IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE
CORPORATE SUPPLEMENTARY STATEMENT COVERING THE DEPARTMENT'S ROLE IN GUIDANCE GIVEN TO CARE HOMES AND ADULT SOCIAL CARE: 1 JANUARY 2020 – 28 FEBRUARY 2022 [FURTHER STATEMENT]

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1. I, Jonathan Marron, Director General of the Office for Health Improvement and Disparities, at the Department of Health & Social Care, 39 Victoria St, Westminster, London SW1H 0EU, will say as follows, and I, Michelle Dyson, Director General for Adult Social Care at the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

2. We make this supplementary statement to address the role of the Department of Health and Social Care ("the Department") in relation to regulation, guidance, policy advice and information produced for care homes and the wider adult social care sector during the relevant period from 1 January 2020 to 28 February 2022. This statement should be read in conjunction with the First Witness Statement of Jonathan Marron and Michelle Dyson, dated 28 September 2023, and alongside the other Module 2 corporate statements.

3. As this is a supplementary corporate statement on behalf of the Department it necessarily covers matters that are not within our own personal knowledge or recollection. It has been reviewed by us and by a corporate team who have examined a very large number of documents. It has also been drawn up in consultation with Sir Christopher Wormald, the Permanent Secretary, and has been shared with Rosamond Roughton who was Director General for Adult Social Care from April 2020 until July 2020. This statement is to the best of our knowledge and belief accurate and complete at the time of signing. Notwithstanding this, it is the case that the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be.

4. As set out above, I, Jonathan Marron, am a Director General at the Department having first joined the Department in 1994 and have subsequently held various roles both inside the Department and across the healthcare system. I am currently the Director General of the Office for Health Improvement and Disparities, having been made a Director General in 2017, initially on temporary promotion. In my current role I am responsible for a group which includes public health, prevention, the Work and Health Unit and the delivery of two major Government programmes (Start for Life and Drug Strategy Treatment). I am responsible for Section 1 of this statement. I am jointly responsible with Michelle Dyson for Section 3 of this statement.

5. As set out above, I, Michelle Dyson, am the Director General for Adult Social Care at the Department. I have been a civil servant since joining as a government lawyer in the Home Office in 1998. I have been a senior civil servant since 2007, holding a number of posts across Government including in the Department for Education (DfE), Department for Work and Pensions (DWP) and the Ministry of Justice (MoJ). I have been a Director General for Adult Social Care in the Department since 17 September 2020, initially on an interim basis and then appointed permanently in May 2021. I am responsible for Section 2 of this statement. I am jointly responsible with Jonathan Marron for Section 3 of this statement.

Structure

6. This statement begins by setting out the Department's involvement in decision-making and the basis for these decisions in the initial stages of the pandemic, before going on to highlight significant areas of activity in the later months in relation to COVID-19.

7. The structure of this statement is as follows:

- Section 1. First phase of the pandemic (Spring / Summer 2020)
- Section 2. Beyond the first phase (July 2020 to February 2022)
- Section 3. Reflections on adult social care and the COVID-19 pandemic

SECTION 1: FIRST PHASE OF THE PANDEMIC (SPRING / SUMMER 2020)

January to February 2020: Initial preparations and early guidance for adult social care

8. In the early months of 2020, the Department's actions focused on sharing the best understanding of COVID-19 and on preparations to respond to any outbreak. Given the limited available clinical data on COVID-19, the Department's planning was informed by knowledge of previous coronavirus that had caused severe illness (Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS)) and on planning for pandemic influenza.

9. On 10 January 2020, Public Health England (PHE) published ***"COVID-19: infection prevention and control (IPC)"*** guidance. **(MD/JM2/1 - INQ000325222)**. This guidance outlines infection prevention and control advice for healthcare providers assessing possible cases of Wuhan novel coronavirus (WN-CoV), subsequently renamed COVID-19, which at the time was considered a high consequence infections disease (HCID).

10. On transmission this guidance states:

> *"As WN-CoV has only been recently identified, there is currently limited information about the precise routes of transmission. Therefore, this guidance is based on knowledge gained from experience in responding to coronaviruses with significant epidemic potential such as Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV).It is known that both SARS-CoV and MERS-CoV can transmit person to person; although this is not yet confirmed for WN-CoV, it is reasonable to assume that human-to-human transmission is possible."* And "*There is currently little evidence that people without symptoms are infectious to others."*

11. On 31 January 2020, the pandemic influenza preparedness stockpile was made available for release to wholesalers to supplement the usual supply chains to social care. Prior to the pandemic social care providers were responsible for the procurement of their own personal protective equipment (PPE).

12. Between 3 and 14 February, Local Authorities and Local Resilience Forums (LRFs) were stepping up their response in preparation for COVID-19. LRFs are multi-agency

partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act (CCA).

13. On 5 February 2020, the first Adult Social Care National Steering Group meeting took place, bringing together national partners and representatives from the sector, to discuss the adult social care response to COVID-19 **(MD/JM2/2 - INQ000325223)**. This included: consideration of the bespoke and general guidance for staff working in residential and care homes and communications across the sector as well as actions to ensure a joined-up local response led by local partners, including LRFs, Directors of Public Health and Directors of Adult Social Services. This group met regularly throughout the first wave of the pandemic, providing real-time feedback to Government about the experience of the sector.

14. On 11 February 2020, an adult social care coronavirus response meeting took place in the Department, which was attended by the Permanent Secretary, Director General and Director for Social Care and Deputy Chief Medical Officer (DCMO) (Jenny Harries) alongside other officials **(MD/JM2/3 - INQ000049363)**. At this meeting, the Department discussed the necessary COVID-19 response for the adult social care sector, including social care providers. Key issues discussed: raising awareness of the COVID-19 risks in the sector to promote prevention; and preparing for Reasonable Worst Case Scenario (RWCS) planning assumptions. The responsibilities of the Department in supporting local authorities and LRFs were discussed. It was noted that any emergency powers must still enable local authorities to react appropriately to local circumstances.

15. Care homes were also discussed in this meeting in relation to issues around the workforce, the need for clinical advice, e.g., on isolation of symptomatic individuals, delayed transfers of care out of hospital, and moving individuals. It was noted that policy options would need to be assessed in relation to their practicalities. The three possible ingress routes for how the virus could enter a care home (infected people moving into homes; staff; visitors) were discussed and it was noted that these should be considered during the response. Difficulties around the implementation of a COVID-19 response in adult social care were also discussed, particularly noting a "*lack of information flow*" between private sector care providers and LRFs.

16. The Permanent Secretary asked that an ethical framework was put in place that was specific to adult social care. This was developed by the Office of the Chief Social Worker and published on 19 March 2020 **(MD/JM2/4 - INQ000303264)**. Its purpose was to provide support to ongoing response planning and decision-making to ensure that proper consideration was given to particular ethical values and principles, when organising and delivering social care for adults. An expert group of sector partners were consulted, as well as the Moral and Ethical Advisory Group (MEAG). The framework was also reviewed by relevant COVID-19 policy cells within the department, and colleagues at Ministry of Housing, Communities & Local Government (MHCLG) and DfE. The framework was adapted from Responding to Pandemic Influenza: The Ethical Framework for Policy and Planning, which was first developed by the Committee on Ethical Aspects of Pandemic Influenza in 2007, and later revised by the Department in 2017.

17. On 14 February 2020, the DCMO commissioned PHE to provide clinical advice for care settings. Drafts of the advice were shared between the Department and PHE and with sector representatives for comments. It was also discussed at a National Steering Group meeting on 18 February 2020, before being signed off by the Chief Medical Officer (CMO) prior to publication.

18. On 25 February 2020, "***Guidance for social or community care and residential settings***" was published on PHE's website having been signed off by the Department. **(MD/JM2/5 INQ000325225)** The guidance stated:

> "*This guidance is intended for the current position in the UK where there is currently no transmission of COVID-19 in the community. It is therefore very unlikely that anyone receiving care in a care home or the community will become infected. This is the latest information and will be updated shortly.*"

19. The guidance included:

    a. Information about the virus, signs and symptoms of COVID-19, how COVID-19 is spread and how long the virus can survive. This included the statement "*There is currently little evidence that people without symptoms are infectious to others.*"
    b. Preventing the spread of the virus, including hand washing, covering coughs and sneezes, cleaning, staying at home if feeling unwell.

c. Advice in case of employees becoming unwell. Including that if the staff, member of the public, or resident has not been to specified areas prescribed in the guidance in the last 14 days then normal practice should continue.

20. On 28 February 2020, the UK reported its first case of unknown origin, with no links to imported cases (i.e., related to travel abroad). By the end of February 2020, a total of 20 cases of COVID-19 identified in the UK **(MD/JM2/6 - INQ000325226)**. There were no reported outbreaks in care homes at this time.

March 2020: Community transmission and revised guidance

21. As the pandemic progressed the risk of community transmission become increasingly likely. In early March the Scientific Advisory Group for Emergencies (SAGE), which the CMO attended, began advising that the pandemic was advancing more quickly than expected **(MD/JM2/ 7 - INQ000109125; MD/JM2/8 - INQ000109142).** On 3 March SAGE considered a Scientific Pandemic Influenza Group on Modelling, Operational sub-group (SPI-M-O) modelling paper (dated 2 March) which concluded that it was highly likely that community transmission was established **(MD/JM2/9 - INQ000325327).**

22. On 1 March 2020, the Government published "***COVID-19: Guidance for infection prevention and control in healthcare settings***" **(MD/JM2/10 - INQ000325314)** in line with expert advice. Although written primarily for the NHS, the principles were expressly said to apply to other settings where healthcare was delivered, with a specific paragraph for care homes in relation to isolation. It noted that "*Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak*". It stated that further updates would be made to this guidance as new detail or evidence emerged. This guidance included details on issues such as transmission risk, infection prevention and control precautions such as cleaning, PPE, isolation and 2-metre distancing.

23. On 4 March 2020, a meeting of the Adult Social Care National Steering Group was held **(MD/JM2/11 - INQ000325227)**. On the same day, the Department held an internal social care meeting. At this internal meeting, the Minister for Care emphasised the need for preparedness on social care issues. At the same time the Department was receiving real-time intelligence from providers about key issues and risks that they were facing regarding contingency planning.

24. From publication of the PHE guidance on "***Social or community care and residential settings on COVID-19"*** on the 25 February to early March, cases in the general UK population had begun to increase. Given the increased risks posed by community transmission, care home settings were preparing for potential outbreaks and seeking further guidance on caring for people with confirmed COVID-19, including: access to testing for social care workforce; what PPE was required and how this should be accessed; and management of isolation for those who refused to isolate. This was in line with wider international guidance including the World Health Organisation (WHO) guidance published on 27 February 2020 **(MD/JM2/12 – INQ000325303)**, which stated as follows: "*The people most at risk of infection are those who are in close contact with a COVID-19 patient or who care for COVID-19 patients*". "*Healthcare workers involved in the direct care of patients should use the following PPE: gowns, gloves, medical mask and eye protection (goggles or face shield)*". Where individuals have no respiratory symptoms, the guidance advised "*no PPE required*".

25. On 6 March 2020, the Secretary of State held an adult social care meeting with the Ministers for Care, the DCMOs (Jenny Harries and Jonathan Van-Tam) and a number of officials from the Department and NHS England and Improvement (NHSE/I) **(MD/JM2/13 - INQ000049530)**. The Secretary of State referred to the higher risk for older people in the social care sector and, therefore, the need for these problems "to be gripped as soon as possible". The Minister for Care "*noted we need to ramp up preparedness around social care*". The Department then set up a regular rhythm of daily meetings to coordinate and discuss the COVID-19 response with ministers and senior officials in the Department.

26. Over the following days there were discussions between PHE and the Department regarding guidance for care homes on isolation, testing, supply of PPE and financial support. PHE and the Department agreed to work collaboratively to develop guidance **(MD/JM2/14 - INQ000325229; MD/JM2/15 - INQ000325228)**.

27. On 10 March 2020, PHE was notified of the first suspected outbreak in a care home in Basingstoke. The first resident from this care home was admitted to hospital on 7 March 2020 after becoming ill on 6 March 2020 and subsequently tested positive for the virus in hospital. Contact tracing proceeded in the care home as directed in the February PHE Guidance and some residents were symptomatic and tested. Three further residents tested positive in the following days **(MD/JM2/16 - INQ000325230; MD/JM2/17 - INQ000325231)**.

28. Also, on 10 March 2020, the National Care Forum, the membership organisation for not-for-profit organisations in the care and support sector held a virtual meeting with over 50 care providers, and feedback was shared with Government **(MD/JM2/18 - INQ000049574)**. Many of the issues raised, such as the need for additional infection prevention and control advice, were already being considered across the Department and where new issues emerged these were considered and escalated. This feedback supplemented the intelligence already being provided from the sector on a regular basis through the Adult Social Care National Steering Group.

29. On 12 March 2020, 100 cases of COVID-19 were identified. The Government announced that it was moving its COVID-19 response from the 'contain' to the 'delay' phase, after the UK Chief Medical Officers raised the risk to the UK from moderate to high.

30. On 13 March 2020, guidance commissioned by the Department on care homes, ***"COVID-19: Residential care, supported living and home care guidance"*** **(MD/JM2/19 - INQ000325236; MD/JM2/20 - INQ000325233; MD/JM2/21 - INQ000325235; MD/JM2/22 - INQ000325234)** was published by PHE on GOV.UK. Three separate documents were published allowing the guidance to be tailored to specific settings. The guidance aimed to set out key messages to support planning and preparation in the event of an outbreak or widespread transmission of COVID-19. The residential care guidance included:

    a. Steps providers can take to maintain services, including working with their local authority on plans for mutual aid, sharing information with local partners and continue the procurement of PPE, which would be supplemented by a free issue of face masks from government pandemic stocks.

    b. Guidance in case a member of staff is concerned they have COVID-19 including following the NHS guidance and if advised to self isolate at home to follow the PHE guidance.

    c. How to minimise the risks of transmission. Care home providers were advised to review their visiting policy. The review should also consider the wellbeing of residents and the positive impact of seeing friends and family.

d. Guidance if a resident has symptoms of COVID-19. Care home providers would be expected to implement isolation precautions in the same way as they would for influenza. The residents own room could be used for isolation, ideally a single bedroom with ensuite facilities. Staff should be trained in hand hygiene. Steps should be taken to reduce the risks of transmission through safe working practices. Staff should use PPE for activities that bring them into close personal contact. If neither the resident or staff member were displaying symptoms suggestive of COVID-19, then no PPE is required above normal good hygiene practices.

