Witness Name:

Statement No.: 1

Exhibits:

Dated: 29th August 2024

UK COVID-19 INQUIRY - MODULE M5

WITNESS STATEMENT THE CARE PROVIDER ALLIANCE (CPA)

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1. When was the Care Provider Alliance set up, and which sectors and care settings of the care sector in the UK does the Care Provider Alliance represent?

The Care Provider Alliance (CPA) was established in the financial year 2006/2007. The Care Provider Alliance (CPA) is an unincorporated Alliance, whose 10 members include the following trade associations: Associated Retirement Community Operators (ARCO); Association for Real Change; Association of Mental Health Providers; Care Association Alliance; Care England; Homecare Association; National Care Association; National Care Forum; Shared Lives Plus; and the Voluntary Organisations Disability Group.

These ten trade associations have only ever represented care and support providers i.e. organisations that provide care and support as opposed to individual care workers or other individuals. They work with diverse client groups, including adults with physical, sensory, and learning disabilities, individuals with mental ill-health, and elderly people.

The Care Provider Alliance is not an accredited body in it's own right. Therefore any commissioned work needs a nominated contract holder from amongst the CPA membership. The contract for work associated with Covid 19 was held by the National Care Forum on behalf of the CPA and oversight of the work and delivery of the work was carried out under the collective responsibility of all members of the CPA **(INQ000492256)**

2. Please provide a brief description of the leadership structure of the Care Provider Alliance.

The CPA has a leadership structure that includes representatives from its Alliance, which are the main national associations in the sector The role of CPA Chair rotates annually across each of the ten trade associations. Working together, the CPA members' CEO's and policy teams provide hundreds of hours of expert advice each year to the co-production of guidance and information across all adult social care workstreams, alongside insights and solutions to mitigate sectoral risks. CPA aims to be the united voice of the sector working with all Government departments and across the NHS, local authorities and the Local Government Association, Care Quality Commission, Skills for Care and other bodies and organisations that can support the sustainability of the social care and support sector.
The CPA's role involves coordinating responses across care provider trade associations, influencing policymakers, providing sector leadership, improving care quality, and raising awareness of the sector. Workstreams include Business Continuity, Commissioning and Funding, Integrated Care, Workforce and Care Provider Sustainability.

For more information, you can visit the Care Provider Alliance website
(INQ000508375)

Below are the details of the CPA chief executives' biographies:

Dr Jane Townson OBE, CEO, Homecare Association

Current chair of Care Provider Alliance

Jane Townson is CEO of the Homecare Association. She has extensive experience in the social care, health, housing, and technology sectors. Formerly Chair of the Board of Kraydel; CEO Somerset Care Group; Chairman YourLife (JV with McCarthy & Stone); and Vice Chair UKHCA. Jane's first career was in international leadership roles in research and development in ICI, AstraZeneca, and Syngenta, where she was Global Head of Bioscience Research. She then established her own business providing consultancy and training on the link between lifestyle factors and public health, working with private individuals and public sector organisations.

Professor Vic Rayner OBE, Chief Executive Officer of the National Care Forum

Incoming Chair of the Care Provider Alliance (1st September 2024)

Vic joined the National Care Forum (NCF) as Chief Executive Officer in 2016.

As CEO she chairs the government national workforce advisory group. In addition, she chairs the National Social Care Advisory Group on social care and technology and has been at the forefront of promoting digital transformation across care. She sits on a range of government and national specialist groups with a focus on the social care workforce, digital transformation, new models of care and regulation. She has recently stepped down from chairing the working group of the APPG on adult social care.

Vic is a regular national and international speaker and has extensive knowledge and expertise across a wide range of care, support, housing and social policy agendas. Prior to joining the NCF, she was the CEO of Sitra, a leading national membership body championing excellence in housing, health, care and support.

Vic is the incoming chair of the Global Ageing Network and has worked extensively with international partners on key areas of innovation and change. In addition, she was awarded an Hon. Professorship in Health Sciences by City University, working closely with the My Home Life programme and the wider University agenda around ageing and care. She was awarded an OBE for services to social care in 2021.

Nadra Ahmed CBE, Executive Co-Chairman, National Care Association

Previous past chair of the Care Provider Alliance

***Nadra** has been Chairman of NCA since 2001. She has been involved in the field of social care for over 35 years and until 2005 was the Registered Manager of two private care homes for older people, having developed and run services since 1981.*

Nadra has served on numerous government task forces, and she was the Vice Chairman of Skills for Care for 11 years having been appointed at its inception. Nadra is a trustee of Parkinson's UK among other charities. In 2023/24 she was the Deputy Lord Lieutenant of Kent and a Kent Ambassador.

