IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

THE UK COVID-19 INQUIRY

WRITTEN OPENING SUBMISSIONS ON BEHALF OF THE DEPARTMENT OF HEALTH AND SOCIAL CARE FOR MODULE 6

---

1. INTRODUCTION

1. The Department of Health and Social Care (the Department) starts this submission by expressing its deepest sympathies to all those who lost relatives and friends during the pandemic, and to those who continue to deal with the consequences of the pandemic. The disruption and effects of COVID-19 on our society were profound, and its effects are particularly felt through health and social care.

2. As explained in the Technical Report on the COVID-19 pandemic in the UK, residents of care homes for older adults were particularly vulnerable to COVID-19 due to their age, the presence of multiple high-risk co-morbidities, and the transmission potential inherent in frequent close physical contact through care (which resulted in large numbers of outbreaks). There were also recognised risks for some working age adults with particular disabilities or conditions (for example Down's syndrome). At the Department, we and our colleagues are painfully aware of the tragic deaths of people with care and support needs arising from the pandemic, as well as the very significant impact on the lives of others of the measures we took to protect the sector. There has naturally been considerable public concern about the large number of people who died in care homes. Every decision-maker, official and scientist working on the pandemic response has been acutely aware that every death is a tragedy and has worked to mitigate the impacts wherever possible.

3. The Department wishes to recognise the sustained pressure put on all those working in the adult social care sector in response to the pandemic. The adult social care workforce

responded with professionalism, dedication, and compassion, providing care and support to those who were most vulnerable to COVID-19, often during the most difficult and emotional situations. In many cases this came at a cost to workers' health and wellbeing, including tragically, some loss of life. Some also live with long-term physical and psychological conditions as a result of their role in the pandemic. On behalf of the Department, we want to thank each and every person who worked in the adult social care sector during the pandemic and express our gratitude for the work they undertook to protect and maintain care for people with care and support needs through this public health emergency.

The Department's role in the adult social care sector

4. The Department's social care remit relates to adult social care in England only. The Department does not directly fund or deliver adult social care and much of the funding for adult social care is raised locally. The Care Act 2014 places the duty to plan and secure adult social care services on 153 local authorities in England, who commission services through a predominantly outsourced market of approximately 18,500 provider organisations. The Department is responsible for setting national policy and the legal framework. The Department also agrees the overall funding envelope for local government with the Ministry of Housing, Communities and Local Government (MHCLG) and HM Treasury (HMT) and monitors the adequacy of local authority spending on adult social care for achieving expected objectives. MHCLG oversees the overall sufficiency of local government funding for all services and the financial framework for providing funding to local government for these services.

5. The Department also sponsors the Care and Quality Commission (CQC), which regulates and inspects adult social care providers (and oversees the financial sustainability of the largest 60 providers of adult social care under a market oversight scheme) and, since 1 April 2023, has had a legal duty to assess the performance of local authorities in the delivery of their adult social care duties under Part 1 of the Care Act 2014.

Overview of the adult social care sector

6. Adult social care covers a wide range of activities to promote people's wellbeing and support them to live independently, and to stay well and safe. Adult social care supports

adults of all ages (those of working age as well as older people) with a diverse range of needs, including:

a. older adults with multiple comorbidities and levels of frailty;
b. people with a learning disability or physical disability;
c. people with mental health conditions;
d. people with sensory impairments;
e. people with social care needs related to substance misuse;
f. people with dementia and other forms of neurological decline;
g. people with autistic spectrum disorder or condition, and other social communication disorders; and
h. people with other long-term conditions.

7. The ways that people draw on care and support vary according to their individual needs and preferences and their stage of life. Some people will require support throughout their whole lives and others may only use adult social care for a short period, such as after a hospital stay. Care needs for some may develop suddenly, and so individuals and their families and friends may have to navigate an unfamiliar landscape at a uniquely stressful time in their lives.

8. Adult social care for both working age and older adults is delivered in a variety of settings including people's own homes, residential care homes with on-site care workers, nursing homes where the staff include a registered nurse to meet assessed needs and, in some cases, day centres. Homecare, or domiciliary care, involves having a carer come to visit an individual in their home. Care provided in an individual's home might be delivered by a homecare worker making short home visits for support with specific tasks, by a live-in carer, or by a personal assistant who is directly employed by the individual.