31. Advice within the "***COVID-19: Residential care, supported living and home care guidance"*** published on the 13 March was in line with wider international guidance. Alongside the mitigations contained within the policy, the guidance also sought to offer practical support to care homes. There were real concerns at the time about how the already stretched workforce of the care sector would manage if sickness levels in staff reached levels that had been predicted. The March PHE guidance therefore provided a number of recommendations for both NHS and local authority stakeholders to support care settings in resilience planning, looking at options in relation to outbreak, management support, management of workforce issues and ensuring continued clinical support.

32. The guidance was subsequently updated to reflect changes in wider policy, such as on 23 March 2020 when it was amended to reflect the new Stay at Home guidance, social distancing and shielding guidance **(MD/JM2/23 INQ000325246)**.

33. On 13 March 2020, the IPC guidance was updated and a section titled 'Infection prevention and control guidance for pandemic coronavirus' includes revised text on the understanding of COVID-19 transmission characteristics: **(MD/JM2/24 INQ000325350)**

"Assessment of the clinical and epidemiological characteristics of SARS-CoV-2 cases suggests that, similar to SARS-CoV, patients will not be infectious until the onset of symptoms. In most cases, individuals are usually considered infectious while they have symptoms; how infectious individuals are, depends on the severity of their symptoms and stage of their illness. The median time from symptom onset to clinical recovery for mild cases is approximately 2 weeks and is 3-6 weeks for severe or critical cases. There have been case reports that suggest infectivity during the asymptomatic period, with one patient found to be shedding virus before the onset of symptoms. Further

study is required to determine the actual occurrence and impact of asymptomatic transmission".

34. Similarly, the rationale for the guidance is given as:

> *"Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak. The initial phylogenetic and immunologic similarities between COVID-19 and SARS-CoV can be extrapolated to gain insight into some of the epidemiological characteristics. The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact \with contaminated surfaces."*

35. Early in March 2020 the Department ensured that stock from the Pandemic Influenza Preparedness Programme (PIPP) stockpile was distributed to providers of social care to address immediate shortages. Between 19-24 March 2020, over 25,000 residential care homes received 300 Type IIR masks to support providers given the initial demand for facemasks.

36. On 16 March 2020, the Department stood up and operationalised the National Supply Distribution Response (NSDR) hotline **(MD/JM2/25 - INQ000049616)**. Providers, including care homes and other providers in the care sector, with an immediate and urgent need for PPE within 72 hours were able to call the hotline to secure an emergency supply. On 21 March, the hotline was expanded to a 24-hour service, providing around-the-clock emergency support.

March to April 2020: Hospital discharge and care home admission

37. The picture from certain other countries was one of hospitals being overwhelmed, spikes in deaths as the need for hospital beds exceeded supply, and people dying in hospital corridors or dying without/before coming to hospital. As a result, there was an urgent and critical need to free-up the maximum possible in-patient and critical care capacity to prepare for patients who required respiratory support; this included older people and other vulnerable groups who were more likely to be hospitalised by COVID-19. In addition, it was also important to protect those people, particularly older people, who

would be at risk from an influx of COVID-19 patients, by arranging for them to be discharged, where clinically appropriate.

38. The rationale for the discharge of people from hospitals to care homes is set out in the Fourth Witness Statement to the Inquiry by Professor Sir Christopher Whitty **(INQ000251645)**:

> ***"Specific issues at this time with regards to discharges from hospitals to care homes***
>
> *7.128. I was not closely involved in the decisions in relation to the need to free up hospital beds by way of discharging patients to care homes. I was aware of them however, and thought that the benefits of doing so outweighed the disadvantages. To that extent, I agreed with the decision even though the impetus for it came from the NHS. It might be worth me therefore laying out why I thought at the time, and continue to think, that this was a prudent decision in which there were both risks in doing nothing and risks in acting, but where doing nothing in my view carried the greater risks.*
>
> *7.129. The first group of people who would benefit from a swift move from hospital to care homes during a rapidly expanding wave of a new infection was the older and vulnerable people who were in medical beds in hospital but were fit for discharge (i.e. they no longer had any medical reason to be in hospital and could have received equally good care in a care or nursing home). The reason for this was that we were having an exponential rise in cases of COVID-19, and it was predictable that this would first manifest itself in hospitals where sick people come. I have already laid out how COVID-19 disproportionately affected the elderly above at paragraphs 5.59 to 5.60. Keeping such individuals in hospital unnecessarily therefore exposed them to a foreseeable risk of harm (from catching COVID-19) whilst conferring no benefit on them.*
>
> *7.130. Given that the doubling time of COVID-19 was measured in days, every additional day that a vulnerable person unnecessarily spent in hospital increased the daily risk that they would catch COVID-19 as a result of them being in that setting, even with the best care and infection control practices available. The idea that hospitals are uniquely safe places is a complete misunderstanding; nosocomial spread of infections in hospitals has always been, and remains, a risk for multiple infections*

everywhere in the world. Hospitals are far from an ideal place to be for someone who is vulnerable to an infection, if they do not need to be there for clinical care. The difficulties in preventing COVID-19 spread within hospitals became clear as our understanding of the virus and testing capabilities later increased, but were not surprising for a respiratory infection. Much (probably most) of the transmission of SARS and MERS occurred in hospital or healthcare settings.

7.131. Whilst the risk of importation of COVID-19 from hospitals to care homes was non-trivial from the time domestic transmission became established, this risk to other care home residents would only increase for every additional day that an elderly person from that care home remained in hospital during the exponential rise of cases in hospital before returning to their care or nursing home. I have previously commented on the scarce availability of COVID-19 tests early in the pandemic but also the slow turn around for those tests which were available. It was therefore, given the limited and slow testing, not the case that someone could have been tested prior to discharge and received the result in a timely manner, so as to allow their clinician to have confidence that the individual being discharged was not infectious.

7.132. A further group of people who benefitted from the discharge of medically fit individuals back to care or nursing homes were patients who became unwell, either from COVID-19 or another condition, and who required hospital beds. This included other people in care and nursing homes, who were at relatively high risk of needing hospital care compared to the general population. There was an obvious need to free up beds, increase hospital capacity and make staff time available for the potentially very large wave of hospitalisations which would occur due to COVID-19. This was a very important operational point for the NHS. We did not know in advance how big the wave was going to be, nor whether we would be successful in getting the epidemic first wave to turn over before the capacity of the NHS was overtopped. As was clear in Module 1 of this Inquiry, the relative lack of capacity in the NHS in terms of available beds was always going to limit our room for manoeuvre in a serious pandemic overall and compared to other nations.

7.133. Two things were obvious from mid-March 2020: that it would be ideal to test patients going from hospital (and indeed other settings) into care homes for COVID-19; and that we did not have sufficient testing capacity nor was the turnaround time quick enough to achieve this. Over time the availability of tests made it realistic - but it was not in March or early April. My advice from mid-April 2020 was therefore that

testing should be undertaken ***(14 April 2020 - CJMW4/099 – INQ000236441)****, but this was of course dependent on having sufficient testing capacity to achieve it, and a fast enough rate that someone would not be sitting in hospital for several days with the potential of becoming infected whilst waiting for a test result. These were operational questions."*

39. On 12 March 2020, there was a meeting between the Prime Minister, the Secretary of State and senior NHS and Government officials to discuss the resilience of the NHS **(MD/JM2/26 - INQ000325240; MD/JM2/27 - INQ000279904)**. Amongst other things, senior NHS officials set out the NHS's plan to stop non-urgent operations and to be '*more assertive'* on long stays to ensure more bed capacity was available to treat the expected rise in COVID-19 patients.

40. A Departmental note was provided by an official to the Permanent Secretary and Secretary of State for the purposes of that meeting, asking the question "*How can we free up hospital bed capacity by rapidly discharging people into social care?"* **(MD/JM2/28 - INQ000325232)**. This note estimated that there were approximately 1,500-2,000 patients in acute hospitals who could be immediately and safely transferred into social care settings. In addition, it estimated that there could be approximately 4,000 – 8,000 further beds occupied by people in need of adult social care but medically fit for discharge. The note raised a concern about workforce constraints in adult social care and the reasonable worst-case scenario that 11% of that workforce would be off work during the peak of the pandemic. The note set out five options to move people out of hospital more quickly:

    a. Extending free care to speed up discharge to residential care homes. Having just mentioned the workforce constraints and capacity in the social care sector, the note stated that "*We need a clinical decision on whether this is the right thing to do. The policy implies that emptying the hospital is more important than protecting residential or domiciliary care capacity to support people currently in the community. We would need this to be taken on a clinical basis*." This statement was in relation to *capacity* in adult social care.

    b. Removing continuing healthcare assessments – individuals would be discharged with continuing healthcare funding or onto other NHS-funded discharge pathways without assessment. Such assessment would subsequently take place after the emergency period had concluded. It was

noted that this would not make a large impact on discharge given the small number of beds accounted for by continuing healthcare-related delayed transfers of care;

c. Rollout capacity tracker information systems – this would allow acute hospitals to see real time care home capacity in their local area and further afield;

d. Greater use of the independent healthcare sector – this would be to allow step-down care of NHS non-elective patients from NHS hospitals; and

e. Live-in carers – commissioning live-in carers to support more people out of hospital.

41. Option A was the preferred choice. On 13 March 2020, it was said in an email that "*for the duration of CoVid SoS favours extending free social care to those leaving hospital, with the NHS paying for this*" **(MD/JM2/29 - INQ000325244); (MD/JM2/30 - INQ000325238); (MD/JM2/31 - INQ000325239).** Funding discussions took place to agree what funding would be required to support this proposal between Departments and NHSE/I.

42. At the same time, there were also discussions between DHSC and NHSE/I relating to discharging individuals with symptoms of COVID-19 into care homes. On 12 March 2020, the Director of Adult Social Care Rosamond Roughton sent an email to an official at NHSE/I seeking agreement to the DCMO's (Jenny Harries) approved position for press queries that, "*care homes should take the same steps to minimise the risk of transmission from the discharged patient, as they would with a resident with suspected Covid-19 within the home*" and that if there were an outbreak in a hospital, individuals could be discharged into community settings including care homes "*where it is safe to do so… with appropriate safeguards to minimise the risk of transmission*". NHSE/I responded emphasising that "*a priority should be to protect care home residents as a highly vulnerable population*", and that "*where possible we should, for now, try to avoid discharging people presenting with possible C19 symptoms into care homes unless they have a negative test*" **(MD/JM2/32 - INQ000325237).**

43. On 16 March 2020, in the context of the shielding policy to be introduced, the Director of Adult Social Care emailed the Deputy Chief Medical Officer (Jenny Harries) and an official at NHSE/I, setting out a working assumption that the discharge of symptomatic

individuals into care homes would be allowed with very strict infection control **(MD/JM2/33 - INQ000325241)**. The DCMO agreed in an email on the same day that "*whilst the prospect is perhaps what none of us would wish to plan for",* in reality this would be necessary and it would be *"entirely clinically appropriate*" **(MD/JM2/34 - INQ000325243)**.

44. On 16 March SAGE considered Imperial College Modelling that concluded that with no government action the NHS was within 3 weeks of exceeding Intensive Care Unit (ICU) bed capacity, emphasising the urgent need to address NHS bed capacity **(MD/JM2/35 - INQ000325242)**.

45. The policy objective of the "***COVID-19 Hospital Discharge Service Requirements"*** guidance was to prevent critical care services from being overwhelmed – and, therefore, catastrophic consequences for anyone needing those services, including older people and other vulnerable groups who were more likely to be hospitalised by COVID-19 - whilst ensuring the safe discharge of individuals during the pandemic. It sought to do so by ensuring the timely discharge of those considered to be fit for discharge, based on the clinical assessment of clinicians, in line with existing good practice on discharge.

46. The "***COVID-19 Hospital Discharge Service Requirements"*** *were* initially developed by NHSE/I with input from the Department and a wide variety of stakeholders. From 16 March 2020, various draft versions of the document were sent between NHSE/I the Department and sector including the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) to ensure wider sector input and consultation **(MD/JM2/36 INQ000325245)**.

47. On 18 March 2020, ministers agreed that the "***COVID-19 Hospital Discharge Service Requirements"*** should be published the following day and that funding would be provided for discharge via Clinical Commissioning Groups (CCGs), and for Local Authorities to meet social care pressures and relevant costs.

48. The hospital discharge guidance was set out in a letter to the NHS on 17 March, and in the "***COVID-19: Hospital Discharge Service Requirements***" published by the Department and NHSE/I on 19 March **(MD/JM2/37 - INQ000325248)**. The guidance aimed to free up at least 15000 beds by 23 March and it set out:

    a. Hospitals must discharge all patient as soon as they are clinically safe to do so.

b. A clinically led review of all patients would determine which patients were suitable for discharge. Criteria were provided to support these clinical reviews.

c. Where applicable COVID-19 test results would be included in the documentation that accompanies a person on discharge.

d. A discharge to assess model would be adopted, with longer term requirements agreed post discharge.

e. The NHS would fund the care packages required to implement the guidance, with the Government providing the NHS with £1.3 billion funding to support this **(MD/JM2/38 - INQ000325247)**.

f. All providers were required to sign up to the care home capacity tracker by 23 March, ensuring up to date data was available on capacity across the system.

