IN THE UK COVID-19 INQUIRY

Before the Right Honourable Baroness Hallett D.B.E.

MODULE 6:
OPENING STATEMENT ON BEHALF OF THE NATIONAL ASSOCIATION OF CARE AND SUPPORT WORKERS

Introduction

1. The National Association of Care and Support workers ('NACAS') was established in 2016 as an independent professional body that advocates for care and support workers, promotes the recognition and value of their work and provides them with support, education and other resources. Prior to its conception, there was no dedicated professional organisation that provided a voice for care professionals. Its ethnically diverse and growing membership (of about 15,000) work in the full range of adult social care roles across the frontline care and support worker profession, including in care homes and homecare, whether employed, self-employed or engaged on zero-hours contracts.

2. NACAS is grateful for the opportunity to assist the Inquiry in Module 6 to fulfil its Terms of Reference. It has contributed to the evidence by way of a witness statement, dated 28 January 2025, from the Chair, Paul Featherstone, himself a former care professional, which is underpinned by surveys of and accounts from the membership, and input from the NACAS Board and Leadership Team.[1] NACAS members have also provided impact evidence, including from Julie Parkinson.[2] Both Mr Featherstone and Ms Parkinson will give oral evidence during the Module 6 public hearings.

3. The important role of the Inquiry in influencing how the adult social care ('ASC') sector responds to a future pandemic – and in determining its future direction – cannot be overstated. Care and care work have long been undervalued by politics and society, a situation rooted partly in their historical association with gendered roles, older people, and in the persistent view that such work is 'unskilled' and economically 'unproductive'. A similar lack of attention and care towards the ASC sector characterised both pre-pandemic preparedness and the response to the pandemic, particularly in its initial phase. NACAS adopts the words of Cathryn Williams of the Association of Directors of Adult Social Services ('ADASS'):

[1] INQ000569768, INQ000518392, INQ000518395
[2] INQ000614375, INQ000614376, INQ000518420

> *"There is a collective hope that the Inquiry will make a mark in recognising just how essential social care is for all of our lives and start to build a new social contract about how we live, work and care for each other."*[3]

4. The oral hearings for Module 6 are timely. In April 2025, His Majesty's Government ('HMG') announced another review of the ASC sector: the independent commission on building a National Care Service which is to be chaired by Baroness Casey of Blackstock DBE CB. The first phase, due to report in 2026, is tasked with – perhaps surprisingly given the extensive body of evidence from previous reviews evident from the Inquiry's disclosure – *"understand*[ing] *the current adult social care landscape and identify*[ing] *a commonly agreed picture of the problems faced"*. The commission will undoubtedly give careful consideration to the Inquiry's findings touching on these matters.

5. It is convenient to structure the remainder of these submissions by reference to certain topics in the Revised List of Issues for Module 6. These include the **(a)** impact of the pandemic on care professionals; **(b)** the structure, staffing and capacity of the ASC sector; **(c)** key decisions taken during the pandemic including those related to hospital discharge policy, testing provision for care professionals, and visitation policy; **(d)** management decisions concerning IPC measures and financial support, PPE provision, mandatory vaccination and guidance for the sector; and **(e)** a recommendation that NACAS invites the Inquiry to consider, throughout the evidence, concerning the professionalisation of the care workforce.

Impact on care workers

6. To understand the impact of the pandemic on those working in ASC, it is necessary to understand what it means to be a care professional. In preparing these opening submissions, NACAS' Chair, Paul Featherstone, offered his "*Reflections on Being a Carer: A Privilege, a Challenge, and a Reward*". His reflections capture the layered reality of care work and echo the dual meanings of the Old English word *caru*, encompassing not only care and concern, but also anxiety, sorrow, grief, and burden. These dimensions are essential to any serious consideration of the pressures faced by the care workforce during the pandemic:

> *"Being a carer (care professional) is a privilege that few fully understand unless they have experienced it first-hand. It is an honour to be entrusted with someone's care, to be allowed into their home and their life in such an intimate and essential way. It goes beyond the traditional sense of just providing support or fulfilling duties; it is about forming a bond, building trust, and offering a sense of independence, no matter the limitations that exist due to age, illness, or disability.*

[3] INQ000571608/3/1.7

Every day as a carer, I was reminded of the profound responsibility I carry, but also the profound impact I can make. In a world where it's easy to feel disconnected, being a carer brings a sense of deep purpose. To know that your presence allows someone to maintain a sense of dignity, to live as independently as their circumstances will allow, is something life-affirming. It became more than a job or a role. It became a calling.

The emotional highs and lows are part of the experience. There were days when the reward felt overwhelmingly tangible: a smile, a thank you, or the simple satisfaction of knowing you've made a day easier or better for someone else. These moments of connection fuel the heart, reminding me why I did what I did. Yet, there are also times when the weight of the responsibility can feel heavy, when exhaustion and frustration creep in. It is mentally challenging to witness someone you care about struggle, and it can be difficult to find the balance between providing care and maintaining boundaries.

But that challenge is what makes it so rewarding. There is an inherent growth that comes with this work – personal growth that stretches you beyond what you thought you were capable of. You learn to be patient, to be present, to find solutions in difficult situations. You learn to read people's needs without words, to comfort with actions, to support with empathy.

Being a carer also meant being an advocate – someone who ensured the person you care for has access to the services and resources they need. It can feel like a fight at times, advocating for their rights, navigating systems that can be complex and overwhelming. Yet in these moments, you realise the true impact you're making: not just in individual lives, but in the broader landscape of care and support.

The role of a carer can often feel like it goes unnoticed by society. It is often the silent work, the behind-the-scenes care, that is rarely recognised or celebrated. Yet, it is one of the most essential roles in any community. We become the quiet backbone, holding up families, supporting health systems, and ensuring that people can live with dignity.