9. There are also 'supported living' arrangements which allow older people, or those with a disability, to live independently in purpose-designed housing with tailored care and support available to them. In addition to this, the Shared Lives scheme supports adults with learning disabilities, mental health problems or other needs that make it harder for them to live on their own. People move into a shared lives placement and are supported within the context of the carer's home and family.

10. Adult social care provision is means-tested. Whether a person qualifies for any financial support towards their care costs depends on the capital assets that they have. Anyone who has assets below £23,250 may be eligible for financial support from their local authority, depending on how much they can afford to contribute from their income and assets combined. Anyone who has assets above £23,250 is considered a self-funder and therefore is expected to cover their total care costs. However, everyone is entitled to a needs assessment and advice from their local authority on how best to meet their needs.

11. Some individuals may qualify for the provision of health and social care support from the NHS under the Continuing Healthcare provision which provides a package of ongoing care for adults with a 'primary health need' (when the main aspect of their care addresses health rather than adult social care needs). If individuals are not eligible for NHS Continuing Healthcare, they may still be able to receive a contribution to the provision of nursing care to those in receipt of social care services.

12. Although there are no exact figures for the number of people who pay for care, ONS estimates that in 2019/20 there were 143,774 people who funded their own care in adult care homes (36.7% of all care home residents) – known as "self-funders". Care homes providing care for older people had the highest proportion of self-funders (49.6%), while care homes for younger adults had the lowest proportion of self- funders (4.8%).

Sector pressures pre-pandemic

13. In the pre-pandemic period, the sector was under considerable financial strain, with a largely low-paid workforce with high turnover rates, accompanied by a long-lasting and unresolved debate over the need for social care reform. Funding made available to local authorities to commission adult social care services had been constrained since the early 2010s, requiring them to find savings in budgets and to make careful judgements on how best to meet local needs. Although there was significant additional funding after 2014/15, nonetheless overall spending on adult social care at the start of the pandemic was only equivalent in real terms to where it was in 2010/11, despite growth in demand. The CQC's 2018/19 annual report stated that: "in adult social care, funding and workforce issues continue to contribute to the fragility of the sector". In its 2019/20 annual report, the CQC maintained that "adult social care remained very fragile… any further shocks to the labour market would be expected to increase the existing level of market fragility and place more

pressure on local authority finances". Many local authorities (as commissioners) and providers lacked the resilience necessary to respond to a shock such as a pandemic.

2. THEMES AND ISSUES

Data and information

14. The Department is not operationally responsible for adult social care and prior to the pandemic its national data collections reflected this. The Department had no national source of operational data from providers on current spare capacity (although the CQC recorded total care home capacity), workforce, or total numbers of people in receipt of care, including self-funded users and NHS-funded users. The scarcity of data, particularly in comparison to that available from the NHS, presented a significant challenge.

15. In early 2020 it quickly became clear that more information was required centrally in addition to that collected by local authorities. The Department, therefore, rapidly and significantly expanded data collection. This new information, which evolved over the course of the pandemic and was informed by new datasets, was comprised of the following:

    a. NHS Test and Trace data;

    b. CQC and ONS data on deaths of care home residents; and

    c. Regular reporting from care homes via the Capacity Tracker (a data collection portal that existed before the pandemic but was significantly enhanced to gather data on a range of topics including IPC measures in place, outbreaks, staff absences, visiting, and vaccinations).

16. To ensure the Department did not return to its pre-pandemic difficulties with data collection and information with regards to adult social care, from 31 July 2022, (using a direction under section 227A of the Health and Social Care Act 2012)[1], the Secretary of State mandated a core subset of the data to be submitted by providers, via the local authority. This data included:

[1] This came into force on 31 July 2022.

a. numbers of users/occupancy,
b. COVID-19 and flu vaccinations,
c. visiting, and
d. staff absence due to COVID-19.

17. This data continues to be gathered on a monthly basis and helps aid the Department's understanding of the operational resilience of the system and will be critical in a future pandemic.

Funding

18. The Department sought to provide levels of additional funding to meet the additional operational costs faced by providers due to the demands of the pandemic and the requirements of COVID-19 guidance. Over the course of the pandemic, over £2.9 billion was made available in specific COVID-19 funding to support the adult social care sector (in addition to extra funding provided to local government). This included £1.81 billion for IPC, £523 million for testing and £583 million for workforce capacity, recruitment and retention.

