Witness Name: Fiona Catherine McQueen
Statement No.: 4
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UK COVID-19 INQUIRY
MODULE 6

WITNESS STATEMENT OF FIONA CATHERINE McQUEEN

Background

In relation to the issues raised by the Rule 9 request dated 20 February 2025 in connection with Module 6, I, Fiona McQueen, will say as follows: -

Positions I have held

1. I am Fiona Catherine McQueen of c/o St Andrew's House, Regent Road, Edinburgh, EH1 3DG, I was the Chief Nursing Officer (CNO) for the Scottish Government (SG) between November 2014 and February 2021. Prior to me taking up this role (interim from November 2014, then substantive from April 2015) I had been an executive Director of Nursing in various organisations within NHS Scotland. My qualifications are a Masters in Business Administration, a BA in Nursing, Diploma in Management Studies, and Registered Nurse.

2. In the preparation of this statement, I have referred to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiry Response Directorate, solicitors taking my statement via interview, and other appropriate assistance to enable this statement to be completed.

3. Unless stated otherwise, the facts stated in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief. Any views or opinions expressed in this statement are my own.

Initial Strategy and Decision Making

4. I have been asked to describe what involvement I had, if any, between January and March 2020, in advising Scottish Ministers on the initial strategy for managing the Covid-19 pandemic and key decisions affecting the adult social care (ASC) sector in Scotland. During this early stage of the pandemic I had no involvement in the overall strategy for managing the pandemic. As I recall, my colleagues, the Chief Medical Officer, the Chief Social Work Advisor (CSWA), the Director General of the Health and Social Care Directorate (DGHSC) and the Director for Community Health and Social Care were more directly involved at that stage and with advice in terms of any key decisions being made which may have impacted the ASC sector.

5. In terms of my views on the correctness or otherwise of key decisions made such as the March 2020 hospital discharge policy, again, I was not involved in strategic decision making at that time and, as a consequence, I have not seen the discussion papers and advice given to Ministers for decisions such as the March 2020 hospital discharge policy. However, my understanding was that it was believed that care homes were likely to be safer than hospitals for older people as hospitals had the potential to be overwhelmed with people infected with Covid-19. I also understand that there was insufficient testing capacity to support testing before discharge from hospital and my understanding was that the extant advice was given only to discharge people who were fit to discharge. My understanding has come from informal discussions with colleagues during the pandemic. In addition to this, the advice was that patients transitioning from hospital to a care home should not be transferred

"inappropriately" (as outlined in the Scottish Government's Clinical Guidance for Nursing Home and Residential Care Residents dated 13 March 2020, provided [FMQ4/01 - INQ000370196]. My use of the word "inappropriately" reflects the use of the word in the guidance.

6. There are situations where ASC settings have expressed concern about the risk of admissions from a hospital setting causing a spread of Covid-19 within that setting. In the early stages of the pandemic where the priority is maximising hospital capacity, steps should be taken to ensure that patients are screened clinically to ensure that people at risk are not transferred inappropriately (as per the guidance noted in the preceding paragraph) but also that flows out from acute hospital are not hindered and where appropriate are expedited.' The Inquiry has asked what I consider is meant by "inappropriately". From my perspective, although I was not involved in developing the guidance, I would have meant someone who was not fit to be admitted to a Care Home; either because of Covid-19 or another reason that they had not been medically fit for discharge.

7. What I have said above would apply to vulnerable people in the ASC sector and those with protected characteristics, for example, although I was not involved directly in such decision making, my understanding was that care homes were viewed as safer than hospitals which had the potential to be overwhelmed with people infected with Covid-19. As levels of general community infection increased, sadly it is inevitable that any external individual entering a care home has the potential to bring infection into care homes, including ASC staff. Without prior planning of how to essentially quarantine residents and staff in the event of a pandemic it was very difficult to completely isolate older people, including those with additional protected characteristics, from the virus. I am unclear as to whether or not early consideration was given to the isolation of residents, staff and patients from hospitals as I was not involved in that from a government policy perspective and individual care homes would have carried out their own assessment of how practical that was in their situation. Patients discharged form hospital

were expected to be appropriately cared for – which would have included isolation.

