that homes
 21 could look into visiting pods, and I know some homes
 22 took that up, and I think the homes that did take it up,
 23 it worked quite well. And I actually think this is
 24 actually a really key issue going forward, because what
 25 the visiting raised -- has raised real fears amongst

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1 virus was going to continue at that early stage, so we
 2 didn't know how long we were in a position of lockdowns
 3 like this.

4 But clearly, by, you know, by the mid to late
 5 summer, the level of concern raised by families to my
 6 office was really significant and the stories that we
 7 were hearing about individuals and the decline and
 8 deterioration of older people in those settings was very
 9 distressing, and I think that certainly this was one of
 10 the areas that I think the learnings from this Inquiry
 11 can actually put into place really concrete changes to
 12 how care homes could cope with this in future, because
 13 it was clear to me that for many older people, that that
 14 system meant that they, you know, didn't see family
 15 members face-to-face for the last weeks or months of
 16 their lives.

17 It was a very awful position to be in, and I think
 18 in the future, we need to weigh up the risk associated
 19 with contracting the virus and putting in place measures
 20 that allow continued social contact and direct human
 21 contact with family members.

22 Q. If I may, then, just actually turn to what you say about
 23 the concrete changes or recommendations which you think
 24 could be made here. At paragraph 117 of your statement
 25 you say:

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1 older people and people of all ages, I suppose, who are
 2 looking into the future and thinking if that was me, you
 3 know, by far the most people I speak to say they would
 4 want to still see their family and have human contact
 5 even if it exposed them to greater risk. And I think
 6 something that changed the contract, changed the -- that
 7 put the resources into providing that within the care
 8 home setting, so if we're in this situation before, that
 9 we don't have to have a total lockdown of visits. I
 10 believe that that social contact is just too important
 11 to lose.

12 And I think, speaking to a lot of the families who
 13 came into the office, and I've, you know, the families
 14 of the bereaved, I think that, you know, was a cruel end
 15 to their loved ones' lives and I actually think
 16 there's -- putting steps in place like that would be
 17 really important for people's end of life. And also for
 18 people going into homes in the future. I think we need
 19 to get increased public confidence and trust that people
 20 wouldn't be faced with that situation again.

21 Q. You've mentioned two issues there, the first being
 22 a resource issue, the second then being some type of
 23 protection for residents' rights.

24 I'm curious, you mentioned twice there that the care
 25 home contract you see would be the way to do that.

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1 In England, regulations which the regulator enforce have
2 been changed to guarantee visiting, and in Scotland
3 there's legislation working its way through the Scottish
4 Parliament, in Anne's Law. Do you consider that it's
5 the care home contract, it's that level at which
6 intervention needs to be made or is it a more
7 legislative or regulative change?

8 **A.** Well, I think -- you know, I wouldn't have a firm
9 position on that, and I think, you know,
10 Northern Ireland should look at what's happened in other
11 jurisdictions. The key for me would be that the system
12 put in place is effective, and whether you need
13 legislation to do that or whether the contracts can
14 cover that, but I do think we need a situation where --
15 that care homes must provide that facility, and that's
16 up for government to look at the best way to do that.

17 I think if you had that in place, you would also
18 address other issues that came up, not just the
19 visiting, but also access. For example, GP access to
20 care homes that was cut out, and also access for the
21 likes of the RQIA in Northern Ireland, the inspection
22 regime. I think it would provide a lot more support for
23 homes if you had that facility.

24 **Q.** Before moving on to RQIA and care partners, do you
25 believe that the decision makers understood the crucial

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1 their loved one which they believe the new guidance
2 entitled them to."

3 And then also, that:

4 "Home providers are stating that they're not able to
5 safely facilitate the visiting arrangements outlined in
6 the most recent Guidance."

7 For the avoidance of doubt, this correspondence and
8 these paragraphs, is that dealing with the care partner
9 concept in particular?

10 **A.** Yes, that's correct, yeah.

