**First Witness Statement of Cathie Williams**

**Chief Executive of**

**the Association of Directors of Adult Social Services**

**Local Government Association**

**February 2023**

**IN THE MATTER OF MODULE 2 OF**

**THE UK COVID-19 PUBLIC INQUIRY**

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**WITNESS STATEMENT OF**
**CATHIE WILLIAMS**
**ON BEHALF OF**
**THE ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES**

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**Background**

1. I am the Chief Executive (CE) of the Association of Directors of Adult Social Services (ADASS) of 18 Smith Square, London, SW1P 3HW. I was appointed to this role in January 2015 having previously worked for the Local Government Association and prior to that as a Director of Social Services. I am authorised by ADASS to make this statement on its behalf.

2. ADASS applied for Joint Core Participant Status together with the Local Government Association (LGA) and the Welsh Local Government Association on 23rd September 2022. The chair's letter on the 13 October 2022 made a decision not to designate ADASS as a Core Participant in Module 2, thereby declining its application dated 23rd September 2022. ADASS was provided with an opportunity to renew their application in writing but decided not to do so. Paragraph 16 of the determination letter stated as follows: - "*As the Applicant will be aware it is also not necessary to be a Core Participant in order to provide evidence to the Inquiry and the Inquiry welcomes any assistance ADASS can provide".* ADASS believes it has relevant information which will assist the Inquiry.

3. I have already provided written evidence by way of a witness statement in relation to Module 1 of the Inquiry, but this is my first witness statement in relation to Module 2 in which I understand that the Covid-19 Inquiry (the Inquiry) will consider and make recommendations about the UK's core political and administrative decision-making between early January 2020 and February 2022.

4. In making this statement I have both drawn on my own memory and records of this period and on information provided to me by the ADASS staff and officers involved in its work over this period as well. My statement must therefore be read as representing the collective understanding and knowledge of ADASS in relation to the period January 2020 to 24 February 2022. The ADASS's staff and officers are highly professional, and it is my belief that they have, again, diligently, and fairly reported to me the relevant information that I set out below.

**Introduction**

5. ADASS wishes to support the Inquiry in understanding how, and with what impact, ADASS provided advice and information to inform the government during decision making, as relevant to the outline scope for module 2.

6. ADASS staff and members are not aware of much of the extent, or content, of briefings that were given to government Secretaries of State or the Prime Minister via Civil Servants and NHSE during the early stages of the pandemic. The Association does, however, have extensive understanding of how briefings, engagement, advice, and intelligence were shared with civil servants and some National Health Service England (NHSE) staff from the initial notice, in February/March 2020, from government of the potential impact the pandemic could have.

7. From early 2020, informed by its surveys demonstrating the increasing fragility of social care, work on pan-flu planning, contingency planning for No Deal Brexit, and frequent communications with its regions in England, ADASS was in regular and detailed contact with civil servants in the Department of Health and Social Care (DHSC) (and to a slightly lesser extent with the Department for Levelling Up, Housing and Communities (DLUHC)) and with parts of NHSE. From March onwards this was at an unprecedented and very senior level.

8. It is ADASS view that, while acute health care needs were overtly the focus of national consideration and decision making early in the pandemic, consciousness of the social care (and primary health, community and mental health) needs of the population and the interconnectedness of these in the overall systems for health and social care were less so. This is despite more people being employed in social care than in the NHS. Whilst concerns about acute and intensive care were very real, our view is that the consideration of social care – and the people needing and working in it - coming as a secondary consideration to hospital capacity and the people needing and working in that environment, had significant impact on the population. Decisions – or the absence of decisions - relating to social care were, we believe, a very significant factor at the time, having an impact more widely than on the social care sector itself. It is our view that morbidity and mortality in people needing or working in social care was disproportionately high.

