CARE ENGLAND
Representing independent care providers

Our Ref: CE_MG_GA
Your Ref: M2/R9R/CE/TJS

09 December 2022

Tim Suter
Module Lead Solicitor
By email only: solicitors@covid19.public-inquiry.uk

Dear Mr Suter

UK COVID-19 Inquiry: Module 2 – Rule 9 Request to Care England

1. We are writing to you to respond to the Rule 9 Request to Care England dated 4 December 2022 (Reference: M2/R9R/CE/TJS).

2. We have responded to each question below in turn.

3. 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 response it has not been possible to carry out a review of all relevant information that we hold.

4. **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.**

    4.1. Care England was formed in December 1986 as the Independent Hospitals Association, a representative body for hospitals in the UK. In 1990 the Independent Hospitals Association transitioned to the Independent Healthcare Association (IHA). The IHA was the leading representative association of the UK's independent health and social care providers. Its members included nursing homes and residential care homes, home care providers, acute hospitals, mental health hospitals, substance misuse clinics, pathology laboratories and other health and social care organisations. The principal activities of the association were to promote and protect standards of health and social care in the independent sector.

    4.2. In 2004 the foundations of Care England were established with the evolution of the IHA to the English Community Care Association (ECCA). ECCA was the largest representative body for community care in England. Working on behalf of small, medium and large providers, it sought to create an environment in which providers could continue to deliver and develop the high-quality care that communities required and deserved. In 2014 ECCA was rebranded as Care England in order to better characterise the diversity of our membership whilst ensuring our mission brief

remained the same, namely, 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.

4.3. Care England is a charity, registered with the Charity Commission. Registered Charity No. 296103.

4.4. Care England has members which sit within the four nations of the UK, however 95% of our members are based in England.

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

5.1. 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.

5.2. 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.

6. **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-19 of (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive.**

6.1. In response to the COVID-19 pandemic, and in order to support our members, Care England instigated the following:

6.1.1. A 5-day-a-week policy-specific communication strategy was operationalised in March 2020. This was aimed at providing our members with an overview and analysis of the fast-paced guidance changes specifically pertaining to COVID-19 which were being distributed by Government bodies daily. This communication strategy remained in place until November 2022.

6.1.2. A 6-day-a-week policy-specific communication strategy was operationalised in September 2020 aimed at providing a summary of all the work Care England undertook the previous week with a forecast of what policy areas Care England will be focusing on during the forthcoming week. This continues to offer Care England members an insight into what we have done and what we will be doing on our members' behalf.

6.1.3. The continuation of our Daily Press Round-Up which aims to keep Care England members abreast with the most pertinent news stories of the day which will affect their service delivery.

6.1.4. The continuation of our Parliamentary bulletin which covers all the latest developments in Westminster and Whitehall. This includes information and analysis on relevant Legislation, Debates, Select Committees, Parliamentary Questions, All-Party Parliamentary Groups and other business.

6.1.5. A weekly bulletin to members of particular Special Interest Groups, within the Care England membership, operationalised from October 2020. Care England operates a number of Special Interest Groups which allows members to engage with other sector specialists. The regular updates provide members with a summary of the policy and news-related items relating to the area of interest in order to keep members with specific interests attuned to the latest policy, news and information.

6.1.6. Weekly meetings with two of our Special Interest Groups, the Public Sector Funding Group and the Learning Disabilities Group. These were respectively formed in 2014 and 2017 and met on a quarterly basis. These represent our longest-standing Special Interest Groups. Our Public Sector Funding Group is comprised of the largest care providers within our membership, which represent circa 20% of the adult social care market; these are all older person care providers. Weekly meetings were stood up for these two groups in order to balance our representation and support across older person and younger adult services.

