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

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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 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. 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 jointly responsible with Michelle Dyson for 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 jointly responsible with Jonathan Marron for this statement.

Introduction

6. The pandemic presented an enormous challenge to all those working in the adult social care sector, and involved having to balance many competing considerations, both ethical and operational, to try and protect those receiving care and support from the virus, whilst balancing their need to see friends, family and live as independent a life as possible. These decisions were and continue to be the subject of much debate. At the Department, we and our colleagues are painfully aware of the tragic deaths of people with care and support needs arising from the pandemic, as well as the very significant impact on the lives of others of the measures we took to protect the sector.

7. We also recognise the sustained pressure put on all those working in the adult social care sector in the response to the pandemic. The adult social care workforce responded with dedication and compassion and provided support during the most difficult and emotional situations. In many cases this came at a cost to workers' health and wellbeing including, tragically, some loss of life. Some also live with long-term physical and psychological conditions as a result of their role in the pandemic. On behalf of the Department, we want to thank each and every person who worked in the adult social care sector during the pandemic and express our gratitude for the work they undertook to protect and maintain care for people with care and support needs through the greatest public health emergency in 100 years in this country.

Structure

8. This statement begins by setting out the general context in relation to the structure of adult social care and then goes on to describe how the sector operated during COVID-19.

9. The structure of this statement is:

- Section 1. The structure of the adult social care system pre-pandemic
- Section 2. Changes to how the system operated during COVID-19
- Section 3. Departmental decision-making on adult social care

SECTION 1. THE STRUCTURE OF THE ADULT SOCIAL CARE SYSTEM PRE-PANDEMIC

Key features and key data

10. Adult social care supports adults of all ages – including young people moving into adulthood and those of working age as well as older people – with a diverse range of needs, including:

a) older adults with multiple comorbidities and levels of frailty, physical or cognitive;
b) people with a learning disability or physical disability;
c) people with mental health conditions;
d) people with sensory impairments;
e) people with social care needs related to substance misuse;
f) people with dementia and other forms of neurological decline;
g) people with autistic spectrum disorder or condition and other social communication disorders; and
h) other people with long-term conditions

11. Adult social care covers a wide range of activities to promote people's wellbeing and support them to live independently, and to stay well and safe. It can include 'personal care', such as support for washing, dressing and getting out of bed in the morning, as well as wider personalised support to enable people to stay engaged in their communities and live their lives in the way they want, for example by supporting them to work, or to engage in training, education or volunteering, or to socialise with family and friends and maintain personal relationships.

12. The way that people draw on care and support varies according to their individual needs and preferences and their stage of life. Some people will require support throughout their life and may become experts in their own care needs. Others' care needs develop gradually or suddenly, and they may have to navigate an unfamiliar landscape at a uniquely stressful time of their life. Still others may only use social care for a short period, such as after a hospital stay.

13. Adult social care for both working age and older adults takes place in a variety of settings, including people's own home, residential care homes with on-site care workers, and nursing homes where the staff includes a registered nurse to meet assessed needs. Both residential and nursing homes provide 24-hour support and must have a Care Quality Commission (CQC)-registered care manager. Care provided in an individual's home can range from short home visits for support with specific tasks to having a live-in carer. Alternatively, "supported living" allows older people, or those with a disability, to live independently in purpose-designed housing with tailored care and support available to them.

14. The Office for National Statistics (ONS) estimates that four in five (82%) individuals in residential care (residential care homes and nursing homes) are aged 65+. Many of those aged 65+ in residential care have dementia or another form of neurological decline. The median length of stay in residential care is estimated to be around 22 months (665 days); for those in nursing homes, it is estimated to be around 14 months (418 days) **(MD/JM/1 - INQ000303278**.

15. Unlike NHS-delivered healthcare, which is free at the point of delivery, adult social care provision is means-tested. Whether a person qualifies for any financial support towards their care costs depends on the capital assets that they have. Anyone who has assets below £23,250 may be eligible for financial support from their local authority, depending on how much they can afford to contribute from their income and assets combined. Anyone who has assets above £23,250 is considered a self-funder and therefore is expected to cover their total care costs. However, everyone is entitled to a needs assessment and advice from their local authority on how best to meet their needs.

16. Although there are no precise figures for the number of people who pay for care, ONS estimates that in 2021/22 there were 126,000 self-funders in adult care homes (35% of all care home residents). Care homes providing care for older people had the highest proportion of

self-funders (47%), while care homes for younger adults had the lowest proportion of self-funders (2%).**(MD/JM/2 INQ000303272)**

17. It is estimated that (in 2017) 95% of care home beds were provided by private sector and not-for-profit organisations, operating in a regulated, competitive market. Responsibility for the operation of services rests overwhelmingly with those organisations. Currently the sector comprises around 14,800 care homes (both nursing homes and residential homes) and 12,500 homecare agencies.

18. The population of England and Wales has continued to age since 2011: the number of people aged 65+ increased from 9.2 million in 2011 to over 11 million in 2021. Around 613,500 people were estimated to be receiving long-term adult social care support paid for by local authorities at the end of 2021/22. Of these, 59% were aged 65+ and the remainder were aged 18-65. Within care homes specifically, 82% of individuals were 65+ in 2021.

19. In 2021/22, net public expenditure through local authorities on adult social care was £21.4 billion **(MD/JM/3 - INQ000303273 .** Over half of the local authority spending on short- and long-term adult social care is used to support younger adults (ages 18-64), whose care needs are often more complex and the majority of whom are funded by local authorities.

