Updated 24/01/2024

Module 2 Written Closing Statement on behalf of National Care Forum, Homecare Association and Care England

1. Introduction

1.1. This is the written closing statement for module 2 of the Covid-19 Public Inquiry made by the National Care Forum, Homecare Association, and Care England.

1.2. The National Care Forum is the membership body for not-for-profit care and support organisations in England, although our members have services in all parts of the UK. Formally constituted in 2003 and building on more than 10 years of experience as the Care Forum, the National Care Forum has been promoting quality care through the not-for-profit sector for 30 years. As of 20 September 2023, the National Care Forum has over 170 members, providing care and support to over 277,200 people across 7,600 care and support settings which employ more than 124,700 staff. Our members provide a wide spectrum of services – everything from services for older people, such as residential and nursing care and specialist dementia care to offering home care, extra care housing, supported living and specialist services for people with a learning disability and autistic people and people with enduring mental health conditions or other complex needs. Some also offer homelessness, substance misuse and resettlement services. Many also offer supported housing, day services, employment support and other types of non-CQC registered care and support services.

1.3. The Homecare Association is the UK's only membership body exclusively for homecare providers. It is a private company limited by guarantee and was established as a not-for-profit Association in Autumn 1989. Founded by 75 homecare providers to represent the interests of the homecare sector, the original aims were to advocate for the sector, develop quality standards and campaign for regulation. Up until 2003, the Homecare Association's (previously UKHCA) Code of Practice was the only quality standard in homecare. Non-Executive Directors are all homecare providers, elected by the Homecare Association's members, representing small, medium, and large providers in both the state-funded and self-funded market. The Homecare Association represents members across England, Scotland, Wales, and Northern Ireland. We currently have 2,200 members, representing about one-third of registered regular domiciliary care providers. 94% of our members are based in England, 3% in Scotland, 2% in Wales and 1% in Northern Ireland. The Homecare Association uses its trusted voice to bring people together in shaping and advancing homecare.

1.4. Care England, a registered charity, is the largest representative body for residential independent adult social care providers in England. Care England members provide a variety of care services, amongst them single care homes, small local groups, national providers and not-for-profit voluntary organisations and associations, as well as private providers, for a variety of service users including older people, those with long-term conditions, learning disabilities and mental health problems. Of our membership, broadly, 60% of care providers provide care to older adults, whilst 40% provide care to younger adults, namely individuals with a learning disability and autistic people. Our members run and manage approximately 4,000 care services and provide over 120,000 beds. Care England's mission brief is to serve as a unified voice for our members and the care sector aimed at supporting a united, quality-conscious, independent sector that offers real choice and value for money.

1.5. In our opening statement for module 2 we drew attention to the general neglect shown towards adult social care by the core political and administrative decision-makers in the UK government. The various witnesses during the module 2 hearings reinforced this in their testimonies before the Inquiry. This neglect can be expressed in three ways:

I. Social care was overlooked in key decision-making moments.
II. Social care was misunderstood (it was seen as care homes for older adults, rather than a diverse system of care and support services for all ages, with a workforce of 1.6m, larger than the NHS).
III. Social care was disadvantaged, especially in comparison to the NHS. Indeed, the focus of decision-making appeared to be protecting the NHS rather than citizens in all communities.

1.6. The neglect of social care by key political and administrative decision makers was prevalent and entrenched prior to the pandemic and was then reflected in those decision makers' responses to the additional challenges faced by the sector as a result of Covid-19. We must return to the nature of administrative and political decision-making during the social care module – module 6 of the Inquiry – as there was not enough time during module 2 for the inquiry to probe deeply on this matter.

1.7. We would also like to draw the Inquiry Team's attention to the use of terminology in some of the questions posed by Counsel, and in some of the responses to these questions by witnesses. There was a tendency to conflate 'care home sector' and 'social

care sector' throughout the hearings. We would like to remind the Inquiry that social care is much broader than just care homes. By asking questions about the 'care home sector' only, there is the risk of inadvertently narrowing the scope of any inquiries, as it allows the witnesses to exclude information on the majority of the social care sector, which must also be considered. Module 6 should not be a ‘care home module’, it should be a ‘social care module’ focusing on the full diversity of care and support. We would be happy to assist the Inquiry in their understanding of the complexities of the care sector.

1.8. Social care covers a range of diverse accommodation-based and community-based services for people of all ages, all of which were impacted by the pandemic and government decision-making. This includes residential and nursing care; home care; rehabilitation and reablement; extra care housing; supported living; specialist services for people with a learning disability and autistic people; services for people with physical disabilities; and people with enduring mental health conditions or other complex needs. Some social care services also offer homelessness, substance misuse and resettlement services. Many also offer supported housing, day services, employment support and other types of non-Care Quality Commission registered care and support services.

2. Reflections on Hearings from Module 2

2.1. The evidence heard in the module 2 hearings has illustrated the general neglect and misunderstanding shown towards adult social care by the core political and administrative decision-makers in the UK government, as we have expressed in paragraph 1.5 above.

Lack of focus on adult social care from witnesses

2.2. This general neglect and misunderstanding is most evidently illustrated in the number of witnesses that appear to have ignored or minimised social care in both their witness statements and oral evidence. This is despite the express reference to social care providers in paragraph 2 of the Outline of Scope for module 2 (emphasis added)[1]:

> *“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*

[1] https://covid19.public-inquiry.uk/documents/module-2-provisional-outline-of-scope/

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****."*

2.3. Two prominent examples were the co-chairs of SAGE, Sir Patrick Vallance, the former government Chief Scientific Adviser, and Sir Chris Whitty, the Chief Medical Officer for England, who both failed to talk about adult social care at all during their public hearings or give any indication that it was even considered. Furthermore, Professor Yvonne Doyle even noted in her witness statement that Public Health England (now UKHSA) "… had no formal remit for the social care sector"[2], which if true, is extraordinary. While we accept that social care will be considered more fully in an upcoming module, we feel that the subject of this module undoubtedly influenced the social care sector, social care providers and those they support – which the Outline of Scope discussed above supports.

2.4. Another prominent example was the Rt Hon Sajid Javid MP, former Secretary of State for Health and Social Care between 26 June 2021 and 5 July 2022. During his public hearing he said nothing of substance about adult social care and continuously referred to himself as the "Health Secretary". This was despite outlining his response to the relaxing of social distancing measures over the summer and autumn of 2021, and his response to the Omicron variant in winter 2021/2022, both issues where social care should have featured prominently[3]. Indeed, this is the same period in which DHSC chose to make vaccination a condition of deployment in care homes, wider CQC registered settings and hospitals, a policy on which it later u-turned, but not before the decision had made a major detrimental impact on the social care workforce, resulting in many care workers leaving the sector. The loosening of restrictions in wider society never fully applied to social care as these announcements don't appear to have been made with any reference to the situation in the sector, resulting in DHSC and UKHSA playing catch-up after the event. For instance, on 25 November 2021, a decision was finally made to relax visiting restrictions in care homes following calls since the summer of 2021 to do so to bring care settings into line with wider society. However, less than a week later this was reversed due to the Omicron variant. Adult social care was an afterthought both at the time, and clearly, in the testimony of witnesses.