9. There was very limited experience of the operational delivery of social work and social care, within DHSC, and, indeed, NHSE. There was insufficient knowledge, capacity, and traction with decision makers. It seemed to ADASS that social care was an afterthought for the civil service, more widely than the small group working with us, and politicians. As a result, much time was spent by ADASS, and colleagues in the Local Government Association (LGA) and in our joint Care and Health Improvement Programme (CHIP) (which is granted funded by DHSC), explaining how social care worked, what it did and its significance. Decisions and actions were therefore perceived as too little and too late as a result. These concerns are exemplified in the ADASS letter dated 09 April 2020 to Jeremy Hunt, MP, Chair of the Health and Social Care Select Committee (CW01- INQ000103750), sent after a briefing and as a result of our perception that social care issues (and the needs of people working in and drawing on it) were not getting sufficient attention.

10. It will be important in any future pandemic, for decisions relating to social care (and to primary health, community and mental health NHS services) to be taken alongside, and at the same time as, consideration of acute hospital needs. (Indeed, this is relevant beyond a pandemic as we have been experiencing during winter 2022/23, with significant increased needs, outstripping the increased delivery of care at home last year, significant staff vacancies, hospitals in crisis and social care at best viewed as a secondary consideration and mainly in relation to hospital discharge).

11. As the pandemic progressed, detailed contact continued with DHSC (at times seven days a week, evenings, weekends, and bank holidays), extending over the next six months or so. This was particularly because in the civil service there was only limited capacity and operational understanding. Nor was there deep experience of the delivery and commissioning of social work and social care.

12. ADASS' input was part of the breadth of work that started early in the pandemic to ensure measured and professional advice was given to inform decision making in areas such as:- discharge from hospital, infection control within social care settings, PPE, vaccinations, provider issues, workforce, emergency legislation and data. This advice was often provided in partnership alongside the LGA and ADASS CHIP.

13. Examples of the work ADASS undertook to inform and advise DHSC are in the papers submitted to NCAG on 18 May 2020 which covered safety, human rights and safeguarding (CW02 – INQ000103751). In addition, ADASS made submissions to

and gave evidence to Select Committees (CW03 – INQ000103756).

14. ADASS is not clear of the full extent to which account was taken, in the advice to government, of the of people needing social care, support and safeguards, or unpaid carers and the staff working in social care decision making.

15. I now set out ADASS comments and contribution to the inquiry in relation to specific paragraphs of the Module 2 Provisional Scope.

**1. The central government structures and bodies concerned with the UK response to the pandemic and their relationships and communications with the devolved administrations in Scotland, Wales and Northern Ireland and regional and local authorities.**

16. The DHSC invited the President of ADASS to co-chair the national care advisory group, (known as NCAG or NACG) urgently convened in mid-March 2020, meeting regularly thereafter, with representatives from DHSC, Ministry of Housing, Communities & Local Government (MHCLG), the Care Providers Alliance (CPA), Care Quality Commission (CQC), Association of Directors of Public Health (ADPH), the LGA and others. This provided advice for communications from central government to local authority Directors of Adult Social Services (DASSs) and care providers during the pandemic. ADASS input to NCAG was informed by regular and frequent meetings with the ADASS regions. Two examples of NCAG notes are attached (CW04 – INQ000103757 and CW05 – INQ000103758).

17. As well as this formal mechanism there were frequent meetings with various bodies to deal with issues. An example of the output of such meetings is this email from the office of Helen Whately, Minister for Social Care (CW06– INQ000103759).

18. During the early months of the pandemic DHSC officials regularly joined meetings, with ADASS Regional Chairs (who are local authority DASSs that chair the meetings of all DASSs based in the 9 regions of England) This was so that the officials were advised of critical operational delivery issues and the impact on people needing and working in social care.

19. Examples of issues raised, early in the pandemic in these meetings that DHSC officials attended include:-

- 30 March 2020 – risk that NHS volunteering initiative was reducing availability for social care, getting accurate information to local authorities about the shielded residents and issues accessing PPE
- 06 April 2020 – ongoing shielded groups issues for local authorities, PPE, testing and concern about needing to understand mortality rates in care homes and community as well as hospitals

20. A summary of the notes of these meetings is exhibited (CW07 – INQ000103760).

21. By Easter 2020 the situation for people needing and working in social care was deteriorating. ADASS Regions communicated over that weekend and summarised concerns which were encapsulated in a letter to a senior civil servant (which was subsequently leaked to the media, by whom we do not know) (CW08 – INQ000103761). However, and whether as a result we do not know, after this the Social Care Sector Covid-19 Support Taskforce was set up and there was the publication of the social care plan.