20. In addition to this, in 2021/22 around 157,000 people in England received NHS Continuing Healthcare (CHC), including around 110,000 via end of life "Fast Track" CHC. CHC is a package of ongoing care for adults with a 'primary health need' (when the main/major aspects of their care addresses health rather than social care needs). In relevant cases the NHS pays for healthcare and associated social care needs outside acute hospitals, including in residential care or at home.

21. According to the Skills for Care (SfC) workforce report 2022, there were around 1.62 million filled posts in the care workforce in 2021/22 (including NHS roles providing social care) and a further 165,000 vacant posts. The vast majority of workers were employed by individual care providers. Care workers and senior care workers made up much of the workforce (around 860,000 filled posts) alongside social workers, nurses, occupational therapists, mental health workers, registered managers, personal assistants and ancillary staff.

22. A significant proportion of adult social care is delivered by informal carers outside formal care settings. The 2021 Census estimated that there are 4.7 million unpaid carers in

England, of whom 21% provide 20-49 hours of care a week, and 30% provide 50+ weekly hours of care.

Summary of central and local government responsibilities

23. The Department's social care remit relates to adult social care in England only. Responsibility for children's social care in England rests with the Department for Education; responsibility for social care in Scotland, Wales and Northern Ireland is devolved to their respective governments.

24. The Department is responsible for the statutory framework for adult social care, sets policy (including through regulation, direction and guidance) and agrees the overall funding envelope for local government with the Department for Levelling Up, Housing and Communities (DLUHC) and HM Treasury (HMT). It also sponsors the CQC, which regulates and inspects adult social care providers and, from 1 April 2023, assesses the performance of local authorities in the delivery of their adult social care duties under Part 1 of the Care Act 2014.

25. The most significant piece of legislation in respect of adult social care is the Care Act 2014. There are also codes of practice issued under the Mental Health Act 1983 and under the Mental Capacity Act 2005 which are highly relevant to some aspects of decision-making in respect of people in receipt of adult social care.

26. The Department had powers prior to the pandemic which allowed it to provide guidance to local authorities on adult social care issues. These powers included section 78 of the Care Act 2014, which requires local authorities to act under the general guidance of the Secretary of State in carrying out its functions under the Act.

27. The Department is responsible for assessing the need for adult social care spending through the Spending Review settlement and monitors the adequacy of local authority spending on adult social care for achieving expected objectives. The Department also agrees the allocations of funding specifically earmarked for adult social care and conditions on its use with HMT and DLUHC. Much of the funding for adult social care, however, does not come from specifically earmarked sources and comes from general funding available to local authorities such as Council Tax, business rates and the wider local government financial settlement. DLUHC oversees the overall sufficiency of local government funding for all services and the financial framework for providing funding to local government for these

services. DHSC works closely with DLUHC and HMT to ensure Spending Review and related decisions about the overall local government funding position include a detailed and robust assessment of the funding needs for adult social care.

28. The Care Act 2014 places the duty to plan and secure adult social care services on local authorities in England. They are accountable for this first and foremost to their local population. Local authorities commission care predominantly from private sector and not for profit providers. Not everyone is eligible for local authority-commissioned care as adult social care provision is means-tested. However, everyone is entitled to a social care needs assessment. A local authority will make an assessment, of an individual's care needs, whether that is through accommodation in care homes or the provision of homecare or other support services, in accordance with their statutory responsibilities. People with care and support needs have to meet eligibility conditions around residence in that area and criteria to receive care paid for by the local authority - whether a person qualifies for financial support towards their care costs depends on the capital assets that they have. In the case of those who meet these criteria, local authorities will decide whether or not they commission care from specific private providers; for example, if CQC inspections identify issues in the delivery of care in a particular provider, a local authority may choose to move care from one provider to another. There are a wide range of statutory duties which fall on local authorities and a failure to comply with their statutory duties can be enforced by the courts. Local authorities determine their total spend on adult social care, funded by earmarked central government grants and a share of core government grants and local revenues.

29. Under the Civil Contingencies Act 2004, emergency planning responsibilities rest with local authorities while the co-ordination of emergency response is the role of Local Resilience Forums (LRFs). Individual care providers are also expected to carry out business continuity planning. In cases of major incidents or major provider failure, the Department has a role in co-ordinating a national approach, working very closely with the CQC, other departments such as DLUHC and sector partners.

CQC functions

30. The CQC is an independent statutory body which regulates all health and social care services in England. From April 2023, it also has responsibility for assessing the performance of local authorities in the delivery of their adult social care duties under Part 1 of the Care Act 2014. Under Chapter 2 of Part 1 of the Health and Social Care Act 2008, care home and homecare providers must be registered with the CQC and must meet a set of essential

requirements of safety and quality. Under the Care Act 2014, the CQC also has a duty to assess and monitor the financial sustainability of the largest and more difficult to replace adult social care providers. This is done via the Market Oversight scheme, and in the event that business failure or service cessation of a provider in the Market Oversight scheme becomes likely, the CQC is required to give advance notice to local authorities so they can put plans in place to ensure that people who are affected continue to receive care. The CQC's main objective, under section 3(1) of the Health and Social Care Act 2008, is "to protect and promote the health, safety and welfare of people who use health and social care services".

