Solicitor to the Inquiry
By email only - solicitors@covid19.public-inquiry.uk

08 December 2022

Dear Mr Smith,

UK COVID-19 Inquiry: Module 2 - Rule 9 Request to Homecare Association Reference: M2/R9R/HA/TJS

We are writing to respond to the Rule 9 Request to the Homecare Association dated 4 December 2022 (Reference: M2/R9R//TJS).

We have responded to each question below in turn.

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.

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.

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 to 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, 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 2,300 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. Together we ensure that homecare is valued so that all of us can live well at home and flourish within our communities.
As a membership association, our focus is on working with central government, local government, regulators, the media, and the public to represent homecare providers, as well as providing the hands-on support and practical tools our members need.

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

The Homecare Association represents regulated domiciliary care providers across the UK. For historic reasons there is a small number of unregistered introductory agencies in membership, representing fewer than 1% of the total. Only regulated homecare companies are now admitted to membership. Members include nearly all the largest providers of homecare (who between them employ almost half of the homecare workforce) and nearly 1200 SMEs. Our members encompass the full diversity of the regulated market: from small to large; predominantly state-funded to predominantly private-pay funded; generalist to specialist; and from start-ups to mature businesses.

Homecare providers support just under 1 million people. A further estimated 1.6 million people at home have unmet need. In contrast, only 0.5 million people are in facilities-based care settings, such as care homes (c. 400,000 beds) and hospital (c. 100,000 beds).

Homecare members provide a range of homecare services, including:

- Regular visiting domiciliary care
- Extra care
- Live-in care
- Supported living
- Housing with care
- Complex care with nursing

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

The Homecare Association provided practical support for homecare providers and represented their interests in the COVID-19 pandemic. We worked hard to ensure that the issues and challenges faced by homecare providers and the people they support were understood by policy makers in central and local government in all UK administrations, Public Health England (now UKHSA), the NHS, regulators, the media, and the public.

We collaborated closely with DHSC, Public Health England (PHE, now UKHSA) and HSE to influence, understand and modify guidance issued, which was often initially inappropriate for homecare settings. We represented members' concerns to the civil service, Ministers, NHS, PHE and HSE, campaigning persistently on a wide range of topics. We provided rapid feedback and informed views to civil servants and Ministers about the potential impact of policies and raised awareness of the need for funding or other resources when required.

Supporting members to understand government guidance was almost a full-time activity, as guidance was being updated and re-issued at a very fast pace, often late on a Friday night, causing widespread confusion. Our normal helpline to support members with practical issues they face quickly became inundated with COVID-19 related enquiries. Our team talked

through guidance, offered advice, and collected questions and feedback. We produced our own documents for members to help them interpret government guidelines. We updated and delivered training and resources that reflected the current regulations for COVID-19.

We instituted weekly webinars to keep all members updated on what was happening and to receive feedback from providers, which we shared with central and local government. As time progressed, these reduced to monthly and then after 2 years, quarterly. We also created a smaller group of board and larger members and delivered weekly calls to update on guidance and key issues, as well as gathering provider intelligence on operational challenges, e.g., staff absence, COVID-19 positive cases in staff and clients, deaths, access to PPE, tests, vaccines.

We conducted regular surveys to understand key issues faced by homecare providers. We used the data from our research to engage journalists and broadcasters with matters of importance to people receiving and giving homecare and achieved substantial traction and national coverage on a range of topics. This reinforced our influencing work with Ministers and civil servants. The first success was BBC coverage of a PPE survey we conducted early in the pandemic, which led to masks being provided from the pandemic store. After this, we achieved extensive coverage on many issues pertinent to homecare providers.