11 **Q.** And in your statement you say that you observed tensions
12 between family members who wished to have access, and
13 care providers who were struggling to implement the
14 concept. What, in your opinion, was the source or the
15 cause of that tension?

16 **A.** This was a really big issue at the time. We were
17 getting really mixed messages after the announcement of
18 the Care Partner scheme. Some of the providers seemed
19 to adapt well to it and put in measures that made it
20 possible to introduce it. There was clearly some
21 providers who wanted to do it but were saying that they
22 had a lack of resources to implement it, and had some
23 difficulties implementing parts of it.

24 And then at the other extreme we came across
25 providers who just seemed to not adopt it at all, and we

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1 role that family carers play in care settings for the
2 residents and loved ones in care homes?

3 **A.** I think that became more clear after a few months of the
4 pandemic. You know, I think the Public Health Agency
5 started to have regular meetings with family members,
6 and I think most of the authorities got that that
7 restriction in visiting was having a huge detrimental
8 impact on the residents.

9 So I do think people realised, you know, when they
10 listened to the stories, when they listened to the
11 impact on families and the older people. I think most,
12 you know, if not all of the authorities realised that
13 this was an issue that needed to be looked at. And
14 obviously the Care Partner scheme emerged from those
15 discussions.

16 **Q.** If we could then move on to care partners, and I'm going
17 to refer back to the 8 October correspondence you sent
18 to the Minister, if we could have that back up on screen
19 please.

20 INQ000250250, and just at the bottom, then, of that
21 page.

22 You say that:

23 "[Your] office has spent the last four weeks dealing
24 with calls from families in distress and then angry,
25 when care providers could not deliver the access to

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1 had families come in to us who had said -- who had heard
2 about the Care Partner scheme, had heard, you know,
3 friends or relatives with people in other care homes
4 getting access and yet the care home that their loved
5 one was in wasn't providing this.

6 So there was a clear inconsistency of approach
7 across the sector.

8 I think part of it was communication. It seemed to
9 be that there was confusion from some of the providers
10 that we dealt with directly who didn't seem to think
11 that they had to introduce this scheme. And I'm not
12 sure where that confusion came from, because they all
13 should have received the guidance, the same guidance,
14 but there definitely was a different approach from many
15 of the homes. Some of it was about resource but some of
16 it, I think, was about the understanding of what they
17 were required to do.

18 **Q.** You talk about issues of confusion and we're trying to,
19 perhaps, delve into where that arose. Do you think,
20 whenever you look at the communications from the
21 Department of Health to the providers and their
22 families, do you think the concept itself was
23 sufficiently defined?

24 **A.** I think it was confusing. It was a new concept, and it
25 was something that, you know, had been brought together

