Questionnaire
UK COVID-19 Inquiry: Module 2 - Rule 9 Request to National Care Forum
Reference: M2/R9R/NCF/TJS

We have sought to respond to the questions raised as fully as we can in the time permitted, however, given the scope of the issues covered in the request / response it has not been possible to carry out a review of all relevant information that we hold.

1. **A brief overview of the history, legal status and aims of the organisation or body. Please explain whether the work of the organisation or body is UK wide, or is instead confined to England, Scotland, Wales or Northern Ireland only.**

NCF was formally constituted in 2003. It is a company limited by guarantee with no share capital and a not-for-profit ethos enshrined in its Articles of Association. NCF had previously been known for 10 years as the Care Forum. It was set up by organisations in the not-for-profit sector to provide a peer support network to focus on quality improvement and innovation and to advocate for the many not-for-profit organisations operating care and support services. We have been promoting quality care through the not-for-profit care sector for 29 years now. We are the leading voice in the not-for-profit sector.

NCF members predominantly operate care and support services in England; while some of them also operate across the devolved nations, the focus of NCF's support is on supporting members to understand and navigate the policy and regulatory environment in England.

2. **A brief description of the group(s) which the organisation or body supports or represents.**

NCF's membership data changes as organisations join and as their portfolios of services evolve, but as at the end of November 2022 the picture was as follows. We represent over **165** not-for-profit organisations who provide care and support to over **230,000** people and operate over **6,950** services, including providing more than **49,500** care home places. The services provided by members and the client groups they support can broadly be summarised as follows:

Services Supported	Care Home with Nursing	Care Home without nursing	Home Care	Extra Care housing	Supported Living	Supported Housing
	55%	64%	32%	24%	43%	27%

Client Groups	Older people	Learning Disability	Physical Disability	Mental Health Needs	Dementia
	68%	45%	43%	39%	51%

3. **A brief overview of the work of the organisation or body in supporting or representing the relevant group(s) between January 2020 and Spring 2022 as it relates to the response to Covid-1: 9 of (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive.**

NCF dedicated significant time and resources throughout the Covid-19 Pandemic to supporting and representing its members. This support took three key forms.

a) **Navigating Guidance** – NCF issued over 200 briefings to members between March 2020 and October 2022. For a period of the first wave, NCF issued daily briefings to support members in navigating the numerous and frequent guidance changes and to share urgent new information from the various government departments and other stakeholder groups. NCF opened up its emergency COVID-19 briefing service to the wider sector, beyond members. This was intended to support smaller organisations who had less resources to analyse and interpret the rapidly changing guidance and best practice.

b) **Engagement with UK Government** - NCF sought to inform and influence national and regional policy making and decisions. The action NCF took varied over the period of the Pandemic. There was little engagement from the UK Government with the social care sector in the very early months of 2020 about pandemic planning and pandemic response. From early March, the government and other stakeholders[1] convened a number of one-off meetings. These initially were ad-hoc and hastily convened and then developed into a wide range of adult social care stakeholder groups. The NCF was part of many of these stakeholder groups which were constantly evolving, changing and merging their remits throughout the time period in question.

As the government started to become aware of some of the key concerns of the social care sector, these government convened stakeholder groups began to focus on issues of real concern to the social care sector, including guidance on PPE and infection prevention and control ("IPC"), testing and vaccination. However, it took far too long for the government to look for input from social care providers into guidance and policy development. The NCF, individually and as part of the wider Care Provider Alliance, sought to engage with the DHSC in the early months of 2020 but it was not until the end of 2020 that DHSC sought to meaningfully engage on a more regular basis. Our first enquiry to the DHSC in relation to the impact of Covid on the care sector was in January 2020. In February we commented on early guidance developed by PHE in relation to how to isolate at home if you thought you had Covid, and how inappropriate it was for people living with dementia. In February we raised questions a number of times in relation to the potential impact of Covid on those receiving care and support. From April 2020 there were more efforts to involve the social care sector in policy making decisions, although these could not be referred to as systematic until later in the year, however, throughout this period there were notable examples of engaging but not listening.

