Oral opening statement – Homecare Association

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My Lady, good morning/afternoon.

1. Introduction and thanks

I appear on behalf of the Homecare Association, the only UK body that speaks exclusively for providers of homecare, which is also referred to as domiciliary care. I am grateful for the opportunity to help the Inquiry and, through it, the bereaved families, people who draw on care, and the dedicated workforce who support them.

2. Who we represent and why it matters

About one million adults of all ages rely on professional homecare at any one time – more than double those living in care homes.

On top of this, six million people receive support and care at home from unpaid carers and a further two million people at home have unmet care needs. This means at least nine million people receive or need care at home compared with only half a million in hospital or care homes at any one time, yet the public could be forgiven for thinking it is the other way round, given where attention and resources are focused.

Some 740,000 professional homecare workers in England alone, more than the 698,000 who work in care homes, deliver care and support in ordinary houses and flats across every community.

They help older and disabled people live well at home; preserve family and community life; uphold human rights; prevent hospital admissions; and enable timely hospital discharge.

Yet before, during and after the pandemic, home-based care and support was and is too often invisible in policy, data and debate.

3. Three overarching themes

Our written statement and the material before you show that:

1. **Homecare was overlooked in key decisions.**

Ministers and officials concentrated on protecting the NHS and later care homes, with an insufficient appreciation or understanding of care delivered behind front doors across the country.

2. **Homecare was misunderstood.**

Decision-makers treated social care as synonymous with residential care for older people and failed to grasp the diversity and complexity of services delivered in people's own homes.

3. **Homecare was disadvantaged in comparison with the NHS and care homes.**

Access to PPE, testing, vaccines, data, guidance, funding and professional respect all lagged behind.

4. The pandemic exposed five structural weaknesses

1. **Fragile foundations**

Years of under-funding and insecure commissioning left providers without reserves. COVID-19-related costs added about 25 percent to hourly delivery costs while fee rates barely moved. Funding designed to keep the sector going often failed to make it to homecare providers.

2. **Knowledge and leadership**

Social care expertise, and especially homecare experience, was largely absent from SAGE, COBR and ministerial briefings. It took over a year before a SAGE Social Care Working Group appeared on any public list. Blind spots in emergency planning cost lives.

3. **Inadequate access to community health and care professionals**

National instructions to "minimise face-to-face contact" led GPs, district nurses, social workers, housing managers and Care Quality Commission inspectors to retreat to remote working. Homecare workers often found themselves the only professionals entering homes, sometimes tasked - without adequate training, supervision or funding - with wound care, insulin injections and even verification of death. One member told us a district nurse "threw dressings over the threshold and ran away" expecting care workers to perform their work.

4. **Communication and data**

There was a paucity of official data about homecare and no reliable national channel to reach every homecare employer.

5. **Deep-rooted inequalities**

A mainly female, ethnically diverse, low-paid and financially insecure workforce received limited sick-pay protection, forcing some to choose between infection control and paying rent.

5. Practical impacts on people and care teams

1. **Restricted access to healthcare**

The government told people, "Stay at home. Protect the NHS. Save Lives." The unintended signal was: keep away from hospital and GP surgeries. Only 7% of deaths at home were ascribed to COVID-19 but by July 2022, hospital deaths from non-COVID-19 causes had fallen by 104,000, while excess deaths at home from conditions such as dementia and cancer soared.

2. **PPE**

Prior to the pandemic, homecare workers did not need to wear masks, except for a small proportion of specialist activities. In April 2020, eight in ten providers were unable to secure PPE. Orders paid for by homecare providers were diverted to the NHS. Homecare workers had no choice but to fashion their own makeshift protection from fabric and bin-bags, whilst being told by the government they did not need it.

3. **Testing**

Routine asymptomatic testing for homecare staff did not begin in practice until January 2021 – ten months after the NHS roll-out – creating unnecessary risk to homecare recipients.

4. **Hospital discharge**

People were sent home from hospital without tests, transferring risk, cost and moral burden to care workers and families.

5. **Vaccination as a condition of deployment**

The policy threatened to remove up to a fifth of an irreplaceable workforce at the height of the workforce crisis. It was withdrawn only after months of sector alarm, by which time about 18,700 workers had left the sector in anticipation.

