Module 2 Written Opening Statement – National Care Forum, Homecare Association and Care England

1. Introduction

1.1. This submission represents the written opening statement for module 2 of the Covid-19 Public Inquiry made by the National Care Forum, Homecare Association, and Care England.

1.2. The National Care Forum is the membership body for not-for-profit care and support organisations in England, although our members have services in all parts of the UK. Formally constituted in 2003 and building on more than 10 years of experience as the Care Forum, the National Care Forum has been promoting quality care through the not-for-profit sector for 30 years. As of 20 September 2023, the National Care Forum has over 170 members, providing care and support to over 277,200 people across 7,600 care and support settings which employ more than 124,700 staff. Our members provide a wide spectrum of services – everything from services for older people, such as residential and nursing care and specialist dementia care to offering home care, extra care housing, supported living and specialist services for people with a learning disability and autistic people and people with enduring mental health conditions or other complex needs. Some also offer homelessness, substance misuse and resettlement services. Many also offer supported housing, day services, employment support and other types of non-CQC registered care and support services.

1.3. The Homecare Association is the UK's only membership body exclusively for homecare providers. It is a private company limited by guarantee and was established as a not-for-profit Association in Autumn 1989. Founded by 75 homecare providers to represent the interests of the homecare sector, the original aims were to advocate for the sector, develop quality standards and campaign for regulation. Up until 2003, the Homecare Association's (previously UKHCA) Code of Practice was the only quality standard in homecare. Non-Executive Directors are all homecare providers, elected by the Homecare Association's members, representing small, medium, and large providers in both the state-funded and self-funded market. The Homecare Association represents members across England, Scotland, Wales, and Northern Ireland. We currently have over 2,100 members, representing about one-third of registered regular domiciliary care providers. 94% of our members are based in England, 3% in Scotland, 2% in Wales and 1% in Northern Ireland. The Homecare Association uses its trusted voice to bring people together in shaping and advancing homecare.

1.4. Care England, a registered charity, is the largest and most diverse representative body for independent adult social care providers in England. Care England members provide a variety of care services, amongst them single care homes, small local groups, national providers and not-for-profit voluntary organisations and associations, as well as private providers, for a variety of service users including older people, those with long-term conditions, learning disabilities and mental health problems. Of our membership, broadly, 60% of care providers provide care to older adults, whilst 40% provide care to younger adults, namely individuals with a learning disability and autistic people. Our members run and manage approximately 4,000 care services and provide over 120,000 beds. Care England's mission brief is to serve as a unified voice for our members and the care sector aimed at supporting a united, quality-conscious, independent sector that offers real choice and value for money.

1.5. Our opening statement for module 2 draws attention to the general neglect shown towards adult social care by the core political and administrative decision-makers in the UK government. This can be expressed in three ways:

- Social care was overlooked in key decision-making moments.
- Social care was misunderstood (it was seen as care homes for older adults, rather than a diverse system of care and support services for all ages, with a workforce of 1.6m, larger than the NHS).
- Social care was disadvantaged (especially in comparison to the NHS. Indeed, the focus of decision-making appeared to be protecting the NHS rather than citizens in all communities).

1.6. The neglect of social care by key political and administrative decision makers was prevalent and entrenched prior to the pandemic and was then reflected in their response to the additional challenges faced by the sector as a result of Covid-19. We would urge the Inquiry Team to use the statements in 1.5 to frame their investigations and questions of witnesses during the module 2 hearings and in the consideration of submitted evidence. A failure to focus on those factors will create a risk that the Inquiry will itself neglect consideration of adult social care. That risk is already demonstrated by the minimal focus placed on social care in the evidence received from core decision makers.

2. Reflections on Hearings from Module 1

2.1. Several statements made by core participants during the module 1 hearings make it clear that in the years leading up to the pandemic, adult social care faced neglect from the core political and administrative decision-makers in the UK government. Social care thus entered the pandemic in a weakened condition. Social care was further weakened as the pandemic progressed. We believe that this neglect put the social care sector at a lasting disadvantage, disproportionately affecting those who give and receive adult social care services.