In 2006 she was awarded the OBE for her services to Social Care. She is a regular contributor to journals and a speaks national and international conferences throughout the world. She is also regularly called upon by the major media networks to represent the views of social care providers. Nadra is driven by a desire to ensure the delivery of quality services to the most vulnerable members of our society. She works across a number of government departments

which have an impact on the social care world giving evidence and expert advice to parliamentarians.

In 2023 she was awarded the CBE for her services to Social Care.

Ian Turner, OBE, Executive Co-Chairman, National Care Association

***Ian** read Pure and Applied Mathematics at Newcastle University before joining International Computers Ltd (now part of Fujitsu) in the early 1970's. He worked as a programmer, then within operating system support, marketing, project management, and sales management. In 1984 he bought a property and converted it into a Nursing Home. He has now developed this into six Homes with 270 beds, all within East Anglia, offering Nursing and Residential Care to older people, and those living with dementia. During 2014/5 Ian was seconded into the DH/LGA team implementing the Care Act. Ian chaired the Registered Nursing Home Association for the past ten years. In 2023, the RNHA merged with the National Care Association, and Ian became Executive Co-Chairman of the NCA.*

Ewan King, Chief Executive Officer, Shared Lives Plus

Ewan is Chief Executive at Shared Lives Plus, the UK Charity which represents the Shared Living sector, which includes Shared Lives, and Deputy Director for Policy Embedding at IMPACT (Improving Adult Care Together), the UK centre for implementing evidence in adult social care. Before joining Shared Lives Plus, he was Deputy CEO at the Social Care Institute for Excellence (SCIE), a charity that identifies and promotes good practice in adults and children's social care, where he led the organisation's work on policy, communications and delivery. Ewan was previously director of research at an independent social enterprise and consultancy and was educated at the London School of Economics and Warwick University. Ewan was also researcher for the late Rt Hon Tess Jowell MP.

Clive Parry, Director, ARC England

Clive joined ARC as the Director for England in late 2020.

Clive has previously undertaken a variety of roles in a number of charities that support people with learning disabilities, and he is responsible for the leadership of the England team which includes agreeing the steps we will take towards becoming an organisation that is led by people who have a learning disability autism or both.

Professor Martin Green OBE, Chief Executive, Care England

Martin Green has had an extensive career in NGO development, both in the UK and internationally, and is Chief Executive of Care England. He is a Trustee of the National Centre for Creative Health (NCCH), Vice President of The Care Workers Charity, Champion of The National Aids Trust and Commissioner of the Royal Hospital Chelsea.

In 2013 he was appointed Visiting Professor of Social Care to Buckinghamshire New University.

In 2012, in his role as Department of Health and Social Care Independent Sector Dementia Champion, he led the development of the Dementia Care and Support Compact for The Prime Minister's Challenge on Dementia.

In 2008 he was named care personality of the year and was awarded an OBE for Services to Social Care in the 2012 Queen's Birthday Honours List. In 2019 he was presented with the Health Investor Outstanding Contribution award.

Martin Green writes and broadcasts extensively on social care issues and is on the Editorial Board of Community Care Market News and Care Talk magazine.

Kathy Roberts, MBE, Chief Executive, Association of Mental Health Providers

Bringing with her over 40 years' experience in NHS, local authority and third sector leadership roles at a strategic level, Kathy has been the Chief Executive of the Association of Mental Health Providers since April 2012. She is an advocate for true coproduction, and throughout her career, Kathy has championed the need for whole-person and whole-system approaches to the design, development and delivery of services, across health, social care and wider community.

Kathy has held key positions on several national boards and fora, representing the interests of voluntary, community, and social enterprise (VCSE) sector mental health service providers. Notably this includes the Department of Health and Social Care's COVID-19 Social Care Stakeholders Group for which she chaired the Mental Health and Wellbeing Advisory Group, bringing together key stakeholders from the sector.

As Chair for the Care Provider Alliance in 2020-21, during the pandemic, Kathy led the representation of the social care sector in national policy, the Mental

Health Act Independent Review Topic Group on Advocacy, the Think Local Act Personal Board, and Professions Allied to Medicine. She has also co-chaired Health Education England's Peer Support Workers Oversight Group.

