

Thursday, 31 July 2025

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2 (10.00 am)

3 LADY HALLETT: Dr Mitchell.

4 Closing statement on behalf of Scottish Covid Bereaved by DR  
5 MITCHELL KC

6 DR MITCHELL: I appear as instructed by Aamer Anwar on  
7 behalf of the Scottish Covid Bereaved. In their opening  
8 submissions for this hearing, the bereaved noted that,  
9 for many of their number, this module was of particular  
10 importance. Their loved ones who died cannot raise  
11 their voices, so the bereaved seek truth and  
12 accountability on their behalf.

13 The bereaved are grateful to the Chair and all at  
14 Dorland House for all that they have done to help the  
15 bereaved discover the truth. Accountability, however,  
16 requires an acceptance and an assumption of  
17 responsibility for decisions made and actions taken by  
18 the decision makers themselves.

19 The bereaved consider that it is the professional,  
20 moral and ethical duty of those who were in positions of  
21 power during the pandemic to take responsibility for  
22 their acts and omissions.

23 The bereaved have listened as witnesses sought to  
24 evade accountability for their decisions. While some  
25 may consider it acceptable to say they cannot recall key

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1 professionals sought to use statistics to explain away  
2 hospital transfers as a mode of infection. While there  
3 may be many who are familiar with Mark Twain's view on  
4 the veracity of statistics, much of the evidence called  
5 to mind the words of a Scot, Andrew Lang, who noted that  
6 some used statistics as a drunk man uses a lamppost:  
7 more for support than illumination.

8 What trust can be placed in these statistics when  
9 hospital patients were being transferred into care and  
10 nursing homes without being tested, when the sick and  
11 dying were not being tested, and when the homes were  
12 suffering from clinical abandonment, with GPs not coming  
13 out to give even the most basic care and treatment.

14 It is a matter of great concern to the bereaved that  
15 there are many in the Scottish Government and NHS who  
16 seem content to conclude that an absence of evidence  
17 must mean there's an evidence of absence.

18 It is not good enough to claim in the early days of  
19 the pandemic that it was enough to leave matters to  
20 clinical assessment.

21 Dr Macaskill gave evidence in Module 2A, when asked  
22 if he recalled when in March 2020 Scottish Care had come  
23 to the view that there needed to be testing of  
24 admissions into care homes. His answer? Very early;  
25 indeed, probably late February.

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1 decisions and processes because of the passage of time,  
2 the bereaved do not have the luxury of saying it was  
3 a long time ago. The passage of time does not dim their  
4 memories or diminish the accountability of others.

5 The bereaved long suspected and now know that  
6 protecting the NHS came at the cost of sacrificing care  
7 and nursing homes. Untested and infectious patients  
8 were cleared from hospital wards into settings where  
9 they came into direct contact with those who were  
10 amongst the most at risk from the disease.

11 The bereaved share the reflection of  
12 Professor Banerjee of wondering whether the effect of  
13 the policies in place was to protect NHS from people in  
14 social care, rather than to protect those people in  
15 social care from Covid.

16 The bereaved listened with great care to the  
17 evidence of Jeane Freeman. It appeared to the bereaved  
18 that over the course of this Inquiry she has emerged as  
19 Schrödinger's health secretary, in Module 2A and in  
20 podcasts admitting to an inadequate understanding of how  
21 the adult social operated and not responding quickly  
22 enough, yet in this module having a good understanding  
23 of adult social care and being able to take that  
24 into account when making these key decisions.

25 The bereaved listened as politicians and

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1 On 11 March he wrote to all care homes advising that  
2 serious consideration to restrict access to their care  
3 homes should be given.

4 Further, on 18 March, after a meeting with the  
5 Scottish Government, he stated to members:

6 [As read] "I explained the concerns of providers,  
7 that we needed to be reassured that anyone entering the  
8 care home was Covid negative."

9 In evidence he stated:

10 "... we were very clear as an organisation,  
11 listening to our clinical colleagues out in the field,  
12 that they needed additional reassurance, and simply  
13 saying 'We leave this to the professionalism of clinical  
14 assessment', I'm sorry, it didn't wash at the time,  
15 I communicated this to the Cabinet Secretary, and  
16 I indicated that what we wanted and needed was testing,  
17 to evidence a negative test."

18 Why, then, was the policy of 13 March implemented  
19 and why did it take until April to changed it?

20 The politicians and clinicians must have known that  
21 the policy of transferring untested patients into care  
22 and nursing homes was causing outbreaks and death.

23 The bereaved considered that should not have taken  
24 Alasdair Donaldson, the official responsible for setting  
25 up the Vivaldi project, to point out that, as a matter

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1 of basic epidemiology and common sense, discharge  
2 without quarantine and tests was very dangerous indeed.

3 There's much else that the bereaved wish to say  
4 about the evidence led during this module and written  
5 submissions will follow.

6 The bereaved have, however, noticed that familiar  
7 themes have once again emerged: the need for proper  
8 preparation, the need for testing and tracing capacity,  
9 the need for equitable access to PPE, the need for  
10 effective IPC measures, the need for proper levels of  
11 sick pay for staff to allow them to isolate, the need to  
12 ensure that staff are not required to work across  
13 locations, and the need for proper equality impact  
14 assessments to fully consider the impact of decision  
15 making on the most vulnerable.

16 It has also become clear from this module that much  
17 more needs to be done to support those who provide care  
18 to loved ones at home.

19 The bereaved are not naive. They know that for the  
20 vast majority of residents, care and nursing homes is  
21 where they will spent their last days. That does not  
22 mean that they and their needs can be disregarded or  
23 they are acceptable collateral damage in the mission to  
24 protect the NHS. Those who lost their lives were loved,  
25 they are remembered, and they deserve justice and

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1 and neglect of the data infrastructure of social need  
2 beyond individual medical care. There is ignorance of  
3 what services a person receives from whom and whether  
4 those services are provided and, if not, why not.

5 If disabled people use personal assistants or rely  
6 on unpaid carers, there was no voluntary means to  
7 formally record those details. For infection control,  
8 there was no centralised basis to inform about PPE,  
9 testing and vaccines.

10 The Inquiry will be neither the designer, nor the  
11 deliverer, of the integrated data system that health and  
12 social care needs, but my Lady can detail the reasons  
13 and human cost to disabled people's visibility that  
14 arises from not having it, and you can suggest the  
15 combination of ethics, interests, experts and users that  
16 would be necessary to make the system effective,  
17 national and trusted by the people that it is foremost  
18 there to serve. In any methodology of change, Disabled  
19 People's Organisations have to be included and funded to  
20 work at the design specification stage.

21 For disabled people, institutions, particularly  
22 various forms of residential homes and confinement, are  
23 complicated spaces. Their history is entwined with  
24 further invisibility and asymmetries of power. The  
25 continuing absence of accessible data for modern care

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1 accountability.

2 These are the submissions of the Scottish Covid  
3 Bereaved.

4 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell.  
5 Very grateful.

6 Mr Friedman.

7 **Closing statement on behalf of Disabled People's  
8 Organisations by MR FRIEDMAN KC**

9 **MR FRIEDMAN:** As my Lady knows, we act for four national  
10 Disabled People's Organisations, or DPO, run by and for  
11 disabled people, they are Disability Rights UK,  
12 Disability Action Northern Ireland, Disability Wales and  
13 Inclusion Scotland.

14 Disabled people are not a homogeneous group, but  
15 their history and social reality gives it many of them  
16 cause to be particularly wary of four things: the way  
17 they are rendered invisible; what happens to them in  
18 institutions; how they can be abandoned in the  
19 community; and whether their lives are valued less than  
20 others.

21 In terms of invisibility, the Inquiry no longer  
22 needs anyone to tell it that central and local  
23 government's incapacity to collect and deploy data  
24 concerning the needs of its people in an emergency is  
25 a fundamental problem. There has been underinvestment

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1 settings does not sit well with the power that providers  
2 hold over persons in highly dependent conditions, which  
3 is why what should never have been allowed to occur  
4 during Covid-19 was the sustained shutting down of  
5 on-site, face-to-face, regulator inspections.

6 They could have been reframed to the pandemic  
7 situation, they needed access to PPE and testing. But  
8 when even the most committed working cultures can become  
9 fearful of criticism and closed off to change, routine  
10 inspections should not have been allowed to stop.

11 What was lost was the opportunity to view the  
12 records, see the residents, not just staff, understand  
13 the environment and reassure relatives. These things  
14 were lost in a fashion that remote calling could never  
15 duplicate at a time when the additional critical  
16 safeguards were removed: family and other visitors were  
17 mostly blanket excluded; death certificates were  
18 completed by non-attending physicians; inquests were  
19 unlikely; funding for infection prevention control had  
20 no auditing. And now, struggling to obtain their own  
21 PPE and testing, the regulators, the ones who were  
22 supposed to establish the quality of IPC in services,  
23 were publicly admitting their lack of capacity and faith  
24 to manage the issues themselves.

25 The principal objective of the inspectorates in all

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1 four nations is to protect and promote the health,  
2 safety and welfare of people who use care services.  
3 They can seek ways to best support the providers to do  
4 that but the inspectors are there for the users.

5 In each of the four nations, the regulators failed  
6 in that principal objective: they allowed their  
7 independence to be compromised, the nature of their role  
8 to be confused and the importance of their oversight  
9 function to be undermined.

10 As the reports of Penelope Dash and Sir Mike  
11 Richards show, this regulated crisis of reputation  
12 continues. The crisis is worthy of note, given that  
13 the UK Government has increased the role of regulators,  
14 especially for local authority care.

15 My Lady, another reason why DPO are ambivalent about  
16 institutions is that they believe in independent living  
17 in the community. But in enacting the Care Act  
18 easements and then failing to monitor how they were  
19 really used, DPO say that disabled people's living  
20 independently in their communities was subjected to  
21 straightforward abandonment.

22 The starting position is that easements should not  
23 have been introduced. With the threshold for  
24 entitlement to social care so high, and the means to  
25 challenge its refusal so limited, no government should

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1 unlawful interpretation, the government then produced  
2 pandemic guidance for easements that made multiple and  
3 undisciplined references to flexibilities, including  
4 general comments about the power to cancel services.

5 With foresight, that line between flexibility and  
6 easements could be obscured and, in full knowledge that  
7 the pre-pandemic system was vulnerable, the government  
8 received eight notifications of easements across  
9 a country now going through the greatest whole-system  
10 crisis since the Second World War. In an organisational  
11 act of wishful thinking, for all intents and purposes,  
12 no one really batted an eyelid.

13 At the same time, stakeholder and DPO services  
14 received multiple reports that care package services  
15 concerning home care were cut, the providers attest to  
16 their procured services being reduced, the in-depth  
17 studies confirm this to be the case and, even after  
18 easements were formally withdrawn, local authorities  
19 admitted to reducing activity to life and limb  
20 protection.

21 The idea that it was only eight is frankly  
22 ludicrous. If you look at the DPO evidence across the  
23 UK, combined with Every Story Matters, disabled people's  
24 worlds were turned upside down. People went without  
25 assistance to get meals, were left in bed for days,

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1 have legislated to allow local authorities to cease  
2 meeting pre-existing eligible needs.

3 Like the issue of staff movement, there needed to be  
4 a national and regional system to expand adult social  
5 care through mutual assistance, secondment from other  
6 public services and business, and with proper inclusion  
7 of DPO, third sector and community participation. We  
8 took extraordinary measures on furlough and  
9 vaccinations; we should have taken extraordinary  
10 measures on this.

11 However, once enacted, the lasting damage of this  
12 emergency legislation has been caused by a legal  
13 mythology that barely any authority across the UK needed  
14 to use it. The source of the mythology is the way in  
15 which the concept of flexibilities has been inflated and  
16 distorted. Flexibilities is a word that does not appear  
17 in the statute. It appears in the care and support  
18 guidance but largely to encourage diverse thinking about  
19 how assessed eligible needs are met, not whether needs  
20 are met.

21 Before the pandemic, with evidence about confusion  
22 over the law and scarce resources, there was lack of  
23 confidence that Care Act obligations were being met.  
24 Rather than policing the foreseeable risk that general  
25 references to flexibility would generate expanded

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1 soiled themselves in wheelchairs, lost home physio or  
2 daily contact visits that could forever damage their  
3 bodies or neurological development. The authorities  
4 that ceased to meet eligible need but failed to declare  
5 easements broke the law. But the ultimate damage of  
6 that law breaking is that derogation from statutory  
7 rights has been refashioned as flexibilities: as we say,  
8 a legal mythology and a terrible way of building back  
9 not better but worse.

10 Lastly, the fundamental concern of disabled people  
11 is that their lives will not be valued in the same way  
12 as others. The issue arises before disabled people are  
13 born, it continues throughout life and, during the  
14 pandemic, it manifested in DNACPR decisions. Some  
15 people at the top of the chains of responsibility still  
16 minimise this issue. The approach of the CQC and other  
17 reports has not helped the analysis because they focused  
18 on whether there was a national blanket policy as  
19 opposed to policies applied in a blanket way in local  
20 settings or to certain groups, about which the Inquiry  
21 has now unearthed ample evidence.

22 There were blanket approaches to agree to  
23 non-resuscitation notices that were flagrantly in  
24 violation of existing guidelines. Nothing signed by the  
25 clinicians were -- so notices signed by clinicians were

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1 added to records without consultation. There was  
2 literally targeting of people with learning disabilities  
3 and in instances where if residents had a DNACPR notice  
4 ambulances would not take them to hospital or care homes  
5 would not ask.

6 All of this could only have occurred because of  
7 a predisposition about the value of disabled people's  
8 lives and needs that arose in an organisational level in  
9 different services across each of the four nations.

10 My Lady, the Inquiry has been entrusted with  
11 strikingly wounded testimonies of what the death and  
12 suffering during the pandemic entailed. There are those  
13 that tried their utmost to mitigate that reality, and  
14 there are fixes that could be made to the system that  
15 can mitigate the pandemics of the future. However, the  
16 reason why this module is the ground zero of your  
17 investigation is because of the terrible inevitability  
18 of it all. It was inevitable not just because of the  
19 lack of planning but because of the constitutional and  
20 economic choices we have made about how we structure our  
21 care system. The shameful result is that under the  
22 system as it presently exists, disabled people's lives  
23 are absolutely valued less.

24 The DPO want to thank you and your team because it  
25 is only through this Inquiry that the stories and

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1 Caroline Abrahams explained that people in care  
2 homes had no rights really at all during the pandemic.  
3 Heléna Herklots identified insidious ageism that is  
4 embedded in our society. Disabled people felt their  
5 lives were less valued. Jane Wier-Wierzbowska explained  
6 a care home is not a hospital, it's a person's home, but  
7 in that moment that was taken away from us.

8 Some of the key factors that caused untold harm  
9 included: one, blanket policies instead of  
10 individualised assessments; two, the removal of  
11 oversight and inspections; three, the failure to listen  
12 to people who rely on care and their representatives;  
13 and four, the failure to record equal status and worth  
14 to the social care sector and those who used it.

15 Other important factors will be covered in our  
16 written closing submissions.

17 So, looking at the first of those, blanket  
18 separation of people from their essential care  
19 supporters had severe impacts on the physical and mental  
20 health of people drawing on care, across the wide age  
21 groups and diverse needs represented in the sector, and  
22 it contributed to many deaths.

23 Contrary to assumptions by witnesses such as  
24 Jeane Freeman, this was not just about social visiting  
25 or social impact. Jane Wier-Wierzbowska explained that

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1 insights of disabled people about what happened during  
2 Covid-19 have come to matter. As their co-advocates, we  
3 also rely on the contribution of the DPO, because people  
4 like Joanne Sansome are modelling what co-production is  
5 and they are sharing their expertise and theories of  
6 change to disabled people's lives, which is their human  
7 right to do.

8 Disabled people can show us what we cannot yet fully  
9 see. From the point of view of ground zero, they're  
10 telling us what has to be done.

11 **LADY HALLETT:** Thank you very much indeed, Mr Friedman.  
12 Extremely grateful.

13 Ms Jones -- oh no, Mr Straw, so sorry.

14 **Closing statement on behalf of John's Campaign, The Patients  
15 Association, and Care Rights UK by MR STRAW KC**

16 **MR STRAW:** My Lady, the evidence in this module has revealed  
17 significant failures during the pandemic to understand,  
18 respect, protect, and care for people who rely on adult  
19 social care.

20 As Caroline Abrahams said, being in a care home  
21 turned out to be almost the worst place you could be  
22 during the pandemic, and people receiving care at home  
23 fared no better. Person-centered care and  
24 individualised provision evaporated while fundamental  
25 legal protections were abandoned.

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1 family carers wanted to continue to provide essential  
2 care and advocacy, as they had been doing for years.  
3 Yet they were turned away when their loved ones needed  
4 them most. She said:

5 "... I want us to not forget what really matters.  
6 The love and care of our families, which no politician  
7 or care home manager should be allowed to deny us."

8 The harm caused by the restrictions were profound,  
9 periods of self-isolation, either for quarantine  
10 following an admission from home or hospital or when an  
11 outbreak was declared, entailed seclusion in a small  
12 room, usually sparsely furnished, often with limited  
13 ventilation, and no opportunity for exercise or to let  
14 fresh air in.

15 What a difference access to a care supporter would  
16 have made.

17 As the pandemic continued, such periods accumulated  
18 until some people were spending weeks in solitary  
19 confinement. Francis, who spent 65 days isolated in her  
20 room, said she felt caged like an animal, just fed and  
21 watered. She described lockdown as worse than living  
22 through the war.

23 My Lady, we recommend that there should be an  
24 obligation for such periods to be recorded and notified  
25 for safeguarding purposes, as they must be in mental

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1 health or prison systems.  
2 Isolation at the end of life also caused permanent  
3 emotional wounds. Jane Wier-Wierzbowska explained the  
4 impact of being denied contact with her mother as she  
5 was dying. She said:

6 "... I just felt that I'd let her down so badly and  
7 that guilt is with me always."

8 Joanna Killian from the Local Government Association  
9 recognised the trauma that people suffered when  
10 separated from their family members was inhumane and  
11 cannot happen again.

12 Paul Featherstone made clear that the starting point  
13 should be safely facilitating access, not denying it.

14 The measures introduced were particularly harmful  
15 for the 70% of people in care homes who had dementia.  
16 Professor Banerjee explained that:

17 "You can't underestimate the value to a person with  
18 dementia ... of visits from people they know and  
19 love ..."

20 Who provide social stimulation and prompt them to  
21 eat, drink, and use the memories that they have.

22 The loss of that care, he said, will cause  
23 a deterioration in those individuals, including through  
24 their dementia progressing more quickly.

25 The disproportionate number of excess deaths of

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1 This right must be enshrined in primary legislation.

2 As Susan Hopkins begins put it: if you want  
3 something done, legislation is where you start, because  
4 that requires people to deliver something; everything  
5 else is on best endeavours.

6 And that was demonstrated in practice. Guidance for  
7 the English essential caregiver scheme was ineffective  
8 and misapplied. The same is true of the fundamental  
9 standard on visiting now contained in Regulation 9A.

10 Michelle Dyson accepted that its exceptional  
11 circumstances opt-out clause means that it would provide  
12 no more protection than the guidance that existed during  
13 the pandemic. It is already regularly set aside when  
14 local authorities order homes to close in outbreaks.

15 My Lady, my second topic is oversight and  
16 monitoring.

17 Eddie Lynch described family members as eyes and  
18 ears on the ground. In their absence, and the absence  
19 of other professionals such as social workers and health  
20 practitioners, oversight mechanisms were all the more  
21 important.

22 Despite this, as Ms Ahmed made put it, the CQC in  
23 England went AWOL. There was no support for the sector;  
24 they were basically shutting down.

25 Inspections in the other nations were also paused

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1 people with dementia underscores how damaging it was  
2 when family care was withdrawn: a quarter of all Covid  
3 deaths were people with dementia.

4 As Professor Banerjee explained, this serious  
5 adverse impact of Covid restrictions on people with  
6 dementia was entirely predictable. Indeed, it was  
7 publicly predicted from the beginning of the pandemic,  
8 but decision makers didn't listen.

9 The evidence of Helen Whately, Professor Holland,  
10 Dr Townson, and others was that welcoming access for  
11 a care supporter who had appropriate protection, such as  
12 PPE and testing, did not significantly increase the  
13 risk.

14 Therefore, as Gillian Baranski and Caroline Abrahams  
15 put it, care supporters should be recognised as equal  
16 partners in care. Professor Barclay rightly said  
17 there's no question that family carers are a court part  
18 of the care team.

19 My Lady, we call for the right to a care supporter,  
20 even during the pandemic, to be protected in law, and  
21 implemented via explicit provisions both in individual  
22 care plans and in all IPC plans.

23 This right, which is also known as Gloria's Law and  
24 is set out in the Care Supporters Bill, is backed by  
25 over 100 health and social care charities and providers.

18

1 and then fundamentally altered. Remote inspections  
2 meant that regulators were speaking largely to care  
3 providers and not hearing directly from people receiving  
4 care. This created a significant gap, and the  
5 withdrawal of effective oversight had serious adverse  
6 impact on care standards.

7 Helen Wildbore gave evidence on the many who were  
8 afraid to speak out to challenge poor practice or report  
9 it due to fear of retribution, including eviction.

10 The regulator's role was crucial and the aim of  
11 reducing footfall in care homes was not sufficient,  
12 particularly as time went on, to outweigh the need for  
13 effective ongoing regulatory presence.

14 In its absence, reports of neglect or abuse of older  
15 people in care rose sharply, by 37%. Cathie Williams of  
16 ADASS agreed that this risk was obvious to ADASS members  
17 "in every conversation ... we had", and it should have  
18 been obvious to regulators and government.