2.2. The oral submission on behalf of Covid Bereaved Families for Justice at the Module 1 public hearing on 18th July 2023 outlines the lack of knowledge by central government about the number of social care facilities at the beginning of the pandemic, as well as the impact of funding cuts to resilience:

"The structural problems in social care are well known, and in that sector there was even a lack of understanding of the number of care facilities at the outset of the pandemic, and the interface between hospitals and care homes will be a major issue in forthcoming modules. Major cuts to local authority funding during the relevant period had affected adult social care and early days nursery provision. If our services struggle to maintain business as usual, what chance do we have when there's a looming disaster like a pandemic? The rights and wrongs of austerity, whether Mr Osborne really did fix the roof while the sun was shining, are not for this Inquiry. Resource allocation is for the democratic institutions of state and elections. But the degrading of capacity through the relevant period, major budget cuts to local and devolved authorities, are for this Inquiry, because they are directly relevant to resilience. The Inquiry should say so".

2.3. Similarly, the submission on behalf of the Scottish Covid Bereaved Families for Justice at the Module 1 public hearing on 18th July 2023 pointed out that the focus on Brexit, led to crucial pandemic preparedness work for adult social care being shelved:

"It was suggested by Mr Gove that he was not aware of any impact that pausing to work on Brexit had caused. The Chair has evidence from the experts which clearly set out the work preparing for the pandemic had stopped. Vital work had not yet been completed, such as guidance on NHS triage arrangements, the operational plans for adult social care, a revised and updated version of the 2011

pandemic influenza strategy, which by 2020 had not been updated to include valuable learning which could have been taken from MERS or SARS, the Hine report or Exercise Cygnus."

2.4. The submission by the Trades Union Congress (TUC) at the Module 1 public hearing on 19th July 2023 outlines these points more starkly, pointing out that The Rt Hon Jeremy Hunt MP, the current Chancellor and former Secretary of State for Health and Social Care, failed to ensure that the adult social care sector had the resources for resilience[OBJ]:

"The Chancellor, for example, was at least prepared to recognise that, as Secretary of State for Health and Social Care, he had been concerned in the years prior to the pandemic as to the resilience and capacity in our health and social care services. Indeed, he described the fact that he was unable to secure a long-term funding settlement for the social care sector as one of the regrets of his time as Secretary of State for Health and Social Care."

2.5. The same submission by the TUC at the Module 1 public hearing on 19th July 2023 makes it very clear that social care was neglected:

"We have also heard evidence about resilience in social care. In our opening, we suggested that in social care the problem has been not so much one of repeated restructuring and reorganisation, but one of neglect. There has been no attempt to structure at all.

We observed that adult social care in England is now provided by around 18,000 organisations. We observed that the overall workforce is larger than in the NHS, yet there is no equivalent to NHS England seeking to provide some strategy and direction to the sector. We pointed out that the TUC has repeatedly called for a national social care forum to bring together government, unions, employers, commissioners and providers to co-ordinate the delivery and development of services, including the negotiation of a workforce strategy."

2.6. The TUC isn't the only organisation that has been calling for a national social care forum *'to bring together government, unions, employers, commissioners and providers to co-ordinate the delivery and development of services, including of a workforce strategy.'* This is something the Care Associations, including the National Care Forum, the Homecare Association and Care England have been calling for long before the pandemic – alongside the necessary funding for increased pay, terms and conditions of the workforce and capital investment in services. This fell on deaf ears.

2.7. Similarly, the TUC showed in their submission to the at the Module 1 public hearing on 19th July 2023 that the little planning for a pandemic that was done was rather limited:

"Bruce Mann described the UK Influenza Pandemic Preparedness Strategy from 2011 as very slim on the social care aspect. From the Department of Health and Social Care's own operational response centre lessons learned reviews, it is clear that there was confusion within the department regarding whether it even had responsibility for social care pandemic planning."

2.8. It is very clear that across government there was no understanding of adult social care when the pandemic began – in terms of how it operates, the demographics of the people who use it, the diversity of services being provided, or the number of locations. This is a glaring oversight. In the words of the TUC submission at the Module 1 public hearing on 19th July 2023:

"…a complex and fragile sector, upon which so much of pandemic response relies, went into the pandemic without even the most basic of preparations. The Inquiry should move forward from Module 1 with some pretty stark findings as to preparedness and capacity in social care."