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1 quite quickly, in fairness, in relation to the response
 2 of families.
 3 Again, it is probably an issue and a concept that,
 4 you know, probably needed a bit more time to be talked
 5 through on a practical level. I think most people were
 6 in favour of what the Care Partner scheme was designed
 7 to do, but again, some of the detail of it wasn't very
 8 clear and there was clearly some of the providers who
 9 struggled with introducing it more than others, and part
 10 of that was resource. Part of it was staff, you know,
 11 sickness. A lot of staff at this time were getting --
 12 were contracting Covid, and there was a lot of issues
 13 around that. So there was extra work involved for the
 14 homes to implement the scheme and I think some of them
 15 were just more -- or had the ability to do that more
 16 quickly than others.
 17 **Q.** In terms of talking this concept through, about a week
 18 or so before your correspondence, Ms Shepherd of the
 19 IHCP wrote to the Chief Nursing Officer flagging that
 20 there'd been no prior engagement with providers in the
 21 care partner concept. Do you understand that there had
 22 been no engagement with the IHCP on the care partner
 23 concept?
 24 **A.** Well, I can't say for sure but I know that at that stage
 25 we had been in regular contact with Pauline Shepherd
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1 in -- and, you know, my view at the time was broadly
 2 supportive of the concept. I didn't think it was
 3 perfect, but it certainly -- it looked to me like
 4 a significant positive move by the department at the
 5 time.
 6 **Q.** And does that continue to be your opinion today?
 7 **A.** Yeah, I think it was a positive development, but I think
 8 it's something that if we were planning again for what
 9 we would do in a pandemic situation, I don't think that
 10 would be the perfect solution. I think it was quickly
 11 pulled together. It helped -- it certainly helped some
 12 families. It gained access for many families. But
 13 I think it's really important going forward that we look
 14 in the round. That it's not -- you know, I think a new
 15 policy needs to look not just at the sort of care
 16 partner type system but also just the wider general
 17 visiting as well in homes, as well as looking at GP
 18 access and inspections as well.
 19 **Q.** I think there's a general acceptance that we're always
 20 going to fall short of the perfect solution for every
 21 scenario, but you're accepting that the care partner
 22 concept is a positive one, it perhaps just needs more
 23 work to work through the practical implications?
 24 **A.** Yes.
 25 **Q.** Robin Swann, former Health Minister, in his written
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1 right throughout this, and there was a frustration on
 2 our side, you know, that the lessons hadn't been learnt
 3 from the previous experience of developing guidance and
 4 consultation. So when we looked back on what happened
 5 in March, again, there was a feeling that there should
 6 have been, you know, a more collaborative approach to
 7 this, and again, that, in my view, led to the
 8 difficulties in implementing the new policy consistently
 9 across the sector.
 10 **Q.** You used the word "our" frustrations there, so was the
 11 Commissioner for Older People consulted or engaged with
 12 prior to the announcement of the care partner concept?
 13 **A.** There was, yes, there was -- there was consultation with
 14 us on it. Again, you know, we were aware it was being
 15 developed. I think it had -- from memory, it had come
 16 out of a lot of the meetings with the Public Health
 17 Agency, so we were aware that this concept was being
 18 worked on.
 19 Again, from the commissioner's point of view, we
 20 probably weren't the experts in terms of, you know,
 21 identifying what was going to work and what wasn't, and
 22 that was probably something that did require more
 23 engagement with the sector as well, in terms of looking
 24 at the practical implication of this.
 25 So whilst we would have had our views on it and
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1 evidence to this module suggests that the concept should
 2 be placed on a statutory footing. What, if any, benefit
 3 do you think that would have?
 4 **A.** Well, again, I think it could have benefit if it was
 5 a revised version of it. I think we would have -- part
 6 of that process, it should be reviewing how it actually
 7 worked in practice. Also any review of that would have
 8 to identify what resources would need to be put in place
 9 from a sector point of view to implement it. I think
 10 the idea is good. I think the idea that family members
 11 should have more of a say in the care of their relative
 12 is a very positive thing, and it should be facilitated
 13 as much as possible.
 14 So, again, I wouldn't say that the care partner
 15 scheme that was introduced in 2020 would be just the
 16 scheme that you would put in in 2025, but it certainly
 17 would form the basis of reviewing what was needed, and
 18 I think it could be built on and made better.
 19 **Q.** Thank you.
 20 I'm going to turn briefly to RQIA inspections, and
 21 your position is set out pretty clearly in your witness
 22 statement at paragraphs 149 and 150. And you think
 23 a degree -- or inspections should have continued to
 24 a greater degree than they were.
 25 If I could just ask you about the Services Support
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Team, which was the reorganisation which took place to enable inspectors to support care providers during the early weeks and months of the pandemic in particular.

First of all, do you consider that that was a helpful step which was taken by RQIA, and secondly do you consider that it was in any way an adequate substitute for the oversight or assurance provided by inspections?

A. I think, again, this is quite a difficult one. I think at the time -- this decision was taken at the time when we were about reducing footfall in care home settings. So there was some rationale for stopping physical inspections, with that in mind.

However, reflecting back on it, you know, I had concerns at the time about that -- what that would actually mean. If there was no oversight of the services happening at a real critical period, you know, that -- that raised concerns with me.