Other meetings and groups were convened in response to NCF raising issues which needed a government response or policy development; issues raised included guidance for CQC inspectors, the immediate insurance crisis for social care[2] and the challenges for day centres/ community services which were unable to operate due to lockdown restrictions, resulting in hugely negative impacts for the people using them and which did not feature in the DHSC policy thinking.

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[1] Including the Department of Health and Social Care ("DHSC"), Public Health England ("PHE") / United Kingdom Health Security Agency ("UKHSA"), National Health Service England ("NHSE") and the Department for Levelling Up, Communities and Housing ("DLUCH").
[2] which was precipitated by insurers refusing to renew policies or placing constrictions on cover that left providers unfairly exposed and risking regulatory non-compliance.

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In the time permitted to provide this response, NCF has not been able to undertake the thorough and lengthy review of all relevant individual's diaries to provide a comprehensive list of all the meetings and groups attended. DHSC will likely have a complete list of all the various meetings and stakeholder groups which involved social care providers and trade associations. It will require significant time and support to carry out a detailed review of our records in order to ensure a full and detailed interrogation, which we believe to be essential in order for the inquiry to hear the full picture.

c) **Advocacy** - While it took far too long for government, NHS and PHE to properly engage social care providers, from mid-late April 2020 the NCF was eventually able to begin to play an active ongoing role in seeking to inform the drafting of guidance for the social care sector and seeking to improve the policy response by government. It was never clear what status responses were given, and there was very limited feedback or evidence of the way in which this feedback was utilised. Examples include repeatedly requesting reviews of the PPE and IPC guidance to remove the flawed clinical assumptions underpinning it and to make it more practically applicable to different types of care and support settings, reminding DHSC that social care is more than care homes for older people. Too much early PPE and IPC guidance was written solely for care homes, compounded by the assumption they were like hospital wards, demonstrating a basic lack of knowledge across government about social care.

The NCF also issued over 150 press releases as part of our advocacy for the sector. The NCF played an active role in the work of the umbrella group the Care Provider Alliance ("CPA") which joins up a range of membership bodies for the social care sector and also actively participated in the Social Care Taskforce convened in the summer of 2020. NCF undertook a range of surveys with members to gather evidence to support its advocacy work and to understand the impact and effectiveness of the government's pandemic response for the social care sector. Examples of topics NCF's advocacy work covered include work in relation to DNACPRs being imposed without consent, policy and practice in relation to visiting restrictions, recording of Covid-19 related deaths and their public acknowledgement and Vaccination as a condition of deployment.

4. **A list of any articles or reports the organisation or body has published or contributed to, and/or evidence it has given (for example to Parliamentary Select Committees) regarding the impact on the group(s) which the organisation or body supports or represents of the response to Covid-19 by (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive. Please include links to those documents where possible.**

NCF was the driving force behind the [LESS COVID research](#); we realised very early on in the pandemic from our members who were experiencing COVID-19 outbreaks that there were some important lessons to be learned from the frontline. NCF was very keen to learn as quickly as possible from the early days of the pandemic and to share this learning to support the sector.

When the government did begin to communicate a little more regularly with the care and support sector, we commented on numerous pieces of guidance to try to improve them and make them more applicable and relevant to a wide range of care and support settings and services. Whilst feedback was sought, the turnaround times were often wholly inadequate for the complexity of the issue, and the resultant guidance often bore little evidence of

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recommendations being taken on, and feedback on how and why decisions were made was never sufficient. The NCF also made a number of submissions to various consultations, Select Committee inquiries and the NAO.