[2] [INQ000273878/21] Witness Statement of Professor Yvonne Doyle, formed Medical Director of Public Health England, dated 17/10/2023.
[3] [29/68/21 – 29/172/14] Transcript of Sajid Javid MP.

2.5. Where adult social care was mentioned by witnesses, this tended to be in relation to care homes for older adults, with a strong focus on hospital discharge policies and deflecting blame away from the key decision-makers towards the health and social care system or local government. There appears to be a lack of awareness by the key decision-makers that the decisions they made impacted not only care homes but also a much wider diversity of adult social care services, such as extra care housing, supported living, home care and wider community services for people of all ages.

2.6. For instance, the former Prime Minister, Rt Hon Boris Johnson, in the closing minutes of his oral evidence, illustrates this narrowing of focus and lack of understanding by beginning to try and allude to an argument he puts forward in his written statement:

> *"…I think the issues of health and social care are absolutely critical, and the government that I led was embarking on a big programme to try and bring them together. I think the fact that we had these delayed discharge patients was very, very difficult in the NHS…"*[4]

His witness statement expands upon this but appears to ignore the very real danger Covid-19 posed to vulnerable people in residential and community social care settings if transmission wasn't contained via lockdown or other non-pharmaceutical interventions (NPIs):

> *"It was very frustrating to think that we were being forced to extreme measures to lock down the country and protect the NHS - because the NHS and social services had failed to grip the decades old problem of delayed discharges, commonly known as bed blocking. Before the pandemic began I was doing regular tours of hospitals and finding that about 30 per cent of patients did not strictly need to be in acute sector beds."*[5]

2.7. In future modules the Inquiry must ensure that there is a much more forensic approach taken to the questioning of witnesses around the impact of decision-making and planning on adult social care. This must go beyond care homes and consider the impact on the full diversity of care services, residential and in the community.

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[4] [7/201/4-8] Transcript of Boris Johnson, former Prime Minister of the United Kingdom.
[5] [INQ000255836/88] Witness statement of The Rt Hon Boris Johnson, former Prime Minister of the United Kingdom, dated 31/08/2023. Paragraph 331.

Lack of Planning and Consideration

2.8. The module 1 hearings clearly showed that in the years leading up to the pandemic, adult social care faced neglect from the core political and administrative decision-makers in the UK government, including omission from key pandemic planning exercises. It is apparent from the module 2 hearings that this state of affairs continued during the pandemic with decisions regarding social care often coming much later than decisions for the NHS or wider society, if at all. Social care continued to be an afterthought in the government's response, leaving social care providers to respond to the unfolding crisis on their own, without the necessary support and resources in place.

2.9. The module 2 public hearings have shown that planning assumptions were based on 2011 flu pandemic planning, and that there does not appear to have been any effective planning in place in general. Helen MacNamara makes this clear in her written and oral evidence when asked about the March 2020 coronavirus action plan and the apparent absence of detailed planning:

> *"So, of all of the things I had to go back and read, I found re-reading this document one of the hardest in retrospect, because it's so far away from what the reality turned out to be. I -- like Mr Cain, I thought it was a communications document and that underneath it there would be things that I would recognise as a plan, as in who's doing what by when, what's the strategy, some enormously laborious bureaucratic documents which I knew and loved at the time, and I thought that's what was there was, and it was, of all of the shocking things at that period of time, discovering that there wasn't actually that sort of document."*[6]

2.10. Likewise, on 13 March 2020, Mark Sweeney, Director General of the Cabinet Secretariat in the Cabinet Office, the person in charge of co-ordinating with DHSC, stated:

> *"I have been told for years that there is a whole plan for this. There is no plan. We are in huge trouble"*[7].

[6] [1/23/11-22] Transcript of Helen MacNamara, former Deputy Cabinet Secretary.
[7] [1/37/7-9] Transcript of Helen MacNamara, former Deputy Cabinet Secretary.

2.11. If there was no general plan, there certainly wasn't one for adult social care and the recognition of this fact came far too late. DHSC appears to have only begun to make inquiries into the state of pandemic planning in social care on 2 March 2020 and found there were only 2 pandemic contingency plans[8] - presumably Local Resilience Forum plans. Despite the obvious scale of the challenge in responding to a pandemic and the obvious co-morbidities of those who access social care, DHSC witnesses continued to try and absolve the government in written and oral evidence from not taking earlier action by stating that the sector had the obligation, regardless of funding, to plan and respond to the pandemic itself:

> *"So our early position had been, according – essentially the constitutional position, which is that care homes are legally responsible to, contracted by, local authorities, and therefore they reported action through local resilience -- to local authorities, through local resilience fora, up to MHCLG, and the department is responsible for social care with respect to policy but not to any of the legal contracting or indeed the reporting. That was the position going into the pandemic. …. Helen Whately then, in early March, came to the very firm view that not enough was happening. In February we had had discussions with the care sector, we'd had roundtables, but the policy position going in was that local authorities are responsible..."*[9]

2.12. Planning that did subsequently happen focused on modelling NHS capacity, when that might be breached, and actions needed to stop hospitals getting overwhelmed – not social care. In his public evidence, Professor Neil Ferguson revealed that SPI-M-O had not modelled the impact on social care before 23 March 2020:

> *"I mean, that's true, we modelled -- all the models had age-related risk in them, and we were looking at shielding options for the elderly, but no models explicitly represented the care sector. They did represent hospitals, in some sense, but we didn't represent nosocomial -- hospital-based transmission.*[10]"

2.13. Similarly, an email from Alexandra Burns on 3 April 2020, confirms that there is no plan for care homes, let alone wider social care, and that NHS capacity is priority:

[8] [30/142/10-25] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.
[9] [30/141/15 – 30/142/7] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.
[10] [17/169/1-7] Transcript of Professor Neil Ferguson.

> *"I know that social care is front and centre of a range of conversations that are happening on eg. PPE or testing (though of course is always second to the NHS) – but do we know whether there is a coherent overall strategy for care homes? In either DHSC or in MHCLG or between them? It feels like maybe we need one in the way we have one for the NHS…. Most of what I've seen on care homes has been about supporting the NHS and capacity…."*[11]

2.14. Evidence presented by several witnesses also confirms that the decision to move towards stricter NPIs and lockdowns away from a mitigation strategy over the weekend of 13-15 March 2020 was due to the realisation that a herd immunity strategy would result in NHS hospital capacity being overwhelmed, rather than any wider considerations about vulnerable people in social care or wider society. That such a policy was ever entertained tells us something about the government's understanding of adult social care and co-morbidities, and the former PM's comments outlined in 2.6 above.