19 It was also an issue for homecare providers.

20 So while the regulators in future must play their  
21 vital role, even during a pandemic, it is also crucial  
22 for there to be an effective means of resolving  
23 individual complaints and enforcing existing statutory  
24 duties. There needs to be a single, clear and  
25 confidential mechanism established for people relying on

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1 care to safely raise complaints and have them speedily  
2 resolved.

3 There also need to be clear lines of accountability  
4 within government. Government witnesses in this module  
5 have described having limited levers to intervene in  
6 social care, yet local authorities described feeling  
7 hamstrung by central government decisions. Care  
8 providers in the middle struggled to make sense of the  
9 differing approaches from both.

10 So whilst some of this difficulty arises from the  
11 fragmented structure of social care, that does not  
12 excuse the lack of transparent accountability.

13 My third topic is consultation with people who rely  
14 on care. There was a clear failure to consult people  
15 with lived experience, and the organisations who  
16 represent them. Their involvement in key decisions and  
17 the formulation of guidance would have helped overcome  
18 what Jane Townson called the absence of social care  
19 expertise in decision-making bodies.

20 As Professor Banerjee explained, consultation with  
21 people with dementia and their families would have given  
22 decision makers a better idea of what the potential  
23 challenges are. The information would have been more  
24 comprehensive, and also more inclusive for people with  
25 dementia. Had they been included, it's likely that

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1 witnesses agreed is needed.

2 My Lady, my final topic is the prioritisation of  
3 the NHS over social care. Within the department, the  
4 NHS had weighty resources, together with strong  
5 structures of accountability, oversight and expertise.  
6 That did not exist in respect of social care.

7 The serious imbalance in resources was described by  
8 Helen Whately as quite extraordinary, and she noted  
9 that:

10 "It was almost as if what matters was hospitals and  
11 not the health of the whole population, including those  
12 living in social care."

13 Unsurprisingly, this meant that the social care  
14 sector was neglected. This was unacceptable and  
15 a dereliction of legal duties.

16 Millions of people depend on social care, and yet  
17 many don't think about it until they need it, often at  
18 a point of crisis. The failure to give social care the  
19 status and prominence it deserves reflects a related  
20 failure to accord equal value to people who rely on  
21 social care.

22 One manifestation of this was the failure to provide  
23 adequate end-of-life care, an example is Allan(?),  
24 a 73-year old man who was refused both hospital  
25 admission and also end-of-life healthcare at home. His

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1 there would have been better and more effective  
2 decisions.

3 Helen Wildbore explained that you cannot understand  
4 social care until you understand what it's like to be  
5 a person who's drawing on care. She said that, from an  
6 early stage:

7 "... the stories were there. The impact was there.  
8 "We knew what was happening and they were shouting about  
9 what was happening, but still it didn't lead to any  
10 change in policy."

11 So even when stakeholders were listened to, as  
12 Professor Rayner found, their recommendations didn't  
13 manifest.

14 Claire Sutton, from the RCN, and others expressed  
15 similar frustrations. Helen Wildbore gave an example  
16 where suggestions for guidance were rejected within  
17 minutes, yet they could not have been properly  
18 considered in that time.

19 This failure to act on the views of people who rely  
20 on and provide care and the organisations who represent  
21 them was coupled with an alarming lack of data about the  
22 care sector. Decisions were made in a state of profound  
23 ignorance about the people who would be affected by  
24 them. The creation of a central base of -- database of  
25 comprehensive care sector data is something which many

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1 daughter said she was told he wouldn't even be given  
2 oxygen, "Simply left to die. A dog is treated better."

3 His experience, like many others, was a gross  
4 violation of his dignity and humanity.

5 It was disappointing that no one from the NHS came  
6 to the Inquiry to address these serious concerns.  
7 Helen Whately's question to GPs "Why aren't you there?"  
8 remains unanswered in this module.

9 The human rights of many in care were disregarded,  
10 yet they provide a vital safety net which is all the  
11 more important at times of crisis. They provide the  
12 standards below which no one should fall, and  
13 a practical tool and framework for the very difficult  
14 decisions that people in the care sector had to make  
15 every day in the pandemic. We therefore recommend that  
16 mandatory human rights training be provided at all  
17 levels to effect cultural change.

18 My Lady, as all the evidence in this module has made  
19 clear, people drawing on care suffered a catastrophe  
20 during the pandemic. It cannot be allowed to happen  
21 again for all our sakes. Thank you.

22 **LADY HALLETT:** Thank you very much indeed, Mr Straw.  
23 Ms Weston.

24 **Closing statement on behalf of Frontline Migrant Healthcare  
25 Workers Group by MS WESTON KC**

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1 **MS WESTON:** My Lady, I speak for the Frontline Migrant  
2 Health Workers Group. The group's members work both in  
3 the residential and domiciliary settings, for privately  
4 run care homes, in nursing and care assistant roles, for  
5 agencies, self-funders and publicly-funded service  
6 users. Many are domestic workers but provide social  
7 care. My Lady, the group is grateful for this  
8 opportunity and for the forensic scrutiny undertaken by  
9 this Inquiry.

10 My Lady, migrant care workers were the backbone of  
11 this fragmented sector during this pandemic. Our  
12 submissions seek to honour the memories of migrant  
13 workers who died during the pandemic, to ensure that the  
14 sacrifices and indignities they suffered are remembered  
15 and learned from, for those who continue to struggle  
16 under the same conditions.

17 The group's core point is that discriminatory and  
18 exploitative working conditions are a key reason why the  
19 risks of transmission disproportionately affected  
20 migrant care workers. Endemic problems in the sector of  
21 low pay, little recognition and support to care workers  
22 generally were compounded for the migrant section of the  
23 workforce by punitive immigration policies which  
24 prevented them from challenging unsafe work practices or  
25 seeking the assistance of public bodies and health

25

1 Some examples are the evidence of Professor Shallcross,  
2 that for-profit status was associated with significantly  
3 higher odds of infection in residents. Other research  
4 has demonstrated that care firms owned by private equity  
5 have significantly higher death rates and a significant  
6 connection between death rates and high rates of  
7 financial leverage. This point was also made powerfully  
8 by Paul Featherstone in his witness statement.

9 Since 2011, 816 care homes have been closed by the  
10 CQC, of those 804, ie 99 per cent, were for-profit care  
11 homes. Professor Rayner also noted in her witness  
12 statement that the not-for-profit sector is structurally  
13 more inclined to provide better pay and conditions. The  
14 Vivaldi Study made similar findings.

15 Professor Rayner also explained in oral evidence  
16 that not-for-profit organisations providing care also  
17 invest surpluses back into their organisations and will  
18 be typically governed by local representatives who  
19 approached their task with a sense of purpose -- of  
20 charitable purpose, in the interests of the service  
21 users, and are invested in the long-term ongoing  
22 provision of that service to meet the needs of that  
23 community.

24 Witness Bella Ruiz agreed when she said:

25 [As read] "Proper sick pay is possible. I currently

27

1 providers. In other words, put simply, low wages, poor  
2 terms and conditions and the lack of a safety net  
3 fatally undermined efforts to control the spread of the  
4 virus.

5 Despite these huge challenges, they performed vital  
6 work in protecting the lives and dignity of those in  
7 care, a contribution which went unrecognised by the  
8 government and the public. In fact, in the thousands of  
9 pages of documents disclosed within this module, few  
10 references to migrant care workers are found and little  
11 thought given to how their conditions should be  
12 improved. Thus, the group is grateful for the Inquiry's  
13 recognition of the incredible contribution these  
14 individuals made and we ask for this point to be  
15 reflected in its conclusions.

16 In this short closing address we summarise a couple  
17 of key points. Firstly, it's become clear during the  
18 course of evidence that the business model at the heart  
19 of care provision in the UK was fundamentally ill suited  
20 to pandemic resilience. The Nuffield Trust noted in  
21 2019 that the market approach incentivises organisations  
22 to provide a bare minimum of services, nothing more.  
23 What did a bare minimum mean? It meant no room for  
24 planning for pandemics.

25 Care for profit made a difference to transmission.

26

1 work in a charitable care home that pays full sick pay.  
2 I am valued, I receive bonuses, I get training for  
3 career progression."

4 It is possible, my Lady.

5 Secondly, the second point we would make is the  
6 downward pressure on pay and conditions impacted  
7 transmission of the virus. Here are the words of some  
8 workers who contribute to the group's evidence:

9 Victoria told Kanlungan about her feelings during  
10 the pandemic and she said:

11 [As read] "Sometimes you feel like what a miserable  
12 life. I can nearly die for £9.10 an hour."

13 Camila added, when faced with people clapping:

14 "What I need is a pay rise. I need an increase in  
15 salary. I don't need claps."

16 This was a recurring theme. Undocumented migrant  
17 workers were paid especially poorly, and in particular,  
18 due to their powerlessness. Gabriella told Kanlungan:

19 "If an employer sees you don't have a visa, then  
20 they don't pay you the minimum wage. They will ... say  
21 '... work for me this week, I'll pay you £600', not  
22 saying how many hours [that will be]. [And then you]  
23 work 100 hours."

24 As another interviewee put it:

25 "When you have nothing, you cannot say 'no'."

28

1 In fact, it was obvious at the outset of the  
2 pandemic, we say, that the lack of contractual sick pay  
3 for workers in the care sectors would lead to avoidable  
4 Covid transmission. The Government's first draft of the  
5 social care strategy in April 2020 recognised this and  
6 it suggested paying workers their full wages for up to  
7 so many weeks of sickness or isolation during the  
8 pandemic. They suggested that they would work with  
9 those representing care workers to ensure that there's  
10 a way that staff can flag if they are not receiving the  
11 support to which they are entitled.

12 However, minutes show that this policy was rejected.  
13 Why? Because it would be the first time that the  
14 government acknowledged that Statutory Sick Pay was not  
15 appropriate and clarification would be needed as to why  
16 the novel policy would not apply to all key workers.

17 Whilst Mr Hancock seemed to be unable to recall  
18 further details of this discussion when asked in this  
19 Inquiry, the reason is clear: the government refused to  
20 adapt sick pay to save face and deadly consequences  
21 ensued.

22 David Halpern, chief executive officer of the  
23 Behavioural Insights Team, explained that they found in  
24 July 2020 that care homes that paid sick leave  
25 immediately when someone had to self-isolate had Covid

29

1 would have been to legislate to create a right on the  
2 part of care workers to receive full pay upon isolation.

3 The consequences were devastating for workers. One  
4 of the group's interviewees, Elena, explained that due  
5 to a lack of sick pay when she was hospitalised from  
6 Covid, she felt she had to rush back to work. She said:

7 "I felt such anxiety. You don't know when it's  
8 going to end ... I have kids back at home."

9 A further key long of this Inquiry is that care  
10 workers are individual people. Some have health  
11 problems, issues with their families or their  
12 accommodation, with domestic violence or abuse. The  
13 difficulty for migrant workers is that, when faced with  
14 those problems, they are barred from the welfare safety  
15 net. Francesca Humi made clear this week migration  
16 status was another vulnerability layered on top of all  
17 the other risk factors that care workers faced.

18 When things went wrong, many were blocked from  
19 accessing vital services or were too afraid of being  
20 reported to the Home Office if they did so. The  
21 evidence highlights two fundamental problems with the  
22 Government's approach to the overseas care workers, we  
23 say: the structure of the visa system and its  
24 implications for public health; and systematic barriers  
25 to vaccination for migrant care workers.

31

1 case levels around 13% lower than care homes that did  
2 not and that this made the case for paying immediate  
3 sick pay for care home staff with possible Covid, and  
4 more generally for paying high risk, low income workers  
5 to self-isolate.

6 Having rejected the obvious case for increased  
7 Statutory Sick Pay to ensure self-isolation and  
8 recovery, the Government's solution was to distribute  
9 funds, not to workers but to local authorities, but this  
10 was hopeless without robust monitoring and enforcement  
11 and, in the end, far too many workers did not receive  
12 the money. In fact, evidence shows that providers were  
13 more concerned that the introduction of pay for  
14 self-isolation would set a precedent and, cynically,  
15 that workers would just take the money and stay home.

16 Helen Whately MP, when asked, was unable to provide  
17 a single example of when a local authority had sought to  
18 recoup money that had not been used for the ICF's  
19 intended purposes, citing local authority complaints  
20 about too much paperwork. Of course, local authorities  
21 were plainly very busy in the fight against the  
22 pandemic, as were care providers, and, as Ms Whately  
23 explained, she was both seeking cooperation and  
24 oversight of the use of the fund, an inherently  
25 conflicted role. A simpler and more effective approach

30

1 It also creates a distrust, the hostile environment  
2 creates a distrust, and the group wishes to highlight in  
3 particular one important aspect of the system that was  
4 routinely overlooked during the pandemic: the sector's  
5 reliance on undocumented care workers, for example,  
6 a domestic worker who came to the UK legally but whose  
7 visa expired because they were not able to find a new  
8 sponsor after leaving an abusive employer.

9 Whilst Covid-19 was excluded from the NHS charging  
10 regulations, researchers demonstrated that undocumented  
11 migrants continued to be deterred from seeking medical  
12 care, even where conditions were excluded, such as  
13 treatment for tuberculosis. This had crucial  
14 implications, my Lady, when it came to the vaccination  
15 programme.

16 Gabriela, an interviewee for Kanlungan, put it this  
17 way:

18 "Covid doesn't care if you have documents or not --  
19 it can spread around anyone."

20 She questioned how could that flatten the curve if  
21 undocumented workers were too scared to engage with  
22 public services.

23 Another point which we would highlight is the  
24 sidelining of domiciliary care. My Lady, the Inquiry  
25 has heard from a number of groups and submissions on

32

1 that issue. However, our group's interviewees do give  
2 colour to the devastating consequences that ensued from  
3 that sidelining. Elena recounted a particularly  
4 harrowing example of this when she was trapped in her  
5 employer's home on half pay on the basis that food and  
6 lodging were being provided, or even Jenny, whose  
7 elderly employer got Covid-19, and was then told she  
8 could not leave the home. She caught Covid-19 herself  
9 and then the family delivered food for the elderly  
10 service user, but did not provide anything for Jenny.  
11 It was Kanlungan that stepped in and provided food so  
12 she could survive, my Lady.

13 My Lady, we have number of very brief  
14 recommendations, four in number. First, is we accept  
15 that structural change in the sector is difficult, but  
16 we do say that the evidence makes a compelling case for  
17 the following:

18 (i) To ensure that rates and availability of sick  
19 pay in the sector are examined within any forthcoming  
20 fair pay review, and that the government promptly adapts  
21 sick pay to ensure that key workers are able to self  
22 isolate and recover safely, even if the criteria don't  
23 meet the terms of sick pay.

24 Secondly, a national social care provision adopting  
25 a model similar to the NHS is required and the role of

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1 recommendations that your Ladyship may wish to consider.

2 But before turning to the future, we must first  
3 address one significant factual issue: the routes by  
4 which the virus entered care homes. This point is  
5 particularly significant to care professionals, many of  
6 whom have felt unfairly blamed as a result of the  
7 overstatement of the scientific evidence in some  
8 quarters.

9 Our primary submission is that the overall effect of  
10 the evidence is that it is not possible to determine  
11 with any confidence what the dominant route of viral  
12 ingress into care homes was, either at any one time, or  
13 overall.

14 Professor Shallcross, who your Ladyship might think  
15 was an impressive and lucid witness, was clear about the  
16 limitations of the Vivaldi Study. She explained that,  
17 in the absence of comprehensive testing in the early  
18 stages of the pandemic, it is not possible to identify  
19 which of the seven potential transmission routes was  
20 dominant. Professor Hall agreed to some extent. Both  
21 experts accepted that the picture was complex, nuanced,  
22 and likely to have evolved over time.

23 Through CTI's careful questioning of Professor Hall,  
24 it became clear that the evidential foundation for the  
25 conclusion set out in the May 2022 consensus statement

35

1 profit extraction business models in social care needs  
2 to be reduced or eliminated.

3 Thirdly, action to rebuild trust between Government  
4 and migrant worker communities is urgently required  
5 before the next pandemic strikes.

6 Fourthly, remove or reduce fees or in-country visa  
7 variation applications to ensure that workers are  
8 empowered to make safe decisions to comply with pandemic  
9 measures in any future pandemic, my Lady.

10 Lastly, we would ask the Inquiry to acknowledge and  
11 reward the vital work of migrant workers during the  
12 pandemic. They were disproportionately affected by the  
13 virus and disproportionately affected by the lasting  
14 pandemic effects of Long Covid, poverty, insecurity and  
15 poor mental health. My Lady, in sum, a properly  
16 protected workforce is an essential public health  
17 measure if the past is not to be repeated.

18 My Lady, unless I can assist further, those are our  
19 submissions.

20 **LADY HALLETT:** Thank you very much indeed Ms Weston.  
21 Mr Payter.

22 **Closing statement on behalf of National Association of Care  
23 & Support Workers by MR PAYTER**

24 **MR PAYTER:** My Lady, on behalf of the National Association  
25 of Care and Support Workers, we focus our submissions on

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1 is not sufficiently robust to support an equivalent  
2 finding by this Inquiry. The absence of meaningful  
3 testing data from the early phase of the pandemic  
4 significantly undermines any such conclusion. Moreover,  
5 the consensus statement was based on a number of  
6 assumptions and over-simplifications. Its hierarchy of  
7 transmission routes was derived from unspecified expert  
8 input, rather than from social contact or mixing data,  
9 which does not exist, and it failed to account for key  
10 variables such as temporal changes and regional  
11 variation. It also inappropriately conflated domestic  
12 staff and care professionals, reflecting a lack of  
13 precision in its approach.

14 Later in his evidence, in the different context of  
15 quantifying the negative impacts of isolation,  
16 Professor Hall said:

17 "... you only assume things to test them later. So  
18 it's incredibly obvious ... to assume that, oh, it's  
19 obvious, it's common sense."

20 That, we submit, applies with equal force to  
21 transmission routes.

22 The Inquiry should also record that hospital  
23 discharges constituted a route of ingress into care  
24 homes, one that was significant, one where far more  
25 could and should have been done to prevent or mitigate

36

1 the associated risks, and one which reflected the  
2 over-focus on the NHS at the expense of adult social  
3 care.

4 We invite your Ladyship to record the position in  
5 which care professionals were left, particularly at the  
6 outset. Far from being thrown a protective ring, care  
7 homes, their residents and staff, were effectively cast  
8 adrift and left to navigate the crisis alone. Despite  
9 being asked three times by Ms Carey, King's Counsel, the  
10 former Secretary of State for Health and Social Care was  
11 unable to identify any specific measures that  
12 constituted his so-called protective ring, or even his  
13 broken circle, at the point the hospital discharge  
14 policy was implemented.

15 As he ultimately accepted, there was limited PPE and  
16 none provided by the Government at that stage, no  
17 testing, no designated facilities for isolation, no  
18 guidance to isolate residents, no advice against staff  
19 movement between settings and wholly inadequate sick  
20 pay.

21 Your Ladyship also heard that the initial business  
22 as usual guidance issued to the sector in February 2020  
23 was inaccurate, misleading and persisted for far too  
24 long, well into March, despite emerging credible  
25 evidence of asymptomatic transmission as early as

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1 occur.

2 In our written and oral opening submissions, we  
3 invited your Ladyship to consider throughout the  
4 evidence whether mandatory professional registration of  
5 care professionals in England would enhance the response  
6 to a future pandemic. We are grateful to your Ladyship  
7 and Counsel to the Inquiry for having explored this  
8 issue with a wide range of witnesses. There was broad  
9 agreement that registration would offer substantial  
10 benefits and contribute meaningfully to a number of  
11 recurring themes in the evidence that undermined the  
12 sector's response.

13 In relation to workforce capacity, registration  
14 forms a key part of the professionalisation of care  
15 work: it provides formal recognition of the value and  
16 importance of the role; supports the development of  
17 consistent training standards and should, in turn, help  
18 drive improvements in working conditions, which will of  
19 course encourage recruitment, retention and improve  
20 employability.

21 There is no substantive evidence from the devolved  
22 administrations, which have a system already, to support  
23 the sole concern raised against a mandatory register in  
24 England: that it could affect negatively workforce  
25 capacity. The tiered system described by

39

1 January and February.

2 On that point, your Ladyship may wish to recall that  
3 a core mistake of the scientific and political response  
4 was that assumption that asymptomatic transmission was  
5 not possible unless proven otherwise.

6 As events showed, if that assumption is wrong, it is  
7 too late to act by the time it is corrected. In the  
8 event of a new pandemic, the assumption should be  
9 reversed on a precautionary basis.

10 My Lady, turning to recommendations for the future,  
11 we begin with a general observation, if we may. Your  
12 Ladyship is quite properly focused on recommendations  
13 that would improve the response to any future pandemic.  
14 However, that focus need not and should not preclude  
15 recommendations that would also have broader systemic  
16 benefits outside of a pandemic context.

17 We would also respectfully urge your Ladyship not to  
18 hesitate in making recommendations that may involve  
19 a cost, even a significant one. Your Ladyship will, of  
20 course, only wish to make realistic proposals but  
21 questions of affordability and implementation are  
22 ultimately for those tasked with acting on your  
23 Ladyship's recommendations. In any case, for the  
24 recommendations we suggest, early investment is likely  
25 to result in long-term savings should a future pandemic

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1 Mr Featherstone to your Ladyship is one way that could  
2 ensure that there are no barriers to entry for new  
3 recruits from all backgrounds.