IPC funding

19. IPC funding was provided through the Infection Control Fund (ICF), starting in May 2020, and funding for testing was provided through the Rapid Testing Fund (RTF) from December 2020. From April 2021, these were consolidated into one fund, the Infection Control and Testing Fund (ICTF), which had three iterations and required local authorities to directly pass on, or 'passport', a proportion of their allocations to every care provider within their local area. This passporting was done on a 'per bed' basis for care homes, and a 'per user' basis for CQC-registered community care providers. Alongside this, PPE was made available to care providers from March 2020 onwards. The distribution of PPE and associated challenges is explained further below.

20. The ICTF, like the ICF and RTF before it, was more prescriptive than was usual in its funding conditions and had to be used to support adult social care providers (including those providers with whom the local authority did not have a contract) to: reduce the rate of COVID-19 transmission within and between care settings through effective IPC practice; increase COVID-19 and flu vaccine uptake among staff; support the testing of staff and visitors in care settings to identify and isolate positive cases; and enable visiting where possible. The ICTF grants also included a number of conditions dictating how it had to be dispensed and how quickly it had to be used.

The Workforce Capacity Fund

21. In response to ongoing workforce capacity and staff movement concerns the Department announced the £120 million Workforce Capacity Fund (WCF) on 16 January 2021. This £120 million fund was introduced with the expectation that it would be used to improve workforce capacity, help alleviate some of the staff shortages identified in the sector and maintain the provision of safe care, by reducing staff movement between care homes and other health and care setting. Local authorities could use the funding to deliver measures to help all providers of adult social care in their geographical area, or could pass the funding directly to providers.

The Workforce Recruitment and Retention Fund

22. In light of the ongoing challenges with workforce capacity across the care sector, the Workforce Recruitment and Retention Fund (WRRF) was introduced in Autumn 2021. The WRRF was a ring-fenced grant of £162.5 million paid in two instalments to local authorities, the first instalment in November 2021, and the second in January 2022. A £300 million extension to the WRRF was also announced on 10 December 2021. The WRRF more closely resembled arrangements made before the pandemic to support winter pressures for the health and social care services. The WRRF was used to support local authorities to urgently address adult social care workforce capacity pressures in their geographical area through recruitment and retention activity, allowing local authorities to decide the best way to do so through engagement with care providers.

23. Local authorities were expected to work closely with providers to determine how funding should best be spent, including passporting funding directly to providers where appropriate. Examples of measures that it could be used to fund included: supporting payments to boost the hours provided by the existing workforce (including childcare costs and overtime payments); occupational health and wellbeing measures; incentive and retention payments; and local recruitment initiatives.

The Adult Social Care Omicron Support Fund

24. The Adult Social Care Omicron Support Fund was announced on 29 December 2021. This was a new grant of £60 million to be spent on the following measures in response to the pressures imposed by the Omicron wave: IPC funding relative to workforce operations

(sickness and self-isolation pay and limiting staff movement); backfilling staff absences; ventilation; and unpaid carer support measures.

Discharge and designated setting funding

25. In addition, between April 2020 and March 2022, over £3 billion was made available via the NHS to fund national implementation of the Discharge to Assess (D2A) model through a standalone discharge fund known as the Hospital Discharge Programme (HDP). NHS England (NHSE) was responsible for administering the discharge funding, which went through NHSE to Clinical Commissioning Groups (CCGs) to be distributed to providers at a local level.

Hospital discharge

March Hospital Discharge Policy

26. In March 2020, there was a significant concern that the NHS would be overwhelmed with COVID-19 patients and that those in hospital were likely to be exposed to the virus. NHSE identified that it would be necessary to try and free up as many beds as possible. Discharging patients from hospital, where clinically appropriate, also protected individuals, from the risk of infection from an influx of COVID-19 patients and it was predictable that this would first manifest itself in hospitals where sick people come. The March hospital discharge policy, published on 19 March 2020, sought to discharge patients from hospital to be returned home or relocated to alternative settings such as care homes. Some of those that returned home did so with individual care plans which included varying levels of health and social care support. Whilst the Department was responsible for implementing hospital discharge policy, it was not responsible for making decisions about who was discharged, and to where, as that was a matter for health bodies and local authorities in local areas.