2.15. Evidence would also appear to show that just like Operation Cygnus in 2016 failed to involve and inform adult social care, Operation Nimbus in February 2020 repeated the same mistakes. The summary slides show that impact on adult social care providers was not considered.[12]

2.16. Even by 17 April 2020, the situation in social care was only accidentally and partially recognised by some decision-makers because of a data exercise looking at the situation in hospitals. An email chain between Graham Medley and Patrick Vallance, which was primarily looking into modelling and data around hospitals, revealed how dire the situation really was for care homes and the need for more dramatic measures.[13]

2.17. Some of the most important policy decisions relevant to the social care sector, particularly in February and March 2020, were taken without appropriate consideration or even consultation with adult social care providers. This resulted in the production of inappropriate guidance (which changed at short notice), a fixation on only one part of the social care sector and a complete failure to put clinical and local government resources in the places they were most needed. This was a theme that repeated at times of crisis,

[11] [INQ000198032/1] Email chain between Alexandra Burns, Simon Ridley and colleagues at No.10 and Cabinet Office regarding protecting social care from COVID, dated 03/04/2020.
[12] [INQ000052022/1, 7, 8] Presentation titled Exercise NIMBUS Briefing, Public Health England, undated.
[13] [INQ000260625/1-7] Emails between Patrick Vallance and Graham Medley, regarding hospital metrics, dated between 14/04/2020 and 17/04/2020.

such as the move towards the third lockdown over the Christmas and New Year period of 2020/21 and the emergence of the Omicron variant in 2021. The exclusion of scientific or operational expertise in social care from SAGE and other government advisory and decision-making bodies contributed towards this, notwithstanding the creation of the 'care home subgroup', and its later widening to a 'social care subgroup'. The creation of the Social Care Covid-19 Support Taskforce in June 2020 came too late and while it helped coordinate a response, many of its recommendations were simply ignored by the government – particularly those relating to financial support for the care workforce.[14]

2.18. Moving through the different phases of the pandemic, it was clear that as restrictions eased or were reimposed for wider society, there was confusion across government about how this might work for those using care and support services – decision-makers simply did not grasp or understand social care nor seek to meaningfully involve those who did.

Culture and Senior Decision Makers

2.19. The module 2 hearings show that the culture surrounding senior decision-makers contributed to the sidelining of social care throughout the pandemic.

2.20. Helen MacNamara in a draft report describes the culture cogently:

> *"Not sustainable. People are exhausted and stressed. Don't feel confident or empowered to take decisions (... universal sense of powerlessness ...). Trying to do too much so nothing is done well ... Views ignored. Bad behaviours from senior leaders tolerated ... Too many people behaving as if they have been parachuted in to save the day…Lots of people mentioned junior women being talked over or ignored. We need a modern culture of organised collaboration not superhero bunfight."*[15]

Likewise in her witness statement:

> *"The dominant culture was macho and heroic. Neither are the preserve of men (women can be macho and heroic too) but the culture was problematic because it*

[14] Social Care Taskforce Workforce Advisory Group Report and Recommendations 7.8.20. Publicly available at https://assets.publishing.service.gov.uk/media/5f6493448fa8f5107025c182/8_Workforce_Advisory_Group_report_accessible.pdf.
[15] [1/65/6-19] Transcript of Helen MacNamara, former Deputy Cabinet Secretary.

meant debate and discussion was limited, junior people were talked over, and it felt that everything was contaminated by ego. It was positively unhelpful when the country needed thoughtful and reflective decision making."[16]

2.21. Such a culture had a direct impact on adult social care as it allowed blind spots to form which prevented the recognition and resolution of key issues by decision makers. One example was the sidelining of women:

"In terms of the policy response the exclusion of a female perspective led to significant negative consequences, including the lack of thought given to childcare in the context of school closures. There was a serious lack of thinking about domestic abuse and the vulnerable, about carers and informal networks for how people look after each other in families and communities"[17].

2.22. A powerful example of this can be seen in the procurement of PPE in adult social care. Over 80% of the workforce is female, and yet it appears that senior decision-makers did not consider the fact that the PPE being procured did not fit female bodies – an issue many of our members faced, exacerbating the issue of shortages of supply. Simon Ridley, Director General, Cabinet Office stated on 16 April 2020 when the issue was raised:

"…it is not something that's been in conversations I have had thus far."[18]

2.23. The attitude of senior decision-makers towards people receiving care and support lacked humanity and displays a fundamental ignorance of the wide range of ages of people adult social care services cater for, or the composition of the workforce. The most prominent example are several comments attributed to the former Prime Minister, the Rt Hon Boris Johnson, made at times of key decisions which are focused entirely on older adults. Behind the attitude of the former PM and other senior leaders appears to be an assumption that only older adults nearing the end of life use social care services.

[16] [INQ000273841/52] Witness statement of Helen MacNamara, dated 09/10/2023, paragraph 102.
[17] [INQ000273841/52] Witness statement of Helen MacNamara, dated 09/10/2023, paragraph 103.
[18] [INQ000286059/1] Email between Helen MacNamara, Deputy Secretary to the Cabinet, Simon Ridley, Director General, Cabinet Office and other colleagues regarding PPE & women, dated between 15/04/2020 and 30/04/2020

2.24. On 26 August 2020, the former PM was recorded as being '*obsessed with older people accepting their fate...'.*[19] This came at the same time as government was actively discussing 'segmenting' older people and others who were 'extremely vulnerable' from the rest of society so they could proceed with lifting further restrictions.

2.25. In October 2020, the former PM argued for *"letting it all rip",* acknowledging that *"there will be more casualties but so be it – they've had a good innings".*[20]

2.26. On 14 December 2020, in the midst of a Covid-19 surge leading to a third lockdown, Johnson is recorded as saying he agrees with the sentiment that "*Covid is just Nature's way of dealing with old people…".*[21]

2.27. On 15 December Johnson is recorded as saying *"I think we should let the old people get it & protect others"*.[22]

2.28. Similarly, there was a culture which cared more about 'optics' than vulnerable people. One striking example is the false assumption from one of Matt Hancock's advisers on 4 April 2020 that people in care settings were at the end of their lives from the perspective of PR management:

> *"Do we also need a push on testing in care? Or at least have some sort of focused effort on testing people in care. I know it is complex and the people dying in care homes are often people who were near the end regardless, but I worry that if a load of people in care start dying, there will be front pages demanding why we weren't testing people in care homes."*[23]

2.29. A culture which failed to properly consider the impact of decisions on social care, and the impact of Covid-19 on vulnerable groups, contributed to a stark outcome. There were 180,000 deaths from Covid-19 March 2020 to end-July 2022 in England and Wales. Those most impacted were not just older adults, but many other groups accessing and