4 As to data, the benefits are multifold. For  
5 example, registration would facilitate more accurate  
6 workforce planning, enabling the identification of  
7 current and projected staffing shortfalls, including on  
8 a regional and local basis, and it would allow for  
9 better targeting of support in areas under pressure  
10 during the pandemic.

11 As to sector fragmentation, a single register will  
12 allow for direct communication with staff, including the  
13 rollout of critical training. It could also operate as  
14 a constructive and non-coercive channel to promote and  
15 perhaps monitor vaccine uptake. It could also be used  
16 to contact and encourage former carers back into the  
17 sector.

18 As my Lady knows, NACAS has established a voluntary  
19 register for England and this month the Professional  
20 Standards Authority confirmed that it met the public  
21 interest test for accreditation. The PSA recorded its  
22 view that professional registration could help improve  
23 care standards and enhance recognition for practitioners  
24 from all backgrounds.

25 My Lady, consideration will need to be given to what

40

1 information is stored on any register. As a minimum, it  
2 should record information on employment locations,  
3 training history and contact details. My Lady may also  
4 wish to recommend that the existing registration bodies  
5 in the devolved administrations review the data held on  
6 their registers to ensure that it is capable of  
7 supporting an effective pandemic response.

8 My Lady, NACAS is willing to take responsibility for  
9 administering such a register but is not possessive over  
10 its work. The critical point is that the register is  
11 created.

12 My Lady, pay and working conditions. Your Ladyship  
13 observed in your remarks to multiple witnesses,  
14 including Mr Featherstone on Monday, that the overriding  
15 message from the sector was a call for recognition.  
16 Recognition of their sacrifices, their contributions,  
17 their skills, and their equal importance to society  
18 alongside the NHS in the event of a pandemic. But  
19 recognition must extend beyond words and the clearest  
20 and most meaningful form of recognition for the adult  
21 social care workforce, as with any workforce in a market  
22 economy, is reflected in its pay and the terms and  
23 conditions of employment. It is striking, my Lady, that  
24 carers in adult social care are not paid at the same  
25 rate as healthcare assistants in the NHS, despite

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1 Ladyship to consider a number of key starting points  
2 that should form the basis of any pandemic plans.

3 First, equity of access. The Inquiry should  
4 recommend that prioritisation for testing, PPE and  
5 vaccine provision should be the same for NHS and adult  
6 social care, including domiciliary care. It is  
7 especially important for domiciliary care. The thrust  
8 of the evidence is that home care was marginalised, even  
9 with a system already treated as secondary.

10 Second, adult social care professionals should be  
11 recognised immediately as essential workers.

12 Third, there should be improved national accredited,  
13 pandemic focused IPC and palliative and end-of-life  
14 training for the sector.

15 Fourth, pandemic plans must identify designated  
16 settings and step-up and step-down facilities. There  
17 must be a mechanism for such plans to be reviewed by  
18 a body with central oversight of them.

19 Fifth, scientific and other advisory and working  
20 groups focused on adult social care should established  
21 at the outset of any future pandemic and should include  
22 voices from across the sector, including users, the  
23 workforce and providers.

24 My Lady, finally there are two points that we urge  
25 you not to recommend.

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1 performing broadly equivalent roles.

2 The Employment Bill, currently working its way  
3 through Parliament, provides for the establishment of  
4 a Fair Pay Agreement sectoral bargaining process in the  
5 sector. It was touched upon in the evidence by  
6 Michelle Dyson from the department.

7 Against that background, your Ladyship may wish to  
8 consider recommending that existing bodies commissioning  
9 adult social care services and the negotiating bodies  
10 that will be established should the Bill pass, should  
11 take into account the need to strengthen workforce  
12 capacity as a core element of pre-pandemic preparedness.  
13 That, in turn, requires consideration of improved pay,  
14 at a minimum the real living wage but preferably parity  
15 with NHS healthcare assistants and the provision of  
16 guaranteed occupational sick pay.

17 Commissioning bodies could embed those baselines in  
18 contracts with care providers, as already happens in  
19 some areas, and these steps would represent meaningful  
20 progress towards achieving parity of esteem with the NHS  
21 and incentivising staff not to work in multiple settings  
22 in the event of a future pandemic.

23 My Lady, under the header of pandemic planning and  
24 while acknowledging that much will depend on the  
25 characteristics of any future pathogen, we invite your

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1 First, mandatory vaccination for care workers. We  
2 challenge the former Secretary of State on his policy.  
3 NACAS members' views on the policy vary but the point  
4 that we sought to make is not that the policy is without  
5 merit but is not without consequences. The consequences  
6 were a significant net fall in the number of people  
7 working in adult social care, as compared to the period  
8 immediately before and after the policy was announced  
9 and put into effect.

10 Second, we urge you not to recommend mandatory  
11 restrictions on staff movement for care workers, either  
12 now or in the event of a future pandemic. During the  
13 pandemic, such restrictions were unworkable due to  
14 critical workforce shortages and, even if capacity was  
15 significantly improved, providers and staff still need  
16 a degree of flexibility to manage absences and working  
17 patterns. Moreover, with adequate workforce planning  
18 and broader pandemic preparedness, such restrictions are  
19 unlikely to be necessary at all and that is all before  
20 even accounting for the concerns for personal freedom  
21 and the discriminatory singling out of this workforce.

22 Finally, my Lady, may I, on behalf of NACAS, express  
23 our sincere thanks to your Ladyship and your entire team  
24 for the thoughtful way in which this module has been  
25 conducted and for giving a voice to, as Mr Featherstone

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1 emphasised on Monday, the amazing adult social care  
2 workforce.

3 **LADY HALLETT:** Thank you very much indeed, Mr Payter.  
4 Professor Rayner, you're over there.

5 **Closing statement on behalf of the National Care Forum by**  
6 **PROFESSOR RAYNER**

7 **PROFESSOR RAYNER:** Thank you.

8 My Lady, I speak on behalf of the National Care  
9 Forum. My Lady, in our opening statement for Module 6  
10 of this Inquiry, we asserted that social care was  
11 overlooked, misunderstood and disadvantaged in a variety  
12 of ways, which worsened the impact of the pandemic on  
13 recipients of care and support, their communities, care  
14 workers, and care and support providers.

15 The evidence we have heard and read over the past  
16 month shows that the situation was significantly bleaker  
17 than we expressed. My Lady, you and your team have been  
18 painstaking in your analysis of the situations facing  
19 the sector. You have heard from officials and  
20 Government ministers that this was a sector that was  
21 underfunded, fragmented and diverse, and the  
22 responsibility of 150 plus different authorities.

23 You have heard that care was delivered by  
24 a patchwork of local authority, not for profit, small  
25 and very large private organisations, that social care

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1 organisations who took on health tasks when community  
2 health services stopped coming. They all did this  
3 within a backdrop where social care, the people it  
4 supports and carers, both paid and unpaid, were not  
5 prioritised and this must never happen again.

6 We heard from some witnesses that all the solutions  
7 for social care come under the umbrella of reform and  
8 that that task has already been assigned to Baroness  
9 Casey. However, whilst we urgently need her focus on  
10 social care, what you've heard during this module are  
11 not the longer-term ambitions of reform. These are the  
12 basic necessities of getting social care to be ready for  
13 another pandemic. These are not things that can wait;  
14 they are urgent. They need gripping and they need  
15 action now.

16 There are two strong themes that I want to emphasise  
17 in this closing statement, alongside a reflection on  
18 many of the recommendations that the Inquiry has heard.  
19 These two areas relate to the status of social care and  
20 its role as a public service.

21 Multiple testimonies during this module has focused  
22 on the inappropriate lower status attributed to social  
23 care in decision making, resourcing, political focus and  
24 prioritisation. Powerful testimony from care providers,  
25 local government colleagues, directors of Social

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1 is complex, delivering home care, residential care, day  
2 services, supported living, extra care housing and more  
3 for all ages. You've heard from a Secretary of State  
4 who felt they had limited levers over the sector and  
5 a Care Minister whose evidence indicated her views were  
6 overlooked and on occasions overruled, and that there  
7 was no real-time data to understand what was happening  
8 on the ground.

9 These things are, of course, part of the picture.  
10 However, I hope that you have also heard that, despite  
11 these factors, social care is staffed by extraordinary  
12 people who during the pandemic worked as hard as they  
13 could to keep people safe. You have heard directly from  
14 witnesses who gave painful and vivid testimony of the  
15 reality of working in a care home during the pandemic,  
16 of people working in the community who overcame enormous  
17 logistical barriers to access the testing and PPE to  
18 continue to deliver.

19 You have heard about organisations, the majority of  
20 which were very small, who turned themselves inside out  
21 to cope with unwieldy, often contradictory, interrelated  
22 guidance that did not recognise their operating  
23 environment, and organisations who completely repurposed  
24 their accommodation to enable visitors within  
25 extraordinarily restrictive guidelines, and staff and

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1 Services and others are clear that there were multiple  
2 occasions where social care was not recognised for the  
3 work that it was doing or for the expertise that was  
4 held by those fundamental to its delivery.

5 Questions asked by the Inquiry have demonstrated  
6 starkly the lack of ownership and accountability  
7 exhibited by public bodies, both in where they thought  
8 responsibility sat and the siloed approach to developing  
9 responses to the challenges facing the sector.

10 Responsibility at the local level swung between NHS  
11 England and local authorities and almost always the  
12 needs of the acute hospital system trumped those of  
13 people living and working in care and support. Even at  
14 ministerial level, accountability was unclear and  
15 confused, with huge delegation of tasks by the Secretary  
16 of State, but seemingly without the associated power,  
17 oftentimes leaving the Minister frustrated at the  
18 system's disregard of many of her concerns.

19 It has been very important that the Inquiry has  
20 gathered evidence in relation to the months before the  
21 pandemic began in the UK. During these precious missed  
22 months of January and February 2020, organisations like  
23 the National Care Forum were raising questions and  
24 challenging the unworkable nature of advice being put  
25 forward by experts without detailed understanding of

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1 social care.

2 While ministers and officials were behind the scenes  
3 discussing the presence of asymptomatic transmission,  
4 guidance was dispatched that was impossible to implement  
5 and created a false sense of assurance about the risks.

6 During this precious pre-pandemic period, there was  
7 no attempt to have a strategic conversation and build  
8 a formal partnership with social care, meaning there  
9 were multiple missed opportunities to work through the  
10 potential implications and the respective mitigations  
11 for those receiving care and the care workforce.

12 The failure to include adult social care  
13 meaningfully in pandemic planning must never be  
14 repeated. Adult social care and support providers and  
15 their representatives must be included as core strategic  
16 partners in pandemic planning exercises, expert advisory  
17 forums, such as SAGE, decision-making groups, relevant  
18 taskforces and policy development. Representatives from  
19 adult social care should also be included in governance  
20 arrangements at a local, regional and central level, to  
21 ensure their perspectives and operational realities are  
22 fully considered.

23 Not recognising the importance of social care  
24 resulted in guidance that was nigh on impossible to  
25 implement, unsuitable to the settings and the people it

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1 were patients. It understood they needed tests. It  
2 understood that those who worked with them needed PPE.  
3 It understood they needed access to clinicians to  
4 address their wider health needs, yet it seemed to lose  
5 sight of those self-same people the minute they stepped  
6 out of the hospital door. This is not a new feeling for  
7 those receiving care, but it must change.

8 In reality, the public service that is social care  
9 is, in fact, often much more fundamental, and embedded  
10 in people's lives than that of the health sector. It is  
11 often providing them with a home, support to access  
12 jobs, education, ensuring they have a positive end of  
13 life, supporting their connection with family and  
14 friends, enabling them to rebuild and reconnect in  
15 a million different ways, for a million different  
16 people. It is delivered through long-term relationships  
17 with an extraordinary workforce who are as diverse in  
18 make-up, skills, experience as the needs of people  
19 receiving care.

20 It has been suggested by a witness in this Inquiry  
21 that it is unhelpful to pit public services such as  
22 health and care against each other. However, I would  
23 politely suggest to that witness that the evidence heard  
24 during this module would suggest that any amount of  
25 pitting that the Inquiry may or may not choose to do, it

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1 applied to with implementation timescales that were far  
2 too tight.

3 This point was made very powerfully when one witness  
4 described the impact of the guidance developed in  
5 relation to visiting, where the lack of understanding of  
6 the needs of those receiving care and support meant that  
7 the guidance was so potentially damaging that people  
8 needed protection from the measures included in the  
9 guidance that had ostensibly been brought in to protect  
10 people.

11 I am of no doubt, my Lady, that you will have  
12 understood just what an integral role social care plays  
13 in the lives of millions of people. It is clear to us  
14 had social care is a vital public service in its own  
15 right. However, at the outset of the pandemic, social  
16 care was seen as a tool to enable the acute health  
17 system to continue functioning. It was noted by the  
18 former Care Minister in her oral evidence:

19 "It was almost as if what matters was hospitals and  
20 not the health of the whole population."

21 She went on to ask:

22 "What would it take for ... [the NHS leadership] to  
23 be thinking about the health of the whole population,  
24 including those who receive social care?"

25 It seemed that the system could see people when they  
50

1 will find its starting point is fundamental and  
2 entrenched dominance by health, the reality of which had  
3 devastating consequences for the social care sector and  
4 everyone connected with it.

5 This embedded disregard for social care has  
6 sustained beyond the pandemic and it has been alarming  
7 to hear from a number of witnesses who spoke of the  
8 dismantling of key measures introduced during the  
9 pandemic to support adult social care around data and  
10 research innovations. It is not good enough for these  
11 to have been crisis-based responses and dismantling them  
12 hamstringing future efforts for academic research, reform,  
13 integration with health services and the ability to  
14 respond to early warning signs.

15 My Lady, during the course of this module there have  
16 been a large number of recommendations that we would  
17 like to offer our support to. In our written submission  
18 we will provide more detailed feedback around the  
19 practical implementation of these. However, for the  
20 purposes of this statement, these include, but are not  
21 limited to: in relation to the workforce, the  
22 development of a register of workers and the provision  
23 of step-up training to be made available for social care  
24 staff in line with new responsibilities and skills  
25 acquired during a pandemic.

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1 In relation to IPC, peacetime preparation of key  
2 building blocks in IPC, such as fit testing, measures to  
3 ensure immediate access to the PPE supply chain and the  
4 free supply of PPE in the advent of the pandemic, and  
5 the establishment of protocols and understanding of how  
6 to prioritise testing and vaccination for all parts of  
7 the care sector, to be delivered in situ where possible.

8 Funding during a pandemic, the ability to get  
9 funding directly to providers at pace and without  
10 bureaucracy, and the instigation of payment mechanisms  
11 such as "pay on plan" that ensure that delivery  
12 decisions are not predicated on financial imperatives.

13 For essential carers, the need to ensure that  
14 families and essential caregivers are still able to see  
15 their loved ones, and that effective IPC measures are in  
16 place to enable this safely.

17 And finally, around data and digital, to rebuild and  
18 sustain the architecture for real-time data to enable  
19 early warning signs in relation to the impact of any  
20 future pandemic, the development of a social care data  
21 observatory, and a commitment to strengthen the digital  
22 framework and expertise.

23 My Lady, in conclusion, it is clear that the people  
24 who work in, draw upon, and provide care and support  
25 services, were simply not prioritised by decision

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1 Homecare Association, which represents and supports  
2 providers of professional home care across the UK. When  
3 I delivered my opening statement, I spoke of devastating  
4 paradoxes and systemic failures.

5 I highlighted how professional home care, supporting  
6 nearly 1 million people across the UK, more than double  
7 those in care homes, was overlooked, misunderstood, and  
8 disadvantaged during our greatest peacetime emergency.

9 Today I stand before you not to rehearse those  
10 failures, but to chart a course towards resilience.

11 The Inquiry has illuminated uncomfortable truths but  
12 it has also revealed something profound: the  
13 extraordinary capacity for transformation that exists  
14 within our care systems when we have the wisdom and  
15 resources to harness it.

16 Through a month of oral evidence, we have heard  
17 a consistent narrative: care workers risked their own  
18 health and well-being to maintain the dignity and safety  
19 for those most at risk at home. Many did so despite  
20 being denied the tools they needed: adequate PPE, timely  
21 testing, fair wages, and recognition as essential  
22 workers.

23 We have learnt that whilst the government proclaimed  
24 'Stay Home, Protect the NHS, Save Lives', the unintended  
25 consequence was over 100,000 excess deaths at home by

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1 makers, whose focus was protecting the acute health  
2 system rather than citizens in all communities.

3 Before I close, I want to pay tribute to the amazing  
4 work of our not-for-profit members and their care and  
5 support workers. They provide an essential public  
6 service and enable people of all ages and all  
7 circumstances to live good lives alongside the  
8 communities and people they love.

9 The care they provide is the backbone of many  
10 communities, families, and local economies, as well as  
11 the wider well-being and population health. We forget  
12 that at our peril.

13 My Lady, my final words are to recognise the  
14 strength of those witnesses who provided powerful  
15 personal testimony to the Inquiry. I have been very  
16 impacted by their words, and one phrase spoken  
17 epitomised what I have heard throughout: we all deserve  
18 better.

19 Those are our closing submissions, my Lady.

20 **LADY HALLETT:** Thank you very much indeed, Professor Rayner.

21 Dr Townson, would you like to take us up to the  
22 break?

23 **Closing statement on behalf of the Homecare Association by**

**DR TOWNSON**

24 **DR TOWNSON:** My Lady, I speak on behalf of the

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1 July 2022, most from non-Covid-19-related causes, such  
2 as dementia and cancers, a stark displacement that  
3 revealed the fatal flaw in hospital-centric emergency  
4 planning.

5 But from around the world we have seen glimpses of  
6 other models and different ways of thinking about the  
7 role of home-based care and support.

8 In Italy, Dr Luigi Cavanna's revolutionary  
9 home-based Covid-19 care achieved hospitalisation rates  
10 of fewer than 10%. Italy's national continuity care  
11 system delivered hospital-grade diagnostics to patients'  
12 homes, with regions embracing this model seeing death  
13 rates six times lower than hospital-focused areas.

14 South Korea also demonstrated that sophisticated  
15 medical intervention can be delivered at home, relieving  
16 pressure on hospitals, whilst maintaining healthcare  
17 access rather than restricting it.

18 These countries prove that home can be the safest  
19 place during a pandemic, if we design our systems  
20 properly.

21 My Lady, the evidence before this Inquiry demands we  
22 fundamentally reimagine emergency preparedness. The  
23 traditional model, hospitals as fortresses, homes as  
24 afterthoughts, failed catastrophically. We propose  
25 a significant shift. Pandemic preparedness must be

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1 community-centric, not hospital-centric. This means  
2 recognising that in any future health emergency, the  
3 battle will be won or lost in people's homes and  
4 communities, not just in hospital corridors.

5 This paradigm shift requires us to think differently  
6 about three fundamental concepts: first, reimagining  
7 essential infrastructure. Just as we wouldn't plan an  
8 ordinary emergency without considering water,  
9 electricity or transport networks, we cannot plan for  
10 a pandemic without seeing home-based care and support as  
11 critical infrastructure. At least 9 million people need  
12 or receive support and care at home. This is not  
13 peripheral. This is the foundation of our care system.

14 Second, redefining medical intervention. The  
15 Italian model and the UK's more recent Hospital at Home  
16 services prove we can deliver sophisticated diagnostics  
17 and treatment in people's homes.

18 We acknowledge the next pandemic may be entirely  
19 different from Covid-19. It may affect children more  
20 than older people, or present challenges we cannot yet  
21 imagine. But with advances in medical devices,  
22 telemedicine, AI and data science, we can use the  
23 principles to transform our approach.

24 Third, reconceptualising workforce deployment.

25 South Korea showed us that, in emergencies, we can

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1 repeated. When crisis strikes, resources must flow  
2 automatically, like water through prepared channels.

3 Pillar 4: valuing the workforce. Sustainable  
4 funding must support professional registration, fair  
5 pay, training and technology adoption. The pandemic  
6 accelerated digital care record uptake from 40 per cent  
7 to 80 per cent, proving the sector's capacity for  
8 innovation when supported. This transformation must  
9 continue.

10 Pillar 5: maintaining healthcare access.  
11 Face-to-face health and care services, supported by  
12 telemedicine, must be protected not suspended. Italian  
13 physicians proved that bringing hospital capabilities to  
14 people's homes achieved better outcomes than  
15 overwhelming hospital systems. We must plan for  
16 enhanced, not reduced, community healthcare during  
17 emergencies.

18 Pillar 6: modern data infrastructure. We must  
19 capture everyone giving and receiving home-based care,  
20 creating the visibility needed for effective pandemic  
21 planning and resource allocation. The data blind spots  
22 that hampered the Covid-19 response were inexcusable and  
23 must never rec.

24 Pillar 7: effective governance. Continuing  
25 oversight with homecare-specific policy development is

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1 rapidly mobilise volunteers and family members as  
2 temporary carers, but this requires preparation,  
3 training and systems, not crisis improvisation.

4 These concepts underpin seven pillars that must form  
5 the foundation of future pandemic resilience.

6 Pillar 1: embedded expertise. Social care  
7 expertise, including home care, must be embedded at  
8 every level of emergency planning, science advice, and  
9 operational command. No longer can decisions affecting  
10 millions be made by those who fundamentally  
11 misunderstand how care works. A standing expert  
12 committee would give decision makers direct access to  
13 homecare insights when developing pandemic responses.

14 Pillar 2: equal protection. We must guarantee  
15 hospital grade PPE quality, testing access, vaccines, if  
16 they exist, sick pay and psychological support across  
17 all care settings. The artificial hierarchy that  
18 prioritised NHS staff over care workers was not just  
19 morally wrong, it was strategically counterproductive.  
20 Parity recognises homecare's critical role in a pandemic  
21 response.

