Witness Name: Melanie Weatherley
Statement No.: 1
Exhibits:
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UK COVID-19 INQUIRY - MODULE 5

WITNESS STATEMENT OF MELANIE WEATHERLEY MBE
CO-CHAIR AND DIRECTOR OF THE CARE ASSOCIATION ALLIANCE

I, Melanie Weatherley, Co-Chair and Director of the Care Association Alliance, Park Lane, Halesowen B63 2RA, will say as follows: -

Introduction:

1. Overview of Care Association Alliance (CAA) and its role

1.1 The CAA is a company limited by guarantee. It is the national body which brings together 50 local care associations supporting around 6500 adult social care providers of all sizes, but with a particular focus on small and medium sized organisations operating in England. Care association members provide care and support to adults of working age and older people with any and all social care needs. The CAA includes organisations with a variety of governance structures, including registered charities, CICs, partnerships and limited companies. It is the national voice of local care provision.

2. Prior to the Pandemic

2.1 Prior to the COVID-19 pandemic as part of normal business processes, most members would have had stocks of PPE to cover their Infection Prevention and Control (IPC) needs for 1-3 months. Larger members would also hold additional stocks in case of temporary disruption to supply chains.

It was not common for members to hold additional stocks specifically to deal with pandemics or epidemics.

2.2 The CAA is not aware of aware of any policies or guidance issued by DHSC or any other Government Department, arm's length body or regulator which required the care sector to have in place contingency plans for stocks of key healthcare equipment and supplies?

3. During the Pandemic

3.1 At the beginning of the pandemic, local care associations in many parts of the country worked with their local authorities and local health protection teams to identify potential sources of PPE. As part of these discussions, attempts were made to estimate demand, but this was difficult as it was not clear how much and what type of PPE would be needed.

3.2 The Care Association Alliance did not carry out and surveys or formal consultations amongst its membership.

3.3 It is difficult to overestimate the impact of making PPE available to the care sector at no cost and more importantly in a reliable way. This enabled care providers, particularly small and medium sized care providers to be reassured that they could meet their IPC responsibilities.

It was not the cost of the additional PPE that was the main concern, but the general lack of availability, the challenges in sourcing correct sizes and variability in quality.

3.4 At the start of the pandemic the key concerns raised were:

- What PPE was needed to keep care staff and those drawing on care and support safe from cross-infection?
- If new types of PPE were needed, where could these be sourced?
- Why was it no longer possible to purchase routine PPE from established wholesalers?

Providers found it increasingly difficult to source PPE, wholesalers reported that supplies had been diverted to the NHS as it was not felt that care providers and the individuals that they supported would be at high risk.

We were made aware of one provider who employed an individual to contact every PPE supplier on a daily basis to find out if anything was available to purchase.

When supplies could be found, prices were continually increasing.

The Care Association Alliance met weekly and was able to share concerns and ways in which they had managed to source PPE. Examples of alternative sources of PPE shared often focussed on masks as these had not been required in the social care sector prior to the pandemic as routine PPE:

- DIY stores
- Agricultural /suppliers
- Local college construction departments when they had closed
- NHS colleagues who had moved onto more advanced masks than those required by care providers.

These discussions enabled individual associations to take suggestions back to their members and local authorities, sharing best practice and reducing anxiety.

Representatives of the CAA took part in regional and national discussions at which concerns around PPE were escalated. As part of these discussions, key wholesalers were identified who had been given access to PPE. Details were shared with CAA members, with limited effect – not all care providers were able to access stocks before they ran out.

CAA representatives also took part in the working group set up to develop the PPE portal and were able to share details of the progress of this initiative with care providers. The programme was welcomed, and eventually enabled care providers to access the supplies that they needed, but implementation was

disappointing. Many providers had difficulty registering, and there was a lack of understanding of non-residential services and the amount of PPE that they required.