6.1.7. Email and telephone support were stood up to 7 days a week, as required.

6.2. In addition to these regular communication channels, Care England's support for its members extended across ad-hoc briefings, summaries, guidance notes and best practice guides. We have outlined an overview of some of these below, but please note this is not an exhaustive list, rather intended to provide an indicative overview as to the type of work we produced or commissioned on behalf of our membership:

6.3. **Briefings**

6.3.1. Care England Cost Collection Exercises

Care England consistently sought to highlight the need for funding to make its way to frontline care services in an effective and timely manner. Data was collected across the months of April, May and June 2020. Care England commissioned Laing Buisson to carry out the analysis of the results of the survey in the months of May and June 2020 by providers of care homes for a) older people and b) younger adults (it should be noted that 'younger adults' refers to learning disability and autism service users). Care England believe that this data has been a key part in legitimising sector statements to Government around the costs being incurred by providers thus stressing the importance of continued financial support for adult social care providers. The results of our costing analysis were sent to HMT, Secretary of State for Health and Social Care and Secretary of State for Housing Communities and Local Government. The publication of multiple briefings on the issue also generated both governmental and press interest.

6.3.2. Occupancy

Care England sought to highlight the pressing nature of decreasing occupancy levels and their adverse effect upon the financial sustainability of the adult social care sector. This has been evidenced through the cost analysis data (above), but also, through broader research and engagement with providers. On 22 July 2020, Care England distributed an occupancy paper to government officials and ministers. It was framed as a formal notice to the Government regarding the deep concerns held by Care England and its members, about the impact that COVID-19 is continuing to have on the sustainability of the care home market. This was really aimed at engaging the

Department of Health and Social Care over this issue and identifying areas for collaboration to support adult social care providers.

6.4. **Summaries**

On 20 December 2021, Care England published a summary note produced by Anthony Collins Solicitors LLP which provided a summary of employment law advice on Vaccination as a Condition of Deployment in relation to people employed or engaged in an activity regulated by CQC in wider health and social care settings.

6.5. **Webinars**

On 23 July 2021, Care England, in collaboration with Barchester Healthcare, hosted a webinar which looked to provide support for adult social care providers following the Government's decision to make vaccination a condition of deployment in care homes. The webinar featured Dr Pete Calveley, Chief Executive of Barchester Healthcare, Genevieve Glover, Group HR Director at Barchester Healthcare, a representative from Radcliffes Le Brasseur LLP, Professor Nicola Stonehouse, School of Molecular Virology at Leeds University and a colleague from the Department of Health and Social Care. Chaired by Professor Martin Green OBE, Chief Executive of Care England, the webinar not only provided an opportunity for adult social care providers to hear from Barchester Healthcare who introduced this policy into their own organisation, but it also provided an opportunity to engage with sector leaders around any issues or concerns providers may have in relation to the policy.

6.6. **Advice in the absence of Government guidance**

On 26 March 2020, Care England published its first of numerous iterations of guidance pertaining to learning disability providers. The advice was prepared by learning disability care providers who are members of Care England and consultants who work collaboratively with Care England. Its purpose was to provide helpful information to providers on how best to deal with the implications of the COVID-19 outbreak. It did not represent formal guidance, but it was shared with both the Department of Health and Social and CQC with a request that they endorse it. The COVID-19 situation was changing quickly and this advice was reviewed regularly.

On 8 May, Care England published commissioned advice from Anthony Collins Solicitors LLP in relation to the health and safety obligations of care providers in the context of the COVID-19 pandemic. From our conversations with providers, we understood that there were significant concerns regarding how the Government guidance should be applied to each provider's specific operations. This was especially important for those providers who support individuals with learning disabilities and dementia who may be aggravated or disturbed by the use of PPE. While the advice was only circulated to our members, the key messages were communicated with DHSC and PHE and appeared to influence a positive change in the relevant guidance.

7. **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.**

7.1. See above. The below represents a modest list of COVID-19 related outcomes that Care England contributed to achieving, copies of committee and consultation submissions are retained in word format. While it will be difficult to provide links, copies can be shared on request.