The Homecare Association was invited to become a member of the National COVID-19 Planning Group at DHSC which met for the first time on 6 March 2020. Fairly quickly it became apparent that it would be necessary to create subsidiary workstreams. We contributed to all the workstreams below raising concerns and making constructive suggestions on behalf of our members:

- Supporting the workforce
- Personal protective equipment
- Testing
- Vaccination (influenza and COVID-19)
- People drawing on services and informal carers
- Discharge from acute to community settings
- Developing practice guidance
- Emergency legislation
- Costs, funding, market stability and insurance
- System assurance, regulation and support
- Collecting and using the right data

One of the key early areas of representation was making the case that additional PPE was required for homecare, especially masks, and then trying to procure it. We worked with Lord Agnew and the Cabinet Office to explain how social care is organised so that the logistics of delivering PPE to care services could be developed. This had clearly been omitted from any emergency planning. In addition to DHSC, other government departments, such as the Department for International Trade, became involved in PPE procurement and sought our advice.

We commissioned Accenture to work with us and our members to analyse likely additional costs of COVID-19, particularly regarding PPE. Our analysis was shared with HM Treasury and was instrumental in ensuring funds were released quickly for social care.

We then worked with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) to produce joint guidance to local authority commissioners on the best way to support providers financially. This led to adopted

recommendations to pay providers on planned work in advance, which made a substantial positive difference to maintaining provider viability throughout.

Providing input to civil servants charged with drafting emergency COVID-19 legislation and Care Act easements was another area of early work. We tried in several meetings to propose amendments to draft emergency legislation to allow central government to be more directive of local authorities, anticipating that an excess of localism could cost lives. We were unsuccessful and then had our work cut out trying to ensure that 152 local authorities didn't come up with 152 different approaches to everything. When, inevitably, local authorities chose individual approaches, we helped members understand the variation in requirements.

We influenced the Care Quality Commission (CQC) to conduct remote inspections of homecare services during COVID-19, after they adopted an approach to suspend inspections. We argued that if journalists could speak to people drawing on services and care workers, so could CQC. They initiated a pilot with 100 volunteer members and developed an approach which enabled the regulators to maintain contact with and inspect homecare providers during COVID-19. Regrettably, though, CQC's focus appeared mainly on care homes and other services where the isolating impact of the pandemic created a greater risk of closed cultures.

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.

See above. The Homecare Association conducted regular surveys and used member webinars to understand key issues that members were facing. We used the evidence to produce blogs on the Homecare Association website and to respond to consultation responses and parliamentary inquiries. A list of the key blogs, articles, consultation responses and evidence provided to select committees is listed below.

Blogs, research and articles

• Homecare Association blog on homecare in the time of coronavirus • Homecare Association blog on funding and workforce – UKHCA's submission to the Health & Social Care Select Committee's inquiry

• Homecare Association blog on progress of vaccination of homecare workers against COVID-19

• Homecare Association blog on shortage of careworkers in homecare • Homecare Association blog on homecare workforce shortages continue • Homecare Association blog on homecare needs recognition not rationing • Homecare Association blog on who will care? Risks of making vaccination a condition of deployment in homecare

• Homecare Association blog on homecare workforce shortages deepen • Homecare Association blog on people at the Heart of Care - our views on the White Paper

• Homecare Association blog on risks of ridiculous regulations
• Homecare Association blog on continuing lack of homecare workers •
Care Management Matters: Dr Jane Townson article Straight Talk

• Care Markets: Dr Jane Townson article Homecare fees 'glaringly short' of the amount required
• Homecare Association contributed to the NAO review on supply of PPE during the COVID-19 pandemic
• Homecare Association contributed to the NAO review on roll-out of the COVID-19 vaccination programme

Consultation responses

• Homecare Association's response to HM Treasury consultation on the comprehensive Spending Review 2020
• Homecare Association's response to DHSC's consultation on staff movement between care settings 2020
• Homecare Association's response to HM Treasury consultation on the spring Budget 2021
• Homecare Association's response to DHSC's consultation on vaccination as a condition of deployment in care homes
• Homecare Association's response to HM Treasury consultation on the comprehensive Spending Review 2021
• Homecare Association's response to DHSC's consultation on making vaccination a condition of deployment in health and the wider social care sector
• Homecare Association's response to DHSC's consultation on extending free PPE to the health and care sector
• Homecare Association's response to DHSC's consultation on revocation of VCOD regulations consultation
• Homecare Association's response to Welsh Government's Health, Social Care and Sports Committee inquiry into the impact of the COVID-19 outbreak, and its management, on health and social care in Wales