[19] [INQ000273901/150] Inquiry Legal Team Chronological List of Key Extracts from Sir Patrick Vallance's Notebooks, dated between January 2020 and February 2022.
[20] [INQ000273901/245] Inquiry Legal Team Chronological List of Key Extracts from Sir Patrick Vallance's Notebooks, dated between January 2020 and February 2022.
[21] [INQ000273901/308] Extract of Inquiry Legal Team Chronological List of Key Extracts from Sir Patrick Vallance's Notebooks, dated between January 2020 and February 2022.
[22] [INQ000273901/312] Extract of Inquiry Legal Team Chronological List of Key Extracts from Sir Patrick Vallance's Notebooks, dated between January 2020 and February 2022.
[23] INQ000093254/6] Matt Hancock's WhatsApp messages from Top Team group, dated 04/04/2020.

working in adult social care. Mortality rates were higher among people with a self-reported disability or a learning disability – the risk of death from Covid-19 in England was 3-4 times higher in more-disabled men and women compared with non-disabled people. Mortality rates were also higher among some ethnic minority groups – particularly Bangladeshi, Pakistani and Black Caribbean groups. Mortality rates were also 2.6 times higher in the most deprived than the least deprived tenth of areas. People working in social care had significantly higher rates of death involving Covid-19 than the population among those of the same age and sex.[24]

Asymptomatic Transmission and Hospital Discharge

2.30. In much of the evidence presented by the government and its officials, and in particular DHSC officials and former ministers, there was an emphasis that the government sought to put a '*protective ring*' around care settings from the beginning of the pandemic and adapted as the science led. Various witnesses have sought to maintain that the nature of asymptomatic transmission wasn't fully understood until relatively late in the first wave and as such, decisions to restrict community testing or implement mass hospital discharges without testing into care settings in March 2020, were based on the best scientific knowledge at the time. The module 2 public hearings however present a different reality – one in keeping with the experience of our members.

2.31. In February and early March 2020 care providers were told there was no risk of community transmission from Covid-19 and that the risk of infection was very small.[25]

2.32. Sir Christopher Wormald, Permanent Secretary of DHSC, in his public evidence, claims that in March 2020 there was nothing to suggest community transmission or asymptomatic spread:

> *"And I think at that particular moment in time that has proved to be correct. Now, obviously later in the pandemic, and as I'm sure I will be giving evidence on this in a future module, that position changes completely, but at this particular moment in time I haven't seen anything to suggest that that advice was incorrect or out of line with our scientific advice at that time."*[26]

[24] The King's Fund - Deaths from Covid-19 (coronavirus): how are they counted and what do they show? https://www.kingsfund.org.uk/publications/deaths-covid-19.
[25] [INQ000051209/2, 6, 12] Guidance for Social/Community Care and Residential Settings. Dated 24.2.20, published on 25.2.20.
[26] [2/161/12-19] Transcript of Christopher Wormald, Permanent Secretary of DHSC.

2.33. However, the module 2 hearings have made it clear that there were strong suspicions of asymptomatic transmission by the end of February 2020 by scientists which were communicated to senior officials and decision makers.

2.34. On 28 January, during a meeting Matt Hancock attended he was told that there was evidence of asymptomatic transmission:

> *"CMO commented that there is now credible evidence of asymptomatic transmission within Germany"*[27]

2.35. At a meeting of SAGE on 4 February 2020, it was stated:

> *"Asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely."*[28]

2.36. A meeting of NERVTAG on 21 February 2020 drew upon emerging evidence from Singapore, South Korea and Japan to conclude:

> "…the evidence suggests that 40% of virologically confirmed cases are asymptomatic."[29]

2.37. On 24 February 2020, PHE formally advised DHSC that no discharges should be made to residential care homes due to the risk of transmission.[30]

2.38. In July 2020, WhatsApp exchange between Vallance and Whitty made it clear that by March 2020 they "*were pretty clear that we thought there was asymptomatic transmission."*[31]

2.39. If asymptomatic transmission was strongly suspected, and senior officials were informed, why wasn't a more precautionary approach taken? Instead, key decision

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[27] [INQ000233747/2] Extract of Email from the Private Office of the Secretary of State for Health and Social Care (DHSC) to Emma Reed (DHSC) and colleagues, dated 29/01/2020.
[28] [30/49/21-23] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.
[29] [30/50/3-6] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.
[30] [1/26/19 – 1/27/23] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.
[31] [INQ000229430/2] Sir Patrick Vallance's SMS messages with Professor Sir Chris Whitty, dated 24/07/2020.

makers appear to have pressed ahead with plans to issue guidance on 25 February 2020 that 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 unlikely that anyone receiving care in a care home or the community will become infected"*[32]

2.40. In paragraphs 40-49 of Matt Hancock's second witness statement, he discusses decision-making on guidance to care homes[33]. Hancock omits to mention guidance for other care settings, though the people these services catered for were also at higher risk than most. Guidance issued to the care sector in February 2020 and March 2020 recommended against the wearing of face masks in care settings; suggested that people in care settings were unlikely to be infected; and that asymptomatic transmission was unlikely. At this time, it is clear that NHS and PHE officials had little knowledge of social care, and the DHSC's adult social care team was inexperienced and understaffed.

2.41. In this context, the decision to move towards mass discharge from hospital to care homes, without the necessary testing, clinical support or resources, and consideration of wider social care settings, was pushed by senior decision makers despite knowing the suspicions of asymptomatic transmission. In making these decisions, it appears NHS capacity was at the forefront of decision making. Thus, Professor Dame Jenny Harries stated on 16 March 2020 that mass discharge to care homes without testing, and regardless of covid-19 status will be[34]:

> *"…entirely clinically appropriate because the NHS will triage those to retain in acute settings who can benefit from that sector's care. The numbers of people with disease will rise sharply within a fairly short timeframe and I suspect make this fairly normal practice and more acceptable, but I do recognise that families and care homes will not welcome this in the initial phase."*[35]

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[32] [INQ000051209/2] Guidance from PHE titled 'Guidance for Social/Community Care and Residential Settings on COVID-19, to social and community care and residential care providers', dated 20/02/2020.
[33] [INQ000232194/10-12] Witness Statement of Matt Hancock, Member of Parliament for West Suffolk, dated 03/08/2023.
[34] INQ000151605: Extract of Email chain from Jenny Harries to various recipients including Rosamond Roughton and Jonathan Van Tam, regarding vulnerable groups pathway - identifying the clinical risk groups and aligning with social and local systems, between 14/03/2020 and 15/03/2020.
[35] [INQ000151606/1] Email from Rosamond Roughton to Jenny Harries, Director for Adult Social Care, DHSC and other recipients regarding shielding and care homes, dated 16/03/2022.

2.42. On 19 March 2020, guidance was issued to care settings and hospitals to discharge without testing or any acknowledgment of the impact on care settings. This came despite a notification by PHE on 10 March of the first outbreak in a care home, which increased to 37 outbreaks by 19 March 2020.[36] It appears the guidance accompanying it was not updated to reflect these changing circumstances and understanding of risk.