CQC enforcement powers

31. The CQC regulates organisations through a system of registration and inspection, ensuring the quality of adult social care providers. Providers must meet CQC standards in order to operate. Under Regulation 12(2)(h), CQC assess all providers on the risk of, and preventing, detecting and controlling the spread of, infections. Through its inspections, the CQC rates health and social care services as either outstanding, good, requires improvement or inadequate:

i. *Outstanding* - the service is performing exceptionally well;
ii. *Good* - the service is performing well and meeting our expectations;
iii. *Requires improvement* - the service is not performing as well as it should and CQC has told the service how it must improve; or
iv. *Inadequate* - the service is performing badly and CQC has taken action against the person or organisation that runs it.

32. In September 2023, 83% of all adult social care settings (locations) were rated Good or Outstanding by the CQC. However, if the care provided harms or puts people at risk, the CQC can take enforcement action to protect them. The action which the CQC can take ranges from working with providers to make improvement to criminal enforcement action if the quality of care provided has resulted in serious harm or put people at risk. Following enforcement action, the CQC inspects services to ensure that improvements have been made. Failure to make changes can lead to more severe enforcement action and in serious cases can result in registration being cancelled, meaning a care home can be closed down. Between 2020 and 2022, 180 care home locations were closed down and removed from the CQC register through enforcement activities, compared to 270 care homes between 2017 and 2019.

33. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009 sets out offences and the CQC's

powers to prosecute, including cancelling registrations and the fixed penalties and fines payable.

Sector pressures pre-pandemic

34. In the pre-pandemic period, the sector was under considerable financial strain, with a largely low-paid workforce with high turnover rates, accompanied by a long-lasting and unresolved debate over social care reform. Funding made available to local authorities to commission adult social care services had been constrained since the early 2010s, requiring them to find savings in budgets and to make careful judgements on how best to meet local needs. Although there was significant additional funding after 2014/15, nonetheless overall spending on adult social care at the start of the pandemic was only equivalent in real terms to where it was in 2010/11, despite growth in demand. The CQC's 2018/19 annual report stated that: *"in adult social care, funding and workforce issues continue to contribute to the fragility of the sector."* In its 2019/20 annual report, the CQC maintained *"that adult social care remained very fragile… any further shocks to the labour market would be expected to increase the existing level of market fragility and place more pressure on local authority finances."* Many local authorities, as commissioners, and providers lacked great resilience to respond to a shock such as a pandemic.

SECTION 2: CHANGES TO HOW THE SYSTEM OPERATED DURING COVID-19

35. In the very early stages of the pandemic, in line with established practice, the co-ordination of the emergency response rested with Local Resilience Forums (LRFs) in each local authority area. In parallel, the Department led joint work at national level, bringing sector leaders and experts together to assess expected challenges and advise on possible actions and early guidance. As it quickly became clear that COVID-19 was a national emergency and required a far more centralised approach, the Department took urgent, further steps to expand its capacity and to reinforce its oversight. The Department progressively strengthened its engagement with DLUHC, local authorities and the sector to inform decision-making and better support the sector, for example with extensive operational guidance. It provided additional funding and support in kind to the sector (e.g. making Personal Protective Equipment (PPE) available to care providers), and improved and centralised its data to reinforce its intelligence-gathering and oversight.

36. Prior to the pandemic the Department's work on adult social care was undertaken by the Care and Transformation Directorate, made up of some 90 staff (April 2020), with overall

responsibility resting with Jonathan Marron, the Director General for adult social care as well as community care and prevention. In April 2020 the Department appointed Rosamond Roughton as Director General with sole responsibility for adult social care; Rosamond left the Department in July 2020 and was succeeded by Michelle Dyson as Director General from September 2020. From early 2020 until 2021 the team working in this area grew to 319, including three Civil Service Director-level posts. This provided the greater capacity needed for close work with the sector, representatives of people with care and support needs, public health and other experts, the NHS, other parts of government, and Ministers to develop a rapid and evolving response to the pandemic.

37. Throughout the pandemic, the Department strengthened its links with sector representatives. In February 2020, a National Steering Group (NSG) was convened, securing sector experts' input to the Department's early COVID-19 response. In early March 2020 the Department set up a National Adult Social Care COVID-19 Group (NACG), comprising of local authority representation (the president of the Association of Directors of Adult Social Services (ADASS) and a representative from the Local Government Association (LGA)), public health representation (the Association of Directors of Public Health (ADsPH) and Public Health England (PHE)), NHS England, and care provider representation (including nominees from the Care Providers Alliance). NACG was vital in providing direct intelligence about what was happening on the ground and on commenting and advising on what would work best and what was needed. Ministers also met regularly with sector stakeholders - providers, local authority representatives and the voluntary sector, representing people with care and support needs.

38. As part of its pandemic response, the Department drew on two senior expert advisers who were recruited into the Department's adult social care group during this period. Professor Jane Cummings, former Chief Nursing Officer for England, joined the Department as director and senior adviser for adult social care testing on 18 May 2020. She stayed in the Department until June 2021. Sir David Pearson provided advice to the Department from Spring 2020. He was appointed chair of the Department's Social Care Sector COVID-19 Support Taskforce in June 2020. He continued to support the Department until June 2021.

39. During this time Sir David Pearson also supported the vaccine programme from December 2020 to June 2021. In December 2021, Sir David Pearson rejoined the Department to support the rollout of the booster vaccine during the increased wave of infections caused by the Omicron (B.1.1.529) variant, a role that finished at the end of February 2022.