6. **Emergency funding distribution failures**

The pandemic exposed fundamental flaws in how emergency support reached frontline care. Seventy-five percent of the first Infection Control Fund went to care homes, with homecare receiving "the scraps under the table." Local authorities distributed the remaining funds at their discretion, often excluding providers without council contracts. Many homecare providers serving self-funding clients or NHS-commissioned care received nothing. Some councils showed what was possible – Hertfordshire's Director of Adult Social Services swiftly distributed funding to every provider regardless of funding source – but this was the exception. When homecare providers received funding, our data showed the vast majority used it to pay full wages to isolating staff, evidencing their commitment to supporting workers when resources are available.

7. **Unworkable movement restrictions**

Government proposals to restrict staff movement between care settings, while well-intentioned, were fundamentally incompatible with homecare operations. Homecare workers inherently move between multiple households daily – this isn't optional but the core nature of the service. Restricting movement would have required significantly more care workers when vacancy rates stood at 12% compared to 2.5%

in the wider economy and turnover rates were already over 25% annually. International evidence showed effective alternatives: countries like Germany and Australia used cohorting strategies, enhanced PPE protocols, and rigorous testing rather than blanket prohibitions. The UK's approach ignored both operational realities and proven international best practice, though some providers adopted such practices anyway when they could.

8. **Guidance chaos**

Initial guidance stated the risk of community transmission of COVID-19 was low and people receiving care services were unlikely to be infected. There was also a narrative from Public Health England that masks would increase rather than decrease risk of infection. Neither proved accurate. We then lurched from one guidance change to the next without adequate understanding or consultation by the government. One erroneous instruction in September 2020 forced providers overnight to scrap vinyl gloves for scarce nitrile stock; it was reversed weeks later, but not before huge unnecessary costs and confusion.

9. **Regulatory vacuum**

The Care Quality Commission paused inspections, leaving providers without oversight or support and people without assurance of safety. This has had lasting adverse effects. Some homecare services have not received an inspection for over 7 years.

6. The human cost

Thousands of frail citizens became isolated at home with deteriorating health, cut off from the healthcare services they desperately needed. Those fortunate enough to receive professional homecare fared better because dedicated care workers became their advocates, lifelines, and often their only human contact. Care workers, already stretched, had to make difficult judgements alone. At times they were the only people to comfort someone at the end of life. Families ask, with justification: whose lives did the Government intend to save when the people most at risk could not access the healthcare they needed?

7. Lessons the Inquiry can draw

1. **Embed social care expertise - including homecare practitioners from day one -** at every level of emergency planning, science advice and operational command.
2. **Create a standing national social care forum with equal status to the NHS** to coordinate strategy, workforce planning and crisis response.
3. **Guarantee parity of access to PPE, testing, vaccines and sick-pay schemes** across health and social care simultaneously. This must include robust supply chain distribution systems accounting for the dispersed nature of homecare provision.

4. **Maintain integrated community services**. Future guidance must require - not discourage - GPs, district nurses and social workers to maintain essential face-to-face visits, supported by safe PPE and clear protocols.
5. **Build a modern data infrastructure** that counts everyone who receives and delivers care at home. This includes the ability quickly to identify and contact all providers and careworkers in emergency situations.
6. **Value and protect the workforce** through ethical commissioning, fair contracts, professional registration like other UK nations, paid training and comprehensive sick pay.
7. **Fund care on sustainable terms** so providers can invest in pay and other employment conditions, training, technology and resilience. Under-pricing social care is a false economy that increases risk of exploitation and reverberates through the NHS.
8. **Design emergency funding mechanisms that reach all providers automatically and equitably**, via direct channels to reach all providers, learning from successful examples like Hertfordshire's approach.
9. **Develop sector-specific policies that account for operational realities**, recognising homecare is fundamentally different from residential care services. This includes learning from successful international practice in managing pandemic response across different care settings.

8. Closing reflection

During national lockdowns, many homecare workers walked through silent streets before dawn so that members of our communities at particular risk could live safely and well at home, with dignity and independence. They filled the vacuum left by others, sometimes at the cost of their own health or lives. Their courage steadied the nation. We owe it to them - and to those they served - to learn the lessons and build a system that will never again leave people unseen and unsupported.

I stand ready to assist the Inquiry further.

Thank you, my Lady.