Kathy is a crucial member of the national network of Mental Health Leads, comprising of 16 leading CEOs, and was selected to chair the Governance Group overseeing the DHSC Mental Health Emergency Covid funding of £5m for the VCSE provider sector.

Kathy qualified as an occupational therapist in the early 1980s practising in both health and social care.

Melanie Weatherley MBE, Co-chair, Care Association Alliance

Melanie co-founded Walnut Care in 2002, now one of the largest domiciliary care providers in Lincolnshire, employing over 200 care professionals and providing 600,000 care visits annually.

A passionate advocate for the provision of home and community care, Melanie has been the Chair of Lincolnshire Care Association (LinCA) since 2016. LinCA represents a range of care providers, working with them to improve standards of care.

Melanie was also a Fellow of NICE and Skills for Care, as well as the Co-Chair of the Care Association Alliance – a national body bringing together representatives of care associations to engage with the wider health and care system.

In 2020, Melanie received an MBE for her services to social care, honoured for helping set up the Care Home Trusted Assessor Scheme. In a national first, Melanie also led a scheme to train care workers to become nurse associates.

Eddy McDowall, Co-Chair, Care Association Alliance

Eddy is Chief Executive of the Oxfordshire Association of Care Provider. He has worked in adult social care for over 30 years, 26 of them in local government and also at Department of Health and Local Government Association. He has wide-ranging experience of leading partnership projects with diverse memberships.

Rhidian Hughes, Chief Executive, VODG

Prior to joining VODG Rhidian's career spanned a range of senior research, regulation and consultancy roles. He worked in management consultancy across the health and social care sectors and before that in regulation. Earlier in his

career Rhidian held academic appointments, leading programmes of social policy research.

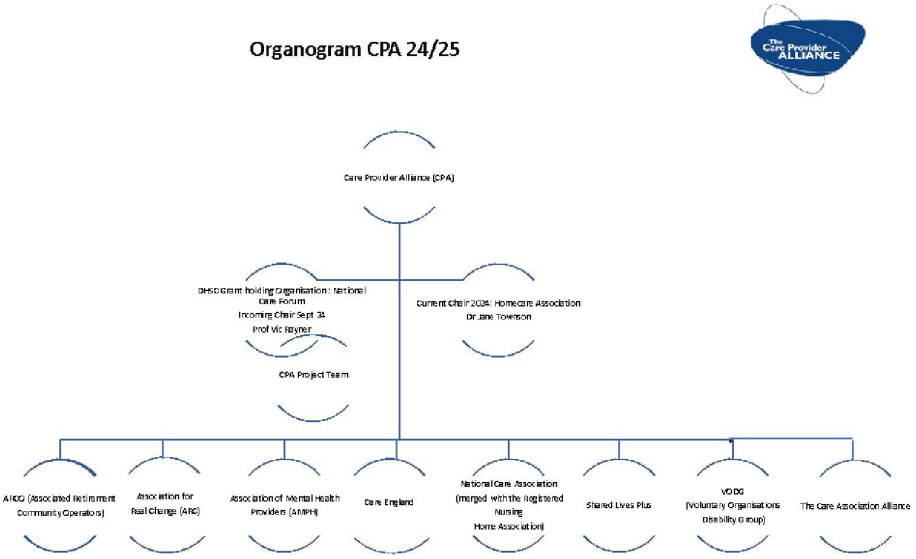
Rhidian was educated at the University of York where he also earned his Doctorate.

Michael Voges, Chief Executive, ARCO

Michael is a leading national expert on older people's housing and social care, and a frequent media commentator on both the economic and political framework for housing-with-care in the UK.

He has overseen ARCO's work to represent and champion the housing-with-care sector since its inception in 2013, taking the organisation from a team of one to a diverse outfit that sets rigorous standards for the sector, runs high-quality events, and influences and shapes key government policy.

Michael frequently speaks at conferences in the UK and abroad, and has served on numerous advisory bodies, commissions and committees with a special focus on social care/policy, housing and ageing.



3. How many members does the Care Provider Alliance have? Please describe the range of client/patient groups that your members work with.

As an umbrella alliance, the CPA does not have individual carers or care providing organisations as direct members. Instead, our Alliance comprises the 10 main representative bodies from across the adult social care sector in England. These trade associations work with care and support providers who deliver services to diverse client groups, including adults with physical, sensory, and learning disabilities, individuals with mental ill-health, and elderly people. As an Alliance CPA's communication channels reach over 95% of all care and support provider organisations, in a sector with 1.6 million employees helping people to live good quality, independent lives.