22 Pillar 3: automatic funding. Emergency support must  
23 reach all providers immediately and equitably through  
24 pre-established systems. The bureaucratic delays that  
25 characterised Covid-19 funding distribution cannot be

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1 essential. Community-based care requires tailored  
2 approaches, not hospital focused adaptations, this means  
3 dedicated governance structures that understand the  
4 unique challenges and opportunities of home care.

5 My Lady, the Government's 10-year health plan  
6 creates an unprecedented opportunity. Its three shifts,  
7 from hospital to community, illness to prevention and  
8 analogue to digital, align with the lessons from this  
9 Inquiry. We can position homecare as essential  
10 infrastructure, working alongside sophisticated medical  
11 intervention. Italian analysis showed dramatic cost  
12 savings alongside better outcomes offering a compelling  
13 case for integrated care models that deliver value in  
14 any circumstances. But transformation requires more  
15 than policy papers: it demands a fundamental cultural  
16 shift in how we perceive home-based care and support,  
17 from a poor relation to the health service to an equal  
18 partner in improving health outcomes.

19 We propose a new metric for pandemic preparedness:  
20 a community resilience index. This would measure not  
21 just hospital bed capacity or ventilator availability,  
22 for example, but the robustness of community-based care  
23 infrastructure. Besides vital public health data on the  
24 severity of infection and transmission rates, this index  
25 could assess factors including, but not limited to, the

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1 ratio of community care workers to population, workforce  
2 sustainability metrics, digital infrastructure  
3 penetration in home settings, integration levels between  
4 health and social care, community diagnostic and  
5 treatment capabilities, data system interoperability.

6 By measuring what matters, our capacity to keep people  
7 Safe at Home, we create accountability for community  
8 resilience, not just hospital preparedness.

9 The pandemic revealed that virus variants respect no  
10 borders and neither should our learning. We recommend  
11 establishing an international homecare emergency  
12 response network, sharing best practices, technologies,  
13 and rapid response protocols between countries. When  
14 the next pandemic emerges, and experts agree it will be  
15 when, not if, we must be able to deploy proven  
16 interventions immediately, not spend months reinventing  
17 solutions that already exist.

18 Throughout this Inquiry, I have been struck by the  
19 testimonies of bereaved families. Their loved ones were  
20 not statistics. They were pioneers, contributors,  
21 cherished family members, who deserved better from the  
22 systems designed to protect them. I have been equally  
23 moved by the testimony of care workers, who, despite  
24 challenging circumstances, maintained their commitment  
25 to those they served. They made impossible choices and

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(A short break)

1 (11.40 am)

2 **LADY HALLETT:** Ms Peacock.3 **Closing statement on behalf of the Trades Union Congress by**  
4 **MS PEACOCK**5 **MS PEACOCK:** Good morning, my Lady. These are the  
6 submissions on behalf of the Trades Union Congress. I'm  
7 instructed by Thompsons Solicitors and led by  
8 Mr Sam Jacobs.9 What this module has surely made clear is that we  
10 cannot afford for the social care sector to be placed in  
11 the same position in a future pandemic. It must be  
12 better protected.13 We return to an account from a care home manager in  
14 Northern Ireland who explained:15 [As read] "Working during Covid was one of the worst  
16 experiences of my career. So horrendous, I left working  
17 in care. As an already struggling sector, Covid has  
18 magnified every element of underfunding. I am glad not  
19 to work in care and will never again."20 The sector lost valuable members of its workforce,  
21 both to the virus itself, and to the trauma of the  
22 experience. It is to that loss that the TUC directs its  
23 lessons learned. In this short oral closing we will  
24 touch upon the following topics: infection prevention  
25

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1 sacrifices, they filled the vacuum left by others,  
2 sometimes at a cost to their own health or lives.3 Importantly too, we have seen proof that homecare  
4 workers and managers, when supported, can deliver  
5 extraordinary outcomes under extraordinary  
6 circumstances. We owe it to those lost and those who  
7 served to ensure we learn lessons and implement change  
8 in a way that is effective and enduring. Your  
9 recommendations will influence whether we emerge from  
10 this process with genuine transformation or just good  
11 intentions. The difference will be measured not in  
12 paper plans but in lives saved and dignity preserved  
13 when the next emergency strikes.14 The question is not whether we can build better  
15 systems, the question is will we choose to do so?  
16 History will judge this moment not by what went wrong  
17 during the pandemic but by what we chose to do next.18 Thank you for the kindness and support of you and  
19 your team and for the opportunity to contribute, my  
20 Lady.21 **LADY HALLETT:** Thank you very much indeed. Extremely  
22 helpful.23 Very well, we'll take a break now and I shall return  
24 at 11.40.

25 (11.21 am)

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1 and control, regulation, vaccine confidence and reform.

2 In our written closing, we will address a number of  
3 related topics, including movement of staff, structural  
4 racism, insecurity of work and financial support.5 Many of these issues, my Lady, are interdependent.  
6 If carers have access to high-quality PPE, which they  
7 are trained to use, there will be less pressure on the  
8 vaccination programme.9 If the social care sector is afforded greater status  
10 in society, workforce capacity will improve.11 And if care workers are financially supported, they  
12 will feel able to self-isolate, and IPC controls will be  
13 more effective.14 Turning first, my Lady, to infection prevention and  
15 control. It will be uncontentious that the lesson in  
16 respect of PPE in Module 6, as in previous modules, is  
17 that far greater planning and preparation is required.  
18 A policy of parity with the NHS is essential. And plans  
19 should acknowledge that, in the circumstances of  
20 a crisis, central and local government must be ready to  
21 step in and support all settings, including the private  
22 sector.23 Helen Whately raised in her oral evidence an  
24 important question regarding the level of PPE which may  
25 be appropriate in a future pandemic of an airborne

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1 virus. She recalls asking on multiple occasions during  
2 the pandemic: is the PPE not working?

3 Ms Whately reflected on research which shows that in  
4 intensive care, where higher levels of PPE were  
5 provided, transmission of Covid-19 was lower than in  
6 ordinary hospital wards.

7 This is an issue in common with Module 3, and we  
8 endorse the same recommendation as we did in that  
9 module: FFP3 should be recommended for all staff likely  
10 to come into contact with the virus, where there appears  
11 to be more than negligible airborne transmission.

12 In closing submissions in Module 3 we suggested that  
13 healthcare workers should be empowered to implement IPC  
14 measures, and that there needs to be significant  
15 investment in training because a whole-workforce  
16 approach is required.

17 We consider that position is the same in the social  
18 care sector. The recommendations which we will endorse  
19 in our written closing, including improved status and  
20 professionalisation of the workforce, the introduction  
21 of a register of care workers, and improved centralised  
22 oversight, will be critical to implementing a robust  
23 system of training and monitoring of compliance  
24 with IPC.

25 The workforce deserves, at the very least, the  
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1 "... cancelled a number of routine inspections and  
2 directed our activities at areas which we considered to  
3 have the most risk."

4 The CQC chose to focus on high-risk environments,  
5 including social and domiciliary care settings, which,  
6 she says:

7 "... presented inherently more risk in terms of  
8 opportunities for people to suffer from unseen harm."

9 This appears an entirely logical approach but one  
10 which was abandoned when routine inspections ceased.

11 A regulatory vacuum was created in social care. As  
12 a result, central government knew very little about what  
13 was happening inside the sector.

14 Minutes from a meeting Helen Whately conducted with  
15 the CQC in July 2020 note:

16 [As read] "... it is likely we will see an increase  
17 in a number of services that haven't been able to cope  
18 during the pandemic and therefore a spike of these cases  
19 being unveiled in the next few weeks."

20 The minutes record Ms Whately's extreme concern.

21 The lesson learned is that in a pandemic, where risk  
22 is elevated and guidance is novel and evolving,  
23 regulators should step forward towards the care sector  
24 as opposed to stepping back.

25 We agree with Ms Cridge that inspections are an  
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1 protection associated with adequate IPC training and  
2 resource.

3 Turning next to regulatory intervention in the care  
4 sector. As the Inquiry has heard, at the outset of  
5 the pandemic, the four nations' regulatory bodies took  
6 a step back, most significantly by pausing routine  
7 inspections.

8 The concerning message sent by Peter Wyman, of  
9 the CQC, to Matt Hancock was: we have pulled right back  
10 on inspections, data collection will be really light  
11 touch.

12 We agree with the submissions this morning on behalf  
13 of the DPO and John's Campaign, Care Rights UK, and  
14 The Patients Association, that this decision led to lost  
15 opportunities to understand what was happening in the  
16 sector, and to protect its service users.

17 A number of witnesses to this module have made clear  
18 the impact this had upon care settings. Rachel Harvey  
19 reflected that Care UK did not get any support from the  
20 Care Quality Commission, Care Inspectorate or Care  
21 Inspectorate Wales. Regulatory inspections and usual  
22 provider meetings ceased and there was only limited  
23 communication.

24 Before routine inspections were cancelled in their  
25 entirety, Mary Cridge explains that the CQC:  
66

1 integral part of regulation, and in the event of  
2 a future pandemic, strenuous efforts should be made to  
3 protect the ability to carry out on-site inspections.

4 Briege Donaghy, of the RQIA, insisted that a single  
5 inspector could have taken Covid into a care home, the  
6 risk of that as a regulator was unacceptable. That  
7 simply belies an unwillingness to take any level of  
8 risk, nor to balance that risk against those associated  
9 with ceasing routine inspections.

10 Given what we know about the level of movement of  
11 staff and other essential persons in and out of care  
12 homes, that explanation does not hold water. We agree  
13 with John's Campaign, Care Rights UK, and The Patients  
14 Association that there was an abdication of  
15 responsibility.

16 To ensure that inspections continue, we say that  
17 regulatory bodies should be required to hold stocks  
18 of PPE, inspectors should be recognised as key workers  
19 from the outset of a pandemic, and that they should be  
20 prioritised for access to PPE, IPC, training, testing,  
21 and vaccines.

22 Turning now to vaccine confidence, my Lady.

23 Sir Sajid Javid has stated in evidence that it is  
24 importance to build vaccine confidence during  
25 non-pandemic times, given the difficulty of doing so  
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1 during a crisis. This appears an entirely sensible  
2 suggestion. However, it is also true that during  
3 a pandemic it will be necessary to share information  
4 about the specific vaccine workers are being asked to  
5 take.

6 Accounts and survey data collected by this -- TUC  
7 suggest that many care workers who had general  
8 confidence in vaccines, and happily took the flu vaccine  
9 each year, did not have confidence in the Covid-19  
10 vaccines. This was due to concerns about the speed at  
11 which the vaccines were developed and the adverse  
12 reactions suffered by some, and due in part due to the  
13 general climate of anxiety and lack of confidence in  
14 leadership and government which pervaded the experience  
15 of Covid-19 for many care workers.

16 However, it's clear from the survey data that  
17 mechanisms for sharing information about vaccines and  
18 providing support to care workers were not in place or  
19 were ineffective. In a survey of over 1,600 care  
20 workers, 58% said that they did not feel they were given  
21 enough information and support by their employers  
22 regarding the Covid-19 vaccines.

23 On being asked about this data, Sir Sajid Javid  
24 confirmed his prior evidence that the fact that the NHS  
25 is a centralised state body meant it was easier for

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1 status, coordination and reform.

2 There is so much overlapping between the severe  
3 workforce shortages faced by the sector and the urgent  
4 need for improved status for the workforce, centralised  
5 coordination across the sector, and long-awaited reform.

6 The call for reform has been virtually universal  
7 amongst those witnesses who have given oral evidence in  
8 this module. Everyone from Matt Hancock, to  
9 Cathryn Williams, to Sir Sajid Javid has endorsed it.  
10 That is evidence which we say this Inquiry cannot  
11 overlook.

12 Despite the unsurprising nature of such  
13 a recommendation, it remains critical that the report to  
14 this module acknowledges the urgent need for reform. We  
15 agree with the National Association of Care and Support  
16 Workers that affordability is a matter for those  
17 implementing the recommendations, but that improved  
18 capacity and resilience will inevitably lead to  
19 long-term cost savings.

20 The interrelated nature of many of these issues  
21 demands wholesale change, and a piecemeal approach  
22 simply will not place the sector in a better position to  
23 face another pandemic. The TUC has long called for  
24 a national care service and, following this module,  
25 considers it will be a crucial step in improving

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1 vaccine hesitation to be addressed.

2 He endorsed the need to develop centralised  
3 mechanisms for communicating with care workers.

4 Helen Whately, similarly, considered that  
5 registration of care professionals would assist, and  
6 noted that greater unionisation of the workforce would  
7 provide a channel of communication.

8 On vaccine as a condition of deployment, we  
9 reiterate our position that it ought to be an approach  
10 of last resort. Ms Whately has suggested that we need  
11 a discussion as a society about when mandating  
12 vaccination is appropriate. We agree. But we also say  
13 that such discussion requires further research.

14 Jenny Harries raised a concern that VCOD policies  
15 could cause longer-term damage to wider trust and  
16 confidence in vaccines. Research is required to confirm  
17 whether that risk has transpired. The TUC is concerned  
18 that the VCOD policy in the care sector compounded the  
19 effects of structural racism, given the higher levels of  
20 hesitancy amongst some minority ethnic groups.

21 More data should be collected on the risks, the  
22 benefits and the efficacy of VCOD policies as compared  
23 to methods involving information sharing, consultation,  
24 engagement via community leaders, and practical support.

25 Turning finally, my Lady, to workforce capacity,

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1 resilience and the capability to respond to any future  
2 civil emergencies affecting the care sector.

3 Thank you, my Lady. Those are our submissions.

4 **LADY HALLETT:** Really grateful, Ms Peacock. Thank you very  
5 much indeed.

6 Mr Boyle. There you are.

7 **Closing statement on behalf of Royal College of Nursing by**  
8 **MR BOYLE KC**

9 **MR BOYLE:** My Lady, the Royal College of Nursing is  
10 extremely grateful to you and the entire Inquiry team,  
11 for giving it the opportunity to participate in and to  
12 contribute to the Inquiry's work.

13 Your Ladyship will hopefully have gleaned from the  
14 evidence to of Claire Sutton on Tuesday of this week  
15 just how keenly felt the desire is that the voices of  
16 nurses and all adult social care support workers are  
17 heard to assist with learning lessons for the future.

18 Not everything which the Royal College may wish to  
19 see change about the provision of adult social care in  
20 England and across the devolved nations can be cured by  
21 this Inquiry or subject to a recommendation by your  
22 Ladyship. But it has great confidence that there are at  
23 least areas where recommendations can be made, or  
24 a narrative provided, to ensure adult social care is  
25 better fitted for any future pandemic on a similar

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1 scale.

2 I intend to address you briefly on three discrete  
3 topics: parity; engagement; visiting. We will address  
4 others in greater detail in writing.

5 First, the evidence has clearly demonstrated the  
6 need for parity of esteem between the NHS and the adult  
7 social care sector and equity of access to resources.  
8 Helen Whately described social care as often being seen  
9 as a Cinderella service. Claire Sutton described how  
10 social care often feels like a second-class citizen, the  
11 poor relation.

12 However, she added that, if it were to achieve  
13 parity of esteem and equity of access to the same  
14 resources available to the NHS, that would boost staff  
15 morale, go some way to changing those perceptions of  
16 inequity, and potentially improve staff retention, which  
17 is such a significant issue in this sector.

18 That evidence echoed Ms Whately's evidence that one  
19 of the things that this Inquiry can do is to raise and  
20 remind people about the importance of social care in our  
21 system. As Ms Whately observed, that would be a good  
22 outcome.

23 There are practical steps that can be taken to try  
24 to achieve that. In particular, the adult social care  
25 sector should, looking ahead, have equity of access to

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1 equity of access for all those who provide care, through  
2 whatever service, whether it be in a large NHS hospital,  
3 to a single domiciliary care provider travelling by bus  
4 from home to home to help the most vulnerable.

5 It can perhaps be achieved through the use of  
6 central procurement, by way of example. Equity of  
7 access to testing for members working in the NHS and in  
8 social care should be provided for. Equity of access to  
9 training should also be facilitated perhaps in two  
10 respects, firstly, recognising that the nature of any  
11 future virus is unknown, training by way of generic  
12 background, for example, familiarising all staff with  
13 where and how to access resources and, indeed, perhaps  
14 in relation to human rights, as my learned friend  
15 Mr Straw KC advanced to you this morning.

16 Secondly, there should be the ability to roll out  
17 rapid training to all care providers on any new  
18 guidance, irrespective of whether they work in an acute  
19 NHS setting or in adult social care. Nurses and support  
20 workers in social care should not have to best guess how  
21 to implement guidance when colleagues in NHS acute  
22 settings are having online webinars. Technology should  
23 enable new guidance to be packaged with rapid access  
24 training for all.

25 The primary objective of the recommendation the RCN

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1 pandemic stockpiles or, at the very least, a system by  
2 which the care sector can rapidly access sufficient PPE  
3 as part of a future pandemic response.

4 This would avoid the concerns voiced by RCN members  
5 in the surveys that were conducted, that your Ladyship  
6 heard in the evidence of Ms Sutton and is contained in  
7 detail within her statement. It also echoes the  
8 evidence of Ms Whately when she said that the fact that  
9 care workers were having to go to work and try and care  
10 for people without even the level of PPE that the public  
11 health team thought they should have was clearly  
12 an incredibly bad situation to be in. It was worse than  
13 that: it was clearly a life-threatening situation to be  
14 in.

15 Your Ladyship understandably queried with Ms Sutton  
16 the extent to which state funding or state resources  
17 could or should be used when provision of care may rest  
18 with independent private companies or organisations.  
19 Ms Sutton's response was to highlight the prevalence of  
20 state funding of those providers through local  
21 authorities and NHS commissioning groups. However, even  
22 allowing for the fact that there may be private  
23 providers involved, from a resident or patient safety  
24 perspective, at a workforce safety and retention  
25 perspective, the unambiguous ambition should be for

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1 seeks in terms of equality is to try and safeguard the  
2 workers and those they care for. The secondary  
3 objective, when those patient and workforce safety  
4 issues are coupled with equality and protection of full  
5 pay, if they need to self-isolate, equality and the  
6 recognition of staff in social care retaining the  
7 freedom of movement which is enjoyed by their NHS  
8 colleagues in their day jobs, will be the elevation of  
9 the esteem in which adult social care is held. If one  
10 is going to be as safe as one's colleagues in the NHS  
11 and have access to the same equipment at the same time,  
12 then the perception of adult social care being of less  
13 import should become a thing of the past, which can only  
14 be to its benefit in the future.

15 Ms Sutton summed up this ambition for equity and  
16 access and parity of esteem in very simple and stark  
17 terms when she told you that to make sure that the  
18 1.6 million people who work in adult social care are on  
19 the same footing as the 1.4 million who work in the NHS  
20 shortly stated but powerfully communicates the need for  
21 a recommendation of this kind.

22 The second and hopefully obvious recommendation  
23 which the RCN invites your Ladyship to consider, is that  
24 the UK Government and the certain devolved  
25 administrations should ensure that there is professional

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1 nursing input from now on in trying to limit the  
2 severity of any future pandemic. We should try and  
3 avoid the mistakes of the past, such as the publication  
4 of unworkable guidance which suggested that carers in  
5 care homes could provide care to residents from  
6 a distance of 2 metres.

7 For whatever reason, there was at times a lack of  
8 meaningful engagement with the RCN, which is difficult  
9 to comprehend, given that it speaks on behalf of over  
10 500,000 nurses and support workers who have an enormous  
11 amount of experience and expertise capable of assisting  
12 those in positions of authority who may not necessarily  
13 have the same healthcare training, background or  
14 hands-on experience.

15 Dame Professor Jenny Harries, former Deputy CMO, in  
16 her evidence, was taken to a paragraph in her statement  
17 in which she said:

18 "In the early phase of the pandemic few people in  
19 DHSC had direct or practical experience of having worked  
20 in or [notably] with care homes ..."

21 That is a situation in which input from the RCN and  
22 other stakeholders should have been not only welcomed  
23 but actively pursued. However, as Ms Sutton described,  
24 at times it felt to the organisation that it was pushing  
25 at a locked door, and it took some persistence to get

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1 returning to the very powerful impact of the video  
2 played at the opening of this module and the  
3 heartbreaking accounts of relatives not being able to be  
4 present to comfort those at the end of their lives.

5 Ms Sutton was asked whether meaningful contact with  
6 loved ones for those at the end of life should have been  
7 facilitated. "Definitely", was her response. It was  
8 a response not based on pure sentiment, it was backed up  
9 by partial and simple rationale. She told your Ladyship  
10 that nurses are very good at carrying out risk  
11 assessments, that had there been flexibility in the  
12 guidance to enable nurses to be able to ascertain  
13 whether a visit at that time was safe and could be  
14 facilitated, then nurses would be ideally placed to make  
15 those decisions with the best interests of those  
16 residents, their loved ones and their staff in mind.

17 Your Ladyship will recall how she explained the  
18 different forms that care homes can take, for example:  
19 large purpose-built buildings, Victorian houses, and so  
20 on.

21 The RCN's voice was not alone in that and we commend  
22 to your Ladyship the evidence of Joanna Killian of the  
23 Local Government Association and some written testimony  
24 of Deborah Sturdy.

25 In any future pandemic, in the event that national

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1 through.

2 We would invite your Ladyship to accept that  
3 evidence. Ms Sutton was an entirely credible witness  
4 who was very direct and candid and humble enough to  
5 accept, on behalf of the Royal College, that when  
6 changes were sometimes made, as she put it, it would  
7 have been fantastic to think of that as a result of the  
8 RCN input, but she did not seek to claim that causal  
9 connection. It matters not if one can show cause and  
10 effect. The important principle is that those who can  
11 speak with authority, like the College and others, are  
12 fully engaged by Government.