Select Committee and House of Lords Committee

• House of Commons Health and Social Care Select Committee House of Commons Health and Social Care Select Committee: Oral evidence given by Dr Jane Townson, CEO
• House of Commons Health and Social Care Select Committee Inquiry into social care funding and workforce in England: Written evidence
• House of Commons Health and Social Care Select Committee Inquiry into Workforce burnout and resilience in the NHS and social care: Joint written evidence with Adult Social Care Taskforce Workforce Advisory Group & National Care Forum, Adult Social Care Taskforce Workforce Advisory Group
• House of Commons Health and Social Care Select Committee Inquiry into Workforce burnout and resilience in the NHS and social care: Written evidence • House of Lords Health and Social Care Committee Science and Technology Committee, Coronavirus: lessons learnt: Oral evidence given by Dr Jane Townson, CEO
• House of Commons Housing, Communities and Local Government Select Committee Inquiry into Long term funding of adult social care: Written evidence • House of

Commons Housing, Communities and Local Government Select Committee Inquiry into Long term funding of adult social care: Oral evidence given by Dr Jane Townson, CEO

- House of Commons Health and Social Care Select Committee Inquiry into Workforce Recruitment, Training and Retention Inquiry: Written evidence

- 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.

It is our view that homecare providers, their staff, and the people they support were not adequately considered when decisions were made about the response to COVID-19, particularly in the early stages, though this improved over time after repeated pressure.

By the end of July 2022, the number of deaths in private homes in England and Wales was 29.5% above the five-year average (709 excess deaths per week). By November 2022, it was 23% above the 5-year average (616 excess deaths per week). Even at the height of the pandemic, only 3% of these were recorded as directly related to COVID-19. By July 2022, this had reduced to 2.2% and by November 2022 to 1.4%. Primary causes of death are reportedly heart disease, dementia, and some cancers. The physical and mental health of people at home has clearly not been adequately addressed, which is having serious consequences for individuals, families, communities, health and care services and the wider economy. The increase in excess deaths, have been exacerbated by government policy in the COVID-19 pandemic and beyond.

Unmet need for health and care services is high and rising. ADASS data record that over 540,000 people in the community are waiting for assessment or care, likely leading to deterioration in health and increased need for acute and critical care. Government policy, including in its response to COVID-19, has led to workforce shortages. Hospitals are struggling to admit and discharge people. Inadequate capacity in homecare is a key contributor to unmet need and delayed discharges, with 1 in 4 delayed discharges attributed to waits for homecare. As a result, ambulance response times are greatly exceeding target, NHS waiting lists are lengthening and waits for community and mental health services are not even being reported. Poor access to health and care services adversely affects us all, directly and indirectly.

Homecare and other non-residential social care services were often an afterthought in government policy and guidance and there was a lack of consideration of the needs of people in their own homes. This, coupled with a lack of understanding of the social care sector and particularly the homecare sector, impacted on many of the areas we believe the inquiry should explore in module 2.

No prior thought had been given to the planning, procurement, and distribution of PPE for homecare and emergency planning was done on the hoof. Business as usual supplies of PPE for homecare were redirected to the NHS and care homes, leaving homecare workers unprotected or making their own PPE from fabric and bin bags.

Routine asymptomatic testing for COVID-19 of homecare workers was denied for almost a year, increasing risk for people at home and those supporting them.

Initial roll-out of the vaccination programme in homecare was shambolic, leading to

unnecessary delays in vaccination of homecare workers at the outset. After we published data indicating that the government's approach would likely result in vaccination targets for homecare being missed, they acted on our advice to open the National Booking System for homecare workers. This resolved most issues related to access to vaccination for homecare workers.

The government then ignored expert advice and pressed ahead with work to implement vaccination as a condition of deployment in homecare, which risked loss of 15-20% of the workforce. Despite a U-turn at the eleventh hour, there was an estimated loss of up to 70,000 homecare workers, which unnecessarily worsened the shortage of care workers and unmet need.[6]

Guidance for the social care sector was often delivered late and after that produced for the NHS, with the expectation to implement it shortly after issue. Much of the early pandemic policy and guidance was designed to "protect the NHS", for example, redirection of PPE, mass hospital discharge, and telling people to "stay at home", without considering the potentially damaging impact on those receiving or giving care in the community.