8. I was not involved with the decision making process between January and March 2020 as noted above however, my experience of the SG during the pandemic had been that they very much tried to align with UK Government (UKG) (or four country approach) approach however they would be prepared to depart from it but only if it was helpful to the people of Scotland. Any departure from UKG approach came once the pandemic was more established and SG had a greater understanding of the impact of the pandemic on Scottish communities, in the early days I am not aware of any time the SG departed from a four country approach. I cannot comment on the transparency and clarity of decision making structures and process at the time because I was not directly involved in this. My understanding is that, to allow decisions to be made at pace, those involved in making those decisions at that time was kept to a relatively restricted number.

9. As the pandemic progressed, the degree of involvement I had in advising ministers on pandemic strategy and response changed. From approximately April 2020 the Health and Social Care Directorate (HSC) took a broader approach to clinical advice and, as far as possible, the National Clinical Director (NCD), CMO and CNO worked as a triumvirate to give clinical advice on healthcare matters. I was not closely involved in the wider pandemic strategy development but more specific decisions within the remit of the CNO. For example, I would attend the Four Harms Group which assessed the Four Harms impact on various decisions made during the pandemic. I believe that copies of the Four Harms Group minutes have already been provided to the Inquiry by the Scottish Government. The Four Harms (as set out in the Scottish Government Covid-19 Framework for Decision Making (April 2020) [FMQ4/02 - INQ000369689]), were as follows:

- Harm 1: direct Covid-19 health harms – primarily, the mortality and morbidity associated with contracting the disease

- Harm 2: broader health harms – primarily, the impact on the effective operation of the NHS and social care associated with large numbers of patients with Covid-19, and its knock-on effects on the treatment of illness

- Harm 3: social harms – the harms to wider society, in terms (for example) of education attainment as a result of school closures

- Harm 4: economic harms, for example through the closure of businesses.

10. I would be invited to contribute to the Four Harms decision making process from a clinical perspective such as Infection Prevention and Control (IPC) and it would then be for others to consider and advise on the impact of other harms such as economic and social impact. All this advice would then have been pulled together and given to the relevant decision maker(s).

11. I have been asked how the SG might have benefited from adopting a more inclusive approach to receiving clinical and health advice in relation to its management of the ASC sector's initial response to the pandemic between January and March 2020. My understanding is that the Social Care Directorate (part of HSC which would have included the Chief Social Work Advisor), the CMO, the DGHSC and the Director for Community Health and Social Care all gave advice to the SG on the initial approach to the ASC sector response. It is difficult to know whether or not there would have been any different outcome had there been wider involvement of the CNO and the National Clinical Director (NCD) given the lack of testing capacity and lack of resources to quarantine care home residents with regards to buildings and staff. This was not a matter or affordability, rather that appropriate building facilities and staffing would not have been available. I have been asked by the Inquiry what advice I might have given to decision makers to mitigate the risks of community or hospital transmission into care homes (and other care settings), had I been involved in the decision making process between January and March 2020. I am unaware of what explicit advice was given by my colleagues as it would have been determined by Scottish Minsters what

advice was taken or rejected. It is not possible for me to comment on what advice I may have given as my view is completely clouded by what I now know. I also do not have access to the papers and advice that was considered.

Guidance

12. In terms of ASC sector specific guidance in relation to IPC, the Care Inspectorate (CI) was responsible for inspection of ASC prior to and throughout the pandemic. IPC is something that the sector is well used to, particularly as outbreaks of RSV, flu and norovirus are relatively common in communities and therefore care homes. IPC is central to this, isolation, intensive cleaning, the wearing of Personal Protective Equipment (PPE) etc. I was not aware of concerns being fed back to me that there needed to be ASC specific guidance and it might be helpful to understand going forward what difference ASC specific guidance made to ASC providers' practice. In terms of specific guidance on face masks in the ASC sector, the only feedback I received in that regard was anxiety over PPE supply difficulties early on in the pandemic, particularly as smaller organisations were finding it difficult to access affordable PPE due to global supply issues. The SG then stepped in to ensure adequate PPE was provided nationally, the decision to provide care providers with PPE through the local PPE Hubs was taken in mid-March 2020, with the Hubs going live on 19 March 2020.

