

Monday, 28 July 2025

1
2 (10.15 am)
3 **LADY HALLETT:** Ms Carey.
4 **MS CAREY:** Good morning, my Lady. My first witness today is
5 Ms Joanna Killian.
6 **MS JOANNA KILLIAN (sworn)**
7 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6**
8 **LADY HALLETT:** Good morning, thank you for coming along to
9 help us.
10 **MS CAREY:** Ms Killian, your full name, please.
11 **A.** My full name is Joanna Elizabeth Killian.
12 **Q.** You, on 18 March 2024, became the Chief Executive of the
13 Local Government Association, or LGA for short; is that
14 correct?
15 **A.** I did.
16 **Q.** And prior to that, during the pandemic, I think you were
17 the Chief Executive of Surrey County Council?
18 **A.** I was.
19 **Q.** Right. And I'm going to ask you, please, about the
20 LGA's role, but if it would help you to give your
21 evidence to give us some examples of actually what
22 happened on the ground in Surrey, please feel free to do
23 so if you think that would help.
24 **A.** Thank you.
25 **Q.** I know that you've set out in your statement that in

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1 sure that policy decisions can land well in places and
2 make a difference to people that live in our places and
3 communities. So we interpret guidance, make them fit
4 for purpose, we lobby for money, but we also do an awful
5 lot of work to support councils and their partners
6 improve the quality of services to people living in
7 their communities.
8 **Q.** And help us, does the LGA have a direct line into the
9 Department of Health and Social Care? How did work
10 during the pandemic?
11 **A.** So the LGA has, and had at that time, very strong
12 relationships into a number of departments that were
13 running the pandemic, including the Department of
14 Health.
15 **Q.** Presumably also MHCLG as was?
16 **A.** Absolutely.
17 **Q.** Right.
18 Ms Killian, can you take it from us that over the
19 last four weeks or so her Ladyship is under no illusions
20 about the underfunding and the fragility of the adult
21 social care sector, but I'd just like to ask, through
22 you, please, to have a look at what the LGA members said
23 in relation to pre-pandemic capacity.
24 And could we have a look at one extract from the
25 survey, please, INQ000400522_21.

3

1 preparing the statement, you have spoken to officers who
2 were in the LGA at the time of the pandemic, and may
3 I thank you for your assistance in preparing and
4 collating the survey responses in November 2024 about
5 the pandemic response.
6 You set out in your statement a description of the
7 Local Government Association, whose membership I think
8 comprises 331 of the 333 principal councils in England,
9 and the 22 Welsh councils.
10 **A.** Yes.
11 **Q.** Right. Can you just help us at the outset, please, can
12 you give us an overview of the role of the LGA and in
13 particular, the role of the LGA in the pandemic
14 response.
15 **A.** Yeah. I mean, before I do that, can I just say, as
16 Chief Executive of Surrey County Council, I was, in that
17 role, co-chair of Surrey's Local Resilience Forum and
18 chaired a number of the gold command meetings that
19 conducted the pandemic. I also was chair of a homeless
20 charity, so saw the pandemic through a number of
21 different lenses.
22 In relation to the LGA's role, we're a voluntary
23 membership body, but in that role we liaise
24 significantly between local government and central
25 government. We lobby on behalf of our councils to make

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1 Because I think one of the questions that you posed
2 of the membership was how they would judge the following
3 elements of the adult social care sector in the year
4 leading up to the Covid-19 pandemic.
5 And if we look down, firstly, at preparedness,
6 a relatively mixed response there with 22% of the
7 English single tier. Can I just ask you to explain what
8 the single tier is, please.
9 **A.** Yes, so upper tier councils, or single-tier councils,
10 are responsible for the daily living of care services
11 including adult social care. District councils provide
12 support into that endeavour.
13 **Q.** So we can see there 22% of the single-tier and counties
14 thought that preparedness was fairly good, 53% not very
15 good, 20% not good at all. And in Wales, 19% of the
16 authorities thought fairly good, 57% not very good, and
17 29% not good at all.
18 I'm going to come back to pre-pandemic planning in
19 a moment but capacity, actually, in England 65% felt
20 fairly good, and similar scores of 67% in Wales. The
21 ability of the care sector to increase capacity -- was
22 that increase the workforce numbers?
23 **A.** Workforce numbers and potentially capacity within the
24 provider sector itself.
25 **Q.** Thank you. Fairly good, 43% in England, 38% in Wales;

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1 not very good, 47% and 43% respectively in England and
 2 Wales; and then resilience was, in fact, by the
 3 respondents -- 70% in England thought it was fairly good
 4 resilience, 52% in Wales. And that might not
 5 necessarily accord with some of the evidence we've heard
 6 about resilience of the sector.

7 Can you help at all with your perspective on why
 8 some of the respondees might have actually said in
 9 England there was fairly good resilience, when we've
 10 heard perhaps that there wasn't?

11 **A.** So I think one of the extraordinary and, sort of,
 12 distinguishing features of the care sector in England is
 13 the goodwill, sort of the passion amongst the workforce,
 14 amongst providers, and I think that really shone through
 15 in the pandemic. So over time, the sector has coped
 16 with reducing amounts of money; the sector has just
 17 about coped with increasing demand and changing
 18 demographics, and that has, required them to be
 19 innovative, creative in, sort of, building solutions
 20 that could make people's lives happy.

21 So there's something inbuilt about the culture there
 22 but, you know, the pandemic definitely tested that
 23 resilience, for sure.

24 **Q.** And perhaps slightly lower figures, though, in Wales,
 25 with only 52% of the authorities there thinking that

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1 I think, esteem away from social care. It led to poor
 2 decision making about the allocation of resources,
 3 whether that was for PPE to begin with, or vaccinations.
 4 It was clear to us that decisions about discharge,
 5 actually, put some care homes at threat of harm. So
 6 despite great work that our sector did with care home
 7 providers, it wasn't the case universally that care
 8 homes were great, safe places for people to be.

9 I think it was also a terrible misunderstanding of
 10 social care in England that so much focus was around
 11 care homes. A much higher proportion of people live
 12 happily and independently in their own homes who need
 13 care and support, and their needs were not addressed
 14 early enough in the pandemic.

15 So we saw holes in provision and, you know, we
 16 cannot agree that there was a ring of protection around
 17 care homes, or sometimes individuals' homes either.

18 **Q.** Do you think it was that the departments, plural, didn't
 19 understand the adult social care sector, or just got the
 20 focus wrong in view of what they thought might be a need
 21 to effectively free up as many hospital beds as they
 22 did? Do you have a sense of which, if either, or both
 23 of those statements might be true?

24 **A.** I think it's both and probably more, actually. I mean,
 25 in the early days of the pandemic it was clear that

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1 resilience was fairly good, and indeed 38% saying not
 2 very good.

3 Can you help with why, perhaps, there's slightly
 4 different figures for Wales than there are in England?

5 **A.** I mean, I don't feel, sort of, confident about talking
 6 about figures in Wales, but the legislation is
 7 different, some of the models of care are very different
 8 between the two nations.

9 **Q.** Right. Thank you.

10 Before we look at some of the pre-pandemic planning,
 11 just some overarching observations from you, if I may.
 12 In your statement you say that the notion of the
 13 protective ring was known to be untrue and caused
 14 distress for families and for those working in adult
 15 social care.

16 Can you help, Ms Killian, with why that's the view
 17 of the LGA?

18 **A.** So it was clear to us from the start of the pandemic
 19 that priority was placed in supporting the NHS. I think
 20 the Department of Health understood or believed that the
 21 NHS delivering sufficient capacity in hospitals,
 22 enabling discharge, was necessary to be able to support
 23 people that might become unwell.

24 Our experience from the start of the pandemic was
 25 that, sort of, continuing focus on the NHS shifted,

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1 there were insufficient numbers of very senior people
 2 within the department who understood what adult social
 3 care was, how it was delivered, and the importance,
 4 actually, of thinking not just about older people but
 5 actually groups of other people that needed care and
 6 support in the community. So I think in the early days,
 7 insufficient capability or leadership to be able to,
 8 sort of, understand; some good policymakers, but again,
 9 a gap between how policy might work in theory but
 10 actually how it would land.

11 So I think absolutely a misunderstanding there.

12 **Q.** What led to that gap, Ms Killian?

13 **A.** I think there had been historically, you know, no senior
 14 director general at the point the pandemic started.
 15 A small number of people -- we accept that the number of
 16 officials working on this grew significantly, but this
 17 goes to the heart, I think, of how we find ourselves
 18 today: that social care was just not, sort of,
 19 a priority in the department against the priorities that
 20 there were for the NHS. And again, as the LGA, you
 21 know, we accepted and understood the evidence that was
 22 in play at the time, that recognised that there would be
 23 benefit in releasing capacities in hospital, because
 24 actually some of the people that might be affected were
 25 older people.

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1 So there was a, sort of a logic, as the science
 2 developed, but our sense always was that to make
 3 capacity available in hospitals, there had to be a safe
 4 way of ensuring that people left hospital preferably to
 5 go to their own home.

6 **Q.** Was there any sense that the gap between the policy and
 7 the actual sector on the frontline was as a result of
 8 a lack of engagement with the sector?

9 **A.** So I will say again, I think there was a lack of sort of
 10 experience within the department, and in the early days
 11 there weren't the sort of mechanisms, the robust
 12 mechanisms, to liaise with local government
 13 associations, providers, service users. And although
 14 that improved sort of notably in June 2020 when
 15 David Pearson was appointed to lead the social care
 16 taskforce, lots of things were done on an *ad hoc* basis.
 17 The LGA was often asked -- and we were happy to do so --
 18 often asked to comment on guidance, but the guidance
 19 often came late, short notice, and sometimes it felt
 20 that guidance had just been adapted from an NHS workbook
 21 into a social care workbook.

22 You know, older people living in residential care
 23 homes do not live in wards. You know, they live
 24 different lives in residential homes, in care homes.
 25 And guidance was frequently changing, so, as the LGA, we

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1 should, sort of, periodically define the threats to the
 2 nation. And as local authorities, we pay attention to
 3 those threats. The local resilience forum that are
 4 formed under the Civil Contingencies Act are accountable
 5 in places for making sure that a county, a group of
 6 counties, whatever the footprint of the LRF, are ready
 7 to be able to respond to these national emergencies.
 8 And absolutely, the flu pandemic was part of that.

9 As an individual responder council, absolutely it's
 10 for the council to be able to say that they are sort of
 11 ready to respond to a national emergency, in that case
 12 a flu pandemic. It's the responsibility of a director
 13 of public health within a local authority to make sure
 14 that planning for infectious diseases under the 2012 Act
 15 are in place.

16 So there's a variety of hierarchies but, absolutely,
 17 a council must understand their contribution to a flu
 18 pandemic.

19 Operation or Exercise Cygnus that started in 2011
 20 I think exposed some of the frailties of that, and that
 21 exercise continued for a number of years. So councils
 22 would have had a response to a flu pandemic, but it
 23 wasn't a flu pandemic that caused, you know, such
 24 disruption as Covid-19.

25 **Q.** Let me pause you there.

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1 absolutely offered ourselves and others into a space
 2 where we could support the department. And things did
 3 improve, but at the beginning it wasn't the most
 4 satisfactory set of arrangements for any party. And nor
 5 for the civil servants, who really did want to make
 6 a difference.

7 **Q.** We may come back to that in a moment. Can I just start,
 8 though, with some pre-pandemic planning.

9 **A.** Yeah.

10 **Q.** I'd like your help perhaps on clarifying different
 11 levels of plans that are in place.

12 **A.** Yeah.

13 **Q.** We have heard from a number of witnesses about the
 14 pre-pandemic flu plans.

15 **A.** Yeah.

16 **Q.** We've also heard witnesses talk about business
 17 continuity plans and indeed contingency plans. And
 18 I wonder if you could help clarify what the plans are
 19 meant to be in place and who was responsible for those
 20 plans, please.

21 Could you start with the pre-pandemic flu plans.
 22 Was every local authority obliged to have a pre-pandemic
 23 flu plan?

24 **A.** So, I mean, as you say, it's important to sort of think
 25 about the hierarchies here. Government nationally

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1 What in fact is a business continuity plan and how
 2 does it differ from a pre-pandemic flu plan?

3 **A.** So imagine I'm in a local authority. One of the
 4 national threats, for example, is a cyber attack. It's
 5 really important that councils understand how they're
 6 going to mitigate that threat and they will have a plan
 7 in place. If, unfortunately, that threat materialises
 8 then councils should also have a business continuity
 9 plan, so if the cyber system knocks out all of your IT,
 10 there must be a mechanism to be able to meet your needs
 11 and that's what is defined in a business continuity
 12 plan, that would be the same in a care sort of scenario,
 13 as well. And we make contingencies in that context.

14 So you would have a national risk plan, a council
 15 risk plan, you would have a plan for dealing with
 16 a pandemic, you would have a plan to manage the
 17 consequence if that pandemic sort of landed in your
 18 place. So I hope that's useful.

19 **Q.** Right. Can I ask you this: is a business continuity
 20 plan often incorrectly termed a contingency plan, are
 21 they used interchangeably?

22 **A.** They are -- sort of mistakenly.

23 **Q.** Right, but they are different?

24 **A.** Yeah.

25 **Q.** All right. So there's the business continuity plan and

12

1 then sitting under it, my word --

2 **A.** Yeah.

3 **Q.** -- a contingency plan for what you do if there is, in

4 fact, a cyber attack?

5 **A.** Yes, yes.

6 **Q.** All right, understood.

7 Can I come back to the pre-pandemic flu plans, then?

8 **A.** Yes.

9 **Q.** And we have heard from Minister Whately that she found

10 it difficult to get hold of the plans. The two that she

11 did see, she did not consider to be adequate. Do you

12 know who was responsible, at that stage, for checking

13 whether the pre-pandemic flu plan was fit for purpose,

14 as far as the adult social care sector is concerned?

15 **A.** So, I mean, accountability for ensuring there was a plan

16 would sit with the LRF, it would sit with the Director

17 of Adults, it would rest with the Director of Public

18 Health.

19 **Q.** And not only ensuring that there was a plan, but that it

20 was up to scratch, if I may put it colloquially. Was

21 that also with the Director of Public Health and the

22 Director of Adult Social Services?

23 **A.** So it would be a sort of responsibility of the local

24 resilience forum. Within a council it would be Director

25 of Adults and Director of Public Health, but sort of

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1 So I think in local government, Pegasus and all the

2 support framework around that is crucial to enable us to

3 play a part in planning for the future.

4 **Q.** That's what I was going to ask you: is the LGA, as far

5 as you're aware, involved in Operation Pegasus?

6 **A.** We've had early engagement and will continue to make

7 sure that we have full engagement on behalf of the

8 sector, partly to come back to this issue about making

9 sure that it's operationally capable and fit to deliver

10 the response that would be needed.

11 **LADY HALLETT:** Exercises are all very well, if the

12 recommendations are then implemented. You've already

13 referred to one where frailties were exposed, Exercise

14 Cygnus.

15 **A.** Yes.

16 **LADY HALLETT:** And the recommendations were not implemented.

17 So how do we ensure that the Pegasus recommendations are

18 implemented?

19 **A.** I think there is a sort of different mindset now within

20 sort of local government. The experience of running and

21 living with a pandemic has made, I think, many senior

22 officers very attuned to the importance of planning, and

23 I think the lessons from Cygnus, but the lessons from

24 Covid is about how do we make sure that there really are

25 robust operational plans in place, and there is

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1 a governance framework should underpin it. I think the

2 reality is for many organisations, you know, flu plans

3 were in place, but, I feel I should say again, you know,

4 Covid wasn't, you know, a flu plan. So I am sorry that

5 the minister felt the plans were unsatisfactory, but

6 many of the plans were built, and existed to deal with

7 a flu pandemic. They didn't exist to deal with a novel

8 coronavirus with completely different sort of

9 transmission impacts into communities.

10 **Q.** Let me ask you, understanding that, that they were

11 effectively a plan for a different virus.

12 **A.** Yeah.

13 **Q.** Clearly we may not know what the next virus is that is

14 coming. What is in place now so that there is perhaps

15 a flexibility for the plan to either meld itself or

16 adapt itself for a novel virus?

17 **A.** So at the moment, the Department of Health, with the

18 Cabinet Office, are sort of working on a new sort of

19 test exercise, Pegasus, and our understanding at this

20 point is that that exercise will test a scenario that

21 would see another respiratory virus be the one that

22 would cause a pandemic, and will test a number of sort

23 of transmission mechanisms.

24 But as yet, that plan and that sort of risk

25 assessment is not, I think, wholly in the public domain.

14

1 a mechanism for us to be held to account for that?

2 I think one of the things that could be

3 substantially improved is, you know, local resilience

4 fora exist as part of the Civil Contingencies Act. It's

5 making sure that the right people sit round the table

6 when there is a hint of emergency, so people with really

7 strong operational experience, with the

8 accountabilities, can sort of guide the reaction locally

9 but can also help to plan, I think, through Pegasus now.

10 **MS CAREY:** Can I ask you, please, about the lead-up to the

11 discharge policy from hospitals to care homes and the

12 care sector more generally. And you say in your

13 statement that the discharge policy and associated

14 guidance was a key concern for the Local Government

15 Association, and that in the beginning, in mid-February,

16 the LGA considered the risk between not expediting

17 discharges versus the risks in doing so once the patient

18 had been discharged, and you say the LGA at that point

19 did not have a definitive position on the balance of

20 risks.

21 Did the balance change, though, Ms Killian?

22 **A.** So I think my statement is clear that it wasn't for

23 the LGA to sort of pre-judge any of the sort of medical

24 advice that was emerging, both in this country and from

25 the World Health Organization. It was a fast-moving,

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1 new virus.

2 I think our position was originally based on the
3 fact that there is such good evidence that the longer
4 someone stays in hospital when they don't need to be,
5 actually the probability of them picking up a disease or
6 losing, sort of, functioning increases. So really
7 strong evidence, which continues to be the case today,
8 that actually enabling people to be moved, if they're
9 well enough, into their own home to be assessed against
10 their needs is a really, like, important feature of how
11 we deliver social care in England.

12 So it felt that some of those principles would be
13 absolutely correct in this scenario, but only if
14 mechanisms are in place to ensure that people could be
15 protected, that as the days emerged, that PPE was
16 available. So, you know, our position, on balance, was
17 actually people being in hospital might cause them to
18 get coronavirus. It was our position that people that
19 were vulnerable might need a bed. So it's on that sort
20 of balance we thought we'd -- cautiously and with
21 conditions enabling people to move out of hospital.

22 But again, best practice is not about moving people
23 into care homes when they do not need to be. It is
24 about making sure that actually people go to their own
25 home. Only about 1% actually should have been admitted

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1 know, recognising that everyone was under pressure at
2 those moments during the pandemic.

3 **Q.** I think you say in the statement that the LGA considered
4 that March 19 guidance to be acceptable, noting that it
5 did not override a care home manager's right to refuse
6 an admission. Does the LGA get any sense of how often
7 a care home manager did in fact refuse to take a patient
8 being discharged from hospital?

9 **A.** So we didn't collect data, and I don't think authorities
10 did, but anecdotally we know that there weren't sort of
11 significant numbers of refusals. You know, many care
12 home managers were incredibly sort of flexible and
13 supportive but recognising they had to protect people
14 within their homes as well.

15 **Q.** And you go on in the statement to say that:

16 "It ... quickly became apparent that the 19 March
17 guidance was problematic at best, and workable (sic) at
18 worst."

19 LGA's words.

20 What were the problems from the LGA's perspective
21 with the 19 March guidance? And if it helps you, I'm at
22 paragraph 334 of your statement.

23 **A.** So we were concerned that -- for a start it felt it had
24 been sort of lifted from a sort of hospital practice
25 guidance. The reality is that care homes are run in

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1 into care homes at that point. But there were some very
2 long and hard and sort of difficult debates about that.

3 **Q.** I think you say in your statement that the 19 March
4 discharge guidance, when it came out, was sent to
5 the LGA at 4.17 on 16 March asking for comments by 6 pm
6 that evening. And you make the point it wasn't possible
7 to respond within just over 90 minutes of notice but the
8 LGA did respond by half past midnight that evening.

9 Did -- can you help with -- did you understand why
10 there was such late argument within the LGA? And
11 perhaps more importantly, did the engagement improve
12 over time?

13 **A.** So, again, you know, we recognised that this was
14 a wholly sort of incredible, difficult, sort of taxing,
15 awful position for the officials to be in, and we
16 recognised that they were working, sort of, furiously to
17 be able to produce guidance, so we were -- we understood
18 why things were being passed to us, at one level, so
19 late, but on the other hand, it made it really difficult
20 to get, sort of, considered responses back to test with
21 experts and professionals that we knew we had available.

22 It was also frustrating for us to know that
23 sometimes guidance was being passed to us to take a view
24 on, but it was under a sort of secrecy seal. That made
25 it harder. But we worked as quickly as we could, you

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1 a very different way. I think we were concerned that
2 the model of discharge that we had endorsed or were
3 familiar with made some assumptions about who would
4 assess people to be able to leave. It was based on
5 a model of really experienced assessors being able to
6 make a judgment that people were fit to leave hospital
7 and be assessed, and we were concerned that that sort of
8 professional evaluation may have been missed.

9 It was also clear that, despite sort of promises,
10 you know, the supply of PPE was not being made
11 available. We were really concerned that, again,
12 testing that had been promised was not available and
13 even where it was, you know, results were not coming in.
14 So there are a number of factors that gave us sort of
15 cause for concern.

16 But it's also true that we relayed some of those
17 concerns on that piece of guidance and other guidance,
18 and, you know, occasionally we were listened to, but
19 I think over a very short period of time, I think there
20 were 11 sets of different guidance offered out about the
21 support given to people moving out of hospital. So
22 I think it was really tricky, I think, for councils but,
23 more importantly, care providers to be able to interpret
24 this and know how to do the right thing.

25 **Q.** I think you say one of the problems with the guidance

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1 was the practical difficulty of isolating people in
2 perhaps some of the smaller care homes.
3 **A.** Yeah.
4 **Q.** Can you help with any sense of scale of, perhaps not
5 necessarily the number of homes, but how much difficulty
6 there was in England and Wales in isolating people in
7 smaller care homes? We've heard, for example, people
8 often had their own bedroom but may have shared bathroom
9 facilities, for example. Can you help with how
10 widespread a problem that is?

11 **A.** I can perhaps provide some supplementary information
12 about sort of the numbers of, you know, smaller care
13 homes, but it's absolutely true that, you know,
14 a significant proportion of care is delivered through
15 small, independent providers. So it may be, you know,
16 a couple of big houses that have been knocked together,
17 so it was just so impractical to think that it was
18 possible to isolate, you know, people (a) into their
19 rooms but into a wing of a very small building. It just
20 was never going to work.

21 Bigger providers in larger accommodation, there was
22 more potential, but still really difficult to organise
23 like that, particularly for residents who may have had
24 dementia. It just felt like a very sort of severe thing
25 and sort of important practical to deliver.

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1 their own homes, and that, I think, should have been
2 a priority. It's also the case that the government
3 wanted to explore the sort of -- the notion of sort of
4 designated settings with sufficient capacity and
5 designated settings in local authority areas to be able
6 to support people. And progress was made on that, but
7 again, that didn't feel like the most satisfactory
8 solution.

9 **Q.** We know that designated settings were effectively
10 brought in from the late 2020 into 2021.

11 **A.** Yeah.

12 **Q.** But can I ask you, please, about an example that the
13 Inquiry has seen.

14 Can I have on screen INQ000545634.

15 This is in April 2020, from someone working in
16 Telford and Wrekin council. It's titled:

17 "Hotel Care Home -- anyone giving this a go?"

18 And can we see there, there was:

19 "... a quick call out to see if any of you are in
20 the same place as me which is about to commission our
21 local Marston's pub and lodge to be a post COVID
22 Community recovery setting for older people.

23 "We are taking a 28 bed hotel and staffing it with
24 our own day care support workers and cleaners ..."

25 And then they go on:

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1 But I'm happy to provide some sort of supplementary
2 statistics about numbers, if that's helpful.
3 **Q.** Well, we know that on 15 April the adult social care
4 action plan specifically stated that asymptomatic
5 discharges should be isolated for 14 days. Was the LGA
6 consulted in the run-up to the publication of the action
7 plan?

8 **A.** So we did have engagement there but again, had concerns
9 about how operationally sort of fit that was. There was
10 an engagement group, there were task and finish groups
11 running at that time, but I think our view was that
12 things only materially improved when Sir David Pearson
13 was brought in to provide that sort of leadership and
14 professional knowledge to the programme.

15 **Q.** Right. That action plan, I think, specifically stated
16 that if appropriate isolation or cohorted care was not
17 available to the local care provider, the local
18 authority would be asked to secure alternative
19 accommodation?

20 And can you help us, Ms Killian, what kind of
21 premises were being considered to -- were considered to
22 be appropriate accommodation for someone who was being
23 discharged from hospital?

24 **A.** So the view of the LGA, then and now, is that the most
25 appropriate place is for people to be able to return to

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1 "... and turning it into a [domiciliary] care/extra
2 care/step down hybrid for when the going gets tough.

3 "We are just sorting the specification [for] this
4 [now] and have a draft project plan underway but could
5 do with a critical friend ... in the same boat to talk
6 [about this]."

7 It may, to some people, sound pretty horrifying, the
8 people that people are going to be discharged to
9 a pub/hotel. Does the LGA have any views about whether
10 that was, in fact, an appropriate setting for discharged
11 patients?

12 **A.** So I think sort of councils with other statutory
13 partners were really, sort of, thinking about all the
14 options to keep people safe, triggered by the
15 requirement of the 12 April guidance. And, I mean,
16 I read this and I can understand why people might be
17 concerned about this as a model. But there was,
18 I think, some careful thinking about whether other
19 settings would be appropriate to enable people to leave
20 hospital, and avoid having to go into a care home.