Furthermore, in line with national guidance, most NHS community staff started working remotely. This meant that many professionals stopped seeing people with health needs in the community at the beginning of the pandemic. This typically left homecare workers as the only professionals attending a person's home. In some areas, homecare providers and their staff felt pressure to take on delegated clinical tasks, such as wound care or verification of death (distinct from certification of death, which was still done by clinicians), when professionals stopped visiting. There was a general lack of support to ensure that providers and their staff were adequately trained, supported, and funded to complete these tasks. Difficulties were also experienced in having competencies signed off by health professionals, leaving grey areas and ambiguity about responsibility for the clinical care.

Guidance was typically published without warning, late on a Friday evening, and providers struggled to assimilate and implement multiple changes at short notice. Furthermore, we found the guidance was often inappropriate for homecare and regularly demonstrated a lack of understanding of the sector within Government. Numerous civil servants were drafted in from other government departments and the social care team at DHSC expanded from 50 to over 350 in a few months. Though very bright, willing, and hardworking, most civil servants lacked knowledge of social care, and their induction processes were inadequate. For example, many did not understand the different settings and service types within the care sector and hours were spent in meetings explaining the basics multiple times. This led to questions about the quality of advice being given to Ministers and we had to spend substantial time communicating directly with Ministers ourselves. The situation has steadily improved, with turnover at DHSC declining, but at the height of the pandemic, depth of experience of social care in DHSC was sorely lacking.

The social care sector had to work under guidance from both national and local government. This led to fragmented and sometimes contradictory approaches and messages being issued at both a national and local level. Local authorities at times took a firmer approach than national guidance or took an approach based on a misunderstanding of the guidance.

Though some improvements have now been made, for many months there was a lack of quality and timely data and intelligence on social care providers and services. With 152 different local authorities commissioning services in England, there was inadequate data on basics such as unmet need, waiting times for assessment and care, local authority expenditure and the number of people who received support. The approach to addressing

data collection was not well co-ordinated between national and local bodies and requests for data were made by various Local Authorities, NHS, DHSC and CQC. We ensured members' interests and views were represented about data collection, particularly the need to minimise the burden of submitting data multiple times to different authorities in varying formats. There was conflict between CQC and the NHS Capacity Tracker over which data collection tool would be used and we influenced decisions about which data were important to collect.

Homecare workers were not valued and supported during the pandemic. Some homecare workers experienced abuse when travelling between visits to provide care and, in some cases, providers had to hire private security firms to protect their staff. Unlike NHS staff they did not always receive priority access, for example many supermarkets would not enable care workers to access priority shopping hours even when they were shopping for the people

they care for. The much-trumpeted Care Badges were not effectively distributed and were not recognised by those outside the sector.

The pandemic presented significant additional costs for homecare providers who provide a necessary public service, but additional funding supplied was often late, and given for short periods that did not allow adequate investment. Systems for distributing and accounting for grant funding were bureaucratic and complex, deterring some providers from accepting funds, though needing them.

Insurance costs escalated and the cover provided diminished, with most insurers refusing to provide any form of Public Liability cover. Early on, we lobbied DHSC and HMT to indemnify the care sector, as they did the NHS. They refused, except for some care homes, which were specifically designated to accept residents who had tested positive for COVID-19. We then persuaded the government to create contingency plans in case the insurance market withdrew from the care sector. Fortunately, this did not happen, but providers have been left with much higher premiums and with no, or extremely limited, Public Liability cover.

5. 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.

See above. The Homecare Association raised many concerns on behalf of our members with the UK Government and the devolved administrations. Due to our level of involvement in supporting the UK Government and the size of our team we provided fewer interventions on behalf of our members in the devolved administrations and collaborated with the care associations in Wales, Scotland, and Northern Ireland to provide specialist input on homecare as required. We are also not able to provide a list of all communications with the

UK Government, Scottish Government, Welsh Government and/or the Northern Ireland Executive as we estimated the communications to be in the tens of thousands. We look to provide in our answer a description of the typical types of communications.