27. There has been much public discourse about the March hospital discharge policy and assumptions that deaths in care homes were as a result of hospital discharge. There have, however, been a number of reports and studies (set out in the Department's corporate evidence for this Module) which concluded that, as the CMO summarised in his 'Technical Report on the COVID-19 Pandemic in the UK', "hospital discharge does not appear to have been the dominant way in which COVID-19 entered most care homes". Instead, as the CMO and Government Chief Scientific Advisor stated the Technical Report, "the majority of outbreaks were introduced unintentionally by staff members living in the wider

community". The Department acknowledges that, inevitably, admissions to care homes from hospital during this period will have accounted for some care home outbreaks. A PHE study commissioned by the Department and a SAGE subgroup suggested that "hospital associated seeding accounted for a small proportion of care home outbreaks"[2] and therefore, most regrettably, some deaths.

Updates to hospital discharge policy, guidance and funding

28. In March and April 2020, the Department, with PHE and NHSE, published a series of guidance documents for the NHS and for adult social care to manage the discharge process and the admission of people to care homes. The guidance reflected the evolving understanding of COVID-19, the nature of transmission of COVID-19, the enlargement of testing capacity and the provision of IPC. Amongst the guidance documents were:

    a. 19 March 2020: COVID-19 Hospital Discharge Service Requirements. As mentioned above, the objective of the guidance was to prevent critical care services from being overwhelmed, whilst ensuring the safe discharge of individuals during the pandemic.

    b. 2 April 2020: Guidance on admission and care of people in care homes. This included advice on admissions and isolation of residents from a care facility and was updated with testing requirements.

    c. 15 April DHSC: 'COVID-19: Our Action Plan for Adult Social Care'. This brought together a comprehensive summary of the action the Government was taking to support social care. In particular, it announced a move to institute a policy of testing all residents prior to admission to care homes, beginning with all of those being discharged from hospital, and recommended a 14-day isolation period.

The Designated Settings Policy

29. The Department worked with the CQC to develop 'designated settings', which came into operation in November 2020. It took about two months, following discussion with the Prime Minister on 18 September 2020, before the first designated settings began operating,

[2] INQ000234332

with each having to be approved by the CQC. Prior to this, local authorities consulted with care providers to identify appropriate facilities and then ensured that the designated accommodation adhered to standards and wider requirements. Designated settings were specific care homes that had isolation facilities to house COVID-19 positive patients that had been discharged from hospital. The purpose of the settings was to restrict further spread of COVID-19. Patients were required to complete a period of isolation for 14 days before returning home or moving into a care home. By early January 2021 designated settings were available in 141 local authorities. At its peak there were 159 CQC approved designated settings providing 2,169 beds. There were an additional 919 beds available through alternative arrangements, where some local authorities made arrangements with local partners to use NHS settings for the same purpose.

IPC and PPE

30. IPC is a key component of routine healthcare and social care. During the pandemic, various pieces of tailormade COVID-19 IPC guidance were developed to reduce the transmission of COVID-19 in health and care settings and protect those accessing care as well as staff and visitors. Guidance was published by PHE and was regularly updated in response to emerging evidence about COVID-19 and the availability of key protective measures such as PPE, testing and vaccines.

31. The Department supported PHE to engage with key stakeholders in adult social care. This helped to ensure that, as far as possible, guidance took into account the practical challenges of delivering enhanced IPC in care settings. However, it was the case throughout the pandemic that adult social care providers needed to make IPC risk assessments and decisions that reflected their own individual circumstances. The Department's actions during the pandemic, including in relation to visiting and testing policy and decisions on hospital discharge, were all underpinned by IPC guidance.

32. Prior to the pandemic, procurement of PPE was the responsibility of the individual organisations providing care and was sourced from a range of private sector wholesalers. PHE guidance set out how available PPE should be used. The guidance evolved in response to emerging evidence on the transmission routes of COVID-19. An effect of these changes in the guidance was to increase the volume of PPE required in health and social care settings.

33. The devolved nature of procurement and logistics meant there was no centralised information on supply resilience in adult social care for PPE when the pandemic emerged. From the beginning of the pandemic, the Government was concerned with potential market failure and competition between health and social care providers for scarce resource, leading to challenges in providers ability to buy PPE. In response to concerns, the Government increasingly intervened to purchase and distribute PPE through wholesalers and Local Resilience Forums (LRFs), and provided a mechanism for providers to access emergency supplies when they were at risk of running out of PPE, early measures included:

a. In line with pre-pandemic plans, from March 2020 the Department supported wholesalers, selling them Government owned PPE to enable them to distribute amongst providers.

b. Also in March 2020, the Department provided CQC registered providers with initial supply of PPE and also activated the National Supply Disruption Response (NSDR). Any health or social care provider could contact the NSDR for emergency PPE if there was a risk of current stocks running out within a 72hr period.

c. In early April 2020, the Department provided PPE to LRFs so that they could provide PPE to local providers otherwise unable to secure it.

d. The establishment an e-portal for direct distribution of PPE to community health and social care providers. This launched in April and by 26 June 2020, 22,000 eligible GPs and smaller ASC providers were registered with the e-Portal.