40. In December 2020 Deborah Sturdy also joined as the first Chief Nurse (CN) for adult social care, advising the Department on Infection Prevention Control (IPC) and other operational issues.

41. Helen Whately was appointed Minister of State for Social Care on 13 February 2020 and remained in that role until 16 September 2021. Gillian Keegan was Minister of State for Care and Mental Health from 16 September 2021 to 7 September 2022. The Rt Hon Matt Hancock was Secretary of State for Health and Social Care from 9 July 2018 to 26 June 2021. The Rt Hon Sajid Javid then held the position from 26 June 2021 to 5 July 2022.

42. In addition to the above, the main elements of the Department's response, novel and unique in its range and intensity, were as follows:

a) Provision of extensive operational guidance

43. During the pandemic a wide range of guidance was issued to the sector, at pace and with frequent amendments, covering critical aspects of the response to the pandemic such as IPC, testing, discharge, PPE, visiting and vaccination. Most of the guidance issued by the Department and PHE during the pandemic to adult social care providers was issued using the Secretary of State's general powers and much of the guidance was therefore not issued on an explicit statutory basis, although organisations consistently drew on it heavily for advice on how to ensure the safest possible environment for people with care and support needs, their families and staff.

44. Paragraph 18 of Schedule 12 to the Coronavirus Act 2020 gave a power to the Secretary of State to issue statutory guidance to local authorities about the amendments made by the 2020 Act to local authorities' adult social care functions in the Care Act 2014 and other related legislation. Guidance was issued and for the period during which the provisions were in force, this guidance superseded the existing care and support statutory guidance where there was a conflict. **(MD/JM/4 - INQ000303269)**

b) Additional funding and support in kind to the sector

45. Over the course of the pandemic over £2.9 billion was made available in specific COVID-19 funding to support the adult social care sector. A breakdown of the funding provided is exhibited here **(MD/JM/5 - INQ000303274)**. It included £1.81 billion for IPC, £523 million for testing and £582.5 million for workforce capacity, recruitment, and retention.

46. Initially IPC funding was provided through the Infection Control Fund and funding for testing was provided through the Rapid Testing Fund. From April 2021, these were consolidated into one fund, the Infection Control and Testing Fund (ICTF), which had three iterations and required local authorities to directly pass on, or 'passport', a proportion of their allocations to every care provider within their local area. This passporting was done on a 'per bed' basis for care homes, and a 'per user' basis for CQC-registered community care providers. Alongside this, PPE was made available to care providers from March 2020 onwards.

47. The ICTF was more prescriptive than was usual in funding the sector; its purpose was to support adult social care providers (including those providers with whom the local authority did not have a contract) to: reduce the rate of COVID-19 transmission within and between care settings through effective IPC practice and to increase COVID-19 and flu vaccine uptake among staff; and to support the conducting of testing of staff and visitors in care settings to identify and isolate positive cases and to enable visiting where possible. To ensure local authorities distributed all of the available funding to all providers, regardless of their pre-existing commissioning arrangements, the ICTF grants included a number of conditions, not just about what the funding could be spent on, but also how it had to be dispensed and how quickly it had to be used.

48. The Workforce Recruitment and Retention Funds (WRRF) more closely resembled arrangements made before the pandemic to support winter pressures, for example. They were used to support local authorities to urgently address adult social care workforce capacity pressures in their geographical area through recruitment and retention activity, allowing local authorities to decide the best way to do so through engagement with care providers.

49. In addition, between April 2020 and March 2022, over £3 billion was made available via the NHS to fund national implementation of the Discharge to Assess (D2A) model through a standalone discharge fund known as the Hospital Discharge Programme (HDP). The funding was critical, especially in the early days of the pandemic, in enabling hospitals to free up beds for COVID-19 patients – the National Audit Office produced a report which sets out that D2A, in combination with measures such as postponing elective surgery, intended to free up 30,000 beds at the start of the pandemic **(MD/JM/6 - INQ000303266)**. In particular, the provision of national funding removed the need to agree the affordability or funding source for people's care upon discharge and ensured that funding was not a cause of delays in discharging people as soon as they were clinically ready to return to, or move into new, care packages. HDP

focused on enabling an individual to reach their optimum recovery at which point their long-term needs (including ability to pay) were assessed.

c) Improved data

50. The Department improved its data on COVID-19 prevalence, and its prevention and control, in care settings during the course of the pandemic. In April 2020 the Department re-purposed an existing tool, Capacity Tracker (CT) **(MD/JM/7 - INQ000235006)** – which was in use in some areas to identify where care home beds were available - and used the Infection Control Fund to incentivise all care homes to supply data into it, for example the availability of PPE at a given location and stock levels. The Department also worked with the CQC to publish data on deaths in care homes from 10 April 2020 **(MD/JM/8 - INQ000220185).**

51. At the same time, the Department announced a data collection system for homecare providers via the CQC. In November 2020 these homecare providers were moved from the CQC data collection system to Capacity Tracker (CT). By summer 2020 response rates in CT had increased significantly, with 99% of CQC-registered care homes using CT to report on key aspects of their activity and workforce. In addition, the Capacity Tracker Data Advisory Group (CTDAG) brought together data and policy officials from the Department, the CQC, providers, and local authorities to discuss, refine and agree data needs and how to meet them. This level of transparency and co-production significantly speeded up data collection and improvement activity.