13 In that regard, the College invite your Ladyship to  
14 recommend that College and other relevant stakeholders  
15 should firstly be included in slow-time, pre-pandemic  
16 planning for the future; secondly, they should sit on  
17 any body or taskforce established to steer the four  
18 nations during the course of any future pandemic, the  
19 voices of those should be in the room when crucial  
20 fast-time decisions are called for; and thirdly and  
21 importantly, should be intrinsically involved in the  
22 production of national guidance that impacts on nursing  
23 and support worker roles, responsibilities and  
24 obligations.

25 Finally, I close on behalf of the Royal College by

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1 decisions or guidance on care home visiting are  
2 considered appropriate, the Royal College of Nursing  
3 invites your Ladyship to consider a recommendation that  
4 includes recognising the human rights of care home  
5 residents and their families, recognises the benefits of  
6 that partnership of care between staff, family and  
7 friends, and recognises the ability of nurses and care  
8 home staff to safely facilitate visiting in individual  
9 cases at end of life.

10 My Lady, thank you very much on behalf of all those  
11 who have worked in the adult social care sector.

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

13 Ms Murnaghan.

14 **Closing statement on behalf of Department of Health,  
15 Northern Ireland by MS MURNAGHAN KC**

16 **MS MURNAGHAN:** Good morning, my Lady.

17 As you know, my Lady, I appear for the Department of  
18 Health in Northern Ireland, and in these remarks,  
19 my Lady, the department would like to emphasise that it  
20 made considerable efforts throughout the pandemic to  
21 prioritise the care of those in the adult social care  
22 sector.

23 References made by Mr Swann to a "Cinderella  
24 service" should not, however, be interpreted as evidence  
25 of complacency in the Department but rather as

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1 an acknowledgement of the difficulties and indicating  
2 an awareness of the need to prioritise tackling those  
3 difficulties.

4 My Lady, the department also agrees that there are  
5 valuable lessons which must still be learnt and, to that  
6 end, we refute the inferences that, in acknowledging  
7 those things that did go well, the Department has  
8 perhaps erred by congratulating itself inappropriately.

9 Prior to the pandemic, my Lady, the adult care  
10 sector in Northern Ireland was historically underfunded  
11 and entirely regrettably was in a position of structural  
12 vulnerability. However, the Department has commenced  
13 work on the development of a ten-year adult social care  
14 reform strategic plan and, while the scale of the reform  
15 that is required cannot be delivered in the short term,  
16 a number of shorter-term delivery plans will support  
17 that ultimate aim.

18 To that end, my Lady, the former Minister of Health,  
19 Robin Swann, also acknowledged that a stable workforce  
20 will be the key to delivering strategic reform and, as  
21 long ago as October 2021, he established a Social Care  
22 Fair Work Forum with the aim of embedding fair work  
23 initiatives and improving terms and conditions of all  
24 employees across this sector. In February 2025, his  
25 successor announced that the sector would become a real

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1 2020, early 2021, lateral flow tests allowed for the  
2 expansion of asymptomatic testing to those working in  
3 the supported living sector, as well as those in the  
4 domiciliary care sector. When routine asymptomatic  
5 testing for staff and residents was introduced, such  
6 testing, however, was always in addition to the other  
7 full suite of public health measures that were already  
8 in place.

9 My Lady, some remarks in relation to discharge.  
10 Unequivocally, the Department reaffirms that throughout  
11 the pandemic, the discharge of patients was always  
12 a clinical decision based on whether the individual was  
13 medically well. Further to that, by April 2020, updated  
14 guidance on testing had advised that those who were  
15 released to care homes should be tested for Covid within  
16 48 hours of that discharge and, prior to that, from  
17 3 April 2020, the advice was that those residents who  
18 may have been exposed should be isolated for 14 days on  
19 return to the care home.

20 In instances, my Lady, when the test results were  
21 pending or were positive, the care homes were asked if  
22 they had the ability to support isolation. Where they  
23 were unable to do so, the responsibility then fell to  
24 the trusts to make arrangements for alternative care.

25 The Department was aware that discharge from

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1 living wage sector and work in Northern Ireland is  
2 ongoing to implement that change.

3 My Lady, I would have some remarks to make about  
4 testing in Northern Ireland in care homes. Testing, of  
5 course, was a critical additional tool in the protection  
6 of the sector and it is uncontroversial to say that, in  
7 the early stages of the pandemic, testing capacity was  
8 limited.

9 Although the Department did work at pace to scale  
10 capacity, undoubtedly its decisions in relation to both  
11 discharge and the testing regimes must be viewed through  
12 the lens of the practical reality of there being only  
13 a finite number of tests.

14 In Northern Ireland, all residents and staff in care  
15 homes were identified early in the pandemic as being  
16 priority groups for symptomatic testing. From 24 April  
17 2020 all residents and staff were tested to risk assess  
18 each outbreak. That had changed from mid-May, by which  
19 stage an incremental programme of testing for  
20 asymptomatic residents and staff was implemented and  
21 that was completed by the end of June and was further  
22 extended on 3 August. But even then, my Lady, the  
23 efforts made by the Department were still constrained by  
24 a global shortage of testing.

25 The position changed considerably when, in late

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1 hospitals could have an impact and, to that end, it  
2 commissioned the Herity report. The Department would  
3 emphasise that there has been no shift, subtle or  
4 otherwise, in the Department's assessment of that Herity  
5 report.

6 In his witness statement, the Chief Medical Officer  
7 clearly indicated that Covid being likely to enter care  
8 homes was from a number of means which included  
9 discharge from hospital. The CMO stated, in line with  
10 the extant evidence, that this was unlikely, however, to  
11 have been the dominant route, and he referenced the CMO  
12 Technical Report.

13 The main point emphasised by the CMO in his  
14 statement was the association between care home  
15 outbreaks and the level of community transmission. This  
16 should not, however, be read as some indication that  
17 discharge from hospital wasn't a possible factor.

18 My Lady, some remarks in relation to the impact of  
19 visiting. The impact of visiting restrictions on both  
20 residents and their loved ones was not underestimated by  
21 the Department. There was, however, a difficult balance  
22 to be struck between protecting residents from infection  
23 and preserving their right to connection with their  
24 families.

25 After the initial months of the pandemic, the

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1 department consulted with residents and their loved ones  
2 and developed the Care Partner scheme.

3 The Inquiry in this module has heard criticisms that  
4 the Department should have consulted more extensively on  
5 the scheme prior to its introduction. However, it is,  
6 my Lady, we submit, incontrovertible that a balance had  
7 to be found between implementing a scheme with such  
8 positive benefits for individuals where some care homes  
9 could implement this with alacrity, and, on the other  
10 hand, waiting to find unanimity across a sector which  
11 had a range of different needs and concerns.

12 We would also emphasise, my Lady, that following the  
13 announcement, the Chief Nursing Officer did lead  
14 a further six-week engagement with the sector in an  
15 attempt to ensure smooth implementation of the scheme,  
16 and that consultation included, in October 2020, the  
17 provision of additional funding to support that  
18 implementation.

19 My Lady, concerns were also raised in relation to  
20 the question of testing that would accompany the Care  
21 Partner scheme, and to that end, we would ask the  
22 Inquiry to note that the department published a Care  
23 Partner leaflet and a frequently asked questions  
24 document which did include detail on testing  
25 requirements.

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1 of care home staff between various homes.

2 My Lady, in relation to data, with the onset of the  
3 pandemic, the department recognised the need for  
4 specific monitoring information to allow it to quality  
5 assure the integrity of information and so ensure that  
6 appropriate support was provided.

7 The department to that end worked closely with  
8 the RQIA, the HSCB and the PHA to collect what became  
9 a fundamental source of care home data.

10 It is worth highlighting that the department's  
11 strategic performance and planning group is currently  
12 developing a regional real-time monitoring system for  
13 care home bed availability, and this initiative will be  
14 completed by October this year.

15 In terms of engagement, my Lady. In terms of  
16 engagement, it is not accepted that there was an  
17 institutional defensiveness in the department or indeed  
18 a need to break down silos. However, we do say that it  
19 should still be acknowledged that when an individual  
20 wrote to one part of government, this would not  
21 automatically equate to communication with the  
22 department.

23 For example, my Lady, there has been criticism of  
24 the degree of engagement between the department and the  
25 Independent Sector Nurse Managers Network, and the

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1 My Lady, such has been said of the demands and  
2 challenges placed on the workforce in the pandemic, and  
3 we agree that the pandemic exacerbated the pre-existing  
4 challenges in this sector, and it was in recognising  
5 those concerns from care homes that the minister  
6 announced that trusts would work in partnership with  
7 providers to help manage staff shortages.

8 Measures that the minister introduced included  
9 adjustments to pre-employment vetting to permit  
10 employers to recruit staff quickly, the deployment to  
11 the sector of suitably skilled individuals from trusts,  
12 as well as prioritising deployment from its workforce  
13 appeal.

14 The department also acknowledges the concerns raised  
15 regarding the movement of staff between care homes, and  
16 that was a risk which the department identified in  
17 April 2020 and predated the Vivaldi Study by some  
18 three months. It was reflected in guidance to  
19 residential and nursing homes, and as early as  
20 April 2020, the department provided financial support to  
21 help providers respond to the staffing challenges.

22 Indeed, in the October 2020 funding package, the  
23 department enabled care providers to claim for those  
24 additional staffing costs, which included block booking  
25 agency staff, which was designed to prevent the movement

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1 department has confirmed that it has no record of  
2 receipt of correspondence referenced in  
3 Ms Claire Sutton's evidence for the RCN. Rather, it  
4 appears to be the case that the ISNMN were in fact in  
5 contact with the PHA, and the then Health and Social  
6 Care Board, which, my Lady understands, is structurally  
7 distinct from the department.

8 Much has also been said in terms of engagement to  
9 the extent in which the department engaged with the  
10 IHCP. Professor Holland's evidence on that issue  
11 confirmed that the IHCP represents only about 50% of  
12 independent care sector providers in Northern Ireland,  
13 and is, rather, focused on business interests.

14 Professor Holland highlighted that the department  
15 had well established and constructive relationships with  
16 individual care homes. And it was therefore in that  
17 context, and in the context of the pandemic, when  
18 matters of practice had to be discussed, it was often  
19 more efficient to liaise directly with the providers  
20 rather than going through the IHCP.

21 My Lady, as explained by both Professors Holland and  
22 McBride, engagement had always to be in the context of  
23 the overarching imperative of providing timely guidance.

24 My Lady, to conclude, the department recognises the  
25 very significant impact that the pandemic had on care

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1 home residents, their loved ones, and the staff, and the  
2 department appreciates the substantial efforts that were  
3 made to support those in this sector.

4 The department remains committed to learning from  
5 this module and thanks the Inquiry for the opportunity  
6 to contribute.

7 **LADY HALLETT:** Thank you, Ms Murnaghan.

8 Mr Macleod, are you over there? You are.

9 **Closing statement on behalf of the Care Inspectorate,  
10 Scotland, by MR MACLEOD KC**

11 **MR MACLEOD:** My Lady, I appear with my learned friend  
12 Ms Toner(?) on behalf of the Care Inspectorate, who are  
13 very grateful to your Ladyship for the opportunity to  
14 have participated in this Inquiry, and in particular in  
15 this most important of modules.

16 At the outset, my Lady, it is necessary in my  
17 submission to highlight the context in which decisions  
18 were made, and actions taken or not taken.

19 Key decisions, such as the discharge of patients,  
20 the pausing of inspections, and the stopping of visits  
21 were all taken at a time when there was no vaccine,  
22 a lack of PPE, and significant concern about the effect  
23 of the pandemic on how best to deal with it.

24 In the face of assurances by governments across the  
25 United Kingdom that their decisions were made on the

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1 daily monitoring of notifications from care homes; the  
2 use of a red, amber and green staffing alert system from  
3 3 April to identify which services may be in crisis;  
4 third, a new Covid-19 flexible response team to  
5 interpret evolving guidance and to support providers;  
6 fourth, at least weekly telephone contact with all  
7 services; and fifthly, the weekly intelligence sharing  
8 and data dashboards and the sharing of information with  
9 the directors of public health and with the Scottish  
10 Government.

11 Despite the suspension of site visits, the  
12 inspectorate continued to gather intelligence and to  
13 respond to complaints and to offer regulatory support.

14 Of course, my Lady, as Mr Mitchell frankly  
15 acknowledged, that remote model reduced, as he put it,  
16 real-time visibility, and therefore had limitations.

17 However, the immediate risk to life from viral  
18 transmission took precedence at that early uncertain  
19 stage of the pandemic, and the halting of inspections,  
20 in the context I touched on at the beginning, was, in my  
21 submission, a proportionate response, and the  
22 inspectorate stands by that decision.

23 Secondly, the decision to stop visits. Once  
24 decisions to restrict visiting in care homes were taken  
25 by the Scottish Government, based on public health

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1 basis of the best clinical advice and guidance,  
2 "following the science", as it was put, it was difficult  
3 to second-guess that advice in a very fast-moving and  
4 uncertain climate. As a result, it may be the case  
5 that, in some instances, an overabundance of caution was  
6 instinctively preferred to the more careful balancing of  
7 risks against rights that was undertaken at a later  
8 stage.

9 Amongst the various areas where the work of the  
10 inspectorate has come under consideration, there are two  
11 that I propose to touch on today: firstly, the pausing  
12 of inspections. On 13 March, the inspectorate took the  
13 decision to cease routine in-person inspections of care  
14 services, due to the spreading of the virus. This was  
15 decided by the inspectorate's internal goal group, in  
16 line with public health advice and in agreement with the  
17 government. It is clear that similar precautionary  
18 steps were taken by regulators across the country at  
19 around the same time.

20 Against that background, it was perhaps more  
21 than a little surprising that Jeane Freeman, the then  
22 Cabinet Secretary for Health and Sport, told the Inquiry  
23 that she did not agree with that decision.

24 In any event, the inspectorate redirected its focus  
25 to remote oversight, including the following five steps:

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1 advice, particularly from the Clinical and Professional  
2 Advisory Group, and the Chief Medical Officer, the  
3 inspectorate's witnesses repeatedly criticised aspects  
4 of the visiting restrictions, especially their  
5 unintended consequences, namely the emotional and  
6 psychological toll on residents.

7 Your Ladyship heard only yesterday from,  
8 your Ladyship may consider, an impressive witness,  
9 Professor Barclay, that there is no doubt that harm was  
10 caused as a result.

11 The restrictions created a severe imbalance between  
12 infection control and residents' human -- imbalance,  
13 I should say, between infection control and residents'  
14 human rights, particularly for people with dementia or  
15 sensory impairments.

16 Mr Mitchell argued that this approach often applied  
17 hospital-like clinical standards to care home  
18 environments, which should instead be treated as  
19 people's homes.

20 Ms Marie Paterson from the inspectorate specifically  
21 raised the issue at three meetings with the directors of  
22 public health, and supported by Dr Macaskill of Scottish  
23 Care, at a meeting of the National Contingency Planning  
24 Group, but unfortunately those concerns appear to have  
25 largely fallen on deaf ears.

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1 As the Inquiry has heard, the inspectorate has  
2 welcomed the development of Anne's Law which gives  
3 residents the right to remain contact with a nominated  
4 loved one during outbreaks. This is, in my submission,  
5 a crucial correction to the initial approach, which  
6 Mr Mitchell said had at times been overly risk averse.

7 Turning then to recommendations, my Lady.

8 Aside from the lessons learnt by the inspectorate  
9 and what it could and should have done better, which are  
10 all set out in great detail in Mr Mitchell's statement  
11 and in the course of his evidence, potential  
12 recommendations are flagged in various statements and  
13 other documents submitted to the Inquiry by the  
14 inspectorate, and indeed in Mr Mitchell's oral evidence.  
15 They will be augmented in due course in the written  
16 submission.

17 But in my submission just now, there are eight which  
18 I invite your Ladyship to consider.

19 First of all, the rights and wishes of care users.  
20 Mr Mitchell stressed the importance of a better balance  
21 being struck between the human rights and wishes of  
22 social care users and their loved ones on the one hand,  
23 and the risks to health that they may face on the other.  
24 He said that inspection frameworks should ensure that  
25 residents are treated with dignity, respect and

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1 a clearer definition of responsibility, especially  
2 during public health emergencies, to prevent duplication  
3 and to ensure a coordinated response.

4 By illustration, your Ladyship heard earlier this  
5 week from Dr Maria Rossi from Public Health Scotland,  
6 who said she was confident that the multiple sources of  
7 guidance had created confusion.

8 Fifthly, planning for inspectors' safety.  
9 Importantly, my Lady, Mr Mitchell described the  
10 difficulties in securing PPE testing and vaccines for  
11 inspectors in the early stages. He acknowledged that  
12 the organisation should have pushed harder for PPE for  
13 its inspectors. As your Ladyship subsequently pointed  
14 out to him in the middle of his evidence: it all goes  
15 back to being properly prepared, doesn't it?

16 He recommended that future pandemic preparedness  
17 plans also include designating regulatory staff as  
18 frontline workers. Both of these steps, in my  
19 submission, will hopefully mean that a suspension of  
20 inspections will be unnecessary in the event of any  
21 future pandemics.

22 Sixthly, involving the regulators and policy  
23 development. There was, in my submission, a lack of  
24 formal consultation with the inspectorate on some  
25 matters of pandemic guidance and legislation and, in

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1 compassion, and this was particularly important in  
2 relation to visiting restrictions.

3 Secondly, it's -- secondly, in terms of bolstering  
4 compliance, Mr Mitchell suggested a change in the legal  
5 framework so that improvement notices could be sustained  
6 beyond the point of initial compliance.

7 Presently if a care home meets the terms of an  
8 improvement notice, that notice is discharged even if  
9 improvements are not maintained afterwards. That leaves  
10 a gap, he said, in ensuring long-term protection.

11 Thirdly, maintaining risk-based and intelligence-led  
12 inspections. Mr Mitchell supported retaining the  
13 scrutiny assessment tool developed during the pandemic  
14 which had been used to prioritise inspections based on  
15 complaints intelligence and staffing data.

16 This approach was more responsive and targeted than  
17 routine cyclical inspections, and allowed for more  
18 effective use of regulatory capacity.

19 Fourth, clarifying roles across agencies.

20 My Lady, there was clearly a degree of confusion and  
21 overlap between the roles and responsibilities of the  
22 Care Inspectorate, the health and social care providers,  
23 local authorities, directors of public health, Public  
24 Health Scotland, and so forth, during the crisis.

25 There should, in the inspectorate's submission, be

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1 future, it is hoped that regulators will formally be  
2 included in national planning and policy decisions. As  
3 an aside, as is clear from the evidence perhaps over the  
4 last few weeks, it also appears that the social care  
5 sector in general is underrepresented at that high  
6 level.

7 Point 7, my Lady: requiring effective design of  
8 buildings. Ms Campbell, King's Counsel, was right to  
9 say that we've heard very little oral evidence about  
10 this issue but Mr Mitchell talked about it and it is  
11 something that the inspectorate has put significant  
12 effort into promoting. To quote from Mr Mitchell's  
13 evidence:

14 "... what we learned from the pandemic about [IPC],  
15 about ventilation, fresh air, [is that] it is possible  
16 to design care homes better to take account of those.  
17 So for example, in a large care home, small group living  
18 is better [he said]. So creating spaces ... that can be  
19 used to cohort both staff and residents, if there's  
20 an outbreak, is helpful. But if the building is  
21 designed to accommodate that, it's even more helpful."

22 That is only one part of it, my Lady. Yesterday,  
23 Rhona Arthur spoke very movingly about her late father's  
24 time in a care home, rejuvenating the greenhouse,  
25 showing nursery schoolchildren how to grow tomatoes,

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1 I think, and playing the piano, and so forth. That  
2 chimes with what is said in the inspectorate's design  
3 guide and I urge your Ladyship to consider it.

4 It's at INQ000510071. At page 11, it is said within  
5 that document:

6 [As read] "A care home must not only be seen as  
7 a physical building but as a culture and a society in  
8 which a person lives, experience of support, opportunity  
9 and citizenship."

10 It is vital, my Lady, in my submission, that care  
11 home design facilitates that aspect as well as the  
12 health and safety of the people who live there.

13 A final point, point 8, is about instituting  
14 exercises between stakeholders, again, I think a point  
15 that no one else may have made.

16 Drawing from his prior experience as a senior police  
17 officer, Mr Mitchell recommended the use of inter-agency  
18 exercises between the various stakeholders. This  
19 results not only in a better ability to react when the  
20 time comes but also to establish relationships between  
21 the relevant individuals.

22 In conclusion, my Lady, the evidence produced by the  
23 inspectorate provides a detailed account of its  
24 operational decisions and practical and forward-looking  
25 recommendations to strengthen care regulation and

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1 and to you also for permitting it and for me to do so  
2 remotely.

3 **LADY HALLETT:** I can now see you.

4 **MR RAFFERTY:** Very good.

5 In preparing to provide the Inquiry with the witness  
6 statement of Ms Briega Donaghy, RQIA's chief executive  
7 and her oral evidence -- and, in the time since, the  
8 RQIA is grateful to the Inquiry for the disclosure and  
9 the assistance that it has received -- the RQIA has  
10 listened with great care to all of the issues which have  
11 been raised in this module. In making these closing  
12 submissions, the RQIA wishes to make plain that it seeks  
13 to acknowledge the experience, the endurance and  
14 resilience of service users and of their families, its  
15 own staff and of service providers during the Covid-19  
16 pandemic.