At its core, for me, being a carer is about connection. It is about walking beside someone on their journey, offering not just physical assistance but emotional and psychological support. It is about making a difference in someone's life, even in small ways. And while the demands are high, the rewards are immeasurable.

The privilege of being a carer is not just in what you do for someone else, but in what they do for you. They teach you compassion, resilience, and the true meaning of selflessness. They show you how to live fully, even when life is difficult. They remind you of the power of presence, of human connection, and of what it means to truly care.

Being a carer is not an easy path, but it is, without a doubt, one of the most fulfilling roles I have ever experienced."

7. Pre-pandemic, and even more acutely during it, the ASC sector relied on that sense of duty, responsibility and commitment.

8. Care professionals are often vulnerable as a result of their class, sex, ethnicity and/or immigration status. The overwhelming majority of the UK's 1.6 million care professionals are women (83%). Individuals from global majority backgrounds and migrant workers are significantly over-represented as compared to the general population (21% cf. 14%; 17% cf. 13%, respectively).[4] One in five live in poverty; about 61% in England and 56% in Wales earn less than the real Living Wage; and it is common for domiciliary carers to earn less than the statutory minimum wage once travel time and fuel costs are considered.[5]

9. It was on that foundation that care professionals suffered the terrible impact of Covid-19. Existing inequalities were exacerbated.[6] Care professionals, particularly in residential and nursing homes, laid witness to the traumatic deaths of colleagues and of those for whom they cared.[7] The ONS analysis shows that the mortality rate for social care professionals was the highest by occupation in the UK and two to two and half times larger compared to the general population.[8] The risks for staff from global majority backgrounds were even higher.[9] Care professionals toiled with shortages of staff, PPE and testing, confusing guidelines, concern for those for whom they cared, limited political and societal recognition and little by way of mental health support. It is little wonder that care professionals felt drained, overwhelmed and exhausted.

10. The absence of dedicated mental health and wellbeing support for the ASC workforce is one example of the disparity of treatment with their NHS counterparts, for whom HMG allocated dedicated funding for such support.[10] Another example was the belated decision to recognise care professionals as key workers.[11] As Dame Jenny Harries aptly observes, the NHS and ASC workforces are "*inextricably linked but we alienate one very regularly*".[12] NACAS hopes that the Inquiry will mark a step toward addressing this imbalance and advancing genuine parity of esteem between the NHS and ASC.

11. The following are a few examples of the impact of the pandemic on care professionals, as reported by NACAS members in their own words:

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[4] INQ000543049/60-62
[5] INQ000475008/91
[6] E.g. INQ000572015/10/27-30
[7] INQ000502030/26/87
[8] INQ000553814/33-34/126-128, 36
[9] INQ000542991; INQ000586665/14/71-72; INQ000543006
[10] INQ000515683/8/27-28
[11] INQ000569768/50/190-192
[12] INQ000587394/31/5.54

- *"I felt like I was having a mental breakdown from all the stress and worry";*

- *"Both clients and workers health deteriorated. Depression was rife and morale extremely low";*

- *"Staff were overworked, not having breaks, working extra and double shifts, made to cover larger areas and not given the time needed with the client. Staff were completely mentally and physically exhausted, some were crashing cars falling asleep at the wheel";*

- *"I have never seen deaths like that in my life. Covid made me feel helpless let alone fearing for my life";*

- *"It is an awful feeling knowing that you might pass on an infection and that this might ultimately have fatal consequences."*[13]

12. Those experiences accord with the wider evidence that frontline health and social care workers are more likely to present with PTSD, anxiety and depression following the pandemic.[14] The Inquiry is invited to recognise the sacrifices made by care professionals and that, to the immense credit of the profession, they continued to deliver high quality care in the most adverse conditions.[15]

Structure, staffing and capacity of ASC

13. In the absence of an expert witness to address the structure, staffing and capacity of ASC immediately prior to and during the pandemic, the Inquiry has collated evidence from the leading bodies operating across the sector. Their authoritative voices speak as one: the immediate pre-pandemic state of the sector was "*perilous*", "*fragile*", "*approaching collapse*" and "*in a markedly weakened state that impaired its ability to respond to the pandemic*".[16] The Inquiry has already concluded that in 2020 "*health and social care, were running close to, if not beyond, capacity in normal times*".[17]

Size, scope and structure of ASC

14. The size, scope and structure of the sector – and, importantly, HMG's understanding of it – were core factors affecting the ASC sector's response to the pandemic. That lack of understanding, compounded by unclear

[13] INQ000569768
[14] INQ000183756/48-49
[15] INQ000515683/50
[16] The Social Care Institute for Excellence ('SCIE'): INQ000576035/10/46; Nuffield Trust: INQ000475008/109/117; British Association of Social Workers ('BASW'): INQ000572015/10/27-30, 39/134
[17] Module 1 Report/Executive Summary

accountability and a lack of ASC visibility in decision-making, are common themes that emerge from the evidence.