49. In addition to the £1.3 billion of support provided to the NHS, Local Authorities across England received another £1.6 billion in additional funding in response to the coronavirus pandemic (**MD/JM2/39 - INQ000325264**).

March – April 2020: Admission and care of residents in care homes

50. There was concern over the ability of care homes to effectively isolate COVID-19 patients, and on the risks to already vulnerable residents of discharging COVID-19 patients into care homes, and as the pandemic progressed, the Department continued to respond to stakeholder feedback and queries about measures to protect care homes during the pandemic. This included a number of questions around infection prevention control, discharge, isolation and admission of residents to care homes. It was decided that additional, bespoke guidance for care homes would provided more comprehensive advice to providers and adult social care staff.

51. This bespoke guidance began as two separate documents: PHE interim guidance on ***"Managing COVID-19 cases and outbreaks in care homes"*** **(MD/JM2/40 - INQ000325341)** and separate NHSE/I infection prevention and control guidance **(MD/JM2/41 - INQ000325324)**. But, following discussion with NHSE/I and the

Department, it was agreed that the work should be combined and it should be co-badged to streamline the amount of guidance going out to the sector.

52. This PHE interim guidance recommended that all symptomatic residents be isolated, that contacts of exposed residents be cohorted separately and that unexposed residents be cohorted in a third group. Transfers into a care home were to be undertaken on a case-by-case basis but the *"threshold for transferring an unexposed person into care home* [sic] *with a possible or confirmed outbreak of COVID-19 would have to be extremely high because of the risk that it poses to that individual and every attempt should be made to accommodate the individual somewhere else with co-ordinated action across all organisations"*. Correspondingly, individuals with confirmed COVID-19 were advised not to be transferred into a care home with no cases recorded. Moreover, PHE was advising that individuals testing positive for COVID-19 ought not to be discharged until they had been isolated for seven days and were free of symptoms.

53. Clinicians from PHE with expertise in the relevant area were engaged to support the development of the guidance. Drafts were cross-checked with the WHO guidance, dated 21 March 2020, *"Infection prevention and control for long-term care facilities in the context of COVID-19"* and relevant content from the WHO guidance was referenced or included. **(MD/JM2/42 - INQ000325328)**

54. The WHO guidance, "*Infection prevention and control guidance for long-term care facilities ('LTCFs') in the context of COVID-19*", published on 21 March 2020, stated, "*LTCFs should be prepared to accept residents who have been hospitalized with COVID-19, are medically stable and are able to care for the patients in isolated rooms. LTCFs should use the same precautions, patient restrictions, environmental cleaning, etc., as if the resident had been diagnosed with COVID-19 in the LTCFs*" (**MD/JM2/39 - INQ000325264).** The guidance went on, in the case of previously positive COVID-19 patients, it stated that, "*where testing is not possible, WHO recommends that confirmed patients remain isolated for an additional two weeks after symptoms resolve"*. The WHO was, on 2 April 2020, identifying asymptomatic transmission as only a possibility and this issue was debated into the summer **(MD/JM2/43 - INQ000325281** .

55. There were concerns raised by NHSE/I and sector stakeholders regarding the discharge elements, outbreak advice and staff cohorting recommendations in the draft guidance mentioned above and developed by PHE **(MD/JM2/44 - INQ000325313)**. NHSE/I was

concerned that the guidance as drafted would concern the care home sector and create blocks in the system. It was felt that the overall balance should be about reducing the risk of care homes not taking back existing residents or new transfers. The feedback from NHSE/I considered that the greater risk at the time was of this population being stuck in hospital. Consequently, NHSE/I suggested changes on the wording and advice around discharge and the amended document was circulated on 25 March 2020 **(MD/JM2/45 - INQ000325249)**. The amended advice did not advise against discharging COVID-19 positive individuals back to care homes. CQC also signed off the discharge guidance.

56. Clinicians had also highlighted a need for a standardised process for the step-down of infection prevention control procedures with respect to patients who were COVID-19 positive, and with specific reference to those who were immunosuppressed. ***"Guidance for stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings"*** – was developed alongside the ***"Admissions and care of residents during a COVID-19 incident in a care home"*** and published on 9 April **(MD/JM2/46 - INQ000325262)**. The guidance aimed to complement existing infection control guidance to provide advice on appropriate infection prevention control precautions for COVID-19 patients recovering or recovered from COVID-19 and remaining in hospital or being discharged to their own home or residential care. It specifically provided clarity for clinicians around the necessary periods for isolation of COVID-19 positive cases and testing requirements.

57. On 31 March 2020, an official at the Department sent the latest version of the draft guidance for review by the Minister for Care **(MD/JM2/47 - INQ000325252)**. This set out a summary of the guidance as well as responses to queries from the Minister on 28 March 2020. The Minister for Care's office outlined her comment, "*do we really want to be discharging patients with Covid into a care home unless it already has Covid cases? MSC is concerned that a patient will take Covid into a care home, and even with PPE that surely materially increases the risks to others in the facility.*" The response from officials was this was necessary due to capacity concerns in hospitals, "*but we would expect care homes would do a risk assessment to ensure that appropriate isolation facilities are available...*". In addition, the draft guidance advised staff immediately to instigate full infection prevention and control measures in these instances.

58. On 1 April 2020, an email was sent to the Secretary of State and the Minister for Care providing a further version of the draft guidance and a summary of what it included **(MD/JM2/48 - INQ000325254)**. It also stated that it could be published the following day

subject to approval by the Secretary of State and Minister. By an email, dated 2 April 2020, the Minister for Care confirmed she was content for the guidance to be published, following two minor amendments, which were addressed ahead of publication **(MD/JM2/49 - INQ000325257)**.

59. On 2 April "***Admission and care of residents during COVID-19 incident in care homes***" was published by the Department, PHE, and NHSE/I **(MD/JM2/50 - INQ000325255)**. The guidance recognised the vital role of social care in the national effort to respond to COVID-19 and set out:

    a. The vital role in accepting patients discharged from hospital. The guidance recognised that some of these patients might have COVID-19, whether symptomatic or asymptomatic, and that all of these patients can be safely cared for in a care home if this guidance is followed.

    b. Negative tests are not required prior to transfers/admissions to care homes.

    c. In recognition of the vulnerability of care home residents, COVID-19 positive patients should be isolated for 14 days on a precautionary basis. Even if they become symptom free, patients with COVID-19 should complete their 14 day isolation before returning to normal care. Guidance was provided on single case isolation and the use of cohorting where not practical to isolate in single occupancy rooms.

    d. As testing capacity increases, the government will aim to offer a more comprehensive package to the sector. Testing may be offered in the case of a single symptomatic resident. If more than one symptomatic resident, the Health Protection Team should be informed, they would arrange for testing of up to 5 patients (to confirm a COVID-19 outbreak) and advise and support effective isolation and infection prevention and control measures.

    e. Advice for staff included use of PPE when caring for possible or confirmed COVID-19 cases. Staff who develop symptoms should not attend work and should self isolate for 7 days.

    f. Family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life. Alternatives to inpatient visiting should

be explored including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.

g. Guidance was also included on infection prevention control practices, decontamination and cleaning, and on PPE supplies, including wholesalers supported by the Department and how to contact the NSDR for advice on obtaining supplies.

COVID-19: infection prevention and control guidance 2 April 2020

60. At the same time IPC guidance was updated and published to reflect the increased risk to health and care workers associated with the high levels of community transmission in some communities. The 2 April IPC guidance was updated to include tables describing recommended PPE use across different clinical scenarios and settings, this including adult social care settings **(MD/JM2/51 - INQ000325351)**.

a. This update included a table **(MD/JM2/52 - INQ000325263)**, extending guidance on the wearing of PPE to direct patient care/assessment within 2m of an individual *not* currently a possible or confirmed case during a period of sustained community transmission of COVID-19. This represented a significant extension of the use of PPE within health and social care.

b. The guidance was issued jointly by the Department, Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS), PHE and NHSE/I as official guidance.

c. The rationale for the change in guidance is given as:

I. "This guidance has been updated to reflect pandemic evolution and the changing level of risk of healthcare exposure to SARS-CoV-2 in the UK. It is recognised that in contexts where SARS CoV-2 is circulating in the community at high rates, health and social care workers may be subject to repeated risk of contact and droplet transmission during their daily work. It is also understood that in routine work there may be challenges in establishing whether patients and individuals meet the case definition for COVID-19 prior to a face-to-face assessment or care episode."

d. The methods of transmission text was updated to include information on case reports suggesting possible infectivity prior to symptoms. The qualifier of the need for further study to define impact and importance remains:

   I. *"Assessment of the clinical and epidemiological characteristics of COVID-19 cases suggests that, similar to SARS, most patients will not be infectious until the onset of symptoms. In most cases, individuals are usually considered infectious while they have symptoms; how infectious individuals are, depends on the severity of their symptoms and stage of their illness. The median time from symptom onset to clinical recovery for mild cases is approximately 2 weeks and is 3 to 6 weeks for severe or critical cases. There have been case reports that suggest possible infectivity prior to the onset of symptoms, with detection of SARS-CoV-2 RNA in some individuals before the onset of symptoms. Further study is required to determine the frequency, importance and impact of asymptomatic and pre-symptomatic infection, in terms of transmission risks."*

e. A section was added in "***Reducing Transmission in the Hospital Setting***" which recommended "*symptomatic patients to wear face masks if able*" to reduce droplet spread from coughing. Asymptomatic patients did not need to wear masks.

61. In early April, the Department worked with MHCLG to engage the network of 38 LRFs to create an emergency channel for PPE supply to which social care providers could go to if they were unable to obtain adequate supplies from wholesalers. The first delivery to LRFs was authorised on 4 April **(MD/JM2/53 - INQ000325261)** and included over 35 million items of PPE.

62. On 4 April 2020, guidance on **"*The management of staff, patients and residents who have been exposed to COVID-19*"** was published by PHE **(MD/JM2/54 - INQ000325260)**. This guidance was for staff and managers in health and social care settings and included:

   a. Guidance for health and social care staff if they develop coronavirus (COVID-19) symptoms, receive a positive test result or are identified as a contact of a COVID-19 case;

b. Guidance on isolation requirements for patients and residents in health and social care settings after contact with COVID-19 cases; and

c. Guidance on repeat testing for COVID-19 for staff, patients and residents in health and social care settings.

63. On 13 and 14 April 2020, Ministers discussed a proposed adult social care strategy and, once outstanding policy questions had been finalised, agreed to publish on 15 April 2020. On 13 April 2020 at the daily testing meeting the prioritisation of care homes for testing was discussed and it was agreed to test people being discharged from hospital to care homes and to work towards testing all people before admission to care homes as testing capacity permitted.

64. On 15 April DHSC published "***COVID-19: Our Action Plan for Adult Social Care***" **(MD/JM2/55 INQ000325315)**. This brought together a comprehensive summary of the action the Government was taking to support social care. It also included significant expansion of testing, taking advantage of the additional testing capacity becoming available and new measures to support the workforce and ensure emergency supplies of PPE:

a. To support safe discharge a move to institute a policy of testing all residents prior to admission to care homes. This was to begin with all those being discharged from hospital. Guidance on isolation and care for both symptomatic and asymptomatic residents was provided.

b. A move to testing all symptomatic residents.

c. Testing for symptomatic care workers and their households.

d. Measures to support the workforce and to increase the social care workforce by 20,000 people over the next three months.

e. As well as continue to supply LRFs with PPE to meet priority needs, the NSDR 24/7 helpline could provide PPE to providers with an urgent need.

65. On 17 April "***How to work safely in care homes***" was published by PHE to provide guidance for care workers on the use of PPE given that COVID-19 was circulating in the

community at high rates and that symptoms can differ from person to person **(MD/JM2/56 - INQ000303275)**. The guidance recognised that about one third of people carry COVID-19 without having symptoms and recommended that PPE was used for all care, and not just for patients with symptoms.

66. On 18 April 2020, a letter was sent to the adult social care sector clarifying routes for access to PPE **(MD/JM2/57 - INQ000325265)**. 161 providers were invited to join the pilot for the parallel supply chain for PPE. On 20 April, the pilot phase of the PPE Portal commenced, with a focus on smaller adult social care providers in particular, to establish further access to PPE for the sector. The Portal was established as an online platform developed and delivered through the Department, partnering with eBay, Clipper Logistic, Royal Mail, the NHS, Volo and Unipart to be an emergency top up system of PPE for providers. By 5 June, all GPs and smaller adult social care providers (both domiciliary and residential) were invited to register on the Portal.

April – May: Emerging evidence of transmission within care homes and May Support Package

67. The scale of evidence around asymptomatic transmission began to increase. For example, on 3 April 2020, the US Centre for Communicable Disease Control released data on a study of residents in a long- term facility **(MD/JM2/58 - INQ000325258)**. This found 57% of those with positive test results were asymptomatic at the time of testing. The majority of these (10 out of 13) went on to develop symptoms shortly thereafter (measured as in the next 7-day period, and three were identified as remaining asymptomatic. The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) discussed the current evidence available around asymptomatic and pre-symptomatic transmission on the same day **(MD/JM2/59 - INQ000220209)**. A subsequent report by the London School of Economics and Political Science (LSE) sought to review practices globally in respect of the management of COVID-19 in care settings **(MD/JM2/60 - INQ000325251)**. This led to PHE and the Department discussions around the need to further understand the risk of asymptomatic transmission. Further details on asymptomatic transmission can be found in paragraphs 75 to 90.

68. As a result of this, and due to testing capacity now being available for this purpose, between 3 and 13 April 2020, PHE carried out two studies in care homes. The first was an enhanced surveillance study and swabbing in 95 care homes. The second was a whole genome sequencing study in six care homes (the "Easter 6 Study"). Available data

was analysed and indicated asymptomatic transmission. Preliminary findings were shared with the UK Senior Clinicians Group and the Department as soon as these were available, in the week commencing 13 April 2020. The data was presented to NERVTAG on 23 April 2020 and to SAGE on 12 May 2020.