13. In terms of the updating of guidance, I am not aware of any guidance in relation to ASC being unnecessarily delayed. ASC in general was the policy responsibility of the Social Care Directorate within ASC in which I, as CNO, and the CNO Directorate offered advice and fed into guidance. What I would say is that teams were trying to work in an inclusive way which, by nature, involved more people. For example, the Clinical Professional Advisory Group for Care Homes (CPAG) was commissioned by myself and the CMO and was established in April 2020, terms of reference provided [FMQ4/03 -

INQ000343806]. The role of CPAG, among others, was to involve a cross section of the ASC community, including family representatives, the Chief Executive of Scottish Care and a Director of a large care home, in the development of guidance. Whilst this was excellent in terms of inclusivity, it inevitably slowed matters down somewhat. In addition, evidence brought forward to support a certain approach would sometimes be ambiguous which would thereafter require further research to be undertaken, again, the result of which would slow the guidance process down, provided correspondence shows discussions regarding testing of asymptomatic staff and/or residents during May 2020 [FMQ4/04 – INQ000547472], [FMQ4/05 – INQ000547470], [FM04/05A – INQ000547471], [FMQ4/06 – INQ000259889]. I was advised by my team on what took place however the specificity is unknown to me.

14. On 2 April 2020 a joint letter was issued by myself and the CMO [FMQ4/06 - INQ000259889] highlighting the revised PPE guidance published by Department of Health and Social Care, HPS, Public Health Wales, Public Health Agency Northern Ireland, Public Health England and NHS England. This guidance allowed for health and social care workers to self-assess the risk associated with the tasks they were being asked to undertake and to make a professional judgement based on that, including choosing to use fluid resistant masks and masks / visors.

15. Following subsequent discussions with COSLA and UNISON, and a request from COSLA, I wrote to to COSLA on 5 April 2020 to provide supplementary guidance on the use of PPE by the workforce in Health and Care settings, provided: [FMQ4/07 – INQ000489902]. Within this letter, it was stated that: "*Where the person is neither suspected to be, nor confirmed as COVID positive, care at home staff carrying out personal care should wear what they have always worn – that is, an apron and gloves; and no mask".* I did not appreciate that this wording may have caused difficulty with local authority staff. Table 4 of the 2 April guidance previously circulated supported the wearing of a mask in areas where staff essentially believed Covid-19 may have been prevalent, even if their clients had no signs or indication of Covid-

19 infection. As soon as this anomaly was brought to the attention of the Scottish Government clarification was provided.

16. The letter of 5 April 2020 [FMQ4/07 – INQ000489902] also clearly stated that a home care worker would be expected to wear the same PPE as a community nurse in a range of situations. The situations being: "*the person being cared for is suspected of, or confirmed as having COVID; the person is neither suspected to be, nor confirmed as COVID positive; or, the person had not been expected to be suspected or confirmation as COVID positive, but then displayed symptoms on visiting their home*". The guidance further stated, "*The guidance is for the health and social care profession, but not specific to any aspect – so, for example, a home care worker would be expected to wear the same PPE as a community nurse, depending on the situation described above*".

17. A joint statement issued on behalf of SG, COSLA and the SJC Trade Unions on 9 April 2020 [FMQ4/08 - INQ000489903] confirming that the UK nations guidance published 2 April was the official and fully comprehensive guidance on use of PPE in the context of Covid-19. The guidance made clear that social and home care workers could wear a fluid resistant face mask along with other appropriate PPE, where the where the person they were visiting or otherwise attended to was neither confirmed nor suspected of having Covid-19, if they considered doing so necessary to their own and the individual's safety.

18. There was never any intention that Scottish social care workers would be out of step with the rest of the UK.

19. I am not aware of any other examples of confusion over applicable guidance in the ASC sector.

20. Guidance, frequency, updates and implementation timescales were agreed often by CPAG. As I have mentioned above at paragraph 13, members of CPAG included representatives from the ASC community including family

representation, the Chief Executive of Scottish Care, as well as a Director from a large charity providing adult social care. This was an inclusive process and CPAG would have considered what consultation with stakeholders would have been necessary. I was not aware of any concerns relating to matters such as the frequency with which guidance was published or updated, consistency with local or other guidance issued for the sector etc. In terms of the level of training and experience of the ASC staff applying the guidance, that was a matter for the CI and that was helped by the extension of responsibilities of the Executive Nurse Directors (ENDs) who could facilitate additional training if required.