52. These data collections provided an invaluable source of information which helped the Department monitor the impact of the pandemic in adult social care. The data were also shared with the Office for National Statistics (ONS) for publication in their pandemic mortality statistics. In May 2022, at the Minister of State for Care and Mental Health's request, the CQC published a summary of statutory notifications (where providers must notify the CQC about certain changes, events and incidents that affect their service or the people who use it) received from each care home over the course of the pandemic.

d) Enhanced situational awareness and assurance

53. Alongside this, the Department created an internal team to provide a better understanding of what was happening on the ground, and a robust process for proactively and preventatively managing risks and intervening when necessary. The team came into existence in late autumn and early winter 2020 and was made up of ten regional leads from the Department and seven intensive support leads, with data management support.

54. Regional leads were recruited for their senior operational and strategic experience in adult social care, and ability to work closely with sector colleagues. The team blended extensive commissioning, delivery and frontline sector experience and ensured Ministers and policy were better able to make decisions based on real-time challenges and views from sector colleagues.

e) Changing the CQC's role in supporting the sector during the pandemic

55. During the COVID-19 pandemic, the CQC:

a. Stopped routine inspections from 16 March 2020 **(MD/JM/9 - INQ000303263** and, instead, put in place a new way of providing proportionate assurance on the safety of services that did not place additional pressure on providers and allowed them to remain focused on patient care;
b. Through its inspectors, acted as a support for registered managers, providing advice and guidance throughout this period and working with providers on information collection to ensure a clear national picture of the impact of the pandemic;
c. Carried out a series of IPC inspections - enhanced, focused inspections assuring the full range of COVID-19 prevention strategies were in place (eg. staff movement practices and testing of staff and residents) - backed by the full range of enforcement powers available;
d. Published a monthly insight report to highlight COVID-19-related pressures on the sector; and
e. Instituted a new statutory requirement on care homes (from 10 April 2020) to inform it of the number of COVID-19 deaths, whether confirmed or suspected, in each care home.

f) Embedding a new role for the Department

56. Building on the experience of the pandemic, the Department has sought to strengthen its oversight over the adult social care system through measures in the Health and Social Care Act 2022. The new duties and powers include:

a. New duties on the CQC to assess local authorities' performance in respect of their statutory adult social care duties and where necessary support local authorities to improve their services;

b. New powers for the Secretary of State to intervene when he or she is satisfied that local authorities have failed or are failing to discharge Care Act 2014 functions to an acceptable standard;
c. New powers for the Secretary of State to require adult social care providers to provide information relating to themselves and their activities in connection with adult social care provision; and
d. New powers for the Secretary of State to make payments direct to adult social care providers.

57. In addition, from April 2023, the Department introduced a new mandatory local authority data collection - client level data (CLD). The first mandated return was received from local authorities in July 2023. CLD is a quarterly person-level data collection that replaces the annual, aggregated Short and Long-term activity reports (SALT) data returns that local authorities had been required to make to date. It brings together data that local authorities already collect to record and monitor the main events and interventions in an individual's journey through the social care system. Work is underway to link CLD with health data via pseudonymised data linkage, which will enable care pathways and interactions across health and social care settings to be better understood.

SECTION 3. DEPARTMENTAL DECISION-MAKING ON ADULT SOCIAL CARE

Introduction

58. During the early months of 2020, the Department was acting in response to a global pandemic, the like of which had not been seen in people's lifetimes, caused by a virus about which there was, in this initial period, relatively little scientific understanding and little scientific consensus.

59. There were no easy decisions. The Department was faced with making rapid policy decisions in the interests of managing the pandemic, in a context where everyone was adversely impacted. Ultimately, the Department had to base its decisions on what, given the scientific understanding at the time and what was feasible, it believed would save the most lives and benefit the most people.

60. Decisions had to be considered and reconsidered at extreme speed and under extreme pressure; and very often involved choices and balances in a world that was not

perfect. Everyone concerned was working at their limits and around the clock to seek to make the right decisions with one overriding focus in mind: to protect and save lives.

Scientific and public health expertise

61. In its decision-making, the Department relied upon the advice given by the Chief Medical Officers, PHE, which had responsibility for public health surveillance, its successor agency the UK Health Security Agency (UKHSA), and the specialist scientific expert groups which provided advice to the government during this period, including the Scientific Advisory Group for Emergencies (SAGE) and the SAGE adult social care Working Group. The role of the Chief Medical Officer (CMO) has been explained at paragraph 10 in the Third witness statement of Sir Christopher Stephen Wormald, dated 29 March 2023, which states:

> *"The Department is supported by the Chief Medical Officer (CMO) who is the UK Government's principal medical adviser and the professional head of all directors of public health in local government and the medical profession in government. The CMO is an independent position at permanent secretary level in the Department and is a member of the Department's Executive Committee and Departmental Board. The CMO advises ministers across government on medical matters. He works closely with CMO colleagues in devolved governments."*

62. Throughout the pandemic, the Department worked with its scientific and clinical advisers to develop, review and update operational guidance relating to adult social care. Clinical sign-off arrangements were put in place for guidance to the sector, including sign-off by the lead Deputy CMO (Professor Dame Jenny Harries up to May 2021) and the relevant clinical lead in PHE and then UKHSA (mainly Dr Éamonn O'Moore and Professor Paul Johnstone) for all guidance relating to adult social care.