69. On 18 April 2020, a PHE deep-dive meeting into care homes took place, bringing together all of the teams working on that issue. It was noted that there was increasing evidence of widespread transmission in care homes and that it was largely being driven by staff and staff movement between care homes. This led to a paper, on 19 April 2020, being written by the PHE Place and Regions Centre and Regions Operations Centre, titled "Preventing infection with SARS-CoV-2 in care home/residential settings: Reactive to Proactive engagement with care homes" **(MD/JM2/61 - INQ000325267)**. This set out various observations on the spread of COVID-19 in care homes following results received from the Easter 6 Study and how to develop a response. It stated that:

> "*The surveillance studies within care homes and the modelling undertaken by PHE are beginning to show that*; *By the time an outbreak is reported, the SARS-CoV-2 infection is widespread in the home Modelling suggests that up to 90% of care homes maybe [sic] affected by outbreaks within the next 6 weeks*
> *Modelling also suggests that the key vehicle for the spread is the movement of care home staff between homes*."

70. The paper went on to say that there may be greater benefits in supporting care homes to minimise the introduction of COVID-19 into care homes rather than focusing on public health advice. It stated that, "*The scale of task within England is (as of 17 April) to move the emphasis from the 3500 care homes currently with an outbreak to the 12000 care homes that have not experienced an outbreak*." On 20 April 2020, an updated version of this paper was sent to the office of the Chief Medical Officer, circulated to the UK Senior Clinicians Group and discussed at their meeting on 23 April 2020 **(MD/JM2/62 - INQ000325266)**. The paper came to "Possible Conclusions" that there were a high number of asymptomatic or pre-symptomatic cases in staff and residents and that infection may be being imported into homes by the staff. The paper then set out a list of possible actions at regional level in care homes that had not yet reported outbreaks.

71. On 20 April 2020, a further ministerial submission was sent from PHE's Deputy Senior Responsible Officer for PHE's COVID-19 Response to the Minister for Care **(MD/JM2/63 - INQ000325268)**. Among other things, it recommended revisions to the guidance in

"COVID-19: how to work safely in care homes" so that staff consider the use of appropriate PPE in all interactions. This proposed revision followed feedback and emerging evidence. In particular, it noted that there was feedback from the sector that some care sector employees may not be capable of undertaking the required risk assessment. The submission noted, however, that this was likely to increase significantly the demand from the sector for PPE. Consequently, it also recommended that the Department consider commissioning modelling to assess the supply and availability of PPE for the social care sector. In addition, the emerging evidence from the surveillance studies referred to above was that outbreaks in care homes were being introduced into care homes by staff and that there were a high number of asymptomatic or pre-symptomatic cases in staff and residents. The paper recommended a change to guidance to include the use of PPE for care episodes of domiciliary care. This led to the publication by PHE on the 27 of April, of resources on using PPE entitled: "***COVID-19: how to work safely in domiciliary care in England***" **(MD/JM2/64 - INQ000325274)**. A document entitled: "*Personal protective equipment (PPE) – resource for care workers delivering homecare (domiciliary care) during sustained COVID-19 transmission in the UK*" set out the PPE requirements and gave case studies on the use of PPE in a variety of situations **(MD/JM2/65 - INQ000303276)**.

72. At a meeting on 22 April 2020, discussing managing and preventing outbreaks in care homes, the Minister for Care agreed to move forward with policies such as restricting movement of staff between care homes **(MD/JM2/66 - INQ000325269)**. The Department and PHE worked with care provider bodies and local government to consider how best to support care providers in making changes to workforce rotations. This was an extremely complex issue which required Government to consider the impact of restrictions on the ability to provide safe levels of care in care homes, and agree funding to provide support to providers and staff who needed to change working practices and patterns. This led to the development of the Infection Control Fund announced on 13 May 2020 **(MD/JM2/67 - INQ000325279)**. This was all part of the wider May Support Plan (published on 15 May 2020) that helped deploy NHS staff to offer further clinical support in care homes, including additional training in infection prevention and control, offered testing for all care homes staff and residents starting with those care homes looking after older people, and assisted with restricting staff to working in only one care home to mitigate the risks of transmission.

73. On 23 April 2020, a ministerial submission was sent to the Secretary of State, the Minister for Care and Parliamentary Under Secretary of State **(MD/JM2/68 - INQ000325273)**.

Amongst other things, this recommended prioritising testing of asymptomatic staff and residents in care homes where an outbreak had been recorded within the past 14 days. This was based on Paul Johnstone's submission of 22nd April [which set out] "*evidence from the US and a PHE study in London suggest[ing] that symptoms are not a good predictor of infection amongst care home residents and staff.*"

74. On 27 April 2020, there was a meeting with Ministers. Following the meeting, the Department was asked to come up with proposals relating to restricting care home workers to working in one home and ensuring that those workers were free from the virus whilst working.

75. On 28 April 2020, Ministers agreed to all of the recommended actions set out in Annex 3 of the Department's slide pack "Social Care: Update and Next Steps", including asking care homes to restrict permanent and agency staff to working in only one care home and mandatory isolation of new residents to care homes **(MD/JM2/69 INQ000325275)**. It was also agreed, amongst other things, that there should be routine testing of care home staff whether symptomatic or asymptomatic. Later that day, the Government announced that testing would be expanded to include both symptomatic and asymptomatic care home staff and residents. Additional recommendations that were agreed at this meeting were included in the 15 May guidance (below).

76. Testing capacity for care homes was increasing. On 1 May 2020, the Department began piloting testing of whole care homes. Subsequently, 30,000 tests per day were made available to the sector and the care home portal was launched on 11 May 2020. This was an online portal allowing all care homes to request tests for all residents and staff. It initially prioritised care homes for the over 65s and/or persons with dementia, and on 7 June 2020 was expanded to include all adults in care homes in England. This coincided with an increase to between 70-80,000 tests being made available to care home staff and residents per day.

77. By 4 May 2020, under Pillar 2 testing, 2,984 care homes in England had received testing kits and 59,330 individual swab kits had been delivered to enable testing of residents and staff. Furthermore, 445 employers had access to the employer referral route and 44,801 individual care workers (including Scotland and Northern Ireland) were referred using the digital portal. Approximately 41,000 care home residents had been tested by this date.

78. On 5 May 2020, PHE and the Department became aware, through the pilot run by the Office for National Statistics, that between 1.21-15.95% of those working in patient-facing healthcare or resident-facing social care roles tested positive for COVID-19 despite being asymptomatic. As this was a pilot, the confidence level in the findings was low but it did add to the growing consensus emerging from the preliminary Easter 6 study results.

79. As of 11 May 2020, care homes could request testing, in addition to the tests available to symptomatic care workers through the GOV.UK portal.

80. On 13 May 2020, the Prime Minister announced the creation of the Infection Control Fund, which was to be launched alongside the May Support Policy on 15 May 2020 **(MD/JM2/70 - INQ000050496)**. This was a new £600 million ring-fenced fund to tackle the spread of COVID-19 in care homes in addition to the £3.2 billion of financial support that had already been made available to local authorities to support key public services since the start of the crisis. Care homes were now being asked to restrict permanent and agency staff to working in only one care home, wherever possible; the funding could be used to meet the additional costs of restricting staff to work in one care home and pay the wages of those self-isolating.

81. On 15 May 2020, the Government published the "***COVID-19: Care home support package***" **(MD/JM2/71 INQ000325278)**. This was backed by the £600 million Infection Control Fund. The document set out that scientific evidence shows significant asymptomatic transmission of COVID-19 in care homes via both residents and staff, similar to transmission in the wider community. By the time a single symptomatic case is identified in a care home, the virus is likely to be already circulating amongst residents and staff. In light of this new understanding guidance was given on:

    a. The importance of Infection prevention control - Based on the latest emerging international evidence, the package set out high impact measures for providers to take, where feasible, such as restricting staff movement between care homes.

    b. Restricting workforce movement – Take all possible steps to minimise staff movement between care homes. Subject to maintaining safe staffing levels providers should employ staff to work at a single location. A check-list of actions care homes should consider taking was provided **(MD/JM2/72 - INQ000325286)**.

c. Comprehensive testing – The Department made testing available for residents and workers in care homes, and the digital portal launched on 11 May 2020 enabling care homes to register for the delivery and collection of test kits directly. **(MD/JM2/73 - INQ000325277)**

d. A PPE portal for ordering PPE had been tested and was being rolled out. 2300 providers were to be invited to join by the end of the week of publication of the guidance.

e. Clinical support – The Department stepped up the clinical support available to care homes. This included ensuring there was a named clinical lead for every care home, better access to clinical advice and the delivery of weekly 'check ins' to review patients. Details of this had already been provided to local areas in the NHSE/I letter on 29 April 2020 **(MD/JM2/74 - INQ000325276).**

f. Local authority Care Home Support Plans – The Department ensured that every local authority had a plan to support care homes and was undertaking a daily review of data as part of this.

g. Building the workforce - The Department outlined our work to attract people into social care through our new national social care recruitment campaign, and the joinsocialcare.co.uk website.

The May Support Policy was accompanied by a letter from the Minister for Care to Council Leaders, Local Authority Chief Executives, Directors of Adult Social Services, Directors of Public Health, Care Home Providers and CCG Accountable Officers **(MD/JM2/75 - INQ000325280))**. This letter briefly set out what was contained in the May Support Policy and how government would work with local authorities to support care homes.

Timeline on the understanding of transmission

82. Until the 28 February 2020, when the UK reported its first case of unknown origin, case numbers remained small and all had known links to travel. It was considered very unlikely that people in care homes or the community would become infected given the community transmission rates thought to be prevalent at the time and the low chance of care home residents travelling abroad. By the end of February there was a cumulative total of 23

cases of COVID-19 identified in the UK. There were no reported outbreaks in care homes at this time.

Asymptomatic transmission

83. On 4 February 2020, a paper by PHE virology cell on asymptomatic transmission was presented to SAGE **(MD/JM2/76 - INQ000279879)**, this outlined that it would be reasonable to assume that the early stages of illness may have lower viral load. It also noted that the current available data was not adequate to provide evidence for major asymptomatic or sub-clinical transmission. SAGE advised that, '*Asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely'* **(MD/JM2/77 - INQ000106091)**. While asymptomatic transmission could not be ruled out, there was no substantial evidence to support it. This was further confirmed in the paper on the 24 February 2020 by the PHE National Infection Service which confirmed "*there is very limited evidence of transmission from asymptomatic cases* **(MD/JM2/78 INQ000325224)**. It is assumed that the substantial majority of transmission is from symptomatic individuals with SARS-CoV-2". This understanding of asymptomatic transmission continued until 20 March 2020, when the NERVTAG noted that, whilst there was data for people testing positive for SARS-CoV-2 without symptoms, there was very little information regarding transmission and the data from sporadic reports of asymptomatic transmission was not convincing **(MD/JM2/79 - INQ000119619)**.

84. On 10 March 2020, in response to a question from the RWCS Team on asymptomatic / pre-symptomatic individuals and potential infection, DCMO (Jonathan Van-Tam) advised "*The evidence that people shed virus and are infectious to others whilst in the pre-symptomatic stages is highly limited and inconclusive. It is not possible to say there are no cases ever of pre-symptomatic transmission, but in relation to transmission from people with established symptoms the force of infection from asymptomatic people is likely to be extremely low. I do not advise that we complicate our case isolation policy and, if we were to do so, the science on pre-symptomatic transmission would need re-visiting by SAGE and/or NERVTAG before we did so*". **(MD/JM2/16 - INQ000119619 , MD/JM2/17 INQ000325231)**.

85. On 24 March, version 7 of the PHE paper "*Are asymptomatic people with Covid-19 infectious*?" was produced. It described cases of asymptomatic infection, but said that these: "*do not provide evidence for asymptomatic transmission of SARS-CoV-2*" **(MD/JM2/80 - INQ000325259)**.

86. On 2 April 2020, WHO said that there were "*few reports of laboratory-confirmed cases who are truly asymptomatic, and to date, there has been no documented asymptomatic transmission*". WHO reported the presence of pre-symptomatic spread in a small number of case reports and studies **(MD/JM2/81 - INQ000325256]**.

87. A substantial evidence base began to build from the beginning of April. This developed as follows:

    a. On 3 April 2020, a very significant study was published by the US Centre for Disease Control and Prevention (CDC), based on outbreaks in care homes in Washington (published as an early release on 27 March **(MD/JM2/82 - INQ000325250)**. This was the first reference to evidence of asymptomatic and pre-symptomatic transmission of the virus. The authors had published an earlier report (published 27 March 2020, pre-print 18 March 2020) on a care home outbreak and its effects on the care homes residents, but this did not mention asymptomatic and pre symptomatic transmission of SARS-CoV-2 focusing on limitations in infection control and prevention and limitation of staff movement. The 3 April study concluded that "*Although these findings do not quantify the relative contributions of asymptomatic or pre symptomatic residents to SARS-CoV-2 transmission in facility A, they suggest that these residents have the potential for substantial viral shedding.*" This study increased the impetus for PHE to conduct its own studies in care homes, as soon as testing capacity became available to support this work.

    b. On 8 April a briefing note was published by LSE citing the pre-print of the Wei et al (2020) study below on pre-symptomatic transmission and the CDC papers discussed above. This referenced the growing asymptomatic transmission evidence base **(MD/JM2/83 - INQ000325331)**. As above, this added further impetus for PHE to conduct its own studies and work started on this from 9 April.

    c. On 10 April 2020, a further study was published by the CDC, by Wei et al, 2020 (published as an early release on 1 April). The study reviewed data from seven epidemiological clusters in Singapore and explored the issue of pre symptomatic transmission. The study concluded that in combination with

evidence from other studies, there was a "*likelihood that viral shedding can occur in the absence of symptoms and before symptom onset*", providing further weight to the evidence base **(MD/JM2/84 - INQ000325253)**.