We believed that an important part of the legacy of the COVID-19 pandemic is the role played by NCF members. To help highlight the incredible response by them, we reached out to members so we could bring together these Caring Heroes stories in this published book with an ebook version as well. The NCF created a specific publication called Caring in COVID to highlight the heroic efforts of the social care workforce, to capture and share the real world experiences and actions of our not-for profit members.

Our Policy Director has provided evidence separately about her experience of membership of the Sage Care Working group.

5. **The view of the organisation or body as to whether the group(s) it supports or represents was adequately considered when decisions about the response to Covid-19 were made by (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive. Please also explain the reasons for the view expressed by the organisation or body in this respect.**

Throughout the pandemic, we have had extensive conversations with our members who all provide not-for profit care and support services. There are a number of key themes we wish to raise in relation to the decisions made by the UK government throughout. NCF does not consider that the social care sector, social care providers and those that use care and support services were 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 primacy had very serious negative impacts across the care and support sector and upon all people using care.

We have outlined below the key themes to support that view:

1) **There was a disregar for the people <u>using</u> 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 policy makers for a significant period, and whole home routine testing for care homes was not reliably available until September 2020.

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c. Some of the most important policy decisions relevant to the social care sector were taken without appropriate consultation with the sector itself.

d. There was blanket decision making around DNACPR for both older people and those with a learning disability.

e. Guidance in relation to visiting showed a lack of understanding of the practicalities of the sector, and those supported within it.

f. 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.

g. Care Act 'easements', 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.

h. 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.

2) **There was a disregard for the people <u>working</u> in social care from government and the wider health system** - 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.

3) **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, IPC, isolation and visiting. Policy changes were often communicated by press release, sometimes days before the final guidance was issued, leading to mismatch between public understanding of the situation and the action that care providers were being instructed to take.

4) **Throughout the pandemic response, there was a concerning lack of understanding of social care by policy makers,** 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. In addition,

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there was **limited understanding of the broader community provision of the not-for-profit sector and the wider community-based provision** that many of our members 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.

5) **The drip feeding of funding support was unhelpful, insufficient, inefficient and bureaucratic** - Whilst all funding was very needed, it came after very significant advocacy from the sector in the form of emergency short term time limited funding. Funding was driven through local authorities, with significant grant conditions, leading to significant administration and bureaucracy in relation to accounting and reporting. It is also worth noting that the emergency financial support stopped in March 2022, but 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.

6) **The collection and use of data was highly problematic throughout the pandemic for social care** - The Capacity Tracker ("**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, did not always eliminate duplication of data requests, was regularly changed with little notice and for many providers there was little perceived benefit to sharing data as it did not result in tangible benefit – i.e., support. Providers who entered the data were then not able to see the wider emerging trends in their collective data.

7) **Whether the organisation or body raised any concerns about the consideration being given to the group(s) which it supports or represents with (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive, when the Government(s) and/or Executive were making decisions about their response to Covid-19. Please provide a list of any such correspondence or meetings with the UK Government, Scottish Government, Welsh Government and/or the Northern Ireland Executive, including the dates on which the body or organisation wrote or such meetings were held, to whom the correspondence was addressed or with whom the meeting was held, and any response received from the UK Government, Scottish Government, Welsh Government and/or Northern Ireland Executive addressing such concerns.**

The NCF, at present, and within the time permitted to provide a response to this request, is not in a position to provide a detailed list of all the various pieces of correspondence with government departments and other key stakeholders. It will require significant time and support to carry out a detailed review of our records in order to ensure a full and detailed interrogation, which we believe to be essential in order for the inquiry to hear the full picture. At this stage, we can provide the overview below.

- The key stakeholders and government departments we communicated and corresponded with included DHSC, DLUCH, DWP, LGA, ADASS, CQC, Skills for Care, PHE and UKHSA.

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- We sent daily emails to either raise emerging issues, follow up on ongoing unresolved issues or to respond to requests for information and feedback. Communication also took place by video calls and as part of the stakeholder groups we are part of. When there was a need to formally escalate a concern, this would normally be through letter. We raised our concerns in the form of open letters as well as formal letters throughout the pandemic and didn't always get a timely response.