21. I have been asked for my reflections on any additional concerns regarding ASC pandemic guidance of which you were or have become aware, for example, in relation to: a. the frequency with which guidance was published or updated; b. implementation timescales; c. the adequacy of prior consultation with stakeholders; and/or d. its consistency with local or other guidance issued for the sector; and/or e. the extent to which it took account of or was appropriately tailored to the unique features of ASC, including, for example: i. the close contact nature of care provided; i. the complexity and range of needs cared for including those with dementia, physical disabilities and learning disabilities; ii. the fact that most adults in receipt of ASC (including those in care homes) received that care in what were their residential homes as opposed to clinical settings; and/or iii. the level of training and experience of ASC staff who would be applying the guidance.

22. As I have noted above, I was not aware of any concerns raised by stakeholders regarding the ASC pandemic guidance. Any concerns would have most likely been fed into CPAG which included members of the ASC sector. I was latterly made aware of some concerns from the sector of guidance being issued on a Friday however my view is that it would have been inappropriate to delay guidance so it could be issued on the Monday of the following week.

23. I do not consider that the absence of tailored guidance specifically for ASC settings prior to 13 March 2020 adversely impacted the ASC sector's response to the pandemic. The sector is used to dealing with outbreaks of very infectious illnesses such as flu and norovirus and so is experienced in the use of IPC methods. Guidance on the use of face masks was universal and I do not consider this to have adversely affected ASC delivery. That guidance was updated in June 2021 which reflected the phase of the pandemic that we were in and was appropriate for that time. Guidance from June 2021 provided [FMQ4/09 - INQ000525332]. I am unaware of any adverse impact on the ASC sector in relation to updates to guidance following key changes to policies, learning about the virus or due to miscommunications, or confusion caused by rapidly evolving guidance. Having said that, I do recognise that, particularly at the start of the pandemic, rapidly evolving guidance would have been something relatively new to the ASC sector which is, by its nature, normally pretty stable. The expansion of the role of ENDs was a response by the SG to try to support the ASC in the understanding and application of rapidly evolving guidance.

Operational Support for the ASC Sector

24. A practical example of nursing leadership assistance that would have been offered was the reviewing of data on the daily dashboard which had been put in place to oversee activity and infection levels in care homes. Had a spike in infection been noted then a team, including a senior nurse and the CI, would have visited the home to provide help and guidance. The visit could have been a remote visit but in person visits were also carried out. This may have involved advising on storage of dirty linen, how to use PPE, or what intense cleaning was needed. Staff ought to have been well versed in matters of IPC such as us of PPE or disposal of linen, however there may have been times when perhaps staff were new and needed a bit of extra support however I cannot comment on how often this would have occurred as my role did not involve me being "on the ground" in care homes. Although staffing was tight,

there may have been assistance given if a care home was finding it difficult to provide safe staffing levels.

25. I met with Scottish Executive Nursing Directors (SEND) on a regular basis. Issues that were raised included lack of assess to vaccines or test results, staffing levels or assistance needed with updated on training around IPC. All such issues were dealt with at a local level by the relevant END.

26. I was not made aware of any difficulties at the time in the ASC sector of access to doctors, medication, ambulance services or other support services.

27. In my view, operational support was introduced to the ASC sector as soon as reasonably practical to do so. I would add that not all ASC staff thought it was necessary, for example, the increased role of ENDs but this did not extend to any serious concerns being reported to me. I do believe that operational support did improve outcomes for the sector was additional advice was given were needed (via ENDs) and issues were identified during a period when there was limited inspections being carried out and visitors were not present to advocate for their family member. To clarify, IPC advice is essentially advice on how to minimise the spread of infection. The virus does not differentiate between someone's home or a hospital. IPC principles are the same across all settings. An example of feedback being given from ENDs was feedback regarding the removal of ornaments. Had the ornaments not been removed, there may have been increased risk of spread of infection due to difficulties in cleaning.

28. In terms of what more could have been done to support the ASC sector in its operational response to the pandemic, due to the nature of ASC being a mixed delivery model, it meant that there was not always structured communication and support readily available. It was this concern that resulted in the expansion of the END role.

Matters relating to End of Life/Palliative Care

29. As outlined in my Module 3 statement to the Inquiry [INQ000474225] (17 June 2024), at paragraphs 148 to 149,

"148. In view of the concerns expressed about DNACPR in the media and in the Scottish Parliament, over whether there was a policy allowing the blanket use of DNACPR forms, Ministers made it clear in their public and parliamentary statements that they expected everyone supported by health and social care services to be treated with sensitivity, dignity and respect at all times, including during conversations around anticipatory care planning (ACP) with individuals and their loved ones, emphasising that no one should ever feel pressured to agree to a specific care plan or completing a DNACPR form if they are not comfortable doing so. These concerns were not raised with me during the specified period.

