Witness Name: Julie Parkinson

Statement No.: 1

Exhibits: N/A

Dated: 7 May 2025

UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF JULIE ANN PARKINSON

I, Julie Parkinson, of PD, will say as follows: -

INTRODUCTION

1. I understand that the Inquiry wishes to receive evidence about the impact of the pandemic on care professionals like me. As a member of the National Association of Care and Support Workers ("**NACAS**") I was contacted about this opportunity by NACAS' representatives and I expressed an interest in providing evidence, as I wanted to share my experiences. I understand the Inquiry has now formally requested evidence from me, so this witness statement sets out my response to that request.

2. I understand that the Inquiry is interested in the period March 2020 to June 2022 and so this statement focuses on that time period, although I also set out below some general background on my experiences before and since that period.

3. I have been a member of NACAS since December 2023.

OVERVIEW OF MY PERSONAL CIRCUMSTANCES AND BACKGROUND

4. I have worked in the care sector for 20 years, in both care home and domiciliary care contexts. Before that I worked as a non-executive director in an NHS hospital trust based in Tyneside for 10 years, and before my role in the NHS I worked for a health-related charity.

5. I decided to work in the care sector after my elderly mother-in-law's difficult experience with the NHS following a stroke. My husband and I felt that elderly people deserved better care. I have always had a connection with the care sector, as my mother worked in a facility which supported disabled people, so I feel as though I have come full circle.

6. I first started working in the care sector with my husband. He retired from the police force, and we used his pension lump sum to invest in land in the Tyneside area. He built two care homes, of which I was a co-director.

7. In 2007 we sold both care homes and set up a domiciliary care agency. When we started the agency, I completed a Level 4 qualification in Leadership and Management in the care sector and following an interview with the Commission for Social Care Inspection (now known as the Care Quality Commission ("**CQC**")), I was appointed Registered Manager. At this point, I was not working as a carer but was in a leadership and management role. Despite my role in management, I completed all the same training courses as care staff. These included courses in communication, confidentiality, catheter care, peg feeding, moving and handling of patients, infection control, first aid and courses relating to specific conditions, such as dementia, diabetes, stroke, epilepsy etc. This training enabled me to provide care to my clients and to support my team practically, particularly in circumstances where we were short staffed. I was well accustomed to providing domiciliary care long before the outbreak of the pandemic.

8. Since then, I have almost completed a Level 7 Diploma in Senior Leadership (Strategic Business Management) which I am due to finish in July 2025, and I am currently finishing my BSc (Hons) Health and Social Care, which I am due to finish in May 2025.

BACKGROUND ON MY ROLE AND AGENCY

9. At the beginning of the pandemic (March 2020) I was working as the manager of my domiciliary care agency, and I remain in that role today. My agency currently has 15 employees, all of whom are on zero-hour contracts but who in practice have guaranteed hours of their choosing. Some work 2 or 3 days a week, others work 4 or 5 days a week. There are three main "routes" on which my employees work: urban, rural and the night shift. Employees on the urban route visit clients in built-up, urban areas, whereas employees on the rural route visit clients in villages and the surrounding countryside. The night shift involves a small team of key workers who provide care for individuals in

supported living. Employees on all three routes visit clients either by walking, cycling or driving if they are travelling over large areas.

10. My agency currently provides care for 19 clients. During the pandemic, my agency had 23 clients. My clients are all classed as vulnerable adults, and therefore have a range of different complex needs, and are aged between 18 and 101 years old. My clients include elderly, frail people; people with substance abuse issues; people living with sensory losses (i.e. deaf or blind); and people living with dementia and other conditions. We deliver quality end-of-life care to the Gold Standard Framework. On a typical day each of my employees will visit between 5 or 6 clients, often visiting our clients repeatedly throughout the day depending on their needs. For example, my employees might visit clients who require support with their personal care, meals and medication four times a day. Other clients, depending on their needs, may only need a daily welfare check.

11. Some of my employees provide care on a one-on-one basis; others provide care in pairs, as some clients' needs are such that they require two carers to be working with them at the same time. Although all of my employees are capable of helping any of the clients, if needed, I try to ensure that clients see the same care professionals every day (unless they are on leave and cover needs to be provided).

12. All clients have personal care plans tailored to their needs. Typical day-to-day tasks include the following:

    (a) assisting clients to get in and out of bed and transferring them from bed to chair.

    (b) assisting clients with their personal care: toileting; washing; bathing; showering; hair washing; and shaving.

    (c) assisting with mealtimes: preparing and serving food; support with eating; washing dishes; and keeping the kitchen clean and tidy.