2.9. The neglect of social care by key political and administrative decision makers described in the submissions made by the Covid Bereaved Families for Justice, the Scottish Covid Bereaved Families for Justice and the TUC placed the sector at a significant disadvantage when responding to the additional challenges and demands created by the pandemic, which was exacerbated by the ongoing neglect of the sector in critical decision making in response to the pandemic itself.

3. The Nature of Core Political and Administrative Governance and Decision-Making During the Pandemic

3.1. When considering submissions and evidence, we ask that the Inquiry should consider the three statements outlined in paragraph 1.5:

- Social care was overlooked in key decision-making moments.
- Social care was misunderstood (it was seen as care homes for older adults rather than a diverse system of care and support services for all ages, with a workforce of 1.6m, larger than the NHS).
- Social care was disadvantaged (especially in comparison to the NHS. Indeed, the focus of decision-making appeared to be protecting the NHS rather than citizens in all communities).

3.2. Throughout the pandemic, the National Care Forum, Homecare Association and Care England had extensive conversations with our respective provider members. We have summarised these themes below which clearly show that the social care sector, social care providers and those that draw on care and support services were not adequately considered in the decisions about the response to the pandemic. One key overarching theme spans our submission, which is the lack of understanding of the care and support sector and those who are supported through it. This lack of understanding can be compared to the absolute primacy given to NHS in all aspects of the government's response to the pandemic, which is a far better understood institution for policy and decision makers. This NHS-centric approach, no matter how well intentioned, had very serious negative impacts across the care and support sector and upon all people drawing on care. We have identified the following themes:

i. **There was a disregard for the people drawing on care and support from government and the wider health system -** For those living in care settings and for those who need care and support in the community, there was a lack of understanding of their needs and circumstances. This lack of understanding and the lack of understanding of the social care sector as a whole, especially the breadth and diversity of it and those who use it, manifested itself as an apparent disregard for the people relying on care and support during the pandemic. This is demonstrated by the following:
    a. PPE supply for the social care sector was particularly chaotic during the first wave.
    b. The importance of testing across social care did not appear to be recognised by policymakers for a significant period, and whole home routine testing for all care homes was not reliably available until September 2020. Testing was not widely available for homecare until January 2021.
    c. Some of the most important policy decisions relevant to the social care sector were taken without appropriate consultation with the sector itself.
    d. Scientific and operational expertise in social care was excluded from the SAGE.

e. There was blanket decision making around do not attempt cardiopulmonary resuscitation decisions ("DNACPR") by NHS colleagues for people with a learning disability and older people without involving people or their families or taking into account each person's individual circumstances.
f. Guidance in relation to visiting showed a lack of understanding of the practicalities of the sector, and those supported within it, particularly when it came to people with learning disabilities and autistic people.
g. The decision to instantly withdraw community health services for the social care sector at the beginning of the pandemic brought significant risks to people's health and may well have precipitated a decline in their overall health and wellbeing.
h. Care Act 'easements', allowing local authorities to cease formal Care Act assessments, applications of eligibility and reviews were made available very promptly in the early pandemic and enabled Local Authorities to abandon some of their responsibilities to people under the Care Act.
i. Moving through the different phases of the pandemic, it was clear that as restrictions eased for wider society, there was confusion across government about how this easing might work for those using care and support services.

ii. **There was a disregard for the people <u>working</u> in social care from government and the wider health system -** Priorities and guidance should be developed in partnership between health and social care services. Within this partnership, independent sector care providers should be seen as long-term legitimate partners instead of being used to overcome short-term pressures. This is demonstrated by the following:
a. Very significant delays to essential practical support for the care and support sector, including timely and reliable access to PPE or testing.
b. There were early issues in evidencing keyworker status for care workers and the associated support and prioritisation for services such as access to childcare, schooling etc., and access to financial assistance to implement the necessary absences for isolation and enhanced sick pay.
c. The implementation of the Vaccination as a Condition of Deployment policy ("VCOD") for those working in care homes against the guidance of senior leaders in social care who repeatedly shared their expertise in the best policy approaches for encouraging vaccine uptake and overcoming vaccine hesitancy, as well as the likely negative outcomes of the policy. The proposal for extending VCOD to homecare, though averted at the eleventh hour, also had a negative impact on workforce numbers.