Adult Social Care Testing

2.43. In all the evidence we have seen and heard in module 2, no one appears to have considered the impact of such discharges and asymptomatic transmission on the wider adult social care sector, rather than just care homes for over 65s. This oversight can also be seen clearly seen in the approach to testing and guidance. It took until 2021 before the entire social care sector had access to asymptomatic testing.

2.44. The NHS had priority access to testing throughout the pandemic, but testing came far too late for adult social care. Announcements that testing was being made available, was not the same as actually providing testing facilities and resources – a mistake several witnesses have made in their evidence.

2.45. Testing for symptomatic staff in care homes for over-65s and up to the first 5 symptomatic residents was announced on 15 April 2020. A further announcement on 28 April announced that this would be extended to one-off asymptomatic care home staff and residents in homes for over-65s, going live on 11 May (capped at 30,000 tests a day). On 7 June 2020, it was announced that asymptomatic whole home testing would be carried out for all care homes, and on the 6 July 2020, it was announced this would become regular asymptomatic testing of staff and residents in older adult homes.

2.46. However, throughout this period it was incredibly difficult to access testing when it was needed. Regular asymptomatic whole home testing was not fully rolled out until late September 2020 due to an issue with Randox Manufactured tests which were withdrawn on 16 July 2020.

2.47. Wider social care settings appear to have been completely deprioritised until winter 2020/2021. Whole home asymptomatic testing was not rolled out to high risk supported

[36] [1/36/1 – 1/39/15] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.

living and extra care settings until October 2020. An announcement was made on 20 November 2020 to regularly test asymptomatic home care staff after months of asking. Most (75%) of the initial tranches of the Infection Control Fund (designed to help those isolate who tested positive) were allocated to care homes. Many homecare workers on zero-hour contracts received no sick pay whilst isolating, until later rounds of the Infection Control Fund addressed this issue. On 23 December 2020, a new testing regime was implemented in care homes for older adults, albeit with no notice, or supply of tests, to require 2 LFD tests + 1 PCR test per week. On 17 February 2021, regular asymptomatic testing was finally introduced for adult social care staff in community settings, such as PAs, unpaid carers and day services.

2.48. Throughout, the NHS was prioritised for testing, and every change or addition of testing for social care, resulted in numerous new pieces of guidance, often issued by PHE/UKHSA at weekends or on bank holidays, and frequently full of mistakes and showing a lack of understanding of the sector and those it supports. This was incredibly difficult to operationalise.

PPE

2.49. We've already touched on the suitability of PPE for the social care workforce in paragraph 2.22, but the supply of PPE during the first wave was a significant issue for our members and the responses of some of the witnesses illustrates the lack of understanding about adult social care.

2.50. The former Secretary of State for Health and Social Care, the Rt Hon Matt Hancock MP, was very keen to emphasise during his oral evidence that the government was making free PPE available to care homes to help them with the discharge policy and that:

> *"Most care homes are private organisations and hitherto had always bought their own PPE, and we decided that they should get free PPE."*[37]

2.51. This statement omits several factors. The first is that the free distribution of PPE did not start until 19 March 2020, the same day as the mass discharges from hospital began – there was no time to operationalise the policy. Second, the free PPE was the equivalent of 300 face masks for care homes but guidance changes in March and April

[37] [1/35/20-22] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.

2020 meant that a typical care home would need thousands of pieces of PPE per month, and not just face masks, to manage outbreaks. Instead, the government assumed that providers would *"order PPE from their usual suppliers"*[38] once that supply ran out, apparently ignorant of the fact that many social care providers had never procured PPE on this scale before. Third, the free PPE was often delivered to the wrong addresses. Fourth, it wasn't just care homes that needed PPE, but the entirety of the adult social care sector. Fifth, adult social care providers had never needed to procure PPE on this scale before and the systems and structures were not in place to enable private procurement. They were initially denied access to NHS procurement. Lastly, where providers did manage to secure PPE, this was often requisitioned by the NHS – this is backed up by the notes of the national steering group meeting on 26 February 2020 which states that there was:

> *"Hard evidence of providers failing to get PPE they had paid for as it was requisitioned for the NHS"*[39]

2.52. The Inquiry must explore the impact of shortages of suitable PPE in adult social care in later modules due to the decisions and practices of key decision-makers and NHS procurement.

Vaccines

2.53. We have touched on this in paragraph 2.4. While we recognise there is a module on vaccination, we were nevertheless surprised that module 2 did not consider the impact of the chaotic introduction of vaccination as a condition of deployment (VCOD) policy and its subsequent U-turn by former Secretary of State, the Rt Hon Sajid Javid MP. The decision-making processes around mandatory vaccination policies had a detrimental effect on the social care workforce and made it harder for providers in their influencing work to encourage vaccine take-up at a critical stage of the pandemic. The government did not properly consider the balance of risk, and the scientific basis of the VCOD policy

[38] [INQ000106256] Exhibit CW3/435: Notice from Rosamond 'Ros' Roughton (Director of Adult Social Care, Department of Health & Social Care) titled Personal Protective Equipment for the Care Sector, dated 18/03/2020. Produced within the Department of Health and Social Care corporate statement of Sir Christopher Wormald at INQ000144792.
[39] [INQ000114887/2] Meeting notes for National Steering Group (Coronavirus), attended by John Kennedy and others regarding Updates from Department of Health and Social Care, local situation and other issues, dated 26/02/2020.

was questionable The Inquiry must revisit this in both the vaccine and social care modules.

2.54. The Inquiry must also explore the vaccine roll-out in the care sector. In residential care settings, there was much wasted time and effort due to vaccination teams visiting residential care settings to vaccinate residents but not staff. For homecare workers and other care workers in the community, booking vaccinations was initially challenging. Either the NHS or DHSC declined to open the National Booking Service for homecare workers and other care workers in the community and instead asked local authorities to organise vaccination. This exposed the fact that many local authorities had little contact with homecare providers serving the self-funder market. Wide variation in performance in rollout of vaccines was observed as a result. The Homecare Association published research showing that vaccination targets for homecare were unlikely to be met unless the National Booking Service was opened for this purpose[40]. This led to a change of plan and homecare workers were able to book vaccination via the national system.

Financial Support to Enable Infection, Prevention and Control

2.55. The drip feeding of funding and support throughout the pandemic was unhelpful, insufficient, inefficient and bureaucratic. Whilst all funding was greatly needed and appreciated, it came after very significant advocacy from the sector and was provided only in the form of emergency short term time limited funding. This short-termism meant providers were unable to put long-term protective measures in place, and plan accordingly. Funding was driven through local authorities, with significant grant conditions, leading to excessive administration and bureaucracy in relation to accounting and reporting. It is also worth noting that the emergency financial support designed to address additional demands placed upon the sector stopped in March 2022, but associated guidance remained in place for several months in relation to testing and isolation requirements, placing continued pressure on employers regarding pay and sick pay without any financial assistance.