    (d) assisting clients with their bedtime routine.

    (e) ordering, collecting and administering medication, and other healthcare tasks (e.g. applying creams and pressure stockings, assisting clients living with tracheotomies, assisting with peg feeding, stoma and catheter care).

    (f) promoting client safety and welfare.

    (g) engaging with families, neighbours and the wider community.

(h) other household tasks including changing bedlinen and sorting laundry, vacuuming, assisting with pets, and shopping.

(i) working collaboratively with social services, GPs, nursing teams, pharmacies and hospital discharge lounges.

13. For some clients, the local authority provides equipment (such as mobile or fixed hoists, slings, hospital beds, profiling mattresses, slide sheets, wet rooms, bath lifts and commodes, powered or manual wheelchairs, and walking aids) and all employees are trained to use this equipment to support clients.

14. Those who work in care are not there for the money, in my experience – they do it for the tremendous sense of satisfaction that they feel each day having cared for vulnerable people. Some of our clients could not survive on their own and could not manage without us. I find the role exceptionally meaningful, despite the long and tiring days, as I feel we have really helped our clients and made a difference to their lives. For some of my employees, the flexibility of the role really suits them, as due to childcare obligations or sharing a vehicle with their partner, a 9am to 5pm working pattern may not be suitable for them. Many of my employees come to the agency with no qualifications, but we train them in all relevant skills. They are supervised at work through "double carer calls" (where a second carer attends the shift alongside them for supervision purposes) until they are competent and confident to provide care on a one-on-one basis. We offer and encourage staff to gain qualifications and continue with continuous professional development. My employees also receive annual mandatory refresher courses.

15. The clients we support are lavished with affection, and the feeling is mutual.

MY EXPERIENCES MANAGING A DOMICILIARY CARE AGENCY DURING COVID-19

16. My staff and I worked tirelessly to care for our clients and ensure their safety throughout the pandemic. I think that this helped to ensure that my agency did not lose a single member of staff or client to Covid-19, and none of my clients caught Covid-19 during the first wave, except for one who became infected following a stay in hospital.

Staff shortages and changes to workload

17. My domiciliary care agency faced staff shortages during, and because of, the pandemic. At the very beginning of the pandemic, I had to let two members of staff go as they believed it was not safe for them to continue working and they feared risking

infecting their family members with the virus. Their confidence was completely undermined by paramedic staff, who were called to assist a client, and who told my employees to go home and that they should not be working. This was extremely distressing for me as a provider of care, because these two members of staff then passed this advice on to the rest of the team and told them all to go home. In this circumstance I had to accept their resignations rather than have the whole team destabilised. I offered the entire team the opportunity to leave if they wanted to, and thankfully no one else did. In fact, my other employees were adamant that they would continue working to ensure that their clients received the care they needed. During the pandemic, there were also increased staff absences due to employees being on sick leave or self-isolating.

18. As I am the manager I am not usually on the staff rota, however in an emergency I cover shifts, and I was required to do so during the pandemic due to staff shortages. Similarly, all my employees were prepared to and did work extra shifts to ensure that all our clients received the care that they needed, especially those who were shielding and so would only have contact with carers.

19. Where we could, we agreed with clients that some shifts/calls (for example, at lunch or tea) would be reduced to a phone call check instead as we could prepare food and leave it for them, to keep contact to a minimum. This was only for the first few weeks of the pandemic until we regained our confidence.

20. The workload for me and my employees increased significantly during the pandemic for other reasons too. Whilst the fundamental care that we provided during our visits remained the same as before the pandemic, we were required to complete additional tasks before and after providing care, which added to the workload.

21. For example, the need to follow burdensome new guidelines concerning the donning and doffing of personal protective equipment ("**PPE**") at the beginning and end of each visit created time pressure during our visits to our clients. I found this concerning, as when clients were more isolated during lockdowns, our time with them was even more precious for them. We also found the requirement to test before every shift to be a significant administrative burden.

22. My employees were also required to carry out more healthcare tasks than usually would be required of care workers. For example, to help the community nurses, we assisted with wound dressings, such as in circumstances where a dressing had come off in the

process of washing or toileting. Before the pandemic, this was strictly a nursing task. We would not attempt any intervention for a wound that required packing or was showing signs of infection, as these were entirely nursing tasks. There was no official training provided to us for this, instead ad hoc arrangements were put in place to provide the best care for our clients, such as the nurses leaving us additional supplies to enable us to do this during the pandemic. I understand that the nurses only did this because they were confident that we could properly perform these healthcare tasks. These arrangements are still in place and allow community nurses to allocate their time to the patients most in need.