Probably the bigger concern, based on my experience as commissioner in dealing with care homes and investigations, my biggest concern was probably the fact that, you know, without friends and family in visiting, I certainly felt that I'd lost my eyes and ears on the ground, because, to me, that was a more valuable source of information than RQIA inspections, that maybe only

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a statement even as late as November 2020 on this issue?

A. Again, this was an issue that kept raising its head every so often, you know, there was people who were -- had come to my office raising concerns about maybe their own family member. There was family members that were discovering that a DNACPR had been put in place without consultation with them, and worried that the resident didn't have capacity to agree to that.

So we were getting *ad hoc* examples like that. We also, at the time, I was working very closely with the Welsh Commissioner, and a series of organisations across the UK. We were having Friday meetings to discuss common issues, and this came up as a wider story across the UK where there was a number of stories that had broken where certain trusts and GP surgeries were writing out to people with underlying conditions and asking them to sign that, and it was seen as not good practice that there was this kind of blanket approach to people who might have been in that position.

Q. And in terms, then, of these statements you make, just to name a few, 30 March, 6 April, and then end of November, what, if any, response did you receive from the Department of Health to those statements?

A. From memory there was -- this came up in a few of the meetings we had with the Department of Health. We

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happen once a year.

So whilst the inspections stopping I think maybe in the public's eye probably was a more worrying thing, I actually think, you know, that the bigger thing was the fact that families weren't allowed in, and I think that was a much more -- probably a much more damaging decision than the inspections.

I think the support services in theory, again, was a good thing, that RQIA would move to the sort of support mode for homes and I think that was a good thing. But I think also, with the reflection, I think it would have been, you know, better if we had -- if homes had the facility to bring in inspectors as well.

Maybe not from an inspection point of view but more, again, as a support point of view, because this was new ground for them as well, and I think if they had a bit more expertise on the ground that might have helped homes get up to speed more quickly.

Q. If I may just then move on to the issue of DNACPR notices. You made a series of statements during the course of the pandemic -- it's not necessary to call them up on the screen but it was 30 March 2020, 6 April 2020, and then, again, further even as late as November 2020.

Why did you think it was necessary to make

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raised it as an issue. We got assurances that this is something that they -- that shouldn't be in place.

There was agreement that it shouldn't -- the process around DNACPRs shouldn't change.

So again, I think the outcome of that was really, again, communicating that. We were, you know, keen that it was being communicated out across the health service, whether it was at trust level or GP level. But as organisations, we felt it important to put it out there, because there was a genuine concern amongst older people at the time that they may not be admitted to hospital, as well, and this was, again, a concern for care home providers, as well, about whether they should ring an ambulance for somebody if they're in this position.

Q. And very briefly, are you satisfied that there was sufficient, then, communication from the Department of Health across the sector in order to deal with those concerns?

A. I think communication did go out, and -- but I think the fact that you've referenced, you know, some of those statements over a period of time reflects the fact that we were still hearing some cases where people were surprised to see this in place. So I think again, the communication got better, but there was still some experience where families were bringing to my office,

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1 saying they were surprised to find out this was in
 2 place, because again, it would be something that should
 3 involve the family.
 4 **Q.** And just in finishing, then, two final points: you
 5 create the impression that there wasn't sufficient
 6 learning from first to second waves of the pandemic. Is
 7 that a fair summary?
 8 **A.** In terms of DNACPR?
 9 **Q.** In terms of a whole heap of issues across -- affecting
 10 the adult social care sector?
 11 **A.** Yeah, I think it could have been better. It could have
 12 been better. I think there was a lot of learning early
 13 on. I think I, you know, I went and gave evidence to
 14 the Health Committee who did a review of the response to
 15 the pandemic in, I think it was August 2020, August,
 16 September, and even at that stage, I felt there was
 17 learnings from the first few months. So I think by the
 18 time we were in the next wave, I felt we could have
 19 learnt more and be better prepared.
 20 **Q.** And just very finally, then, your kind of global or
 21 ultimate recommendation coming out of all of your
 22 experiences is that future planning must be informed, if
 23 not created, by a group of experts, by experience,
 24 including private care home providers, their operational
 25 staff, and family members of care home residents.