21 I think the ongoing, sort of, flaw in all the plans
22 was the lack of testing, the lack of understanding of
23 the transmission. But to be fair to my colleagues, it
24 was so pressured, and colleagues really wanted to enable
25 people to be in safe spaces but this is not an ideal

24

1 way, is it, of managing that.

2 **Q.** I think, more generally speaking, one of the concerns of
3 the LGA was issues with the lack of PPE and, indeed, the
4 lack of suitable PPE?

5 **A.** Yes.

6 **Q.** And can I ask you about that -- and can take it as read
7 that we're familiar with the worldwide clamour for PPE,
8 if I may put it like that, but I think in your statement
9 you make reference to the fact that PPE was diverted to
10 the NHS, and indeed the survey found that 42% of
11 respondees said PPE was diverted either very often or
12 fairly often.

13 We've heard a number of pieces of evidence on
14 a similar theme. What did the LGA do when it started to
15 learn that there was certainly a belief by some, if not
16 the reality, that PPE was being diverted or prioritised
17 to the NHS?

18 **A.** So, for me, I think it's going, sort of, back to
19 a principle. In the early days of the pandemic,
20 colleagues in social care were just not prioritised
21 for PPE. It was the case that many care homes, you
22 know, have made use of PPE in their operations
23 pre-pandemic, but they would never have been keeping,
24 sort of, stocks to the level that was required during
25 the pandemic.

25

1 LRFs to enable care home provision but some of the drops
2 were wholly inadequate, not fit for purpose, and, you
3 know, LRFs were sometimes hampered because they didn't
4 have the information about where to drop.

5 **Q.** All right. Can I just ask you there, when you say that
6 some of the drops were not fit for purpose, they didn't
7 contain enough stock, or the stock that they did contain
8 was poor quality or both? Can you help?

9 **A.** Stock volume that we had been promised did not arrive.
10 So we might have been told we'd get, you know, 50,000
11 products, you know, I remember vividly, you know,
12 opening the box -- or opening our container and it might
13 be a thousand products. Some of those were out of date,
14 some of those were not fit for sort of medical or
15 care use.

16 The Clipper service came online, I think in May or
17 June of 2020, and again, that was designed to be, you
18 know, a cool-off arrangement that would allow providers,
19 local government, to go directly into the Clipper
20 system. And things were improving, but even then,
21 again, anecdotal but strong evidence that call handlers,
22 the email processing, again, saying, "Actually, we can't
23 provide what you need today because we've got a supply
24 problem, the NHS has to be prioritised."

25 So, you know, things did improve, but not quickly

27

1 So, from lots of intelligence-gathering that the LGA
2 did, it was clear that this was a really, sort of,
3 significant and urgent problem. It was a problem for
4 frontline care workers, it was a problem for, you know,
5 experienced social workers that should have been in
6 homes being able to support people. It was a problem,
7 actually, for CQC not being able to have PPE to be able
8 to go in and make their assessments.

9 So our experience from the LGA point of view was,
10 despite, you know, very clear stories that PPE was
11 available, it just wasn't.

12 And from a very personal point of view, I mean,
13 I remember chairing a gold meeting one Sunday night,
14 relatively early into the pandemic, and it was a gold
15 meeting that covered the needs of hospitals as well as
16 local government and other bodies. You know, there were
17 just no gowns available. There just wasn't PPE
18 available in any sort of levels to support the
19 functioning of hospitals, let alone care homes. And it
20 was a very difficult moment just to, sort of, work out
21 how do you allocate the very small number of products
22 that we had.

23 So we absolutely acknowledge that the government
24 sought, through the, sort of, national supply disruption
25 route model -- you know, they did deliver drops through

26

1 enough to be able to meet the needs of all providers.

2 **Q.** Can I come back to the -- you mentioned the LRF drops.

3 **A.** Yeah.

4 **Q.** And we know there were number of emergency drops --

5 **A.** Yeah.

6 **Q.** -- I think from March onwards. One of the things you
7 say in your statement at paragraph 553 is that:

8 "This emergency planning had set out the expectation
9 that upper tier authorities ..."

10 What are they please, Ms Killian?

11 **A.** So upper tier authorities are county councils, city
12 councils, London boroughs.

13 **Q.** Thank you.

14 "... that [those] upper tier authorities would play
15 a role in the distribution to social care staff of face
16 masks from the national stockpile ... However, at short
17 notice, the LRF route was introduced ..."

18 And there's a sense in your statement that that was
19 perhaps -- that change in the plan was perhaps not the
20 most helpful. What practical difference did it make to
21 change from having the upper tier authorities
22 distributing to the LRFs doing the distribution?

23 **A.** So individual authorities would absolutely know their
24 care providers. They would have had intelligence about
25 what needs they may have had. LRFs cover sort of wider

28

1 geographies, mostly. So an LRF might cover sort of,
2 say, three or four big single-tier authorities,
3 sometimes. In my case, in Surrey, we had a co-terminus
4 LRF and county council and that made mechanisms easier,
5 actually.

6 **Q.** Right. One of the suggestions that we have heard is
7 that local authorities should hold a stockpile of PPE.
8 Is that something that you would recommend? Is it
9 realistic?

10 **A.** So a number of authorities would have held PPE prior to
11 this pandemic, but, again, their stocks, had they had
12 them, would have been based on assumptions about a flu
13 pandemic, and therefore had a smaller level of stock.

14 I think the issue is the importance of the nation
15 having a supply chain that can be drawn down in the
16 event of this crisis. So it may be that, you know,
17 local authorities can hold it and can distribute it, but
18 the fundamental problem was the lack of supply.

19 **Q.** Can I change to a different topic, please, and changes
20 to the regulatory inspection regime and, indeed, the
21 impact of that on safeguarding.

22 And I think you say that the LGA did not raise any
23 objection to the CQC pausing routine inspections, given
24 that there was the Emergency Support Framework in place
25 to act as either intelligence to monitor risk, or,

29

1 concerns, once those inspections were suspended, that
2 there may be safeguarding risks --

3 **A.** Yes.

4 **Q.** -- but does the LGA have any detail about what actually
5 materialised and whether there were in fact very real
6 safeguarding cases that were brought to light?

7 Because concern is one thing, but did it actually
8 happen, I suppose is really what I'm asking you?

9 **A.** So there were some concerns, I mean, both in relation to
10 older people, but actually to other vulnerable groups.
11 So reporting levels did increase, for example, for
12 women, for example, you know, who had been in domestic
13 settings at threat of harm from their partners. So for
14 a while, referrals about care home issues dropped, but
15 we did see an increase in sort of vulnerabilities about
16 people being in their own homes without support, as
17 well.

18 **Q.** I think in your -- in the survey, if I can have up on
19 the screen, please, INQ000400522_83 and then into 84,
20 the survey asked about this and the bottom section
21 there:

22 "The Authorities were generally supportive" -- or
23 sorry, they were asked:

24 "How supportive were you or not of the Care Quality
25 Commission's decision to temporarily suspend ..."

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1 indeed, to support care home providers that needed some
2 assistance, but there was, nonetheless, some concerns,
3 I think, of the LGA about the ceasing of routine
4 inspections, and what were they, please?

5 **A.** So I mean, CQC's function is very much about sort of
6 operational safety care for people in residential
7 settings. It's a really important tool. And, you know,
8 CQC have -- deliver both planned inspections, but are
9 available if there are enough alerts or signals from
10 a place that would cause it to think there was
11 a breakdown in care provision.

12 So our initial concern was, you know, making sure
13 that where there were safeguarding concerns, that there
14 were mechanisms available. As a local authority, you
15 know, there are statutory duties to make sure that
16 adults are safe and protected, and we were concerned
17 that that initial lack of sort of intelligence gathering
18 maybe had been a deficit.

19 However, as the pandemic progressed, I think local
20 government, with its partners, its statutory
21 safeguarding partners, put in place some really strong
22 mechanisms to assure itself that, actually, people were
23 being protected and sort of safeguarding threats were
24 recognised and dealt with.

25 **Q.** I think -- I want to be clear, there's obviously

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1 Generally speaking, you can see there, 26% and 54%
2 were very or fairly supportive in England, higher
3 figures in Wales, where they were very and/or fairly
4 supportive was 91%.

5 And then if we go, perhaps, to the next page:

6 "How do you feel the suspension of inspections of
7 care homes" -- sorry:

8 "Do you feel that the suspension of inspections of
9 care homes had a negative [effect] ... or not?"

10 In England, yes, 65%. Sorry, 43%; in Wales, 32%.

11 Then perhaps slightly different figures for the nos.
12 In England, 36% of authorities felt it had a negative
13 effect. 59% in Wales.

14 So quite mixed views there about that.

15 What was the overarching concern, though, from the
16 LGA's perspective about whether there was a negative
17 impact on safeguarding or not in care homes?

18 **A.** I think our view was also based on the fact that we
19 knew, and we know, that, actually, suspension of
20 visitors into care homes was a problem. You know,
21 relatives, friends, visiting, they will often -- in the
22 small number of circumstances where there is abuse or
23 harm, they will often spot signs and signals. So for
24 us, yes, we had concern about suspension of inspections,
25 but we were also concerned that actually the mechanisms

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1 to understand potential harm was being, sort of, blocked
2 in this dimension as well. The fact that community
3 health visitors at the beginning were not permitted into
4 homes as well.

5 But, you know, the relationships between councils
6 and providers are strong. I think many councils would
7 have picked up the phone. You know, providers would
8 have rung if they had felt there were concerns. There
9 was a variety of other mechanisms to, sort of, pick up
10 concerns aside from CQC.

11 The issue about not having inspections was also
12 a concern, I think, from providers that if their ratings
13 had been "required improvement" or, you know,
14 "inadequate", there was no opportunity for them to, sort
15 of, be seen to have improved their services at this time
16 as well.

17 **Q.** I think one of the insight reports that was conducted in
18 2020 by the LGA -- can I have up on screen, please, in
19 fact, Ms Killian's statement. INQ000587382_200
20 into 201 -- considered why there may have been an
21 increase in safeguarding concerns raised in the second
22 half of 2020. And you set out there that it was
23 attributed to different factors. I'm not going to go
24 through them all, but if you perhaps just scroll down to
25 the bottom bullet point. There was concerns that the

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1 important way of gathering information. But it's also
2 true that people were protected for -- you know, through
3 other mechanisms as well.

4 I think for us, you know, inspection is important
5 but it's not the only mechanism to ensure people are
6 safe in care homes or their own homes.

7 **Q.** Does the LGA have any view on whether a hybrid model,
8 perhaps of some remote inspection, some in-person
9 inspections, might perhaps redress the balance in some
10 way?

11 **A.** So, I mean, hybrid activity did take place on the part
12 of CQC, but also other safeguarding partners that are
13 crucial, and there's some really fantastic examples of
14 that. Hybrid is fine, but at the end of the day I think
15 great inspectors, you know, can understand and, sort of,
16 see and feel how it is to be in a care home doing well,
17 but doing less well. So I think eyes and ears in
18 a place is crucial, actually.

19 **Q.** Slightly different topic, in relation to the Infection
20 Control Fund, and certainly there is concern that
21 perhaps the Infection Control Fund was not being used to
22 ensure that staff who isolated received their normal
23 wages, which was one of the main aims of the ICF. Were
24 the LGA aware of problems with the ICF not being used
25 for its intended purpose?

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1 rise in safeguarding concerns in second half of 2020 was
2 in part related to "staff not wearing or inappropriate
3 use of PPE".

4 From the LGA's perspective, do you think there was
5 a need for inspections to continue to perhaps ensure
6 that staff were either wearing it or that indeed the PPE
7 was fit for purpose?

8 **A.** So CQC's regime looks at a number of factors, including
9 how safe care is delivered. So they may have well been
10 able to sort of pick up this use of PPE in their
11 inspection. But I just think there are a number of
12 other factors that caused some areas of potential
13 concern.

14 **Q.** Just standing back from a moment, does the LGA have
15 a view now on whether the decision to suspend routine
16 inspections was the correct one and should be a model
17 adopted in the event of a future, perhaps, respiratory
18 pandemic?

19 **A.** So, you know, inspections take time to prepare for, and
20 if done, sort of, correctly, you know, will look and,
21 sort of, establish great things that are happening as
22 well as, sort of, defects. So if there could be safe
23 provision for inspection, if they could be proportionate
24 to the environment that we would find ourselves in
25 a future pandemic, absolutely, yes, because they're an

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1 **A.** We weren't. We were -- we understood why the
2 government, sort of, chose to put in place quite, sort
3 of, onerous grant conditions, including concerns they
4 had about state aid, like, proper use of money, ensuring
5 it was directed. So we could recognise why those grant
6 conditions were in place.

7 We didn't feel concerned that money was being
8 diverted to inappropriate areas, and indeed, there was
9 a lot of bureaucracy to complete those grant requests,
10 and we understand that the Department of Health and
11 Social Care has since audited all of that work and are
12 content that it was spent correctly against the grant
13 conditions.

14 **Q.** Ms Whately told us that accompanying, say, the
15 publication of the Infection Control Fund package, she
16 included a reference that there should be a care home
17 support plan put in place by the end of May 2020 which
18 should be made public.

19 From your perspective, perhaps indeed even as
20 the Chief Executive of Surrey, what did you envisage
21 those care plans would include or might include, and do
22 you have any views about whether it was necessary for
23 them to be made public?

24 **A.** So there was a requirement to produce a plan. And
25 indeed, sort of, grant release was dependent on having

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1 those plans. I think the vast majority of plans were
2 drawn up in good faith and talked about how they would
3 support people in care homes, the expectations they had
4 about people being safe, the really good work that was
5 happening then with the providers, including support to
6 the workforce, including additional payments that were
7 being made.

8 One of the positive things, actually, about those
9 plans, if you look at them now, they sort of illustrated
10 really, sort of, positive, like, good work to make sure
11 that people were safe.

12 **Q.** Can you give us an example, practically.

13 **A.** Yeah. So, for example, support being given into
14 a particular, sort of, care home where -- I'm just
15 thinking of one that -- support being given into
16 a particular care home where, for example, sort of,
17 cash flow was problematic, and there had been really
18 good sort of debate with a provider about, actually, the
19 value of being able to, sort of, forward fund their
20 work, not least to be able to invest in, sort of,
21 workforce reform.

22 So, I mean, these were expected to be dynamic plans,
23 and I think, in part, you know, they also illustrated
24 the continuing, sort of, financial pressure that those
25 providers were under.

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1 encouraged councils to think about in their places, how
2 would they work with health partners to prioritise, say,
3 vaccinations for people from BME communities to make
4 sure that vaccination programmes, you know, prioritised
5 the needs of those people, that where possible, there
6 were, you know, plans in place to deliver those.

7 I think councils were also concerned more broadly
8 about the impact that -- of Covid on BME communities, so
9 there's some really fantastic examples about councils
10 working in partnerships with faith groups, for example,
11 to encourage vaccination take-up, to encourage testing,
12 which also, I think, had an impact on, sort of, the
13 workforce.

14 But I mean, the legacy in this area is really bleak.
15 So working together, I think, as we think about the next
16 exercise about how we really do, sort of, protect those
17 groups of people and enable, actually, people to
18 self-isolate, and I think that was a really profound
19 concern, that some of the members of those communities
20 just didn't feel empowered to be at home or supported.

21 **Q.** Perhaps one of the other bleak areas, to use your
22 phrase, was the measures in place to notify DHSC if
23 a care worker had died, and you say that there was
24 a manual process in place but that LGA considered it
25 unsatisfactory. Does the LGA have any suggestions for

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1 I mean, there was some hesitancy about the plans,
2 because again, the focus was on care homes where many of
3 our members were saying, "Actually, you know, we've got
4 to be able to support people living in their own homes,
5 the carer supporting those living in their own homes, as
6 well."

7 So it felt slightly unbalanced, but that's where
8 I think the government continued to think the risk was.

9 **Q.** Can I ask about a few discrete topics, please,
10 Ms Killian.

11 **A.** Yes.

12 **Q.** In your statement, you make reference to the
13 disproportionate impact of Covid-19 on black and
14 minority ethnic individuals and, indeed, migrant
15 workers, and her Ladyship is familiar with the Public
16 Health England's disparities report that came out in
17 June 2020, but can I ask, what did the LGA do in
18 response to the growing awareness that there was this
19 disproportionate impact on a number of members,
20 particularly of the adult social care workforce?

21 **A.** Yeah. One of the roles we have is about support into
22 councils on really, sort of, sensitive issues like this.
23 So part of our role was hearing back from the sector
24 about, sort of, the incidence and the prevalence of this
25 really, sort of, profoundly distressing issue. We

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1 how notification of adult social care worker deaths
2 could be improved?

3 **A.** I think we were concerned that just having a sort of
4 email and directing people to respond to an email and
5 not actually being clear about what would happen,
6 I mean, was our concern. I mean, many people lost their
7 lives, our workers lost their lives, and it was
8 important to have the data to be able to make
9 a difference in the future, but we were just concerned
10 that an email just might drop nowhere and nothing
11 happened. So there has to be a better system, I think,
12 of understanding which groups would be affected in the
13 future and a better way of recording that, sort of,
14 dynamically.

15 **Q.** And to be collated by who, the Department of Health and
16 Social Care, MHCLG as was?

17 **A.** I think it is important that -- you know, this is about,
18 sort of, local intelligence. I mean, some of our
19 councils serve highly diverse communities and they
20 should have that data. It should be collected I think
21 by Public Health England because they can, sort of,
22 think about what the response to that should be. But
23 throughout the whole of this incident, the issue about
24 sort of data collection, data ownership, the value of
25 data, I think, you know, made things more difficult for

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1 all parties, I think, whether it's on this issue or many
2 others.
3 **Q.** I've asked you a number of questions about care homes.
4 Can I ask you about unpaid carers, though.
5 **A.** Yeah.
6 **Q.** In your statement you say that one council described the
7 impact on unpaid carers as "intolerable", where carers
8 were caring without a break in addition to them
9 providing childcare and supporting the person they were
10 looking after.

11 What role, if any, does the LGA have in trying to
12 support unpaid carers?

13 **A.** Yeah. I mean, councils have a duty to assess the needs
14 of carers and that is a really important duty. I mean,
15 we have millions of carers in this country. I mean,
16 through the pandemic I think their contribution just
17 wasn't recognised sort of nationally, but from an LGA
18 point of view, we were working with councils who were,
19 again, were trying their best to be able to support
20 carers, were, you know, organising colleagues from the
21 voluntary sector to step in to support, you know,
22 organising food parcels, you know, beyond the point when
23 government was funding it, trying to do assessments.

24 But I think, again, the legacy for unpaid carers is
25 a long-lasting one, and again, it's something that has

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1 an increased understanding by people of the need for
2 recognition of the work the adult social care workforce
3 did, that perhaps it might have slipped down the agenda.
4 Do you agree that perhaps there isn't that focus now on
5 adult social care and we've returned to pre-pandemic
6 ways?

7 **A.** I think in many ways we are where we were sort of
8 pre-2020. The only change is the work that's been done
9 on sort of workforce reform but I think as a society, in
10 government, there's just still a really fundamental lack
11 of understanding about how we support older people,
12 those with learning disabilities, for example, to live
13 happy lives. I just, I think we have not made the
14 progress that I and others would have wished.

15 **MS CAREY:** I'm sorry to end on that note, Ms Killian, but
16 that is the final question I have for you. There are
17 some Core Participant questions though, my Lady.

18 **LADY HALLETT:** Thank you.

19 Mr Weatherby. Just there.

20 Questions from MR WEATHERBY KC

21 **MR WEATHERBY:** Thank you very much, my Lady.

22 Good morning, and I ask questions on behalf of Covid
23 Bereaved Families for Justice UK. And just one point
24 from me and it's relating to visiting restrictions and
25 it's something that you've touched on already. At

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1 to be corrected, understood and corrected for the next
2 pandemic. The levels of isolation, the impact on their
3 mental health, I mean, I think is still to be
4 discovered.

5 **Q.** Can I ask you, please, whether the LGA considers that
6 a register of the adult social care workforce would
7 assist in the event of a future pandemic, and if so, in
8 what ways?

9 **A.** I mean, there are, again, at the heart of this is the
10 importance of ensuring that care workers are recognised
11 as a really strong, capable profession. You know, if
12 registration enables that, if registration as part of
13 a new employment and career structure is important, then
14 we would absolutely endorse it. On the other hand,
15 I think we have concerns that a sort of onerous
16 bureaucratic registration system would force people out
17 of the market. So we are keen that through the case
18 review, actually we talk to workers about what they want
19 in the context of workforce reforms that the government
20 are putting in place now.

21 **Q.** Final question, please, and it just picks up on what you
22 mentioned there about recognition. It's a word that her
23 Ladyship has heard mentioned a lot, and in fact I think
24 Helen Whately told us that she felt there was certainly
25 an increased focus on adult social care, that there was

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1 paragraph 573 of your statement you say, and I quote:
2 "The LGA held significant concerns over the impact
3 of visiting restrictions on recipients of care. The
4 restrictions separated clinically vulnerable people from
5 their loved ones, leading to incredible trauma and grief
6 as people died alone or suffered from loneliness or
7 sadness at the absence of a loved one's touch."

8 Does the LGA believe that government restrictions
9 and guidance got the balance right between visiting
10 restrictions as an IPC measure and supporting the
11 wellbeing of residents and their families? And if not,
12 what should we be doing in the future?

13 **A.** Yeah. So I should start by offering my condolences to
14 your families and also to, sort of, recognise the pain
15 that people are living with now, still, post-Covid.

16 I think, sort of, my statement is really clear about
17 how difficult it was. I think from the, sort of, very
18 firsthand experience in my role in Surrey, it was
19 heartbreaking, actually, to, sort of, see the impact on
20 relatives and those living care settings that they
21 couldn't see their loved ones.

22 I think, you know, the science wasn't clear, but, on
23 balance, for a future pandemic, it cannot be that people
24 are separated. I think the trauma that families face
25 now, the trauma of people not being able to see their

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1 relatives -- and I, sort of, experienced that myself --
 2 it was, sort of, inhumane. So I think that really does
 3 have to be a different way of protecting the most
 4 vulnerable, but ensuring that they can have the most
 5 important thing to them, which is, like, love,
 6 basically.

7 **Q.** Yes. How do we do that?

8 **A.** So I think we've got to really work hard through the,
 9 sort of, planning that we're doing now on a future
 10 pandemic. I think we've got to think again about how we
 11 do deliver, sort of, safe protective care.

12 We've got to think again about, you know, whether
 13 it's right in that scenario to place people in homes.
 14 It should have been in their own homes where loved --
 15 you know, that sort of relationship can be formed. So
 16 I think, you know, we've got to work with the science
 17 but I think we've also got to, sort of, remember what
 18 matters to people. And so a whole bunch of objective
 19 tests have to be met.

20 But I think, you know, we've got to have a better
 21 way of engaging with people who have had the experience,
 22 engaging with people that are living in, sort of,
 23 residential settings and talking to them and planning,
 24 and co-design work. Which I think could have made
 25 a difference, actually.

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1 Care Act. But at the heart of the Care Act and other
 2 supporting legislation is this sort of driving principle
 3 about people being supported to be independent and live
 4 well, and for prevention to be in place to ensure that
 5 people can live sort of happy healthy lives as long as
 6 they can.

7 So I think genuinely, through the crisis, councils
 8 absolutely in thinking about support for not just older
 9 people, but a variety of other people, was about
 10 protecting their wellbeing. And sometimes that
 11 absolutely was about their physical wellbeing, but an
 12 awful lot of support went into enabling people to sort
 13 of cope and to address, I think, poor mental health that
 14 was becoming obvious through stages of the pandemic.

15 So I think where councils had a very specific duty
 16 to an individual, of course it was about protection, but
 17 I know, including from my previous role, the importance
 18 that councils placed on making sure that, you know,
 19 people could cope as well as they could.

20 So for many councils, as well as sort of delivering
 21 on their sort of statutory duties, did a huge amount of
 22 work in terms of welfare support, working with the
 23 community and voluntary sector, to support people in
 24 their places, including people living in their own
 25 homes, provided food packaging, you know, delivered sort

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1 I think people were so shocked and stunned about
 2 the, sort of, instant, you know, "We're going to stop
 3 visiting", I think it was terrible for people.

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

5 My Lady, my other two points have been dealt with so
 6 that's --

7 **LADY HALLETT:** Thank you very much, Mr Weatherby. Very
 8 grateful.

9 Now it's Ms Jones, who is over that way.

10 **Questions from MS JONES**

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

12 Ms Killian, I ask questions on behalf of John's
 13 Campaign, The Patients Association and Care Rights UK.

14 And I want to ask you about the support that was
 15 given to care providers to meet their legal obligations.

16 Firstly, and related to the question that
 17 Mr Weatherby just asked, statutory guidance under the
 18 Care Act confirms that the wellbeing principle is
 19 a guiding concept and it places individual wellbeing at
 20 the heart of the provision of care and support. Can you
 21 explain what steps local government officials took to
 22 ensure that wellbeing was properly considered during the
 23 pandemic?

24 **A.** Yeah. So I mean, I'm assuming there's been a lot of
 25 discussion here about, you know, the functioning of the

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1 of online sort of conversations, support. So I think
 2 the wellbeing principle was, you know, in the minds of
 3 social workers making their assessments as well as it
 4 was for councils.

5 But it was -- it was tough to do that, you know,
 6 consistently in a circumstance where, for example, you
 7 know, people couldn't see their families.

8 **Q.** Was the conflict that arose between different aspects of
 9 wellbeing, so the physical wellbeing that had caused the
 10 introduction of things like the visiting restrictions as
 11 compared with the more holistic view of wellbeing, as we
 12 came to understand the damage that those restrictions
 13 were having on people, was that conflict something that
 14 you at the LGA were discussing with the people or had
 15 ever had to balance before?

