Module 6 Written Opening Statement on behalf of the National Care Forum

1. Introduction

1.1. This is the written opening statement of the National Care Forum for module 6 of the Covid-19 Public Inquiry.

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. 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. At the outset we want to acknowledge the loss of life and the impacts of the pandemic on the lives and relationships of all those with a connection to adult social care. Care workers, people accessing care and support, their families and loved ones, were all deeply impacted, and many continue to grapple with ill-health and the legacy of those years. Despite it all, care and support workers went above and beyond to ensure people's care and support needs were met, often with little recognition in the face of huge challenges. We hope that our contributions and evidence during Module 6 will go some way to ensuring we learn the lessons needed to prevent a repeat of the Covid-19 pandemic, as well as shining a light on the valuable and skilled work care and support workers undertake every day.

1.4. As the Inquiry embarks on its investigation of the impact of the pandemic on adult social care, we want to use this opening statement to outline some of the areas we hope the Inquiry will explore with regard to the impact of the pandemic on adult social care and the key decisions made by the UK government during that period which made the response more difficult. We urge the Inquiry not to make the same mistake that key decision-makers did: assuming that social care is only comprised of care homes for older adults with high levels of frailty. If module 6 proceeds down this route, we will not learn all the lessons that need to be learnt about the impact on a diversity of care and support services serving older and younger adults, both in the community and in a range of residential settings.

2. The Role of Care and Support Providers

2.1. Much of the evidence already presented to the Inquiry by representatives on behalf of the government, and which will likely be repeated during the module 6 hearings, has failed to recognise the skill, professionalism and dedication of the social care workforce in the face of the pandemic.

2.2. Social care is fundamentally about people providing care and support to one another at different points in life. It is inherently relational. It is not a set of services that can be turned on and off with little consequence. The response of adult social care providers in the face of limited resources, limited support from wider system partners and increasing restrictions was only possible because the people who make up social care – the frontline staff, the managers, IT support, the caterers, the cleaning teams, the maintenance teams, the CEOs and Boards, alongside many others - all came together to find a way through and innovate. Many took on jobs and activities they wouldn’t normally do. Indeed, we are aware of senior managers and CEOs who took on frontline roles alongside their staff during the pandemic, and many care workers took on additional tasks and responsibilities relating to healthcare. Everyone was working together to ensure that quality care and support was maintained.

2.3. Care and support providers and their workforce were not passive in the face of the pandemic and the lack of support from both central government and local systems. Despite confusing and repeatedly changing guidance and the lack of PPE, testing, wider clinical and IPC support, care and support workers stepped up to protect hundreds of thousands of people. This came with great sacrifices that they should not have been expected to make, including moving into care settings to better protect those there or to cover staff shortages due to sickness. When community health services stepped back, care workers found themselves doing more and more delegated healthcare tasks in the absence of community health colleagues. This was all done with little recognition from wider society and the lack of any meaningful support or funding for staff from central government. The prominence given in government communications and media coverage to hospitals and other NHS acute services only reinforced the perception that it was only NHS workers on the frontline. It was not just NHS workers on the frontline, and it is vital that the inquiry understands that care workers played a huge role in the response to the pandemic. We must also remember and recognise those that died during the pandemic in this effort.

2.4. A fact often forgotten is that care and support workers develop close relationships with the people they support, often lasting years. It is very different from the relationship of an NHS doctor or nurse to their patients which is more treatment-based. For this reason, while end-of-life care may be routine for some forms of social care, the scale and speed of infection and death during the pandemic was traumatic. Some of the witnesses to module 6 will illustrate this impact personally. While NHS staff had access to bespoke wellbeing and mental health services, social care was an afterthought. Care and support workers were simply given access to the tailored NHS services, rather than bespoke support of their own, and only later in the pandemic after much advocacy from organisations like the National Care Forum. Even then the care workforce largely struggled to access this support and didn't have anything like the occupational health schemes within the NHS. We also note that England was the only part of the UK where the government did not pay bonuses to all care staff.