4. What proportion of members are institutions, and what proportion of members are carers who work alone and/or in domiciliary settings?

The Care Provider Alliance's members are trade associations and outlined in the answer to question 2.

5. What is the role of the Care Provider Alliance in respect of its membership?

This is provided in question 2.
The CPA's role involves coordinating responses across care provider trade associations, influencing policymakers, providing sector leadership, improving care quality, and raising awareness of the sector. Workstreams include Business Continuity, Commissioning and Funding, Integrated Care, Workforce and Care Provider Sustainability.

For more information, you can visit the Care Provider Alliance website
(INQ000508375)

Prior to the pandemic

6. How common was it for members to have in place contingency plans to deal with pandemics or epidemics in respect of emergency stocks of key medical equipment and supplies, including PPE, prior to the pandemic.

The Care Provider Alliance (CPA) does not possess specific statistics on how common it was for care providers to have contingency plans for pandemics or epidemics, including emergency stocks of key medical equipment and PPE before the COVID-19 pandemic.

Prior to the COVID-19 pandemic, it was not universally common for care providers to have detailed contingency plans specifically for pandemics or epidemics, including emergency stocks of key medical equipment and PPE. While general business continuity plans were expected and encouraged, these plans often focused on a variety of disruptions such as severe weather, fuel shortages, or flu outbreaks.

CPA care provider guidance has always advocated for the development of robust plans to ensure continuity of care in various scenarios, such as flu outbreaks, which implies that pandemic preparedness was considered important but may not have been universally implemented to the extent seen during COVID-19.

7. Is the Care Provider Alliance 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?

Yes, the Care Provider Alliance is aware of several policies and guidance issued by the Department of Health and Social Care (DHSC) and other government bodies that required care providers to have contingency plans. Specifically, there were expectations set by local authorities, healthcare commissioners, and the Care Quality Commission (CQC) for care providers to maintain business continuity plans. This expectation, however, did not always explicitly cover pandemic-specific preparations such as stockpiling PPE until the COVID-19 pandemic highlighted the need for such measures.

A notable example is the DHSC letter from December 2020 **(INQ000508373),** *which provided guidance on continuity of supply and preparation steps for care providers. These plans needed to identify critical aspects of their operations, such as information, stock, premises, and staff, and outline how to maintain these in the event of an incident.*

The CPA provides templates and guidance to help care providers develop and update their business continuity plans, addressing various risks and ensuring that services can continue during disruptions. Examples of this guidance can be found on the CPA website: (The Care Provider Alliance). **(INQ000508375)** *This guidance was part of ongoing efforts to support resilience in the sector, even before the pandemic underscored the necessity of robust emergency preparedness. The first edition of The Care Provider Alliance Business Continuity Planning published 20th May 2020 is attached as* ***Appendix 1.*** *The 3rd Edition remains on the CPA current website: (The Care Provider Alliance)* **(INQ000508375)**

9. Prior to the pandemic, please confirm whether the care sector generally purchased its key medical equipment and supplies on the private market, or whether any local authority or government departments assisted in the purchase of such items.

Generally, care providers purchased their own medical equipment and supplies, particularly with respect to the purchasing of gloves, aprons and clinical waste services. There are some products that are issued for free by Local Authorities through equipment stores (for commodities such as wheelchairs and specialist medical equipment for specific conditions).

More details on how the care sector procured PPE can be found in the National Audit Office report **(INQ000145895),** *which detailed how PPE was largely purchased from the private market.*

During the pandemic

10. Did the Care Provider Alliance or its members liaise with local authorities, NHS bodies or government bodies or departments regarding the likely demand for PPE during the pandemic? If so, please describe how this was estimated and communicated onwards.

Please see Appendix 2

The matters outlined were raised in writing on the 27th March, 2020, (Appendix 2) when CPA wrote a letter to Prime Minister Boris Johnson and Health Secretary Matt Hancock outlining 3 key asks:

- Ensure all people discharged from hospital are tested prior to entering care settings

'Social Care staff MUST have the PPE of the correct specification and quantity in order to protect staff and deliver safe care'.

- Instruct local authorities to pay providers

CPA never received a response to this correspondence.