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1 a serious gap.
 2 **MR BEECH:** Thank you very much, Mr Lynch.
 3 Thank you, my Lady, I've no further questions.
 4 **LADY HALLETT:** Thank you, Mr Beech.
 5 Now it's Mr Wilcock who is just sitting there.
 6 **Questions from MR WILCOCK KC**
 7 **MR WILCOCK:** Good afternoon.
 8 **A.** Good afternoon.
 9 **Q.** I am asking you questions on behalf of the Northern
 10 Ireland Covid Bereaved Families for Justice, and I'm
 11 going to -- I've been given permission to ask you
 12 questions on four topics.
 13 The first topic is the one you've just been dealing
 14 with, DNACPR, and I want to ask you about a question
 15 that the Minister of Health was asked by a fellow MLA in
 16 March 2021 about the application of DNACPRs in
 17 Northern Ireland. And the written question that he was
 18 asked was this: how many audits have been undertaken to
 19 monitor adherence to policies and guidance in relation
 20 to do not resuscitate orders in respect of people with,
 21 one, learning disabilities and, two, dementia, who have
 22 died with Covid-19?
 23 And Mr Swann's answer, as he has explained to the
 24 Inquiry Module 3, was this: he wanted to make it clear
 25 that orders based on age or disability were

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1 Just in terms of practically, how would a group of
 2 that nature work and how would it have improved the
 3 response of the adult social care sector?
 4 **A.** Well, again, as I said, I do believe there was a lot of
 5 commitment from a lot of organisations and members of
 6 the public who wanted to feed in to these very difficult
 7 discussions, and decisions. And I think, in the future,
 8 you would want to see more of a commitment from
 9 government to press the button on starting up a group
 10 like this, if we were faced with another pandemic, that
 11 this group would spring into action pretty quickly,
 12 working collaboratively with government. And I think if
 13 it did do that, you would probably get to the stage
 14 where you could get guidance, better guidance more
 15 quickly.
 16 In terms of the practical implications, none of us
 17 have a crystal ball about when the next pandemic hits,
 18 so obviously just from a practical point of view, that
 19 would be something the government would need to keep
 20 updated on an ongoing basis to know. But I do think it
 21 would be valuable to have a group of experts because
 22 I was kind of -- I was surprised, even three or four
 23 months in, when I had some of my meetings with experts,
 24 about how little they had been called on from
 25 government, in terms of decisions. And I felt that was

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1 discriminatory and unethical, and he further asserted,
 2 in terms of the policy in Northern Ireland, media
 3 reports about the application of DNACPRs were
 4 ill founded.
 5 But he was unaware, at this time, whether his
 6 department had ever considered or conducted an
 7 investigation into the concerns that were raised about
 8 inappropriate use of DNACPRs.
 9 First question, did the Department of Health or any
 10 other agency in Northern Ireland proactively contact
 11 COPNI in an effort to understand the depth and breadth
 12 of concerns about the use of DNACPR in Northern Ireland?
 13 **A.** I don't believe there was any specific requests for
 14 meetings to discuss that. I believe this issue came up
 15 in several meetings that I had throughout the course of
 16 the pandemic with officials, where that issue was one of
 17 a number of issues that we had raised with the
 18 department, but I don't recall any specific meetings
 19 being requested from the department to us.
 20 **Q.** Thank you very much.
 21 And presumably in those meetings you told them what
 22 you've told us, in your statement, et cetera?
 23 **A.** Yes.
 24 **Q.** Are you aware of any internal or independent audit that
 25 would have been sufficient, carried out by any agency,