22. The Social Care Plan, the Taskforce and Winter Plan emerged as DHSC recruited temporary senior operational experience. ADASS provided key professional advice to inform these documents and guidance.

**2. The initial understanding of, and response to, the nature and spread of Covid-19 in light of information received from the World Health Organization and other relevant international and national bodies, advice from scientific, medical and other advisers and the response of other countries. This will include the government's initial strategies relating to community testing, surveillance, the movement from 'contain' to 'delay' and guidance and advice to health and social care providers.**

23. ADASS made comments on almost every, if not every, piece of advice and guidance that related to social care. Specific concerns were raised in formal letters to senior DHSC officials (and to NHSE) to complement informal channels. ADASS President, Julie Ogley, wrote to Jonathan Marron, DHSC, on 11 April 2020 (CW08 – INQ000103761). ADASS and ADPH wrote jointly on 15 April 2020 to two secretaries

of state (CW09 – INQ000103762) and more informally ADASS CEO emailed DHSC on 17 March 2020 (CW10 – INQ000103763). Some, but certainly not all, advice was acted on.

24. DHSC funded ADASS to support national and regional teams in several contracts over the relevant period for specific work. This includes the covid-19 contracts April (CW11 – INQ000103765) and November 2020 (CW12 – INQ000103766) which asked ADASS to provide 'advice and support to DHSC and other Whitehall departments about social care and social work delivery and best practice activity in response to emerging social care issues related to Covid-19'. These contracts took a disproportionate amount of time to negotiate given their size and the gaps between them meant that staff and members nationally and regionally were significantly challenged. There was also the Carers' Day Services contract 13 October 2020 (CW13– INQ000103767) which asked ADASS to 'present the picture … of Covid-19's impact on levels of provision and day-care and respite services'.

**3. The decision-making relating to the imposition of UK-wide and, later, England-wide non-pharmaceutical interventions (NPIs), including the national lockdowns in March-July 2020, November-December 2020 and January-April 2021, local and regional restrictions, circuit breakers, working from home, reduction of person to person contact, social-distancing, the use of face-coverings and border controls; the timeliness and reasonableness of such NPIs, including the likely effects had decisions to intervene been taken earlier, or differently; the development of the approach to NPIs in light of the understanding of their impact on transmission, infection and death; the identification of at risk and other vulnerable groups and the assessment of the likely impact of the contemplated NPIs on such groups in light of existing inequalities.**

25. ADASS worked hard to advise and guide governmental decision-making in relation to NPIs – particularly on PPE for social care, the decisions on discharge from hospital, quality and safeguarding, the impact on people needing care and support, visiting in care homes and staff.

26. In a letter to the Secretary of State for Health and Social Care, dated 27 March 2020, the LGA and ADASS jointly raised specific concerns about the provision of PPE and the need to 'move faster in making PPE available for the adult social care sector'.

The letter was sent because, at that time, it seemed that messages and advice to civil servants didn't appear to be resulting in effective responses. The two bodies put forward clear asks of the government to improve the position (CW14 – INQ000103768).

27. Hospital discharge, testing and those testing positive were all controversial. ADASS made representation in private and in published statements relating to considerations across the whole health and care systems, including safety issues.

28. For example, on 12 March 2020 there was a meeting with DHSC civil servants where, it is ADASS' view, that broad agreement was gained to work to a 'home first' approach for people leaving hospital and to avoid 'moving people into settings unnecessarily'. This also seemed to agree that 'people who have covid-19 will be moved to community NHS facilities, those without - home or to a care home/other provision.' This is set out in the ADASS internal meeting note attached (CW15 – INQ000103769).