As mentioned in question 3, we became members of the National COVID-19 Planning Group at DHSC which met for the first time on 6 March 2020. We contributed to all the workstreams below raising concerns on behalf of our members:

- Supporting the workforce
- Personal protective equipment
- Testing
- Vaccination (influenza and COVID-19)
- People drawing on services and informal carers
- Discharge from acute to community settings
- Developing practice guidance

- Emergency legislation
- Costs, funding, market stability and insurance
- System assurance, regulation and support
- Collecting and using the right data

We also participated in the following government stakeholder groups:

- ADASS/LGA Funding meetings May to July 2020
- Capacity Tracker Data Advisory Group
- CQC External Advisory Group on COVID-19
- DHSC Capacity Tracker Operational Change Advisory Board
- DHSC COVID ASC Working Group of Stakeholders (CAWGS)
- DHSC ASC Stakeholder Vaccines Group
- DHSC Customer Engagement Panel
- DHSC Flu Vaccinations Working Group
- DHSC PPE Task and Finish Group (ASC PPE stakeholder working group) • DHSC Social Care Taskforce
- DHSC Task and Finish ASC workforce and COVID-19
- DHSC Testing Task and Finish
- DHSC Vaccines Booster Taskforce
- NHS Home Care Sector Stakeholder Group
- NHSX Digital Social Care Advisory Group

We worked closely with DHSC, Public Health England (PHE, now UKHSA), HSE, CQC, Local Government and NHSE&I to help them understand the challenges facing homecare providers. During periods of the pandemic there were significant levels of communication, in particular with DHSC, which would constitute multiple phone calls with senior civil servants and emails to civil servants daily, as well as stakeholder meetings and one-to-one meetings.

We also worked with other government departments, again having contact via phone calls, emails to civil servants and meetings as well as letters from Dr Jane Townson to Ministers. For example, we raised concerns about whether the insurance market would continue to

support the social care sector during COVID-19. Whilst the government indemnified NHS trusts, social care was left to fend for itself. We thus worked with the British Insurance Brokers Association and others to influence DHSC and HMT to develop a contingency plan in case insurance became unavailable.

6. 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.

Lesson 1: resilience in a pandemic requires underlying strength – central and local government need to invest in social care, particularly homecare, over the long term.

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The pandemic occurred against a backdrop of persistent issues in social care, including workforce shortages, funding pressures and provider instability which have failed to be addressed over many years. These long-term issues meant that the sector entered the pandemic in a weakened state, hampering its ability to respond to the impact of COVID-19.

Lesson 2: pandemic planning and operational delivery must consider social care as well as the NHS. Care providers and their representatives need a seat at the table in emergency planning and operational discussions.

It quickly became apparent that whatever pandemic planning had been done, it had not adequately considered social care and the different settings within this. This meant that many aspects of emergency planning for COVID-19 were developed on the hoof, from technical requirements of PPE for different settings, to logistics and distribution of PPE and test kits to 17,000 individual social care organisations in England alone.

Planning had also assumed an influenza pandemic and appeared not to have considered potential PPE requirements for other diseases, such as a novel coronavirus, despite risks related to SARS emerging in other countries years previously. This led to delays in decisions about what PPE was required and in which settings.

There also seemed to have been little contingency planning for disruption of global supply chains. Many distribution chains operate "just in time" practices, so shortages of PPE emerged very quickly when factories in China were in lockdown. Shortages of PPE in social care were further exacerbated by business-as-usual supplies being redirected to the NHS without discussion. At one point, stories were circulating of PPE pirates lurking behind goods containers at ports with bags of cash. Some larger homecare providers had no choice but to organise deliveries of PPE in private jets, at huge cost, calling on assistance from international colleagues who purchased supplies directly from PPE factories across Asia. Supply issues caused prices to skyrocket, causing additional problems for already cash strapped care providers, particular small homecare agencies with limited purchasing power.