17 The RQIA recognises the manifold impacts of the  
18 pandemic upon families, particularly the lost of loved  
19 ones, and recognises and appreciates their determined  
20 pursuit for the truth.

21 The RQIA also seeks to acknowledge that  
22 relationships of trust and support between it and its  
23 staff, with patients, service users and families, and  
24 service providers, are of paramount importance when it  
25 seeks to heal and learn from the lessons which arise

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1 coordination in future emergencies. At its heart, that  
2 evidence underscores the importance of clarity,  
3 proportionality, collaboration and rights-based care  
4 across all aspects of the care system.

5 My Lady, unless there is anything else in which  
6 I can assist at this time, that concludes the submission  
7 on behalf of the inspectorate.

8 **LADY HALLETT:** Very grateful, Mr Macleod, thank you very  
9 much.

10 I think we're now going to Mr Rafferty, who is  
11 remote.

12 **Closing statement on behalf of Regulation and Quality  
13 Improvement Authority by MR RAFFERTY**

14 **MR RAFFERTY:** Yes, good afternoon, my Lady.

15 **LADY HALLETT:** I can't see you yet, Mr Rafferty, but, by all  
16 means, start speaking, if you don't mind the fact that  
17 I can't see you.

18 **MR RAFFERTY:** No, my Lady, I'm more concerned that you can  
19 hear me correctly.

20 **LADY HALLETT:** I can hear you perfectly well, thank you.

21 **MR RAFFERTY:** Thank you.

22 My Lady, the Regulation and Quality Improvement  
23 Authority, the RQIA, is thankful to you for the  
24 opportunity to make brief oral submissions this  
25 afternoon at the conclusion of Module 6 of this Inquiry

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1 from this investigation.

2 In the time available it is not, of course, my Lady,  
3 possible to traverse all of the substantive points of  
4 evidence which may be relevant to the RQIA. However,  
5 from its own evidence and its continued observation of  
6 the evidence received by the Inquiry from others, it is  
7 perhaps appropriate to reflect on four particular  
8 issues.

9 The first is in relation to inspections, my Lady.  
10 Having listened to the evidence in this Inquiry, no  
11 person could now be, if they ever were, in any doubt as  
12 to the importance of inspections of care homes and  
13 domiciliary care providers by the RQIA. As the  
14 challenge and difficulty of having safe inspections may  
15 arise during a pandemic, so does the need to protect the  
16 ability of the RQIA to perform inspections and its  
17 regulatory functions and it is right that, in  
18 circumstances where there was any material impact at all  
19 on the RQIA's inspection of adult social care, the  
20 Inquiry investigates the reasons for this and their  
21 impact. My Lady, I know that the Inquiry has heard much  
22 evidence on these issues from the RQIA and others.

23 The RQIA's position moving forward is that its  
24 regulatory role must be, and it must be permitted to be,  
25 one which is adaptive to the modern demands of adult

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1 social care, for example in circumstances where people  
2 now live longer and seek independence for longer, and  
3 which adopts modern approaches, including the assessment  
4 of intelligence and technologies to discharging those  
5 regulatory functions.

6 The Inquiry has heard, my Lady, that the RQIA is  
7 required by current regulations made in 2005 and 2007 to  
8 inspect care homes twice per year and domiciliary care  
9 agencies once per year. This model of inspection is of  
10 its time and, my Lady, the RQIA is firmly of the view  
11 that this time is passed.

12 The RQIA, as the Inquiry has heard, is a small  
13 organisation of professionals and its assessment,  
14 supported by the evidence that the Inquiry has received  
15 from others during this module, is that inspections  
16 should not be performed simply by reference to  
17 frequency. This is not the most effective way to  
18 regulate adult social care to secure the safety and  
19 quality of services.

20 Rather, the RQIA's regulation of the adult social  
21 care system should have, as a core element, which are  
22 reflective of informed judgements about the likely  
23 levels of risk. One factor, my Lady, well of course be  
24 timeliness. Services must be inspected regularly, but  
25 this must not be at the cost of thoroughness or

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1 evaluating and interpreting this information makes it  
2 meaningful and actionable, for decision making.  
3 Information can come from families, service users,  
4 advocates and from care homes and domiciliary care  
5 agencies directly, including through their staff and  
6 from other regulators and agencies.

7 There can be little doubt that the RQIA's role will  
8 be enhanced and it will be best able to implement  
9 an effective intelligence-led and risk-based regulatory  
10 system when all partners, including those service users  
11 and their families, trust RQIA and communicate freely  
12 with it. For this to happen, there must be transparency  
13 and a clear flow from information to action.

14 Service users and their families should be in no  
15 doubt, my Lady, that the RQIA values and respects their  
16 experience and their information, and that RQIA's  
17 actions are governed by the public interest and guided  
18 in line with the values of integrity, honesty,  
19 objectivity and impartiality.

20 The RQIA has heard in this Inquiry how it needs to  
21 take key steps in order to build its relationships with  
22 service users and families and with service providers,  
23 and these are to communicate -- and to communicate  
24 effectively. It intends, my Lady, to redouble its  
25 efforts to achieve these steps.

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1 a substitute for professional and informed judgement.

2 In order to achieve this change in approach, RQIA's  
3 role as an independent healthcare regulator (*remote link  
4 disruption*) and relevant policy, policy and legislative  
5 change is required.

6 The RQIA restates the need for modernisation of the  
7 current regulatory frameworks, for health and social  
8 care services in Northern Ireland, with a move to using  
9 information and data, including information from service  
10 users and families to identify equality of service  
11 provision and enable it to take appropriate action.

12 The second point, my Lady, is related to the first  
13 and is of no less importance. Whilst the RQIA submits  
14 that inspection activities play a key role in its  
15 ability to carry out its functions, that is of course  
16 one very important part but it is not the only important  
17 part. The RQIA wishes to make clear that the strength  
18 of its relationships with service users and families and  
19 their advocates with service providers, other regulators  
20 and agencies, and with the Department of Health, is  
21 central to its ability to carry out its functions.

22 This is best exemplified in relation to inspections.  
23 Using a risk-based model, my Lady, requires first  
24 a sound assessment of the risks. This depends upon  
25 access to information. Collecting, analysing,

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1 The third point is in relation to DNACPRs. The  
2 Inquiry will observe, my Lady, that the issue of DNACPRs  
3 was addressed in simple and short terms in the statement  
4 of Ms Donaghy. As a result of investigations carried  
5 out prior to giving evidence in the Inquiry, the RQIA  
6 was in a position to confirm that DNACPRs were not  
7 a matter raised with it in any or any significant way  
8 during the pandemic itself.

9 What has arisen in this module however, and of which  
10 the RQIA is now acutely aware, is that DNACPRs is  
11 an issue with which it could have a role. The RQIA will  
12 assess whether it could have a role in, for example, the  
13 checking and testing of advanced care planning  
14 arrangements in Northern Ireland. It will consider the  
15 evidence and the views of its staff, of the report which  
16 has been prepared by its regulatory colleague, the CQC,  
17 and it will seek and consider the views of other  
18 relevant stakeholders in Northern Ireland.

19 The fourth issue, my Lady, is in relation to  
20 isolation and the ability of care homes and domiciliary  
21 care agencies to have and to implement effective and  
22 safe policies and procedures for isolating. The  
23 importance of this, in the context of steps taken during  
24 the pandemic, which saw the restriction of visiting and  
25 access of family members to their loved ones, is

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1 appreciated.

2 The need to ensure that the RQIA maintains  
3 an up-to-date picture of the readiness of adult social  
4 care to move to react to emergency situations is again  
5 patently clear. The RQIA is developing its view, which  
6 is strengthened by the evidence that it has heard in  
7 this module, of the areas of practice and the data which  
8 require ongoing attention and where refinement is  
9 needed.

10 This will help RQIA to identify and understand where  
11 change is needed and how change can be embedded for the  
12 future. RQIA is committed to taking the practical  
13 actions required, both in relation to matters around  
14 available information and, more generally, to improve  
15 its ongoing responses at and to fortify it and the adult  
16 social care against challenging times.

17 In conclusion, my Lady, the RQIA is committed to  
18 assisting the Inquiry. It looks forward to the findings  
19 and recommendations which will enhance its ability to  
20 carry out its core purpose of securing and improving the  
21 quality and availability of health and social care  
22 services in Northern Ireland more effectively.

23 In this spirit, it has sought to engage with the  
24 Inquiry with candour, openness and transparency. This  
25 is reflected in the evidence of the RQIA where it has  
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1 about the impact of decisions made during the pandemic  
2 and their varied experiences of CQC over that period.

3 It has become clear that a number of themes have  
4 emerged from the evidence, and I will wish to address  
5 you briefly on three of them, with expansion in written  
6 submissions to follow.

7 Those three matters are: the pausing of routine  
8 inspections, discharge guidance from hospitals, and  
9 contingency planning.

10 First, pausing routine inspections and what should  
11 happen in the future. It's important to note the  
12 qualitative difference between routine inspections and  
13 inspections prompted by intelligence regarding a risk of  
14 harm.

15 To quote from Helen Whately's summary, she said:

16 "... a care home or care provider was only going to  
17 be inspected every so often, anyway, to do their rating  
18 as to whether they are good or requires improvement ...  
19 and it might make sense in the future, as it did in  
20 this, to deprioritise doing those because those aren't  
21 triggered by a particular concern about the care home  
22 and everything is going to be different probably in the  
23 care setting during a pandemic anyway, so are you even  
24 going to get a fair sense of how you should be rating  
25 a care provider in that circumstance?"

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1 acknowledged its shortcomings during the pandemic, and  
2 sought to indicate where it can improve now and in the  
3 future. It is committed to listening and reflecting and  
4 putting into action the learning from this Inquiry. It  
5 recognises that more work and change is necessary in  
6 order to protect its regulatory function and it is ready  
7 to take these steps.

8 Thank you, my Lady. Those are the submissions we  
9 have for RQIA.

10 **LADY HALLETT:** Thank you very much indeed, Mr Rafferty. I'm  
11 very grateful.

12 Right, we shall break now and, I'm afraid,  
13 a shortened lunch, I shall return at 1.30.

14 (12.39 pm)

(The Short Adjournment)

16 (1.30 pm)

17 **LADY HALLETT:** Ms Wilkinson.

18 **Closing statement on behalf of the Care Quality Commission**  
19 **by MS WILKINSON KC**

20 **MS WILKINSON:** My Lady, the Care Quality Commission wish to  
21 thank you and your team for the obvious care and  
22 attention paid to the important evidence heard in this  
23 module and wish to assure the Inquiry that they too have  
24 followed the evidence attentively.

25 CQC acknowledges the observations of many witnesses  
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1 However, risk-based inspections of the kind referred  
2 to earlier by the TUC differ, and are critical in  
3 ensuring safe care, and these are never paused.

4 CQC would invite the Inquiry to conclude that at the  
5 time, in March 2020, as regards routine inspections, the  
6 competing interests, with a need to ensure that the  
7 public received safe care whilst not exposing the  
8 vulnerable in those care homes to the virus being  
9 introduced by an inspector crossing the threshold  
10 without adequate PPE, testing or vaccination, the clear  
11 mandate at that time to those not designated as  
12 frontline workers, as CQC inspectors were not, was to  
13 stay at home, because the risk of death to the  
14 vulnerable was too great and it was not known how long  
15 that threat would persist.

16 Amongst the many witnesses from whom this module has  
17 heard, there was Ms Gillian Baranski from  
18 Care Inspectorate Wales, whose evidence on this same  
19 point, as the Welsh regulator, was, it is suggested,  
20 powerful.

21 She said:

22 "... the thought of our inspectors taking Covid into  
23 a care home, of which we were the regulators, and we  
24 know how vulnerable many of the people who live in our  
25 care homes are. That just seemed unacceptable."

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1 One might test the merit of that decision to pause  
2 by imagining the very criticisms that might now be faced  
3 by regulators in this Inquiry if they had continued  
4 their routine inspections without adequate PPE and could  
5 be traced, just as care worker movement has been, as one  
6 of the key sources that introduced Covid-19 into care  
7 homes.

8 This balance, in favour of a pause, was canvassed  
9 with and understood by relevant stakeholders and  
10 ultimately endorsed by government. Indeed, the Inquiry  
11 will recall the very clear evidence from the then  
12 Secretary of State Mr Hancock, which was for the CQC to  
13 pull back more than they were currently planning on  
14 inspections and data collection, to reduce the  
15 administrative burden on providers of social care.

16 He told the Inquiry that he considered the  
17 consequences of pausing inspections to be:

18 "... a balance, and that's the challenge ... often  
19 in policy, especially in these terrible times, we were  
20 taking actions in order to preserve life."

21 CQC understands and accepts that, to some providers  
22 and users of services, it would have felt different, as  
23 many things did during the pandemic, but CQC does not  
24 accept that it is a fair characterisation to say it  
25 abandoned the adult social care sector, went AWOL, or

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1 received targeted IPC inspections. So whilst there may  
2 not have been the same sights, sounds and smells  
3 available, there was a sound body of intelligence to  
4 understand, prioritise, and target risk, and in this way  
5 CQC maintained oversight during the pandemic.

6 For the future, however, my Lady, lessons have been  
7 learned. And as this Inquiry is aware, there is ongoing  
8 transformation within the CQC.

9 Whilst it will always be for government to determine  
10 how best to protect public health, depending on a future  
11 pandemic's transmission route, CQC recognises that there  
12 would need to be the widest toolkit available to enable  
13 regulation to continue. This could include, and should  
14 include, a robust registration system, broad  
15 intelligence-gathering methods, but also, CQC has said  
16 and maintains it is committed to the recommendation it  
17 made in its written evidence: to recognise the  
18 importance of on-site inspections, and to ensure the  
19 ability to continue to conduct them in a future  
20 pandemic.

21 Secondly, discharge from hospitals to care homes and  
22 future guidance drafting. CQC did not draft the  
23 Covid-19 hospital discharge service requirements that  
24 the Department of Health and Social Care issued on  
25 19 March 2020. When the Department's sought CQC's

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1 withdrew its oversight.

2 From mid-March 2020 onwards, CQC gathered  
3 information to carry out its duties in the following  
4 ways: inspectors made proactive telephone calls to  
5 providers in their portfolios, which triggered further  
6 action from CQC where a provider was not coping. And  
7 that did include the virtual meetings and online  
8 meetings that were called, in those times, "management  
9 review meetings", and it did include in-person  
10 inspections.

11 Between 4 May and 29 October 2020, there were 11,935  
12 ESF calls with care home providers within the sector,  
13 and an additional 6,281 to domiciliary care providers.

14 Intelligence was also gathered from provider  
15 collaboration reviews from July 2020, and the "Give  
16 feedback on care" form on the CQC website, which  
17 received 138,000 comments between March 2020 and  
18 June 2022. Emails and telephone calls raising concerns,  
19 including whistleblowing, were another source.

20 All this information was logged on the customer  
21 relationship management system and reviewed by the  
22 National Customer Service Centre.

23 It marked a 50% increase in contacts from the public  
24 and 55% increase from people working in the services.

25 In addition, large sample groups of providers

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1 agreement to suspend entirely the requirement for  
2 trusted assessment before a patient was discharged from  
3 hospital, CQC refused to agree.

4 Mary Cridge explained that this was because CQC will  
5 always put safety first, and the trusted assessors must  
6 take account of the legal responsibilities of the social  
7 care providers, who must ask themselves: can they care  
8 for this person safely?

9 CQC's only engagement in the full document was to  
10 ensure that the content of annex C, the trusted assessor  
11 guidance, remained as unaltered as possible, changing  
12 only to require that the NHS employ and use more trusted  
13 assessors.

14 Going forward, CQC's position on drafting this sort  
15 of guidance is, as stated by Mary Cridge:

16 [As read] "Our position on current powers, on  
17 guidance, are confined to guidance about compliance and  
18 how to meet the fundamental standards. It doesn't go  
19 wider than that. We think government after the best  
20 placed to provide guidance in a pandemic.

21 "What we need is guidance that is relevant to social  
22 care and is not health sector guidance adjusted for  
23 social care. It's a very diverse sector, with lots of  
24 different-sized providers. The best way to really good  
25 guidance is to have that genuinely co-produced with

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1 those who provide services, those who receive services,  
2 and the various experts.

3 "CQC has a role in that, perhaps even as a lead  
4 facilitator, but I think," she said, "CQC providing  
5 guidance about guidance, that's not a healthy state.  
6 It's the road to confusion for providers."

7 And finally, my Lady, contingency planning and the  
8 CQC's role in future preparedness.

9 At present, the regulations by which CQC must  
10 exercise their oversight do not presently require any  
11 provider or local authority to hold a pandemic plan.  
12 What was required, both in 2020 and remains the position  
13 today, is that when a care home registers with CQC, they  
14 are told they may be asked to supply some additional  
15 documents, which, depending on the type of service they  
16 plan to provide, may include a business continuity plan  
17 and an emergency plan.

18 To date, there has not been a definition that  
19 emergency plans must include pandemic plans.

20 As was clarified during Joanna Killian's evidence,  
21 the aim of a pandemic plan differs from that of  
22 a business continuity and business contingency plan.  
23 She said that it falls to national government to define  
24 the threats to the nation, which range from flu  
25 pandemics to cyber attacks.

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1 confirm that it is one of the organisations which has  
2 been invited to be "around the table" in this planning  
3 work, and CQC stands ready to play whatever part is  
4 deemed necessary as a result of that process and this  
5 Inquiry's recommendations for the future.

6 My Lady, those are those three matters highlighted  
7 by CQC at this stage.

8 **LADY HALLETT:** Thank you very much, Ms Wilkinson.

9 Mr Rawat.

10 **Closing statement on behalf of the UK Health Security Agency**  
11 **by MR RAWAT KC**

12 **MR RAWAT:** Good afternoon, my Lady, I am here on behalf of  
13 the United Kingdom Health Security Agency, or UKHSA as  
14 I will refer to it going forward.

15 My Lady, at the start of these hearings, you rightly  
16 described the impact of the pandemic on the adult social  
17 care sector as devastating. The complexity of the  
18 sector presents its challenges, but what must be  
19 remembered is that those it is intended to support are  
20 often the most vulnerable among us. It is vital,  
21 therefore, that we all continue to learn and implement  
22 lessons for the future.

23 As your Ladyship has heard, UKHSA, like Public  
24 Health England before it, has a discrete role to play in  
25 supporting the sector. That operational role

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1 It then falls to the local resilience forum to make  
2 sure that the local authorities within their footprint  
3 are ready to respond to a national emergency.  
4 A business continuity plan is a mechanism to make sure  
5 that business can continue in the event of a cyber  
6 attack or similar threat such as a flood.

7 It is with this evidence in mind that the  
8 recollection of Helen Whately should be viewed when she  
9 was referred to a WhatsApp message dated 3 March 2020  
10 stating, in relation to an Essex local authority  
11 contingency plan, that providers are required by CQC to  
12 have plans in place to provide safe care in the event of  
13 a pandemic. She suggested that she would expect CQC to  
14 be the natural organisation to oversee plans held by  
15 providers or local authorities, given the new powers to  
16 inspect.

17 But CQC is not qualified to risk assess what amounts  
18 to an adequate pandemic plan for a care provider.  
19 Indeed, its work in oversight of local authorities is  
20 limited to their duties under Part I of the Care Act.  
21 It is, however, expected that setting the criteria for  
22 adequate pandemic plans will be part of the government's  
23 current work referenced by Michelle Dyson as the  
24 pandemic preparedness strategy to tackle the five  
25 different potential transmission routes, and CQC can

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1 encompasses surveillance of pathogens and infectious  
2 outbreaks, contributing public health advice to national  
3 guidance published by Government departments and  
4 producing IPC guidance and, at local level, UKHSA's  
5 health protection teams offer specialised support.  
6 UKHSA does not have policy oversight for the sector nor  
7 is it a regulator of it.

8 Our corporate witness statement and our opening  
9 statement set out UKHSA's reflections as to what, having  
10 regard to the agency's role, could be better done to  
11 support the sector for a future pandemic. I want  
12 therefore today to address two matters: the first has  
13 been a central issue in this module, and that is the  
14 impact of hospital discharge decision of March 2020 on  
15 infection rates in care homes; and the second is the  
16 production of guidance.

17 To turn to the first, discharging an individual who  
18 no longer needs to be in hospital has long been been a  
19 best practice and continues to be so. There are good  
20 clinical reasons for this. But it meant, for example,  
21 that even prior to the pandemic, guidance existed for  
22 the discharge to a care home of a patient who had flu  
23 symptoms or had been diagnosed with a flu infection.  
24 It's not in dispute that Public Health England was not  
25 consulted on the policy decision to free up NHS bed

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1 capacity and only became aware of it when it was  
2 announced on 17 March 2020.

3 You've heard evidence for the rationale for that  
4 policy decision, including from the former Secretary of  
5 State for Health and Social Care. He spoke of concerns  
6 that hospitals were "likely to be overwhelmed" and, as  
7 Mr Hancock explained, the policy decision was made at  
8 a time when it was recognised that there was limited  
9 testing capacity.

10 The consequence was that Public Health England and  
11 others worked at pace to produce what has been called in  
12 this module the April Admissions Guidance published on  
13 2 April 2020. This was consensus guidance coordinated  
14 by DHSC and to which the NHS, CQC and Public Health  
15 England contributed.

16 It preceded the announcement on 15 April 2020 that  
17 all symptomatic care home residents and staff would be  
18 offered a PCR test. It has been argued that hospital  
19 discharge was the predominant route by which Covid-19  
20 reached care homes, particularly in those early months  
21 of the pandemic.