2.5. From the very beginning, where decisions or guidance were unclear, or other issues emerged, providers and their national representatives sought to engage, influence and work in partnership with policymakers and local government colleagues in key areas. The National Care Forum, on behalf of our members, engaged with a series of stakeholder groups on every IPC measure you can think of and fought for the full diversity of social care to be considered to shift the focus for government beyond that of care homes for older adults. We continuously raised the experiences of the frontlines and questioned the direction of policy making or decisions. However, our strategic and operational insights were often not taken on board, including on issues such as the initial guidance around PPE, vaccination as a condition of deployment, visiting restrictions and asymptomatic testing, amongst other measures. We also worked with academics to develop research on the impact of Covid-19 in adult social care to bolster the adult social care response as the pandemic progressed.

2.6. One example of our advocacy centred on a more balanced approach to visiting restrictions alongside several campaigning organisations and our members. It was very clear to us that prolonged isolation caused by restrictions on visits from loved ones was intrinsically harmful to everyone involved. From June 2020 onwards, we worked with our members and wider campaign groups to push for an approach which recognised the need for essential family caregivers to have access to care settings and the need to loosen guidance as far as possible. While not ideal, our members also worked to find ways to keep people connected within the constraints of visiting guidance, such as pod and outdoor visits and innovations with technology. Unfortunately, there were often months between guidance being relaxed for general society and the same being applied to visiting guidance for care settings. Such delays meant that some faced perpetual restrictions for nearly two years as guidance wouldn’t be relaxed in time before a new variant emerged.

3. Impact of the Pandemic on ASC and Key Decisions Made by UK Government

3.1. Below we've given an overview of the impact of the pandemic on care and support services, care and support workers and the people they supported as well as our concerns with decision-making by the UK government during that period. These matters are dealt with in more detail within the witness statement of our CEO, Vic Rayner [INQ000475131].

3.2. We first want to highlight **pre-pandemic preparedness**. While outside the timescales of this module, it is important for the Inquiry to remember that social care went into the pandemic ill-prepared, with over 100,000 staff vacancies, a precarious financial situation following a decade of austerity, and the lack of any investment by the state in digital, data and physical infrastructure. Since 1990, there have been at least 6 green or white papers, numerous policy papers, a royal commission and inquiries into adult social care, all with recommendations on how to reform and fund it. In every single case, governments of all political stripes have simply failed to enact these recommendations. There really is no excuse for the lack of action on adult social care reform before the pandemic and it was even highlighted in the Exercise Cygnus pandemic planning exercise in 2016 as an urgent risk due to the lack of capacity.

3.3. Second, **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. One consequence was that **guidance and policy created during the pandemic** was marked by poor communication and lack of understanding of the diversity of adult social care services and the people using those services. Guidance was developed with healthcare settings in mind, with little or no consideration for the practical realities of delivering social care in people's homes and communities. The flow and communication of guidance from government and key stakeholders was poor and chaotic and this was exacerbated by unclear chain of command, particularly the role of national versus local decision-makers. The divergence in guidance produced, and differences in how guidance was interpreted at a local level, were challenging to navigate. 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, let alone input into. Often, changes in policy and lockdown restrictions were communicated by press release or the daily briefings, sometimes days and weeks 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. The sheer amount of effort to interpret and respond to ever changing guidance and confusing information cannot be underestimated and involved the joint effort of the national trade associations, senior management teams of care and support providers and frontline staff when there was little time.

3.4. Third, **there was a disregard for the people accessing or working in care and support from government and the wider health system.** The need for routine regular asymptomatic testing was not recognised until far too late – it took until 2021 for homecare and other community services to have reliable access to it - and some of the most important policy decisions, such as the mass discharge from hospitals regardless of testing status, the withdrawal of community health services and visiting restrictions were taken without the input of adult social care experts or people accessing services. Access to PPE was also difficult during the first lockdown, in part due to supplies being diverted to or held back for the NHS. The advice of social care experts was also ignored at times, as typified by the decision to push ahead to mandate vaccination as a condition of deployment in the middle of a workforce crisis. We note that the policy was reversed as soon as the NHS opposed it being implemented in healthcare. Much ink has been spilt over the dominant route of transmission into care settings, particularly during the first few months. Regardless of the transmission route, staff movement and the mass discharge people from hospital into care settings and their own homes, will both have spread infection because the government failed to put a ring of protection in terms of clinical support, PPE, testing, isolation support, tailored guidance, and wider IPC measures in place before making its decisions. Despite this, providers and care workers stepped up, implemented testing regimes where they could from scratch, changed staffing systems and plans, provided pastoral care, took on delegated health care tasks in the absence of community nursing and did what they could to put IPC measures in place with limited support or resources from system partners.