Please see Appendix 3

On April 9, 2020, (Appendix 3) CPA wrote a letter to all 650 local MPs in the UK, making an urgent call for action on:

- Securing PPE supplies

- Increasing COVID-19 testing capacity for people discharged from hospital

- Providing funding to local authorities from the £1.6bn government support package

Please see Appendix 4

On April 9, 2020, (Appendix 4) CPA wrote a letter to Helen Whately MP, the Minister for Care, regarding a meeting that had taken place the week of March 16th, to which CPA had not received a response. The outstanding issues raised included:

- Securing adequate PPE supplies

- Increasing capacity for COVID-19 testing

- Providing funding directly to care providers

In addition:

The Care Provider Alliance assisted with distributing requests for information on PPE requirements to its membership – such as the planning information request from Mark Bush dated 30 July 2020. **(INQ000508374)**

11. Did the Care Provider Alliance liaise directly with procurement bodies in England regarding the purchase of PPE (e.g. SCCL)? If so, please provide an overview of such liaison and describe how effective it was.

No, there were DHSC fora which allowed for some discussion between people from NHS Supply Chain working on the PPE Portal and Adult Social Care representatives. However, this liaison was managed by DHSC. These interactions were through the Adult Social Care Task and Finish Group – Personal Protective Equipment and later the COVID Adult Social Care Working Group of Stakeholders known as CAWGS (established September 2021) which combined the several different social care task and finish groups together. There were also PPE customer experience panels organised by DHSC for the PPE Portal that was created which were facilitated via these fora.

In March 2020, DHSC provided 300 face masks to each CQC registered care provider – far from enough to support the response to the pandemic or operationalise guidance.

Questions by CPA colleagues quickly arose regarding the appropriate timing for mask usage and what other types of masks could offer staff protection. Guidance addressing these inquiries was issued by Public Health England (PHE) in early autumn 2020, several months after the initial distribution of masks.

This followed months of engagement by CPA with DHSC PPE task and finish groups. PPE supplies continued to be slow to get to the sector throughout the first wave and summer/autumn 2020, however CPA continued to work with and advise DHSC on the launch of a PPE portal from Spring/Summer 2020. The launch date of the PPE Portal was in May 2020, however access to this portal for the entire sector took a significant amount of time – non-CQC registered providers were unable to access PPE from the portal initially and therefore were directed to Local Resilience For a (LRF). The level of support from the LRFs was inconsistent across the country.

12. Did the Care Provider Alliance carry out any surveys or consultations amongst its membership during the pandemic regarding:

(i) access to PPE.

(ii) the quality and fitness for purpose of PPE that was provided by central government, local authorities or distributed through Local Resilience Forums.

(iii) access to LFT and PCR tests.

(i) access to PPE

Yes, CPA did carry out a survey. Our business continuity work with the Department of Health and Social Care resulted in a survey to the care sector on Contingency Planning in response to the COVID-19 pandemic. The survey went live on Tuesday 17th March 2020 and closed on Thursday 26th March 2020. A total of 223 care providers took part in the survey, representing a broad range of care provision in the sector supporting a wide variety of service user groups.

The link to the survey results published on the 2nd April 2020 can be found here:https://careprovideralliance.org.uk/assets/pdfs/contingency-planning-survey-report-to-providers-02Apr20.pdf **(INQ000508371)**

The results showed that care providers were experiencing significant difficulties in accessing PPE. Suppliers were cancelling orders and stating that all PPE has been requisitioned for the NHS, or that goods were confiscated at importation/customs border for use in the NHS.

We specifically highlight these responses from care providers to the survey questions:

1. ***"Do you have any further concerns regarding the management and control of infection?"***
   85% of all responses indicated PPE shortages was the top concern.

2. ***"What more could Public Health England do?"***
   The highest response was increased PPE availability.

3. ***"What are the key pressures in the next 12 months?"***
   PPE/supplies - listed as the fourth largest concern.

In addition to the March 2020 survey CPA published on the 1st May 2020 the Care Provider Alliance Response to Coronavirus https://careprovideralliance.org.uk/cpa-shining-the-spotlight-on-social-care **(INQ000508378)**

This stated on personal protective equipment (PPE):

"Key concerns on the supply and availability of personal protective equipment (PPE) for care workers has put intense pressure on providers managing the spread of infection. Since February we have been campaigning to ensure ongoing supplies of PPE was made available to care providers.

Though there is still more to be done to make sure ongoing supply of PPE continues to be available to care providers, significant progress has now been made to ensure providers have access to this vital equipment in all care settings.