iii. **Guidance flow and communication from government and key stakeholders was poor and chaotic throughout the first and second phase of the pandemic.** Changes in guidance were often communicated last minute, sometimes over bank holiday weekends and often late on Friday nights, making it hugely challenging to implement promptly. Particularly chaotic guidance changes were linked to PPE, Infection Prevention and Control, isolation of those receiving care and support following a positive Covid-19 test and visiting the different types of settings in which care and support is provided. Lack of understanding of the settings where care is provided led to policies that were unworkable in practice and required substantial change at short notice, adding to the chaos. Policy changes were often communicated by press release, sometimes days before the final guidance was issued, leading to a mismatch between public understanding of the situation and the action that care providers were being instructed to take. By way of example, restrictions upon visits to care settings by friends and relatives was, understandably, a highly emotionally charged issue. Government

announcements that restrictions were being reduced created an expectation that increased access would be allowed with immediate effect. The ensuing delay in issuing the guidance necessary to allow care providers to implement those changes caused immense frustration to those expecting that the change in restrictions would be implemented immediately.

iv. **The chain of command and communication were unclear, particularly the role of national vs. local decision-makers.** The divergence in guidance produced, and differences in how guidance was interpreted at a local level, were challenging for all social care providers. For example, District Nurses were told they didn't need to wear masks any longer, whilst homecare workers did.

v. **Throughout the pandemic response, there was a concerning lack of understanding of social care by policymakers,** leading to an unhelpfully narrow focus on care homes for older people, with little consideration of the breadth and diversity of care and support settings and services, which all needed help and support. The importance of co-production and joint strategic planning were crucial yet overlooked during the pandemic. The views of care sector representatives need to be afforded the same level of attention as the views presented by Public Health bodies. Whilst the latter is able to present theoretical data, the former is able to present empirical evidence from real-world experience.
    a. The understanding of the social care sector amongst Government bodies was not taken into account. The nuances of the sector, including fundamental differences between older person care homes and services for people with learning disabilities and autistic people were not recognised.

vi. **There was a lack of understanding of home-based and community services in social care.** Home-based and community services in social care involve half of the workforce and millions of citizens. Officials, Ministers, and other relevant parties, e.g., UKSHA need to understand the care sector, and ensure it receives the guidance, funding, and other resources it needs.
    a. Operational guidance was typically written for NHS services without consideration of relevance to the setting and service type, resulting in guidance that was often unworkable and, in some cases, counterproductive.
    b. PPE supplies were diverted to the NHS ignoring homecare and wider community social care services.
    c. There were delays in access to asymptomatic testing for homecare; and challenges with the COVID-19 vaccine roll-out in homecare.
    d. When issues with guidance related to homecare were identified, it was not acted on quickly enough. It could take significant time to get relatively simple changes made to guidance.
    e. The additional costs of managing infectious diseases for the sector were not well understood by the Government. For example, assumptions were initially made that homecare employers could cover the cost for all the time staff spent testing, without any additional funds.

vii. **There was limited understanding of the broader community provision** that many providers offer alongside regulated care services. There was also limited understanding of the needs of those who use care and support services – for example, the needs of those with dementia or those with learning disabilities or enduring mental health issues.

viii. **The drip feeding of funding support was unhelpful, insufficient, inefficient and bureaucratic –** Whilst all funding was greatly needed and appreciated, it came after very significant advocacy from the sector and was provided only in the form of emergency short term time limited funding. This short-termism meant providers were unable to put long-term protective measures in place, or plan for the future accordingly. Funding was driven through local authorities, with significant grant conditions, leading to excessive administration and bureaucracy in relation to accounting and reporting. It is also worth noting that the emergency financial support designed to address additional demands placed upon the sector stopped in March 2022, but associated guidance remained in place for several months in relation to testing and isolation requirements, placing continued financial pressure on employers regarding pay and sick pay.

ix. **The collection and use of data were highly problematic throughout the pandemic for social care** – The Capacity Tracker became the 'pandemic data capture tool' and was then regularly amended, with many additional questions to require and capture a wider range of data from the wider adult social care sector to inform the emergency response to COVID-19. The final tool created a daily burden for care providers, did not always eliminate duplication of data requests and was regularly changed with little notice. For many providers, there was little perceived benefit to sharing data as it did not result in any discernible change in decision making by those in receipt of the data reflecting the impact of the pandemic that was being reported. Providers who entered the data were then not able to see the wider emerging trends in their collective data, which would have given them greater warning of the expected impact of new variants or the anticipated need for additional capacity.