16 **A.** I mean, I think, sort of, "conflict" is a, sort of,
 17 difficult word. I think many colleagues in local
 18 government, individual social workers, care home
 19 providers, were genuinely trying to, sort of, balance
 20 keeping people safe, some of the most vulnerable people
 21 safe, based on evidence that was emerging from, you
 22 know, Public Health England, from the Chief Medical
 23 Officer, in trying to balance that immediate protection
 24 against, sort of, the wellbeing principles.

25 And I think, as the pandemic progressed, I think,

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1 you know, more and more people believed the need to get
2 those two in sync was imperative. But I think it was
3 really hard at times to do that, including for people
4 that had to self-isolate. They -- these were a very,
5 you know, restrictive bunch of arrangements that people
6 had to live with.

7 But I believe strongly that, you know, staff, both
8 commissioners and providers, really wanted to do the
9 right thing consistently, and sometimes it was just
10 tough to do that.

11 **Q.** Thank you. And then can I ask, what, if any, steps were
12 taken to support care providers in taking individualised
13 approaches to people who need care rather than imposing
14 blanket restrictions?

15 **A.** So, I mean, in the early days of, you know, the
16 pandemic -- I mean, we've talked earlier about sort of
17 multiple sets of guidance that was available, but as
18 things eased -- I don't mean "ease" -- as things, sort
19 of, changed, I think a number of providers went above
20 and beyond to absolutely, sort of, tailor and
21 individualise packages in the context of the provisions
22 that were available to them.

23 And people that run care homes know exactly,
24 I think, about how they should support individual needs,
25 and I know that they worked really hard to meet those

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1 absolutely clear that, you know, local government
2 absolutely knew it had to meet duties towards
3 individuals, and delivered that.

4 **Q.** So when you use the word "flexibilities" in your
5 statement in that way, you mean that the councils still
6 met the eligible needs but did so in a different way
7 because the usual means were unavailable, for example?

8 **A.** Yes.

9 **Q.** And just to put that into concrete terms, you've
10 mentioned day centres, so if, for example, someone had
11 an eligible need of meal support or provision, and they
12 would normally get that at the day centre that they
13 attended and that was in their care plan but the day
14 centre was closed, an alternative could be, obviously,
15 to provide that meal at home or make some other
16 arrangements so that that need was still met; would that
17 be right?

18 **A.** Precisely, yes.

19 **Q.** And an easement, though, would be required, and just to
20 be clear about this, for streamlining of services,
21 instead of providing a genuine alternative it, is that
22 right? Or reducing care to a person that's provided
23 under their plan?

24 **A.** So the matter of easements is a sort of contentious one.
25 Local authorities are, and remain, clear about the

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1 needs in the context of the arrangements that were being
2 forced on them, I think.

3 **MS JONES:** Thank you.

4 Thank you, my Lady. Those are all my questions.

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

6 Ms Beattie.

7 Ms Beattie is over that way.

8 Questions from MS BEATTIE

9 **MS BEATTIE:** Ms Killian, I ask questions on behalf of
10 Disabled People's Organisations, and can I ask you,
11 please, about easements, and when they were required and
12 when they could otherwise be avoided under the existing
13 Care Act framework.

14 At paragraph 669 of your statement you say that:

15 "... most councils were able to find sufficient
16 flexibilities within the existing Care Act framework to
17 avoid the need to [make use of easements]."

18 Is it right that flexibilities in this context is
19 about how eligible needs are met, but not whether
20 they're met?

21 **A.** So, I mean, the Care Act duties are clear, and councils
22 knew they had to meet the needs of individuals.
23 Sometimes it was more complex to meet those needs if,
24 you know, day centres, for example, were shut or there
25 weren't provision in some bits of the sector. But I'm

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1 importance of delivering for people's needs. So to even
2 contemplate an easement was a big thing at that time,
3 and it was about I think publicly saying, "Actually,
4 we're going to have to sort of think about how we
5 deliver needs." I honestly do not recognise a council
6 saying, "We're not going to meet the need", it was about
7 how we would do it differently but still meeting the
8 needs that an individual had.

9 **Q.** So Ms Killian, just to go back to my question, the
10 streamlining of services as opposed to providing an
11 alternative or actually reducing care would be in
12 easements territory and require an easement; is that
13 right?

14 **A.** I'm not sure about the sort of language of streamlining.

15 **Q.** Okay. I think the LGA and ADASS produced some guides
16 I think, for local authorities for -- to explain the
17 easements; is that right? Some joint guides, and that
18 said in terms that streamlining and reducing personal
19 care for a person would be in easements territory; is
20 that right?

21 **A.** So I mean, we sort of commented on guidance and I just
22 feel I'm going to repeat myself again. I mean, the
23 importance was about continuing to meet needs. It might
24 have done it differently and in extremis, you know, may
25 have had to acknowledge, you know, I think in your

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1 language a sort of streamlining, but I think all
 2 councils knew they still had to meet needs effectively.
 3 **Q.** And if that document confirmed that that streamlining or
 4 reducing care was in what was called stage 3 or stage 4
 5 of easements, that was definitely easements territory,
 6 wasn't it --
 7 **A.** Yeah.
 8 **Q.** -- stages 3 and 4?
 9 So again, for example, cancelling home care visits
 10 to assist someone with hygiene or toileting needs
 11 contained in the care plan and not doing anything in
 12 substitute to meet that need would, again, be in
 13 easements territory; yes?
 14 **A.** Yeah, yeah.
 15 **Q.** And is it right that at the time during the pandemic,
 16 local authorities were not under a duty to report
 17 replacement services or flexibilities, if I can put it
 18 that way, to central government, but they were required
 19 by the guidance to report easements; is that right?
 20 **A.** Report incidents? Sorry, I didn't get the last bit,
 21 sorry?
 22 **Q.** Sorry, to report easements. To report their use of
 23 easements.
 24 **A.** Yes, there was a requirement -- if an authority took
 25 a decision to report an easement, then that had to be

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1 councils had done during the pandemic?
 2 **A.** Yes, it's recognising -- to meet a person's needs, you
 3 know. During the time of the pandemic not all
 4 facilities or options were open, so needs were met in --
 5 using sort of different tools or different approaches.
 6 So that's my, sort of, language of "flexibility".
 7 I think, you know, invoking a, sort of, easement was
 8 something that councils considered very carefully and
 9 had reporting requirements attached to it.
 10 **Q.** Do you think that the organisation Think Local Act
 11 Personal was right in their report of October 2020 that
 12 there were different approaches taken by local
 13 authorities across the country, with some using what
 14 they called so-called "flexibilities", and some using
 15 easements, such as there was what they described as the
 16 very grey area between the two?
 17 **A.** So only a very small number of councils chose to invoke
 18 easements. You know, local authorities deliver care to
 19 very different communities in different ways across the
 20 country. It's very different delivering sort of home
 21 care in a rural area versus delivering home care, say,
 22 in a city. So, inevitably, care packages are built on
 23 the basis of what people need, what's available in their
 24 communities. And I think that sort of publication
 25 partly, sort of, highlights the difference that have

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1 put into the public domain, registered with CQC.
 2 **Q.** Not just if they took a decision to report it, but if
 3 they were at stage 3 and 4 and using easements, they had
 4 to red them, didn't they?
 5 **A.** Yes.
 6 **Q.** But at that time, the part 1 of the Care Act duties
 7 which include some flexibility were not subject to any
 8 reporting or, indeed, regulated inspection by the CQC,
 9 were they?
 10 **A.** Sorry, I'm not sure of the point. Sorry.
 11 **Q.** Well, I think -- are you aware that since April 2023,
 12 the CQC has had a role of conducting reviews of
 13 regulated care --
 14 **A.** Yes.
 15 **Q.** -- and functions by local authorities?
 16 **A.** Yes.
 17 **Q.** That wasn't in place during the pandemic time --
 18 **A.** Yeah.
 19 **Q.** -- or during easements' time. So flexibilities weren't
 20 required to be reported but easements were; is that
 21 right?
 22 **A.** I believe so, but I will absolutely clarify the sort of
 23 your language of "flexibilities" versus "easements".
 24 **Q.** Well, I think it's -- Ms Killian, you had used the word
 25 "flexibilities" as saying you said that's what most

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1 always existed and I think drew a sort of line about how
 2 different easements were.
 3 So I'm sort of familiar with that. I think the
 4 language of, sort of, a grey area, again, is not helpful
 5 in that, you know, councils do have packages built to
 6 meet the needs of their communities. They are not, sort
 7 of, one-size-fits-all packages, but absolutely, the duty
 8 to deliver care is paramount.
 9 **Q.** But is one of the consequences, though, that we are now
 10 left without a complete and comprehensive picture of how
 11 care plans were subject to replacement services under
 12 the Care Act, or actually being eased and reduced and
 13 streamlined in stages 3 and 4 territory easements?
 14 **A.** So I don't think there is one single record that sort of
 15 sets out for every recipient what sort of care package
 16 they got, you know, pre-the pandemic, during the
 17 pandemic, and for those small number that were affected
 18 by easements. We don't have a single record.
 19 **Q.** And it may be obvious, but do you accept that a system
 20 can't rely on individual disabled people who are care
 21 recipients of care plans to make complaints or even
 22 commence litigation to establish whether or not the
 23 local authority services being provided during the
 24 pandemic were being provided flexibly or actually
 25 reduced?

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1 **A.** Sorry, can you just say the question again? Do I?
 2 I can't hear brilliantly.
 3 **Q.** Sorry.
 4 **LADY HALLETT:** Basically, the individual recipient of care
 5 or their loved ones can't complain about the level of
 6 care delivered in the care package.
 7 **A.** So I think, you know, disabled people and other
 8 people -- I mean, absolutely have a right to be able to
 9 express their concerns about the nature of care that
 10 they were provided with, and there is a number of routes
 11 in to local authorities, to trigger alerts if people are
 12 concerned through a sort of section 42 and through to
 13 the CQC. So there were mechanisms then; they exist now.
 14 **MS BEATTIE:** Yes. In a pandemic, though, it wouldn't be
 15 right, would it, for a system to rely on individuals
 16 isolated in their homes in pandemic circumstances to
 17 make those -- such complaints in order to find out and
 18 again, a systemic -- systematic oversight of what was
 19 happening in care plans, would it?
 20 **A.** It wouldn't be right for individuals to feel like they
 21 have to do that, no.
 22 **Q.** And is that all the more so in a situation where the
 23 emergency law themselves -- itself brought in for Covid,
 24 the Coronavirus Act, had altered what were the usual
 25 duties to provide and meet needs into a discretionary

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1 (11.37 am)

2 (A short break)

3 (11.50 am)

4 **LADY HALLETT:** Ms Paisley.5 **MS PAISLEY:** My Lady, the next witness is Dr Maria Rossi.6 **DR MARIA ROSSI (affirmed)**7 **Questions from COUNSEL TO THE INQUIRY**8 **LADY HALLETT:** Good morning.9 **THE WITNESS:** Morning.

10 **MS PAISLEY:** Dr Rossi, thank you for attending the Inquiry
 11 today and for providing your statement to this module,
 12 dated 2 April 2025. That statement has been co-signed
 13 with Paul Johnston, chief executive officer of Public
 14 Health Scotland, and Scott Heald, who is head of Data
 15 and Digital Innovation, and the Inquiry understands that
 16 they assisted in the production of the statement; is
 17 that correct?

18 **A.** Yes, thank you.

19 **Q.** Briefly, please, dealing with your background, you hold
 20 a masters in health services research and public health
 21 epidemiology, and since 2005 you have been registered as
 22 a UK specialist in public health medicine.

23 You joined the pandemic effort at Public Health
 24 Scotland in March 2020, where your main areas of work
 25 were in response coordination, including adult social

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1 power? So changing those goalposts, if I can put it
 2 that way.

3 **A.** So I mean, I think it's really important to say, I mean,
 4 the easement provision was there. It wasn't used, you
 5 know, authorities wanted to continue to deliver the best
 6 care packages they could in the circumstances that were
 7 there, and present.

8 **Q.** And is it right that --

9 **LADY HALLETT:** Sorry, Ms Beattie, I'm afraid we're going to
 10 have to leave it there.

11 **MS BEATTIE:** Okay, thank you, my Lady.12 **LADY HALLETT:** Thank you very much.

13 Those are the questions we have for you, Ms Killian.

14 Thank you very much indeed. I'm sorry we had to take
 15 you back to what was obviously a distressing time for
 16 everybody concerned. But thank you very much for your
 17 help, and I don't know how much of this very lengthy
 18 statement you produced and how much your colleagues did,
 19 but could you thank them for all the help that they've
 20 given to the Inquiry as well.

21 I've got a feeling we may be asking you for more
 22 help in modules to come so I can't say goodbye, but
 23 thank you for the help you have given so far.

24 **THE WITNESS:** Thank you. Thanks very much.25 **LADY HALLETT:** Thank you. I shall return at 11.50.

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1 care and general liaison with the Scottish territorial
 2 health boards, the other UK public health agencies, and
 3 the Scottish Government?

4 **A. (Witness nodded)**

5 **Q.** And presently you work at Public Health Scotland as head
 6 of division for environmental and emergency response in
 7 the Clinical and Protecting Health Directorate; is that
 8 all correct?

9 **A.** Yes, and I also have a medical degree from University of
 10 Rome.

11 **Q.** Grateful, thank you.

12 Public Health Scotland is an NHS Board sponsored by
 13 Scottish Government and the Convention of Scottish Local
 14 Authorities on behalf of local government. It is
 15 Scotland's national public health body, which leads and
 16 others work across Scotland to prevent disease for
 17 a long and healthy life and promote health and
 18 wellbeing; is that correct?

19 **A.** Yes.

20 **Q.** Can you assist, please, how did its joint accountability
 21 to both local and national government work in practice
 22 throughout the pandemic?

23 **A.** So the dual sponsorship to Scottish Government and COSLA
 24 is important because public health is actually an
 25 area -- a discipline of medicine but also an area of

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1 other work that has to encompass both health and social
2 care, and we work with government, working on policies,
3 advice, et cetera, particularly during the pandemic
4 phase, therefore it's important that that sponsorship
5 that was there at the start of our organisation, from
6 1 April 2020, made an important contribution to ensuring
7 that that happened.

8 **Q.** The Inquiry is familiar with the establishment of Public
9 Health Scotland in April 2020, and the retention of the
10 Antimicrobial Resistance and Healthcare Associated
11 Infection, or ARHAI, within National Services Scotland,
12 but I just have a few questions, please, focusing on the
13 scope of this module.

14 In your statement you say Public Health Scotland
15 would acknowledge that the coincidence of the start of
16 the pandemic with the establishment of new organisations
17 caused challenges in how it responded to the pandemic.

18 And if we could have on screen, please, INQ000586047
19 at page 2. And this is an email dated 23 April 2020
20 from Dr Ramsay, who was then the Strategic Incident
21 Director for Covid-19, to Angela Leitch, who was the
22 then chief executive. And he said:

23 "This is an update on developments in relation to
24 the PHS work on the Care Homes situation.

25 "The number of people in PHS involved in this work
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1 protection and public health generally are very used to
2 working across organisational boundaries, team
3 boundaries and topic boundaries, so this wasn't an
4 unusual situation to have to work in the pandemic with
5 multiple agencies and organisations, so whether -- at
6 the start of a pandemic, an unusual event, obviously
7 there is a lot of organisation that goes on in setting
8 up a response, which has to happen in very short time,
9 and Public Health Scotland, or Health Protection
10 Scotland as it was prior to 1 April, had the incident
11 and emergency response plan in place, and when the
12 determinations were made, I believe, in late January
13 that this required that type of response, that process
14 kicked into place.

15 **Q.** And do you think that there was some confusion until the
16 time of this email?

17 **A.** I'm not sure I would note it as confusion. There were
18 many people involved in doing a lot of work in very
19 short time frames. So the coordination of that was
20 important and needed to certainly settle at the start,
21 and it took a while for that to settle, mainly because
22 the situation of care home situations had to, by its
23 very nature, involve many agencies. So we didn't have
24 specifically a care home group in Public Health Scotland
25 before the pandemic --

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1 has escalated resulting in a lack of clarity in terms of
2 who has overall responsibility and leadership. I have
3 therefore tried to clarify who within PHS is involved in
4 this work associated with the Care Homes issue and to
5 address how this is being coordinated."

6 Then scrolling down a bit, it says:

7 "In view of the increasing complexity of roles in
8 PHS in relation to this topic and the risks for
9 confusion on overlapping work I called a meeting this
10 evening with Scott Heald, and others to discuss the
11 situation and to try to clarify roles and
12 responsibilities."

13 Were those the sorts of challenges experienced at
14 the start of the pandemic?

15 **A.** Yes, so this relates particularly to the situation
16 within Public Health Scotland, but in the pandemic, of
17 course we had to and wished to work in collaboration
18 with many other agencies. So having a focus within PHS
19 for the likes of care homes was important, and my
20 colleague Dr Ramsay was pointing this out as an issue
21 towards the beginning of April.

22 **Q.** And in the view of Public Health Scotland, did this
23 cause any difficulties prior to 23 April?

24 **A.** I should premise that I joined in -- towards the end of
25 March, but I'm aware that -- well, generally, health
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1 **Q.** We'll come up on to that, please, in just a moment, but
2 if I can look at the response of Angela Leitch, please,
3 who said:

4 "Thanks for this update. That sounds much more
5 joined up than had previously been the case."

6 So do you think that there was further clarity
7 beyond 23 April, and do you think the organisation
8 perhaps got a grip on that clarity early enough?

9 **A.** Yes. By way of example, and Angela Leitch who was our
10 chief executive at the time would have been going to
11 certain meetings, covering certain meetings at the last
12 minute and with, perhaps, colleagues in the health
13 protection area that weren't with her or, possibly,
14 sometimes, not able to brief her and the impression that
15 she had wasn't surprising but it must be said that
16 during pandemic this sort of thing did happen
17 recurringly because there were so many entities that had
18 to play a part in it and I think she's highlighting,
19 particularly in this email from Dr Ramsay -- between
20 Dr Ramsay and herself, the issue, for example, of data
21 when there were many sources of data, everyone trying to
22 put something together in order to support the care home
23 situation and that's being reflected.

24 **LADY HALLETT:** Can I ask you to slow down. I know it's
25 difficult.

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1 **THE WITNESS:** Sorry.

2 **LADY HALLETT:** Don't worry, I have a fast speech pattern

3 too, but we have a stenographer struggling to keep up.

4 **THE WITNESS:** Of course, apologies.

5 **MS PAISLEY:** Thank you, my Lady.

6 And something you just touched upon, you explain in

7 your statement that there were corporate arrangements

8 put in place in Public Health Scotland to drive its

9 response to the pandemic and you say:

10 "It should be noted that from the outset, none of

11 the corporate groups in these arrangements had

12 a specific [adult social care] focus."

13 Was that an oversight or was there a particular

14 reason for that?

15 **A.** A pandemic response has to be ready for anything that

16 arises, and care homes, although an important setting,

17 particularly by way of the nature of the virus, the

18 novel virus that was coming on board was particularly

19 vulnerable, there are a number of settings for which we

20 couldn't, in anticipation, set up processes or pieces of

21 work or individuals dedicated time against for all the

22 time, nor could we always foresee it. So this not

23 something unusual in an emergency response, but an

24 organisation like PHS needs to be prepared to get that

25 coordination into play relatively quickly, and perhaps

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1 and taken on board from that, and still working to

2 improve on coordination, particularly with external

3 partners, and some work also internally.

4 **Q.** And then one final comment, please, from Ms Leitch on

5 this email. And she says:

6 "I had asked [an individual] to coordinate to avoid

7 the confusion that was played out at the meeting with

8 DPHs yesterday but I understand from speaking to her

9 that she hadn't been able to make the connections

10 necessary."

11 Is DPHs -- is that a reference to the directors of

12 public health?

13 **A.** Correct.

14 **Q.** Can you please help, what was the division as between

15 Public Health Scotland and the directors of public

16 health insofar as the pandemic response to the adult

17 social care sector?

18 **A.** So the directors of public health are directors in each

19 of the 14 health boards in Scotland. They report

20 through their chief executives directly to Scottish

21 Government and are accountable -- that's the pathway of

22 accountability.

23 Public Health Scotland is an organisation in itself

24 also directly accountable to Scottish Government and

25 COSLA, and the relationship between the two is that

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1 that's where PHS being a new organisation had

2 a particular challenge, I guess.

3 **Q.** So in the future, is there a specific corporate group

4 that would be set up to deal with that sector?

5 **A.** So we are looking at that and certainly that has already

6 started in the area of data. In the Data and Digital

7 Innovation team that Scott Heald leads, there has

8 already been a review of care home data that has

9 tried -- that has looked at multiple sources of

10 information that can inform the care home situation, and

11 that's even outwith the pandemic but ready for any sort

12 of crisis that could arise.

13 **Q.** Are there any lessons, in particular, to be gained from

14 Public Health Scotland's initial structure over the

15 first few months of the pandemic that could be taken

16 forwards as learning for a future pandemic?

17 **A.** So 1 April had been set as the start for PHS, many

18 months before, I would have thought even a year before.

19 And so in that, in the ensuing time there was much

20 preparation going on for the new organisation. I guess

21 that elements of Health Protection Scotland, as was, got

22 somewhat deviated from the attention of that from

23 December, January of 2020, and therefore that might have

24 taken away from the health protection element of it, but

25 I think that there are many lessons that we have learnt

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1 Public Health Scotland is there to advise the public

2 health elements that boards effect at the front line,

3 and it is -- and it is very much an advisory role that

4 we have. The directors of public health do not in any

5 way report or are accountable to PHS in their work,

6 which is a different model to what may happen in

7 England.

8 So the meeting that Ms Leitch would have gone to

9 with the DPHs would have been something at the start

10 that she went to in order to support the directors of

11 public health, an active -- a very active group

12 currently and during the pandemic, but it was

13 essentially their role, as directors of public health

14 and the health boards, to protect the -- their

15 population based on geographical grounds. Whereas PHS

16 had a national remit in supporting each of them.

17 **Q.** The Scottish Directors of Public Health Care Home

18 Working Group that was attended by Public Health

19 Scotland, one of the main outputs of that group was the

20 'Final Joint Framework for Action - Covid-19 Care Home

21 Settings', which was jointly drafted by Dr Ramsay of

22 Public Health Scotland, and the Inquiry understands

23 that's date in around April 2020.

24 Does Public Health Scotland have any views on

25 whether that sort of document was useful in dealing with

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1 different lines of accountability during the pandemic,
 2 and would something like that help in the future?
 3 **A.** Oh, definitely. I mean, even in non-pandemic times we
 4 work very much with the directors of public health and
 5 their teams on the area of health protection, their
 6 health protection teams, but that was exactly a nice --
 7 a good manifestation of how we work together. What they
 8 agreed in that document, with the input from PHS and
 9 also directors of public health, was no surprise, but
 10 also very helpful to get it down as a schematic that
 11 should be followed.
 12 **Q.** Just finally dealing with background, please, you
 13 explain in your statement that Public Health Scotland
 14 was aware of confusion between the role that Public
 15 Health Scotland played and the role of local HPTs at the
 16 front line. I understand that's health protection
 17 teams. Why do you think that confusion arose and did it
 18 have any impact upon the response?
 19 **A.** So, not infrequently, and it does still happen
 20 sometimes, frontline services will say, "Public health
 21 said that that's what we need to do" or "This is
 22 a guidance from public health", and that generic "public
 23 health" term could mean, depending on the context,
 24 a local health protection team that is directly
 25 supporting services in the health boards, or it could be

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1 So an infection prevention and control remit, it's
 2 understandable that we have four teams that work on
 3 that, but they do work on a four nations approach.

4 If anything goes awry in that relationship,
 5 certainly that can create a problem, but the evidence
 6 base that is gleaned in order to inform guidance, and
 7 indeed policy, should be the same, and should use the
 8 same criteria to judge it, but there can be nuances and
 9 work that goes more or less in depth. So the four
 10 nations approach is paramount, but we appreciate and
 11 understand how that can be slightly different for the
 12 four nations.

13 **LADY HALLETT:** If I can ask you again to slow down.

14 **THE WITNESS:** Sorry.

15 **MS PAISLEY:** There is space then, perhaps, for nuanced
 16 advice in each nation?

17 **A.** Yes.

18 **Q.** Are you aware of whether Public Health Scotland or ARHAI
 19 provided any training for care homes in respect of IPC
 20 during the pandemic?

21 **A.** So the training of staff in services is the
 22 responsibility of the employer. The -- in local health
 23 boards, support for training can come either from the
 24 local infection prevention and control teams, usually
 25 based in healthcare settings, hospitals, or from the

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1 national, ourselves as a national agency, that would be
 2 supporting or advising the health protection teams but,
 3 by reflection, also advising the local services.

4 So it would be important -- a classic example might
 5 be that if a care home had an outbreak and they
 6 reflected that public health had advised them to cease
 7 visiting or undertake certain interventions, what they
 8 sometimes said was Public Health Scotland, and that
 9 wasn't the case, because we did not have a direct
 10 relationship with care homes and services of front line;
 11 that was always through the health protection teams.

12 **Q.** Thank you.

13 Can I move, please, to the topic of infection
 14 prevention and control. And before we come on to the
 15 specifics of who was responsible for the guidance, can
 16 I first ask, in the view of Public Health Scotland, is
 17 nation-specific IPC guidance required for care home
 18 settings in Scotland?

19 **A.** So, we take a four nations approach, and always have,
 20 and all the more so during pandemic. And on the issue
 21 of infection prevention and control, it's important that
 22 any policy or guidance then comes out -- that comes out
 23 is reflective of how each of our systems work. Health
 24 is devolved, therefore our health systems are a little
 25 bit -- moderately diverse between the four nations.

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1 health protection teams.

2 And broadly speaking, although each health board can
 3 do it as best fits them, broadly speaking, infection
 4 prevention and control teams would support healthcare
 5 setting -- training, and health protection teams would
 6 support advice and guidance for -- in community-facing
 7 services such as care homes.