The CPA has lobbied for the removal of VAT from PPE products for many weeks and are delighted by the recent announcement from the Treasury to cut taxes on the cost of PPE to care providers for the next 3 months from 1 May to 31 July 2020. It is a welcome move to support providers who are contending with spiralling costs due to the increased need to use various forms of PPE to keep staff and people who require support safe, coupled with inflated PPE prices. However, the key issue remains that PPE must be available in the right quantities at the right time - and this is still an ongoing issue."

(ii) the quality and fitness for purpose of PPE that was provided by central government, local authorities or distributed through Local Resilience Forums.

Challenges with accessing PPE through the National Supply Disruption Response (NSDR) https://www.gov.uk/guidance/reporting-to-the-national-supply-disruption-response-nsdr **(INQ000508377)** *and Local Resilience Fora (LRF's), as well as delays in the rollout of the PPE Portal were due to lack of comprehensive contact information for all care providers in their areas, particularly those operating nationally rather than regionally. There was no centralised social care contact database for LRFs or the NSDR to draw upon. Similarly, the LRFs did not always publish their contact details to assist providers.*

(iii) access to LFT and PCR tests.

The same comments and actions apply to COVID-19 testing such as PCR and LFT tests. Initially they were all given to the NHS, and only much later were tests made available to social care providers.

CPA published on the 1st May 2020 the Care Provider Alliance Response to Coronavirus https://careprovideralliance.org.uk/cpa-shining-the-spotlight-on-social-care **(INQ000508378)**

This stated on access to LFT and PCR tests:

"We asked the government to prioritise testing for social care workers and service users to help manage the spread of the virus. The delay in getting access to testing early on has had a huge impact, with many providers having to spend a disproportionate amount of time trying to find solutions.

Access to testing centres, mobile units and home testing kits have now been announced to include access to care providers and individuals, as the capacity for tests have increased. We are delighted that the government is now providing testing for more than its target of 100,000 tests, but echo NHS colleagues by calling for testing with purpose for the people we care for and our workforce.

We will continue to monitor the progress of COVID-19 testing within care settings to make sure providers, the care workforce and service users are prioritised in getting the access they need."

14. If formal surveys weren't carried out, does Care Provider Alliance have a record of any informal discussions or meetings or emails from members about the matters outlined at question 11. If so, please provide details and any documents relating to these discussions (examples could include meeting minutes).

This question is not applicable.

16. What was the impact of free PPE being made available to the care sector on your membership?

The care sector initially welcomed the introduction of free PPE, as this provided much-needed relief. However, this relief was quickly followed by some disappointment, as the free PPE was widely considered to be insufficient and coming too late.

Until the PPE portal was fully operational, access to free PPE through the NSDR and LRF systems was inconsistent and often inadequate in many areas. The free PPE helped mitigate the increased operating costs for providers, as the fee rates paid were not sufficient to cover these additional expenses. It also ensured availability of supply, gave reassurance on product quality, and prevented price hikes and profiteering that had been seen in parts of the market early in the pandemic.

In the early stages, there were significant concerns about whether the PPE stock being offered met the necessary specifications. The free PPE was critical in ensuring availability and usage, which was necessary to keep both care recipients and care workers safe, protect worker wellbeing, and allay concerns about risks to their families.

However, questions remained about how effectively the free PPE reached the entire care sector, as personal assistants and other unregulated forms of care were particularly at risk of not securing adequate supplies.

Overall, the free PPE was a welcome development but faced implementation challenges and did not fully meet the needs of the entire care sector.

20. Did members raise any concerns regarding PPE with the Care Provider Alliance or its members during the pandemic? If so, please set out what these were, whether the picture changed over the course of the pandemic, and what action the Care Provider Alliance or its members took, if any, to escalate or meet those concerns.

This question is answered in the response to question 12

21. Did the Care Provider Alliance or its members raise any concerns regarding PPE with DHSC, local authorities or any other government body or department during the pandemic? If so, please set out what concerns were raised, how they were raised, and what response was received.

Yes, these issues related to PPE were raised by the Care Provider Alliance (CPA) through regular contact with the Department of Health and Social Care (DHSC). This included emails, phone calls, and meetings with care providers and senior civil servants at DHSC. However, the phone calls were not formally minuted. Any meetings between CPA and public bodies were minuted by the public bodies themselves.

The CPA website provides an indication of the government's response to these concerns through the timeline outlining the provision of free PPE from DHSC and the challenges faced by the care sector.