15. The sector is large, complex, fragmented, unintegrated with health services (in England and Wales) and misunderstood. The position may be summarised as follows. Care is provided in varied settings including care within dedicated accommodation (residential and nursing homes), the community (e.g. day care centres) and the home (domiciliary care, personal assistance and supported living). Care recipients have diverse needs from short-term recovery post-discharge from hospital to long-term support for disabilities. Care is delivered by a large number of providers (18,500) operating across an even larger number of settings (38,200) including regulated locations (29,900). There are a wide range of mostly private providers from large companies to individual employers.[18] Services are commissioned by local authorities ('LAs'). Funding is received from a variety of sources, for example, the central Social Care Grant administered by the Ministry of Housing Communities and Local Government ('MHCLG'), locally though council tax and the precept, from NHS sources and from clients themselves. There is unclear, limited and *"weak"* central oversight and control by the MHCLG, and by a second department ('DHSC') on matters of policy.[19] There are different governance structures, and degrees of integration with health services, across the devolved nations.[20]

16. Skills for Care identifies one of the problems presented by this structure:

> *"…interconnections between organisations, which can bring about benefits such as collective bargaining and transfer and scale of innovation, are less developed than we see in other sectors including the NHS… In many ways, the sector exists as thousands of separately managed workforces. This in turn means there are very few strong levers available to drive change and improvement at scale."*[21]

17. Against that backdrop, it was inevitable that, when the pandemic arrived, it was not sufficiently clear who, or which organisation, was responsible for different aspects of the response for the ASC sector, particularly in the initial phase.[22] This hindered rapid and coordinated responses to the pandemic.[23] By contrast, countries (such as Japan and Denmark) with clear accountability arrangements were able to use them to manage their responses more effectively.[24]

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[18] INQ000543049/49/248; INQ000576035/7/31; INQ000571608/9/4.4; INQ000475008/43/50
[19] INQ000587394/11; INQ000553872/12; INQ000502030/24/82; INQ000148331/8
[20] INQ000475008/5-6
[21] Skills for Care is the strategic workforce development and planning charity, INQ000543049/49/249
[22] Research undertaken by the Nuffield Trust in 2020 identified that unclear accountability and the absence of a central support infrastructure hampered and delayed the response at INQ000475008/119-120/130-132; INQ000553857; INQ000553872; INQ000553873. See also INQ000475008/112/121.1
[23] INQ000576035/24/101
[24] INQ000475008/119-120/130-132; INQ000553857; INQ000553872; INQ000553873

18. It is also apparent that a lack of understanding of the ASC hindered HMG's response to the pandemic. ADASS observes that, from the outset of the pandemic, "*many in DHSC did not have sufficient understanding of social care alongside the difficulties of infrastructure*" (described as "*extremely thin*"). Similarly, the Social Care Institute for Excellence ('SCIE') observed that HMG's "*understanding of* [the sector's] *readiness, capacity, and capability appears to have been incomplete, poorly understood or overlooked.*"[25]

19. This resulted in a delay in addressing ASC as compared to the NHS. A particularly striking example is of procurement officials expressing disbelief that four million aprons would be required each day for social care – a reaction that reveals a failure to grasp basic facts about the sector, such as the existence of approximately 1.6 million care professionals.[26]

20. These observations mirror Dame Harries' statement that, in February 2020, DHSC was focused on healthcare at the expense of ASC (as it had been since social care was added to its remit in 2018) and that it lacked dedicated resources including personnel and leadership at the outset of the pandemic.[27]

21. The Inquiry is invited to explore the reasons for HMG's poor understanding of the sector and how it might be improved. The evidence suggests that the reasons include a lack of institutional knowledge as a result of the civil service rotation model,[28] insufficient reliable data from the sector, the misperception of ASC as an adjunct to the NHS and the exclusion of ASC voices from key decision-making.

22. In relation to data, Dame Harries identifies that at the onset of the pandemic flows from the sector, particularly from private providers, to DHSC were "*underdeveloped and poor. What data available was mostly held by local authorities rather than central government.*" It was not of the type that would be needed to understand the progress of a pandemic.[29] As the King's Fund observe, it did not include routine data on key factors such as sector capacity, the state of the workforce and the financial health of providers. The limited data flow from LAs to DHSC was slow with a time lag of at least six months.[30] To take an example, DHSC did not appear to understand that ASC professionals often work in multiple locations and did not request data in respect of this issue until October 2020.[31] In addition, differing definitions of a care home in each

[25] INQ000576035/7/30-31
[26] INQ000571608/4/2.2, 28/8.5, 63/14.4, 67-68/14.15
[27] INQ000587394/11
[28] INQ000543049/49/249
[29] INQ000587394/13/5.8, 55/7.1
[30] The King's Fund is the leading independent health and care think-tank in England. INQ000f/24/82
[31] INQ000543049/3/12, 40/213

devolved nations rendered it unfeasible for the ONS to produce a UK figure for care home deaths.[32]

23. There was a complete absence of ASC voices in key decision-making in the early stages of the pandemic. By way of example**: (a)** there was no dedicated Director General for Adult Social Care in DHSC until June 2020 (when the position was reinstated after its abolition in 2016); **(b)** there was no ASC voice in SAGE until the establishment of the Care Home Working Group ('CHWG') in summer 2020. It is of note that the CHWG was renamed the Social Care Working Group ('SCWG') in September 2020, itself a sign that the scope of ASC was misunderstood; **(c)** there were no regular channels of communication between ASC providers and recipients and HMG; and **(d)** references to ASC were absent from high-level framework documents produced by the Cabinet Office in the early stages of the pandemic.[33] The effect of that exclusion was that ASC was invisible in the early stages of the pandemic and key decisions were made without any or adequate consideration of the impact on ASC.[34]

24. NACAS invites the Inquiry to consider whether there was a difference in the pandemic response as between public, small-scale private and large-scale private care providers. It notes the evidence published in the Lancet Healthy Longevity journal, dated 11 February 2021, that the odds of infection for residents, staff and of large outbreaks were significantly higher in long-term care facilities that were for profit versus those that were not for profit.[35] One explanation, about which NACAS members have expressed concern, is that profit-making homes invest less in staff and facilities than their publicly funded equivalents.[36]