29. In the afternoon of 16 March 2020 NHSE asked ADASS to comment, within an hour and a half, on the draft hospital discharge guidance. On the morning of the 17 March, Cathie Williams, CEO ADASS commented this 'only looks at discharge and unless you look at the capacity of the whole system – including primary, community health care, social care and the inevitable additional needs if unpaid family carers cannot function, then there is serious potential to make things worse' (CW10 – INQ000103763).

30. On 19 March DHSC published Covid-19 Hospital Discharge Service Requirements, which did not look at the capacity of the whole system. The impact of those decisions will no doubt be looked at the inquiry later. ADASS regions later agreed criteria for supporting Discharge to Assess with a view to minimising impact on individuals and the wider system. These were appended to a document developed with the LGA: 'Discharge to Assess: An investment in Reablement' and published in July 2020 (CW16 – INQ000103770)

31. Visiting in care homes was particularly challenging. In November 2020 ADASS produced an internal advice note for DASSs setting out people's human rights and councils' Public Sector Equalities Duties and exemplifying the complexity of issues locally for councils (CW17 – INQ000103771). It is not clear to what degree DHSC

took account of such aspects when providing national guidance on care home visiting.

32. In relation to identification of at risk and other vulnerable groups - ADASS' Coronavirus survey in June 2020 (CW18 – INQ000103772) highlighted that Covid lockdowns had a significant impact on people needing care and support, on carers, on councils' social work and social care and on the interface between the NHS and social care. Older and disabled people, in particular, were often isolated or trapped with carers who couldn't cope and got less support because of diminished availability or fear of letting people in. The survey noted, in its Foreword, 'Covid-19 has disproportionately hit those of us who are in the most vulnerable circumstances: older people at the end of our lives, particularly in care homes, and people with learning disabilities. Concerningly, it has affected black and minority ethnic people and poorer communities that already experience ingrained inequalities'. As all ADASS surveys are shared with central government, ministers and civil servants it is evident the departments would have been given an understanding of this to inform their decision making. See also ADASS budget survey June 2020 (CW19 – INQ000103773).

**4. Access to and use in decision-making of medical and scientific expertise, data collection and modelling relating to the spread of the virus, including the measuring and understanding of transmission, infection, mutation, re-infection and death rates; the certificate system and excess mortality; the relationship between and operation of systems for the collection, modelling and dissemination of data between government departments and between the government, the NHS and the care sector.**

33. As far as ADASS understood there no-one with social care expertise on the Scientific Advisory Group for Emergencies (SAGE) and very few, if any, with operational social care or local government expertise in DHSC or NHSE. It was not until the establishment of the Taskforce (with Sir David Pearson, ex-President of ADASS brought into DHSC) and then until May 2020 that DHSC officials invited Taskforce members to suggest areas for a sub-group of SAGE to look at (CW20 – INQ000103774). The infrastructure was very thin for Local Government regionally and nationally via the LGA. This was even more so for ADASS.

34. The development of data systems was contentious. At the beginning of the pandemic there was fragmented information about the care sector. Upper tier Local

authorities, with their social care commissioning responsibilities all maintained their own arrangements, with varying degrees of sophistication and comprehensiveness, for tracking various aspects of provision, particularly relating to capacity or quality. For example London authorities had worked together for some time to maintain an information system and there was concern that the developing national 'capacity tracker' could undermine this.

35. There were also difficulties in systems to identify people needing shielding, how the information was shared between health and local authorities was not consistent and always effective – see notes of ADASS regional chairs meetings, entry dated 06 April 2020 (CW07 – INQ000103760).

**6. The public health and coronavirus legislation and regulations that were proposed and enacted: their proportionality and enforcement**

36. Through the NCAG (established mid-March) both ADASS and LGA worked to advise civil servants in DHSC on drawing up the guidance to underpin relevant sections of the Coronavirus legislation enacted on 25 March 2020.