88. From the 9 to 13 April 2020, PHE identified testing capacity at Colindale Laboratory in London to allocate tests to a care homes study, referred to as the "Easter 6 Study". PHE carried out two studies in care homes between 13 April 2020 and 24 April 2020 **MD/JM2/85 - INQ000325352**; **MD/JM2/86 - INQ000325353**; **MD/JM2/87 - INQ000325354**). The first was an enhanced surveillance study and swabbing in 95 care homes. The second was a whole genome sequencing study in six care homes (the "Easter 6 Study"). PHE was the first in the world to undertake these kinds of studies, which went significantly further than the research published by the CDC, studying both care settings with known outbreaks, those with no known cases and utilising whole genomic sequencing. The purpose was to understand better the transmission of the virus in care homes and inform urgent public health interventions.

89. As part of these studies, PHE assessed SARS-CoV-2 positivity in residents and staff at the care homes and followed them daily for two weeks. The resulting data found that 44.9% of the residents and staff tested had COVID-19 but were asymptomatic. It was the largest international dataset and strongest evidence to date showing that it was likely that the virus was being transmitted asymptomatically and that staff played a key role as a vector of asymptomatic transmission. The available data was analysed, and preliminary findings shared with the UK Senior Clinicians Group and the Departments as soon as these were available in the week commencing 13 April 2020. Similar studies seeking to explore asymptomatic infection were also underway during this period, with further studies conducted in a Military Barracks (440 individuals), as well as screening of 5000 individuals across 11 hospitals (**MD/JM2/88 - INQ000325283**).

90. Interim results and analysis from the enhanced care home outbreak study, the Easter 6 study (**MD/JM2/89 - INQ000325271**) and the Barracks study (**MD/JM2/90 - INQ000325272**) were presented at NERVTAG on 24 April 2020 **(MD/JM2/91 - INQ000325270))** and further analysis presented to SAGE on 12 May 2020. NERVTAG noted the evidence of the presence of virus was found in individuals without symptoms (**MD/JM2/92 - INQ000215622)**. NERVTAG concluded that there remained uncertainty around the level of transmissibility of asymptomatic cases and around cases that were truly asymptomatic as distinct from pre-symptomatic or mildly symptomatic. However,

scientific advisors recommended that steps should nonetheless be taken to protect vulnerable individuals in care settings from asymptomatic transmission.

91. This new evidence was significant as it highlighted that staff and residents could be asymptomatic and potentially transmit infection. The advice that scientists gave to Government on risk in care homes was updated in light of the international and national studies. From the publication of the CDC Washington study onwards, PHE applied a precautionary approach, and over the course of April, they began to advise that:

    a. There is likely to be a degree of asymptomatic transmission of COVID 19 in care homes in both residents and staff.
    b. By the time a single symptomatic case is identified in a home, the virus will probably already be circulating in the home amongst residents and staff. Temporary staff are likely to be vehicles for imported transmission with infections being imported into care homes and between care homes by staff, especially whilst the usual staff are self-isolating.

92. Over the course of the summer, studies continued to address this issue in the UK and globally, but still the evidence was mixed. SAGE and NERVTAG continued to consider the evidence.

93. On 3 July 2020, the "Vivaldi 1: COVID-19" care homes study found that 5,455 out of 6,747 of residents who took part in the Whole Care Home Testing Programme (of all 9,081 homes tested via pillar 2 between 11 May and 7 June) and tested positive for COVID-19 were asymptomatic **(MD/JM2/93 - INQ000106159)**.

94. It was not until 9 July 2020 that WHO published a report acknowledging asymptomatic transmission, but its conclusion was still that the scale of asymptomatic transmission remained unknown **(MD/JM2/94 - INQ000325284)**.

95. In early September 2020, NERVTAG noted that the evidence of asymptomatic transmission was still very mixed between studies, showing a wide variation in the proportion of infections that are symptomatic across different studies **(MD/JM2/95 - INQ000120434)**.

96. Even at the end of 2020 understanding of asymptomatic infection and transmission continued to be explored, in terms of the scale of asymptomatic infection and its role in transmission.

97. The current understanding is that SARS-CoV-2 has a much greater proportion of asymptomatic cases than previously seen with other coronaviruses

Understanding the impact of hospital discharge on COVID rates in care homes

98. There has been much public discourse about the discharge policy and assumptions that deaths in care homes were as a result of hospital discharge. This topic is also covered in the UK CMO's technical report in Chapter 8.2 **(MD/JM2/96 - INQ000087225)** which states that:

> *"Epidemiological and genetic evidence from across the UK suggests that for COVID-19 while some care home outbreaks were introduced or intensified by discharges from hospital, hospital discharge does not appear to have been the dominant way in which COVID-19 entered most care homes. Prior to testing being widely available, the risk of keeping care home residents in hospital at a time of increasing nosocomial infection risk needed to be balanced with the risk that they might already have acquired COVID-19 and introduce it to the care home. Nevertheless, hospital discharge to care homes connects 2 high-contact environments, and it was and should remain a high priority for preventive actions in similar pandemics."*

99. The Department commissioned a consensus statement on the association between the discharge of patients from hospitals and COVID-19 in care homes. SAGE published this report on 26 May 2022 **(MD/JM2/97 - INQ000107084)**, which found that discharge did not appear to be to have been the dominant way in which COVID-19 entered care homes:

> "*Any person infected with COVID-19 going into a care home could introduce infection into the care home. Hospital discharge to care homes connects 2 high contact environments, where contact rates with carers in the course of care are high, and potential consequences of COVID-19 in vulnerable populations severe. Overall, we*

interpret the identified studies as showing that at least some care home outbreaks were caused or partly caused or intensified by discharges from hospital. However, based on the very much larger associations between care home size (a proxy for all footfall) and outbreaks, hospital discharge does not appear to have been the dominant way in which COVID-19 entered care homes'.

100. There were further reports and studies which set out that the Department's policies which were and still are subject to challenge, were not a significant cause of deaths in care homes. Figures published by the Office for National Statistics (ONS) show that, since the beginning of the COVID-19 pandemic (2 March to 12 June 2020, registered up to 20 June 2020), there were 66,112 deaths of care home residents (wherever the death occurred) in England and Wales; of these, 19,394 involved COVID-19 **(MD/JM2/98 - INQ000325323)**. There has naturally been considerable public concern about the large number of people who died in care homes in the UK. Every decision-maker, official and scientist working on the pandemic response has been acutely aware that every death is a tragedy and has worked to mitigate the impacts wherever possible.

101. There have been some retrospective studies which looked specifically at the impact of discharge policies. The multiple available studies of this are in respect of England **(MD/JM2/99 - INQ000325322)**, Scotland **(MD/JM2/100 - INQ000325321)**, Wales **(MD/JM2/101 - INQ000325325)** and Northern Ireland **(MD/JM2/102 INQ000325326)**, where parallel instructions were issued. Whilst there was slight variation to the policies implemented across the four nations and the evidence is not conclusive, the various studies have indicated discharge policies were not responsible for a significant number of outbreaks in care homes in the UK. A summary of these is outlined below:

a. In respect to England, an unpublished PHE study has explored the impact of discharge on care homes. The study was requested by the Department and a SAGE subgroup, to investigate care homes that received COVID-19 positive patients discharged from hospital and subsequently experienced an outbreak (herein referred to as "hospital associated seeding of care home outbreaks"). The report utilised laboratory data of confirmed COVID-19 cases and existing data to derive residential status. In doing so, it identified cases residing in care homes. Hospital discharge records were linked to these records to identify care home residents who may have acquired their COVID-19 infection whilst in hospital, and where their care homes

experienced an outbreak of COVID-19 after their discharge. The report reached the following conclusions summarised below:

i. From 30 Jan to 12 Oct 2020, there were a total of 43,398 care home residents identified with a laboratory confirmed positive COVID-19 test result.
ii. Of these, 35,760 (82.4%) were involved in an outbreak (two or more positive cases), equivalent to a total of 5,882 outbreaks.
iii. 1.6% (n=97) of outbreaks were identified as potentially seeded from hospital associated COVID-19 infection, with a total of 806 (1.2%) care home residents with confirmed infection associated with these outbreaks
iv. The report went on to find that "*findings of this report suggest hospital associated seeding accounted for a small proportion of all care home outbreaks*".

b. The Scottish study concluded that it was the size of a care home that was the strongest predictor for an outbreak of SARS-COV-2. It said that *"after accounting for care home size and other care home characteristics, the estimated risk of an outbreak due to hospital discharge reduces."* No statistically significant association was found between hospital discharge and the occurrence of a care home outbreak. *"However, due to the uncertainty observed, we cannot rule out a small effect, particularly for those patients who were discharged untested or discharged positive"* **(MD/JM2/100 - INQ000325321).** Care home size was very strongly related to outbreaks. Of the care homes with 90 or more registered places, 90.2% had an outbreak, compared to just 3.7% of homes with less than 20 registered places.

c. The Welsh study found that the evidence did not support the hypothesis that the discharge instructions caused outbreaks. It demonstrated that SARS-CoV-2 outbreaks in care homes during the first pandemic surge correlated better with SARS-CoV-2 admissions rates during the same week than with the numbers of people discharged to care homes. In other words, they correlated with general community transmission and infection rate. The exposure to hospital discharge was not associated with a significant increase in the risk of a new outbreak. **(MD/JM2/101 - INQ000325325).** When stratified for care home size, the outbreak rates were similar for periods when

homes were exposed to a hospital discharge, in comparison to periods when homes were unexposed.

d. In Northern Ireland, researchers concluded that there was no evidence to support a view that Ministerial or Departmental communications actually changed consultants' clinical decisions around discharge during the first pandemic surge, including decisions to discharge people to care homes **(MD/JM2/102 - INQ000325326).** Consultants indicated decisions were made based on a clinical decision, independent of any external influence.

e. An interim conclusion published by the SAGE Social Care Working Group on 23 September 2020 based on studies available at the time of the publication stated that "*the weight of evidence is stronger in some areas than others, however evidence of staff to staff transmission has emerged in the genomic analysis (high confidence). Weak evidence on hospital discharge (…) does not suggest a dominant causal link to outbreaks from (this) source*". On 30 October, NHSE National Medical Director Professor Stephen Powis wrote to the Public Accounts Committee setting out some of the available evidence. **(MD/JM2/103 - INQ000325330)**

102. More broadly, evidence regarding causes of infection in care homes has demonstrated a direct correlation between care home incursions and community levels of infection **(MD/JM2/104 - INQ000325312)**. Whilst comparisons are difficult, international studies also show a clear correlation both in the UK and elsewhere between the levels of care home deaths and the levels of community deaths.

103. Significant measures have been implemented during the course of the pandemic to mitigate the impacts of COVID-19 on individuals within care settings.**(MD/JM2/105 - INQ000325346)** This includes measures to protect against incursion from staff within care homes, including a wide range of staff testing programmes. Despite these measures, the impacts of COVID-19 continued to be experienced by those living within care homes. Care homes operate as a window to the wider local community, and despite all measures have remained susceptible to the experience of the wider population since the First Wave.

SECTION 2: BEYOND THE FIRST PHASE (JULY 2020 TO FEBRUARY 2022)

104. Beyond the first phase, the Department's planning was underpinned by the Social Care Sector COVID-19 Support Taskforce report which formed the basis of the Department's Winter Plan 2020/21. During winter 2020/21, as well as implementing the published Winter Plan, the Department introduced new policies and interventions in response to further COVID-19 developments and as increased testing capacity and vaccines became available.

105. The evidence suggests that this approach was effective in reducing the impact of the virus in care homes during the second wave.

> *"While COVID-19 accounted for around 40% of all deaths of care home residents between April and June 2020 in the first wave of the pandemic, it accounted for only a quarter (26%) of all care home resident deaths between September 2020 and February 2021 in the second wave This compares with a global average of 41% between March 2020 and January 2021 (This is based on 22 countries, from the start of the pandemic, updated to various different dates the latest of which is the 25 January 2021, from the International Long Term Care Policy Network report.) Whilst cause and effect is difficult to unpick, the evidence strongly suggests that the actions taken since the beginning of the pandemic, including those outlined in the winter plan, have had a significant impact in reducing risk"* **(MD/JM2/106 - INQ000279947)**.

106. Beyond the second wave, the effect of vaccines and other measures to protect care users reduced hospitalisations and excess deaths in care homes further **(MD/JM2/107 - INQ000325347)**.

107. In this part of the statement, we:

a. Explain the background to the report of the Social Care Sector COVID-19 Support Taskforce and the Department's Winter Plan for 2020/21.

b. Summarise the papers and minutes from the regular COVID Operations Committee (COVID-O) meetings on adult social care which took place in autumn 2020/ spring 2021 (and related ministerial correspondence). These were the formal means by which key decisions on adult social care were taken during this period and illustrate how the Department was both implementing the published Winter Plan and introducing new interventions.

c. Provide more detailed information on decision making in two areas of particular sensitivity: visiting in care settings; and making vaccines a condition of deployment in adult social care.

d. Cover briefly the development of the Winter Plan 2021/22 and work in relation to Omicron.

The Social Care Sector COVID-19 Support Taskforce

108. The Social Care Sector COVID-19 Support Taskforce (the Taskforce) was established on 8 June 2020. The Taskforce replaced the National Adult Social Care and COVID-19 Group, which had been established in March 2020 to oversee the development and execution of the Department's preparations for adult social care during the COVID-19 pandemic.

109. Sir David Pearson, former President of the ADASS, chaired the Taskforce, reporting to the Minister of State for Care. Taskforce membership consisted of leaders from across government and the sector: DHSC; MHCLG; NHSE/I; the Care Quality Commission (CQC); PHE; Cabinet Office; LGA; Care Provider Alliance; ADASS; Unison; Association of Directors of Public Health (ADPH); Healthwatch England; Think Local Act Personal; and Carers UK.