25. NACAS also encourages the Inquiry to consider whether the complexities of the unstable and financially fragile private market for social care, including the high turnover of staff and decreasing numbers of providers as a direct result of the low price paid for care, left it particularly vulnerable to the pandemic (and, it follows a future one).[37] In that context, Dame Harries has observed that:

> "[with a] *dispersed private business model there was inevitably very limited routine focus on detailed, connected or coherent pandemic response plans… The effect was that local pandemic plans within ASC settings tended to be underdeveloped*".[38]

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[32] INQ000553814/21/99
[33] INQ000088326, INQ000056086, INQ000146695
[34] INQ000475008/111/121.2
[35] INQ000553814/58/208; INQ000503454/1: *Factors associated with SARS- CoV-2 infection and outbreaks in long-term care facilities in England: a national cross-sectional survey*; there is a correlation between that research and the CQC's observation that smaller residential and nursing homes have a higher proportion of good and outstanding ratings: INQ000571608/22/6.12.
[36] INQ000569768/7/19
[37] As the Nuffield Trust has observed. INQ000475008/44, 49
[38] INQ000587395/15/5.12

26. The Inquiry is also invited to consider whether additional funding from 2020 to 2022 reached the frontline of care recipients or was instead designed and used by care providers to cover higher costs incurred as a result of the pandemic.[39] NACAS has noted evidence to suggest that dividends for 122 larger, 'for profit' care homes increased by 11% in the first year of the pandemic.[40]

Workforce capacity

27. It is widely acknowledged – and the Inquiry is invited to recognise – that a core reason the ASC sector was in such a precarious state was inadequate workforce capacity.[41] That is a direct result of structural and systemic issues with low pay, poor working conditions, unmanageable workloads, a lack of status, a false perception of care work as 'unskilled', and a lack of opportunities for training and career progression. Those issues resulted in the pre-pandemic workforce being overburdened, underpaid and undervalued with associated low rates of staff retention. It may be helpful to highlight some examples from the evidence.

28. LAs reported considerable pre-pandemic difficulties in the ASC sector.[42] 31% of respondents in England, and 38% in Wales, said that the pre-pandemic capacity of the ASC sector was 'not very good' or 'not good at all'. 52% and 67% said the same about the ability of the sector to increase capacity. 23% and 43% said the same about the resilience of the sector. 95% and 100% of those expressing concern cited workforce recruitment difficulties, 93% and 91% cited funding pressures and 91% and 100% cited workforce retention difficulties.[43]

29. Local Government Association ('LGA') research found that the problems with workforce capacity (including recruitment and retention) were *"broadly similar"* during the pandemic with the additional challenges of '*staff mental health/anxiety/burnout*' (85%/67%); '*isolation requirements*' (92%/83%) and '*pressure to accept discharged patients*' (89%/92%). These issues were consistently reported across England and Wales: all but one of the workforce issues relating to care workers had been experienced by care homes in at least three-quarters of areas.[44]

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[39] INQ000502030/6/14

[40] INQ000569768/7/20-21

[41] As Dame Jenny Harries observes the limitations of the ASC sector in the pandemic were driven by the availability of staff rather than premises: INQ000587394/19/5.26. That accords with the LGA Research Report for Module 6, in which a small minority of respondents in England who expressed concern about the capacity of ASC during the pandemic identified issues with the number of providers (27%) and places (26%) as compared to the overwhelming majority who expressed concerns about workforce capacity issues: INQ000400522/24.

[42] In the LGA Research Report for Module 6.

[43] INQ000400522/5, 21-22

[44] INQ000400522/22-24, 35

30. Skills for Care published a workforce intelligence report for 2019 that identified that pre-pandemic the vacancy rate in the ASC sector was 7.8% (equating to 122,000 unfilled positions), the staff turnover rate had been steadily rising since 2012 and was 30.8% (equating to 440,000 staff leaving their jobs each year), and the mean hourly pay for a care professional was just £8.30 per hour.[45] Based on its data and analysis, Skills for Care diagnosed the cause of these problems as continuing "*systemic*" issues with poor terms and conditions and a lack of opportunities for learning and development.[46]

31. The vacancy rate fell during the pandemic, but, by August 2021, it was back to pre-pandemic levels and, by March 2022, it had reached the highest rate (10.7%, x3 the national average[47], 165,000 vacancies) since records began with a 52% increase since the previous year. The Nuffield Trust observes that the vacancy rates are now so high that 90,000 additional workers are required to meet the unmet care needs of the over 50s in England alone.[48]

32. The reasons for the high vacancy rate includes poor working conditions and low pay, which have failed to keep pace with other sectors, a lack of opportunity for career progression and burnout.[49] SCIE observes that the pandemic exposed and amplified longstanding weaknesses in ASC including "*insufficient resources*", intensified by a decade of austerity and real-term cuts to central grants, and the related "*ongoing workforce crisis, marked by low wages, high vacancies and high turnover* [which] *has further undermined care quality*".

33. Dame Jenny Harries, drawing on her experience of social care and as DCMO, observes that the workforce:

> "*…had (and has) inherent structural vulnerabilities. At a national level, capacity in the workforce is simply insufficient for the demands placed upon it… There are issues with recruitment and retention, exacerbated by poor terms and conditions.*"[50]

That analysis accords with the views of NACAS members.[51]

34. The systemic issues affecting the ASC sector, the fragility of the workforce and the circumstances in which it operated should have been considered both as