37. The DHSC Chief Social Worker drew up the Ethical Framework for Adult Social Care (published 19 March 2020) and sought engagement and views from a range of people and bodies, including ADASS (CW21 – INQ000103775). This was viewed as necessary as social workers and councils were involved already in difficult decision making about prioritisation, eligibility and eking out resources in the context of underfunded social care.

38. While recognising the huge pressures created by the pandemic and the need to respond at pace, frequently the time to comment on proposals was extremely tight, for bodies such as ADASS, this was challenging and could have led to less fully rounded responses.

39. Schedule 12 to the Coronavirus Act 2020 provided 'easements' to local authority obligations under the Care Act 2014. The obligations were replaced with directions given in guidance in 'Care Act easements; guidance for local authorities' published by DHSC on 1 April 2020. ADASS, along with LGA CHIP provided advice to

government in relation to this guidance, then later reviewing it.

40. ADASS undertook a review to understand the learning from these easements (CW22 – INQ000103777). The review was titled 'Themes and Learning from ADASS Members on the Local Response to COVID-19 in Spring and Early Summer 2020' and published in October 2020. It demonstrated that:-
'Adult Social Care provides a crucial role – the sector employs many people – more than the NHS. Many of the people supported by adult social care receive care and support services in the community that are unrelated to discharge from hospital, or the immediate prevention of an admission to hospital. It is essential to support adult social care in its own right, and not only to protect the NHS from being overwhelmed' (p57 of CW22 – INQ000103777).

41. It also noted that:
'it would have been helpful to have better national and local public-facing communication regarding the expectations on local government and social care in particular. This would have been helpful to redress the imbalance between how the public initially valued the NHS contribution to the pandemic alongside that of Adult Social Care' (p74 of CW22 – INQ000103777).

**Final comments**

42. The pandemic was unprecedented and of a scale not experienced within the UK for many decades. The work of central government to ensure that the voice, knowledge, and experience of social care professionals informed key national decisions is recognised. Although we have made this point earlier, it is worth repeating that the lack of social care operational understanding and limited capacity in DHSC hampered the ability of officials to draw up the most advantageous processes and guidance for social care and may have reduced traction with politicians. It is not evident that the advice given by ADASS and other social care professionals was fully understood and incorporated into decision making. The national focus on protecting acute healthcare was not able to take account sufficiently of the whole system of community health, primary health and social care – it is likely that the result of this was that the most effective decisions were not always made.

**Key messages**

a) During any future pandemic, or similar, or indeed any period where the public have increasing need for health and social care, such as during winter difficulties, it is vital that the entirety of the health and social care system be considered by the government from the beginning.

b) Social care staff should be considered on a par with NHS staff, part of the social infrastructure of the country, and protected in the same way as health staff. During the pandemic there was insufficient consideration of this and then tragically high mortality rates.

c) The underfunding of social care, and decisions not to address the social care reform needed, had an impact on the population both during the pandemic itself and in its aftermath.

d) There was and is a lack of recognition of, and infrastructure for, leadership in social care in government and in the civil service in terms of operational experience, capacity and thus traction within government. This also covered a lack of understanding of capacity of national membership organisations such as ADASS

e) It is not evident that the advice given by ADASS and other social care professionals was fully understood and incorporated into decision making. The national focus on protecting acute healthcare was not able to take account sufficiently of the whole system of community, primary health and social care – it is likely that the result of this was that the most effective decisions were not always made.

f) ADASS regions were the critical infrastructure to delivery and intelligence gaining during the pandemic. It should be understood how incredibly fragile their funding is.

g) It is our belief that it is a false dichotomy to consider that the government needs to focus on either care or the economy. Social care is critical supporting the economy, not a drain. The consideration of health and social care for the population must not be undertaken in a way that puts it as either 'growth and the economy' (ending lockdowns, 'eat out to help out' for example) or expenditure on health and social care. The economy is damaged if health and social care and the workforce are damaged.

**I, Cathie Williams, declare that the contents of this my statement are true and accurate to the best of my knowledge and belief,**

**Signed** Personal Data

**Dated** 8th February 2023