2.56. The module 2 hearings give wider context to why this was – the Treasury was resistant to making the money available to tackle the virus effectively among vulnerable groups. One example was the attempt by DHSC to prohibit the movement of staff

[40] https://www.homecareassociation.org.uk/resource/vaccination-of-homecare-workers-against-covid-19.html

between care homes as a matter of law, backed by financial support to make this possible. This was blocked on more than one occasion in 2020 by the Treasury despite several attempts by the Minister for Care, Helen Whately MP, before a watered-down version appeared in Spring 2021. The then Chancellor claims not to have been privy to these conversations and decisions.[41]

2.57. The Treasury also appears to have pushed back against the proposals for a 'circuit breaker' lockdown in early autumn 2020 highlighting the impact on businesses, without considering the impact of delay on vulnerable people.[42]

The Diversity of Care

2.58. The evidence heard in module 2 makes clear that there was and still is a limited understanding by senior decision makers of the broader community provision that many providers offer alongside regulated care services. There was also limited understanding of the needs of those who use care and support services – for example, the needs of those with dementia or those with learning disabilities or enduring mental health issues.

2.59. The evidence from the module 2 witnesses makes it clear that decision makers did not give enough consideration of people with disabilities or autism during the pandemic, and the sad statistics outlined in paragraph 2.29, testifies to this fact. However, the Inquiry has not considered the fact that many of these people were and are supported by various forms of adult social care. The support, or lack thereof, from government needs to be explored in future modules.

2.60. Future modules will also need to explore how it was possible for blanket decision making around do not attempt cardiopulmonary resuscitation orders ("DNACPRs") to be made by NHS decision makers for people with a learning disability and older people without involving people or their families or taking into account each person's individual circumstances. This does not appear to have been explored in any great detail as part of the module 2 hearings.

[41] [11/192/19 – 11/196/9] Transcript of Rishi Sunak MP in his capacity as former Chancellor.
[42] [INQ000184589/2] Briefing for Covid Strategy Committee (Covid-S), regarding Circuit Breaker, Hospitality restrictions, Mass Events and Joint Bio-Security Centre - Local/Regional interventions, dated 21/09/2020.

2.61. The lack of action and understanding by government decision-makers is perhaps best highlighted by the fact that the former Minister for Disabled People did not mention social care once in his written or oral evidence.

2.62. The experience of our members is that while care homes for older adults did eventually get some measure of engagement from policy makers, providers of services for people supported at home, people of working age or with a learning disability or autism were generally neglected in comparison in terms of guidance, resources, and support.

Accountability, Fragmentation and Data

2.63. It has not gone unnoticed that many of the key decision makers and officials have used their witness statements and oral evidence to claim they never saw certain documents, weren't involved in certain key decisions, had no recollection of documents or discussions, or that someone else or another organisation had responsibility. Some of these have already been outlined in our reflections above. This fixation on avoiding blame is unhelpful as it prevents the Inquiry from getting to the root of problems, so they aren't repeated.

2.64. For instance, Professor Yvonne Doyle stated in her witness statement that *"PHE had no formal remit for the social care sector"*[43] before going on to describe the creation of guidance and management of infection control measures in residential social care settings which very much sounds like PHE has a formal remit for the people served by social care.

2.65. Common reasons given for the difficulty in grappling the crisis in adult social care by witnesses included the lack of data, the fragmentation of the adult social care sector and the fact that responsibility lay with local government (ignoring the obvious fact that central government funds local government). For instance, the former Secretary of State, the Rt Hon Matt Hancock MP, when questioned about PPE and funding responds by outlining the responsibilities of local government and DLUHC:

[43] [INQ000273878/21] Witness Statement of Professor Yvonne Doyle, formed Medical Director of Public Health England, dated 17/10/2023.

"Also there's another structural point which is really important here, which is that care homes and all of social care is legally responsible to local authorities, it is commissioned by local authorities, and so there's a structural problem which is that the responsibility and policy questions inevitably, especially in a crisis, flow to the national government but the levers, the policy, the formal policy, and all of the legals are in the hands of local government. And so we started this with a social care sector, you know, in need of reform, where the reforms hadn't happened and where the formal legal responsibility was for local authorities."[44]

2.66. The former Cabinet Secretary and Head of the Civil Service makes the same point:

*"**…**I think your example of the social care sector is particularly pertinent because of the fragmented nature of that sector. DHSC had oversight of it but no direct control, and it's provided through a mixture of public and private, national, local, third sector, et cetera. So a complex sector. I suspect we may come back to this point. But the contingency planning should have covered that sector, even though it wasn't directly within the department's responsibility."*[45]

2.67. Such considerations should not absolve central government of its responsibilities to prepare for a pandemic and ensure that, in a global crisis of the scale of Covid-19, central decision-makers are making every effort to protect vulnerable people. It is, after all, the Department Health ***and Social Care***. The evidence presented in module 2 shows that there was enough data from abroad, particularly with what was happening in Italy in February 2020, and from care providers, as well as the concern of scientists around asymptomatic transmission (particularly findings from the Diamond Princess in Japan[46]) to have known what the impact of Covid-19 would be for the demographics of people using adult social care services. At the very least, the precautionary principle should have triggered a greater, and earlier, response by central government to the unfolding crisis in adult social care. Our members could only do so much on their own, backed by underfunded local authorities. When we needed the full might of the state behind us, it was absent.

[44] [1/28/21 - 1/29/8] Transcript of Matt Hancock MP, former Secretary of State for Health and Social Care.
[45] [8/61/15-24] Transcript of Lord Mark Sedwell, Former Cabinet Secretary and Head of the Civil Service.
[46] [INQ000052172/3] Coronavirus - Sitrep Update No. 46 from the Home Office, dated 25/02/2020.

2.68. On the fragmentation point, we would point out that the NHS is also a fragmented organisation, made up of thousands of organisations and sites, including private healthcare providers, such as private hospitals, GP clinics, dental clinics and pharmacies, not to mention the multiple Health Trusts. Yet, the government is not using the same argument about fragmentation with regards to its response to the NHS.

3. Concluding Remarks

3.1. Following the evidence and oral testimony presented during Module 2, and the notable absence of meaningful discussion relating to adult social care despite the Outline of Scope, we trust that it is clear to the Inquiry that adult social care was largely an afterthought before, during and after the pandemic. This can be expressed in three ways:

i. Social care was overlooked in key decision-making moments.
ii. Social care was misunderstood (it was seen as care homes for older adults, rather than a diverse system of care and support services for all ages, with a workforce of 1.6m, larger than the NHS).
iii. Social care was disadvantaged, especially in comparison to the NHS. Indeed, the focus of decision-making appeared to be protecting the NHS rather than citizens in all communities.