[45] INQ000543049/60-62/298-299
[46] INQ000543049/2/5, 50-51/253-256
[47] As noted by the King's Fund, INQ000543049/51/255
[48] INQ000475008/88-95/91, 106/106, 109/117
[49] INQ000502030/19/64, 20/68-69; 24/81; INQ000543049/65/305; INQ000587394/62/9.12-9.13; see too ONS data/INQ000553814/49-52
[50] INQ000587394/62/9.12-9.13
[51] INQ00056978/5-6/15-18

part of pre-pandemic preparedness[52] and as the pandemic approached the UK. The failure to do so had a profound impact on the pandemic response. It led to what the British Association of Social Workers ('BASW') described as the *"chaos of the initial stage"*.[53] The April 2020 ASC Action Plan recognised that workforce capacity was both a *"short-term"* and *"long-term"* problem and set a modest, target to recruit 20,000 more staff within three months.[54] According to, for example, Public Health England ('PHE') (now the UK Health Security Agency 'UKHSA') and the Chief Social Care Officer for Wales, those concerns about staff shortages contributed to the delayed decision to restrict staff movement.[55] It also placed intolerable pressure on an already overstretched care workforce, leaving many struggling to manage infections and implement IPC measures effectively. Unsurprisingly, the quality of care inevitably declined as a result.[56]

35. In view of that unanimous evidence from the ASC sector, and the pandemic experience, it is of concern that even now HMG does not appear to understand the structure of ASC, and the conditions in which care professionals work. For example, on 11 May 2025, HMG announced that it intends to cease overseas recruitment of care workers, which, unless there is substantial investment in the UK workforce, will leave the sector dangerously understaffed.[57]

Impact of key decisions during the pandemic

36. NACAS has sought to highlight a number of decisions that have been of particular concern to its membership. A consistent theme emerging from the evidence is that HMG's failure to understand, consider, and meaningfully consult the ASC sector – especially in the early stages of the pandemic – resulted in a response marked by inaction, delay, and, in some cases, fatal misjudgements.

Initial guidance to ASC

37. Initial guidance for the ASC sector published by PHE (and in similar terms by the Welsh Government) on 25 February 2020 ('February 2020 ASC Guidance') demonstrates that ASC was not adequately understood, considered or consulted. That flawed guidance advised the ASC sector, including care professionals working in different settings across the sector, that it was *"very*

[52] E.g. Harries/INQ00058739416/16/5.17; June 2018 influenza briefing paper: INQ000105391/13; RWCS slides presented on 11 February: INQ000575555/6, LGA Research found that 73% (England) and 86% (Wales) of LAs thought preparedness for a pandemic was not very good or not good at all: INQ000400522/21; INQ000531673; INQ000224524/24-25/121-122; PHT000000010/11-13

[53] INQ000572015/10/30; INQ000509533

[54] INQ000233794/15/2.12

[55] INQ000119481/15; INQ000389958/13/46, see too COVID-19 Operations Committee minutes 12/6/2020: INQ000088789/5

[56] INQ000499381/64; INQ000569768/8-9/22-23

[57] INQ000475008/91/91

unlikely that anyone receiving care in a care home or the community will become infected"; "*there is no need to do anything differently in any care setting at present*"; there was "*little evidence*" of asymptomatic transmission; facemasks "*do not need to be worn by staff*"; guidance as to "*what to do if an employee becomes unwell and believe they have been exposed to COVID-19*" said that, unless an employee had travelled to affected countries in the last 14 days, "*normal practice should continue*" and, if they had travelled, they should simply maintain a two metre distance. It will only persons returning from Wuhan who should self-isolate; "*all other staff should continue to attend work*".[58] Visits and staff movement between settings were unaddressed. That guidance remained in effect until 13 March 2020, effectively lulling the ASC sector into a false sense of security during a critical window in which meaningful measures to prevent transmission could – and should – have been implemented.

38. The Inquiry is invited to examine the circumstances in which the February 2020 ASC was issued and maintained for such a prolonged period, despite strong emerging evidence to the contrary. For example, on 28 January 2020, the Chief Medical Officer ('CMO') observed in a meeting with the Secretary of State for Health and Social Care ('HSC') that "*there is now credible evidence of asymptomatic transmission…*"[59] On 4 February 2020, a SAGE meeting recorded "*Asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely*".[60] On 11 February 2020, it was recognised, at a meeting about the ASC response led by the Permanent Secretary to DHSC, that there were three routes by which Covid-19 could enter a care home: "*infected people moved into homes; staff; visitors*".[61] On 21 February 2020, the New and Emerging Respiratory Virus Threats Advisory Group ('NERVTAG') concluded that "*the evidence suggests that 40% of virologically confirmed cases are asymptomatic.*"[62] On 24 February 2020, PHE advised DHSC that no hospital discharges should be made into care homes due to the risk of transmission.[63] The next day the flawed guidance was published and, thereafter, the evidence of asymptomatic transmission continued to gather pace.

Hospital discharge policy and guidance

39. It is in that context that the Inquiry will consider the hospital discharge policy and associated guidance, including the March 2020 ASC Guidance which was in force from 13 March 2020 until 6 April 2020[64], and the March 2020 Discharge Policy and March 2020 Discharge Guidance, dated 17 and 19 March 2020

[58] INQ000499433, INQ000336270
[59] INQ000233747/2; PHT000000052/13/49/8-9
[60] INQ000051925/3/19; PHT000000052/13/49/21-23
[61] INQ000151448
[62] PHT000000052/13/50/3-6
[63] INQ000074910; Transcript of Matt Hancock, former Secretary of State for Health and Social/1 December 2023/26-27
[64] INQ000300278: *Guidance: Coronavirus (COVID-19) – Guidance on Residential Care Provision – Public Health England'*

respectively, in force until 15 April 2020.[65] The aim of the hospital discharge policy – to release capacity in the NHS – is understandable, but the Inquiry is invited to consider whether it is emblematic of an over-focus on the NHS at the expense of ASC despite the interdependence between the two sectors. It is also invited to examine whether the implementation of the policy was adequately planned and whether sufficient consideration was given to its practical impact on the ASC sector.