8 However, these are -- there are over 1,100, I think,
 9 care homes in Scotland, and 14 health protection teams,
 10 for example, so the -- any training or advice and
 11 guidance that was brought from the health protection
 12 teams to care homes was very much focused on outbreak
 13 management rather than routine training, and I think
 14 that that's a need that needs addressed.

15 **Q.** And would it be the health protection teams that would
 16 be best placed to deliver that training, in your view?

17 **A.** Interesting question. Something that really needs to be
 18 worked through.

19 The health protection teams would use ARHAI's
 20 National Infection Prevention and Control Manual for
 21 that training, so the resource is there produced by
 22 ARHAI nationally, but who does the training is actually
 23 something for each of the health boards to determine.

24 **Q.** Just a few more brief questions, please, on IPC
 25 measures.

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1 Following 1 April, there were three categories of
2 guidance: health protection guidance that was developed
3 and maintained by Public Health Scotland, health and
4 social care IPC guidance developed and maintained by
5 ARHAI, and then joint outbreak management IPC guidance.

6 How was consistency ensured between Public Health
7 Scotland and ARHAI guidance? So, for example, did the
8 guidance interrelate? Did it have links? Can you help
9 us, please.

10 **A.** I should also point out that there was a fourth element
11 of guidance, and that was coming from Scottish
12 Government.

13 **Q.** Yes.

14 **A.** The links during the pandemic on guidance matters were
15 very easy, so to speak. We had been part of the same
16 organisation up until 1 April, ARHAI and Health
17 Protection Team, as it was, was lodged within NSS, and
18 that relationship continued throughout a good part of
19 the pandemic in a very close way.

20 So when it came time for guidance to be written,
21 on -- in an iterative and infrequent basis, we were
22 working very much in tandem, and in fact, in order to
23 keep up with the changes in policy that then led -- had
24 to lead to changes in guidance, we took the tack, in
25 PHS, that we would link directly to ARHAI's guidance and

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1 participated in with the other three IPCs of the three
2 nations, and the way that that information came
3 ultimately to PHS that were trying to operationalise
4 Scottish policy was sometimes challenging. It could go
5 down a route of directly, ARHAI was directly involved in
6 IPC where decisions were being made and would reflect
7 those back to us, but if there were, understandably,
8 chief medical officers groups involved or Scottish
9 Government policy people involved, the pathway could be
10 more tricky, shall we say.

11 **Q.** Can I just interject at that point. How was that dealt
12 with during the pandemic, practically?

13 **A.** It's a big point of learning, that one, I must say and
14 we've taken that on board to work with the -- across the
15 four nations much more closely on that and to have
16 a recognised structure pathway for that, including with
17 infection prevention control colleagues. Sometimes
18 changes that we would need to reflect in our guidance
19 came to us very late in the day, sometimes even through
20 press briefings by our political leaders. And we would
21 immediately try to find what was meant by it, what the
22 source was, what was the understanding behind it, in
23 order to put it into our guidance, and that took time.

24 **Q.** So better lines of communication may be one way?

25 **A.** Yes.

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1 where it was of additional benefit to provide a little
2 bit more explanation, we did so in our guidance
3 documents, but anything that we put into our guidance
4 that was in relation to a specific point of guidance, if
5 the policy changed, we had to do another version, right,
6 so we tried to keep it through links that that would be
7 the way.

8 **Q.** Now, you refer to two issues, if I can put it that way,
9 in your statement, and you say at 2.3.12:

10 "The lack of clarity contributed to some of the
11 delay in issuing changes in relation to the guidance,
12 since IPC policy positions came to PHS guidance teams
13 sometimes at third hand ..."

14 Then you also explain that PHS was responsible for
15 supporting local health protection teams in the
16 management of outbreaks, yet the guidance was owned and
17 composed by ARHAI. And you call that an operational
18 challenge.

19 How were those challenges addressed in the pandemic,
20 and is any further work ongoing?

21 **A.** Okay, so those are two separate issues. So briefly, the
22 first one was really more about the pathway of
23 communication from decisions being made or attempting to
24 be made at a four nations basis by an IPC cell,
25 infection prevention control cell that ARHAI

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1 **Q.** And just finally, in Module 3, Dr Phin told the Inquiry:

2 "I think it's important to realise that ARHAI's
3 remit is defined because it's part of the NHS Assure,
4 which is for healthcare-associated infection. That does
5 leave a gap when it comes to community settings."

6 He referred to:

7 "... the role of Health Protection Scotland in
8 taking the principles that were developed for the
9 healthcare setting, and adapting and trying to use them
10 in those wider settings. This is something that's being
11 discussed at the moment to make sure that ... gap is
12 addressed, and we're in ... discussion with ARHAI, and
13 indeed with Scottish Government about how we address
14 this going forward."

15 Was there a gap, then, as regards IPC guidance for
16 the sector during the pandemic, and if so, how is that
17 being addressed?

18 **A.** So during the pandemic, as I mentioned earlier, we were
19 working very closely with ARHAI. I think probably the
20 gap there was more along the lines that ARHAI's remit
21 very much concentrates on healthcare settings, and in
22 pandemic, suddenly we had to do a lot of infection
23 prevention control, interventions, guidance, in relation
24 to the wider community. Things like physical distancing
25 was something that it was -- we were aware of it as

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1 a concept, a potential public health intervention but,
 2 actually, finding the evidence base to back that up
 3 required time, and that wasn't in the outright remit of
 4 ARHAI, hence we did have a gap that Public Health
 5 Scotland very much wishes to address now.

6 **Q.** Is work going on, then, to address that?
 7 **A.** So there is work going on in terms of how these gaps
 8 that may relate to ARHAI's work and Public Health
 9 Scotland's work, how do we address them? Are there true
 10 gaps, and how can we fill them?
 11 But the other way to think of that is, which is what
 12 we're also proactively taking forward, is working more
 13 closely at four nations basis. So UKHSA, on our
 14 guidance formulation, and you may be aware of the Mpx
 15 outbreaks that arose in recent year, we were very much
 16 more embedded in with their guidance teams than during
 17 pandemic, and we hope to see more of that going forward.

18 **Q.** Can I change topic, then, please, and can I move to
 19 hospital discharge and testing, and moving to March
 20 specifically, please. And on 12 March 2020, Public
 21 Health Scotland produced guidance for the sector, and
 22 the Inquiry heard evidence from Ms Freeman last week
 23 that this followed concerns raised on 11 March of
 24 reports that some care home providers were restricting
 25 new admissions and visitors.

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1 the local Health Protection Team to self-isolate.
 2 People who are self-isolating and have no symptoms do
 3 not pose a risk to others."
 4 My question is, given the emerging knowledge of
 5 asymptomatic infection and transmission so, for example,
 6 in February 2020, SAGE had been unable to rule it out,
 7 is there a possibility that that guidance may have
 8 provided false assurances?
 9 **A.** It could have done but it was very much a developing
 10 understanding that we had with this novel coronavirus.
 11 **Q.** Now, moving to 13 March then, please. You explain that
 12 the Scottish Government reminded services to continue to
 13 discharge patients into care homes, and the letter that
 14 was sent stated:
 15 "In the early stages where the priority is
 16 maximising hospital capacity, steps should be taken to
 17 ensure that patients are screened clinically to ensure
 18 that people at risk are not transferred inappropriately
 19 but also that flows out from acute hospital are not
 20 hindered and where appropriate are expedited."
 21 And you explain that it has not been possible to
 22 identify advice provided directly by HPS, as it then
 23 was, to Scottish Government. However, the letter did
 24 include a link to the Health Protection Scotland
 25 guidance.

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1 Was Public Health Scotland asked to include any
 2 information in the 12 March guidance on accepting
 3 patients from hospital or wider hospital discharge
 4 issues?
 5 **A.** So I can't quote you all the dates of each of our
 6 guidance documents, but I do know that there was also
 7 a PHS guidance document on that topic, the 13th. So
 8 things were happening quite quickly.
 9 In terms of discharges from hospitals, those were --
 10 into care homes -- that was something that the
 11 government were looking at very closely at that stage.

12 **Q.** But just specifically, do you recall if anything was
 13 asked to be included about that topic in the 12 March --
 14 **A.** Not as yet. That was being figured out, so to speak,
 15 and worked through with support of UKHSA and the Chief
 16 Medical Officer's team, et cetera.
 17 **Q.** And we'll come on to that in just a moment, but can
 18 I please have on screen INQ000189305, which is the
 19 12 March guidance and on page 11 under the heading "Home
 20 Visits/Care at Home", can I take it, then, that this was
 21 in part relevant to domiciliary care?
 22 **A.** Yes.
 23 **Q.** And that guidance said:
 24 "People who have been in close contact with
 25 a confirmed case of COVID-19 are also being advised by

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1 In those circumstances, then, is it the view of
 2 Public Health Scotland that it should have been
 3 consulted on the contents of that letter?
 4 **A.** So the letter that you're referring to is the letter
 5 from Scottish Government, not from us --
 6 **Q.** Yes.
 7 **A.** -- yeah. Yes, as the Public Health Agency for Scotland,
 8 we take very seriously our advisory role to the health
 9 boards but also to Scottish Government. That may have
 10 to do something with us starting as an organisation,
 11 since -- we worked closely with Scottish Government even
 12 before the institution of PHS. But when the pandemic
 13 came along, I think that our specific and structured
 14 advisory role to government was not as clear as we would
 15 have wished it to be, and we were often involved in such
 16 discussions through, perhaps, the Chief Medical
 17 Officer's team, but not directly in advising ministers.
 18 **Q.** Are you able to assist with what the view of the -- of
 19 Public Health Scotland was about discharges at that
 20 time? Did it think it was a sensible idea? Was it
 21 a requirement? What was the conversation in Public
 22 Health Scotland?
 23 **A.** Yeah, so in the March, it made sense in that we could
 24 see this pandemic coming. We could see what was
 25 happening in other countries, and the severe challenges

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1 that the health systems were undergoing with that, and
 2 so it was very logical that we had to make space for the
 3 more severely affected individuals who required hospital
 4 care. Therefore, creating that space, by ensuring that
 5 only people who required to stay in hospital was what
 6 was happening, was very much the right policy to
 7 undertake.

8 There are always challenges with healthcare systems
 9 nowadays. One very clear one is that of delayed
 10 discharges, and that was an issue at the time in March,
 11 that it would make sense to find a better place for
 12 individuals who did not require to be in hospital for
 13 clinical purposes anymore, but should be supported in
 14 going either back home or to -- or placement for their
 15 home.

16 So we could see how that was a very important issue
 17 to consider, and as the knowledge and understanding of
 18 how the novel coronavirus was working, we also became
 19 very clear that one pathway, the one into care homes,
 20 had to be addressed carefully.

21 **Q.** And if I can focus on 13 March, Public Health Scotland
 22 had a key role in testing and contact tracing. Did
 23 Public Health Scotland have an awareness of the number
 24 of tests available at 13 March?

25 **A.** Generally speaking, yes, throughout that period of
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1 has been progressed, most definitely.

2 **Q.** And was Public Health Scotland ever specifically asked
 3 if there would have been enough tests available to test
 4 all patients on discharge from 13 March?

5 **A.** I think we knew that there wouldn't be, in terms of the
 6 priority for testing at that time was diagnostic. The
 7 system needed to make sure that people who had
 8 coronavirus, the Novel Coronavirus, and required
 9 hospital care, were going into hospital care with that
 10 knowledge. So it was understandable that the primary
 11 priority for testing at the time was diagnostic.

12 **Q.** And given that you've said that Public Health Scotland
 13 didn't have access to the numbers, is it right to say
 14 that it was never actually investigated if there would
 15 be enough? Was it an assumption that there wouldn't be
 16 enough?

17 **A.** We had numbers to the tests -- we were kept briefed of
 18 the tests on a pretty much daily basis of how many tests
 19 were available at UK level in Scotland -- but we didn't
 20 have access, ready access, to the numbers of people
 21 coming out of care homes. But yes, that would have been
 22 useful. Coming out of hospital, sorry.

23 **Q.** Thank you.

24 Now, the letter sent by Scottish Government also
 25 said, based on the emerging picture around Covid-19,
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1 expansion of testing we were kept very much briefed.

2 **Q.** And did Public Health Scotland have access at this time
 3 to the numbers of people being discharged from hospitals
 4 to care homes?

5 **A.** That was more difficult.

6 **Q.** Would that have been helpful information to be provided
 7 to Public Health Scotland?

8 **A.** Yes, indeed.

9 **Q.** Is that data that is capable of collection, and if so,
 10 who should collect it in the future?

11 **A.** So that was a big challenge of the -- I'm sure we'll
 12 come on to it -- the report from Public Health Scotland
 13 undertaken by University of Edinburgh and Glasgow
 14 colleagues, where they had to look at the discharges
 15 from hospital to care homes. And if they didn't have an
 16 actual denominator of individuals to whom this related,
 17 then they couldn't do the work. A lot of time was spent
 18 in deciphering what that denominator was, what the
 19 numbers of individuals were that were going -- that had
 20 a pathway from hospital to care homes, using multiple
 21 sources of data, because it wasn't there automatically.

22 **Q.** Is it now available? So, in the event of a future
 23 pandemic, is that readily available information?

24 **A.** I would have to check if it's readily available but it's
 25 certainly -- the methodology that was used at the time
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1 that the CMO advice suggests that long-term care
 2 facilities should be subject to social distancing. Was
 3 Public Health Scotland asked to provide advice on the
 4 social distancing in care homes at that time?

5 **A.** If by "advice" you mean as I would, that were we asked
 6 to seek the evidence base by which that was -- that was
 7 the thing to do? Not specifically.

8 **Q.** Not specifically. Was it discussed with Health
 9 Protection Scotland, as it then was?

10 **A.** Yes, and a lot of the information that we had would come
 11 from our colleagues down south.

12 **Q.** To combat the risk of potentially asymptomatic patients
 13 being discharged into care homes, what is Public Health
 14 Scotland's view on whether all new admissions should
 15 have been isolated either before or upon entry to a care
 16 home from 13 March?

17 **A.** So the isolation of individuals transferring from
 18 hospitals, where we knew there was Covid, to care homes
 19 where, unless -- at that stage, unless people were
 20 symptomatic, we assumed that they didn't have Covid, was
 21 very important.

22 We agreed with that policy as isolation would be one
 23 of the hierarchies of control to institute if you're
 24 trying to remove a risk from a population. So that was
 25 a very sensible albeit challenging thing to do.
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1 Q. And do you think it should have come in from 13 March in
2 retrospect or in hindsight?
3 A. What happened at that stage is that we were very much
4 working on a basis of symptoms being a -- evidence of
5 infection, and the advice at that stage was anyone who
6 had symptoms certainly would often not go to -- they
7 wouldn't take that pathway into care homes. But anyone
8 who had been in contact with someone who had symptoms or
9 a diagnosis in Covid in hospital, ie, a contact of
10 exposure, was advised to be isolated as far as was
11 possible at that stage. That's how --

12 **LADY HALLETT:** Can I ask something about that? Sorry to
13 interrupt.

14 Given that Ms Paisley put to you earlier, the basis
15 of someone being infectious even though asymptomatic had
16 not yet been ruled out, and I appreciate that as
17 scientists you act on evidence but, as I've heard the
18 expression a number of times, the absence of evidence --
19 I can't remember which way round it is, but anyway, the
20 fact that you don't have any evidence doesn't mean that
21 it's not going on, surely the wisest course would be to
22 say: look, we think this is only transmitted
23 symptomatically, but just in case, we're going to
24 recommend that everybody that's going from a high-risk
25 environment like a hospital is put into isolation.

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1 through a very vulnerable community?
2 A. But if they were able to keep to the isolation
3 principles, which they should have been able, and most
4 of them did, in a care home where rooms, for the main,
5 are single, then they would have been able to keep the
6 individual isolated for the period of time accorded.
7 **LADY HALLETT:** I think that was the point of my first
8 question, but anyway I'll leave it to you, Ms Paisley.
9 **MS PAISLEY:** Thank you, my Lady.
10 Can move to 26 March, please, and there was Scottish
11 Government clinical guidance for nursing homes and
12 residential care residents published on that day, and
13 that incorporated Health Protection Scotland advice, and
14 the guidance by that stage was: individuals being
15 discharged from hospital do not routinely need
16 confirmation of a negative test.

17 My question is: to what extent, in the view of
18 Public Health Scotland, was that decision based on
19 testing capacity?
20 A. I would assume as a policy decision that was the major
21 factor.
22 Q. And Public Health Scotland had also produced an updated
23 version of its guidance on that day. What was the
24 difference in reality between the guidance being
25 produced by the Scottish Government and the guidance

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1 Wouldn't that have been the sensible course?
2 A. It could be, but we also have to consider -- and here's
3 the discipline of public health, where it comes in -- we
4 have to consider a number of factors when we provide
5 that advice to people who are working at the front line,
6 and if, for example, as we've heard, there were issues
7 of PPE supply or training in the care homes, or even the
8 buildings -- in the main I think we're adapted for that,
9 but if those were issues, then issuing such
10 a recommendation on the basis of what we call the
11 precautionary principle might not have been the best at
12 the time.

13 I think there's little doubt that symptoms, and at
14 the very start of somebody with symptoms, who might not
15 even realise that they're coughing inadvertently, is
16 a high-risk time, and therefore, that was taken as the
17 signal to put interventions in a place.

18 When it became clearer from others' experience and
19 studies that were being done that solely relying on that
20 might not be sufficient, then the advice changed.

21 **LADY HALLETT:** But again, going back to principle, surely it
22 should have been -- the advice should have been: care
23 homes, unless you have the PPE, unless you have the
24 isolation facilities, do not accept these people from
25 a high-risk environment because it might then spread

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1 being produced by Public Health Scotland at this time?
2 A. So, generally speaking, and in relation to this, the
3 Scottish Government guidance included more clinical
4 notions that were very useful for care homes to use and
5 abide by. Public Health Scotland does not have
6 a clinical function per se. We're looking at the public
7 health aspects of interventions and risk assessment,
8 those that relate to a population, in this example
9 a population of a care home, and the risk factors that
10 might make somebody more or less vulnerable to it.
11 Whereas the Scottish Government guidance, with its
12 clinical advisers, was also able to provide background
13 information and advice on, for example, the condition of
14 dementia that many of the individuals would have had who
15 were in care homes, and other things, such as
16 therapeutics, if that were needed.
17 But that wasn't the remit of Public Health Scotland
18 guidance, so they added to that.
19 Q. Now the Inquiry has heard evidence from both Ms Freeman
20 and Ms Lamb that mandatory isolation for seven days,
21 either in a hospital or in a care home, was introduced
22 on 26 March, and an annex was added to the Scottish
23 Government guidance on that date.

24 Can we have on screen the updated Public Health
25 Scotland guidance at page 17, INQ000189302.

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1 And this deals with 14 days' isolation for an
2 exposed individual. However, it doesn't mention the
3 seven days' mandatory isolation.

4 Do you think there could have been a risk, then,
5 that care homes could have been following the one piece
6 of guidance that didn't mention the mandatory isolation?

7 **A.** So, I'm pretty confident that this guidance that you've
8 put here, which I think you noted as 26 March from PHS,
9 would have also noted the seven-day issue. We have to
10 be really clear here and -- seven days of isolation was
11 what, at the start of pandemic, was advised for people
12 who were diagnosed with Covid or thought to have Covid
13 because of symptoms. And that reflected the period of
14 their infectiousness as determined from the onset of
15 their symptoms.

16 **Q.** If it helps, this does deal with the seven days
17 isolation for someone who is symptomatic?

18 **A.** Yes.

19 **Q.** But the Scottish Government at this point said that all
20 residents should be isolated, and the isolation period
21 could be in hospital or in isolation to ensure that they
22 do not develop new symptoms. And so it's this, it's the
23 seven-day isolation for everybody else, that I've been
24 unable to locate.

25 **A.** So remember that at this point in time, people who had
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1 **A.** Yes.

2 **Q.** Do you think that the multiple sources of guidance in
3 Scotland caused confusion, and going forwards, is there
4 a way that that can be addressed?

5 **A.** I am confident it did cause confusion, because we had
6 feedback on that, and I know that Scottish Government
7 had that too. I think we need to work out what to do
8 next time in a crisis, but let's remember that,
9 generally speaking, it is not for -- the Scottish
10 Government rarely puts out guidance in that that is
11 reactive and needs to work in terms of incidents. That
12 is the role of PHS.

13 The reason Scottish Government were undertaking that
14 was because we were in that emergency footing type of
15 scenario, whereby Scottish Government was leading, it
16 was leading the pandemic even for the roles that PHS
17 would normally have in an outbreak that wasn't
18 a pandemic.

19 **Q.** In respect of guidance provided to the sector, then,
20 what was the impact of the emergency footing on what
21 Public Health Scotland was able to produce regarding
22 guidance?

23 **A.** Our guidance essentially was operationalisation of
24 policy that Scottish Government was developing. In an
25 incident such as Mpox, for example, we would be
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1 Covid would not normally have been transferred to care
2 homes. So those are the folk who would be isolated for
3 seven days.

4 The individuals who would be on the pathway from
5 hospital to care homes would have been those that had
6 possibly been exposed to the virus in the hospital, and
7 therefore it was the 14-day period that anybody going
8 into a care home should relate to, because we were
9 waiting for the incubation period of 14 days to
10 complete, so that -- and that they should be an
11 isolation during that time, in case the symptoms arose.

12 **Q.** So that's for people who have been exposed.

13 **A.** Exposed.

14 **Q.** But I understand the Scottish Government's policy was
15 that all residents should be isolated on admission for
16 seven days?

17 **A.** It could be that that was in reflection to the early
18 point of pandemic, where the days were changing about
19 what -- how long somebody was infectious for, but
20 I think what you're suggesting there, and I'm not quite
21 sure if that's correct, I don't recall seven days being
22 a period of incubation period at any point. It could
23 have been 10 at some stage, it could have been 14.

24 So --

25 **Q.** Can I just ask a general question on guidance, please.
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1 determining -- well, we would be determining PHS policy,
2 not government policy, obviously, but we would be
3 leading on the response in an incident that was
4 non-pandemic, as opposed to in the emergency footing, it
5 was Scottish Government that clearly, legitimately and
6 for good reasons, was leading on the response to the
7 pandemic.

8 So our role then followed suit to make guidance to
9 inform the local health protection teams on what needed
10 done by operationalising that policy, how to make it
11 happen.

12 **Q.** In January 2025, Public Health Scotland produced health
13 protection guidance methods for guidance development.
14 Do you think that might go part of the way to address
15 the potential for confusion in the various roles?

16 **A.** So the methodology piece of work that we've done on
17 guidance follows on from 10, 15 years of the Scottish
18 Health Protection Network doing similarly, and this
19 January document revises that, makes it more robust. It
20 is a guidance methodology that is very collaborative,
21 takes in stakeholder views, and allows quite an
22 extensive time period to happen. That methodology, it
23 wasn't possible to apply it in pandemic because things
24 were happening so quickly.

25 There is provision with the methodology for a next
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1 pandemic or, indeed, an incident that requires quick
2 guidance to take, so to speak, shortcuts, which may very
3 well be along the lines of not being able to consult for
4 as long as needed but certainly that methodology is what
5 we use now, and we look -- we are looking forward to
6 seeing how we could apply it better for a next pandemic.

7 **Q.** The Inquiry heard evidence -- returning to hospital
8 discharge, please, the Inquiry heard evidence from
9 Ms Lamb that the use of step-down facilities or
10 designated settings was considered by the Scottish
11 Government and effectively discounted due to the
12 potential for staffing issues or risks to people,
13 including additional disruption. Was Public Health
14 Scotland ever asked for advice about the use of
15 step-down facilities?

16 **A.** I am not aware, but it might not have come to me at the
17 time.

18 **Q.** In the view of Public Health Scotland, is that something
19 that should be considered for a future pandemic,
20 particularly if it is factored into planning?

21 **A.** I think the rationale given for which that path wasn't
22 undertaken in Scotland is pretty sound. I think what
23 needs to happen differently is that there needs to be
24 greater efforts in training up care homes, should this
25 happen again, in the notions of IPC, in order to make

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1 34 days unless something is done to alter this predicted
2 spread/trajectory ...

3 "The results were stark: over 50% of the staff were
4 already test positive, so infected, and an even higher
5 [percentage] of the residents were infected ...

6 "The conclusion is that by the time an outbreak is
7 spotted using existing criteria -- it is already too
8 late to control it effectively ...

9 "The conclusion of a [public health] meeting on
10 Friday was that the emphasis on testing is misplaced and
11 that the real emphasis must be on preventing infection
12 getting into [care] homes at all."

13 And I'm sorry, I chopped and changed through that
14 quote there, but it's quite a long quote.

15 These were clearly worrying matters for the sector.
16 Was this escalated by Public Health Scotland to anyone
17 in particular in the Scottish Government that you
18 know of?

19 **A.** Yes, this would have been something that, I don't know
20 exactly to whom, but that government would have been
21 aware of, the work and the dialogue that we had with the
22 directors of public health. I'm not sure if sometimes
23 they would have been copied into such emails or at the
24 meetings. So, yes.

25 **Q.** Now, the Inquiry understands on 21 April Ms Freeman

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1 isolation a true intervention for that setting.

2 The problem this time is that they weren't trained
3 up. They didn't have as much equipment or PPE needed
4 as -- that would have been able to address that issue.
5 It wasn't so much that a separate facility was required;
6 the facilities could work if the training and the
7 equipment were in place.

8 **Q.** Do you think that it would be worth having step-down
9 facilities as an option? So should it be included in
10 planning for the future?

11 **A.** It should be included as an option, yes, because we
12 don't know what the next pandemic will be and it could
13 be that the organism lends itself to those types of
14 facilities being needed, definitely.

15 **Q.** But in the view of Public Health Scotland, perhaps if
16 there was greater training in place, that --

17 **A.** In infection control, yeah.