110. Eight advisory groups to the Taskforce were established in parallel, to widen the depth of advice in relation to: people with learning disabilities and autistic people; older people and people living with dementia; mental health and wellbeing; self-directed support; carers; minority ethnic communities; workforce; good practice, guidance and innovation.

111. The Terms of Reference of the Taskforce **(MD/JM2/108 - INQ000325349)** were to ensure the delivery of the Social Care Action plan and the Care Home Support Package. The remit of the Taskforce was also to consider the impact of COVID-19 on the care sector over the next year, and advise on a plan to support it through this period **(MD/JM2/109 - INQ000325282)**.

112. The Taskforce met for the first time on 18 June 2020, fortnightly between 18 June 2020 and 12 July 2020, then weekly until the final meeting on 26 August 2020. These meetings

were supported by a daily operational group, a weekly planning group, and additional workshops as required to cover specific issues.

113. The final report of the Taskforce was published on 18 September 2020, alongside reports from each of its advisory groups, which were considered in tandem as an extension of the main report **(MD/JM2/110 - INQ000087229)**. The report contained 52 recommendations across: PPE; testing; flu vaccination; workforce and family carers; funding; evidence and guidance; communications; clinical support; movement of people between care and health settings; inspection and regulation; capacity, expertise and information; use of data and digital; national, regional and local structures; care home support plan; adult social care action plan; managing community outbreaks and the response of social care; planning for the next phase of the pandemic.

114. The recommendations were directed at a range of organisations and groups across the health and care system, including the Department, HM Treasury, local authorities, the CQC and the NHS.

Development of the Winter Plan 2020/21

115. In parallel to supporting the Taskforce to reach its conclusions and produce its final report, officials were tasked on 17 July 2020 by the Secretary of State to work on a Winter Plan 2020/21 for adult social care.

116. The Winter Plan therefore was positioned to translate recommendations from the Taskforce into an operational plan as well as provide a framework to bring together elements of the adult social care COVID-19 response that had been published separately up to that point, into one coherent document.

117. COVID-O considered the Winter Plan on 15 September 2020 **(MD/JM2/111 - INQ000058320)**. It approved the publication of the plan **(MD/JM2/112** **INQ000090180** **)**. In the light of a concerning uptick in positive cases in care homes and in response to a Prime Ministerial request of 14 September 2020, it also looked at more radical options going beyond the Winter Plan. Of these, it agreed that the following should be implemented: further enforcement powers relating to care homes including on staff movement; strengthening of the CQC inspection regime; publishing data at an individual care home level on how much testing had been undertaken and how many of them were positive tests; exploring a measure to ensure that no patient was discharged to a care home unless they tested negative (the existing policy was that those testing positive

could be discharged to a care home if they were isolated). On this final point, following a discussion with the Prime Minister on 18 September 2020, it was decided instead to set up designated settings into which COVID-19 positive patients could safely be discharged **(MD/JM2/113 INQ000325287)**.

118. On 18 September 2020 the Department published the Winter Plan 2020/21 **(MD/JM2/114 - INQ000058216)**. The plan set out the government's priorities for adult social care and key elements of national support available for the adult social care sector for winter 2020/21, as well as the main actions for local authorities and adult social care providers. The key national policies and support actions were:

a. Provide over £500m of additional funding to extend the Infection Control Fund to March 2021, to help the care sector restrict the movement of staff between care homes to stop the spread of the virus.

b. Lead and coordinate the national response to COVID-19 and provide support to local areas, where needed, as set out in the Contain Framework.

c. Appoint a Chief Nurse for Social Care to the DHSC.

d. Create, with the CQC, a designation scheme for premises that were safe for people leaving hospital who had tested positive for COVID-19 or were awaiting a test result.

e. Continue to develop and publish relevant guidance.

f. Continue to deliver and review the social care testing strategy in line with the latest evidence, scientific advice on relative priorities and available testing capacity. Work to improve the flow of testing data to everyone needing it.

g. Provide free PPE for COVID-19 needs in line with existing guidance to care homes and domiciliary care providers via the PPE portal until the end of March 2021. And provide free PPE to LRFs and local authorities to distribute to social care providers ineligible for the PPE portal.

h. Make available for free and promote the flu vaccine to all health and care staff, personal assistants and unpaid carers.

i. Play a key role in driving and supporting improved performance of the system, working with local authorities and the CQC to strengthen CQC's monitoring and regulation role to ensure infection prevention and control procedures were taking place.

j. Publish the new online Adult Social Care Dashboard, bringing together data from the Capacity Tracker and other sources, allowing critical data to be viewed in real time at national, regional and local level by national and local government.

k. Publish information about effective local and regional protocols and operational procedures based on what had been learnt so far to support areas with local outbreaks and/or increased community transmission.

119. The key national actions for the NHS were that Primary Care Networks (PCNs) – working with community healthcare providers – became responsible for delivering the Enhanced Health in Care Homes Framework. This built on the COVID-19 care home support service announced in May, and included:

a. Timely access to clinical advice for care home staff and residents, including a named clinical lead from the PCN for every care home, and weekly multidisciplinary team support.

b. Support for care home residents with suspected or confirmed COVID-19 through remote monitoring, and face-to-face assessment where clinically appropriate.

c. Training and development for care home staff.

Implementation of the Winter Plan 2020/21

120. Throughout autumn 2020 and spring 2021, there were regular meetings of the COVID-O Committee to consider adult social care. These meetings considered the latest Covid data in care homes, tracked progress with implementation of the Winter Plan 2020/21 and, as new issues arose, provided the mechanism for Cabinet decision-making on adult social care policy.

121. A summary of these meetings is set out below.

COVID-O meeting of 6 October 2020 **(MD/JM2/115 - INQ000325288) (MD/JM2/116 - INQ000090171)**

122. This was the first meeting after the publication of the Winter Plan. It looked at data on the COVID-19 situation in care homes at the time and reviewed the programme of Winter Plan implementation.

COVID-O meeting of 23 October 2020 **(MD/JM2/117 - INQ000090126) (MD/JM2/118 - INQ000325290)**

123. This meeting focused on:

a. Enforcement and action to drive local performance, in particular data on staff self-isolation and CQC IPC inspections.

b. Testing. The paper included operational data on how quickly PCR tests from care homes were being turned around, what percentage of care homes were not adhering to the testing regime and on both points what could be done to drive up performance. COVID-O asked for the plan and timetable for more effective/quicker testing methodologies.

c. The progress in setting up of discharge and isolation units (designated settings) for the discharge of Covid positive individuals from hospital.

d. Visiting. The paper summarised a SAGE adult social care working group consensus statement on the evidence on visiting, covering beneficial impacts and the relative contribution of visiting in transmission risk. It noted that new visiting guidance had been introduced on 15 October 2020 and that options to permit more visiting were being worked up including through the use of testing of regular visitors.

COVID-O meeting of 17 November 2020 **(MD/JM2/119 - INQ000090928**

124. The paper for this meeting provided the latest data on the state of COVID-19 in care homes. It also provided an update on the implementation of the Winter Plan: the paying out of the £546 million infection control fund; number of CQC IPC inspections; social care access to the PPE Portal; progress on care home compliance with testing and testing turnaround times; expansion of testing to visitors, visiting professionals such as CQC inspectors and to other parts of social care e.g. domiciliary care; progress on a

consultation to limit staff movement between social care settings, on paying staff sick pay, on the creation of designated settings and on NHS support for care homes.

125. The paper focused in on two policy issues. First on visiting where it noted the existing rules set out in the guidance for the period of national restrictions issued on 5 November 2020. These allowed outdoor visits and indoor visits with a screen as well as visits in exceptional circumstances. The paper noted that the end of national restrictions meant more visiting and a return to the tiered approach. It said that the objective by Christmas was to enable each resident to receive visits including close contact through the roll out of testing, except where there was an active outbreak of COVID-19 in a home. Second, the paper noted the Joint Committee on Vaccination and Immunisation (JCVI) interim advice on vaccine prioritisation with older adults resident in a care home and care home workers in priority one and all other social care workers included in priority two, and it considered the likely delivery route for vaccines.

126. This paper was prepared for COVID-O but the adult social care meeting was cancelled. However, it shows the issues that the Department was grappling with at the time in question.

COVID-O meeting of 8 December 2020 **(MD/JM2/120** **INQ000325294** **) (MD/JM2/121 -** **INQ000091044** **)**

127. The focus of this meeting was adult social care COVID-19 testing. There were updates on action to drive compliance with the testing regime and a progress report on testing turnaround times. But the main focus was the ramping up of testing for adult social care from 120,000 tests to 776,500 tests per day to support all parts of the adult social care sector. An important part of this was Lateral Flow Device (LFD) tests to support visits into care homes and the paper noted that the Department expected all care homes to be able regularly to test visitors by 18 December 2020 although the delivery was complex and there were many risks. The paper also noted that the tests would support working age adults to leave care homes to join their families for Christmas in support of the new guidance that had been published on 1 December 2020.

128. A report on progress in implementing the Winter Plan was provided: the number of designated settings including by region; progress on PPE and IPC training; progress on driving up the payment of sick pay; and the number of CQC inspections/amount of enforcement action. On restricting staff movement, it was noted that responses to the

consultation indicated that providers considered the proposals would be very difficult to implement and there were ongoing discussions with HM Treasury about compensation.

COVID-O meeting of 11 January 2021 **(MD/JM2/122** **INQ000325299** **) (MD/JM2/123 -** **INQ000325297** **))**

129. The context for this meeting was the sharp increase in positive rates but also the beginning of the vaccine roll out in care homes. The paper noted a survey from December which suggested that staff willingness to be vaccinated was mixed and that the Department was therefore doing extensive work to encourage take up but was also considering harder levers that could be deployed if take up was lower than expected. The paper noted the action that had been taken to mitigate the impact of the new variant on care homes including the introduction of LFD testing for care home staff (supported by £149 million of extra funding) and the stopping of visits in Tier 4 areas ('stay at home' alert level).

130. On the workforce side, the paper noted that key sector partners were now unlikely to support regulations to restrict staff movement given acute workforce capacity issues and that this would instead be promoted through communications. There was also a reference to developing a new proposal for funding to support workforce capacity. This became the £120 million workforce capacity fund. In addition, updates were provided on Winter Plan areas: sick pay; testing; delayed discharge; designated settings; CQC inspections; and PPE. There was also an update on the development of a possible indemnity in the light of a significant contraction in the adult social care insurance market.

131. A follow up action from the COVID-O meeting of 11 January 2021 was to provide a report for the Prime Minister on all the key issues covered at the meeting **(MD/JM2/124** **INQ000325301** **)**. This was sent on 20 January 2021. It was followed by a deep dive into adult social care at the regular Prime Minister dashboard meeting on 25 January 2021 **(MD/JM2/125 -** **INQ000325302** **; MD/JM2/126 -** **INQ000325304** **)**. The Minister of State for Care wrote to the Prime Minister on 29 January to follow up on the issues discussed on 25 January 2021 **(MD/JM2/127 -** **INQ000325305** **)**: restricting staff movement and the justification for using guidance rather than regulation; CQC action following the discovery that some COVID-19 positive staff were continuing to work because of workforce pressures; staff vaccination and the parallel work to encourage further uptake and work up potential regulatory approaches.

COVID-O meeting of 10 February 2021 **(MD/JM2/128 - INQ000325298)**

132. The paper for this meeting set out the data on COVID-19 prevalence in care homes. It also provided data on vaccine roll out in care homes, noting that the proportion of staff vaccinated lagged residents particularly in London. The paper noted that the Department was urgently gathering more data/evidence on the reasons for vaccine hesitancy and significant activity was under way to persuade staff to be vaccinated.

133. On the question of regulatory options, a further paper was provided. This said that the case for requiring the care home workforce to be vaccinated would be (1) to protect care home residents as among the most vulnerable to the virus (2) because of the emerging evidence of reluctance on the part of the staff to be vaccinated. The case was further strengthened by emerging evidence of the effectiveness of COVID-19 vaccines. The paper set out four options for mechanisms to make COVID-19 vaccines a condition of work in care homes. It noted that there was a risk to an already fragile workforce if care home workers opted to leave rather than have the vaccine and that the Department was modelling this potential impact. The initial focus was to be on care home workers as they had been at the vanguard of the vaccination programme, prioritised by the JCVI and as there was more robust data on the take up of the vaccine of this group. But there would potentially be a logical extension to the NHS and wider social care workforce, as well in relation to the flu vaccine.

134. In addition, the main paper for this COVID-O meeting provided an update on: the £120 million workforce capacity fund; staff pay; staff movement; designated settings; infection control; and testing. It also noted a possible call to action such as for those on furlough and for military assistance to support the workforce. On visiting, the paper noted that the Department was taking swift action to open up some indoor visiting ahead of the lifting of national restrictions through enabling a single named visitor to visit each resident, supported by testing and PPE.

135. These papers were prepared for COVID-O but the meeting was cancelled. **(MD/JM2/129 - INQ000325306)** However, it shows the issues that the Department was grappling with at the time in question.

COVID-O meeting of 18 February 2021 **(MD/JM2/130 - INQ000325307; MD/JM2/131 - INQ000325308)**

136. This COVID-O meeting considered the care home visiting policy and other measures for inclusion in the 22 February 2021 COVID-19 strategy position. The paper set out the

existing guidance on visiting and the case for expanding visiting from 8 March 2021 to a single named visitor as well as the risks of this. The Committee agreed to the single named visitor proposal. It also agreed to taking a decision no later than mid-April 2021 as part of the next Roadmap stage, on whether to encourage providers to allow more visiting based on an assessment of the latest data at that point, and said that the Department should set out its criteria to enable more visiting in the 22 February 2021 publication. The paper also set out the funding that was coming to an end in March 2021 (Infection Control Fund, Workforce Capacity Fund, discharge funding that was supporting designated settings) and the case for extending these funds. The Committee asked the Department to work with HM Treasury on a potential extension likely to a Budget timescale.