7.2. **PPE**

7.2.1. It was announced on 30 March 2021 that the Government would be extending the provision of free PPE to health and social care providers until the end of March 2022. Care England, with the help of members, called for this outcome, presenting evidence to senior Department of Health and Social Care officials on what the implications would be for ceasing free PPE and changing to a charging model.

7.2.2. On 17 May 2021, following feedback from guidance across the adult social care sector, Public Health England reviewed and updated the How to work safely in care homes guidance, initially published on 6 April 2021. The guidance clarified many of the queries raised following the 6 April 2021 iteration of the guidance, for instance on when to change the facemask following direct or personal care and the difference between wearing a face mask for source control (i.e. protecting others from you) and for PPE (i.e. protecting yourself as well as others). Care England presented queries and questions from members directly to PHE in order for these to be taken into account when the guidance was updated on 17 May 2021.

7.3. **Continuation of Government support funds in 2021**

7.3.1. Care England continued to illustrate to Government that COVID-19 has and will continue to impose unprecedented costs upon the sector.

7.3.2. On 27 June, the adult social care sector was given over £250 million extra to continue COVID-19 protections. The new money represents a continuation of the Infection Control and Testing Fund (ICF), which was due to run until the end of June 2021 and would now last until the end of September 2021. Although we were disappointed to note the decreased amount from the previous fund, this announcement followed extensive work by Care England, highlighting the continued necessity of the fund in light of the continued cost pressures induced as a result of COVID-19.

7.4. **Insurance for Designated Settings**

7.4.1. The Designated Settings Insurance Scheme (DSIS) initially provided cover for designated settings until the end of March 2021. Designated Settings had been identified for people who were medically fit for discharge from hospital (i.e., they did not require to be in an acute NHS bed) but whose ongoing care and support needs were such that they required full-time residential or nursing care. Many providers operating Designated Settings were unable to obtain insurance cover on a commercial basis and DSIS was implemented to address this. Following a review of DSIS, it was extended until 30 June 2021, in order to maintain the current level of support for these vital settings. Care England, working with members and the DHSC, worked hard for this outcome.

7.4.2. On 29 June 2021, following a review of the indemnity support, the DHSC announced in a Written Ministerial Statement that Designated Settings Indemnity Support (DSIS) will

remain available until 30 September 2021 for those Designated Settings needed by commissioners for local capacity needs and which are unable to secure sufficient commercial insurance cover. Care England, working with those members who operate Designated Settings, worked hard for this outcome.

7.5. **Data**

7.5.1. Digital Social Care, of which Care England is a part via our role within the Care Provider Alliance, has worked with the Local Government Association, NHS Digital and NHSX (now NHS Transformation Directorate) on how to help care providers keep information safe. As part of this work 'Better Security, Better Care' was launched. This is a programme of national and regional support for care providers completing the Data Security & Protection Toolkit (DSPT). Care England continues to provide a Helpline to assist Digital Social Care customers with technical problems when using specific digital tools. Care England also supported the Large Provider Workstream for the Better Security, Better Care Programme.

7.5.2. Through our representation on the Data Advisory Group and Steering Board, two of the three governance groups for Capacity Tracker, Care England took part in discussions and helped influence the refining and removal of questions, making the system more streamlined and efficient. This included the temporary removal of flu vaccination questions, refining the PPE questions, updating the visiting questions to reflect current policy (soon to be implemented) and refining/removing ICF questions.

7.6. **Care home visiting**

7.6.1. On 21 April 2021, Care England hosted a meeting between the Department of Health and Social Care and members of Care England's Learning Disabilities Group where members highlighted the issues associated with the April 2021 iteration of the visiting guidance, predominantly the visiting out guidance which placed undue restrictions on those in receipt of care.

7.6.2. Subsequent to this meeting, Care England issued two letters to the Minister for Care which reflected upon the feedback given by members in the meeting with the DHSC and called for urgent action. The 'Visits out of care homes: supplementary guidance' was issued on 1 May as a result of our continued pressure.