18 **Q.** Can we please have on screen INQ000584250, which is an
19 email from Dr Ramsay to a Director of Public Health.

20 And I believe this email makes reference to the
21 Easter 6 study, and there's a long quote about that, so
22 I won't read it all out. But it says:

23 "... [PHE's] prediction so far is that they expect
24 based on current trends for 90% of all care homes to
25 have been affected with outbreaks within the next 30 to

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1 announced it would be mandatory for all hospital
2 patients to have two negative tests on discharge, which
3 I'll come to in a moment. But as a result of that email
4 and the concerns, do you think that there should have
5 been wider testing announced at that time beyond just
6 the two negative tests on discharge, if there had been
7 capacity?

8 **A.** So the thrust of the email that was just on screen there
9 was outlining that the evidence that had been gleaned
10 from the Easter 6 studies undertaken by UKHSA, or
11 through UKHSA, was showing that by the time the care
12 home itself had appreciated that they had ingress of the
13 virus into the home, it was highly likely that many more
14 folk than they expected were already infected, and,
15 therefore, doing testing would illustrate that, fine,
16 but would it have impact?

17 Because at the point when a care home is diagnosed,
18 so to speak, with an outbreak, you must get the
19 interventions into place. It has to switch to the
20 interventions.

21 So testing everybody at that stage would have been
22 redundant, so to speak, once -- once there was almost --
23 well, one case, we came to learn, by the time you have
24 one case. The importance was getting the interventions
25 into place.

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1 And the point that's being made in the email is that
2 we need to shift our emphasis to prevention of it
3 getting into care homes at all, because by the time it's
4 in, it was so transmissible that it spread rapidly.

5 **Q.** And in respect of the decision to require two negative
6 tests on discharge, on 20 April, Public Health Scotland,
7 the CMO directorate and the CNO directorate, had advised
8 for 14 days' of isolation, and again, the position was:
9 no test required prior to admission.

10 What were the reasons, or were they similar to what
11 you've just been discussing for advising that no test
12 was required prior to discharge?

13 **A.** So if you are instituting isolation for anybody coming
14 from hospital into a care home, anyone, then the test
15 itself doesn't add much if you have somebody who has no
16 symptoms, because you are undertaking the intervention
17 that you would put into place, whether their test was
18 positive or negative.

19 So the emphasis on testing, as is outlined in the
20 email, was overly egged, shall I say -- shall I suggest.

21 The important thing was the interventions were
22 effective and impactful once they were undertaken. And
23 the testing in this instance, the initiative, did create
24 problems, as you had an individual who was, for all
25 intents and purposes, ready to go back to a home, or

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1 you say:

2 "... in one instance, [Public Health Scotland]
3 advised Scottish Government of delays in 11 sets of
4 guidance as [Public Health Scotland] waited for
5 a response from the Scottish Government: six of the
6 11 guidance documents had been with Scottish Government
7 for nine days ..."

8 And the Inquiry has seen that a number of those
9 specific pieces of guidance were relevant to the care
10 sector, including both care homes and domiciliary care.

11 Did Public Health Scotland agree with the need for
12 the PAC process, and did it cause any particular delays
13 as regards to the adult social care sector?

14 **A.** So PAC stands for policy alignment check?

15 **Q.** Yes.

16 **A.** Which meant exactly that: that there were concerns on
17 the part of the Scottish Government that Public Health
18 Scotland's guidance sometimes they thought seemed to
19 come out in misalignment with the government's policy.
20 Maybe that was the case in some instances, I can't put
21 my finger on any, but what it did do was, in its
22 operationalisation, it may have allowed for a less black
23 and white way of a policy being rolled out at the
24 front line.

25 So if I can give an example of the discharge

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1 indeed their home, the care home, but was being
2 prevented from doing so because a test had not come back
3 as negative.

4 And there are many reasons why a PCR test for Covid
5 came back as positive and yet it did not necessarily
6 present a risk to the care home. One of them is if you
7 had the interventions in place at the care home, you
8 could isolate the individual from others, but another
9 one is also that we were learning all the time about
10 these -- the PCR tests for -- and this novel virus, and
11 the PCR test is able to assess how much generic
12 material -- or assess the presence of generic material,
13 but not necessarily whether the virus is viable.

14 **Q.** I wonder if I can just -- perhaps in summary then, it's
15 that -- not that the tests weren't important but the
16 view of Public Health Scotland was that there were other
17 measures which were perhaps more appropriate in care
18 homes at this point than just testing itself?

19 **A.** Yes. And testing had its own potential disbenefits or
20 harms.

21 **Q.** Can I ask a question, please, on the PAC process that
22 was put in place by the Scottish Government.

23 Now, the Inquiry has seen evidence submitted by
24 Public Health Scotland that this process led to delays
25 in guidance that was produced. And at paragraph 8.5.11

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1 testing, for example. Yes, the policy was: anyone going
2 into a care home from that certain date from a hospital
3 required two negative tests. But there were instances
4 where that wasn't in the best interests of the
5 individual and wasn't actually needed even to safeguard
6 the care home. But with a policy that was as black and
7 white as that, that would -- we were getting reports
8 from -- via our health protection teams from care homes
9 that that was preventing people going back to their home
10 when in fact they were fit enough to do so.

11 So if we didn't put that nuance, that explanation,
12 into the operationalisation of the policy, then that
13 would clog up the system, so to speak.

14 So those types of reflections in our guidance
15 sometimes were felt to be misaligned with the policy
16 when, in fact, there was good justification for that.

17 A test always has to be consented --

18 **Q.** Just to clarify that, in the view of Public Health
19 Scotland, was it necessary and did it lead to delay?

20 **A.** I would like to see in a future pandemic that we didn't
21 require a PAC process.

22 **Q.** Grateful.

23 I have two final topics and I just wonder if I could
24 ask, if you could keep your answers just a little bit
25 shorter, if that's possible, please.

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1 A. Sorry.

2 Q. On data, the Inquiry understands Public Health Scotland
3 acknowledges that there were gaps in respect of the data
4 it held regarding care homes. Can you please give
5 a brief overview of the difficulties in respect of data
6 and whether any steps have been taken since to resolve
7 them?

8 A. A key one I've already highlighted is that for
9 individuals who are being discharged from hospitals to
10 care homes, and although the information could be
11 gleaned from multiple data sources, that was something
12 that we're working on just now. We have a very good
13 pathway of data for notifiable diseases and organisms,
14 an electronic pathway from the health boards'
15 laboratories to Public Health Scotland. So that worked
16 well.

17 There were -- there was information, for example, on
18 even care home outbreaks that we didn't have a system in
19 place for, but if we had had, would have made things
20 much easier, but also, for outbreaks of all sorts of
21 settings, not solely and we're working that up with the
22 systems that we have in place to make that a much more
23 routine element of data.

24 Q. And briefly, then, dealing with visiting guidance. In
25 your statement you say in retrospect, a more nuanced and
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1 would have been important to review more regularly and
2 ease up on the restrictions.

3 Q. And just one final point before I ask for your final
4 reflections. I understand Public Health Scotland wish
5 to clarify whether it had any role in the regulatory
6 inspections during the course of the pandemic, and
7 I just wonder if you could assist with that.

8 A. Yes, we had no role in that -- we had an advisory role
9 to Care Inspectorate as we did when requested.

10 Q. Now, beyond anything we've already covered in your
11 evidence; are there any further recommendations you
12 would urge the Inquiry to consider, please?

13 A. So I think we've touched on the role of Public Health
14 Scotland in advising government. We would like to see
15 that more structured as we move forward, particularly
16 for a next pandemic. We haven't touched very much on
17 the human rights-based approach that we've already done
18 much work with Scottish Government in the sphere of care
19 homes, but we would like to see that progress, and it
20 will do through a code of practice on Anne's Law, but
21 bearing in mind that there still needs to be
22 safeguarding from what our health protections do in
23 supporting care homes that have outbreaks.

24 The testing we've also touched on, and it would be
25 really very useful to have some sort of evaluation of
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1 locally sensitive approach might have been implemented
2 for care home settings in the summer of 2020, and a less
3 restrictive visiting regime for some of this period
4 would likely have led to some preventable illness and/or
5 deaths arising. Where does Public Health Scotland see
6 the balance lying in respect of visiting restrictions in
7 the event of a future pandemic?

8 A. So visiting restrictions for a care home were addressing
9 the risk of the virus coming into the home when it
10 wasn't already there.

11 A key mitigation for that was vaccination once it
12 was ready. So that came in December 2020. After that
13 period, and a bedding-in period of rolling out of the
14 vaccination and individuals reacting to that through
15 their immune systems, that would have been the time to
16 start to reduce on the restrictions, the quite heavy
17 restrictions that were in place, both for visiting and
18 other elements, and the impression is that the
19 restrictions went on for too long. This was in the
20 hands of Scottish Government, who were leading on the
21 response, and we would have wished to have been able to
22 influence that more and shorten the time period whereby
23 visiting restrictions were in place, and other
24 interventions.

25 So vaccination would be a key point after which it
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1 testing during a pandemic at population level. The very
2 expansive -- it's not specifically related to care
3 homes, but that was part of it.

4 And I guess, finally, strengthening IPC. And we've
5 touched on the collaboration both at four nations basis
6 and with other organisations, including ARHAI.

7 **MS PAISLEY:** Thank you very much.

8 My Lady, those are my questions.

9 **LADY HALLETT:** Thank you very much, Ms Paisley.
10 Ms Mitchell, who sits up there.

11 **Questions from DR MITCHELL KC**

12 **DR MITCHELL:** I appear on behalf of Aamer Anwar on behalf of
13 the Scottish Covid Bereaved.

14 Donald Macaskill, the CEO of Care Scotland, that's
15 the membership body for organisations that provide care
16 in care homes, home care and housing support across
17 Scotland, has given evidence to this Inquiry, and part
18 of that evidence related to the relationship between
19 Public Health Scotland (or, as it was then, HPS) and
20 itself. And he said that they were disappointed with
21 the process of the development of the guidance of
22 13 March.

23 He said:

24 [As read] "We found that there was a minimum level
25 of engagement with Public Health Scotland in the time of
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1 the guidance, as was seen both here in the necessity to
2 both repeat that guidance ..."

3 And that meant to change the guidance from the early
4 days of 13 March to the later guidance:

5 [As read] "Mainly as a result of our remonstrations
6 later in the month, we found both here but also through
7 the main, professional respect from Public Health
8 Scotland and its understanding of the social care sector
9 and its unique situation, particularly in relation to
10 infection prevention and control in care homes, to be
11 wholly regrettable."

12 Were you aware of the views of Care Scotland at that
13 time, ie March 2020?

14 **A.** I was aware of it. I wasn't involved directly in that
15 aspect.

16 **Q.** Were there any steps taken by Public Health Scotland to
17 resolve the issue?

18 **A.** So there were a number of groups that Scottish Care as
19 well as PHS partook of in the sphere of care home work
20 throughout the pandemic. So that would be a key way of
21 undertaking that.

22 The other way was through the advice that was being
23 given to government, and the feedback that Scottish Care
24 were offering government, and trying to play into that
25 and provide our advisory role a little bit better. But

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1 but we did produce the 12 March and then we produced the
2 13 March. So you can imagine that the time to consult
3 with various partners would have been very challenging
4 and limited, and that's not to say that we shouldn't
5 find a better way of doing that, obviously, but there
6 were time imperatives based on something that, actually,
7 we were trying to operationalise what was coming from
8 government, so even getting that took time.

9 **Q.** Indeed, I wholly understand the imperative of time. It
10 just seems a very short period of time for that whole
11 sector to respond in that way, given we know what the
12 limitations of the guidance were available for the care
13 sector. Do you think it was too short?

14 **A.** Yes, all of our time was too short to undertake the
15 challenges that we were dealing with, definitely.

16 **Q.** Moving on, then, in relation to testing, what
17 Mr Macaskill said was this:

18 [As read] "Against that backdrop we then had the new
19 coronavirus being introduced, and we were very clear as
20 an organisation, listening to our clinical colleagues
21 out in the field that they needed additional reassurance
22 and simply saying 'We leave this to the professionalism
23 of clinical assessment', I'm sorry, it didn't wash at
24 the time. I communicated that to the Cabinet Secretary
25 and I indicated what we wanted and needed was testing to

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1 that -- as I've mentioned before, that was already quite
2 challenging.

3 **Q.** Well, I'd like to ask about the feedback that Care
4 Scotland gave. Care Scotland indicated that they had
5 limited engagement in respect of the guidance on
6 13 March, and Mr Macaskill was asked whether or not he
7 was given time to consult, and he was asked:

8 [As read] "Is it correct, I think you were only
9 consulted, is it, on 12 March about the draft guidance?"

10 And he said:

11 [As read] "Yes. And given the quite tight
12 timeframe, a matter of hours to make comments. And it's
13 not just in terms of admission; we made comments about
14 the reality of how difficult it was to transfer a system
15 of essentially infection prevention and control
16 methodology developed for an acute sector such as
17 hospital into an environment such as a care home,
18 particularly as a residential, but including a nursing
19 home, which was first and foremost somebody's home."

20 Were you aware of the fact that Care Scotland
21 considered it had been given insufficient time to have
22 input into this process of the guidance of the 13 March?

23 **A.** Yes, and time and pace were a big limitation of everyone
24 in the pandemic effort. I can't remember when -- what
25 the date of the previous guidance to the 12 March was,

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1 evidence a negative test, which, with nothing else,
2 could mean -- and we appreciate this testing was for the
3 moment", and I think you've highlighted that caveat in
4 your evidence already" -- and we appreciate that the
5 testing was for the moment but it would mean a reduction
6 in the potential period of isolation for an individual
7 in a care home."

8 Were you aware of the views of Care Scotland about
9 the need for testing before discharge?

10 **A.** Yes, I can't say precisely when, but yes.

11 **Q.** Do you think that would have been before the policy was
12 put in place to allow without discharge?

13 **A.** I can't say.

14 **Q.** Given the views of Care Scotland's undeniable expertise
15 in this area, why were those views and their concerns
16 not followed?

17 **A.** So you've noted the understanding of Care Scotland in
18 relation to the tests to be applied to individuals
19 coming from hospital to care homes, and the seeming
20 understanding that, if two negative tests derived from
21 an individual who was still in hospital, but making
22 their way to a care home, meant that their isolation in
23 the care home would reduce in days, that's not the case.
24 I think it's -- I think that was part of the problem of
25 the overreliance on testing, that there were -- it was

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1 very difficult and challenging. We were all learning,
 2 but it provided false assurance in many instances. For
 3 someone, an individual going from an area of risk,
 4 hospitals, to an area of, let's assume no risk, a care
 5 home that didn't have the virus as yet, if they were
 6 negative upon departure from the hospital but had not
 7 been in so-called isolation at that point, they carried
 8 that risk for another 14 days into the care home,
 9 therefore the negative tests would have been not very
 10 much help at all.

11 **Q.** I see what you say in relation to false confidence and
 12 I think, my Lady, picked up on this in her question to
 13 you. It was at a time when the very most vulnerable
 14 people were at greatest risk, and there were no other
 15 procedural safeguards in place, so surely even though
 16 limited as it was, it was better than nothing?

17 **A.** Well, there were other possibilities. You could keep
 18 the individual in hospital, but at that point you had to
 19 balance the risk of staying in hospital, for someone who
 20 otherwise didn't require to, from the benefits of not.

21 You could, as we advised, have them in isolation in
 22 the care home, and if a care home struggled with that,
 23 they had the Health Protection Team to advise them on it
 24 24/7, and we worked seven days a week at that stage, but
 25 there was also an on-call service that the care home

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1 or the results or the conclusions, but strongly
 2 suggested that they could have been outlined more
 3 clearly and that is the extent of -- not the extent, but
 4 the nature of the changes undertaken for the April
 5 report, in addition to including some further
 6 information that had come to light.

7 **Q.** Indeed, further information including some wrong
 8 instances that people were included in care home
 9 discharges when they weren't?

10 **A.** So I think there was an instance of six discharges that
 11 were re-categorised as not being from hospital to care
 12 home, and that was a reflection of the challenges around
 13 the data. And in the interim, after the publication in
 14 October, the team had noted that there were six
 15 discharges relating to three people who had not actually
 16 gone from hospital to care home, and therefore, in the
 17 April report, they were excluded.

18 **Q.** But there was also a different emphasis placed, was it
 19 not, on the understanding of a causal relationship
 20 between positivity and outbreak in care homes?

21 **A.** So what was being assessed was the discharge from
 22 hospital and some further information was done on
 23 whether a person was tested and tested negative, tested
 24 positive, or untested in further analysis, but that
 25 didn't change the conclusions, and did not increase the

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1 could call upon if they couldn't figure it out, if they
 2 had difficulties with equipment -- I'm talking about the
 3 isolation once the person had transferred.

4 And we've heard also about facilities could have
 5 been used, as step-downs, but that also was considered.

6 So there were choices, and choices have to be made
 7 on the basis of the balance of harms and risks -- and
 8 benefit. Sorry.

9 **Q.** There came a stage when the -- when a report was brought
 10 out in relation to where Covid may have come from when
 11 entering care homes, and it included staff movement, but
 12 also included the possibility of a relationship between
 13 positivity and outbreak in care homes and then, I think,
 14 as you'll understand or, perhaps, you can confirm you do
 15 know, that at a later stage the report was slightly
 16 changed as a result of the Office for National
 17 Statistics getting in contact?

18 **A.** Yes.

19 **Q.** Are you aware of that?

20 **A.** Yes, yes.

21 **Q.** And are you aware of the reasons why it was changed?

22 **A.** Yes, I've seen the letter from Mr Humpherson who made
 23 reflections on the October version report which PHS then
 24 revised, according to his advice, into the April
 25 version, and he did not object to the methodology used

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1 causality of the study, because the study was not of
 2 a -- using the method that could outline cause and
 3 effect, it could only give an observation as to what may
 4 be acting here in terms of risk factors, and the
 5 dominant risk factor was the size of the care home.

6 **Q.** Indeed, and part of the difficulty with the whole report
 7 was that the data -- you've referred to data earlier --
 8 was very limited in relation to the period of time when
 9 the first discharge was made; is that correct?

10 **A.** Limited in what way?

11 **Q.** The data was limited in respect of there being little
 12 information in relation to testing because there was so
 13 little testing being done?

14 **A.** The team that undertook the report took all tests and
 15 all people discharged as they could identify. The
 16 challenges were around how they gleaned that. So yes,
 17 there was always potential for certain individuals or
 18 discharges to have been missed.

19 **Q.** Indeed. Moving on, then.

20 You touched upon visiting restrictions and I'd like
 21 to take you back to that. One of the most distressing
 22 post-pandemic issues for people that lost loved ones, as
 23 I'm sure you may appreciate, was that there was no
 24 consistent visiting guidance given by any public body to
 25 any care home, and as a result, people now consider

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1 whether or not they should have done things differently
2 or they blame themselves, they should have tried harder,
3 and of course, that's clearly not their fault, and that
4 should be made clear.

5 Ought, in retrospect, do you think Public Health
6 Scotland should have provided some guidance, even at
7 a high level to allow people to know when it was
8 appropriate to ask for a visit and when not?

9 **A.** We did do that in our guidance. We outlined that for
10 a large part of the pandemic, that when there were the
11 severest of visiting restrictions in place, that there
12 should be, based on individual risk assessment, the
13 possibility to attend to visit a loved one in a care
14 home in that end-of-life phase, or to relieve distress.
15 So we did give those high-level pointers.

16 I think the point that you're understandably making
17 is that could be left to interpretation, but I'm afraid
18 that's the way that risk assessment in the public health
19 sphere works. There has to be a review at that
20 individual level, and it doesn't have to take long at
21 all, of what the harms and the risks -- the harms and
22 the benefits are of undertaking a certain action.

23 And if a care home manager was thinking: gosh, this
24 guidance, I'm not sure what they mean by distress, they
25 could have picked up the phone to the Health Protection

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1 three.

2 But even there, if none of those three were
3 available, it was perfectly fine for an exception --
4 a fourth person to come on board. And that's where that
5 risk assessment tries to help the process.

6 And the third tier was, if for some reason it was
7 completely clear that there should be no visits into the
8 care home, then only in those instances would a named
9 person, one per resident, not be allowed in, but only
10 for end-of-life or distress situations.

11 **DR MITCHELL:** Thank you.

12 My Lady, those are my questions.

13 **LADY HALLETT:** Thank you very much, Ms Mitchell.

14 Thank you very much indeed, that completes the
15 questions we have for you. Thank you to you, obviously,
16 Dr Rossi, for your help but also to your colleagues who
17 helped contribute to the witness statement provided.

18 And don't worry, if there's stuff included in the
19 witness statement, I promise you, that's always
20 considered as well as the oral evidence you've given.

21 **THE WITNESS:** Thanks.

22 **LADY HALLETT:** So thank you very much indeed. I shall
23 return -- I'm sorry, we have a lot to get through today
24 and I have to rise early, so 1.50 pm.

25 (1.06 pm)

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1 Team and the onus should not be on the relatives and
2 friends that found themselves in the midst of that.
3 That is true. That will have been very difficult for
4 them, but there were -- there were resources in place to
5 try to support that process, and allow for exceptions,
6 two of which were outlined in our guidance.

7 **Q.** If there were such guidance and were such resources
8 available, but the experience of the Scottish Covid
9 Bereaved was that they were at a loss, going forward,
10 would it be better, then, if such guidance was made
11 perhaps more strongly or more obvious to those that
12 would need it?

13 **A.** So the initiative around that's led to Anne's Law has
14 tried to address that, and has, to all intents and
15 purposes, addressed that, but many of the principles
16 that are outlined now in statute through Anne's Law,
17 over the course of the pandemic came into being even
18 through our guidance. So at one stage -- and I can't
19 recall when, perhaps even a year into the pandemic -- we
20 tiered the type of visiting that might take place in
21 a care home: from routine, when there was no outbreak,
22 to named persons, where every individual could lodge
23 with the care home management the names of three people
24 that, if there were an outbreak and residents were
25 limited to one visitor per day, it could be any of those

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(The Short Adjournment)

2 (1.50 pm)

3 **LADY HALLETT:** Ms Hands.

4 **MS HANDS:** Good afternoon, my Lady. May I please call
5 Mr Paul Featherstone.

6 **MR PAUL FEATHERSTONE (sworn)**

Questions from COUNSEL TO THE INQUIRY

7 **LADY HALLETT:** Thank you for coming to help us,
8 Mr Featherstone.

9 **MS HANDS:** Mr Featherstone, you're attending today as the
10 Chair and Founder of the National Association of Care
11 and Support Workers, or NACAS; is that right?

12 **A.** That's correct.

13 **Q.** And in addition to the roles that you hold within NACAS,
14 is it also right that you have worked as a support
15 worker in domiciliary care, and provided care to your
16 mother, who had dementia?

17 **A.** That's also correct.

18 **Q.** And you have provided a statement to the Inquiry which
19 can be found at INQ000569768, and within that, you have
20 explained how it is informed by your own knowledge, the
21 experience and evidence from NACAS members, including
22 through two surveys that were undertaken; is that right?

23 **A.** That is right.

24 **Q.** Now, you have explained how NACAS represents and

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1 provides education, resources and training for care
 2 workers both in domiciliary and residential care?
 3 **A.** Yes.
 4 **Q.** And that includes nurses who are employed,
 5 self-employed, or agency staff?
 6 **A.** Correct.
 7 **Q.** So is it right to say that you do not represent care
 8 home providers?
 9 **A.** That's also correct.
 10 **Q.** Now, NACAS has seen its membership grow substantially
 11 from around 4,000 in March 2020 to around 15,000 today.
 12 What do you think has led to such fast and significant
 13 rise in membership?
 14 **A.** Well, I think it's because of our mission statement.
 15 Our mission statement was to provide support, career
 16 support, to the care workforce.
 17 The overriding catalyst for me to set up NACAS was
 18 to shine a light on the care workforce, and I think that
 19 the members see that they belong to something that is
 20 exclusively for them, and they get a lot of support and
 21 encouragement from it.
 22 So I'm -- if I'm allowed to say this, I'm quite
 23 proud of the fact that we've gone -- you know, our
 24 membership has tripled in, what, three or four years,
 25 and some feedback that we've had from members actually

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1 I think there was a general concern that: could they
 2 cope? Pre-pandemic -- I mean, it's well known that
 3 there are significant staff shortages even today, but at
 4 the start of the pandemic it was an unknown, and I think
 5 there was a lot of uncertainty from the membership.
 6 But I think that uncertainty has been somewhat
 7 waylaid by the resilience of the workforce. They've
 8 found a way, they've coped, and they've managed through
 9 what was a very, very difficult period of time.
 10 **Q.** And what do you mean when you say public perception of
 11 adult social care, and what was the impact of that
 12 during the pandemic?
 13 **A.** Well, if I may say, I always described the social care
 14 workforce as the invisible visible workforce, because
 15 much of what we do is behind closed doors, whether it's
 16 in a nursing home or it's in a person's own home,
 17 whereas our National Health Service, the wonderful
 18 doctors and nurses, people can see what's going on day
 19 to day, but in social care it's not. So that's the
 20 perception, I think. People don't think about social
 21 care until they actually need it.
 22 So it's something we need to get changed. The
 23 narrative needs to change around what care working is.
 24 It needs to be seen as a distinct profession in its own
 25 right, along with our colleagues in the health care.