Social Care was overlooked in key decision-making moments

3.2. The Inquiry has seen that adult social care was overlooked in key decision-making moments. Indeed, a striking example, as we have shown above, is the silence of the Rt Hon Sajid Javid MP, on adult social care in his evidence. This is despite outlining his response to the relaxing of social distancing measures over the summer and autumn of 2021, and his response to the Omicron variant in winter 2021/2022, both issues where social care should have featured prominently[47]. The loosening of restrictions in wider society never fully applied to social care as these announcements don't appear to have been made with any reference to the situation in the sector, resulting in DHSC and UKHSA playing catch-up after the event.

[47] [29/68/21 – 29/172/14] Transcript of Sajid Javid MP.

Social care was misunderstood (it was seen as care homes for older adults, rather than a diverse system of care and support services for all ages, with a workforce of 1.6m, larger than the NHS).

3.3. Social care was completely misunderstood by policymakers and decision-makers throughout the pandemic, as shown in the evidence presented by witnesses. Guidance, testing and financial support often came late, were ill-thought through and skewed towards care homes for older adults. The chaos around PPE illustrates this point well. It is clear that policymakers did not consider that 80% of the social care workforce was female when procuring PPE that was designed for men. Similarly, the decision to distribute 300 facemasks to all care homes for older adults on 19 March 2020 appears to have overlooked the fact that a typical care home would need thousands of masks a month to meet the demands of the guidance, as well as other forms of PPE. It also overlooked the fact that it wasn't just care homes that needed PPE, but the entirety of the adult social care sector. Adult social care providers had never needed to procure PPE on this scale before and the systems and structures were not in place to enable private procurement.

Social care was disadvantaged, especially in comparison to the NHS. Indeed, the focus of decision-making appeared to be protecting the NHS rather than citizens in all communities.

3.4. It is clear from the evidence in Module 2 that the overarching concern of decision-makers during the pandemic was the capacity of NHS hospitals, rather than the protection of citizens in all communities. Such logic enabled key figures, such as Professor Dame Jenny Harries, to recommend the mass discharge of people to care homes without testing, regardless of Covid-19 status in March 2020. It also enabled the former PM, the Rt Hon Boris Johnson, to state"[48]:

> *"It was very frustrating to think that we were being forced to extreme measures to lock down the country and protect the NHS - because the NHS and social services had failed to grip the decades old problem of delayed discharges, commonly known as bed blocking."*

[48] [INQ000255836/88] Witness statement of The Rt Hon Boris Johnson, former Prime Minister of the United Kingdom, dated 31/08/2023. Paragraph 331.

Future Modules

3.5. The Inquiry must return to the nature of administrative and political decision-making during the social care module – Module 6 of the Inquiry – as there was not enough time during this module for the Inquiry to probe deeply on this matter. Many witness statements were conspicuously silent about anything relating to adult social care or limited their response to talking about care homes only. We have included an appendix outlining the issues our respective provider members experienced during the pandemic and which the Inquiry must consider.

3.6. As we have outlined, there was a tendency to conflate 'care home sector' and 'social care sector'. We would like to remind the Inquiry that social care is much broader than just care homes. By asking questions about 'care home sector' only, the scope of the inquiries is being inadvertently narrowed, as it allows the witnesses to exclude information on most of the social care sector.

3.7. Module 6 must not be solely a ‘care home module’ or just a ‘registered care module’. It must be a ‘social care module’ focusing on the full diversity of care and support. The Inquiry must recognise that social care covers a range of diverse accommodation-based and community-based services for people of all ages, all of which were impacted by the pandemic and government decision-making. This includes residential and nursing care, home care, rehabilitation and reablement, extra care housing, supported living, specialist services for people with a learning disability and autistic people, and people with enduring mental health conditions or other complex needs. Some social care services also offer homelessness, substance misuse and resettlement services. Many also offer supported housing, day services, employment support and other types of non-Care Quality Commission registered care and support services. Such a focus will allow the Inquiry itself to avoid the pitfall suffered by key administrative and political decision makers before, during and after the pandemic, of overlooking and failing to understand adult social care.

Appendix: What the Inquiry Must Consider in Future Modules

Throughout the pandemic, the National Care Forum, Homecare Association and Care England had extensive conversations with our respective provider members. In our opening statement for Module 2, we summarised the themes arising from these conversations. The Inquiry must consider these themes in future modules as many of them have not being explored during Module 2:

i. **There was a disregard for the people drawing on care and support from government and the wider health system -** For those living in care settings and for those who need care and support in the community, there was a lack of understanding of their needs and circumstances. This lack of understanding and the lack of understanding of the social care sector as a whole, especially the breadth and diversity of it and those who use it, manifested itself as an apparent disregard for the people relying on care and support during the pandemic. This is demonstrated by the following:
   a. PPE supply for the social care sector was particularly chaotic during the first wave.
   b. The importance of testing across social care did not appear to be recognised by policymakers for a significant period, and whole home routine testing for all care homes was not reliably available until September 2020. Testing was not widely available for homecare until January 2021.
   c. Some of the most important policy decisions relevant to the social care sector were taken without appropriate consultation with the sector itself.
   d. Scientific and operational expertise in social care was excluded from the SAGE.
   e. There was blanket decision making around do not attempt cardiopulmonary resuscitation decisions (“DNACPR”) by NHS colleagues for people with a learning disability and older people without involving people or their families or taking into account each person’s individual circumstances.
   f. Guidance in relation to visiting showed a lack of understanding of the practicalities of the sector, and those supported within it, particularly when it came to people with learning disabilities and autistic people.
   g. The decision to instantly withdraw community health services for the social care sector at the beginning of the pandemic brought significant risks to people’s health and may well have precipitated a decline in their overall health and wellbeing.

h. Care Act ‘easements’, allowing local authorities to cease formal Care Act assessments, applications of eligibility and reviews were made available very promptly in the early pandemic and enabled Local Authorities to abandon some of their responsibilities to people under the Care Act.
i. Moving through the different phases of the pandemic, it was clear that as restrictions eased for wider society, there was confusion across government about how this easing might work for those using care and support services.

ii. **There was a disregard for the people <u>working</u> in social care from government and the wider health system -** Priorities and guidance should be developed in partnership between health and social care services. Within this partnership, independent sector care providers should be seen as long-term legitimate partners instead of being used to overcome short-term pressures. This is demonstrated by the following:

a. Very significant delays to essential practical support for the care and support sector, including timely and reliable access to PPE or testing.
b. There were early issues in evidencing keyworker status for care workers and the associated support and prioritisation for services such as access to childcare, schooling etc., and access to financial assistance to implement the necessary absences for isolation and enhanced sick pay.
c. The implementation of the Vaccination as a Condition of Deployment policy (“VCOD”) for those working in care homes against the guidance of senior leaders in social care who repeatedly shared their expertise in the best policy approaches for encouraging vaccine uptake and overcoming vaccine hesitancy, as well as the likely negative outcomes of the policy. The proposal for extending VCOD to homecare, though averted at the eleventh hour, also had a negative impact on workforce numbers.