Government Guidance

23. We received a blizzard of guidance documentation from the government via the local authority during the pandemic. At times, I was overwhelmed and bewildered with the amount of guidance that we received.

24. I felt that the guidance was tailored towards care homes rather than domiciliary care, and therefore was often not appropriate or even relevant for our line of work. It seemed as if any reference to domiciliary care was only tacked onto guidance that clearly had been designed for care homes, and not with us in mind. Consequently, I had to decide which of the guidelines I should interpret as being applicable for my service, and my team looked to me for support with this, but I sometimes felt I was operating without proper guidance.

25. I felt that the guidance received by domiciliary care professionals regarding infection prevention and control ("**IPC**") measures and PPE was excessive, redundant and at times complex to follow in practice. As domiciliary care workers, we were already well accustomed to wearing PPE (such as aprons and gloves) and adhering to IPC measures (such as hand hygiene and using sanitising gel). My agency had always used aprons and gloves, and we knew what steps to take to help control infections, so the only changes to our way of working were the requirement to wear masks and/or visors, and social distancing restrictions. I felt that these existing practices were not acknowledged by the government guidance provided to domiciliary care professionals.

26. Another issue was that some of the guidance was not practical and did not make sense. For example, we were told that domiciliary care workers who were working in pairs were required to remain two metres apart, including when travelling in cars to each client, however such social distancing would be impossible to maintain when assisting

the client. The initial instructions for face masks were confusing, as (according to the instructions) they were not allowed to be touched once in place and they were to be worn for many hours before being changed, yet they could be removed for a coffee break or to eat. Masks became hot and damp on the face over this time period and staff had rashes on their skin. These instructions could have been cost related or associated with PPE shortages and were later amended so that face masks were to be changed in between clients, which I felt was common sense. I feel that this initial instruction came from an initial lack of understanding from the government regarding our work. This, in concert with the historical lack of recognition for domiciliary care workers, made me feel as though we were all alone.

Sick pay and other financial support

27. As a company, we outsource payroll; however, I am aware that statutory sick pay was available for staff. My understanding is that they might not have received this for the first three days of an illness, and they would have needed a sick note from a GP. There is no funding in the system for enhanced sick pay schemes as far as I'm aware.

28. An infection control fund was made available to the adult social care sector in May 2020. My understanding is that the fund was accessed through the local authority and was directed towards care homes and their workers. For example, I understand that it was intended to assist care homes to financially compensate staff who were prevented from working in different locations due to restrictions, which did not apply to domiciliary care. My agency did not attempt to access the fund, as we were receiving free PPE by that time through the government's portal (see paragraph 43 below).

Vaccination as a condition of employment

29. In the first instance, several staff did not want to be vaccinated, but ultimately, they were persuaded that this was in everyone's best interests. Northumberland County Council organised vaccinations for care professionals early on, in about March or April 2021. I felt that they did this well overall. However, Northumberland is a very large county and organising transport and finding allocated time slots for staff at the designated vaccination centres was challenging. This was further complicated by the queues and a post injection wait for twenty minutes afterwards to ensure that there were no side effects. One senior carer suffered severe side effects, and we made a yellow card report.

30. I agreed with and supported the policy of vaccination. That being said, the management of this placed an additional administrative burden upon me, as I was required to keep necessary records. By the original deadline for all care professionals to receive the required two doses of the vaccination, all of my staff had received theirs.

31. I always recommended that my employees received the vaccine (and I still encourage my staff to have covid and flu jabs), and initially I considered making mandatory vaccination my formal company policy. Most of my employees had already decided to have the vaccine at that point in time, however, and none of them expressed to me any concerns about having the first two doses or feeling coerced into having it. This was probably helped by the fact there was largely positive publicity when it was initially offered to care workers. When it came to the six-month booster, however, there was much more negative publicity, and some staff objected to having it.

32. Ultimately, I did not incorporate mandatory vaccination into my agency's policy because this felt unnecessary, especially after the government insisted on vaccination as a condition of employment for health and social care workers. At this point in time, some of my staff took the booster vaccine despite not wanting to, and later they felt abused when the government reneged on the policy after NHS staff objected to it. By then, it was too late for them, as they had already had the booster vaccine under duress. This was another example of care staff being treated differently to NHS staff. If I had then tried to enforce a policy of mandatory vaccination, I believe that several of my employees would have quit and I would have been short staffed.