63. This included regular updates to the 'How to work safely' guidance for care homes and domiciliary care, which outlined recommendations on which PPE to use, in addition to other IPC measures **(MD/JM/10 - INQ000303275 MD/JM/11 - INQ000303276)**

64. From 31 March 2022, most COVID-19 guidance for adult social care was replaced by the IPC resource for adult social care and accompanying COVID-19 supplement. The Department also produced guidance for Supported Living, initially published on 6 August 2020 **(MD/JM/12 - INQ000303268** , and for those in receipt of Direct Payments (**MD/JM/13 - INQ000303271)** – i.e. those who organised and paid for their own care in the home - both of which were regularly updated throughout the pandemic.

65. Clinical advice to the Department considered the infection risk to residents and service users and the impact of COVID-19 on them, including the risk of death or serious disease. Clinicians also considered the impact of restrictions on residents' health and wellbeing including the risk of deterioration caused by isolation. Decision-making was also informed by legal advice on the Secretary of State's duties, including with regard to the European Convention on Human Rights, the Equalities Act 2010, the Care Act 2014 and the National Health Service Act 2006 (including on health inequalities). The way that Human Rights and Equalities considerations were taken into account is covered in more detail in paragraphs 69 - 73 below.

66. The Department also drew on the expert advice of the Chief Social Worker for Adults (CSW). Mark Harvey joined as joint CSW from October 2019 until March 2021, alongside Fran Leddra who worked in the Department from October 2019 until September 2021; NR NR who was appointed to the role in 2013 but was on a career break from 2019, then returned to the role of CSW from April 2021, initially part-time but then on a full-time basis from October 2021. CSWs provide expert advice to Ministers and senior officials on social work, social care reform and cross-cutting policies in national and local government. They are an independent expert voice for social work in government and provide professional leadership to Principal Social Workers in each local authority area and to the wider sector.

67. During the pandemic the CSWs supported elements of the Adult Social Care Action Plan that formed the first, focused social care response to the pandemic. The CSWs also provided support to Principal Social Workers through fortnightly touch-in meetings which operated remotely. They provided direct support to ethnic minority groups, and/or people with ethnic minority backgrounds, as well as self-directed support sub-groups. The CSWs also worked with the Social Care Institute for Excellence (SCIE) - a charity which produces advice and support to the social care sector - to develop a hub of resources, including guidance for care staff and support to people providing unpaid care during COVID-19. **(MD/JM/14 - INQ000303277)**

Adult social care sector input

68. From the outset, the Department strengthened its links with sector representatives to secure intelligence about what was happening on the ground and their view on actions needed. These links have been described in para 37, above.

Equality and human rights

69. The Department has to comply with the Public Sector Equality Duty ("PSED") as set out in s149 of the Equality Act 2010 when shaping policy and delivering services, alongside its substantive duties under the Equality Act 2010 and with Human Rights legislation, and other relevant legislation (such as the National Health Service Act 2006, the Autism Act 2009 and the Care Act 2014) all of which have equality, non-discrimination and lessening disparities as part of their aims and objectives. The way the Department sought to comply with these requirements in its overall response to the pandemic is set out in the Fourth witness statement of Clara Swinson.

70. In respect of adult social care, examples of the way the Department sought to embed equalities legislation and principles in its response to the pandemic are:

a. Through the CSW, bringing together best practice for providing "culturally competent care" - care which takes into account, reflects and acknowledges religious and cultural differences - during COVID-19 and beyond.
b. The publication of a COVID-19 adult social care workforce risk reduction framework in June 2020 to support employers to sensitively discuss and manage specific risks with their staff – including risks by ethnicity, age, sex and underlying health conditions. **(MD/JM/15 - INQ000303267)**
c. The provision of £10 million funding to the voluntary sector to provide help, particularly for under-served groups in respect of mental health, and funding for learning disability and autism charities to support their COVID-19 response. **(MD/JM/16 - INQ000184066).**
d. Translating Government guidance about COVID-19 into languages most commonly spoken in England to improve accessibility, and disseminating this via organisations which work with relevant communities. Translated versions of the guidance became available from 20 March 2020. **(MD/JM/17 - INQ000303265)**

71. At the very start of the pandemic the Department recognised the need to provide support to the adult social care system to ensure that proper consideration was given to ethical values and principles when organising and delivering adult social care. An Ethical Framework for adult social care was commissioned on 11 February 2020 **(MD/JM/18 - INQ000049363** and published on 19 March 2020 **(MD/JM/19 - INQ000303264)**. The Framework provided a structure for local authorities to measure their decisions against, following the principles of respect, reasonableness, minimising harm, inclusiveness, accountability, flexibility, and proportionality. It reinforced that the needs and wellbeing of individuals should be central to

decision-making during the pandemic. It particularly provided an underpinning for challenging decisions about the prioritisation of resources where they were most needed.

72. Throughout the pandemic the Department sought to ensure that human rights and equality considerations were taken into account in policy-making. The Coronavirus Act 2020 provided for a relaxation of several local authority duties under the Care Act 2014 (known as Care Act easements) if, as a result of the pandemic, it became impossible for them to continue to fulfil these in full. Any local authorities deploying the "easements", as they became known, were expressly subject to the need to comply with their obligations under the Human Rights Act 1998. The Coronavirus Act 2020 stated that the duty to meet care and support needs (or support needs for a carer) continued to apply unequivocally where not doing so would breach a person's rights under the European Convention on Human Rights.