149. The SG has had a policy and guidance on DNACPR in place since 2010, which was updated in 2016, provided: [FMQ4/010-INQ000429278], to reflect changes in guidance from the BMA, the RCN and Resuscitation Council (UK). Its purpose is to provide guidance and clarification for all staff in NHS Scotland regarding the process of making and communicating decisions about CPR. The guidance makes it very clear that characteristics such as age, disability or neurodivergence should never be the sole reason for considering whether a person would benefit from CPR. It also explicitly states that there is never a justification for blanket DNACPR policies to be in place. Additionally, the SG Ethical Advice and Support Framework, published on 29 July 2020, provided: [FMQ4/011-INQ000233594], emphasised this point and made clear that health conditions or disabilities that are unrelated to a person's chance of benefiting from treatment must not be a part of clinicians' decision making regarding accessing treatment. I was not aware of any blanket issuing of DNACPR notices, however I was aware of disquiet about a reminder sent early in the pandemic to ensure, where appropriate everyone should have advanced directives in place, including DNACPR, in place. It is

my understanding that this was only a reminder for what would be expected practice was put in place to assist with ongoing healthcare delivery in what was expected to be a very demanding period."

30. I was aware that some homes were struggling to provide quality care in general (not specifically end of life/palliative care) due to staffing shortages, particularly for experienced staff. This difficulty in providing quality care was picked up by the CI and oversight by the END who would have actioned it appropriately. I do not have records of specific examples however I recall my team advising me that there were increased number of pressure sores being an example of inadequate care or inadequate wound care.

ASC Nursing Workforce

31. I am not aware of the enhanced role of ASC nursing staff had in the pandemic from April/May 2020, although the skill and dedication of ASC nursing staff were fundamental in providing care within the ASC sector during the pandemic. Staff were already trained and experienced in the use of IPC measures. In terms of a disproportionate impact on their mental health and wellbeing, to my knowledge the impact would have been then same as for wider healthcare staff. Nursing staff across health and social care faced a relentless demand on them to care for people with Covid-19. This, at least until vaccines were introduced, meant many nurses were seeing deaths in a far greater number than they would have outside the pandemic. The SG ensured measures were put in place to provide support for all health *AND* social care workers to try and mitigate distress. I am not aware of any impact that the enhanced assurance and reporting processes had on the mental health and wellbeing of ASC nursing staff, including any disproportionate impact. This information may come from colleagues who were closer to the workforce.

32. I believe a workforce which has increased numbers and increased education and training would provide a more resilient base for the ASC sector, particularly if/when another pandemic were to take place.

Lessons Learned and Recommendations

33. In terms of my reflections into what worked well during my time as CNO in the pandemic, I think a primary example has to be that of the extension of the responsibilities of ENDs. I believe this provided a vital tool to the ASC sector in understanding and implementing rapidly evolving guidance. This worked particularly well when used in conjunction with the daily dashboard safety huddles where care homes were required to provide daily status reports which included information relating to outbreaks of infection, occupancy and bed status - which facilitated situational awareness and risk assessment for care homes. This enabled care home managers to identify care needs and staffing levels to deliver safe and effective care and facilitated local Care Home Clinical and Professional Oversight teams to provide support where needed and if necessary escalate issues to the CI/ Health Boards and/or SG. In addition, as mentioned above at paragraph 13, the establishment of CPAG gave the ASC sector, and families of those using the ASC sector, a voice to be heard as well as input into guidance.

34. On entering the pandemic, SG policy on social care to have a mixed model of provision (public, third sector, private, charitable). Whilst this allowed choice for those using the sector and the ability for the sector to truly support individualised needs when the pandemic hit, this disjointed nature of the social care provision was a barrier in providing a comprehensive response to social care and starting off the pandemic with a health and social care workforce that was struggling with resilience in places was not ideal. By disjointed nature of social care, I found this to be so as care was being provided by a number of different organisations who were not necessarily connected. This meant that specialist and expert advice, or access to

purchasing PPE was a challenge until other arrangements were put in place, which did happen as soon as it was recognised as being problematic.