7.6.3. Care England issued a further letter to the Minister on 6 May 2021 to highlight the continued issues, such as lack of recognition of medical appointments and low-risk activities, which remained largely unaccounted for.

7.6.4. Following our letter, on 11 May 2021, it was announced that from 17 May 2021 care home residents will be able to have more named visitors and more opportunities to make visits out with no need to self-isolate when they return.

7.7. **Care home admissions**

7.7.1. From 18 June 2021 new residents who had been admitted from the community did not need to isolate upon arrival into the care home. This announcement followed pressure from Care England as we continued to hear the impact of the 14-day isolation period for admissions from the community.

7.8. **The publication of CQC death figures in care homes**

7.8.1. Care England was in correspondence with the CQC regarding this matter for some months. We issued a letter, informed by legal advice, to the CQC in November 2020 which outlined our concerns, including, but not limited to: it risks undermining the comprehensive inspection regime whilst offering none of its procedural safeguards; it may give rise to unnecessary anxiety on the part of residents, or their loved ones; it may significantly prejudice the viability of some providers by creating the impression that such mortality rates are a reliable quality metric; and it may fuel unfair criticism of individual providers in the media, online or elsewhere. It remained the CQC's position for some months that they were not planning to publish the data, however, they have always kept this position under review.

7.8.2. Although the data was published on 21 July, CQC made clear to the sector how this data will be presented, prior to the data being made public. This was an outcome that Care England fought hard to achieve.

7.9. Care England contributed to a range of Government, Parliamentary Committee and APPG responses. We would be happy to share these upon request. The below is an indication of the responses we gave:

7.9.1. Care England submitted written evidence to the Public Services Committee inquiry on Public services: lessons from coronavirus in June 2020.

7.9.2. Care England submitted written evidence to COVID-19 Committee inquiry on Life Beyond COVID-19 in August 2020.

7.9.3. Care England submitted written evidence to the Health and Social Care Select Committee inquiry on Social care: funding and workforce in August 2020.

7.9.4. Professor Martin Green OBE, Chief Executive of Care England, gave evidence to Joint Committee on Human Rights inquiry on The Government's Response to the COVID-19: Human Rights Implications for Long Lockdown in April 2021

8. **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.**

8.1. Care England consider that the care sector, care providers and those who receive care were not adequately considered by the UK Government when decisions about the response to COVID-19 were made.

8.2. Decisions were made during the pandemic, particularly within during the first wave, with the ambition of throwing a protective ring around the NHS, with little to no regard for the adult social care sector. This was evidenced by the following:

8.2.1. The decision to withdraw NHS community services from care homes left providers feeling unsupported in the first wave of the pandemic.

8.2.2. The prioritisation of the NHS in PPE distribution put service users and the Adult Social Care workforce alike at risk, as did the discharge of Covid positive individuals into care settings.

8.2.3. The lack of parity with the NHS, which led to policy that often overlooked the operational similarities between the NHS and social care (for example, staff movement and the Vaccination as a Condition of Deployment), still has long-term implications on the sector.

8.2.3.1. The disparity had very real implications. For example, care providers who operated supported living services lost staff who had second jobs which meant agency staff had to be utilised in supported living which proved challenging when trying to maintain infection control. The lack of consideration regarding homecare and supported living services in this guidance caused so much disruption to the continuity of care having very real implications upon the lives of those who draw on care and support.

8.2.4. The decision-making and the resulting communications were fragmented, last-minute and often secondary to guidance given to the NHS. Often care providers were creating their own guidance before government guidance was issued or were required to implement at incredibly short notice as a result of the lack of consideration as to how quickly providers can implement new policies.

8.2.4.1. The fragmented decision-making and failure to address the needs of the social care sector soon enough resulted in providers generating their own internal guidance, which was often shared with bodies such as the CQC.