40. The evidence is that care homes overwhelmingly felt pressured to accept discharged patients without knowing their infection status.[66] There was inadequate consideration of the impact on ASC – how the sector would deliver safe care, what resources it would need to manage increased demand, and how care professionals would be affected – and no meaningful consultation undertaken. By way of examples, ADASS were given a "*derisory*" hour to comment on near-final guidance.[67] SCIE's research concludes that ASC had not been prepared for, and did not have the capacity to, implement the 'discharge to assess' policy successfully as a result of a lack of investment and workforce shortages.[68]

41. About 20,000 care home residents died in the first wave of the pandemic. The Inquiry is invited to consider the evidence about the impact of the hospital discharge policy on the number of care home deaths with care. The evidence, including from the Vivaldi study as explained by Professor Shallcross MBE, is clear that the policy was a source of ingress into care homes.[69] Those responsible for that policy – such as the former Secretary of State for HSC – have downplayed that evidence and misstated certain other analysis to imply that care professionals were to blame.[70] However, the evidence base for such claims has been characterised as *"less than ideal"* as a result of the low levels of testing in the care home population and because of a lack of data concerning care home residents and individuals discharged from hospitals at that time.[71] As Dame Harries has acknowledged, there is a danger that evidence referring to care staff "*could be misinterpreted*"[72]*;* indeed, it has been. NACAS members have described the consequences of such misinterpretation in stark terms -

[65] INQ000087317: *'Next Steps on NHS Response to COVID-19'* and INQ000087450: *'COVID-19 Hospital Discharge Service Requirements'*; see also INQ000325255 *'Admission and Care of Patients During COVID-19 Incident in a Care Home'* dated 2 April 2020 ('April 2020 Admissions Guidance')
[66] INQ0004005022/6
[67] INQ000571608/32/9.1, 47/12.5, 51/21.4; INQ000572015/47
[68] INQ000576035/31/124-125
[69] INQ000503454/1; INQ000613177/18-21/39-43
[70] INQ000587394/20/5.28; INQ000234332
[71] *Consensus statement on the association between the discharge of patients from hospitals and COVID in care homes* published 26 May 2022: INQ000215624/19-20. It is notable that Liz Jones, policy director at the National Care Forum and SAGE member, refused to sign up to the consensus statement.
[72] INQ000587394/42/5.80

reporting that they become *"a target of abuse"*, felt *degraded"*, *"depress[ed]"*, *"humiliate[ed]"*, *"angry and upset"*, *"discriminated against"* and *"not valued"*.[73]

42. Irrespective of retrospective data analysis, the critical question remains: why were steps not taken to address the recognised risk of transmission by staff (and others attending care homes) at an early stage? As set out above at §38, the risk of transmission from staff and visits (including asymptomatic transmission) was identified at the latest by 11 February 2020, but the general advice to the ASC sector was to continue 'business as usual'. The March 2020 ASC Guidance maintained PPE was not necessary unless a care professional or recipient was symptomatic, contradicting the March 2020 NHS guidance which recommended PPE be worn by all healthcare workers.[74] This is a glaring example of the inconsistent guidance issued during the pandemic, and the prioritisation of the NHS over ASC. Instead, the hospital discharge policy *encouraged* the sharing of workforces between providers. It made little or no provision for testing, isolation and IPC measures. The March 2020 Discharge Policy and Guidance, and subsequent April Admissions Guidance, unlawfully failed to recommend asymptomatic patients should be isolated, which compounded the problem of discharging untested patients into residential homes.[75] Put simply, care professionals were left in the dark or actively misled – denied both the warning and the means to respond to risks already known to decision-makers.

43. With the benefit of informed foresight, decision-makers should have recognised that care recipients relied on care professionals being able to attend work, that many care professionals operated across multiple settings, and that specific measures were needed to mitigate the associated risks of transmission. Yet DHSC, in the early stages of the pandemic, did not appear to understand how the ASC and care professionals *"practically operated"*. As Dame Harries identifies, a better pre-pandemic understanding of the sector would have provided a "*solid platform from which to build the pandemic response"* and *"a more balanced focus to DHSC's work which included ASC as opposed to just health would have provided a better starting point for both the ASC and hospital response"*.[76]

Testing for care professionals

44. Against the background of the hospital discharge policy, the Inquiry is invited to consider the prioritisation and availability of testing for care professionals. 84% of care providers in England and 73% in Wales found it 'very difficult' or 'fairly difficult' to access testing in the first six months of the pandemic.[77] On

[73] INQ000569768/43-44/167-172
[74] INQ000300278; INQ000088334
[75] INQ000268347: *R (Gardner & Harris) v SSHSC, NHS England and PHE* [2022] EWHC 967 (Admin) at [285]-[298]
[76] INQ000587394/51/5.13
[77] INQ000400522/52

17 March 2020, HMG announced that the NHS (patients and then healthcare staff) would be prioritised for testing.[78] It was not until the April 2020 ASC Action Plan that testing for symptomatic residents and staff in care homes for the over 65s, was introduced.[79] It was not until 28 April 2020 that asymptomatic staff became eligible.[80] Consistent with the general approach to ASC, the Inquiry may find that the sector was given secondary priority.