22 The Inquiry is very familiar with the technical  
23 report published by the Chief Medical Officer and  
24 Professor Laura Shallcross -- who undertook the Vivaldi  
25 1 Study at the invitation of Professor Susan Hopkins,

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1 Stepping back, however, what the studies do show is  
2 that hospital discharge does not appear to have been the  
3 dominant route of ingress, that there was a correlation  
4 between care home outbreaks and rates of community  
5 transmission, and that staff living in the community and  
6 moving between care homes unintentionally was  
7 an important route of ingress.

8 Looking to the future, consideration of what is  
9 a complex issue cannot be seen as a simple binary choice  
10 between hospital discharge, on one hand, and movement of  
11 staff, on the other. The 2025 National Risk Register  
12 identifies a respiratory pathogen as the most likely  
13 cause of a future pandemic affecting the UK. It would  
14 undermine effective pandemic planning if a particular  
15 fruit of ingress into care homes were not given proper  
16 examination.

17 So, of course, the impact that hospital discharge  
18 could have in a future pandemic needs to be prepared  
19 for. However, as your Ladyship has heard, that staff  
20 will work in more than one care setting is  
21 a long-established feature of the sector and to ignore,  
22 therefore, the possibility that staff movement could  
23 make a contribution to infection spread in a future  
24 pandemic is to undermine the need to look at practical  
25 measures that may mitigate that risk.

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1 then incident director for Public Health England -- drew  
2 your attention to the schematic in the technical report  
3 which set out seven potential routes of ingress for  
4 Covid-19 into care homes. You will have noted that the  
5 authors of that part of the technical report came from  
6 UKHSA. The technical report, citing various research  
7 studies, paints a more nuanced picture of ingress. It  
8 was why Professor Shallcross could make the point that  
9 there was a dynamic component to the contribution of  
10 different routes, depending on, for example, the time  
11 point of the pandemic.

12 The list of relevant studies begins with Easter 6 in  
13 April 2020 and continues with other studies conducted  
14 in 2021 and 2022. We intend to address the findings of  
15 those studies in our written closing statement but  
16 your Ladyship may find that they offer the best evidence  
17 as to the contribution of different routes, including  
18 hospital discharge, to infection rates in care homes.

19 When considering those studies, it is useful to keep  
20 in mind the following: first, the need to have regard to  
21 the intended purpose of a particular study; second, the  
22 extent to which a study identified its own limitations,  
23 including as to what data was then available; and,  
24 third, the need to take care when comparing different  
25 studies done at different points in time.

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1 As with support payments for those isolating, such  
2 measures are not within UKHSA's gift but they do need to  
3 be given thought. Could that mitigation involve, for  
4 example, supplementing incomes in a time of emergency so  
5 that staff do not need to move and, if that measure is  
6 adopted, then how do you plan for sufficient staff  
7 members across all settings?

8 My Lady, wider points have also been made about the  
9 role of DHSC and Public Health England in relation to  
10 data. It's been suggested by reference to the Vivaldi  
11 Study that there was a cultural reluctance to share  
12 data, that there were occasions when the utility of  
13 Vivaldi was ignored by some, whilst its data was also  
14 being presented by others as their own.

15 Professor Hopkins told you of the importance that  
16 Public Health England and UKHSA place on being able to  
17 conduct and publish research independent of government,  
18 and of the ethical standards expected of their  
19 scientists and which those scientists expect of  
20 themselves. That's not to ignore, as Professor Hopkins  
21 acknowledged, that some things could have been  
22 progressed faster but the Inquiry is aware, across all  
23 modules, of the numerous studies that Public Health  
24 England produced and shared during the pandemic.

25 The difficulties in getting PHE data into the NHS

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1 Foundry, managed by NHS Digital, was the example  
2 canvassed with witnesses and it will be for you to  
3 decide if those difficulties were reflective of  
4 a culture or flowed from the practical need to ensure  
5 that there was appropriate measures in place to allow  
6 for lawful data sharing as well as the infrastructure to  
7 transfer data safely.

8 UKHSA's corporate statement addresses how Public  
9 Health England and then UKHSA collated and used data.  
10 The agency has never suggested that the infrastructure  
11 in place before the pandemic was as effective as it  
12 could have been. The evidence is that data sharing  
13 improved rapidly during the pandemic. However, as your  
14 Ladyship is aware, UKHSA has in more than one module  
15 argued that building better data systems and addressing  
16 associated governance issues is key to pandemic  
17 preparedness.

18 Professor Hopkins pointed out that much has returned  
19 to pre-pandemic baselines and yet not every change  
20 requires significant financial resource or the creation  
21 of a bespoke system. As Professor Hopkins explained to  
22 you, it remains the case that the fact that someone is  
23 living in a care home is not automatically recorded in  
24 GP records. The workaround adopted during the pandemic  
25 was to use postcodes. Moving to a situation where this  
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1 Safety Executive, and directors of public health, in  
2 peacetime, will be critical to assisting different care  
3 settings.

4 UKHSA's corporate witness statement has set out how  
5 the agency now interacts with the sector, including with  
6 care providers and particularly through the work of its  
7 dedicated ASC team. Learning from the pandemic has been  
8 embedded and is being embedded. However, UKHSA  
9 recognises that more work can be done to ensure that  
10 guidance continues to be directed towards specific  
11 components of the adult social care sector, reflecting  
12 the different ways that care can be provided.

13 Further, guidance is always better for a stronger  
14 evidence base. Whilst research funders such as UK  
15 Research and Innovation and the National Institute for  
16 Health and Care Research, cannot fund all areas where  
17 research is needed. UKHSA can contribute by  
18 highlighting key evidence gaps to those funders to  
19 consider when determining funding priorities.

20 Finally, an important lesson from the pandemic is  
21 the need to find ways to listen to the direct  
22 experiences of those who use the care sector as well as  
23 family and friends, and then to use those experiences to  
24 inform the production of guidance.

25 My Lady, those are the submissions for UKHSA. Thank  
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1 simple detail is recorded, something which might, we  
2 acknowledge, need regulation, would prove valuable. As  
3 to the use of Vivaldi data, Professor Shallcross'  
4 evidence was that:

5 "Absolutely everybody was very receptive to the  
6 information we were putting out."

7 As Michelle Dyson pointed out: Vivaldi was  
8 an important study which provided robust and independent  
9 validation of steps, including in relation to staff  
10 movement, that DHSC was already taking.

11 My Lady, to turn briefly to the question of  
12 guidance. The expectation is that in a future pandemic,  
13 UKHSA would continue to fulfil the role it has in the  
14 production of national guidance. The guidance produced  
15 for the adult social care sector during the pandemic  
16 drew upon that which existed before the pandemic.

17 It reflected the need to have guidance which could  
18 be adapted to different care settings. It is ultimately  
19 those providing care who have the best understanding of  
20 a particular setting and of the needs of those that they  
21 look after. They are best placed to undertake the risk  
22 assessment which is a necessary step to implementing  
23 national guidance, and should be seen as such and, in  
24 doing that, the oversight shown by DHSC, as well as the  
25 operational work undertaken by CQC and the Health and  
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1 you very much.

2 **LADY HALLETT:** Thank you very much, Mr Rawat.

3 Ms Khaliq. I think you're -- oh, you are --

4 **Closing statement on behalf of the Welsh Government by MS**  
5 **KHALIQUE KC**

6 **MS KHALIQUE:** Here, yes. Good afternoon, *prynhawn da*,  
7 my Lady.

8 My Lady, the Welsh Government has listened very  
9 carefully to the evidence and reflected on the concerns  
10 of the Core Participants and the bereaved families.  
11 Full written submissions will, of course, be provided  
12 later but I make the following brief submissions to  
13 address a number of key areas.

14 First, it is important to be clear about the Welsh  
15 Government's role in the social care sector. The Welsh  
16 Government, as you've heard before, sets national policy  
17 and legislation, whereas day-to-day responsibility for  
18 managing and delivering adult social care in care homes  
19 and domiciliary care falls to the 22 local authorities  
20 who also commission services, and also to the care  
21 providers. The Welsh Government does not have  
22 operational control in this area, and that is  
23 an important distinction.

24 Second, on hospital discharge, Vaughan Gething, in  
25 his evidence, explained that the discharge framework  
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1 dated 13 March 2020 was underpinned by the need to  
2 manage the risk that Wales, as a whole, was facing, at  
3 that time, of the potential catastrophic collapse of the  
4 health and social care system, if action was not taken  
5 to try to ease the pressure of hospital capacity at that  
6 time.

7 In this, and in all other decisions during the  
8 pandemic, as noted by Mr Gething, the Welsh Government  
9 considered the balance of harms inherent in one decision  
10 as against the alternative. Decisions had to be taken  
11 at pace and were based on, to quote Mr Gething's words,  
12 "The best understanding of the scientific and medical  
13 evidence available at the time".

14 You also heard from Albert Heaney. He accepted  
15 that, with the benefit of hindsight, it would have been  
16 better to test upon discharge from the beginning of the  
17 discharge framework being in place, but that approach  
18 was not in the scientific or medical advice at the time,  
19 and you will recall that the Welsh Government accepted  
20 in opening that, between 15 and 29 April 2020, there was  
21 a delay between the decision to require negative tests  
22 before admission to a care home being made and the  
23 communication of this decision to health boards and the  
24 publication of the updated guidance. This was  
25 acknowledged by Mr Gething and Mr Heaney in their oral

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1 and staff, and the need to promote the wellbeing of  
2 those residents.

3 Mr Gething reflected in evidence that, in hindsight,  
4 the Welsh Government could have progressed permitting  
5 low-risk visiting sooner but, at the time, again, the  
6 scientific evidence and knowledge was not there to  
7 support this. The Inquiry has also heard there were  
8 many iterations of the care home visiting guidance in  
9 which restrictions were adjusted to reflect a developing  
10 and evolving understanding of the virus.

11 You heard from Gillian Baranski. She told the  
12 Inquiry that the guidance sought to achieve this  
13 difficult balance and Care Inspectorate Wales delivered  
14 seminars to aid the understanding of guidance and risk  
15 assessment. The Welsh Government and the Inspectorate  
16 sought to ensure stakeholder groups and the needs of  
17 people with specific vulnerabilities, including those  
18 with learning disabilities, were recognised in that  
19 guidance. Mr Heaney confirmed that the Welsh Government  
20 did not endorse a blanket ban approach to visiting, and  
21 took prompt and appropriate action when it became  
22 apparent that some local authorities or care providers  
23 had introduced blanket bans at a local level.

24 In recognition of the benefits of social contact and  
25 wider wellbeing, the Welsh Government sought to approach

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1 evidence.

2 Third, on asymptomatic testing. Mr Gething  
3 confirmed in his evidence that decisions on asymptomatic  
4 testing were similarly based on the scientific advice  
5 available at the time and not based on testing capacity.  
6 However, you heard from Mr Gething that, had the advice  
7 to engage in asymptomatic testing come earlier, the  
8 reality is that the Government would have faced the very  
9 practical challenge of delivery and how to prioritise  
10 the tests available.

11 In May 2020, targeted asymptomatic testing was  
12 introduced in care homes. General asymptomatic testing  
13 in care homes was not introduced before 16 May because  
14 the advice received up to that point by the Welsh  
15 Government was that the scientific evidence did not  
16 support it. You also heard in evidence that the advice  
17 relating to asymptomatic testing of all care home  
18 residents that was referred to by Matt Hancock in  
19 a Health Minister's meeting on 5 May 2020 was never  
20 shared with the Welsh Government at any level nor were  
21 its contents reflected in SAGE advice at that time.

22 Fourth, on visiting restrictions. My Lady, the  
23 Welsh Government always sought to strike a careful  
24 balance between preventing the spread of Covid-19 and  
25 the significant risks to vulnerable care home residents

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1 the issue innovatively and successfully rolled out the  
2 visiting pod scheme, enabling safe visits to take place  
3 outdoors, and promoted the use of video technology by  
4 a device loan scheme.

5 Fifth, on inspections in care homes. The decision  
6 to pause routine inspections was taken in March 2020  
7 amidst a rapidly emerging picture of Covid-19 and was  
8 made due to the very real risk of inspectors bringing  
9 the virus into care homes to a vulnerable cohort of  
10 residents. As Ms Baranski recognised in her evidence,  
11 inspections are a powerful tool in the regulatory  
12 framework but they are only one of a number of ways in  
13 which assurance is and was provided within the social  
14 care system. You heard from Ms Baranski that, despite  
15 the temporary pause, inspectors continued to monitor and  
16 follow up on notifications, concerns and safeguarding  
17 incidents, and services that were already on the  
18 enforcement pathway to ensure quality and safety of  
19 care.

20 Although inspections were paused, my Lady, Care  
21 Inspectorate Wales intensified its scrutiny and  
22 monitoring of services, a series of check-in calls with  
23 providers were introduced from 30 March 2020, which  
24 performed a supportive function to providers, and was  
25 a further source of information for the Inspectorate.

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1 Finally, on PPE. The Inquiry has heard evidence  
2 that PPE supplies did not run out at a national level in  
3 Wales, but challenges were experienced in the very early  
4 months of the pandemic due to distribution difficulties  
5 at a local level. As Mr Gething explained, about  
6 two-thirds of the care sector PPE needs were met by NHS  
7 Wales Shared Services Partnership by 7 May 2020 with the  
8 remainder being met by other sources. In terms of  
9 learning in this area, Mr Gething reflected that, in the  
10 event of a future pandemic, the Welsh Government should  
11 immediately progress to an NHS Wales Shared Services  
12 Partnership-led procurement of PPE for the care sector,  
13 as this model worked very well once established.

14 Overall, and to conclude, throughout the pandemic,  
15 the Welsh Government was committed to protecting the  
16 people living and working in the care sector, and  
17 balancing the protection of the health and well-being of  
18 recipients of care and the need to save lives.

19 My Lady, the Welsh Government is very grateful for  
20 the opportunity to assist the Inquiry. Thank you.

21 **LADY HALLETT:** Thank you very much indeed, Ms Khaliq.

22 Now, Mr Mitchell.

23 **Closing statement on behalf of Scottish Ministers by MR**  
24 **MITCHELL KC**

25 **MR MITCHELL:** Thank you, my Lady. This is the closing  
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1 knowledge. Policy officials, professional advisers and  
2 advisory groups all contributed to keeping ministers  
3 fully informed.

4 Prior to the pandemic, there was extensive,  
5 meaningful engagement and consultation with the sector.  
6 During the pandemic it intensified.

7 The evidence would suggest that stakeholders accept  
8 this to be so.

9 As Ms Freeman observed, Scottish Care was a key and  
10 critical voice. Ms Lamb noted that a broad  
11 cross-section of stakeholder voices was listened to,  
12 albeit those voices were not always in agreement.

13 Turning to the decision to discharge patients into  
14 care homes. Ms Freeman pointed out that decisions made  
15 by the Scottish Government were not binary, but were  
16 decisions between levels of risk. In March 2020,  
17 delayed discharge had to be effectively tackled. We  
18 stress the following points: first, the discharge of  
19 a patient from hospital is a clinical decision over  
20 which the Scottish Government has no control.

21 Second, the Scottish Government cannot and did not  
22 compel care providers to accept admissions from  
23 hospitals. It did ask local authorities to put  
24 additional effort into reducing delays in discharging  
25 those assessed as clinically fit.  
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1 statement on behalf of the Scottish Government.

2 I appear today along with junior counsel Julie McKinlay,  
3 and we're instructed by Caroline Beattie and  
4 Heather Auld of the Scottish Government Legal  
5 Directorate.

6 To begin where this module began, and indeed where  
7 it ended, that is with the impact evidence, the poignant  
8 testimonies could not fail to move. This form of  
9 participation in the Inquiry process shows a bravery  
10 that an onlooker may not fully understand, and that we  
11 who regularly appear in courtrooms perhaps come to take  
12 for granted.

13 The Scottish Government pays tribute to those who  
14 participated in the film and who gave evidence. It  
15 passes its sympathies and its condolences to the  
16 bereaved across the UK. It acknowledges the Herculean  
17 efforts of the workforce, including the unpaid carers,  
18 who looked after our most vulnerable. As Ms Freeman  
19 said, their response was absolutely exemplary.

20 Today we examine some of the issues that arose in  
21 evidence to which we can offer some context and clarity.

22 In Scotland, adult social care was prioritised in  
23 the pandemic response alongside the NHS. The Scottish  
24 Government did have a good understanding of the sector.  
25 There existed a wealth and breadth of specialist  
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1 Third, from the outset, great efforts were made to  
2 ensure that the process of discharge was conducted  
3 safely, through guidance directed at social distancing,  
4 clinical screening and periods of isolation.

5 Testing prior to admission was introduced just as  
6 soon as capacity existed.

7 Fourth, not all patients were discharged into care  
8 homes.

9 Fifth, hospital discharges were not the dominant  
10 route by which the virus entered care homes. Analysis  
11 has revealed ingress of infections to be primarily  
12 attributable to staff footfall and directly related to  
13 care home size.

14 The Scottish Government submits that the decision to  
15 discharge reflected a considered approach to  
16 a long-standing issue. It required to be taken amidst  
17 an urgent, rapidly developing situation. While  
18 protective measures at this time were, as Ms Freeman  
19 acknowledged, perhaps not fully adequate, they were the  
20 only measures available to us at that point. The  
21 alternative was to leave someone ready for discharge in  
22 hospital, which was a high risk environment.

23 Looking now at infection prevention and control, the  
24 principles of sound IPC practice have long been  
25 recognised in Scotland. Since 2012, Scotland has  
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1 published a National Infection Prevention and Control  
2 Manual. It contains standard precautions. It was, and  
3 continues to be, applicable to all care staff, in all  
4 care settings, at all times, in respect of all patients  
5 and service users, whether infection is known to be  
6 present or not. It ought to have been well known to the  
7 care sector, although, as Ms Freeman recognised,  
8 training and delivery were not consistent.

9 On 12 March 2020, HPS issued guidance specific to  
10 the social care sector. On 13 March that guidance was  
11 supplemented with standalone clinical guidance for care  
12 homes issued by Scotland's Chief Medical Officer and  
13 that was updated on 26 March and 15 May.

14 Earlier in the pandemic, understanding of the virus  
15 and its effects developed rapidly. Guidance existed for  
16 the well-being and safety of individuals. There was  
17 a clear need for updates as new data and evidence  
18 emerged. Whilst recognising that it was challenging for  
19 care homes to respond to changing guidance, it was  
20 essential that it be updated and at speed.

21 A few brief words on PPE. Concerns were raised in  
22 evidence as to its availability, yet it is important to  
23 remember pre-pandemic arrangements for its supply and  
24 the speed with which the Scottish Government and  
25 partners responded to increased demand.

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1 care workers absent from work due to coronavirus or  
2 self-isolation received an amount similar to their usual  
3 salary.

4 Further, in July 2020, it introduced a death in  
5 service scheme. A one-off payment of £60,000 was  
6 available to a named survivor of any social care worker  
7 who died without death in service cover as part of their  
8 contracted pension arrangements.

9 Both measures had retrospective effect.

10 Thinking now about visiting. The Inquiry heard  
11 powerful evidence of the effect that visiting  
12 restrictions had on care home residents and their  
13 families. Yet, as Ms Freeman noted, decisions in this  
14 area highlighted that the entire experience of the  
15 pandemic concerned the balance of harms. There was no  
16 situation at any point where a decision could be made  
17 that carried no harm.

18 The Care Reform (Scotland) Bill promoted by the  
19 Scottish Government received Royal assent on the 22nd of  
20 this month. Amongst other provisions, the Act imposes  
21 a duty on Scottish Ministers to require providers of  
22 care home services for adults to facilitate certain  
23 visits. Those provisions are known as Anne's Law, in  
24 memory of Anne Duke, whose family were unable to see her  
25 for extended periods during the pandemic.

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1 As the Inquiry heard in Module 5, when in March 2020  
2 concerns were raised, swift action was taken to support  
3 the sector. The Module 5 evidence suggested that by the  
4 latter half of April, concerns about PPE supply in care  
5 homes had subsided.

6 Considering funding and sick pay, the Inquiry heard  
7 evidence about what is said to be the negative effect of  
8 fiscal austerity in the sector. However, in contrast to  
9 some other parts of the United Kingdom, since 2009-2010,  
10 expenditure on ASC in Scotland increased in real terms  
11 by 7% in total and by 5% per capita.

12 In 2020-21, Scottish integration authorities  
13 received funding of £561 million for Covid-19, and  
14 £712 million the following year. This was in addition  
15 to wider social care support, such as reducing delayed  
16 discharges, loss of income, and staff costs.

17 On 12 May 2020, an initial £50 million in  
18 sustainability payments was announced, with a further  
19 £50 million on 3 November 2020.

20 In relation to sick pay, some social care staff were  
21 reluctant to be tested for fear that a positive test  
22 would lead to self-isolation, a reliance on SSP and  
23 a reduction in income.

24 In June of 2020 the Scottish Government put in place  
25 its Social Care Staff Support Fund to ensure that social

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1 The Act strengthens residents' rights, allowing them  
2 to identify at least one essential care supporter. This  
3 will help ensure that supporters can continue their  
4 role, even in infectious outbreak situations when  
5 visiting is barred(?) for others.

6 That the Scottish Government introduced Anne's Law  
7 is recognition that families and friends play an  
8 essential part in the health and well-being of  
9 residents, and that the care home is their home.

10 Turning to information and advice for unpaid carers.

11 Access to information was a key issue for them and  
12 for local carer support services. Carers needed advice  
13 on how to protect the person they were caring for. That  
14 person was often at higher risk. Carers also felt an  
15 added responsibility to protect themselves from  
16 infection, both to reduce risk of transmission to the  
17 person in their care, and so that they might continue to  
18 provide that care.