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1 to answer the MLA's questions, particularly with respect
 2 to those with learning disabilities or dementia in
 3 Northern Ireland?
 4 **A.** No, I'm not aware of any audit.
 5 **Q.** Did you have any sense that the department or any other
 6 agency was taking the concerns that you were mentioning
 7 in the meetings that you've told us about, that were
 8 being publicised in the media about DNACPRs in the year
 9 following -- between March 2020 and, let's say,
 10 March 2021, did you think the department were taking
 11 those concerns with the appropriate degree of
 12 seriousness?
 13 **A.** I think, whilst these issues were raised in meetings
 14 with the department, I think it's fair to say that the
 15 majority of the time that I had to go out in the media
 16 and speak on these issues is because I wasn't convinced
 17 that they were all fully being taken on board. It
 18 certainly, with the DNACPR, when we did -- when I did
 19 the joint statement with other organisations across
 20 the UK, the feeling was, I suppose, we all were getting
 21 similar assurances, but we felt it was really important
 22 to raise that publicly, and put it out there in the
 23 public interest that this shouldn't be happening.
 24 Just one other point that I would make. I was
 25 particularly concerned in Northern Ireland because we

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1 explains the reason and rationale behind the decision.
 2 **Q.** And you've explained to us, when answering questions
 3 from Mr Beech, that in short, you feel that
 4 a consequence of this decision was that you, in
 5 particular, and every other agency looking at the care
 6 homes lost their eyes and ears as a result of this
 7 decision.
 8 Now, in his evidence to Module M2C in Belfast, May
 9 last year, the Chief Medical Officer told the Inquiry
 10 that because RQIA staff were being, in his words,
 11 proactive in telephoning care providers to check in with
 12 them, then this by itself provided eyes and ears from
 13 the RQIA on the ground. Do you think that that did
 14 provide sufficient compensation for the loss that you've
 15 described?
 16 **A.** Again, I don't think so. You know, I think the
 17 inspection regime stopping going in was one thing, but
 18 I think maybe a lot of the public would maybe not
 19 appreciate that that doesn't happen very often, and
 20 again, the biggest concern for me was probably family
 21 not getting access to the home.
 22 I think certainly the support services were
 23 a welcome development, but I think, looking back, you
 24 would still have wanted some sort of physical presence
 25 for inspectors to go in in that circumstance,

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1 were the only part of the UK and Ireland that still
 2 doesn't have age discrimination legislation in place, in
 3 relation to goods, facilities, and services. So I felt
 4 that we were even more at risk with some of this. So
 5 whilst there was concerns from me and others that there
 6 was maybe ageist elements to decisions being taken,
 7 I was conscious as well that we didn't have the legal
 8 protection that other jurisdictions had as well.
 9 **Q.** Understood.
 10 Second topic, which I can take relatively swiftly,
 11 RQIA. We know that in March 2020 a decision was taken
 12 to reduce the frequency of statutory inspections in care
 13 homes and to cease all non-statutory inspections.
 14 Paragraph 149 of your statement, you indicate that
 15 there was no public announcement that physical
 16 inspections had in fact ceased. Do you think there
 17 should have been such an announcement? And if so, why?
 18 **A.** Yeah, I think from transparency, I think it should have
 19 been publicly announced. As I say it was, I can't
 20 remember the exact time that I found out that they were
 21 completely stopped and then it's, you know, I had some
 22 discussions with the RQIA on that, but I think in these
 23 situations, it's, you know, public trust is really
 24 important, and I do believe when decisions like that are
 25 taken, that any public authority tells the public and

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1 particularly under the strain that the providers were
 2 under.
 3 So yes, I think that was a -- that would have been
 4 a concern.
 5 **Q.** Understood, thank you.
 6 Third topic: the evolution of care partner guidance,
 7 again a topic that you have covered broadly already.
 8 But in her statement in evidence to this Inquiry,
 9 Module 3, the Chief Nursing Officer of Northern Ireland,
 10 Charlotte McArdle told the Inquiry that "Northern
 11 Ireland led the way in ensuring that restrictions were
 12 applied in a person-centred way" and she pointed in
 13 particular to the evolution and implementation of the
 14 care partner guidance as an example.
 15 Now, you showed us some of the correspondence you
 16 had had when dealing with the Care Partner scheme when
 17 answering questions from Mr Beech, and you told us about
 18 the tensions you had observed between families and care
 19 providers during that process.
 20 Did you think that you were witnessing
 21 a world-leading example of person-centred care when your
 22 officers were receiving phone calls from anxious
 23 families and care homes about the implementation of this
 24 scheme?
 25 **A.** Well, clearly the scheme was inconsistent, was operating

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1 at many different levels across different care homes.
 2 Some care homes, the scheme worked well, but clearly
 3 there was a lot of care homes that were struggling with
 4 the implementation of it. And then at the other end of
 5 the spectrum, there was homes that just weren't
 6 implementing it.