8.3. The views of SAGE and Public Health bodies were given precedence over care sector professionals who were presenting lived experiences and real-time data of the reality on the frontline. The disproportionality weighted towards a strand of science and data modelling from a small group of public health professionals did not accurately or proportionally represent the adult social care sector. As a result, decisions were founded on theoretical application to a real-world problem.

8.3.1. The lack of meaningful data collection for the sector meant there was no robust data to help guide decision-making throughout the pandemic.

8.3.2. Decisions made should have been coproduced with sector bodies to ensure there was a real understanding of the sector. Proper involvement of the sector would have circumvented the implementation of ineffective or poor guidance.

8.3.3. When decisions were made that did not accurately meet the needs of the sector, sector feedback was often ignored, or disproportionate amounts of time were taken to correct/adjust guidance accordingly.

8.4. Evidenced throughout the pandemic was a lack of central understanding of the diversity of the adult social care sector. Particularly the concerns articulated by those who support individuals with a learning disability and/or autism were largely overlooked, leading to a predominant focus on older person care guidance which did not appropriately reflect the needs of adults with a learning disability and autistic people.

8.4.1. From the outset, it was evident that additional boundaries faced by adults with learning disabilities continued to be exacerbated by the COVID-19 pandemic. Government guidance led to the continuation of restrictions on those with learning disabilities, whilst they were lifted for others in the adult social care sector.

8.4.1.1. Care Home Admission Guidance meant those who received short respite care were deprived of their liberty. In some instances, respite care had to be stopped because the admissions guidance was unworkable.

8.4.2. Decisions made should have taken into account that not all of those in receipt of care within the sector were clinically vulnerable and therefore should have taken into consideration the impact on the restrictions of liberty and independence.

8.4.3. Care England members operating within the younger adult sector found themselves having to rewrite guidance as a result of its predominant focus on older people living in residential care homes and it taking 6 months following the introduction of Covid-19 restrictions to produce Supported Living-specific guidance for matters such as infection, prevention and control.

8.5. Care England considers that when making decisions about the response to COVID-19 the UK Government did not take sufficient account of the impact and ramifications of previous decisions made and did not have the proper resources and mechanisms through which to do this.

8.5.1. The COVID-19 financial packages from Government did not, in the main, reach the frontline in a timely and effective manner as a result of a lack of consideration as to how funds could be best utilised within the sector.

8.5.2. The NHS has received major financial boosts directly, such as the cancelling of over £13bn debt overnight, whilst the money allocated for social care was routed through Local Authorities and was slow to materialise or has not reached the frontline at all.

8.5.3. This is despite the fact that over the Summer and Autumn of 2020 the Government allocated an unprecedented amount, approximately £4bn, to Local Authorities to aid the pandemic response.

8.5.4. The failure of this money to reach the frontline was evidenced in the House of Commons Public Accounts Committee on 22 June. Local Authorities are a failed mechanism for delivery.

8.5.5. We believe that this was not the Government's intention for the money, or the spirit in which the funds were intended. Rather additional bureaucracy made it hard for providers to access the intended funds and seemingly undermines the Ministerial pledge to create a protective ring around care homes.

8.6. Care England reflects the considerations above arise from a more fundamental point that decision-makers across Government generally did not have a clear and sufficient understanding of the social care sector and the nature and type of the support it provides. As a result of the lack of knowledge and understanding of the intricacies of the sector, a range of issues arose that could have been prevented by more thorough consideration in regard to the COVID-19 response. Therefore, it is vital that the issues

within the response are considered throughout the Inquiry and within the scope of Module 2 as they very much evidence the lack of appropriate consideration of the care sector and those supported in the Government's decision making.