Visitation policy

45. NACAS recognises the importance of slowing the spread of the virus and preventing its entry into vulnerable environments; however, the impact on residents' mental health and well-being was so severe that the Inquiry may consider that the restrictions on family visits to care settings were disproportionate. Clinical evidence appears to support this view, indicating that the Quality Adjusted Life Years ('QALYs') lost due to isolation were substantially greater than those lost from the risk of infection associated with visiting.[81] This is another area where more effective, informed pre-pandemic preparedness – combined with a robust test and trace system – might have enabled a different policy approach that permitted controlled family visits.[82]

Management of the pandemic in adult residential and nursing homes

46. In this section, NACAS has sought to highlight some of the management issues of most concern to its membership.

IPC measures including isolation, staff movement and financial support

47. As the Director of ADASS has identified, while the hospital discharge policy is the highest profile concern of the ASC pandemic response, "*arguably the critical issue was that social care was understaffed, under-recognised and had insufficient infection prevention and control*".[83]

48. The Inquiry is invited to consider whether the introduction of IPC measures – along with the associated guidance and funding – was timely, clear, and practical. It should also assess whether the approach adequately accounted for the complexity of ASC infrastructure, particularly in nursing and residential care settings, the capacity of smaller providers to interpret and implement the guidance, and the ability of frontline care professionals to apply it effectively in practice. It may be helpful to identify a number of specific points.

[78] INQ000055915
[79] INQ000233794
[80] INQ000499381/28
[81] INQ000587394/46/5.89
[82] INQ000569768/17/55-62
[83] INQ000571608/65/14.7

49. *Financial support*: The incentive – and in many cases, the necessity – for extremely low-paid care professionals to continue to work while unwell should have been recognised from the outset of the pandemic.[84] So too that ASC professionals, particularly those on zero-hour contracts, are not, unlike their NHS counterparts, entitled to sick pay at full pay.[85] As the CMO, Professor Whitty, observed in December 2021, *"we didn't spot the effects of people not having adequate sick pay – it's one of those things that's obvious when you see it".*[86] The Inquiry is invited to consider whether the belated financial support (first introduced on 15 May 2020 with the ASC Infection Control Fund) was prompt and adequate. 49% of LAs in England thought it was too slow.[87] Skills for Care have observed the same, and that it was available in an inconsistent manner.[88] The Inquiry is also invited to consider whether the fragmented nature of the sector led to many workers being unaware of the financial support that was available[89] and whether it in fact reached its intended recipients.

50. *Staff movement*: As the Nuffield Trust observe, the issue of staff movement, and the policy to restrict it, is *"another example where a better understanding of the characteristics of the workforce was needed"*. The issue ought to have been considered from the pandemic outset but does not appear to have been recognised until April 2020[90] and was first acted upon in May 2020. The policy was unworkable for domiciliary carers who, by definition, move between multiple settings each day. Its implementation was delayed by existing workforce capacity issues (see above at §34) and further hindered by the absence a workforce register that identified where staff held multiple jobs.[91]

51. *IPC training*: Dame Harries acknowledges *"recognised systemic weaknesses"* in IPC control within ASC including those arising from reduced training provision following the transition of ASC from Primary Care Trusts to LAs. Greater focus on IPC in ASC could have improved better pandemic preparedness.[92] NACAS members have expressed the view that IPC training was often absent or inadequate.[93] The Inquiry is invited to explore whether 'professionalisation' (addressed further below at §62-63), including common standards for training, is a way to address the issue.

PPE provision

[84] INQ000571608/71/14.22-14.24; INQ000569768/34/129
[85] INQ000475008/122/139
[86] INQ000518396
[87] INQ000400522/79
[88] INQ000543049/33/174
[89] INQ000543049/31/166
[90] INQ000198061
[91] INQ000475008/120-121/135; INQ000553878; INQ569768/22/78-80
[92] INQ000587394/34-35/5.63
[93] INQ000569768/22-23/81-82

52. The Inquiry is invited to consider whether the ASC, and particularly domiciliary care, was promptly considered for, and adequately supplied with, suitable and safe PPE. NACAS members have expressed considerable concern that ASC was "*forgotten about or de-prioritised*" in relation to PPE distribution.[94]

53. At the outset of the pandemic, the unclear accountability for ASC led to confusion within HMG as to who was responsible for the supply of PPE.[95] That, in turn, contributed to, as ADASS has identified, the "*fundamental issue* [which] *was that there was not a mechanism to, in the first instance, ensure sufficient supply, and secondly to ensure effective supply routes to a diverse sector or thousands of providers, PAs and unpaid carers.*" The establishment of a national supply chain is a matter that could and should have been resolved in pre-pandemic preparedness and, if not then, at the pandemic outset. The initial approach of leaving it to the market saw ASC and the NHS competing for the same supplies.[96]

54. The evidence also shows that, as with other issues, the ASC was sacrificed for the NHS resulting in the sector feeling that it was an "*afterthought*".[97] PPE that ASC would have, and had otherwise, sourced for itself was diverted to the NHS. The issue persisted for months. On 26 February 2020, there was "*hard evidence of providers failing to get PPE they had paid for as it was requisitioned for the NHS.*"[98] On 22 April 2020, after a national mechanism in the form of LRF supply drops had been established, the Prime Minister's Private Secretary said there were "*big problems on PPE. The situation is more acute* [for care homes] *than in hospitals, which are – in practice – being prioritised for supply*".[99]

55. 87% of LAs in England and 55% in Wales reported that care providers found it 'difficult' or 'fairly difficult' to access PPE in the first six months with 20% and 24% expressing concern about diversions to the NHS and 12% and 29% expressing concern about quality.[100] The Inquiry is invited to examine why professionals from global majority backgrounds were more likely to be unable to access suitable PPE.[101]

56. Those issues left ASC workers insecure and vulnerable, and forced them to rely on donations, makeshift items and intermittent supplies until summer 2020. The Inquiry is invited to explore whether that exposure – along the issues with