3.5 Concerns as set out above were raised initially at local levels with local authorities and health protection teams with varying levels of success. Some local authorities were very supportive, examples of this support included:

- In the very early days of the pandemic, some Health Protection Teams held supplies of PPE which were issued to care providers when a case was confirmed
- Some local authorities bulk purchased PPE and issued supplies either direct to the local care providers or through Local Resilience Forums.
- At least one local authority received a gift of PPE from China for use by local care providers
- One local authority with PPE manufacturing links was able to secure supplies for local care providers

As the pandemic progressed, concerns were raised with DHSC and at cross-sector discussions.

3.6 The frequent changes in IPC guidance for the care sector caused concern and confusion across our members, particularly when it was required to be introduced with little or no warning.

Of particular concern was the initial focus on residential care services only, leaving providers in home care, extra-care and supported living service unsure about what IPC routines they should be following.

It was also challenging having to amend policies and procedures at short notice, and communicate those changes to staff members, particularly in home care with a dispersed workforce.

Another concern was that guidance issued to the care sector often differed from that issued to the NHS. This reduced the confidence of staff in using PPE:

i. Community nurses frequently challenged care staff for not wearing PPE which was not required under the care sector guidance in place at the time, and in many instances was not available to the care sector.

ii. Care staff who were undertaking Aerosol Generating Procedures were anxious that they would not be protected as they did not have access to the same PPE as NHS staff.

The sudden change in guidance around mask wearing sometimes caused concern about the amount of PPE would be needed when compared to the supplies available. This resulted in care providers spending significant amounts of time and money sourcing PPE (specifically masks), working together with other providers and in some instances local authorities. There was often a high level of anxiety amongst care providers about having sufficient PPE with stocks being measured in hours rather than days.

3.7 The CAA worked regularly with Department of Health and Social Care on the Workforce Advisory Group and as part of the CAWGS, with representation on working groups concerned with

- Infection Prevention and Control
- Workforce
- Grant funding
- PPE
- Data collection
- Insurance
- Visiting
- Testing
- Vaccination – lobbying during the discussions around the mandating of vaccination, and supporting the programme of vaccinating care home residents, staff and other vulnerable adults.

The smaller task and finish groups worked on:

- PPE – supply issues and usage guidance
- IPC guidance
- Vaccination
- Workforce grant conditions

- Visiting

3.8 The CAA also met with staff from

- Cabinet Office
- Dept of Business and Trade

3.9 The CAA met regularly with the Minister for Care. During these meetings the CAA was able to raise issues which were of concern to care providers in particular geographic areas as well as those having a more national impact. As stakeholders the CAA took part in regular virtual meetings with Health and Social Care Minister, during which we contributed to discussions around a number of key areas including:

- Testing
- Funding of additional IPC requirements in care homes
- Funding for sick pay due to isolation
- Guidance for care workers in the community
- Visitors
- Vaccination

3.10 Local care association members worked with individual local authorities and sometimes with ADASS regional branches. At a national level the CAA worked with ADASS and LGA regularly, particularly with regard to the most effective way to ensure that the most up to date guidance was understood by small and medium sized organisations.

3.11 Many (but not all) local associations were part of their Local Resilience Forums, either at a strategic level or as part of the Health and Care cell. It was sometimes a challenge for social care to gain a voice at a local level, but the Care Association Alliance gave support and guidance, alongside suggestions for what local areas could do to support local strategy during the pandemic.

3.12 CAA nationally supported Public Health England/UKHSA as part of the adult social care working groups on guidance drafting and communication. It was able to communicate changes quickly, and to support providers to understand the

reasons for the change and to explain them to staff and visitors. The CAA supported the webinars which were delivered as part of the offer to providers.

3.13 The CAA worked alongside CQC in many of the cross-sector working groups established during the pandemic.

3.14 CAA worked with NHSE to support the various vaccination programmes.

3.15 CAA also took part in cross-sector groups developing data collection, including the Capacity Tracker.

3.16 The CAA has not submitted any substantive submissions or reports previously.

4. Lessons Learned

4.1 The Care Association Alliance has not taken part in any internal or external reviews lessons learned exercises or similar

4.2 The Care Association Alliance has no plans relating to the procurement and distribution of key healthcare equipment and supplies in the event of any future pandemic, as this is outside our remit. We are part of the DHSC Adult Social Care Resilience Forum and expects to take part in future plans as part of this workstream.

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: 6th November 2024