The main issues raised by CPA included:

- *The cost of PPE, the need for free PPE, and the request for VAT relief, as providers were facing unplanned cost increases and rapidly rising prices.*
- *Access to PPE at the start of the pandemic, with shortages of supply, issues with wholesalers, price increases, and difficulty verifying quality standards.*
- *The NHS commandeering PPE supplies in early 2020. Challenges with accessing PPE through the NSDR and LRFs, as well as delays in the rollout of the PPE Portal. The potential need for FFP3 masks and fit-testing, including the associated costs for training and fit-testing the workforce. Logistics issues with the PPE Portal distribution, such as delivery trucks being too large for small offices, lack of storage space, and the need for out-of-hours deliveries.*
- *LRFs not having comprehensive contact information for all care providers in their areas, particularly those operating nationally rather than regionally. Slower resolution of access to PPE for Aerosol Generating Procedures.*

- *The need for transparent masks to support communication for people who lip read or rely on non-verbal cues.*
- *Disparities between the PPE provided to the NHS and that provided to care workers, both at the start of the pandemic and towards the end when universal masking was advised.*
- *Uncertainty around the continuation of free PPE, with a decision not being made until mid-January 2022, by which time many local authorities had already set their fee rates.*

27. To the extent that the Care Provider Alliance is aware of its members' experience, what was the impact of changes made to IPC Guidance for use in the care sector during the pandemic on:

(i) the confidence of staff in using PPE.

(ii) the amount of PPE required within the care sector.

(iii) the ability of staff working in the care sector to source and purchase compliant PPE?

Please read the responses below in conjunction with our answer to question 12.

(i) the confidence of staff in using PPE.

Prior to the pandemic, PPE usage in the care sector was limited, with specific guidance existing mainly for mask-wearing during suction procedures, which was not a common practice.

Frequent changes to PPE guidance without clear communication from PHE/UKHSA/NHSE and DHSC further eroded confidence, not necessarily in PPE usage, but in the guidance itself. The guidance often was written from a clinical perspective, with no understanding about how care services operated.

As a result, the issue was less about staff confidence in using PPE and more about a lack of confidence in the guidance itself, alongside concerns about the availability of sufficient PPE.

(ii) the amount of PPE required within the care sector.

The guidance around the amount of personal protective equipment (PPE) use during the COVID-19 pandemic was complex and often evolving. There were meetings with PHE and DHSC colleagues who were drafting the guidance; however, the development of new PPE guidance often followed a challenging process. Draft versions of the guidance would be circulated to CPA for comment, but the timelines provided were frequently very short - sometimes just an hour or

a single afternoon. This made it difficult for us to provide thorough feedback and input.

Once the initial feedback was received, the guidance would then need to go through an extensive DHSC clearance process before being finalised and published. This clearance process could take 2-3 weeks, during which time healthcare and social care workers had to continue using the previous version of the guidance. Once the new guidance was published the volume of PPE would change to reflect the legal duties on the care provider to ensure their staff were not placed at risk.

In addition, there were care providers wanting to use higher levels of PPE than specified in the guidance or not comfortable returning to pre-pandemic PPE usage levels (this was discussed with Public Health England in CAWGS).

A clear example of this was during the Easter weekend 2020 when an easily missed note was added to the top of existing PPE guidance which announced that the UK was experiencing 'sustained community transmission' **(INQ000508372)** *and therefore social care providers should use 'Table 4' of the then PPE guidance* **(INQ000300616).** *Table 4 required a significant increase in the amount of PPE required by providers. The change was not properly communicated by DHSChttps://web.archive.org/web/20200410155017/https:/assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879111/T4_poster_Recommended_PPE_additional_considerations_of_COVID-19.pdf/* **(INQ000300616)** *PHE to PPE suppliers or to providers. Nor was enough PPE made available to implement Table 4 of that guidance.*

(iii) the ability of staff working in the care sector to source and purchase compliant PPE?

Sourcing and purchasing compliant PPE for care staff was a major challenge, particularly during the beginning of the pandemic during spring/summer 2020. The government's development of the Infection Protection Control (IPC) guidance for PPE was inconsistent and often delayed due to lengthy approval processes. Additionally, the difficulty for staff in sourcing and purchasing compliant PPE was compounded because the PPE suppliers and systems brought in by the government were not familiar with the social care sector, making it difficult to secure the necessary volume of PPE. This lack of understanding impacted the third-party logistics and supplier distribution of PPE products, for example in relation to how to access the Care Quality Commission (CQC) registered care facilities.