34. From the start of May 2020, under the direction of LRFs, local authority public health departments and CCGs, CCG infection control nurses carried out “training the trainers” sessions in care homes on the recommended approach to IPC, PPE requirements and usage and testing advice.

35. After the first wave of COVID-19 there was recognition of the ongoing need to support social care providers in sourcing and supplying PPE, resulting in the ongoing supply of free PPE to the sector, this arrangement was maintained until March 2024. By the end of July 2021, 10.5 billion items of PPE had been distributed.

Testing

36. Testing was an important tool for controlling outbreaks within social care, although it was not able to prevent all outbreaks. As the Inquiry heard in Module 7, the limiting factor in care homes was the overall testing capacity available for the UK, especially in the early months of the pandemic when difficult decisions had to be made on prioritisation. Early into the pandemic, the projected increase in demand for testing, and the scale of testing required, meant it would not be possible to test everyone. Therefore, guidance was issued to ensure testing resource was allocated appropriately, as testing supply was scaled up.

37. Within this constraint, testing for adult social care was prioritised and rolled out as capacity allowed. First, for symptomatic cases in care homes from 12 April 2020, then asymptomatic staff and residents from 28 April 2020, followed by whole care home testing from 11 May 2020. This occurred alongside other measures to widen access to testing such as for patients who were discharged from hospital prior to admission to care homes.

38. Guidance continued to be issued and updated as testing capacity increased. This was based on the available evidence on need and risk at the time, prioritising those groups where testing was required to support clinical management of the most vulnerable to COVID-19. Regular asymptomatic testing of staff using PCR in domiciliary care was introduced from 23 November 2020 and was extended to extra care and supported living settings from 9 December 2020. In early December 2020, following the introduction of lateral flow device (LFD) testing, testing was again scaled up and introduced for all visitors to care homes, and to facilitate visits out of care homes.

39. A huge logistical exercise was required to deliver tests to the adult social care sector, and much time was spent on the practicalities of sending the tests out to around 15,500 care homes, tracking whether they were being used, picking them up to take them to laboratories, and speeding up the time within which results were sent back to care homes. This became much easier over time with the introduction of lateral flow tests in late 2020. This was all covered and the Inquiry is asked to consider the evidence given in Module 7 by the Department in this respect which provides a significant amount of detail about the implementation of widespread testing and its logistical challenges.

Vaccines and Vaccination as a Condition of Deployment (VCOD)

40. The roll out of vaccinations from December 2020 made an enormous difference to protecting those drawing on adult social care, particularly in care homes. It was a significant

undertaking requiring stringent prioritisation to allocate according to greatest need, and careful work between the Department and NHSE to ensure timely delivery of the vaccine across over 15,000 care homes. The Inquiry has heard significant evidence about the roll out of vaccination in Module 4 and its challenges. This evidence should be taken into account by the Inquiry when dealing with issues concerning vaccination in respect of Module 6.

41. The UK vaccination programme began on 8 December 2020. By March 2021, all care home staff and residents had been offered at least one vaccination, but the take up rate was only 73.4% (versus 91.7% for adult care home residents) for those working in residential care settings. In early 2021, the Department therefore introduced a number of measures to make it as easy as possible for care workers to access the vaccine and undertook a programme of work to overcome vaccine hesitancy. Despite this action, vaccination remained below the SAGE recommended threshold of 80% of staff and 90% of residents having at least one vaccination to avoid outbreaks. Work also began on putting in place legislation to require vaccination among the care workforce to protect care home residents from COVID-19. In parallel to the work on this legislation, efforts were made to monitor the uptake of the vaccine and to work with those local authorities where uptake was lowest (generally areas of high deprivation and significant ethnic minority population). The regulations for the vaccination as a condition of deployment (VCOD) policy came into effect in November 2021. The Inquiry heard evidence in Modules 3 and 4 about this policy and its implementation.