[94] INQ000569768/24-25/88-89
[95] INQ000103762
[96] INQ000571608/63/14
[97] INQ000400522/6
[98] INQ00011488
[99] INQ000198061/3; INQ000088643/7; INQ000528675; INQ000103761
[100] INQ000400522/45-46
[101] INQ000542991, INQ00058665/14/71; ECHR doc: INQ000543006

testing provision – may explain the disproportionate morbidity and mortality rates for care professionals.[102]

Mandatory vaccination

57. The Inquiry is invited to consider whether the policy and legislation introduced in July 2021[103] imposing mandatory vaccination by 11 November 2021 for ASC professionals in England was necessary, achievable and fair. It is significant that the policy was not adopted by the devolved nations. It did not apply to health workers. It was not in accordance with international practice. It was imposed despite concerns being expressed across the sector.[104] It caused many NACAS members to feel discriminated against.[105] In addition, it is of concern that the clinical evidential base for the policy was uncertain, as Dame Harries identified in February 2021.[106]

58. Care providers warned in advance that it would lead to staff losses in a sector already experiencing severe shortages.[107] HMG's risk assessment estimated 40,000 staff might leave their posts.[108] When the statutory requirement was revoked in July 2022, it was estimated that 19,000 professionals had lost their jobs as a result. The Nuffield Trust found that 70,000 staff had left their posts between April and October 2021 with the policy provided as the second most commonly cited reasons.[109] 43% of LAs in England thought the policy negatively impacted retention.[110] It disproportionately affected women and individuals from a global majority background and may have undermined wider support for the vaccination programme.[111] Ultimately, the Inquiry may conclude that the policy was counterproductive and indicative of the unjustified disparities in treatment between ASC and the NHS.

Guidance

59. In general, the guidance for ASC was issued too late and announced with little to no time for preparation before implementation. It was often confusing, lacked specificity, and was frequently inapplicable or not easily adaptable to ASC settings – especially domiciliary care. Furthermore, the guidance was updated so frequently that the ASC sector struggled to keep pace.[112] For

[102] As suggested by ADASS and the National Care Association; INQ000183756/46; INQ000509645; INQ000515683/7/25, 17/57; INQ000571608/8.14
[103] The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021
[104] E.g. INQ000475008/120/133-134
[105] INQ000569768/19-20/63-67
[106] INQ000587394/49/5.99, INQ000153735, INQ000153736, INQ000153737
[107] INQ000571608/31/8.15; INQ000468682/5
[108] INQ000502030/20/70
[109] INQ000091577; INQ000475008/120/134
[110] INQ000400522/88
[111] INQ000587394/49/5.99; INQ00092238/7
[112] INQ000515683/6/24; INQ000119481; INQ000543049/36/188; INQ000119481; INQ000499643

example, guidance on admission and care of residents was updated 11 times from June to December 2020.[113] Similarly, the visitation guidance was difficult to implement, in part because it failed to account for the complexity and variation in the design and layout of residential care settings.[114] In practice, in many cases, this resulted in visits continuing to be prohibited.[115] Once again, Dame Harries identifies the root of the problem as the fundamental lack of understanding of adult social care within the DHSC.[116]

Do Not Attempt Cardiopulmonary Resuscitation ('DNACPRs')

60. The ASC sector consistently reported concerns about the blanket use of DNACPRs during the pandemic. In particular, NACAS members highlighted that there was poor communication to service users and their families prior to the issue of a DNACPR and communication with care professionals about what they needed to do in circumstances where a DNACPR was in place. In October 2020, the DHSC commissioned the CQC to conduct a review of DNACPRs. A final report was released in March 2021 and found that "*poor record keeping and lack of audits meant that* [the CQC] *could not always be assured that people were being involved in conversations about DNACPR decisions, or that these were being made on individual assessments*."[117]

61. Whilst this issue was particularly acute in the initial stages of the pandemic, confusion about the use of DNACPRs persisted.[118] NACAS invites the Inquiry to consider whether and how a uniform system of documenting the DNACPR process may assist in the future.

Recommendations: professionalisation of the ASC workforce

62. NACAS will make submissions about recommendations that the Inquiry may wish to consider after the evidential hearings. At this stage, the Inquiry is invited to examine whether achieving parity of esteem between ASC and the NHS, including through the professionalisation of care work, is part of the solution to workforce capacity issues in ASC. The Nuffield Trust identifies:

> "[the] *growing interest in professionalisation as a solution to the workforce shortages that England faces. The rationale is that developing a strong professional identity for social care workers, facilitated by registration and adherence to common professional standards, would make the sector more attractive to new entrants as well as encouraging workers to stay within the sector by offering more opportunities for career progression in social care.".*

[113] INQ000509825
[114] INQ000515683/9-10/32
[115] INQ000571608/59-61/13.14-13.18
[116] INQ000587394/60/9.9
[117] INQ000518407
[118] For example, see INQ000227368; INQ000501655; INQ000501714

63. One aspect of professionalisation is registration and adherence to minimum standards. England is the only country in the UK for which there is no professional body responsible for the regulation of social care workers which is mandated by and accountable to HMG. The Nuffield Trust's research suggests this has *"hindered the development of a strong professional identity underpinned by shared improved status, standards and qualifications (i.e. professionalisation)"* and the absence of a register makes developing an accurate picture of the workforce more difficult. There are degrees of registration in the devolved nations and there is evidence to suggest it has had *"real benefits in terms of knowledge of workforce makeup, its movements, and for future planning"* (Scotland); helped to identify staff in need of IPC training (Wales); and, in Northern Ireland where there is complete mandatory registration and there has been the first evaluation of the process, has found that it has *"increased confidence among the workforce"* and *"service users and workers have also reported a positive impact on the quality of care"*.[119]

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[119] INQ000475008/41, 88, 91, 94-95, 104, 120; INQ00054309/48/247; INQ000569768/11/33-34