Correspondence from the Minister of State for Care, to the Prime Minister **(MD/JM2/132 - INQ000325309)**

137. On 25 February 2021, the Minister of State for Care wrote to the Prime Minister setting out the latest data on vaccine take up, measures that the Department was taking to make it as easy as possible for care workers to access the vaccine and approaches to address fear and hesitancy. The letter also set out the option to use secondary legislation to make vaccination a condition of deployment in care homes. It highlighted the risk around the workforce and that the DCMO (Jenny Harries) had warned that this kind of approach could undermine trust and confidence in the vaccine programme. The letter said that, if the Department was to go down this route, it would be best to do it as part of a drive to raise appreciation of care workers e.g., guaranteed sick pay, which would have cost implications. The point about the logic of extending to the NHS and wider social care was made. Finally, the letter referred to exploring lighter touch options for example using statutory guidance.

Visiting

138. During this period (July 2020 to February 2022), there was an enormous focus on visiting in care settings. The Department was trying to balance benefits and risks – the benefits of visiting in terms of a resident's health and wellbeing against the risk of disease coming into care settings – in a fast moving situation where national guidance was frequently changing in response to COVID-19 developments. The difficulty of striking the right balance between protecting residents' physical health and their mental wellbeing is illustrated by the fact that the Department was both judicially reviewed for failing to shut

down visiting early enough in the first wave and received a number of pre-action-protocol letters in late 2020 challenging guidance for not allowing enough visiting.

139. There were many discussions between officials, DCMO (Jenny Harries), PHE and the Minister of State for Care on this issue. In these discussions, the challenge was always whether there were changes or even tweaks that could be made to visiting policy that would enable more visiting whilst still keeping residents safe. This, together with changes to national restrictions flowing from COVID-19 developments, meant that there were many changes to visiting policy during the period between July 2020 and February 2022, as is set out below. Decisions went through collective agreement processes – normally COVID-O Committee meetings to agree policy as part of wider discussions on national restrictions, and Cabinet Office/No.10 to clear publications.

140. The Department held regular stakeholder meetings on care home visiting, including with representatives of care providers and charities, ADASS, ADPH and the CQC. Stakeholders were broadly in favour of loosening guidance but within that there were different levels of caution. The Department also worked very closely with stakeholders on how the guidance would be implemented.

141. The table below outlines all changes made over the course of the pandemic from July 2020 onwards to the approach to care home visiting.

142. It is important to recognise the context in which these decisions were being taken. To take the example of 5 November 2020 guidance. The SAGE Adult Social Care Working Group published a consensus statement on visiting on 2 November 2020 **(MD/JM2/133 - INQ000215625)**. This cited evidence that isolation had a strong negative impact on quality of life. Evidence was weaker on the risk of introduction and transmission of COVID-19 infection from visitors. Further work through the commissioning of new studies was needed. In the meantime, it concluded: "*there is no existing simple solution to balance quantifiably both harm and benefit to inform policy development*".

143. The risk posed by COVID-19 at this time was high - on 31 October 2020 the Prime Minister had announced a new lockdown. Ministers, policy officials, the DCMO (Jenny Harries) and PHE sought to balance these considerations. It was decided that, during the period of national restrictions, the sector would be supported to increase opportunities for virtual visiting and visiting where people could see each other through a window, using a pod or with a screen between them. Options to be more permissive

were considered at that point but decided against due to the high rates of COVID-19. However, when rates in the general population declined and testing was available for visitors, it was agreed it would be clinically appropriate to encourage care homes to enable carefully managed in-person visits for a single regular visitor per resident.

Date	Event	Policy/guidance change
22 July 2020	The Department published first dedicated guidance on visiting into care settings **(MD/JM2/134 - INQ000325285)**	• Stated that providers, based on the advice of their Director of Public Health, should take a risk-based approach to allow visiting where safe • Asked providers to develop a policy for limited visits from a single constant visitor per resident where community transmission rates were low • Advised against visiting in areas of high prevalence • Stated that where there was an outbreak, providers could impose visiting restrictions, but should consider options to maintain social contact
15 October 2020	Guidance updated after publication of the Winter Plan **(MD/JM2/135 - INQ000325289)**	• Set out role of local Directors of Public Health on visiting • Set out tightened infection, prevention and control measures, including enhanced PPE, testing and social distancing • Introduced limits on visiting to 2 constant visitors per resident • Stated where there was an outbreak or evidence of community hotspots or local lockdown, visiting restrictions should be imposed, subject to exceptional circumstances only such as end of life
5 November 2020	Guidance updated at the start of the national lockdown **(MD/JM2/136 - INQ000325291)**	• Set out role of providers in assessing risk subject to advice from local Director of Public Health • Advised on options for visiting, which included the use of visiting pods, screens, windows, outdoor settings, and video calls
1 December 2020	Guidance updated at end of the national lockdown, and first dedicated guidance	• Set out role of local Directors of Public Health and Directors of Adult Social Services in supporting visiting unless good evidence to take a more restrictive approach in a particular care home

	on visiting out of care settings published (**MD/JM2137 - INQ000325293**; **MD/JM2/138 - INQ000325292**)	• Introduced testing for visitors prior to entry to the care home (alongside existing infection, prevention and control measures) • Advised that working age residents could join their families in their homes subject to an individual risk assessment, negative test before leaving, and self-isolation upon return • Advised that working age residents could form a bubble with one other household (not a three-household Christmas bubble)
19 December 2020	Guidance updated with the creation of Tier 4 (MD/JM2/**139 INQ000325295**; **MD/JM2/140 - INQ000325296**)	• Stated that all care homes, regardless of tier, and except in the event of an active outbreak, should seek to enable outdoor visiting and screened visits • Stated that care homes in tier 1, 2, or 3, except in the event of an active outbreak, should enable indoor visits where the visitor had a negative test result • Gave information on visiting out of care homes in tier 4
12 January 2021	Guidance updated at the start of national lockdown **(MD/JM2/141 - INQ000325221**; **MD/JM2/142 - INQ000325300**)	• Stated that all care homes, except in the event of an active outbreak, should enable outdoor visiting and screened visits, and visits in exceptional circumstances including end-of-life should always be enabled • The visiting out guidance reflected the national stay at home guidance with visits out supported only in exceptional circumstances
8 March 2021	Guidance updated at the point of step 1 of the national roadmap out of lockdown **(MD/JM2/143 - INQ000325310**; **MD/JM2/144 - INQ000325311**)	• Stated that every care home resident should be able to nominate a single named visitor to have regular visits • Advised on additional arrangements for essential care givers who would provide a greater degree of personal care • The visiting out guidance reflected national restrictions (i.e., visits outdoors), and set out the need to self-isolate for 14 days upon return

12 April 2021	Guidance updated at the point of step 2 of the national roadmap out of lockdown **(MD/JM2/145 - INQ000325319; MD/JM2/146 - INQ000325320)**	• Increased the number of named visitors to two
4 May 2021	Supplementary guidance published to continue easing restrictions **(MD/JM2/147 - INQ000325329)**	• Stated that residents could leave their care homes to spend time outdoors without the need to self-isolate on return
17 May 2021	Guidance updated at the point of step 3 of the national roadmap out of lockdown **(MD/JM2/148 - INQ000325333; (MD/JM2/149 - INQ000325332)**	• Increased the number of named visitors to five • Stated that residents could go to medical appointments (excluding overnight stays in hospitals), a workplace, educational settings, and day centres without a period of self-isolation upon return
21 June 2021	Guidance updated during step 3 **(MD/JM2/150 - INQ000325337; MD/JM2/151 - INQ000325336)**	• Permitted residents to stay overnight out of their care home without a period of self-isolation upon return (unless the visit was high-risk or involved an overnight stay in hospital)
19 July 2021	Guidance updated at the point of step 4 of the national roadmap out of lockdown	• Removed restrictions on visitor numbers (overall or on any one day)

	(MD/JM2/152 - INQ000325339 MD/JM2/153 - INQ000325338)	
16 August 2021	Guidance updated at the point of national changes to self-isolation regulations **(MD/JM2/154 - INQ000287661) (MD/JM2/155 - INQ000325340)**	• Stated that visitors to care homes should avoid visiting for their would-be self-isolation period if they were identified as a close contact of someone with COVID-19 (national guidance said fully vaccinated individuals would no longer need to self-isolate)
25 November 2021	Guidance updated to increase clarity **(MD/JM2/156 - INQ000287688)**	• Emphasised that there were no national restrictions on visiting and providers should facilitate visits wherever possible • Advised on how care homes could support residents on visits out of the home
14 December 2021	Guidance updated at the point of increased prevalence due to the Omicron variant **(MD/JM2/157 - INQ000287702)**	• Limited the number of visitors each resident could receive to 3 (not including essential care givers or preschool age children) • Required residents to test or self-isolate following visits out of the care home (depending on their vaccinations status) • Changed testing arrangements for essential care givers to align with arrangements for staff
31 January 2022	Guidance updated at the point of evidence on the impact of Omicron **(MD/JM2/158 - INQ000287738)**	• Removed the limit on visitor numbers • Removed the need for residents to test or self-isolate following a normal visit out • Advised residents to self-isolate for 10 days, with testing arrangements to end isolation sooner, following an emergency hospital stay or high-risk visit out

Vaccination as a condition of deployment and developments from March 2021

144. This section of the witness statement explains the policy making on making vaccination a condition of deployment (VCOD) in social care. The aim of the policy was to protect

the most vulnerable given evidence of the effectiveness of the vaccines and concerns about vaccine hesitancy amongst staff, alongside extensive efforts to persuade staff of the benefits of having the vaccine. The Department always recognised there was a balance to struck between the aim of protecting the most vulnerable on the one hand and individual rights of care workers and risks to workforce capacity on the other. This balance changed with the advent of the Omicron variant which was less severe and where vaccines were less effective. In the light of this, the Department changed the policy and revoked the relevant regulations.

145. This next section of the witness statement provides detail on key decision making from March 2021 onwards, both through COVID-O discussions and more generally. There had already been significant discussions on VCOD in earlier 2021. Decision making was informed throughout by the best up to date scientific and clinical evidence available to government. The Department worked very closely with Éamonn O'Moore, the Senior Responsible Officer (SRO) at PHE for the response to COVID-19 in adult social care, and with the DCMO (Jenny Harries).

COVID-O meeting of 17 March 2021 **(MD/JM2/159 - INQ000325316) (MD/JM2/160 - INQ000091817)**

146. This meeting was focused on VCOD in adult social care and health settings. The paper noted that the Prime Minister and the Secretary of State had discussed this issue several times and wanted to put in place legislation to require vaccination among the care workforce, in order to reach a position of much greater safety for care recipients. The paper considered how to implement this policy through secondary legislation, including the need for consultation. Reference was also made to the fact that there were moves by some larger care providers to require staff to be vaccinated and that the public/media was increasingly supportive of a requirement for vaccination. The Secretary of State's view was that the focus should first be on older adult care homes and later broaden to other social care workers and health care workers.

147. The paper noted that SAGE had advised that the safe level of vaccination in each care home was 90% for residents and 80% for staff and these levels had not been reached, particularly in London. The proposition was therefore to create a legal requirement, whilst continuing to pursue all other softer levers (detail on the significant programme of work to improve access to vaccines and address vaccine hesitancy was provided in the annex). The rationale for this was not only the lagging uptake of the vaccine but also (1) the vulnerability of care home residents, considered by JCVI along with their carers to be

the top priority group for vaccination (2) the fact that most care home residents were in their final years of life and stood to lose what remaining time they had left (3) the nature of care homes, as closed environments where COVID-19 could spread rapidly with devastating consequences.

148. The Committee agreed to the proposals to introduce secondary legislation in relation to those working in older age residential care homes, noting that they were in JCVI cohort one and had access to the vaccine for the longest time. As well as scope, the paper also discussed the optimal legal route for delivering the policy, the workforce risks, the legal risks around vires, human rights and proportionality (plus the development of a Public Sector Equality impact assessment) and the ethical risk. On this last point, the paper proposed that the issue be brought before the next meeting of the MEAG on 31 March 2021 **(MD/JM2/161 - INQ000325318).**

149. Following this meeting, on 24 March 2021 the Chancellor of the Duchy of Lancaster (CDL) wrote to the Prime Minister setting out COVID-O's proposals following the meeting together with the risks of proceeding with VCOD. As explained in this letter, as older-age individuals in residential care homes were "*the highest priority cohort identified by the JCVI, it is imperative to do everything we can to protect this extremely vulnerable group*" **(MD/JM2/162 - INQ000325317)**. It was therefore agreed to run a public consultation on the proposals.

COVID-O meeting of 15 June 2021 **(MD/JM2/163 - INQ000091970 ; MD/JM2/164 - INQ000092238**

150. This meeting was focused on VCOD in adult social care and health settings. The paper noted that a consultation on VCOD for those working in residential care homes with residents over the age of 65 had been launched on 14 April 2021 and had closed on 26 May 2021. The rationale relating to lagging uptake was still a factor - only 64% of care homes were meeting the SAGE threshold (and much lower in London). Given the responses to the consultation, the paper proposed changing the scope of the policy to cover all care homes, not just those with residents over the age of 65 and to include a wider range of people coming into care homes, although not visitors. The paper noted the preparation of an Equality Impact Assessment. It also discussed the workforce risk and the assessment, based on survey data, that 3-7% of the workforce would leave because of the vaccine requirement and ways of mitigating this. The Committee agreed that the Department should proceed with the proposed regulations.

151. On 22 June 2021 the consultation response on the Department's VCOD proposals for care homes was published **(MD/JM2/165** **INQ000325334** together with an Equality Impact Assessment **(MD/JM2/166** **INQ000325335**, and the Department laid the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 before Parliament. The regulations were made on 22 July 2021. There was full Parliamentary scrutiny of the changes brought in by the Department, including debates in both Houses of Parliament, as well as an appearance by Minister Zahawi at the Secondary Legislation Scrutiny Committee on 13 July 2021.