7 So whilst it was progress on the issue, it was far
 8 from being a very effective option.

9 **Q.** Thank you.

10 Final topic, and this is about the role you played,
 11 and I want to give you an opportunity to comment on some
 12 of the concerns that families I represent have raised as
 13 to the role your office played during the pandemic. And
 14 to be frank, some families have expressed concern, and
 15 indeed criticism, that COPNI was not sufficiently
 16 effective in advocating for older people's needs and
 17 rights prior to and during the pandemic, and indeed
 18 since. They consider that there was a lack of
 19 visibility on the part of COPNI -- you've told us about
 20 the efforts you did take to get publicity -- and the
 21 slow pace of change, particularly in relation to adult
 22 safeguarding legislation, which you've spoken about as
 23 well, and the protections -- lack of protections against
 24 age discrimination.

25 Can you see why some people hold that view?
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1 perfect, but I was able to get access to the likes of
 2 the Health Minister, on a regular basis to senior
 3 officials, and have some influence in there.

4 I would have liked to have seen things move a lot
 5 quicker, as I've given in my other evidence.
 6 I definitely think there's a lot of learning there for
 7 the future. And as I say, I hope that this Inquiry
 8 teases that out and actually puts in place real, strong
 9 recommendations that can actually bring about
 10 a situation that, if we face this awful situation again,
 11 that everyone will be in a better position to take
 12 action more quickly.

13 **MR WILCOCK:** And I have no doubt my clients agree with those
 14 sentiments. And I want to make sure, and I'm sure
 15 you've already noticed, I deliberately didn't say that
 16 the views I've given are universally held, but they are
 17 held by some.

18 Thank you.

19 **A.** Thank you.

20 **LADY HALLETT:** Thank you very much, Mr Wilcock.

21 Ms Jones is over there, just a couple more
 22 questions.

23 **Questions from MS JONES**

24 **MS JONES:** Mr Lynch, I ask questions on behalf of the John's
 25 Campaign, Care Rights UK and The Patients Association.
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1 **A.** Well, I think in terms of our -- myself and my team
 2 during the pandemic, you know, looking back on it,
 3 I don't believe we could have worked any harder than we
 4 did on the issues. We were working very long days, and
 5 linking up with ministers and officials in a very
 6 difficult situation.

7 I think it's fair to say that we weren't experts on
 8 a pandemic, so we were learning, and having to learn
 9 very quickly of the issues we were dealing with. This
 10 was all new to us as well. But I can assure you that we
 11 were -- certainly with the resources we have -- you
 12 know, we are quite -- or COPNI is quite a small
 13 organisation -- that we were using all of our resources
 14 to try to influence where we could. But it was clearly
 15 a very difficult and challenging time. There's no doubt
 16 about that.

17 What I would say is, you know, post-pandemic as
 18 well, that there's been a lot of people who have raised
 19 personally with myself, older people saying that -- many
 20 older people who had actually campaigned for
 21 a commissioner many years ago were actually appreciative
 22 that there was a commissioner in place at that time, and
 23 it actually highlighted one of the reasons that they had
 24 campaigned for that. And I think what it proved to me,
 25 it was far from perfect, and the responses were far from
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1 I want to start by asking you about the suspension
 2 of inspections by RQIA. The decision to suspend
 3 inspections arose, as you say, from a desire to reduce
 4 footfall in care settings and the risk that was thought
 5 to be associated with that. But in your experience did
 6 that decision take account of the risks on the opposite
 7 side at all, so the risks arising from suspending
 8 inspections such as an increased risk of abuse or
 9 neglect, or of a general deterioration in care, was that
 10 something that was taken into account before inspections
 11 were suspended?