19 In March of 2020, the Scottish Government created  
20 pages on its website to help people and carer  
21 organisations find the most up-to-date information. It  
22 created similar pages for young carers on the Young Scot  
23 Young Carers platform, covering a range of practical  
24 issues, including infection control and PPE.

25 Finally, turning to regulation. The Scottish

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1 Government was aware of concerns raised by the public  
2 regarding both pausing and resumption of care home  
3 inspections. From 13 March 2020 the Care Inspectorate  
4 paused physical inspections due to potential risks posed  
5 to care home residents and staff, and to Care  
6 Inspectorate staff.

7 On 17 April, following a deep dive meeting on care  
8 homes and a resolution that the Care Inspectorate should  
9 reinstate inspection visits, the Scottish Government  
10 requested that directors of public health take immediate  
11 action to ensure an enhanced system of assurance; that  
12 is, by working with the Care Inspectorate, local IPC  
13 teams, primary care teams and others to oversee the  
14 provision of local support and assurance to care homes.

15 As Ms Freeman made plain in evidence, the Scottish  
16 Government wished to see inspections resume, albeit in  
17 a manner that balanced potential risks.

18 Decisions to perform in-person inspections were  
19 informed by individual risk assessments of each home,  
20 under the clinical direction of directors of public  
21 health. This allowed consideration such as quality of  
22 care in each home to be taken into account.

23 My Lady, we conclude by, on behalf of the Scottish  
24 Government, once again passing sincere condolences and  
25 sympathies to those who have lost loved ones and to  
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1 in due course in their written closing statements.

2 Today I shall only summarise shortly some key points  
3 that they wish to make orally and at the conclusion of  
4 the hearing part of the module.

5 There are some common general points. My Lady, you  
6 know, for their part, both those associations aim and  
7 have the aim to ensure that the delivery of the best  
8 possible adult social care is done by their member  
9 authorities. You know how both are concerned to help  
10 local government to help people from all walks of life  
11 to live their lives to the best and that they will  
12 undertake that work in another emergency to the best of  
13 their ability, building on the experience of the last,  
14 and the wisdom that will emerge from your report on this  
15 module.

16 They are both fully aware, as you now will be, of  
17 the mental, physical, financial, logistical constraints  
18 of this pandemic for the provision of ASC. While every  
19 aspect of care at such times is more cumbersome and  
20 dangerous, both associations and their members know the  
21 essential importance of effective, humane and thoughtful  
22 engagement.

23 You've heard how, despite the many problems of lack  
24 of PPE, of difficulties over testing and vaccination and  
25 in the face of sometimes confusing and contradictory  
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1 those who continue to suffer, and by once again  
2 acknowledging the efforts and sacrifices of our  
3 workforce in the pandemic.

4 Before I sit down, I would like, on behalf of the  
5 Scottish Government, to extend our thanks to the Inquiry  
6 for the work that has gone into this module. Those  
7 thanks of course go to everyone involved: the legal  
8 teams, the ushers, witness support, and RTS, and of  
9 course to you, my Lady, for your continued chairing of  
10 this Inquiry. Thank you.

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

12 Mr Allen.

13 **Closing statement on behalf of the Local Government  
14 Association and the Welsh Local Government Association by MR**

15 **ALLEN KC**

16 **MR ALLEN:** Ah, yes. My Lady, good afternoon and, as you  
17 know, I represent both the Local Government Association  
18 and the Welsh Local Government Association. Before  
19 I start, may I just echo what Mr Mitchell has just said  
20 about our thanks generally to the Inquiry teams. He put  
21 it very eloquently and I can't find better words than he  
22 used, so thank you on behalf of my two associations.  
23 Both are very grateful to the Inquiry for the  
24 opportunity for their chief executives to give oral  
25 evidence in this module and both will have more to say  
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1 advice, those connected with the adult social care  
2 sector, whether in England or Wales, worked tirelessly  
3 and diligently, and you've heard also how this sector is  
4 not well understood, and how too often, particularly in  
5 the early phases of the pandemic, local government  
6 stepped up, even though government in London and Cardiff  
7 did not act as fast or as well, perhaps as it should  
8 have.

9 You have heard also of the many awful situations in  
10 which the pandemic took the lives of those receiving or  
11 giving adult social care, despite the sector's best  
12 efforts. Their bereaved families carry the weight of  
13 this trauma and both associations repeat their fullest  
14 sympathies to all those thus affected.

15 Now, my Lady, focusing particularly on points  
16 relating to the LGA, the Association fears that the  
17 country is still not addressing the fissures in adult  
18 social care provision that have so been exposed during  
19 the pandemic and by the hearing in this module. We are  
20 simply no closer, even in these peacetimes, to  
21 a sustainable and thriving sector or a national  
22 understanding of social care's inherent value or  
23 ensuring care recipients can always live as they wish.  
24 There is now a fear in the sector that the focus on  
25 improving adult social care is on the back burner, while  
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1 yet another NHS organisation is underway. That is why  
2 this module is so important.

3 There are four points for immediate urgent action  
4 which sit alongside the recommendations in  
5 Joanna Killian's witness statement, which need to be  
6 made orally and now.

7 First, we need sustainable funding and meaningful  
8 reform that is co-designed with all involved. You've  
9 heard the Casey Commission is on the horizon, but that  
10 multi-year process is no substitute for action now.  
11 Addressing deficits in resources and capacity that this  
12 module has exposed, system changes for both emergency  
13 and normal times are absolutely necessary now.

14 Second, government, Whitehall and the NHS must work  
15 closely and regularly with the adult social care sector  
16 to ensure that policy translates to feasible and  
17 desirable practice. Local government must be an equal  
18 and trusted partner in planning for, and responding to,  
19 emergencies, and that means better involvement for local  
20 government in this autumn's pandemic preparedness test,  
21 Exercise Pegasus. It means engagement with all pandemic  
22 planning with senior LGA representation at relevant COBR  
23 meetings, and it means co-design and co-production of  
24 all relevant guidance, both in respect of pre-pandemic  
25 planning and any new guidance that might be required

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1 points, insofar as they are relevant to Wales, but it  
2 wishes me to present orally three points of critical  
3 importance to Wales, which sit alongside the longer and  
4 detailed recommendations in the witness statement of its  
5 chief executive, Chris Llewellyn.

6 Well, first, the Welsh Local Government Association  
7 also emphasises the LGA's last point about parity of  
8 esteem with the NHS. In a pandemic, the health and  
9 social care sectors are equally important and they are  
10 truly interdependent. They must be treated as such in  
11 all matters of policy and operation, whether testing,  
12 PPE, financial support or public health control and  
13 easements, and this must not be seen as some mere  
14 chimerical aspiration.

15 The evidence from the Care Inspectorate Wales, from  
16 Care Forum Wales and ADSS Cymru was equally to the same  
17 effect. The mantra in future must be: protect health  
18 and care equally. Government policy and action must  
19 follow through on this aim. It is essential this  
20 happens.

21 Second, despite the evidence to the contrary from  
22 the former Minister for Health and Social Services,  
23 Vaughan Gething, any assumption that social care  
24 settings are safer than hospitals must be rejected as  
25 a fallacious generalisation. No future policy should be

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1 during the next pandemic, as and when it occurs.

2 Third, more work needs to be done to work out the  
3 very best way to balance steps to keep people safe  
4 whilst enabling them to see their loved ones and their  
5 loved ones to connect with them, and allowing them to be  
6 assured of the care recipient's well-being.

7 This is not an easy issue. It involves looking  
8 again at issues such as the content of Care Act  
9 easements, of visiting restrictions, and also decisions  
10 to suspend CQC's routine inspections. Central advice  
11 and guidance must be fully aware of the multiplicity of  
12 different physical care settings, and must enable local  
13 flexibility.

14 Lastly for the LGA, it wishes to reiterate, with  
15 emphasis, that adult social care must have parity of  
16 esteem with the NHS, both ordinarily and, even more  
17 importantly, in a future health emergency. As  
18 a minimum, this requires a mandatory cross-Whitehall and  
19 NHS programme of induction for new and existing senior  
20 civil servants and officials, whose departments have  
21 an interface with the adult care and support sector, to  
22 increase understanding of adult social care's  
23 operational and policy imperatives.

24 Now, my Lady, changing my focus to the Welsh Local  
25 Government Association, it notes and agrees with these

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1 built on this assumption. Policy must be built on the  
2 recognition of the many and varied constraints on  
3 delivering residential care, the dangers of homecare,  
4 and the dangers arising from a peripatetic and part-time  
5 workforce. Obviously, this requires a deeper look at  
6 discharge policies.

7 Third, again echoing points made by the LGA, the  
8 WLGA emphasises the importance of investing in the  
9 workforce. It is not enough for the Chief Social Care  
10 Officer for Wales, Albert Heaney, to have noted how the  
11 system is very fragile, with problems of high turnover  
12 of staff, and a very low-paid workforce. It is obvious  
13 that such fragility, if continued, will cost lives in  
14 a future pandemic. So the WLGA emphasise, this is the  
15 time for urgent meaningful action to improve the  
16 resilience and quality of the social care sector and to  
17 rebuild public confidence.

18 My Lady, the associations thank you yet again for  
19 your attention, and they will flesh out their  
20 submissions in writing and submit them in due course.

21 **LADY HALLETT:** Thank you for your help, Mr Allen.

22 Lastly, Ms Stober.

23 **Closing statement on behalf of Association of Directors of  
24 Adult Social Services by MS STOBER**

25 **MS STOBER:** Thank you, my Lady. Can you hear me?

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1 **LADY HALLETT:** Yes.

2 **MS STOBER:** I represent the Association of Adult Social Care  
3 Services. My Lady, may I apologise for my phone going  
4 off earlier on today, even though it was completely  
5 switched off.

6 ADASS welcomed the opportunity to contribute as Core  
7 Participants in this Module 6. They were anxious to  
8 acknowledge the sorrow to the bereaved and those needing  
9 and working in social care who were traumatised by the  
10 experience, or who still suffer Long Covid, to pay  
11 tribute to unpaid carers, to the committed care staff  
12 and to mark the very significant efforts everyone who  
13 worked excessively long hours, days and nights, over  
14 months, without break.

15 My Lady, you've heard with remarkable consistency  
16 from witnesses that what happened to people needing and  
17 working in social care was both tragic, in terms of the  
18 lives lost or compromised, but you've also heard  
19 evidence of remarkable demonstration of commitment,  
20 courage, and the best of human nature.

21 In relation to better and timely planning for  
22 a future pandemic, ADASS has the following five  
23 recommendations which they would like the Inquiry to  
24 consider reflecting in the recommendations of the final  
25 reports of this module.

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1 partners to ensure that social care leadership and  
2 workforce are trained and equipped to deal with  
3 a pandemic. This would include the identification of  
4 those needing and working in care and effective  
5 mechanisms for shielding, vaccination, testing, PPE  
6 provision, data, professionalisation, pay and sick pay,  
7 access to healthcare, mental health support, access to  
8 care, support and safeguards, such that we're all better  
9 protected, connected and valued.

10 (3) Serious consideration should be given to  
11 increasing awareness, recognition and valuing of social  
12 care through embedding very operational experience and  
13 social care personnel in government with  
14 cross-government recognition and mandatory induction  
15 delivered by leaders in social care field for DHSC's  
16 civil servants, and politicians with briefs in social  
17 care and the NHS, and also for people working in senior  
18 roles in the NHS.

19 (4) A thorough revision of the discharge to access  
20 practice, to include greater focus on integrated  
21 intermediate care, namely the care, treatment and  
22 support offered to people, so as to avoid the need for  
23 hospital admission and to enable people discharged from  
24 hospital support to recover, rehabilitate and, if  
25 long-term care is needed, to weigh up the benefits,

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1 First, a thorough review of the infrastructure  
2 needed at every level, national, regional and local,  
3 such that social care and our social and psychological  
4 needs are addressed in a pandemic, alongside the  
5 clinical and hospital focus. That means ensuring that  
6 there is regular social care advice to scientists and  
7 government at the highest level, alongside the NHS, from  
8 the people with operational as well as policy  
9 experience. It means a review of the local resilience  
10 forum, and the NHS arrangement and accountabilities and  
11 what the best mechanisms are for planning and responding  
12 in the case of a national care and health emergency.

13 (2) The creation of a national mechanism that could  
14 take the form of reserved taskforce to be stood up  
15 annually, so as to continually review and assess  
16 readiness and fit test plans. It should cover the work  
17 of the same advisory groups as that of the taskforce  
18 that Sir David Pearson chaired in 2020. It should  
19 review the recommendations made by each of those  
20 advisory groups, be informed by and draw on regional  
21 perspectives, for example the ADASS regional chairs, be  
22 ready to stand up at the earliest indication of a future  
23 pandemic.

24 Central government should be required to act on the  
25 recommendations of such a taskforce with relevant

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1 risks and cost of the option.

2 (5) ADASS would recommend a quality safety and  
3 safeguarding are integral to planning for, and  
4 responding to, a pandemic, given that people needing and  
5 working in care and support may once again be behind  
6 closed doors, at home, or in closed institutions.

7 Finally, my Lady, there is a collective hope that  
8 the Inquiry will make a mark in recognising just how  
9 essential social care is for all our lives, and to start  
10 to build a new social contract about how we live, work  
11 and care for each other.

12 Thank you, my Lady.

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

14 Ms Carey.

15 **Closing remarks by LEAD COUNSEL TO THE INQUIRY for MODULE 6**

16 **MS CAREY:** My Lady, may I just conclude these hearings by  
17 inviting you to publish an additional 70 statements  
18 later. I won't read all of them, but up on screen now  
19 are going to be the names, indeed the reference numbers,  
20 and a description of the people and indeed the  
21 organisations that provide the statements to us. They  
22 include from local government, interest groups, the  
23 Northern Irish health and social care trusts,  
24 politicians, the COSLA survey, and indeed some remaining  
25 impact witnesses.

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1 May I finally just say this: a few word of thanks  
 2 from me. Many of the Core Participants have been kind  
 3 enough to commend the Inquiry for the smooth running of  
 4 this module. As I think your Ladyship knows, but others  
 5 may not, those words of thanks go not just to counsel  
 6 and the solicitors but to the paralegals, the  
 7 secretariat, the operations team, and to all the other  
 8 staff, security here at Dorland House, who have looked  
 9 after us so very well.

10 I truly am grateful.

11 **Closing remarks by THE CHAIR**

12 **LADY HALLETT:** Thank you very much indeed, Ms Carey. And  
 13 can I add to that list, I entirely echo what you say,  
 14 can I add our very patient stenographer --

15 **MS CAREY:** Indeed.

16 **LADY HALLETT:** -- who has had to cope with a lot of very  
 17 difficult evidence.

18 **MS CAREY:** Indeed.

19 **LADY HALLETT:** Thank you very much. That completes the  
 20 hearings into Module 6, the care sector. It has been an  
 21 intense and, at times, difficult five weeks. I've heard  
 22 some powerful evidence, and some powerful advocacy, and  
 23 from the very first moment I met the bereaved during my  
 24 consultation on the terms of reference, and I went  
 25 around the United Kingdom, I learned just how important

1 on several reports, but I do undertake that we will  
 2 publish the report as soon as we possibly can. And  
 3 I very much have taken on board the point that, as  
 4 worthwhile as Baroness Casey's review will be, it's  
 5 going to come sometime in the future, or the results of  
 6 it will come sometime in the future.

7 So, thanking everybody for all their assistance,  
 8 I will now declare these hearings at an end. The next  
 9 evidential hearings for Module 8, Children and Young  
 10 People, will begin on 29 September.

11 Thank you all very much indeed.

12 (2.33 pm)

13 **(The hearing concluded)**

1 this module would be to so many.

2 I hope that those who have suffered so much agree  
 3 that we have conducted a thorough inquiry and  
 4 investigation into the most important issues.  
 5 I certainly believe that we have.

6 And as Ms Carey has said, we've done it with the  
 7 assistance of so many people: obviously the Inquiry  
 8 team, the witnesses, the material providers, the Core  
 9 Participants, everybody involved in putting on hearings  
 10 here, and Core Participants' representatives, many of  
 11 whom have provided substantial insight. And I'm  
 12 extremely grateful to everybody.

13 If I could be forgiven the repetition, I will now be  
 14 considering all the material, the oral evidence, the  
 15 written material, and of course any written closing  
 16 submissions that the Core Participants may submit. I'm  
 17 afraid we've had to restrict their time for oral  
 18 submissions, but there will be no restrictions on the  
 19 length of their written submissions.

20 I understand the need for urgency in publishing my  
 21 findings and recommendations, and we will do the best  
 22 that we can, but everyone, I'm afraid, must remember  
 23 that the report writing for this module in itself would  
 24 take some time if we are to get things right and, in any  
 25 event, the Inquiry team as a whole are already working

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<p><b>workforce... [5]</b> 138/3 144/5 144/9 144/12 147/2</p> <p><b>working [26]</b> 8/8 25/18 39/18 41/12 42/2 43/19 44/7 44/16 46/15 46/16 48/13 60/10 63/16 63/17 65/2 75/7 83/2 110/24 129/16 137/12 145/9 145/17 147/4 147/17 148/5 150/25</p> <p><b>works [1]</b> 58/11</p> <p><b>world [2]</b> 11/10 56/5</p> <p><b>worlds [1]</b> 11/24</p> <p><b>worse [3]</b> 12/9 16/21 74/12</p> <p><b>worsened [1]</b> 45/12</p> <p><b>worst [2]</b> 14/21 63/16</p> <p><b>worth [2]</b> 15/13 87/10</p> <p><b>worthwhile [1]</b> 151/4</p> <p><b>worthy [1]</b> 9/12</p> <p><b>would [73]</b> 7/16 10/25 13/4 13/5 16/15 19/11 21/17 21/21 21/23 22/1 22/23 28/5 29/3 29/8 29/13 29/15 29/16 30/14 30/15 31/1 32/23 34/10 38/13 38/15 38/17 39/5 39/9 40/5 40/8 42/19 50/22 51/22 51/24 52/16 54/21 58/12 60/20 70/5 70/6 73/14 73/21 74/4 78/2 78/6 79/14 80/19 81/25 82/3 84/2 85/12 85/20 85/21 86/6 87/20 108/4 108/15 109/22 111/12 114/13 117/17 119/13 122/2 122/13 125/15 126/8 131/7 134/22 138/4 145/23 147/3 148/2 150/1 150/23</p> <p><b>wouldn't [2]</b> 24/1 57/7</p> <p><b>wounded [1]</b> 13/11</p> <p><b>wounds [1]</b> 17/3</p> <p><b>writing [3]</b> 73/4 144/20 150/23</p> <p><b>written [16]</b> 5/4 15/16 39/2 52/17 64/2 65/19 79/23 93/15 107/5 111/17 118/15 124/11 139/1 150/15 150/15 150/19</p> <p><b>wrong [4]</b> 31/18 38/6 58/19 62/16</p> <p><b>wrote [2]</b> 4/1 87/20</p> <p><b>Wyman [1]</b> 66/8</p>	<p><b>year [9]</b> 23/24 60/5 69/9 81/13 87/14 101/8 101/9 134/14 141/10</p> <p><b>years [1]</b> 16/2</p> <p><b>yes [4]</b> 98/14 124/6 138/16 145/1</p> <p><b>yesterday [2]</b> 92/7 96/22</p> <p><b>yet [15]</b> 2/22 14/8 16/3 21/6 22/17 23/16 24/10 51/4 57/20 98/15 121/19 133/22 135/13 141/1 144/18</p> <p><b>you [111]</b> 6/4 7/14 11/22 13/24 14/11 14/21 17/17 19/2 19/3 22/3 22/4 24/7 24/21 24/22 28/11 28/19 28/20 28/21 28/22 28/25 28/25 31/7 32/18 34/20 36/17 43/25 44/10 45/3 45/7 45/17 45/19 45/23 46/10 46/13 46/19 50/11 54/20 54/21 55/9 62/18 62/18 62/21 72/3 72/4 72/6 72/10 73/2 75/15 76/17 80/10 80/12 80/17 89/7 89/8 89/8 98/8 98/15 98/16 98/17 98/18 98/20 98/20 98/21 98/23 99/1 99/3 106/8 106/10 106/21 107/5 107/23 107/24 115/8 115/15 118/4 120/6 120/15 121/2 121/22 124/1 124/2 124/3 125/14 125/19 126/6 126/16 127/11 128/14 129/20 129/21 129/25 138/9 138/10 138/11 138/16 138/22 139/5 139/9 139/16 140/9 144/18 144/21 144/25 144/25 148/12 148/13 148/17 149/12 149/13 149/19 151/11</p> <p><b>you're [2]</b> 45/4 124/3</p> <p><b>you've [9]</b> 46/3 47/10 117/3 124/16 139/23 140/3 141/8 145/15 145/18</p> <p><b>young [4]</b> 136/22 136/22 136/23 151/9</p> <p><b>your [53]</b> 13/16 13/24 35/1 35/14 37/4 37/21 38/2 38/11 38/17 38/19 38/22 39/3 39/6 40/1 41/12 41/13 42/7</p>	<p>42/25 44/23 44/23 45/17 45/18 62/8 62/19 72/13 72/21 74/5 74/15 76/23 78/2 78/13 79/9 79/17 79/22 80/3 89/13 92/7 92/8 93/18 95/4 95/13 97/3 106/21 115/23 118/2 118/16 119/19 121/13 138/9 139/14 144/19 144/21 149/4</p> <p><b>your Ladyship [2]</b> 92/8 118/16</p>	<p><b>Z</b></p>	<p><b>zero [2]</b> 13/16 14/9</p>		