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1 mentioned the fact that they are so pleased that they
 2 found NACAS and that they are happy to be -- you know,
 3 proud to be members.
 4 So, yes, I'm very pleased of where we are now, and
 5 in the short space of time that we've been in existence.
 6 **Q.** Yes. And I think you said NACAS is UK wide but is it
 7 right that the majority of your members are based in
 8 England?
 9 **A.** That would be correct.
 10 **Q.** Do you know what percentage of members are based in the
 11 devolved nations?
 12 **A.** This would be a loose estimate but I would imagine 60%
 13 of our members are from England, with the other 40%
 14 being split across the -- Scotland, Northern Ireland and
 15 Wales.
 16 **Q.** And you have explained in your statement that two of the
 17 key reasons why NACAS believes that there was a lack of
 18 resilience in the adult social care sector at the time
 19 of entering the pandemic, are significant staffing
 20 shortages, and public perception of the adult social
 21 care sector, along with a few others in your statement.
 22 So if I may deal with the first, what were NACAS's
 23 members' experience of the shortages in the workforce as
 24 we entered the pandemic?
 25 **A.** Well, I think they were genuinely worried that --

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1 **Q.** And what impact do you think that perception had at the
 2 start of the pandemic?
 3 **A.** I think -- I mean, it's difficult to quantify impact,
 4 but I just think that social care -- because it seems
 5 the Cinderella service to the NHS, I just think that
 6 there was a misunderstanding of what social care stands
 7 for and what it is. I mean, I think that's probably the
 8 best way I can put it.
 9 **Q.** And you have described how the lack of resilience in the
 10 workforce at the start of the pandemic led to an
 11 increased workload and responsibility for those that
 12 were working in adult social care, and the impact that
 13 had on their mental health, wellbeing and the long-term
 14 retention and recruitment within the sector.
 15 Firstly, do you know if there was sufficient
 16 training and support for care workers to deliver the
 17 additional tasks?
 18 **A.** As far as I'm aware, the training for social care, in my
 19 own experience, is hit or miss. One of the things that
 20 we provide as an association is access to better quality
 21 training -- or we like to think it's better quality
 22 training.
 23 I think that the workforce are reasonably well
 24 trained -- well, better than reasonably well trained.
 25 I think they're well equipped to do the jobs that they

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1 are doing.

2 In terms of the training throughout the pandemic,
3 I don't have a particular comment about that, but just
4 to say that the workforce do receive what I would
5 consider to be adequate training, more than adequate
6 training.

7 **Q.** What about access to mental health support and wellbeing
8 for staff during the pandemic?

9 **A.** Well, I mean, again, that's one of the things that we
10 were able to offer as an association is access to --
11 sorry, excuse me, health and wellbeing support to the
12 membership. You know, we could give them access to
13 counselling sessions and things like that. Because
14 without doubt, our members, again, said that they felt
15 as though their mental health was deeply affected by
16 working through that pandemic.

17 So we tried to, as best we can, or could, offer some
18 kind of mental health support to the membership, because
19 it was needed.

20 **Q.** When was that support available from?

21 **A.** Where?

22 **Q.** When, sorry.

23 **A.** It's always been a benefit of the association to get
24 access to mental health, so it's been there from 2019.

25 **Q.** And was there a lot of uptake for that support during

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1 you've listed three that you have deemed most
2 noticeable, and I'd like to go through those with you
3 today.

4 So the first is that there was a lack of care sector
5 visibility and representation within government. Where,
6 in particular, do you believe that there was a lack of
7 visibility? So was that central government, local
8 government, or public health?

9 **A.** Central government. I personally believe that because
10 social care was misunderstood, is misunderstood, and to
11 some degree I think it still is, there was that complete
12 lack of visibility. There was -- it was all -- at the
13 start, it was all NHS, NHS, NHS, and nobody was talking
14 about social care, which was odd, to say the least.
15 I mean, they go hand in hand, social care and the NHS.
16 But you would never have thought, in my humble opinion,
17 that there was a social care sector at the start of the
18 pandemic, because it was never spoken about.

19 **Q.** Mm.

20 **A.** And it was quite frustrating to see that lack of
21 visibility and lack of acknowledgement.

22 **Q.** And I think you have included in your statement some of
23 your members' responses to survey questions around this
24 topic. So I'm at your paragraph 36 and 37 if that
25 assists. One of the questions in that survey was: did

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1 the pandemic?

2 **A.** I can't give you specific numbers but I do know from
3 feedback from members they were very grateful they had
4 access to that, and those that did use it found it very,
5 very, very useful.

6 **Q.** Were you able to provide it to everybody that required
7 it, or came to your service for that support?

8 **A.** Yes.

9 **Q.** Another consequence of the staffing shortages that
10 you've described showed through the respondents to one
11 of your surveys, where they reported that there'd been
12 changes to care ratios, and in your statement you quote
13 a NACAS member who said that:

14 "... terrible staff shortages meant that there were
15 two carers and one nurse on night shifts for 48
16 residents. For more than a year, me and many others
17 worked on this 'ratio'."

18 Were those kinds of practices and experiences
19 widespread, from your experience?

20 **A.** I can only refer back to what the members have said
21 through our surveys and I would concur that that was
22 fairly widespread during the pandemic, yes.

23 **Q.** You also say in your statement that there are a number
24 of systemic and structural issues that impacted the
25 ability of the sector to respond to the pandemic, and

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1 the government make the right decisions during the
2 pandemic? To which 78 responded, "No", and several
3 members reported that there appeared to be no long-term
4 planning or strategy in government decision making?

5 And at paragraph 38 you have provided some examples
6 from your members. Could you perhaps summarise some of
7 those for us?

8 **A.** Well, I just think what you're hearing there are the
9 voices from the front line that there is -- there was no
10 cohesive -- what's the word I'm looking for? There was
11 no cohesive communication, if you like.

12 So I can only go on what the members are saying
13 through their survey. They lived it. They were there.
14 They were experiencing what the government was or was
15 not doing. So I am going to defer to our members,
16 because, I mean, unfortunately I wasn't active.
17 I wasn't an active care worker during the time of the
18 pandemic. So if that's what our membership are saying
19 to us, "This is what happened", I think we need to
20 listen to them and learn from that, if that makes any
21 kind of sense.

22 **Q.** Yes, thank you, Mr Featherstone.

23 One of the policy decisions that you have referred
24 to in your statement is around the hospital discharge
25 policy. So what was NACAS's view on the policy and

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1 perhaps your experience around its implementation?
 2 **A.** Okay, I think the discharge policy into care homes was
 3 ill advised at best. It was not a good decision to
 4 discharge Covid-positive patients into a care home.
 5 We were able to play a minor part in bringing that
 6 into the public eye. As an association, we were
 7 contacted by Sky News, to find out whether or not we had
 8 any members who had had experience of discharged
 9 patients coming into care homes, and we were able,
 10 through our network of members, to put the Sky reporter
 11 in contact with a care home provider in the south west.
 12 And that -- through that engagement with that reporter
 13 and that care home owner, we were able to play a small
 14 part in bringing that much more into the public eye.
 15 I'm not going to say here we were the cause of it or the
 16 reason for it, but we certainly played a small part.
 17 **Q.** Could you perhaps, if you know, tell us a little bit
 18 more about the experience that you were hearing from
 19 those care homes or from your workers directly?
 20 **A.** It's just that they were just having to think on their
 21 feet as to how best to protect the staff within those
 22 care homes, whether it's creating Covid rooms and things
 23 of that nature, but they were absolutely having to think
 24 outside the box, if you like, to keep everybody as safe
 25 as possible. That was coming through to us from some of
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1 **A.** Well, I think restricting visiting into a care setting
 2 is in and of itself a draconian measure. If you're
 3 caring for somebody with, for example, advanced dementia
 4 they're already in a confused state. And not to see
 5 their loved ones, which may have been, you know,
 6 a source of extreme comfort for them during that
 7 pandemic, I imagine it would have caused even more
 8 confusion. Why am I not seeing my wife or my husband?
 9 And I think if the care homes were allowed to
 10 think -- not for themselves, but been able to think:
 11 what can we do to the best of our ability to make people
 12 safe -- that's the staff and the residents -- and allow
 13 them access to their loved ones?
 14 I mean, it's fundamental that you'd want to be close
 15 to a loved one, especially, you know, at end-of-life
 16 care, for example.
 17 So I think to restrict access to loved ones into
 18 a care home, I think was extreme. I think there should
 19 have been more thought given to how it could have been
 20 done to allow people access to their loved ones.
 21 I mean -- yeah, I mean, it's quite an emotive topic, but
 22 people should have had access to their loved ones.
 23 It's -- to me, it's fundamental and it's -- they should
 24 have had the right.
 25 And I think if the care homes were given that
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1 our members.
 2 **Q.** Did you hear about any issues that they were having with
 3 implementing some of those measures, for example, like
 4 you've just said, around cohorting or isolating
 5 patients, residents that were coming in?
 6 **A.** I don't have any specific examples to give you. Again,
 7 I can only refer back to what was in my statement from
 8 our members, through -- you know, through the survey
 9 questions, but I don't have any other experience -- you
 10 know, knowledge or experience to share with you today.
 11 **Q.** Okay. And what about any concerns that you may have
 12 heard around testing before discharge?
 13 **A.** Again, I think the members again were very concerned
 14 that there was no testing or very limited testing prior
 15 to discharging people into care homes. Which, looking
 16 back at that, was nonsensical. There should have been
 17 a layer of protection provided before someone, bless
 18 them, who is living with Covid or suffering from Covid
 19 is discharged into a care home.
 20 **Q.** Turning then to another topic and that's visiting of
 21 loved ones in care homes. You have told us in your
 22 statement how some of your members have observed that
 23 the restrictions on visiting were different between care
 24 settings. Are you able to help us as to why you think
 25 that might have been?
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1 flexibility to be able to say, "Well, if we did this
 2 measure, if we implemented that measure", we could let
 3 one or two family members in to see their loved one.
 4 **Q.** And you have touched there on the impact of the
 5 restrictions on the residents of care homes, but in your
 6 statement you've also included some examples of the
 7 impact on staff.
 8 **A.** Mm-hm.
 9 **Q.** So if we may have on screen, please, INQ000569768,
 10 page 18, paragraph 60. Thank you.
 11 Paragraph (a), one respondent to the NACAS survey
 12 said that:
 13 "more emotional and physical support was needed from
 14 staff as the clients didn't have visitors to speak to or
 15 to do small things for them which would normally be
 16 carried out day-to-day by family members, neighbours,
 17 et cetera. Clients were in a depressed state, which in
 18 turn affected their general wellbeing and health."
 19 Then at subparagraph (b), another member said:
 20 "Literally their whole family support was taken away
 21 and strained carers were left to plug that hole."
 22 Were those kinds of views and experiences widespread
 23 amongst your members?
 24 **A.** I'd have to say yes, it was widespread. I mean, if you
 25 can try and imagine trying to fill the gap of a family
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1 member, when that family member -- I mean, I'm talking,
 2 by family member, I mean the person actually in the care
 3 setting is no longer allowed to see that family member
 4 but a care professional is now expected to fill that
 5 gap, that is going to have a -- take a toll on their
 6 mental health, and understandably, because they are not
 7 family. I mean, they are family in the sense that they
 8 are there to provide the care and support to them but
 9 they're not that person's flesh and blood, and to have
 10 those care professionals step up like that and be able
 11 to do that function, I think speaks volumes for our care
 12 workforce. I think they were -- they went above and
 13 beyond.

14 **Q.** And picking up on that first experience there of
 15 emotional but also physical support, as well, so is it
 16 right that family members or carers that were coming in
 17 would quite often provide additional physical support
 18 with tasks, that that burden then fell upon the care
 19 professionals?

20 **A.** Yes, I think that's a fair statement.

21 **Q.** You -- a slightly different topic, please. And that's
 22 access to sick pay and isolation policies.

23 In your statement you say that NACAS considers that
 24 the insecure nature of much care work and the absence of
 25 limited availability of occupational sick pay

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1 make that right decision about not going into work if
 2 they're feeling under the weather.

3 But I just think in that pandemic -- in that
 4 situation right then, they made those conscious
 5 decisions to go to work because they don't want to let
 6 their clients down. They go to work because they care.

7 Pardon. No pun intended.

8 **Q.** Turning to the second systemic and structural issue that
 9 you've identified in your statement, and that is unclear
 10 accountability. Can you explain what you meant by that?

11 **A.** Well, I mean, I think it's just a general statement.

12 There just didn't seem to be anyone or any one
 13 organisation taking accountability for things.
 14 Everything was done -- and I hope I'm answering the
 15 question -- this is my -- I think everything was done in
 16 a rush. It was done almost reactively. There was no
 17 cohesion around the decision-making processes. That's
 18 the way I saw it. Others may see it slightly different.

19 But that's my understanding of it. There was no clear
 20 person, organisations, you know, taking a specific
 21 accountability for things.

22 **Q.** And you describe a lack of integration and coordination
 23 between health and social care services and a fragmented
 24 structure in your statement. How do you think that
 25 impacted the response of the adult social care sector

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1 significantly impacted care professionals' ability to
 2 self-isolate and shield during the pandemic.

3 Can you tell us a little bit more about the
 4 experiences of your members around their ability to
 5 self-isolate and shield and whether access to sick pay
 6 informed or affected those decisions?

7 **A.** I do believe that the access or non-access to sick pay
 8 did -- it did influence their decisions. I firmly
 9 believe that a lot of care professionals thought to
 10 themselves: I can't afford to get sick, because if
 11 I can't work because I'm sick I don't get paid.

12 So I think there would have been occasions where
 13 a care worker was not feeling a hundred per cent,
 14 feeling a little bit under the weather, would have gone
 15 to work because they needed to earn money and because,
 16 in some instances, you know, there was no -- anything
 17 else other than Statutory Sick Pay. They just made that
 18 decision, that: I need to go to work. I need to go to
 19 work to earn a living. And I need to go to work because
 20 if I don't go to work because I'm sick, I'm not going to
 21 earn anything.

22 So that's -- it's a heck of a decision to have to
 23 make, isn't it? Especially in a pandemic. It's maybe
 24 an area that needs to be looked at in terms -- in terms
 25 of sick pay, but they need -- they need to be able to

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1 during the pandemic, and how do you think it could be
 2 improved in future?

3 **A.** Well, I think this is -- this goes to the heart, the nub
 4 of the matter. There's no parity of esteem between
 5 health professions and social care, and that needs to be
 6 brought up fairly rapidly, in my opinion. There needs
 7 to be absolute parity to between health and social care
 8 and adult social care. So that the communication lines
 9 between those two facets are much better aligned.

10 And if I may say so, it goes back to the visibility
 11 question that you asked me earlier. It would certainly
 12 raise the public's perception of what social care is,
 13 and what it means, and what it means to work in it.

14 **Q.** And the third and final systemic and structural issue
 15 you identify is inadequate regulation.

16 **A.** Mm-hm.

17 **Q.** Again, what did you mean by that in the context of the
 18 pandemic?

19 **A.** England is the only nation in the United Kingdom that
 20 doesn't have any form of mandatory registration. And
 21 I think that there been a register in place, any data
 22 held on that register I think could have been a massive
 23 fillip during that pandemic. That's -- that's where
 24 I was coming to there, in terms of -- excuse me, that's
 25 where I was referring to in terms of lack of regulation.

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1 Q. I'd like to ask you some more questions about the
2 register. Before I do so, you said there that data
3 could have been a massive flip during that pandemic.

4 A. No, it's --

5 Q. Can you just explain --

6 A. I beg your pardon, I didn't say "blip", I said "fillip".

7 Q. Fillip.

8 A. You know, it could have been a huge asset is what
9 I meant to say. Sorry, if I said "blip", I didn't mean
10 to say "blip" at all.

11 Q. No, no, that's okay, I think that might have been my
12 mistake.

13 But if I may just ask how it could have been
14 a massive asset during the pandemic?

15 A. Okay. Is it okay if I refer to my notes here --

16 Q. Yes.

17 A. -- so I get everything right?

18 If there was a register, a form of register, in
19 England, then that data could have been made available
20 to all the emergency services, all the relevant
21 organisations within healthcare. I mean, there's rapid
22 deployment of information, if you have got a register
23 with 1.5 million people on it, I mean, that's if
24 everybody was on the register, you could just
25 disseminate information real-time instantly. It would

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1 data held on the register could be a fundamental point
2 of that.

3 I think there's -- it's capable of doing so many
4 things. It's not just a register of people or care
5 professionals; it enables us to be able to be much more
6 proactive in getting information out there and deploying
7 the workforce where it's needed.

8 Q. And who do you envision being eligible to join such
9 a register? So for example, would it include unpaid
10 carers?

11 A. Well, at the moment, we are -- we are actually
12 concentrating on the paid professional workforce.
13 That's not to say that in future, our work could look at
14 extending that to the unpaid care professionals, but at
15 the moment, we are just focusing our attention on the
16 paid workforce.

17 Q. And Mr Featherstone, when you say "at the moment", do
18 I assume from that that you're referring to the care
19 professional register that your organisation has helped
20 to set up, the voluntary register?

21 A. Yes, maybe I should have said that at the outset.

22 Q. Not at all.

23 A. So yes, we operate the care professional register. It's
24 in a prototype framework at the moment. I'm pleased to
25 say that through some hard work, we have been able to

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1 enable people to -- it would mean rapid deployment, so
2 people with certain skills, certain attributes could be
3 deployed in the right areas through the data on the
4 register.

5 It could be a skills-based, role making. There's
6 direct communication, which I just referred to. I mean,
7 say, one of the massive areas of support that the
8 register could provide its registrants is that
9 dissemination of information. So as the information is
10 being made public, then instantly, there's a scope there
11 for us to disseminate that information to everybody on
12 that register. So everybody gets the same information
13 at the same time. I think that would be -- that alone
14 would have been invaluable.

15 And it also -- it would also provide an opportunity
16 for people who maybe leave social care that were on the
17 register. We'd still have that data so we'd still be
18 able to communicate with those people to say, "Would you
19 be prepared to volunteer your services as a former care
20 professional and help out in this pandemic?" I mean,
21 God forbid there'd be another pandemic, but that's
22 something that register could help to do. It would
23 enable us to give -- provide access to these people who
24 may want to say, "Do you know what? Yes, I'm quite
25 happy to lend my services during the pandemic", and that

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1 pass the Professional Standards Authority's public
2 interest assessment so that we now know that the CPR, to
3 give it an acronym, is fit -- sorry, not fit, it does
4 meet the public interest. So at the moment, yes, we are
5 -- we do maintain that register.

6 Q. And that will be a voluntary register for professional
7 social care workers that are paid --

8 A. Correct.

9 Q. -- in England?

10 A. Yes.

11 Q. And what will the care professionals that join the
12 register benefit -- what will they get from joining?

13 A. Well, we see it as a statement of their professionalism,
14 that they take accountability for their actions. They
15 demonstrate that they are properly trained and qualified
16 to carry out -- can I call it the care profession? --
17 because that's what I fundamentally and firmly believe
18 it is. That it raises the profile of care working as
19 a profession, alongside the individual care worker. It
20 gives a certain prestige, a gravitas, to the work that
21 we do. And that's the Royal "we", because I still
22 consider myself a care professional.

23 There's -- it's a public declaration that I care
24 about what I do. I am a professional and I'm happy to
25 have an entry on that register to demonstrate that.

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1 I mean, it improves employability. There's so much
2 that being on that register does. It's not about
3 control. Again, registration is about protecting the
4 public interest and that public interest is better
5 demonstrated through a person who takes accountability
6 for their --

7 **Q.** And just if I may, what information will be recorded on
8 that register? So I think you alluded to, perhaps,
9 qualifications?

10 **A.** Yes.

11 **Q.** Personal information, ethnicity, those -- that kind of
12 data, as well?

13 **A.** We do capture that data but that data is not shared if
14 the register is searched, if you understand what I'm
15 saying.

16 **Q.** So it will be available publicly to be searched?

17 **A.** The register in its present form can be searched.
18 Because, for example, if you went onto the register
19 website and put my name in there, it would show up my
20 name, whether I'm active in the profession, and what
21 training I've done. It doesn't -- and my PIN number.
22 It doesn't display anybody's personal information or
23 their ethnicity, because that would be wrong. But the
24 only information that somebody needs, we feel we need to
25 see, is what's their name, are they qualified, what

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1 experience, training, and/or an educational
2 qualification.

3 So that's why -- that's our thinking on how we could
4 reduce the barriers.

5 And the other thing that hasn't been mentioned, but
6 I think I should mention, is the cost. We wouldn't want
7 the cost either of registration to be a barrier, but, at
8 the same time, any register would have to be
9 sustainable. So we are mindful of that. And when we
10 are setting -- thinking about settings costs, they would
11 be at a level that would be, we think, manageable to be
12 able to, you know -- not to distract -- detract from
13 people wanting, my Lady, to join the register.

14 But I do take the point.

15 **MS HANDS:** Thank you.

16 Moving on to a different topic, Mr Featherstone, and
17 that's IPC measures and PPE. So one of the IPC measures
18 the Inquiry has received a lot of evidence about is the
19 restriction of staff movement, which you've addressed in
20 your statement.

21 So, starting, if I may, with what NACAS's views and
22 its members' views were on the guidance and timing of
23 that guidance around May 2020.

24 **A.** I do apologise. Could you just repeat the question for
25 me?

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1 training have they done, and are they still active on
2 the register? And then they can make an informed
3 decision then.

4 **LADY HALLETT:** Forgive my interrupting, this a voluntary
5 register and you've set out very clearly the possible
6 benefits to your members. I have heard an argument to
7 suggest that if you had a mandatory register, that that
8 might discourage some workers from entering the
9 profession?

10 **A.** I do think that's a valid point. It has -- it does have
11 some credence. But to me, speaking personally as a care
12 worker, I think it's right that there should be some
13 kind of mandatory element to it, especially if you're
14 declaring yourself to be who you are: a professional.

15 I think the -- I've heard those comments around the
16 possibility of the workforce being depleted because
17 people don't want to go on a register, but I think
18 that's one of the challenges. We need to form the
19 register in such a way, my Lady, that it doesn't create
20 barriers.

21 So it could be that we have a tiered type of
22 register, sort of: people are brand new into the sector;
23 people who are more experienced, maybe have completed
24 all their mandatory registration; and then maybe
25 a higher tier for those who have got significant

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1 **Q.** Yes, of course. The topic is around restriction of
2 staff movement.

3 **A.** Yes.

4 **Q.** And guidance was issued around May 2020. And I was
5 asking what your members' views were on the guidance and
6 the timing of the guidance.

7 **A.** I think the members' views of the guidance was mixed.
8 I think it was a bit -- there was either very limited,
9 or it was -- it's either limited or it was changing too
10 frequently.

11 I mean, from my experience receiving feedback from
12 the members, they -- it was that they couldn't get
13 access -- sorry, they couldn't get access to stuff like
14 the PPE that would improve their -- you know, their ...
15 I can't think of the right word -- improve their
16 protection against contamination.

17 But I think generally, they were -- they felt as
18 though the guidance was either out of date or it was --
19 not not relevant, but it was too *ad hoc*.

20 **Q.** Are you talking about the PPE guidance there, around IPC
21 and PPE?

22 **A.** I mean, I think that's included in it. Because, you
23 know, as part of the infection prevention and control
24 measures, one would expect to have access to the
25 appropriate equipment, protective equipment. So that's

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1 where I was coming from there.
 2 If I've misread -- misunderstood the question,
 3 I apologise.
 4 **Q.** That's okay. I think in your statement you spoke about
 5 your members reporting mixed views on restrictions of
 6 staff movements, so we have that there. Did NACAS play
 7 any role in advocating for any changes to the policy or
 8 guidance around staff movement?
 9 **A.** I beg your pardon, in terms of restricting movement,
 10 through social care, one has to recognise intrinsic
 11 nature of domiciliary care work. So it would be
 12 difficult to restrict movement in that setting. But
 13 I think, in terms of restricting movement in care homes,
 14 that would need to be carefully thought through as to
 15 how that would work, in terms of staff flexibility,
 16 providers wanting flexibility, and things of that
 17 nature. So I think a blanket ban would be inappropriate
 18 in terms of staff movement.
 19 There needs to be a -- just to say: right, stop,
 20 I think that's a complete -- no, I don't think that
 21 would be appropriate.
 22 **Q.** Okay. You mentioned there around access to PPE, and
 23 you've told us in your statement that NACAS bought and
 24 distributed 2,000 disposable face screens.
 25 **A.** Yes.