9. **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.**

9.1. Care England, throughout the entire pandemic, had continued communication with Government and other key stakeholders. Communication was with, but not limited to, the following:

9.1.1. Prime Minister, Department of Health and Social Care including the Secretary of State for Health and Social Care, APPG on Vulnerable Groups to the Pandemic, Department for Business, Energy and Industrial Strategy, Chief Medical Office, Department for Levelling Up, Housing and Communities, the Migration Advisory Committee, No10 Health Taskforce, HM Treasury, National Audit Office, Care Quality Commission, NHS Providers, Equality and Human Rights Commission, Joint Committee on Human Rights, NHS England and Improvement, Public Health England, British Retail Consortium, UK Hospital, various Universities, including Nottingham, Newcastle and Kings, Health Education England, the Human Rights Select Committee, the Health and Social Care Select Committee, the Disclosure and Barring Service.

9.2. Our communication took a variety of forms, including formal letters, emails, stakeholder meetings, engagement with various Government Taskforces, phone calls, consultation responses, roundtable discussions, written feedback on guidance. These communications varied with emails, phone calls and stakeholder meetings occurring daily and consultation responses, written feedback and feedback on guidance occurring between weekly and monthly throughout the pandemic, with emails reaching the hundreds of thousands. A tracker of formal letter correspondence from Professor Martin Green OBE to various key figures can be made available upon request. This tracker represents the highest level of our communication and correspondence with Government.

9.3. Care England has evidence to demonstrate our members were pursuing their own communication channels to ensure senior Government and local actors were presented with key messages from their respective organisations. This communication ranged from weekly contact with DHSC Ministers to working dynamically with DHSC officials. For example, one Care England member was involved in the following: from the Autumn of 2020 onwards, senior colleagues joined calls with the DHSC on testing and infection control and shared concerns on these calls with the DHSC that the guidance did not reflect the specialist needs of younger adults; from Spring 2020, senior colleagues assisted the DHSC in updating its testing guidance as the first sets of guidance were not appropriate for adults with autism; and from late 2020, the organisation were part of saliva testing pilots rolled out by DHSC in response to our

lobbying on inappropriate testing guidance for adults with specialist needs. In addition, some Care England members were heavily involved in writing Government guidance on testing, with the work being led by Deloitte. This group did the pilot for testing and feedback results to Government. This is not an indication that Care England members were integrally involved in helping shape Government policy.

9.3.1. Care England members also issued internal guidance to their own organisational colleagues, based on last-minute government guidance and sometimes even before guidance was announced, on topics such as infection prevention and control.

10. **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**

10.1. Care England is of the belief that the Inquiry must ensure that the right lessons are learned both as a response to the pandemic but also in general to inform the relationship between Adult Social Care, the NHS and wider Government for the benefit of the sector and the population as a whole in future.

10.2. Care England has identified the following to be crucial lessons learned from the Inquiry. The below is by no means an exhaustive list but is illustrative of the types of lessons we hope to be learned.

10.2.1. **Lesson 1.** The importance of co-production and joint strategic planning. 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.

10.2.2. **Lesson 2.** 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. The social care sector plays a vital role in keeping the NHS moving and thus it is important to include representatives in key discussions and considerations across both health and social care. Integrated Care Systems represent such a vehicle for this ambition to be fostered.

10.2.3. **Lesson 3.** New Government bodies such as Integrated Care Systems are a vehicle to foster success in integrating health and social care services and creating a joined-up approach to the delivery of care. Decisions during the pandemic were not made with care services serving as a legitimate partner. Moving beyond Covid-19, we need to craft a new approach, one that ensures that vulnerable people are not abandoned by the NHS. We need a system of support in which health and social care act in a coordinated fashion focused on the person and are financed adequately and appropriately.

10.2.4. **Lesson 4.** The understanding of the social care sector amongst Government bodies needs to fully take account of the nuances of the sector, including fundamental differences between older person care homes and services for people with learning disabilities and autistic people to ensure that in future we do not lack specialist guidance or planning.

11. Please do not hesitate to contact us should you have any questions or require any further information from Care England.

Your sincerely

Personal Data

Professor Martin Green OBE
Chief Executive, Care England