28. Did the Care Provider Alliance liaise with the DHSC or any other government body or department regarding IPC guidance and changes to that guidance during the pandemic? If so, what points did the Care Provider Alliance make, with whom were they raised and when, and what response was received?

Yes, the Care Provider Alliance (CPA) raised numerous issues with the infection prevention and control guidance (IPC) experienced across the care sector. The main problems included:

- *General issues with announcements being made without sufficient detail, and the guidance itself often being released late on Friday nights, leaving little time for implementation and preparation over the weekend.*
- *Initial delays in the guidance being provided, as well as concerns about the trustworthiness of the information, as early draft guidance in March 2020 had left the section on PPE blank.*
- *Lack of specificity in the initial guidance around the required PPE and infection control measures. The PHE guidance being oriented more towards care homes and clinical settings, requiring interpretation for those working in people's own homes.*
- *Lack of clarity around "sessional use" of PPE and whether carers needed to change masks between each household visit. Uncertainty about the point at which a live-in care worker would be considered part of the household. Guidance on the use of PPE when accompanying someone out of the home.*
- *Issues with the guidance around glove use, including a mistake in October 2020 specifying nitrile gloves when many providers were using vinyl.*
- *Discrepancies between PHE guidance and guidance issued by local authorities.*
- *Cost implications of complying with testing and self-isolation requirements, leading to staff shortages. Issues with self-isolation guidance leading to insufficient workforce availability.*
- *Problems with jargon and unclear language in the guidance. Plus the lack of clarity on how to properly conduct risk assessments under the current guidance.*
- *Uncertainties around car-sharing and whether vaccinated/unvaccinated staff should be treated differently as contacts.*

Overall, the CPA highlighted significant challenges with the timeliness, clarity, consistency, and applicability of the infection prevention and control guidance provided by the government during the pandemic.

Lessons Learned

29. Please provide a chronological list of any internal or external reviews, lessons learned exercises or similar produced or commissioned by the Care Provider Alliance or that the Care Provider Alliance has been involved with relating to any of the issues in the Scope for Module 5 since January 2020. This should include:

a. A summary of the conclusions and recommendations of those reviews, lessons learned exercises or reports.

CPA has not conducted a formal review; however, our view is that pandemic preparedness must fully involve care providers. It is essential to recognise all types of care and support providers, including those for adults with physical, sensory, and learning disabilities, individuals with mental health issues, and elderly people. When planning and distributing crucial resources such as PPE and access to testing, the care sector should be an integral part of pandemic planning rather than an afterthought.

Future pandemics may not follow the same pattern as COVID-19, so all agencies need to be flexible and have alternative pandemic response strategies ready. A "one-size-fits-all" approach is unlikely to be effective.

The Government must address common problems, such as clearly defining "key workers" in social care and having mechanisms to identify and support them. There also needs to be better coordination around knowing who requires care and support, including self-payers, and ensuring centralised access to these records.

Some specific recommendations for improvement include:

- *Ensuring social care PPE supply is considered alongside the NHS, to avoid issues in supply chain distribution intended for the care sector.*

- *Ensuring the Government works with the NHS, suppliers, providers and local authorities across the adult social care sector to support the continuity of supply of non-clinical goods and services. Care providers would then be able to flag these issues with the supply disruption alert processes that are available in the DHSC and NHS for clinical goods and services. For example, one such solution would be creating a centralised social care contact database for LRFs or the NSDR to draw upon.*

Details of these escalation routes can be seen within the example: Guide to managing medicines supply and shortages.

https://www.england.nhs.uk/wp-content/uploads/2019/11/a-guide-to-managing-medicines-supply-and-shortages-2.pdf **(INQ000330790)**

- *Ensure early and clear guidance on PPE specifications for social care, aligned with supply chain processes. Maintain sufficient stockpiles and secure supply chain and distribution logistics.*
- *Avoid over-reliance on local distribution systems, which proved ineffective in some regions. The centralised PPE portal was more reliable once operational.*
- *Provide sufficient lead time and notice for any changes to infection control guidance, to allow care providers time to prepare and implement.*
- *Plan ahead for the potential need to roll out FFP3 masks and fit testing for care workers, as the logistics of doing this quickly would be considerable in a future outbreak.*

Overall, CPA emphasise the need for true partnership and coordination between the care sector, the NHS, and government to ensure effective pandemic preparedness and response in the future.

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: ____17th February 2025_____