iii. **Guidance flow and communication from government and key stakeholders was poor and chaotic throughout the first and second phase of the pandemic.** Changes in guidance were often communicated last minute, sometimes over bank holiday weekends and often late on Friday nights, making it hugely challenging to implement promptly. Particularly chaotic guidance changes were linked to PPE, Infection Prevention and Control, isolation of those receiving care and support following a positive Covid-19 test and visiting the different types of settings in which care and support is provided. Lack of understanding of the settings where care is provided led to policies that were unworkable in practice

and required substantial change at short notice, adding to the chaos. Policy changes were often communicated by press release, sometimes days before the final guidance was issued, leading to a mismatch between public understanding of the situation and the action that care providers were being instructed to take. By way of example, restrictions upon visits to care settings by friends and relatives was, understandably, a highly emotionally charged issue. Government announcements that restrictions were being reduced created an expectation that increased access would be allowed with immediate effect. The ensuing delay in issuing the guidance necessary to allow care providers to implement those changes caused immense frustration to those expecting that the change in restrictions would be implemented immediately.

iv. **The chain of command and communication were unclear, particularly the role of national vs. local decision-makers.** The divergence in guidance produced, and differences in how guidance was interpreted at a local level, were challenging for all social care providers. For example, District Nurses were told they didn't need to wear masks any longer, whilst homecare workers did.

v. **Throughout the pandemic response, there was a concerning lack of understanding of social care by policymakers,** leading to an unhelpfully narrow focus on care homes for older people, with little consideration of the breadth and diversity of care and support settings and services, which all needed help and support. The importance of co-production and joint strategic planning were crucial yet overlooked during the pandemic. The views of care sector representatives need to be afforded the same level of attention as the views presented by Public Health bodies. Whilst the latter is able to present theoretical data, the former is able to present empirical evidence from real-world experience.

   a. The understanding of the social care sector amongst Government bodies was not taken into account. The nuances of the sector, including fundamental differences between older person care homes and services for people with learning disabilities and autistic people were not recognised.

vi. **There was a lack of understanding of home-based and community services in social care.** Home-based and community services in social care involve more than half of the workforce and millions of citizens. Officials, Ministers, and other

relevant parties, e.g., UKSHA need to understand the care sector, and ensure it receives the guidance, funding, and other resources it needs.

a. Operational guidance was typically written for NHS services without consideration of relevance to the setting and service type, resulting in guidance that was often unworkable and, in some cases, counterproductive.
b. PPE supplies were diverted to the NHS ignoring homecare and wider community social care services.
c. There were delays in access to asymptomatic testing for homecare; and challenges with the Covid-19 vaccine roll-out in homecare.
d. When issues with guidance related to homecare were identified, it was not acted on quickly enough. It could take significant time to get relatively simple changes made to guidance.
e. The additional costs of managing infectious diseases for the sector were not well understood by the Government. For example, assumptions were initially made that homecare employers could cover the cost for all the time staff spent testing, without any additional funds.

vii. **There was limited understanding of the broader community provision** that many providers offer alongside regulated care services. There was also limited understanding of the needs of those who use care and support services – for example, the needs of those with dementia or those with learning disabilities or enduring mental health issues.

viii. **The drip feeding of funding support was unhelpful, insufficient, inefficient and bureaucratic –** Whilst all funding was greatly needed and appreciated, it came after very significant advocacy from the sector and was provided only in the form of emergency short term time limited funding. This short-termism meant providers were unable to put long-term protective measures in place, or plan for the future accordingly. Funding was driven through local authorities, with significant grant conditions, leading to excessive administration and bureaucracy in relation to accounting and reporting. It is also worth noting that the emergency financial support designed to address additional demands placed upon the sector stopped in March 2022, but associated guidance remained in place for several months in relation to testing and isolation requirements, placing continued financial pressure on employers regarding pay and sick pay.

ix. **The collection and use of data were highly problematic throughout the pandemic for social care** – The Capacity Tracker became the 'pandemic data capture tool' and was then regularly amended, with many additional questions to require and capture a wider range of data from the wider adult social care sector to inform the emergency response to Covid-19. The final tool created a daily burden for care providers, did not always eliminate duplication of data requests and was regularly changed with little notice. For many providers, there was little perceived benefit to sharing data as it did not result in any discernible change in decision making by those in receipt of the data reflecting the impact of the pandemic that was being reported. Providers who entered the data were then not able to see the wider emerging trends in their collective data, which would have given them greater warning of the expected impact of new variants or the anticipated need for additional capacity.

x. **The regulator of adult social care services, the Care Quality Commission (CQC) was largely absent during the pandemic.** Providers had a frustrating relationship with CQC due to the slowness of the regulator in reacting to unfolding events and its apparent reluctance, despite its position, practical understanding, and oversight, to advocate on behalf of the sector:

    a. In March 2020 on-site inspections were stopped and CQC staff worked remotely. That was followed by a move to a risk-based model for inspection and regulation, effectively resulting in the withdrawal of CQC oversight from adult social care services for the duration of the pandemic. As a result, there are adult social care services that have not had an inspection since the pandemic began and, in some cases, for over 6 years. Outdated ratings caused issues for providers accessing insurance cover and in securing public sector contracts at crucial points in the pandemic and, in many cases, still are.
    b. CQC was the only body which held data on deaths of residents in care homes but failed to make this available or accessible in the early stages of the pandemic.
    c. CQC spent considerable time and money competing with the NHS and NECS Capacity Tracker on systems to collect data submitted by providers on various metrics. Ultimately, the NECS Capacity Tracker prevailed. Arguably, CQC's time would have been better spent ensuring service quality and safety.

d. Despite the risk of asymptomatic spread, during the majority of 2020, CQC inspectors were not required to access regular testing when they conducted on-site inspections, much to the frustration of providers.
e. The regulator was slow to act on serious concerns about clinical practice and decisions relating to social care. For instance, on 31 March 2020, CQC signed a joint statement on advance care planning and DNACPR with the Care Provider Alliance, British Medical Association and Royal College of General Practice but it took until March 2021 for CQC to publish the result of its investigations into the practice. The CQC also appeared not to consider the experience or safety of people discharged from hospital during the pandemic.
f. CQC does not appear to have used its influence in debates about key issues such as guidance on infection prevention and control, vaccination as a condition of deployment, the prioritisation of testing and PPE, funding and resources, and the loosening/reimposition of restrictions.
g. Given its practical knowledge, position and powers, consideration should be given to whether CQC should have taken a leading role in the preparation of guidance to the social care sector, which arguably would have ensured more realistic and practical guidance that gave providers greater confidence that in following that guidance they were meeting their obligations in relation to infection prevention control and care quality.