42. The Department always recognised that there was a balance to be struck between the aim of protecting the most vulnerable to COVID-19 on the one hand, and individual rights of care workers and risks to workforce capacity on the other. This balance changed with the advent of the Omicron variant, which was less severe and where vaccines were less effective at preventing transmission. In light of this, the Department made the decision to revoke the relevant regulations, subject to consultation. Following the consultation and final report, the Government decided to bring forward regulations to revoke VCOD, with the regulations taking effect from 15 March 2022.

Visiting

43. The Department was concerned throughout the pandemic with trying to balance the need to have restrictions to prevent ingress of COVID-19 into residential care settings, or

other places where those with vulnerabilities to COVID-19 lived, and with enabling friends and family to visit. Thus, the Department sought to balance the need to minimise COVID-19 risk to residents and staff with the need to protect residents' wellbeing. This was an exceptionally difficult set of decisions. This balance was constantly reassessed and the goal throughout was to enable visits as much as possible in the context of the public health advice at the time. The difficulty surrounding decisions and their outcomes on this delicate issue, can be demonstrated through the fact that the Department was both judicially reviewed for failing to shut down visiting early enough in the first wave of the pandemic, and received a number of pre-action-protocol letters in late 2020 challenging guidance for not allowing enough visiting.

44. The Department was very aware of the impact that closing care homes to visiting had on residents. It was constantly looking for ways to ease restrictions on visiting where this was consistent with public health advice. This became easier as time went on and as tools such as testing and vaccines enabled a more permissive approach. Initially only end of life visits were permitted, then visiting with safeguards, and later visits from essential care givers and specific numbers of named visitors. Although some restrictions were introduced when the Omicron variant emerged, the role of the essential care giver was protected, and the number of named visitors was reduced rather than being stopped altogether, thus learning the lessons of the previous waves of the pandemic. Ensuring that those in care homes, particularly working aged adults, could make visits out into the community was also an important element of the policy.

Workforce

45. The adult social care workforce was incredible during the pandemic. Whilst the nation was locked down, they continued to go out to work and support those requiring care in the most difficult of circumstances. In some cases, this came at a risk to their own lives.

46. During the pandemic, the Department sought to ensure that there were enough care workers in the workforce, bearing in mind a high vacancy rate going into the pandemic. This was done in a number of ways including initially through fast-track recruitment and fast track Disclosure and Barring Service checks. Later on, there were specific grants to local authorities for recruitment and retention, separate from the wider grants going to local authorities. There was particular concern around the contraction of the workforce in late 2021, as the economy reopened, and the second of these recruitment and retention funds

(which was adapted in the light of the experience of the first) was designed to help the sector to cope with this.

47. The Department took various steps both to protect the workforce and to protect care users from COVID-19, mindful of the fact that many care workers had insecure employment and were paid at minimum wage level. The Department grant funded providers through the Infection Control Fund (ICF) as set out above. The ICF could be used to ensure that staff who were isolating in line with government guidance received their normal wages whilst doing so, meaning providers could uplift the pay of those who needed to isolate and who would otherwise only have been entitled to Statutory Sick Pay. The extent to which staff were being paid sick pay and were self-isolating was monitored very closely. There was extensive discussion around staff movement between care homes, with significant thought given and work undertaken on seeing if such movement could be stopped or minimised. In the end following consultation, staff movement was not prohibited by legislation but guidance advising against it was issued and it was made clear that the ICF could be used to compensate staff accordingly.

DNACPR

48. A DNACPR decision is an instruction not to attempt cardiopulmonary resuscitation (CPR). DNACPRs are designed to protect people from unnecessary suffering by receiving CPR that they do not want, that may not work or where the harm outweighs the benefits. The Department was made aware early in the pandemic that allegations of instances of inappropriate use of DNACPR procedures had been made. As has been identified in Module 3 and the evidence given there, the Department made sure that strong guidance was issued condemning any such use and making clear that blanket DNACPR were never acceptable and should not be put into place in any circumstances. During the course of the pandemic, the Department supported the advice and guidance published by relevant stakeholders (such as the CQC, the British Medical Association (BMA) and the Care Provider Alliance (CPA)) in response to concerns within the care sector, which was discussed and outlined in the evidence given in Module 3 both by the Department and others.

49. On 7 October 2020, the Department commissioned the CQC to conduct a special review, under s48 of the Health and Social Care Act 2008, of DNACPR decisions during the COVID-19 pandemic. The final report of this review was published on 18 March 2021.