73. The Department faced particular challenges where a tension arose between human rights considerations and the requirements for particularly restrictive measures as seen as necessary on public health grounds needed to protect particularly vulnerable groups such as care home residents. Some examples were the tensions between the residents' right to family life (Article 8 ECHR) and right to liberty and security (Article 5 ECHR) against the right to life (Article 2 ECHR), freedom from inhumane or degrading treatment (Article 3 ECHR) and protection from discrimination (Article 14 ECHR). The Department sought to deliver a proportionate response to the pandemic, respecting human rights while protecting individuals and communities from the public health risks posed by COVID-19.

Departmental governance

74. The governance of the Department has been outlined in the First witness statement of Sir Christopher Stephen Wormald, dated 25 November 2022, at paragraphs 56 - 85, which can be found below:

> ***SECTION 2: DHSC structures***
>
> 56. *This section of my statement will cover the committees and decision makers within DHSC, both in relation to senior decision making and to specific pandemic preparedness activity. It will also cover how DHSC worked with departmental agencies (such as UKHSA and the Medicines and Healthcare products Regulatory Agency (MHRA)), NHS England (NHSE), Other government Departments (OGDs), Local Government, the Devolved Governments, and international partners.*

57. *Decision-making in DHSC (as in OGDs) is largely carried out through submissions to the Secretary of State and other DHSC ministers which set out an issue and recommendation and give information to note. The relevant ministers take decisions based on this advice, and sometimes will call meetings to discuss this advice before making a decision. Urgent decisions are sometimes taken in meetings or in other discussions. All government decisions should be recorded by the minister's private office. Decisions that require cross-government input or alignment are made through the well-established approaches to collective agreement. These are led by the CO and agreement is sought and received either meeting in person or in writing, through Cabinet Committees, or Cabinet itself.*
58. *Financial allocations, including for public health and the NHS, are agreed in regular Spending Review processes between the Department and His Majesty's Treasury (HMT). Depending on the level of spend and its features, areas are either within departmental delegation or require further agreement with HMT or CO. The Department implements the policy and financial decisions accordingly. In the time period covered by Module 1, there were Spending Reviews in 2010, 2013, 2015 and 2019.*
59. *These processes apply to pandemic preparedness policy and spending as they do for any other area of government responsibility.*

Role of DHSC

60. *The Secretary of State has a statutory duty to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical illness: 2006 (NHS Act 2006), s.1.*
61. *DHSC is supported by two executive agencies, UKHSA (and its predecessor bodies) and MHRA, and partner organisations, for example NHSE. Their involvement in pandemic preparedness is discussed later in Section 3.*
62. *Generally, DHSC does not directly fund or deliver adult social care and much of the funding for adult social care is raised locally. The Care Act 2014 places the duty to plan and secure adult social care services on 152 Local Authorities (LAs) in England, who commission services through a predominantly outsourced market of approximately 14,000 provider organisations. DHSC is responsible for setting national policy and the legal framework, while DLUHC oversees Local Government funding and the financial framework.*
63. *The Secretary of State also has a duty to take such steps she considers appropriate to protect the public in England from disease or other dangers to*

health: s. 2A NHS Act 2006. I set out more information on public health services in Section 4.

Executive decision makers and advisers

64. *Key decision makers in respect of the Provisional Outline of Scope of Module 1 including names, roles and dates in roles are exhibited at* ***(CW/9 - INQ000023138)****. The data provided is to the best of the Department's knowledge based on records the Department has been able to access. More information on senior roles and responsibilities are set out below.*

Ministers and Special Advisers

65. *Ministers in role from 11 June 2009 to 21 January 2020 including names and dates in roles are exhibited at* ***(CW/10 - INQ000023137)****.*
66. *Special Advisers in role from 11 June 2009 to 21 January 2020 including names and dates in roles are exhibited at* ***(CW/11 - INQ000023140)****. Responsibilities have not been included for Special Advisers due to the changing nature of their roles and shared ownership of portfolios.*

Permanent Secretary

67. *As Permanent Secretary, I am responsible for:*
    a. *Ensuring ministers receive advice on strategy and objectives for the health and social care system;*
    b. *Acting as the Department's chief executive, setting standards and managing risk and assurance; and*
    c. *Acting as the Department's accounting officer, reporting to Parliament.*
68. *The Permanent Secretary is the most senior civil servant in a department. Each supports the government minister who is the head of the department, who is accountable to the Prime Minister, Cabinet, Parliament and the public for the department's performance.*
69. *The people who held the post of Permanent Secretary between 2009 and my appointment in 2016 are Sir Hugh Taylor (until 2010), Richard Douglas (Acting Permanent Secretary from June-September 2010 inclusive), and Dame Una O'Brien (October 2010- April 2016).*

Chief Medical Officer for England

70. *The CMO acts as the UK Government's principal medical adviser, and the professional head of all directors of public health (DPH) in Local Government and the medical profession in government. The CMO provides public health and clinical advice to ministers in DHSC and across government on both communicable and non-communicable diseases. The CMO is an independent position at permanent secretary level. The current post holder is Professor Sir Chris Whitty who took office*

in October 2019. Professor Sir Liam Donaldson was in post from 1998 to 2010 and Professor Dame Sally Davies was in post from 2010 to 2019.