152. The policy came into effect on 11 November 2021. Extensive work was carried out by the Department over the summer and into the autumn to gather data from providers and local authorities on progress with vaccination uptake and actions put in place to mitigate the potential impact of VCOD. The Department, working closely with the UK Health Security Agency (UKHSA), NHSE, ADASS, LGA, CQC and sector representatives, made available a range of bespoke resources to support care homes and local authorities engage with their staff, residents and families. The Department also facilitated several webinars with DCMO (Jonathan Van-Tam), NHSE, UKHSA and CQC to address vaccine hesitancy and support uptake. Additionally, the Department's Regional Assurance Team worked closely with individual local authorities to quality assure data on vaccine uptake, identify and escalate areas of concern, work with funded partners to provide support and guidance where appropriate and promote the need for robust contingency planning at regional level. The Department also provided £25 million specifically to support care workers to access COVID-19 and influenza vaccines as part of the third round of the Infection Control & Testing Fund (ICTF) announced on 30 September 2021. On 21 October 2021, the Department announced a £162.5 million Workforce Retention and Recruitment Fund. This was intended to help the adult social care sector with workforce pressures including those which resulted from the VCOD policy.

Extending VCOD across health and wider social care

153. COVID-O had agreed in June 2021 with the Department's proposal to launch a separate follow up consultation on extending the VCOD regulations across health and wider social care and make them apply to flu as well as COVID-19. In relation to applying VCOD to wider social care settings, it was noted that the risk of outbreaks was much lower than for those living in care homes and that the workforce implications were likely to be greater. But the strong feedback from social care stakeholders to the first consultation was that, if the rationale was to protect those most vulnerable to COVID-19,

it should be extended more broadly to the health and wider social care sectors. Others argued similarly on the basis of simplicity and parity between health and social care settings.

154. The Department then ran a second public consultation from 9 September 2021 to 22 October 2021 regarding whether to make COVID-19 and flu vaccination a condition of deployment within health and wider social care settings **(MD/JM2/167 - INQ000257101).**

155. The Secretary of State wrote a personal minute to the Prime Minister on 28 October 2021 saying that, having carefully considered the response to consultation and advice from officials, his view was that VCOD was essential as part of confidence in health and care services **(MD/JM2/168 - INQ000325343).** COVID-O considered the issue on 9 November 2021. The paper stated that the basis for the policy was evidence that vaccination reduced the likelihood of infection and therefore helped break chains of transmission. The paper further noted: that the Department was recommending proceeding with VCOD in relation to COVID-19 but not flu; the proposed scope of the policy; the proposed implementation date; and risks around workforce and potential mitigations. COVID-O agreed that the Department should proceed with the regulations as proposed and should draw up a detailed delivery plan as well as supporting local systems to develop local workforce mitigation strategies.

156. Later that day (9 November 2021) the Department published its consultation response on VCOD **(MD/JM2/167 - INQ000257101)** and laid regulations to amend the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations to introduce vaccination as a condition of deployment across all CQC regulated settings. The regulations were approved by Parliament on 14 December 2021 and made on 6 January 2022. A 12-week grace period was imposed to allow time for providers to engage with their staff and the plan was that regulations would not come into force until 1 April 2022.

Revoking Vaccination as a Condition of Deployment

157. This initial decision to extend VCOD was kept under review and, in the event, the revised policy was not pursued due to the changing evidence available to government.

158. On 31 January 2022 a meeting of COVID-O was presented with a paper on the new evidence in relation to Omicron **(MD/JM2/169 - INQ000325344).** UKHSA data showed that the effectiveness of all vaccines against symptomatic infection was lower against

Omicron compared to Delta and waned rapidly. It was therefore very likely that the effect of VCOD as a means of protecting patients and people with care needs was less than it had been against previous variants. In addition, the population as a whole was better protected against Omicron compared to Delta, with markedly lower levels of hospitalisation and mortality compared to that seen in Delta. This reduction in benefits needed to be considered alongside the impact on individuals (i.e., the choice to be vaccinated) and the risk to workforce capacity and in turn users of health and care services. In the light of these factors, the Committee decided that VCOD, both in relation to care homes and in relation to wider social care and healthcare, should be revoked and that there should be a consultation on this in order for government to take a final decision. **(MD/JM2/170 - INQ000091577)**

159. The Government launched a further consultation between 9 and 16 February 2022 regarding revocation of VCOD. A further Equality Impact Assessment was conducted. The government published its response on 1 March 2022 **(MD/JM2/171 - INQ000325348).** In light of the scientific advice received, as well as the strong preference for revocation expressed by consultation respondents, a decision was taken to revoke VCOD (together with the relevant Regulations) with effect from 15 March 2022.

160. Notwithstanding the revocation of VCOD, the Department continued to take steps to increase vaccine uptake amongst the NHS and social care workforce, as well as the wider public.

Winter Plan 2021/22

161. Between March and June 2021, the Social Care Sector COVID-19 Stakeholder Group, chaired by Sir David Pearson, completed a review of the effectiveness of the Department's interventions to support the social care sector in winter 2020/21, including those in the Winter Plan 2020/21 **(MD/JM2/106 - INQ000279947)**. The review made 33 recommendations to prepare for the coming winter, which shaped the Winter Plan 2021/22 (and was published alongside the Winter Plan) **(MD/JM2/172 - INQ000325342).**

162. On 26 June 2021 the Minister of State for Care commissioned officials to work on a Winter Plan 2021/22. Officials discussed winter planning with a range of stakeholders, including in a workshop on 12 August 2021 with the MHCLG, NHSE, CQC, PHE, ADASS, LGA, UK Home Care Association, National Care Association, Associated Retirement Community Operators, Carers UK, Healthwatch, Age UK, Alzheimer's UK, Think Local

Act Personal, National Care Forum, Care England, Skills for Care, Association of Mental Health Providers, HC-One and Barchester (care home operators).

163. On 20 October 2021 the COVID-O Committee agreed to publish the Winter Plan **(MD/JM2/173 - INQ000092237)**. The Winter Plan was published on 3 November 2021. Ahead of this, on 21 October 2021, the Department announced £162.5 million to support local authorities and providers to recruit and retain sufficient staff over winter, and support growth and sustain existing workforce capacity (the Workforce Recruitment and Retention Fund) **(MD/JM2/174 - INQ000257083)**.

164. The elements of national support in the Winter Plan built on those from the previous year, with particular focus on flu infection prevention and control, on how visits to care facilities would be maintained over the winter months, and vaccination.

Omicron

165. At the end of November / beginning of December 2021, the Department became very concerned about the spread of the Omicron variant. In addition to concern around the direct risk to care users, there was increasing concern about the indirect risk to care users flowing from the impact on the workforce and likely staff absences. The Omicron impact on the workforce was against the backdrop of already acute workforce pressures – since the opening up of the economy in spring 2021 workforce numbers had fallen consistently, and modelling projected further falls.

166. The Department put in place a range of measures:

a. First, the Department instituted very close monitoring of the situation on the ground. This involved keeping a close eye on the data, including on the social care workforce through COVID-19 sitreps which included data on vaccination rates, sickness absence and overall workforce numbers. Engagement with the sector was also rapidly stepped up. In addition to the existing Stakeholder Group, the Department set up a dedicated Winter Steering Group. This brought together DHSC, clinical experts in UKHSA, NHSE, representatives of local authorities, directors of public health, and the CQC. The group reviewed the Omicron response planning and implementation, and shared data and intelligence.

b. Second, the Department used all possible levers to drive uptake of vaccine boosters. The Department set up the Adult Social Care Vaccine Boosters

Taskforce, chaired by Sir David Pearson, to drive the uptake of boosters across the sector. This brought together DHSC, NHSE, LGA, ADASS, and representatives of providers and Integrated Care Systems.

c. Third, IPC measures were stepped up. Testing was increased for staff in high-risk settings on 15 December 2021 to three LFDs a week (in addition to one PCR test). Free PPE was also extended until 31 March 2023. Visiting guidance was amended.

d. Fourth, additional funding was put in place to mitigate the impact of Omicron. On 10 December 2021 a £300 million extension to the Workforce Retention and Recruitment Fund was announced, which providers could use to pay bonuses, bring forward pay rises, fund overtime, and fund staff banks. In addition, a £60 million Adult Social Care Omicron Support Fund was announced on 29 December 2021 for local authorities.

e. Fifth, further workforce interventions were explored, including contingency options on military assistance and volunteer surge capacity. On 23 December 2021 the COVID-O Committee agreed to make care workers and home carers eligible for the Health and Social Care visa and add frontline care roles to the shortage occupation list. This was implemented on 15 February 2022, although it was always the case that this would not impact on the ground quickly enough to assist with the Omicron wave.

167. In the event, although numbers of COVID-19 deaths rose during Omicron, the proportion of deaths of care home residents involving COVID-19 was 3.6%, a very low proportion compared to the first and second waves **(MD/JM2/107 - INQ000325347)**. Sickness absence in the workforce peaked at 2.9% in CQC-registered care homes and 4.8% in CQC-registered homecare providers in January 2022 **(MD/JM2/175 - INQ000325345)**, but never reached levels where additional national intervention was deemed necessary.

SECTION 3: REFLECTIONS ON ADULT SOCIAL CARE AND THE COVID-19 PANDEMIC

168. Throughout this witness statement we have sought to provide a clear factual account of the major events and decision making relating to adult social care in the COVID-19 pandemic. In this section we provide some high-level reflections on the challenges from

COVID-19 for adult social care as it relates to this Module. Module 6 of the Inquiry on the Care Sector will provide further detail and the underpinning evidence.

169. As already set out in our First Supplementary Statement on adult social care, it is of course important to remember the very different context within which adult social care operates, particularly in contrast to the NHS. The model for the delivery of adult social care is based around 15,000 regulated provider organisations, many of them very small. Local Authorities are responsible for assessing needs for adult social care, and for securing care for those who qualify for financial support. Many pay for their own care, from private providers or the charitable sector. The Secretary of State has some powers to provide guidance, but very limited powers to intervene. As set out in Module 1, the underlying resilience of any sector before the pandemic mattered. The adult social care sector was under considerable financial strain before the pandemic, with a largely low-paid workforce with high turnover rates, accompanied by a long lasting, unresolved debate over social care reform.

170. Our high-level reflections are:

a. Adult social care is one of the areas where our approach evolved the most over the course of the pandemic. Over the course of the pandemic, we made significant, additional targeted funding available to the sector, strengthened the data available, enhanced our assurance of the system, and very largely nationalised testing and the supply of PPE to adult social care. Our guidance and requirements for adult social care providers evolved to cover many aspects of their operations, including IPC practice, visiting and movement of staff between care locations and vaccinations of staff.

b. The original model for responding to an emergency such as a pandemic, based largely on local response, maintaining existing supply chains and LRF coordination, proved insufficient for the task. In the initial stages we lacked data, arrangements for supply (such as for PPE) were insufficiently robust, and arrangements for practical support from the NHS to adult social care providers were insufficiently developed.

c. The issues in adult social care required very difficult decisions to be made about the balance of benefits and risks – the benefits of visiting in terms of a resident's health and wellbeing, against the risk of disease coming into care settings. There

were no easy answers to these questions which also, of course, raise ethical issues.

d. The Department's decisions and actions were guided by the best available evidence at the time. In the initial stages of the pandemic there was inevitably very limited evidence about this novel disease, and so decisions were based on international reporting and our understanding of other coronaviruses that had caused serious respiratory disease (SARS and MERS). As more evidence became available on COVID-19 we adjusted our approach accordingly, for example extending isolation to 14 days for hospital patients and care home residents. From April 2020 onwards credible evidence of a significant contribution from asymptomatic transmission started to emerge leading to changes in advice on PPE, a greater emphasis on restricting visitors and staff movement and, as capacity allowed, a wider roll out of testing.

e. Discharging clinical appropriate people from hospital was appropriate and does not appear to be the dominant way COVID-19 entered care homes. Freeing hospital bed capacity was essential to allowing the NHS to treat those most seriously ill with COVID-19. Discharging people from hospital moved them away from the environment with the highest levels of COVID-19 patients. Isolation practices for COVID-19 patients could allow care homes to safely care for them. Our decisions and guidance were not out of line with others, and the WHO published guidance including the acceptability of discharging COVID-19 patients to long term care facilities. Scientific studies some of which discussed are above (paragraphs 99 to 103), including a SAGE Consensus Statement (*Consensus statement on the association between the discharge of patients from hospitals and COVID in care homes*), Scottish study and Welsh study have shown that while discharge of hospital patients is highly likely to have caused some COVID-19 outbreaks in care homes it does not appear to have been the dominant way in which COVID-19 entered them.

f. Throughout the pandemic the Department sought to minimise the risks to the most vulnerable. Social distancing policies aimed to reduce infection rates overall. Shielding guidance provided advice to those most at risk on how best to protect themselves. Specific guidance on how to minimise risks of COVID-19 was provided for care homes, home care and supported living providers, and supported living. Testing was prioritised for those most at risk, initially symptomatic hospital patients

and for outbreak control in care homes, but as testing capacity increased expanding testing for care home residents and staff was prioritised. As vaccines became available they were made available to the most vulnerable groups first, starting with residents in a care home for older adults and their paid carers.

g. Our experience was far from unique. Countries across the world struggled with COVID-19 in care homes. While international comparisons are difficult, international studies show that the UK share of COVID-19 related mortality of care home residents was 34%, lower than the average across the OECD of 41% between March 2020 and January 2021 **(MD/JM2/105 INQ000325346)**.

171. The experience in adult social care was one of the most challenging areas of the whole pandemic, causing understandable anger both from those who lost loved ones and from those who were denied contact with friends and relatives. The Department would like to reiterate its thanks to all those who worked in or supported the care sector as it battled the pandemic.

Statement of Truth

172. I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false

statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: _____

Dated: _____12 October 2023_____

Personal Data

Signed: _____

Dated: ___12 October 2023_____