12 **A.** As I've said, I think at the time the decision was
 13 taken, the focus was on protecting life and protecting
 14 the spread of the virus in the very early, early stages.
 15 But as I've said, I think that over the course of time
 16 in those opening months, it became increasingly clear
 17 about the negative side of not having access for family
 18 members into homes, as well.

19 So I think, for me, this is one of the key learnings
 20 in terms of what really would be done differently next
 21 time around if we were in this situation. I think it
 22 has illustrated just how important that family contact
 23 and social contact is with people living in those
 24 settings, and the damage as a result of removing those,
 25 you know, eyes and ears on the ground. As I said,
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previously, as well, the removal of on-the-ground inspections, again, is something that I think the public probably would like to see in future continue, but for me, getting family members to be still able to access their loved ones face to face is probably the bigger issue here and giving reassurances to families, to the commissioner's office in future, and for other charities that represent older people.

Q. Thank you.

Just on the role of families, so not only in terms of the importance of access of family members for the wellbeing and care provided to people who live in care homes, but also in terms of the monitoring and oversight role that they play. Can I ask, do you think that was something that was properly recognised and taken into account when RQIA inspections were suspended?

A. I certainly think, in my experience, in the post as commissioner, the role and the intelligence from family members is absolutely critical in ensuring that the care home sector has the monitoring in place to ensure good quality care, and I think, based on my previous experience investigating a care home in Northern Ireland and the report that came out of that, the Home Truths report, it was really clear to me that that was probably the biggest single issue, that family members are so

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really the basis of it.

Q. Thank you. And then my final question is on a slightly different point.

At paragraph 178 of your witness statement, where you set out the recommendations that you would make, you say that:

"Future planning must be informed, if not created by, a group of experts by experience, including private care home providers, their operational staff and family members of care home residents."

You don't include in that list the care home residents themselves, and I just wonder if you think that work should include people who live in care homes and who can bring their own experiences to bear on what preparation and planning should be undertaken?

A. That's a good point, and I would, of course, include care home residents in that, and I would probably go further and say, you know, you'd probably want to include older people who aren't care home residents currently; because I think it's really important to get the views of people who may be future users of those services as well. We need to have a clear understanding of what people want, it's back to the point about care homes being people's homes, and that, we need to protect that, we need to protect the privacy, the family life,

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important in ensuring that care is of a high quality, and that when they have concerns about that, that they're listened to and acted upon. And I think that is absolutely fundamental. And I think, going forward, certainly we need to restore public trust that authorities will take the appropriate action if we're faced with the circumstance again.

Q. I hear your recognition of how important those things are. In your experience during the pandemic, were they recognised to be important by decision makers?

A. Well, I think decision makers did recognise the importance of contacting family. I think -- I mean, and that was clearly in the conversation at the start. I don't think there was a -- people didn't see that as a big issue, but I think, as I said before, there was no right -- there was no good decision here.

At the time, we that deep concerns just about the scale and impact that Covid-19 would have in care home settings. There was -- it was frightening, some of the conversations that were being had at that stage. And I think, you know, everyone knew that there was consequences for restricted access, whether it was inspectors or family, but I think at that time the decision -- the primary thing was to save life and to take decisions to try to protect life, and that was

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and all of those wider things as well as their health and social care needs.

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

LADY HALLETT: Thank you, Ms Jones.

That completes the questions we have for you. Thank you very much indeed, Mr Lynch, for the help you've given to the Inquiry. Extremely grateful to you.

I think this is probably the last time we're going to call upon you, so the burden is over. I don't know if you still live in Northern Ireland, but if you do, safe journey home.

THE WITNESS: Thank you, my Lady.

LADY HALLETT: Thank you.

10.00 tomorrow.

(4.11 pm)

(The hearing adjourned until 10.00 am the following day)

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