71. *The CMO is assisted by Deputy Chief Medical Officers (DCMOs), one of whom is specifically responsible for health protection, which includes infectious threats. The DCMO for health protection was Professor Sir Jonathan Van Tam from 2017 to 2021. His predecessor was Professor John Watson, from 2013 to 2017. The second main DCMO normally covers health improvement (non-communicable diseases), but is in an emergency expected also to cover health protection issues. Professor Dame Jenny Harries was the DCMO for health improvement from July 2019 to May 2021, but due to the pandemic spent much of her time on health protection issues related to COVID-19.*
72. *Scotland, Wales and Northern Ireland also have CMOs and DCMOs for devolved health issues. The UK CMOs meet regularly.*

Second Permanent Secretary

73. *The role of the Second Permanent Secretary in DHSC was created in response to the COVID-19 pandemic. Initially the role was held by David Williams who led on Finance (including COVID-19 Finance), Group Operations and business as usual. Increasingly, as COVID-19 became the majority of the Department's work, David acted as my deputy across the board.*
74. *Shona Dunn became Second Permanent Secretary in April 2021. She is an additional accounting officer on all departmental matters and acts as deputy to the Permanent Secretary across the board. She has direct responsibility for all matters relating to Finance and Group Operations.*

DHSC Chief Scientific Adviser

75. *DHSC also has a Chief Scientific Adviser (CSA), who acts also as the head/CEO of the National Institute for Health Research (NIHR) and advises on scientific aspects of health. In the period 2016 to 2021 this was held by Professor Sir Chris Whitty. Prior to that it was held by Professor Dame Sally Davies. Professor Lucy Chappell is the current CSA, taking over from Professor Sir Chris Whitty in August 2021.*

Chief Nursing Officer

76. *The Chief Nursing Officer (CNO) for England provides clinical and professional leadership for all nurses and midwives in England (with the exception of public health and adult social care nurses) including the 350,000 nurses and midwives who work for the NHS and who make up the largest group of the total NHS workforce. Prior to 2020, leadership was provided by PHE's Director of Nursing*

and the Chief Nurse for Adult Social Care for public health and adult social care nurses respectively.

77. *Prior to the pandemic (and the merger between NHSE and NHS Improvement (NHSI) in 2022), The CNO was accountable for providing expert clinical and workforce advice to the NHS, and the Boards of NHSE and NHSI.*

78. *The CNO was a member of the joint NHSE / NHSI national leadership team, and participated fully in the wider work of NHSE and NHSI Boards as a voting member of each Board.*

79. *Prior to the establishment of NHSE in 2013, the CNO was an employee of DHSC. Previous CNOs were Dame* NR *from 2004 to 2012 and Professor Jane Cummings between 2012 to 2019. The current post holder is Dame Ruth May.*

Department of Health and Social Care Executive Structures

80. *The bodies that are most relevant to departmental governance are the following:*

Departmental Board

81. *The Departmental Board is chaired by the Secretary of State. The Departmental Board is an advisory board made up of members of the DHSC leadership team, ministers and independent non-executive board members (NEDs). It meets quarterly to discuss how the Department is performing against its objectives; identify potential threats, emerging issues and opportunities that could have an impact on policy; and provide oversight of delivery partners (namely, the Department's Arm's Length Bodies (ALBs)). The Board's work is at the discretion of the Secretary of State, with whom powers and responsibilities ultimately lie.*

82. *The Audit and Risk Committee (ARC), a sub-committee of the board, advises the Departmental Board and the Department's accounting officer on risk management, corporate governance and assurance arrangements for the Department and its subsidiary bodies and reviews the comprehensiveness of assurances and integrity of financial statements.*

Executive Committee

83. *I chair the Executive Committee (ExCo) which oversees the management of the Department. Issues it considers include strategy, finance, performance and core departmental business including Secretary of State and other ministers' priorities; system-wide finance; matching resources to priorities; and departmental pay policy decisions. ExCo meets monthly, except in August, and ad hoc when the Department's business needs require. Its current membership includes the Second Permanent Secretary, CMO, CSA, Directors General (DGs) and Directors of*

Human Resources (HR), Information Risk Management & Assurance (IRMA) and Ministers, Accountability and Strategy.

84. *ExCo does not create departmental policy. Its role is to set standards and procedures in the Department.*

85. *From June 2009 to 2013, Executive Committee was known as the "Executive Board" which comprised the Permanent Secretary, CMO and DGs. From 2013 to 26 March 2015, it was known as the "Leadership Team", before becoming the ExCo. Membership of ExCo from 11 June 2009 to 21 January 2020 are exhibited at* ***(CW/12 - INQ000023139)****, including names, roles, dates in roles and reporting lines. The data provided is, to the best of the Department's knowledge based on records the Department has been able to access.*

75. From the start of March 2020 major decisions about adult social care, along with other responses to COVID-19 were taken by the Cabinet and Prime Minister.

76. Within the Department a Gold structure was implemented on 11 June 2020 to provide oversight of the local containment aspects of the Test and Trace programme, and escalated issues requiring national decisions. As set out in the Third witness statement of Sir Christopher Stephen Wormald, dated 29 March 2023, paragraph 77, *'Weekly Gold meetings (also known as Local Action Committee meetings) were chaired by the Secretary of State and covered the latest epidemiological briefing and assessment; assurance for containment action underway; discussed the implications of any trends identified; and proposed issues to raise with the CO and Prime Minister on a weekly basis. Final decisions were taken by Ministers following recommendations to COVID(O) and COVID (S). These meetings remained in place throughout the period with which the Inquiry is concerned'.*

Statement of Truth

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.

Signed: Personal Data

Dated: 28/09/2023

Personal Data

Signed: _____

Dated: 28/09/2023