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1 training around the risks for Covid-19 in the adult
 2 social care sector?
 3 **A.** Not that I was aware of. I can say, my Lady, to this
 4 Inquiry that one of our corporate members did put
 5 together a Covid training package which they made
 6 available to our members should they want to access
 7 that. That is the only example I can give you where
 8 there was specific training for Covid, but that was
 9 something that was done in-house, through our corporate
 10 partner.
 11 **Q.** Do you know when that was made available?
 12 **A.** I would say around about 2021. I can't -- I'd have to
 13 give you -- come back to you with an exact date. It
 14 should be fairly easy to find --
 15 **Q.** Thank you.
 16 **A.** -- because it's still on our training platform.
 17 **Q.** And perhaps it's an obvious question but do you think
 18 that it would have helped if there had been more
 19 training and support available to members?
 20 **A.** Oh, definitely.
 21 **Q.** The final IPC measure I wanted to ask you about was in
 22 regard to testing and whether your members reported any
 23 issues around access to testing or issues with following
 24 the testing regimes that were introduced.
 25 **A.** We certainly had instances of members not being able to

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1 **Q.** Just to clarify, were they face masks or perspex
 2 screens?
 3 **A.** They were perspex single-use screens. The reason we did
 4 that was I was getting regular calls from members to
 5 say, "I can't get hold of PPE", so I just took it upon
 6 myself to try to do something about it. I felt almost
 7 like an obligation to our members to try to do
 8 something. So we purchased a quantity of those masks
 9 and shared them out on a first come, first served basis.
 10 I mean, it was -- that didn't even scratch the --
 11 scratch on the surface, but it -- I just felt that we
 12 needed to try to do something to help them.
 13 **Q.** Did that distribution include to people that were
 14 working in care homes and domiciliary care?
 15 **A.** Yes, yes.
 16 **Q.** Okay. I wanted to ask you about some of the feedback
 17 you received from a NACAS survey around training
 18 about -- for Covid-19 and the risks that workers faced.
 19 We don't need it on screen. Thank you. But in
 20 a questionnaire that NACAS put out, approximately 47%
 21 responded that they hadn't had any training, and 87%
 22 that did receive training said that it did not include
 23 information about a potential enhanced risk to ethnic
 24 minorities.
 25 From your members' experiences, was there widespread

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1 get access to testing kits. Again, this was something
 2 I tried to do something about. I tried to get on to the
 3 government portal that was distributing the testing kits
 4 at that time, but because NACAS was not providing care,
 5 I couldn't get access to that. The idea was that if we
 6 were able to get access to those kits, then we could
 7 get, you know, we would get quantities of them and ship
 8 them out to members who were having trouble getting the
 9 kits. But yes, there was -- there are, I think, several
 10 instances where members were having trouble getting
 11 access to the testing kits, certainly at the start of
 12 the pandemic. It got better.
 13 **Q.** Finally, in regards to lessons learned and
 14 recommendations, you have identified in your statement
 15 some areas that went well, and I just wanted to ask you
 16 if you could perhaps provide us with a few examples of
 17 those?
 18 **A.** I'm sitting here and I'm struggling to think of an
 19 answer, but I mean, it certainly wasn't all bad.
 20 I think the -- I mean, the vaccine rollout was, I think,
 21 is a good example of things that did go well. That was
 22 done very, very quickly, even though there was a, you
 23 know, there was some reluctance on some people not to
 24 get vaccinated but I think the government should be
 25 commended on the speed in which the vaccine rollout was

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1 implemented. I think that's probably the biggest
 2 spotlight I could shine on something that did go well.
 3 **Q.** And then, in terms of looking to the future, you've
 4 identified some key objectives that you think are
 5 important. Perhaps you could explain what they are.
 6 **A.** I mean, moving forward, I think -- and probably I'm
 7 repeating what a lot of other people have said sat in
 8 this chair, but we need to give proper recognition to
 9 our workforce, and that would be my biggest
 10 recommendation, is let's get our amazing workforce
 11 properly recognised. And dare I say it, properly paid
 12 and remunerated. We need to do more around the
 13 narrative of how brilliant being a care professional is,
 14 rather than concentrate on the negative side of care
 15 working. That, for me, moving forward, would be job
 16 done. If we can get our amazing workforce -- I keep
 17 calling them amazing because they are. I mean, they're
 18 the ambassadors for their providers, they're out there
 19 doing the job, you know, seven days a week, 365 days
 20 a year. We need to give them that respect, can I say
 21 that? They need to be respected and recognised as the
 22 amazing people that they are.
 23 And I can't -- I mean, it might seem silly and a
 24 little bit simple to say those things but that's what
 25 I would love to see, moving forward, is that focus given
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1 during a pandemic there should have been more
 2 inspections. I mean -- and I suppose even if those
 3 inspections, when we -- were not, you know, full
 4 inspections, but there was some level of inspection
 5 throughout the course of the pandemic, that would have
 6 been very, very useful.
 7 And also, they needed -- it needed -- the CQC needed
 8 to be more supportive during the pandemic, because we
 9 have members who have -- you know, it's in my statement,
 10 I think, we have members saying that the support from
 11 CQC was not as it should have been.
 12 So that -- so the impact would have been -- well,
 13 severely felt. I mean, if they are going to cut back on
 14 inspections, that, to me, is a detrimental step. There
 15 should have been more, not less.
 16 **Q.** When you say there should have been more, are you able
 17 to elucidate why that would have been -- why during
 18 a pandemic inspections are particularly important?
 19 **A.** I think it would have been -- it would have been
 20 a vehicle to raise issues and concerns about whether an
 21 establishment was failing to meet a certain standard,
 22 for example.
 23 This is just my view, being asked -- as I've been
 24 asked the question today, but I just think that, rather
 25 than minimise the amount of inspections, there should
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1 to our workforce, and being brought up to the same level
 2 as our colleagues in the National Health Service. We
 3 need it. It's far too long overdue.
 4 **MS HANDS:** Thank you, Mr Featherstone.
 5 My Lady, those are my questions.
 6 **LADY HALLETT:** Thank you, Ms Hands.
 7 Ms Peacock. Ms Peacock is over there. Just a few
 8 more questions.
 9 **Questions from MS PEACOCK**
 10 **MS PEACOCK:** Thank you, my Lady.
 11 Good afternoon. I ask questions on behalf of the
 12 Trades Union Congress. My questions are on the topic of
 13 regulation in the care sector during the pandemic.
 14 You refer in your statement at page 41 to the
 15 decision of regulators to pause routine inspections in
 16 care settings in March 2020 and you explain that:
 17 "... the CQC continued to inspect in response to
 18 immediate risks and concerns about safety as identified
 19 by staff or members of the public, but this totalled
 20 just 50 inspections between 16 March 2020 to July 2020."
 21 My question is, what do you consider was the impact
 22 of this reduction in inspection activity upon the safety
 23 of care settings?
 24 **A.** I mean, I think to reduce inspections during the
 25 pandemic was the -- is reverse psychology. I think
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1 have been more, even if they were slightly redacted
 2 inspections. Because I think that would have had a bit
 3 of a more of a positive impact on the provider. You
 4 know, it would have been -- I just think in general it
 5 would have been -- it would have been better if more --
 6 more was done in terms of the inspections.
 7 I hope I'm answering your question for you.
 8 **Q.** Thank you.
 9 And in addressing why routine inspections were
 10 paused during the pandemic, Mary Cridge of the CQC set
 11 out in her supplementary witness statement that:
 12 "... [the] CQC did not want to put our employees, or
 13 anyone that we came into contact with, at any greater
 14 risk than they already were."
 15 However, you mention in your statement that the
 16 significant reduction in on-site inspections inevitably
 17 placed care home residents at greater risk of harm at
 18 a time when they were particularly vulnerable; and
 19 you've just explained some of that risk.
 20 Was there a failure of the CQC and other regulators
 21 to recognise and to balance the risks involved in
 22 significantly reducing on-site inspections as against
 23 the risk of transmission potentially associated with
 24 on-site inspections taking place? In essence, should
 25 more emphasis have been placed on mitigating the risk of
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1 transmission so the inspections could take place?
 2 **A.** I think so, yes, but then that's a difficult balance to
 3 try to get to, but there should have -- but there should
 4 have been a ...
 5 I'm trying to say the balance between the risk of
 6 infection and non-risk of infection needed to be looked
 7 at. I think -- I can understand Mary Cridge's
 8 statement, saying she wants to protect the staff, but
 9 the people in the care homes themselves wanted to
 10 protect their staff. So surely, between them, there
 11 could have been some middle ground that could have been
 12 reached that: yes, there might still well have been
 13 transmission, but could it have been reduced? Possibly.
 14 So that's why I think -- that's my initial thought
 15 there is: more should have been done, more engagement,
 16 and maybe -- I don't want to use the word "failure", but
 17 maybe there should have been that collaboration between
 18 the CQC and the providers as to what can we do together
 19 to make sure that you're still getting inspected and
 20 mitigate the risk of transmission? I don't think that
 21 was done.
 22 **Q.** Thank you. And turning to look at future pandemics,
 23 Mary Cridge has stated in her evidence that:
 24 "... in the event of a future pandemic, strenuous
 25 efforts should be made to protect the ability to carry
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1 as key workers from the outset of a future pandemic and
 2 that they should be given priority access to testing,
 3 PPE, vaccinations and IPC training. Is that
 4 a recommendation you and your members would support?
 5 **A.** I think that's a good point. I think they should, if
 6 they're going to be out there doing the job in the
 7 pandemic then absolutely they should be able to get
 8 access to that equipment.
 9 **MS PEACOCK:** Thank you.
 10 I'm grateful, my Lady, those are my questions.
 11 **Questions from THE CHAIR**
 12 **LADY HALLETT:** Thank you, Ms Peacock.
 13 Can I ask you a question? It sounds as if you might
 14 have -- your experience in social care was in Wales,
 15 was it?
 16 **A.** Correct, my Lady.
 17 **LADY HALLETT:** Bit of a clue in the accent.
 18 You have said your membership is 60% English and the
 19 other 40% around the devolved nations.
 20 **A.** Yes.
 21 **LADY HALLETT:** You haven't actually specified any
 22 differences around the four nations of the United
 23 Kingdom. Did you detect any particular problems that
 24 were more prevalent in England or more prevalent in
 25 Scotland or ...?
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1 out on-site inspections as much as is practically
 2 possible."
 3 So my question is: do you agree that strenuous
 4 efforts should be made to maintain in-person inspection
 5 activity in a future pandemic? And do you have any
 6 reflections on how that may be achieved? Is it an issue
 7 of planning and preparation, for example?
 8 **A.** I think that's exactly it. I think it's preparation and
 9 planning. There needs to be -- I'm going to refer back
 10 to my previous answer -- that there has to be that
 11 aligned thinking around protecting the staff of the, you
 12 know, the CQC staff, but also the residents and staff
 13 within the care setting itself, and maybe that was
 14 lacking during the pandemic, and that needs to be looked
 15 at moving forward, so that care providers are not left
 16 wondering about when the next inspection might because
 17 it's a pandemic, but also, may I say, that when care
 18 providers are asking for guidance and support from the
 19 inspectorate, they don't get told, "We're not here to
 20 give advice", or things of that nature.
 21 That simply doesn't help the situation at all, you
 22 know, and places everybody on a -- yeah, it's just not
 23 an acceptable situation for that to happen.
 24 **Q.** And just by way of a short follow-up, Mary Cridge,
 25 I think has suggested that inspectors should be treated
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1 **A.** I didn't detect anything along those lines during the
 2 pandemic, my Lady, no.
 3 The members who contacted us throughout the pandemic
 4 would have been across the whole of the UK. But I can't
 5 sit here and tell you I can say "Well, this happened in
 6 Wales, this happened in Scotland."
 7 Each of the devolved governments reacted slightly
 8 differently to the pandemic. I think -- from a personal
 9 level, I think the Welsh Government did a reasonably
 10 good job, but I can't give you a specific example of
 11 differences in the regions as a whole, sorry.
 12 **LADY HALLETT:** No, I'm very grateful. That's what
 13 I detected: that actually the concerns you were hearing
 14 seemed to be replicated around the United Kingdom.
 15 **A.** Yes.
 16 **LADY HALLETT:** Is really the impression I got from your
 17 evidence.
 18 **A.** Yes, they were. I think that's a fair comment, yes.
 19 **LADY HALLETT:** Well, thank you very much indeed.
 20 That completes all the questions we have for you.
 21 I've received a number of messages during the course of
 22 this module, and I can promise you that the message
 23 I received particularly loud and clear is the message
 24 you wanted to get across, which is the importance of
 25 recognising the social care workforce.
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1 And if I might say so, you asked if you could be
2 proud of setting up the association, you should be
3 rightly proud. It was obviously a gap that you foresaw
4 long before many others had. So thank you very much for
5 all you've done to try and get the care profession
6 recognised, and it is certainly a message I have
7 received.

8 **THE WITNESS:** That's very kind of you, my Lady.

9 And might I just finish by saying, can I thank,
10 my Lady's Inquiry for giving me the opportunity to give
11 a voice to our workforce. Very grateful.

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

13 **MS CECIL:** My Lady, may I call Professor Hatton. He's just
14 on his way in.

15 **PROFESSOR CHRIS HATTON (affirmed)**

16 **Questions from COUNSEL TO THE INQUIRY**

17 **LADY HALLETT:** I hope we haven't kept you waiting,
18 Professor.

19 **THE WITNESS:** Not at all, my Lady.

20 **MS CECIL:** Thank you, Professor Hatton.

21 You are here today to assist the Inquiry with regard
22 to the specific position of people, adults, with
23 learning disabilities in the social care sector.

24 To that end, you have produced, along with
25 Professor Richard Hastings, an easy-to-read report and
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1 IDRIS, at the University of Birmingham.

2 **A.** He does.

3 **Q.** Thank you.

4 If I can turn then, please, to the report. Just
5 dealing with methodology for a moment, much of the
6 report draws on the Coronavirus and People with Learning
7 Disabilities Study, a study that you and
8 Professor Hastings undertook?

9 **A.** That's correct.

10 **Q.** Thank you. And that tracked the lives of adults with
11 learning disabilities across the UK at four points
12 during the Covid-19 pandemic, the first of those in
13 December of 2020?

14 **A.** Yes, correct, through to late 2022.

15 **Q.** Indeed, thank you.

16 If I can ask you first of all, please, what is
17 a learning disability? How is it defined?

18 **A.** A learning disability -- "learning disability" is the
19 term that's used in the UK. Internationally the term
20 "intellectual disabilities" is quite often used.

21 I think a really important thing to point out is
22 that a learning disability is not a health condition.
23 It is -- as it says on the tin, it's an issue with
24 learning new things.

25 There are three elements to common ways in which
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1 a full report for the Inquiry.

2 **A.** Yes, that's correct.

3 **Q.** Just for those, the assistance of those following, the
4 Easy Read report is at INQ000616456, and the full report
5 is at INQ000587296.

6 In terms of your professional background, you are
7 a professor of social care at Manchester Metropolitan
8 University.

9 **A.** Yes.

10 **Q.** You set out within the report a very impressive and
11 extensive list of both your experience and
12 qualifications. Perhaps if I can just draw these two
13 out: from 2013 to 2019 you were the co-director of the
14 Public Health England Learning Disabilities Observatory?

15 **A.** Yes.

16 **Q.** And you are also a senior investigator at the National
17 Institute for Health and Care Research?

18 **A.** Yes.

19 **Q.** Your co-author, Professor Richard Hastings, is also in
20 attendance today.

21 **A.** He is.

22 **Q.** He is a professor of psychology, health and social care.
23 He holds the 125th Anniversary Chair in the School of
24 Social Policy and Society, alongside being the director
25 of the Intellectual Disabilities Research Institute,
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1 learning disability is classified or identified. One is
2 about an issue with cognitive ability, quite often
3 measured through IQ testing.

4 The second is an issue with managing the kind of
5 functional tasks of daily life. So that might be from
6 things like, kind of, reading and reading, getting
7 around, being able to care for yourself and social
8 skills.

9 And the third element is that it is a condition,
10 a diagnosis, an identification that happens during
11 childhood, to distinguish it from cognitive impairment
12 due to dementia or traumatic brain injury.

13 **Q.** Indeed. And to put it in another way: it's a lifelong
14 developmental condition?

15 **A.** Yes.

16 **Q.** Thank you.

17 In terms of health needs, we've heard already from
18 Professor Banerjee in relation to individuals with
19 dementia that you should not treat, effectively, that
20 group as one homogenous group, there are obviously quite
21 differences within it. To that extent, what do the
22 needs and extent of the disability vary?

23 **A.** Yes, we're talking probably about over a million adults
24 with learning disabilities across the UK, so any group
25 of a million adults is going to be incredibly diverse.
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1 The way that people's needs have been characterised,
2 some of the terminologies that people might find
3 offensive, is in terms of how severe a person's learning
4 disability is; typically from sort of mild to moderate
5 learning disabilities, so most people with learning
6 disabilities have this designation of mild to moderate.
7 People will usually be living fairly independently,
8 maybe with some support, and that's distinguished from
9 a smaller number of people with moderate to severe,
10 severe to profound learning disabilities.

11 And that characterisation, people normally need
12 a lot more support with kind of daily living and they
13 are people who are much more likely to be getting adult
14 social care services in the UK.

15 **Q.** Indeed. And within your report you point to one of the
16 issues being identification of those with learning
17 disabilities, and that it follows from, effectively, the
18 level of need that a higher level of those individuals
19 with more severe learning disabilities will be known to
20 services.

21 **A.** That is correct. So overall, probably only about
22 a quarter of likely adults with learning disabilities
23 are known to health and social care services. So there
24 are large numbers of adults with learning disabilities
25 who don't get adult social care support most of the

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1 that mean it's one million diagnosed? Or is that your
2 best estimate if they all came within your purview?

3 **A.** Yes. It's -- one million is the best estimate. There
4 are much higher numbers of children identified with
5 learning disabilities in education than there are in
6 adulthood. So there's something called a transition
7 cliff, where many children identified in education
8 systems don't then go on to be identified in adult
9 services, but the one million is our best estimate, yes.

10 **LADY HALLETT:** The reason I ask is because you said
11 one million across the United Kingdom but only a quarter
12 known to the health and social care authorities.

13 **A.** Yes.

14 **LADY HALLETT:** It just seemed to me that if there is
15 a diagnosis, why are they not known?

16 **A.** Yes, that's based on research, based on prevalence
17 estimates, going out and assessing people directly.

18 **LADY HALLETT:** Thank you. Sorry to interrupt.

19 **MS CECIL:** No, not at all.

20 I wish to turn now, please, to focus on the
21 interrelationship with adult social care within the
22 United Kingdom.

23 In that respect, can I please call up the Easy Read
24 report, we're aware that a number of individuals with
25 learning disabilities are indeed following today's

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1 time, but under conditions of emergencies, like
2 a pandemic, some support might be needed. But those
3 people will not usually be known to any health or social
4 care agency.

5 **Q.** I am going to move on to that in just a moment but
6 continuing, if I may, just on need for one moment.
7 There are also those with profound and multiple learning
8 disabilities within that group; is that right?

9 **A.** Yes, and people with profound and multiple learning
10 disabilities need pretty much round the clock support.
11 Many people are still living with families at home, but
12 with extensive support coming in, rather than
13 necessarily living in, kind of, care homes, which I know
14 have been discussed a lot in this Inquiry, but there's
15 a real importance for that group of ongoing therapy and
16 support, because in the absence of that, there might be
17 permanent damage that's caused without that kind of
18 therapy being available.

19 **LADY HALLETT:** Forgive my interrupting. You said there were
20 three criteria all coming within the category of having
21 a learning disability, one of which was a diagnosis
22 during childhood.

23 **A.** Yes.

24 **LADY HALLETT:** But you've also said there are one million
25 adults across the UK with learning disabilities. Does

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1 proceedings.

2 If we can go to page 4 of that, this sets out,
3 essentially, a profile of what is known about those
4 adults with learning disabilities and the types of care
5 they do or do not receive.

6 So the first aspect is that most adults with
7 learning disabilities do not get support from their
8 local council, otherwise known as social care; is that
9 right?

10 **A.** Yes, that's as we've discussed.

11 **Q.** Indeed. Turning to those people that do get social care
12 and support, the majority of those are aged under 65?

13 **A.** Yes, the vast majority. So it's usually over 80% of
14 adults with learning disabilities getting social care
15 are under 65.

16 **Q.** And just to place that in some level of context in
17 relation to adult social care generally, it's about 18%
18 of all adults receiving adult social care have learning
19 disabilities?

20 **A.** Yes.

21 **Q.** Typically, again, looking at the demographic profile,
22 the age profile, they were typically younger --

23 **A.** Yes.

24 **Q.** -- those individuals with learning disabilities, with
25 88% of those adults being under 65?

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- 1 **A.** Yes.
- 2 **Q.** In terms of where individuals live, as we see here, the
3 majority of people, of adults with learning
4 disabilities, depend on family for some form of their
5 care, often living with their family or receiving
6 support from their family?
- 7 **A.** It is the most common living situation for adults with
8 learning disabilities who are getting social care,
9 living with family, parents or siblings.
- 10 **Q.** The next most common is living in flats or shared
11 housing or supported living?
- 12 **A.** Yes, that's correct, and that is an expanding number of
13 people.
- 14 **Q.** Indeed. And then expanding again, we have those
15 individuals that use day services or take part in
16 community groups.
- 17 **A.** Yes, so those services are often available to people in
18 a wide range of living situations. So yes, but they're
19 a really important part of adult social care for this
20 group.
- 21 **Q.** And what's not included in the easy to read report are
22 those numbers that live in residential, the people that
23 live in residential care, and just dealing with that,
24 it's quite a small part of that population?
- 25 **A.** Yes.

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- 1 data, how good is the data with regard to adults with
2 learning disabilities and social care? I appreciate
3 it's a broad question. Just a snapshot.
- 4 **A.** In the context of the pandemic, I think there are, kind
5 of, two answers to this. One is the data are not good
6 at all, it's really hard, there aren't consistent tracks
7 of data over time, there's not consistency across
8 countries. There's real issues with the reliability of
9 what's recorded when there are data systems. So I think
10 that's one set of things. But having said that, I think
11 in the context of the pandemic, there was clearly enough
12 evidence and enough data there to make informed policy
13 decisions in terms of pandemic planning before the
14 pandemic.
- 15 **Q.** And just picking up, if I may, on each nation and the
16 way in which data is collated, it's not consistent
17 across the four nations, is it? So that poses its own
18 challenges.
- 19 **A.** No. For some people it's people known to services. For
20 some, it's people getting, kind of, long-term care.
21 There's differences in the minimum age, there's
22 differences in, kind of, how that information is
23 collected, and how often, so they vary hugely, and in
24 some places, there's currently not been any data
25 collected at all, for example in Scotland.

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- 1 **Q.** It's around 16% --
- 2 **A.** Yes.
- 3 **Q.** -- of those aged under 65?
- 4 **A.** Yes, it's relatively small and it's decreasing over
5 time.
- 6 **Q.** Indeed. And that compares to those over 65 who live
7 most commonly in care homes, those adults with learning
8 disabilities, and those numbers are increasing over
9 time.
- 10 **A.** Yes, and there may be some adults with learning
11 disabilities, some older adults with learning
12 disabilities in general care homes who aren't identified
13 as a person with learning disabilities or having those
14 needs.
- 15 **Q.** With regard to the social care services that are
16 provided across the United Kingdom, there is -- it
17 varies, depending on geography and areas of social
18 deprivation. Does that sum it up?
- 19 **A.** Yes, I mean, there's not good evidence in terms of
20 comparing across the different parts of the UK, but
21 there is consistent evidence of variation within
22 countries, so different local authorities have different
23 levels and profiles of the kinds of services that they
24 offer to adults with learning disabilities.
- 25 **Q.** Indeed. Moving to data, more generally, in terms of

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- 1 **Q.** Indeed. So in Scotland there's been no data on social
2 care services received by those individuals with
3 learning disabilities since 2019?
- 4 **A.** That's correct, and I think again, this is thinking
5 forwards, that I know there's been a lot of discussion
6 of data in this module, but recommending the new data
7 system will take years. So I think there needs to be
8 something around data that is more immediate and
9 short-term and pragmatic than that as well.
- 10 **Q.** Indeed. And you do set out some of those
11 recommendations towards the end of your report, and we
12 may touch upon those later.
- 13 But if I can just pick up, also, on Northern Ireland
14 because Northern Ireland in particular has significant
15 data limitations.
- 16 If I may call up the statement of Joanne Sansome,
17 please, paragraph 97. What we see here is that she
18 records, on behalf of Disability Action Northern
19 Ireland, that:
- 20 "The sheer absence of data within the Care Sector is
21 shockingly demonstrated by the fact that during the
22 pandemic there were not even accurate figures of the
23 number of adults with learning disabilities receiving
24 health and social care in Northern Ireland", instead
25 relying on estimates all the way back to 2015.

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1 And we've also heard evidence in the course of this
2 module from the Chief Medical Officer of Northern
3 Ireland, Professor McBride who explained it's not
4 possible to disaggregate data, including by adult social
5 care.

6 What challenges did those pose in monitoring --
7 well, first of all, identifying those adults with
8 learning disabilities, and secondly, in monitoring the
9 impacts of the pandemic?
10 **A.** Well, it makes it impossible to identify people and that
11 makes it then very difficult to track any impacts of the
12 pandemic. So the only sort of continuous data series
13 over a length of time, kind of before and through the
14 pandemic, is probably England, and in England we found
15 that the number of adults with learning disabilities
16 getting social care dropped during the pandemic, but
17 there's not sufficient continuity of data across other
18 parts of the UK to be able to draw any firm conclusion.
19 And that's a real -- a real problem when you're trying
20 to understand the impacts of policy or practice in
21 different parts of the UK.

22 **Q.** Indeed. And a further example you give within the
23 report is that there's no public data on mortality, so
24 deaths among adults with learning disabilities in
25 Northern Ireland also; is that correct?

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1 fill in the gaps. I think there are basic things like
2 consistency, reliably -- you know, reliability of
3 coding.

4 So, for example, in GP systems, they don't reliably
5 record the ethnicity of adults with learning
6 disabilities. That's quite a basic thing. So I think
7 some of it is we can really improve and fix what we have
8 and make better use of it, and that, I think, is
9 a more -- you might have some more immediate protocols
10 for use in terms of pandemic planning and then pandemic
11 action than you would by staking everything on building
12 the perfect data set at some point down the road.

13 **MS CECIL:** Thank you very much.

14 My Lady, this may be a convenient moment.

15 **LADY HALLETT:** Yes, of course.

16 I hope you were warned that we take a regular break.

17 I shall return at 3.15.

18 **(3.02 pm)**

(A short break)

20 **(3.15 pm)**

21 **LADY HALLETT:** Ms Cecil.

22 **MS CECIL:** Indeed.

23 Professor, may I now turn to the impact of Covid-19
24 and again call up, please, the Easy Read report, page 5,
25 INQ0006 -- thank you very much.

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1 **A.** Yes, there wasn't anything produced that we know of
2 during Covid about Covid mortality or all-cause mortality
3 in Northern Ireland.

4 I mean, Northern Ireland is smaller in terms of
5 population, which might present some challenges in terms
6 of the sophistication of the analyses you can do, but
7 it's clearly sufficient for people to be able to draw
8 the conclusions you need to make policy choices.

9 **Q.** And in terms of collation of data, what might that look
10 like in terms of good quality data? What does it mean?
11 You've said it, and we've heard many times, we need more
12 data, or data is insufficient, but what does "good" look
13 like in this context and what is needed in this
14 particular context?

15 **A.** I think in this context the first thing is to work out
16 the purposes for which you want data. I think a blanket
17 "We need more or better data" doesn't really help
18 anybody. So I think having a clear set of purposes of
19 what you need the data for is step one.