35. In addition, I would also refer the Inquiry to my thoughts on lessons learned as outlined in my previous statements. As outlined in my Module 2A statement [INQ000273977] (15 November 2023) at paragraph 27,

"27. On balance, much of what happened when responding to the pandemic was predicated on a plan for flu without due consideration being given to other options that may have altered the course of the pandemic. There was an opportunity from January to March 2020 to take actions that were different rather than put actions in place that assumed we were going to be overwhelmed with the virus. We did not properly consider the aftermath of reducing most NHS services, including treatment of drug and alcohol use, or mental health, which could have taken place remotely or been categorised as essential and taken place with NPIs in place. The decisions we seemed to be taking were linear in their nature around how to create capacity in the NHS to save lives and provide access to clinical care rather than how to prevent the virus from circulating by the use of border control, earlier lockdown, testing and tracing. Current SG policy on social care is to have a mixed model of provision (public, third sector, private, charitable). The disjointed nature of the social care provision was a barrier in providing a comprehensive response to social care and starting off the pandemic with a health and social care workforce that was struggling with resilience in places was not ideal. By disjointed nature of social care, I found this to be so as care was being provided by a number of different organisations who were not necessarily connected. This meant that specialist and expert advice, or access to purchasing PPE was a challenge until other arrangements were put in place, which did happen as soon as it was recognised as being problematic. Whilst we recognised the impact the virus had on the more vulnerable in our society, I wonder if we could have done more during the pandemic to support such groups."

36. With hindsight, a number of measures may have been beneficial: enhanced financial support to support families living in poverty to deal with food inflation of the additional expense of being at home; improved access to healthcare – in particular to mental health services or for those suffering from addiction who perhaps had lost their support network during lockdown in addition ot some services being curtailed; strengthening efforts to address food security; improved social isolation support; changing restrictions to support new mothers to receive additional in person support from family and friends; offering targeted support for children with additional needs; and more comprehensive support services for people who used drugs including alcohol.

37. As regards, pre-pandemic preparedness and planning, I refer the Inquiry to my Module 3 statement [INQ000474225] (16 June 2024) at paragraph 209,

"209. For the future, improved preparedness, including public debate about what actions will be taken (with consequences – so trading wellbeing and education of our young people with increased transmission of the virus. This could be tolerated with a firmer grip of protecting care home residents and those who shielded – it just needs to be thought through). There is no doubt that additional funding is needed to invest in preparedness and emergency planning – the question of course is where that money comes from – along with additional investment in our health and social care workforce."

38. I would also refer the Inquiry to my Module 5 statement [INQ999592216] (30 August 2024), paragraphs 45 to 46,

"45. I believe there were missed opportunities for us to model approaches other than lockdown to prevent spread of the virus. We were perhaps too focused on what we called 'harm one' (i.e. the direct health impacts of Covid-19') when more modelling could have been done on the other harms so we could better understand the longer-term implications of the approach we were taking. Harm one was the first of the 'Four Harms', which was the Scottish Government's process for assessing the multi-faceted harms of the Covid-19 crisis, namely the direct harm of the disease itself, the wider health harm, the

broader societal impacts, and the economic impacts of both the virus itself and our necessary responses to it.

46. The disjointed nature of the social care provision was a barrier in providing a comprehensive response to social care, and starting off the pandemic with a health and social care workforce that was struggling with resilience in places was not ideal. I describe the nature of social care as "disjointed" because care was being provided by a number of different organisations who were not necessarily connected. This meant that specialist and expert advice, or access to purchasing PPE, was a challenge until other arrangements were put in place, which did happen as soon as it was recognised as being problematic. The current policy of a mixed model of social care provision mitigated against easy access to expert advice or having purchasing power when there was international demand for products (such as PPE). Similarly there was not routine or regular clinical oversight of the organisation - as opposed to the individuals receiving care. Whilst we put measures in place to try and mitigate against this - it was applied hastily and was a change to existing practice. I can see two ways of improving this. Firstly, change the policy of social care delivery to one where there is a more systematic approach across the country to delivery of social care. This is not without its challenges as the very nature of social care means that bespoke services can provide personalised care to people who need social care support. Secondly, put in place systems and structures that would support a whole system approach to social care delivery should the need arise - such as in future pandemic responses - or other major crises or global shock."

Statement of Truth

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

Signed: Personal Data

Dated: 22 April 2025