A Ministerial Oversight Group (MOG) was established to look in depth at the issues raised in the report. One of the key outputs of the MOG was the joint publication of a set of Universal Principles for Advance Care Planning, which was first published in March 2022 by a coalition of partners. These principles intended to facilitate a consistent national approach to 'what good looks like' in advance care planning in England, setting out the need for individualised decision making focussed upon person circumstances, full discussion between the individual, their family and the relevant clinicians, and ensuring full and proper consent. As was identified in Module 3, there is more work which could be done nationally to raise awareness, understanding amongst patients and their families and amongst clinicians as to how to sensitively and ethically deal with these issues.

Inequalities

50. At the very start of the pandemic the Department recognised the need to provide support to the adult social care system to ensure that proper consideration was given to ethical values and principles when organising and delivering adult social care. An Ethical Framework for adult social care was published on 19 March 2020. The Framework provided a structure for local authorities to measure their decisions against, following the principles of respect, reasonableness, minimising harm, inclusiveness, accountability, flexibility, and proportionality. It reinforced that the needs and wellbeing of individuals should be central to decision-making during the pandemic. It particularly provided an underpinning for challenging decisions about the prioritisation of resources where they were most needed.

51. In respect of adult social care, examples of the way the Department sought to embed equalities legislation and principles in its response to the pandemic are:

    a. Translating Government guidance about COVID-19 into languages most commonly spoken in England to improve accessibility. Translated versions of the guidance became available from 20 March 2020.

    b. The publication of a COVID-19 adult social care workforce risk reduction framework in June 2020 which covered risks by ethnicity, age, sex and underlying health conditions.

    c. Through the Chief Social Worker, bringing together best practice for providing "culturally competent care" - care which takes into account, reflects and acknowledges religious and cultural differences - during COVID-19 and beyond.

d. The provision of £10 million funding to the voluntary sector to provide help, particularly for under-served groups in respect of mental health, and funding for learning disability and autism charities to support their COVID-19 response.

3. LESSONS LEARNED AND RECOMMENDATIONS

52. The Department has identified the following set of recommendations for supporting the adult social care sector in future pandemics. These take into account and are in addition to the vital lessons that the Department learned on how to control transmission of respiratory disease in care homes over the course of the pandemic.

a. It is essential to take into the account the complexity and breadth of the adult social care sector when preparing for and dealing with any future pandemic. The heterogeneous nature of the sector must be accounted for when considering how to communicate with and support the sector. This is particularly relevant both for the drafting and dissemination of guidance and for practical support to the sector. It was essential during the COVID-19 pandemic that the Department worked in partnership in a systematic way with provider representatives, charities representing those who draw on care, and local authorities (as well as other stakeholders), ensuring that each of these groups was involved every step of the way.

b. Timely data and intelligence on the adult social care sector is critical to provide a sense of what is happening on the ground and to enable targeted interventions. The Department now has monthly data from every CQC-registered provider, which is a vital source of information and one that did not exist before the COVID-19 pandemic. It is possible to add to this data collection where new issues arise. However, data alone is insufficient; equally vital is intelligence from the sector, which comes from the very close partnerships with the key stakeholders that the Department has established.

c. Close relationships between the adult social care system and the health system are essential at all levels. These relationships were essential during the COVID-19 pandemic, particularly to ensure that discharge processes worked smoothly, to facilitate vaccine delivery, and to ensure that there was sufficient

medical support to care homes. These relationships continue to be vitally important in supporting joined-up health and care services, helping people to stay independent for longer, preventing avoidable hospital admissions, and ensuring timely hospital discharge.

d. It is important to ensure that care home residents are able to receive visits from their loved ones. This was recognised by the introduction of Regulation 9A into the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in 2024, which set a new fundamental standard of care on visiting. This regulation states that, unless there are exceptional circumstances, both visits in and out of care homes must be facilitated.

53. It is clear that the underlying resilience of the system is central to pandemic preparedness. The adult social care system was fragile going into the pandemic due to considerable financial strain and workforce pressures, and this remains the case now post-pandemic. The Casey Commission started work in April 2025 to examine all issues relating to adult social care, including how to create a fair and affordable system.

54. The experiences of recipients of care and workers in adult social care was one of the most challenging and devastating aspects of the whole pandemic, causing understandable anger both from those who lost loved ones and from those who were denied contact with friends and relatives. The Department would like to reiterate its thanks to all those who worked in or supported the sector as it battled the pandemic.