3.5. Fourth, **the drip feeding of funding support was unhelpful, insufficient, inefficient and bureaucratic**. Whilst all funding was greatly needed and appreciated, each new fund only 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 for both Local Authorities and providers. The first ring-fenced fund for adult social care wasn't available until June 2020, long after the first wave, and largely neglected non-care home settings. While the scope of the Infection Control Funds did expand in future iterations, the amount of money available was never enough to cover the costs associated with implementing enhanced IPC measures, including isolation of people in receipt of care and support, implementing testing regimes, hiring additional staff to cover staff sickness and reduce staff movement, and paying staff who needed to isolate, among other measures. 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 extended sick pay.

3.6. Fifth, **the collection and use of data were highly problematic throughout the pandemic for social care**. Infrastructure around data was lacking before the pandemic, and during the pandemic it became far too focused on the policy aim of freeing up hospital beds via Capacity Tracker. The Tracker was regularly amended, with many additional questions capturing a wider range of data from the wider adult social care sector. This created a data burden for care providers and did not always eliminate duplication of data requests from local commissioners. For many providers, there was little discernible change in decision making and providers who entered their data were then not able to see the wider emerging trends in the collective data, which would have given them greater warning of the expected impact of new variants or the anticipated need for additional capacity. This is perhaps best illustrated by how long it took to report on the impact of **the rising number of excess deaths in care settings**. CQC collected data on deaths of residents in care homes, but this information was not made publicly available or accessible in the early stages of the pandemic.

3.7. Sixth**, staffing and capacity became increasingly difficult due to the direct impact of the pandemic and the nature of guidance which required isolation but came without the financial support to make it successful**. According to Skills for Care data, the vacancy rate in the sector, which was already at a high of 7.3% in 2019/2020 jumped to 10.7% in 2021/2022 and 9.9% in 2022/2023. Sickness trends jumped from an average of 4.2 sickness days in 2019/2020 to 7.6 in 2021/2022 and 6.8 in 2021/2022. See what we've said around the drip-feeding of funding above in 3.5.

3.8. Finally, the **pandemic has revealed the deep-seated inequalities in our health and care system**. Due to its composition and the people who access care, this is a sector where several inequalities intersect along ethnic, gender, age, disability and socioeconomic lines. This was seen in the inequality of access to healthcare services for people drawing on care and support, the improper imposition of do not attempt cardiopulmonary resuscitation decisions (DNACPR) on groups of people of all ages without consent, the difficulty in visiting loved ones in residential and hospital settings, and ultimately, the high death rate for people accessing care and support, and those working in it.

3.9. All of the above were exacerbated by the general neglect and misunderstanding shown towards social care before and during the pandemic by the core political and administrative decision-makers in the UK Government. This can be expressed in three ways:

i. Social care was overlooked in key decision-making moments.
ii. Social care was misunderstood. It was reduced to care homes for older adults in the minds of policymakers, rather than a diverse interconnected system of care and support services for all ages, with a workforce larger than the NHS.
iii. Social care was disadvantaged, especially in comparison to the NHS. The focus of decision-making appeared to be narrowly on protecting NHS hospital capacity rather than citizens in all communities. This led to unintended consequences elsewhere, such as the inability for social care providers to source PPE during the first wave, or an increased difficulty in accessing community healthcare.

4. Lessons Learnt and Recommendations

4.1. The witness statement of our CEO, Vic Rayner [INQ000475131], outlines the full list of lessons learnt and recommendations we believe need to be considered by the Inquiry. We won’t list all of these in detail here, but we have given an overview.