We received numerous emails and social media messages from UK and overseas companies offering to repurpose factories to manufacture PPE or to procure PPE on our behalf. After a while, we decided we could not deal with any of them as there was no way of doing the necessary due diligence, though we did learn a lot about PPE manufacture and supply chains in the process. Glove manufacture, for example, requires specialist equipment and it was not possible to modify UK factories designed to make other products, though it was possible for them to pivot to producing masks and aprons.

Initially, there was also no way of directing potential supply offers to central government to investigate. When central government did eventually produce an online form for enquiries, those who submitted offers did not receive responses, triggering further correspondence back to us. There was a team in the Cabinet Office who were addressing procurement of PPE, but for some time they were woefully under-resourced. In their defence, they were flooded with offers and it was hard to separate scams from bona fide suppliers. Central government appeared slow to scale-up resources in critical areas and to coordinate activities across teams and departments. This led to a period of high frustration as care providers lacked PPE and nobody in government seemed to be in overall charge of addressing this problem. Eventually, someone senior was appointed to address PPE and gradually the situation improved. We urged the government to use its procurement power and ability to conduct due diligence to bulk buy PPE for the care sector, which is comprised of thousands of SMEs. Numerous meetings and months later, a procurement portal was launched, and we persuaded the government to supply PPE free to care providers, which they are still doing until at least March 2023. At the outset, many problems were experienced with ordering from the portal and the quantities available were insufficient. The latter was partly a consequence of lack of understanding of social care in government and partly genuine supply issues. Over time, however, this improved.

Guidance for social care should be issued at the same time as guidance for the NHS, recognising that the NHS and care sector work collaboratively to provide care for individuals.

Lesson 3: home-based and community services in social care involve half of the workforce and millions of citizens and are just as important as care homes (which support a max of only 400K people at a time). Officials, Ministers, and other relevant parties, e.g., UKSHA need to get up to speed about the care sector, understand the importance of homecare, and ensure it receives the guidance, funding and other resources it needs.

Homecare often appeared to be an afterthought during the pandemic with, for example, operational guidance typically written for NHS services without consideration of relevance to setting and service type; PPE supplies diverted to the NHS and care homes, ignoring homecare; funding directed straight to care homes, with homecare left with the crumbs under the table dispersed via local authorities; delayed access to asymptomatic testing for homecare; and challenges with the COVID-19 vaccine roll-out in homecare.

Concerns raised about draft guidance related to homecare need to be acted on more quickly. It could take significant time to get relatively simple changes made to guidance.

The additional costs of managing infectious diseases for the sector must be better understood by the Government and support to cover them made available. For example,

assumptions were initially made that homecare employers could cover the cost for all the time staff spent testing, without any additional funds. The funds issued should be appropriate for the sector, providing consistent support over an appropriate duration, and reducing bureaucracy.

Knowledge of homecare and social care more widely in DHSC was weak. Policy and guidance relating to the sector was often inappropriate and demonstrated this lack of knowledge, as did the lack of priority given to social care during the initial phase of the pandemic The prominence of social care within DHSC should be enhanced and the relative lack of knowledge and experience of social care within DHSC and senior levels of the NHS should be addressed. The Department should ensure that future policy and guidance relating to the sector is well-informed and reflects the diversity of the sector.

Lesson 4: chain of command and communication needs clarity in an emergency. Balance between national and local decision-making in a pandemic needs to be addressed.

The divergence in guidance produced, and differences in how guidance was interpreted at a local level, was challenging for homecare providers. For example, District Nurses were told they didn't need to wear masks any longer, whilst homecare workers did. This created difficulties for care workers and confusion for people drawing on services, which persist today.

Larger providers working across multiple local authorities had challenges with different public health guidance promoted in different local authority areas. There needs to be greater

consistency in the implementation of guidance and greater consideration of when national rather than local guidance would be appropriate.

Lesson 5: we need better data on social care.

Data collection on social care needs to be simplified and improved. Data on social care also need to be collected from local authorities and the NHS. Data must be shared with providers as well as with central and local government. Data requests need to be realistic and costs recognised.

Yours sincerely,

Personal Data

Dr Jane Townson
Chief Executive