- We would use intelligence from our weekly members' calls and then raise issues with relevant people in department or stakeholder organisations.

- Once the government started to seek feedback on draft guidance and policy ideas, NCF then spent a significant amount of time commenting on various iterations of guidance, such as that relating to PPE, IPC, testing and isolation, vaccination, visiting and emergency funding. There was then the subsequent work to support members to understand the constantly changing guidance and raise queries for clarification with the government and other stakeholders.

- The topics we discussed in the correspondence include those mentioned in the answers to questions 3 and 5 – e.g., including PPE, IPC, insurance, workforce, sick pay, infection control etc.

8) A brief summary of the views of the organisation or body as to any lessons, if any, that can be learned from any consideration which was given to the group(s) that the organisation or body supports or represents by (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive when they were making decisions about their response to Covid-19

There are some very important lessons to be learned for both the government and key stakeholders from the government's response to the pandemic.

In respect of future pandemic planning:

- Policy makers must build a solid understanding of and actively consider the impact of their pandemic response planning on people who use care and support services. It is clear that there is an urgent need to build a better fundamental understanding of social care across policy makers in government, health and local authorities. This understanding must cover the breadth and diversity of those services, so pandemic policy responses match the operating environment better (for example, considering those who receive care in supported housing as well as care in a residential or nursing care home).

- We need visible leadership of social care at the top tables across the DHSC, NHSE, ICSs and HWBBs, including the system of developing emergency guidance for future pandemics/ crisis. It is not acceptable to simply replicate inappropriate health system guidance and expect it to work in care and support environments

- Social care must have an equal voice in pandemic response planning policy from the very start; the last two years have highlighted the importance of a fully inclusive approach to the social care sector within pandemic preparation and policy response. Current mechanisms for the involvement of the sector remain underdeveloped.

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- There must be a better more inclusive use of data intelligence. A key learning is that the DHSC and PHE aggregated data picture should have been shared regularly with care providers so that they could benefit from the real time aggregated data picture they were helping to inform. There must be a requirement to share such data with the care and support sector.

- There is a need for proper infrastructure to be in place to stand up supply routes for both PPE and testing.

- The artificial distinction between CQC-regulated and unregulated care and support in the way that the pandemic response was conceived was hugely unhelpful and must not be repeated.

- The absolute primacy of the NHS in all aspects of the government's response to the pandemic had very serious negative impacts across social care and this remains a remains a key problem still.

In addition to those specific learning points above, the wider points of learning below can be identified.

- Policy makers and decision makers need to build their understanding of the breadth and diversity of social care. There genuinely seems to be little awareness of how the care and support sector works in practice, the range of people who use it and their needs and circumstances and any understanding of the range and type of organisations providing care and support. Care providers and associations can assist policy makers and decision makers in building this understanding.

- Visible leadership of social care is needed at the top tables across the DHSC, NHSE, ICSs and HWBBs to reshape the power relationships, the hierarchies and the culture, to address the lack of accountability to social care and the people who use it

- The government needs better mechanisms to involve the sector in day-to day policy making.

- It is essential to respect and recognise the skill and expertise of those working in the care and support sector. This needs to be manifested in both a structural approach to pay, terms and conditions and in some formal recognition of professionalism of care workers.

- There is a requirement for much better co-commissioning with people at its heart. Commissioning of care and support needs to be shaped around what people want and need, with input from care and support providers about the art of the possible. It is vital that the government does not repeat the disregard for people that was apparent in decisions made during the pandemic.

- It is time to consider the mindful prioritisation of the not-for-profit model in future commissioning strategies. The willingness of our members to support each other throughout the pandemic despite the many challenges resulting from the inadequate government response, to focus on meeting the needs of those they support , share rapid learnings and ideas and find ways to support their workforce has highlighted to us the strength of the not-for-profit model.

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