4. Reflections on the Inquiry's Chronology

4.1. The neglect of the social care sector by core political and administrative decision makers is reflected in the evidence that has been submitted for module 2 and as a consequence the Inquiry's chronology does not reflect the experiences outlined in section 3 above. It appears to represent a government-centric timeline of meetings and announcements, without the necessary context that defined the experience of the adult social care sector borne out of the administrative decision-making. This is something the public hearings must address. Without providing an exhaustive list of key omissions from a high-level review, we observe the following:

- There is no reference to SAGE Social Care Working Group meetings.
- There is limited reference to care homes or home care.
- There is no reference to Vaccination as a Condition of Deployment (VCOD).

4.2. We would welcome an indication as to how the Inquiry team devised the chronology shared with Core Participants. Both the National Audit Office (Readying the NHS and Social Care in England for COVID-19) and Health Foundation (Health Foundation Policy Tracker) have chronologies for 2020 that encapsulate the key issues related to the adult social care sector. We suggest it would be beneficial for the module 2 team to consult these chronologies to capture key timeline events for the adult social care sector. We would be happy to make introductions to these two organisations.

4.3. The National Care Forum, Homecare Association and Care England can also provide details from their own detailed chronologies if requested which encompass the entire pandemic period.

4.4. It is well-documented that announcements and guidance changes, particularly in the early months of the pandemic, were made public in a number of different ways; televised announcements, press releases and live media interviews, with written guidance following such announcements at various speeds. Accordingly, the time taken to implement such changes also varied. The Inquiry's chronology does not appear to account for this. The time between first announcing a policy change, publishing the accompanying guidance and implementing the new policy is a core component of understanding the decision-making and political governance throughout the pandemic.

4.5. It is also important to note that the adult care sector is not homogenous and even when initial announcements were made, for example in relation to testing or PPE or vaccination, they did not apply to the whole sector but were often segmented in their application, such as a focus initially on care homes and a significant time lag for the rest of the sector such as home care, supported living etc. Indeed, some parts of the wider care and support sector never featured in government planning and decision making.

5. Concluding Remarks

5.1. It is clear from the experiences and evidence from the memberships of the National Care Forum, Homecare Association and Care England that adult social care was largely neglected before, during and after the pandemic by the core political and administrative governance and decision-makers. The Inquiry should be guided in its investigations by the three statements made in paragraph 1.5:

- Social care was overlooked in key decision-making moments.
- Social care was misunderstood (it was seen as care homes for older adults, rather than a diverse system of care and support services for all ages, with a workforce of 1.6m, larger than the NHS).
- Social care was disadvantaged (especially in comparison to the NHS. Indeed, the focus of decision-making appeared to be protecting the NHS rather than citizens in all communities).

5.2. Such a focus will allow the Inquiry itself to avoid the pitfall of overlooking adult social care. Indeed, as key decision-makers neglected social care before, during and after the pandemic, the evidence and witness statements presented to the Inquiry also tend to overlook adult social care. As a result, there is the potential for a tendency for the Inquiry itself to inadvertently neglect adult social care in its investigations. We strongly recommend that the Inquiry ensures it considers adult social care ***in every module***.

5.3. Finally, for this to be done effectively, we once again call on the Inquiry team to make available public funding for the National Care Forum, Homecare Association and Care England as Core Participants for module 2, and any future modules we are granted Core Participant status for. Currently, the UK government has significant resources to draw upon, as does the NHS and other public bodies. Adult social care does not. We are concerned that this is limiting the evidence we can present on behalf of our members and those they employ and provide care for, and therefore reinforcing the neglect of adult social care and risks perpetuating the neglect of the social care sector during the pandemic outlined in these submissions.