20 I think then there's something then at looking at
21 what the data are that are available, whether you can
22 link them, whether you can actually disaggregate them,
23 what that gives you that enables you to answer some of
24 those policy questions or planning questions you have.
25 And then it will be a question of working out how to

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1 And these are the headlines, ultimately, aren't
2 they, in relation to people with learning disabilities.
3 And so, as we can see here, that during the pandemic,
4 people with learning disabilities were, firstly, more
5 likely to get Covid-19 than people without learning
6 disabilities.

7 What did your research demonstrate there?

8 **A.** That's correct, the evidence that we've found, there's
9 actually quite good evidence in the UK about the deaths
10 of people with learning disabilities during Covid
11 internationally.

12 They found that during the earlier phases of the
13 pandemic, before the vaccine was widely available,
14 people with learning disabilities -- well, adults with
15 learning disabilities were between -- seven times more
16 likely to die from Covid-related issues compared to
17 people without learning disabilities.

18 Even with the advent of the vaccine, absolute death
19 rates for people with learning disabilities from Covid
20 dropped, but there was still that disproportionate gap
21 in the risk of Covid death between people with learning
22 disabilities and people without learning disabilities.

23 So this was a very stark difference that remained
24 throughout the pandemic.

25 **Q.** Indeed. And we see that, don't we, at the very end of

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1 this page, where it says that individuals with learning
2 disabilities were much more likely to die from Covid in
3 that regard.

4 And you've given some of the statistics. In the
5 first wave, I think it was -- overall it was 8.69 times
6 more likely to die. The second wave, approaching seven
7 times, as you said, more likely to die.

8 And you explain that later in the pandemic that risk
9 decreased, but it was still between four to ten times
10 more likely than those without learning disabilities.

11 What does that mean? Why do we have that range
12 there, four to ten times?

13 **A.** The range is usually about methods. Because of all the
14 issues that we've talked about, with data, about
15 identifying people with learning disabilities, about how
16 people use different -- and whether the people are dying
17 in particular kinds of services, there are different
18 ways to do that so you get that range. I guess what you
19 get is a very consistent pattern of increased risk of
20 death. And that is particularly high, from the evidence
21 that we have, among people with Down syndrome within the
22 group of people with learning disabilities.

23 **Q.** Indeed. And that's one of the further disproportionate
24 impacts, isn't it? There are other aspects or risk
25 factors that come into play, one of them being, as you

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1 one study suggesting that people were less likely to get
2 active Covid treatments in hospital compared to other --
3 people with learning disabilities were less likely to
4 get active treatments in hospital compared to people
5 with Covid.

6 **Q.** Indeed, and you've set out the various statistics within
7 your report, I won't go into details with those now, but
8 they were less likely, for example, to receive
9 non-invasive respiratory support, intubation, less
10 likely to be admitted to intensive care units, and
11 overall, there's a 56% increased risk of dying after
12 they were hospitalised compared to those individuals
13 without learning disabilities in hospital.

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

15 **Q.** Thank you.

16 In terms of the risks of death -- we've obviously
17 just gone through some of those aspects, but if I can
18 just pick up one further aspect there, and it relates to
19 one specific risk factor, and that is in relation to
20 care homes. You explain within the report that UK
21 evidence is relatively limited not least because there
22 are relatively few adults with learning disabilities
23 that reside in such settings.

24 **A.** Correct.

25 **Q.** But what does the evidence that you do have show or

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1 say, Down syndrome. Others mirror what is known more
2 generally about Covid and disproportionate impacts, for
3 example, on men, age being a risk factor --

4 **A.** Yes.

5 **Q.** -- minority ethnic individuals also facing greater
6 risks, and then multiple health conditions, and in
7 particular those with profound and learning disabilities
8 that we were talking about earlier?

9 **A.** Yes. I guess one thing I'd say on the age front is that
10 the peak age of death from Covid for people with
11 learning disabilities was younger than for the general
12 population, so the peak age was some time between 50 and
13 64 years old.

14 **Q.** Thank you.

15 And with regard to other aspects that feed into
16 that, as we've seen from that -- the Easy Read report,
17 those individuals with learning disabilities were more
18 likely, firstly, to get Covid, as in to be infected?

19 **A.** Yes, sorry, I realised I did answer a different question
20 to the one you asked a little bit earlier.

21 **Q.** Not at all. It's the headline point from the report,
22 ultimately.

23 **A.** So people were almost twice as likely to be infected
24 with Covid. People also more likely to be hospitalised
25 with Covid, but once in hospital, with Covid, there's

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1 demonstrate?

2 **A.** The evidence showed that living in what's described as
3 a congregate care setting or residential nursing care
4 home was associated with increased risk of death for
5 adults with learning disabilities compared to adults
6 living in other situations.

7 **Q.** Did that remain the case throughout the pandemic or was
8 it limited in time to any of the waves?

9 **A.** No, it was a consistent finding throughout the pandemic.

10 **Q.** Now if I may look at it through the other end of the
11 telescope and in a broader sense and just place that,
12 please, within the context of deaths in care homes more
13 widely, obviously increased risk for those adults that
14 were in care homes that had learning disabilities, but
15 compared to the broader care home population, they were
16 at less risk than others, than those in older people's
17 homes; is that right?

18 **A.** That's correct, and again, I think one of the big
19 differences in care homes that tend to be registered for
20 adults with learning disabilities versus care homes for
21 older people is that they're much smaller in terms of
22 the number of people who are living in those care homes.
23 So the average is something like nine or ten adults in
24 a care home as compared to, you know, perhaps 40 or more
25 in care homes for older people.

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1 **Q.** Indeed, and you set that out within a table within your
 2 report, it's at page 14 of your report. And we see that
 3 the picture is similar, this relates to the position in
 4 England, and so we see here the care homes without
 5 nursing registered for older people, as you say, with
 6 learning disabilities compared to those registered for
 7 older people. If we go down, average number of places
 8 per home, 9.8 for those with learning disabilities; 30.2
 9 for those for older people, and although the numbers
 10 increase, there is still a differential when it comes to
 11 care homes with nursing. If we go across, for those
 12 individuals with learning disabilities, it's around 38.2
 13 places per home compared to 54.2 places for those that
 14 are older without learning disabilities.

15 **A.** That's correct.

16 **Q.** Thank you.

17 And in terms of your research, are there any
 18 features of smaller homes that you can point to that you
 19 consider decrease that risk? Is that something you can
 20 comment on?

21 **A.** Well, I think it's a general feature that smaller care
 22 homes reduce risk of Covid transmission in a wide
 23 variety of ways. So, obviously, it reduces the number
 24 of people who you are, kind of, with every day. It
 25 reduces the number of staff who were coming into the

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1 programme for rollout had been updated --

2 **A.** Yes.

3 **Q.** -- in terms of prioritisation to include those
 4 clinically extremely vulnerable people individuals in a
 5 banding along with those individuals who are aged 70 and
 6 older?

7 **A.** Yes.

8 **Q.** That also included Down's syndrome?

9 **A.** Yes.

10 **Q.** And those with severe and profound learning
 11 disabilities; is that right?

12 **A.** People with severe and profound learning disabilities
 13 I think were put into band 4. The issue, there again,
 14 as we've talked about before with the data, is that
 15 would have to be based on GP records, and GP records do
 16 not consistently or reliably record that at all. So
 17 making that a requirement in terms of having to specify
 18 that group would have led to a huge amount of
 19 bureaucratic gatekeeping, which would be completely
 20 counterproductive in a pandemic, when the evidence was
 21 quite strong that it's people with learning disabilities
 22 as an entire group who are at increased risk.

23 So the position they eventually came to, which
 24 I think makes sense, was everybody registered with a GP
 25 as a person with learning disabilities would be placed

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1 home. So I think all those things help, and it's easier
 2 to negotiate, I guess, a kind of restricted life if you
 3 have smaller numbers of people together.

4 **Q.** Thank you. And then just dealing with a connected
 5 matter, which is all-cause mortality, what was the
 6 position immediately prior to the pandemic in that
 7 regard?

8 **A.** So before the pandemic, consistently people with
 9 learning disabilities were more likely to die from
 10 all-cause mortality than other groups of people. So
 11 that was an inequity that was, kind of, well established
 12 and not really shifting beforehand. During the
 13 pandemic, all-cause mortality actually
 14 disproportionately increased for people with learning
 15 disabilities compared to other groups, so that existing
 16 inequality got worse.

17 **Q.** Indeed, by May of 2020 it had doubled, effectively, that
 18 of in 2019?

19 **A.** Yes.

20 **Q.** If I may now just touch upon, please, the position of
 21 vaccinations for those adults with learning
 22 disabilities, the Inquiry has heard fairly substantial
 23 evidence in relation to this, both in Module 4 but also
 24 in relation to the healthcare module, Module 3. And for
 25 these purposes, by December of 2020, the vaccination

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1 in that priority band 4 -- priority band 6, sorry.

2 **Q.** Not at all. So there were practical difficulties in the
 3 initial instance but certainly within the report, as the
 4 pandemic went on, you point to that as being one of the
 5 success stories and points of learning in terms of the
 6 actual rollout to individuals with learning
 7 disabilities; is that right?

8 **A.** Yes. So in the end we have data for England showing
 9 that rates of vaccination for adults with learning
 10 disabilities was actually slightly higher, if anything,
 11 than for other groups of people. And we did see a very
 12 proactive mobilisation of vaccination efforts that,
 13 again -- that were reasonably adjusted to people with
 14 learning disabilities, as is required in the Equality
 15 Act. But there was a fantastic mobilisation of
 16 vaccination efforts which really stood out as being
 17 different, I think.

18 **Q.** And some of those different mobilisation efforts
 19 included proactively going to those individuals' homes
 20 to -- for vaccination purposes?

21 **A.** Absolutely, yes. And that will kind of -- wouldn't
 22 normally happen, but yes, there was, you know,
 23 visiting -- visiting homes where there would be groups
 24 of people and vaccinating everybody at the same time
 25 where you could.

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1 There's a small minority of adults with learning
2 disabilities, often people with quite complex needs,
3 people with profound and multiple learning disabilities,
4 for whom a vaccination is not possible, for various
5 reasons. This might be on health grounds or it might be
6 a very severe needle phobia. And I think there's a real
7 issue about what happened in the pandemic to that group
8 of people.

9 **Q.** Indeed. And certainly some of those issues have been
10 explored previously at length.

11 If I can now turn, please, to the -- turn back to
12 the Easy Read report to page 8. Pre-pandemic, there
13 were known issues with do not attempt cardiopulmonary
14 resuscitation notices in relation to adults with
15 learning disabilities; is that right?

16 **A.** Yes, there was quite consistent evidence from the
17 Learning from Deaths Review and from other sources that
18 quite high proportions of adults with learning
19 disabilities who had died had a DNACPR. These were
20 reviewed by local health service staff, and a proportion
21 of them were found to have been completed without due
22 consultation. And this fitted with consistent stories
23 about were coming up about, kind of, people discovering
24 a DNACPR on their relatives' notes when they were in
25 hospital without them knowing how that had got there.

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1 relation to that so I'm not going to take you there, but
2 just to go to the next aspect, please, it says:

3 [As read] "Some groups of people were all given
4 DNACPRs at the same time. This is not okay."

5 I just want to pick up on one aspect of that, if
6 I may, that in terms of the NHS, they resorted to
7 sending out letters to doctors and healthcare workers to
8 explain that, for example, the terms "learning
9 disability" and "Down's syndrome" should never be
10 a reason for issuing a DNACPR order or to be used to
11 describe the underlying or only cause of death.

12 **A.** Yes. And you wonder why they felt the need to issue
13 those letters, what the practice was that led them to
14 issue those letters. And certainly there didn't seem to
15 be much that we could find that was written down but
16 people quite consistently reported GP practices, for
17 example, sending round those kinds of letters.

18 Sometimes they were rescinded under challenge but
19 that was definitely an issue. And again, the sort of --
20 the high-level issuing of a letter doesn't necessarily
21 mean widespread implementation of that in practice,
22 hence all the reviews from PHSO and CQC and others in
23 other parts of the UK.

24 **Q.** Thank you.

25 So, and in terms of the people that you were

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1 **Q.** If I can just interrupt you, you say this fitted with
2 the stories that you were hearing?

3 **A.** Yes.

4 **Q.** Do you mean during the pandemic?

5 **A.** Some of that was before but it was -- potentially there
6 was some evidence that during, that increased.

7 **Q.** So that's -- that was going to be my next question, is
8 what was the impact during the pandemic, and what we see
9 here is that in the pandemic, some people had -- with
10 learning disabilities had DNACPR in their notes, but
11 they or their family had not agreed to this.

12 **A.** Yes, that is the case.

13 **Q.** Setting aside the aspect of agreement, in relation to
14 the communication, was that something -- were there
15 problems with the communication processes that were gone
16 through in terms of consulting families or those
17 individuals themselves?

18 **A.** Yes, people reported quite widespread problems with how
19 DNACPR decisions would be communicated to them. Again,
20 there was some of that before the pandemic, but there
21 was certainly more of that, potentially, during the
22 pandemic.

23 **Q.** Indeed. And within your report you set out the findings
24 of various reviews, including the CQC, Care Quality
25 Commission. Again, we've heard some evidence in

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1 speaking to and the research that you conducted, were
2 concerns expressed that people with learning
3 disabilities were having those notices recorded solely
4 on the basis that they had a learning disability?

5 **A.** Yes.

6 **Q.** More broadly, is it right to say that a large number of
7 people were very scared about the prospect of having
8 those notices put in place?

9 **A.** Yes, they were. I think people had not had the
10 conversation about what that meant. I think people had
11 not had the conversation to then be able to make an
12 informed choice about that. And I think people were
13 concerned that a DNACPR notice accompanied other things
14 that might or might not happen to them in hospital in
15 terms of health treatments.

16 So people were concerned that that might be a marker
17 of other issues in terms of lack of health treatments
18 that they may get during Covid.

19 **Q.** Indeed, within your report then you go on to explain
20 that people and their families did not get
21 easy-to-understand information about those notices or
22 the process or end-of-life conversations --

23 **A.** Yes, and this is --

24 **Q.** -- and planning?

25 **A.** Yes, this a consistent feature of people's experience in

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1 the pandemic in all sorts of ways.

2 **Q.** I want to move on now, please, to other impacts that
3 individuals faced, and the first one being the
4 imposition of PPE and face masks. And certainly, in
5 relation to some individuals with learning disabilities
6 they were exempt from wearing face masks but for some it
7 was quite difficult, is that right, for them to
8 understand why they might need to or, indeed,
9 experiencing others caring for them with face masks
10 around them?

11 **A.** Yes. So again, we're talking about a very diverse group
12 of people. So I think many people with learning
13 disabilities understood why they were needed, even if it
14 was uncomfortable or really strange in terms of trying
15 to sort of interact and communicate with people who knew
16 you well. Many people who had an exemption still wore
17 face masks anyway when they were out because of their
18 sense of public duty and protecting others as well as
19 themselves, but yes, for some people it was incredibly
20 difficult in terms of communication and in terms of
21 heightening how scary the whole Covid pandemic was.

22 **Q.** And you'll be aware that a number of people were subject
23 to visiting restrictions if they lived in either forms
24 of supported housing or, indeed, in care homes or
25 alternatively, were subject to restrictions in their own

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1 were handled and how they weren't particularly adjusted
2 for the circumstances that people with learning
3 disabilities found themselves in.

4 **Q.** Thank you. And on the converse side of that, you also
5 had difficulties -- or we've heard evidence of people
6 who were living at home and are very frustrated because
7 they're not being allowed to go out and the problems
8 that that caused within their own home and those
9 individuals that were caring for them and the
10 relationship breakdowns that took place.

11 **A.** Yes.

12 **Q.** Is that also a feature?

13 **A.** Yes, absolutely. So people's worlds became incredibly
14 small, often -- well, we'll come to this, but social
15 care support was withdrawn or severely reduced. And,
16 you know, many people did not really understand why they
17 couldn't go out. I should say in terms of some of the
18 early advice on being able to leave the house, again,
19 early advice and guidance was only once a day for
20 everybody. That was subject to legal challenge and that
21 was changed for people in some groups including people
22 with learning disabilities.

23 So again, I think that's an example of how the lack
24 of consideration of adults with learning disabilities
25 led to a period of distress that was completely

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1 homes --

2 **A.** Yes.

3 **Q.** -- during the pandemic as a consequence of the various
4 non-pharmaceutical interventions put in place.

5 If I could just call up, please, the Every Story
6 Matters record for this module. It's INQ000587564
7 at page 50.

8 This records the account of an individual whose son
9 was in a residential care home with severe autism and
10 learning disabilities. She explains that she was unable
11 to visit him, they could not visit through a window, or
12 Facetime, because he would not understand and so become
13 upset:

14 "... it was a choice between keeping him calm or
15 upsetting us all by seeing him through a window."

16 Do those experiences also resonate with some of what
17 you found during your research?

18 **A.** Yes, the research that we did, this is not an extreme or
19 particularly unusual heartbreaking story, and there are
20 stories that people have very much like this in a whole
21 range of situations, and that have, I think, quite
22 a lasting impact on people, that those experiences and
23 those memories are still quite raw for people, if you
24 ask people about them now, so there is a real sort of
25 long-lasting impact of those restrictions and how they

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1 unnecessary because if that guidance had been written
2 that way in the first place it wouldn't have been
3 an issue.

4 **Q.** And that's one of your overarching recommendations,
5 isn't it, that there needs to be accessible guidance for
6 individuals with learning disabilities and their
7 families and friends who are caring for them?

8 **A.** Yes. So NHS England has had an Accessible Information
9 Standard since 2016 that applies to health and social
10 care services. They refreshed it in June 2025 partly
11 because it hasn't been implemented. So some of the
12 building blocks are there; they are just not being used.

13 **Q.** Indeed. More broadly within your report, you set out in
14 quite some detail the impact of the withdrawal of
15 services, care, support, and more broadly, social care
16 provision during the pandemic.

17 **A.** Yeah.

18 **Q.** And you also set out the impact of that disruption to
19 routines, but also physical impacts, cognitive impacts,
20 and, indeed, behavioural and emotional impacts. And we,
21 more broadly, have heard evidence in relation to the
22 impact upon individuals' health and wellbeing.

23 **A.** Yes.

24 **Q.** And similarly in relation to family carers, we've heard
25 evidence of the very substantial impacts on those,

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1 concerns of physical and mental health, and your report
 2 mirrors that, doesn't it, in terms of identifying
 3 burnout, anxiety, isolation, fear, and a sense of
 4 abandonment?
 5 **A.** Absolutely.
 6 **Q.** Can you just expand on the sense of abandonment, because
 7 I know that's another area in which you feel strongly
 8 that there needs to be some form of future planning and
 9 rebuilding?
 10 **A.** Yes. So people with learning disabilities and family
 11 members quite often will talk about today, that the
 12 importance of that sense of being abandoned, just being
 13 left on your own to get on with it with no warning,
 14 sometimes it felt like it was overnight. There was no
 15 sense of transparency or fairness and no sense of when
 16 things might ever come back. And again, they haven't
 17 yet come back, as far as we know, to pre-pandemic
 18 levels, which is at the end of a decade of austerity
 19 anyway. And I think that abandonment is really
 20 important for this Inquiry, that the loss of trust that
 21 people have in services and in governments to help them
 22 when the chips are really down, and I'm not sure that
 23 governments and social care services have really
 24 appreciated the job they have to rebuild that sense of
 25 trust, that in the absence of that, that's going to make
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1 picking up those threads and turning it into pandemic
 2 planning that was national and that could be then
 3 thought of in a local way. So I think our main
 4 recommendation is to find a mechanism and find a way
 5 that people with learning disabilities' family members
 6 to be closely involved in some kind of way to do
 7 coherent pandemic planning, that has some kind of clout
 8 institutionally, that has some kind of independence,
 9 that has some kind of transparency so that people can
 10 trust in it.
 11 And I think that would find a lot of things that can
 12 be done in the short term, we've talked -- we've got
 13 a lot more sort of specific recommendations in there but
 14 without that kind of drawing together and that sense of
 15 urgency, I think all those threads would be lost.
 16 **MS CECIL:** Thank you very much.
 17 My Lady, those are my questions but there will be
 18 some more questions for you.
 19 **Questions from THE CHAIR**
 20 **LADY HALLETT:** There are. Just before Ms Beattie asks her
 21 questions, can I ask you the same question I asked the
 22 previous witness. Your report does cover England,
 23 Wales, Scotland and Northern Ireland. Were there any
 24 particular discrepancies, or better practice, worse
 25 practice, in any of the nations that you or your
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1 a lot of other things that governments and services are
 2 trying to do a lot more difficult.
 3 **Q.** Indeed.
 4 And then finally, if I may, within the easy to read
 5 report, you set out, very clearly, lessons learned,
 6 things that you have learned, and then in terms of
 7 recommendations, things to do in a future pandemic, and
 8 then separately to that, things that can be done now.
 9 If there was one overarching recommendation or
 10 message to take away from your evidence today, what
 11 would that be? The most important one.
 12 **A.** Yes. I think what we've been discussing is how many of
 13 the building blocks are there and they weren't perfect,
 14 but in terms of information, in terms of aspects of
 15 systems, in terms of guidance, that was -- some of
 16 that -- enough of that was there for policymakers to
 17 really plan properly for a pandemic.
 18 So there is no excuse for a government to not -- to
 19 say that they don't know who, where adults with learning
 20 disabilities are, in terms of social care services.
 21 It's no excuse for them to say they have no information.
 22 We know that people with learning disabilities are at
 23 vast increased risk of health inequalities, for example,
 24 that will make a massive difference.
 25 So the real issue is that there was nobody who was
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1 colleague Professor Hastings wish to emphasise?
 2 **A.** In terms of the experiences of people through the
 3 pandemic? In a way, to our surprise, there weren't,
 4 really, big differences across different parts of the
 5 UK, because they have quite different systems when it
 6 comes to adult social care, but we didn't find
 7 particularly big differences. I think there are some
 8 differences in how responsive national governments were,
 9 so for example, in terms of vaccination, the first
 10 country to decide that everybody with a learning
 11 disability on the register would be prioritised was
 12 Scotland. So devolution helped, I think, in terms of
 13 Scotland having the leeway to do that, but there were
 14 not big differences in people's experiences of services,
 15 which was something that we were exploring.
 16 **LADY HALLETT:** Thank you very much.
 17 Ms Beattie.
 18 **Questions from MS BEATTIE**
 19 **MS BEATTIE:** Thank you, my Lady.
 20 Professor, I ask questions on behalf of Disabled
 21 People's Organisations, and the questions concern Care
 22 Act easements and reductions in services.
 23 In your report you touch on Care Act easements as an
 24 example of legislation during the pandemic with
 25 particular relevance to adult social care for adults
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1 with learning disabilities, and you've explained earlier
 2 in your evidence how adults with learning disabilities
 3 use social care.

4 You say in your report that the local authority
 5 adult social care responses to the pandemic did not seem
 6 to map onto whether local authorities had used easements
 7 or not. So my question is, did that reflect that only
 8 a few local authorities were actually formally using
 9 easements, while others seemed to reduce services
 10 without formally using them?

11 **A.** Correct, yes. So, in terms of geography and in terms of
 12 time, many more people will experience those reductions
 13 in adult social care services whether they were in an
 14 easements area or not.

15 **Q.** And did that -- the fact that -- it didn't seem to map
 16 onto what local authorities were doing, and there seemed
 17 to be a disconnect there, did that reveal a lack of
 18 oversight and transparency around those reductions in
 19 services?

20 **A.** I think that's -- we don't really have much evidence to
 21 speak to that, but I think I can say the experience of
 22 adults with learning disabilities and family members,
 23 they experienced it as lacking in transparency and
 24 lacking in fairness and lacking in due process.

25 **Q.** And I think you said earlier that people, for example,
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1 released when, in advance, I think that will really help
 2 in terms of transparency.

3 **MS BEATTIE:** Thank you, my Lady.

4 **LADY HALLETT:** Thank you very much, Ms Beattie. Very
 5 grateful.

6 Professor, that completes all the questions we have
 7 for you, thank you very much indeed. And I think
 8 Professor Hatton -- Hastings is also sitting here -- for
 9 somebody whose name begins with "Ha" as well, I should
 10 have got that right, shouldn't I?

11 Thank you both very much indeed for all the help
 12 you've given to the Inquiry in preparing the report, and
 13 the easy reading report, which is obviously a great help
 14 particularly for this particular aspect of our Inquiry,
 15 so I'm really grateful to you both for your help and for
 16 coming today.

17 **THE WITNESS:** Thank you, my Lady.

18 **LADY HALLETT:** Very well, that completes today's hearing.

19 I shall sit again at 10.00 tomorrow morning.

20 (3.46 pm)

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

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1 with profound and multiple learning disabilities who may
 2 live at home with extensive support coming in might
 3 suffer permanent damage if that support was reduced. Is
 4 that the kind of impact that was experienced?

5 **A.** Absolutely. So people with profound and multiple
 6 learning disabilities are quite a small group in terms
 7 of number, but in terms of support people need, they
 8 need quite extensive support. And that's exactly the
 9 kind of thing where there's permanent impact.

10 So, for example, postural care. If you're a person
 11 with scoliosis and you miss out on three years of
 12 postural care, that might be damage to your spine which
 13 no amount of future postural care will completely
 14 correct.

15 **Q.** And would it be of benefit to have greater transparency
 16 on -- in a future pandemic, or in any event, on
 17 reductions to services of that nature?

18 **A.** Absolutely. Yes. I'm always in favour of transparency.
 19 And I think one of the things we can do around that,
 20 around data, is set protocols for publication of data of
 21 evidence in advance. So that we know exactly when
 22 things are going to be published. Because otherwise,
 23 you can get delays in publication and people start to
 24 question why those delays are happening. I think
 25 protocols on transparency, what data is going to be
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