Workforce and Wider Reform

4.2. Decades of neglect in terms of funding and fundamental reform left adult social care in a fragile and vulnerable position going into the pandemic, with over 100,000 staff vacancies. The government must fully commit to funding and measures to fully reform adult social care and ensure it has both the resources and staffing required to respond effectively to future pandemic threats. The government’s announcements in relation to the establishment of an Independent Commission into Adult Social Care Reform led by Baroness Casey and a Fair Pay Agreement for care workers, are welcome. However, policymakers must make this one of their top political priorities and move faster to ensure meaningful change is achieved within the current parliament rather than pushing it into the 2030s and beyond.

Pandemic Planning and Governance

4.3. The failure to include adult social care meaningfully in pandemic planning must never be repeated. Adult social care and support providers and their representatives must be included as core strategic partners in pandemic planning exercises and policy development, including future SAGE style groups. Representatives from adult social care should also be included in governance arrangements at a local level (via ICBs, LRFs etc) and at a central level to ensure they are fully considered.

Lack of Understanding from Policymakers and Guidance Formulation

4.4. It is clear from the experience of adult social care and support providers during the pandemic and its aftermath, that there is not enough adult social care expertise within DHSC, MHCLG and wider government. The Civil Service must ensure they have cross-department teams of people with a deep understanding of how adult social care is structured and funded. These teams should understand the diversity of care and support services, the people they support, how commissioning works, and the nature of the activities involved in providing care and support. Ideally these teams would include lived experience of either working in or accessing adult social care services, as well as local government and NHS commissioners. These teams should lead cross-government work on policy areas which impact on adult social care.

4.5. This would help the formulation and communication of critical guidance before and during a pandemic situation because there would already be an understanding of the sector. Guidance and policy relating to adult social care, regardless of whether there is a pandemic or not, should always be co-created with adult social care and support providers. This will help prevent an overly clinical bias to policy which sees social care through a hospital lens.

4.6. Ample time must be allowed for co-production and comments on guidance and policy changes. Communicating changes to policy or guidance needs time for implementation and for questions to be clarified. Communication must not come at the last minute or at times which makes implementation very difficult – i.e. Friday evenings or bank holidays with an immediate implementation – or by press release.

4.7. The government should work with the adult social care trade associations that make up the Care Provider Alliance when communicating with the sector. Our communication networks, alongside those of local government and CQC, would enable the entire sector to be reached by messaging in a timely and effective way.

IPC Measures

4.8. Asymptomatic transmission should be assumed in a pandemic situation unless proven otherwise. As such, the government and local systems should maintain a readiness to step up PPE, rapid testing and vaccination infrastructure at short notice. This should include maintaining a national stockpile of PPE for adult social care and support for providers to access it at short notice in the event of a pandemic. There should be continued work on rolling out fit-testing in adult social care for FFP3 masks. Social care staff should have priority access to testing.

4.9. Take any developed vaccines to those who need it. Requiring care workers to travel to get a vaccine when residents in care settings were visited by GPs was counterproductive and added a barrier to uptake. Work with providers and local communities to dispel misinformation about vaccination and encourage greater uptake. Aim to co-administer as many important vaccines as possible.

4.10. A ‘Human Rights Approach’ should be taken when considering measures that would restrict someone’s rights or freedoms. When it comes to visiting restrictions in care and support settings, we must ensure that families and essential caregivers are still able to see their loved ones and that effective IPC measures are in place to enable this safely.

Data and Digital Infrastructure

4.11. Infrastructure around data was lacking before the pandemic, and during the pandemic it became far too focused on the policy aim of freeing up hospital beds, rather than helping policymakers and care and support providers respond to the pandemic. The establishment of new data infrastructures and a minimum data set for adult social care would allow insights about care to be harnessed. This could take the form of a ‘Social Care Data Observatory’. This must be co-produced with the sector and people, and it must balance data burden with data benefit and clarity on data ownership and access. Data is not free, so any strategy must ensure that it meets the costs of increased data reporting requirements. There should also be a commitment to transparency around data. Those that supply data should be able to access the insights that come from it. It shouldn’t be reserved for commissioners and policymakers alone.

4.12. The digital maturity of the care and support sector was limited at the time of the pandemic but there has since been rapid transformation, helped by government investment leading to the mass adoption of tools such as digital care planning. However, there is a need for constant investment in digital and data architecture to enable care and support services to continue this transformation and be better ready to respond to the next pandemic with timely data and insights to support decision-making and operational readiness.