MY EXPERIENCE OF INFECTION PREVENTION AND CONTROL ("IPC") MEASURES

Testing

33. Initially, I found testing to be a significant burden. I struggled to obtain testing kits to distribute to my employees. These were available from pharmacies, but I faced difficulties in accessing them, even though I was in uniform and had ID, as the pharmacies were protective over their limited stock and wanted to ensure that these were only going to key workers. I suspect that customers were stockpiling tests and pharmacies were rationing the tests in an attempt to ensure that the right people were getting them. Acquiring (often from several different pharmacies) enough test kits to circulate amongst my employees became an additional task I was required to undertake. This was alleviated once we started to receive test kits via the portal (see

paragraph 34 below). We were also instructed that completed tests had to be posted in special post boxes which we had to locate.

34. When it became mandatory for care workers to test before each shift, we received testing kits from the government and a portal for distribution was opened in May 2020. This made life a lot easier. I did not face difficulties in accessing these kits and found that the supplies were always sufficient.

35. As regards the testing guidelines, I faced difficulties in ensuring that some of my employees were testing for Covid-19 and found it difficult to motivate them and to persuade them that it was a worthwhile thing to do, particularly with the amount of PPE that they were wearing on each client visit.

36. The strict record keeping requirements of the CQC regarding testing represented an additional administrative burden and cause of stress. Each member of staff was required to test before each shift and then log their results into the NHS app, which they first had to download and register for. Once the result was logged, they had to send the confirmation via email to an account which I had to set up to receive their testing results, to assist me with logging these into a central spreadsheet. Although many of my employees were very willing to test before every shift, several of my employees did not want to test and register their results on the NHS app at the beginning of every shift, as they found this to be an additional burden in their already busy and stressful days. Some employees would simply share with me a photograph of their negative test result, rather than logging this. I recognised from the perspective of the CQC that this would not be adequate and ensuring their compliance created further pressure for me.

37. Some of my employees did not remember to send their results to the correct email address and I spent a lot of time chasing my employees for their results, often while I was on duty and providing care. As domiciliary care days are 7am to 10pm, there was limited time for me to perform these additional administrative tasks. I had no office staff at this time, as our office was closed, and I was working from home. I recall receiving a stern notification from CQC reminding managers that records would be part of upcoming inspections.

Access to PPE

38. Throughout the pandemic, my employees and I were very careful, and we tried to protect ourselves, each other and our clients as much as possible. I did my utmost to ensure that my employees and my clients were safe and supported. I provided my

employees with extra tunics so that they could wash their uniforms more frequently, at my own expense. I also purchased hazmat suits for my employees after learning that one of my clients had been discharged from hospital with Covid-19. The hazmat suits were not required by the government but gave my staff a sense of security. These were very unpleasant to wear while working indoors and were worn with goggles or visors and gloves. The first visors we purchased had been rushed to market and were simply rigid plastic across the forehead. These were very painful to wear and as a result some of my staff declined these. Later, visors had cushioned headbands which were more comfortable. I acquired the visors at my own expense to ensure that my employees felt protected and supported, and to help prevent the spread of Covid-19 to any of my employees or clients.

39. During the first two months of the pandemic, I found that it was hard to access our usual supplies of PPE. Fortunately, we had our own stock of PPE as far as aprons, gloves and hand sanitising gel were concerned, as we were well accustomed to using PPE prior to the outbreak of Covid-19. We had no masks at that time, as this was not part of our typical day-to-day service. Had I not had this stock of PPE, I think that my agency would have run out, and I am not sure what we would have done in terms of sourcing PPE at this time as the government had sequestered all supplies. I am aware that care homes had no stock of PPE, which was concerning, as I felt this suggested they were not already working to IPC guidelines, and I expect some care homes would therefore have had carers working without PPE.

40. I am aware that some PPE companies took advantage of this situation and increased their prices. The only item that my agency ever ran out of was hand sanitising gel. I found small bottles (which usually cost 33p) on sale for £11 in a local pharmacy; these would not have lasted one of my employees a week, and we went without. I suspect that my low stock of hand sanitising gel was partly due to my employees taking this home for personal use, to which I had no objection. I wanted my employees and clients to remain safe.

41. I was told by my usual supplier that the government was prioritising the NHS and care homes. I felt as though the government – if they considered us at all – assumed either that we did not require PPE or that we already had stockpiles of supplies, which fortunately I did. Clearly, this was not the case for all domiciliary care providers. I found this disappointing and annoying as we were treated as less important than hospitals and care homes, and our standards of professionalism were not recognised.

42. I later found out that the Department of Health and Social Care ("**DHSC**") provided NHS trusts with 80% of their estimated need between March and July 2020, but only provided the adult social care sector with 10% of its estimated need. When challenged by journalists, the DHSC said that its formal reporting arrangements did not identify any health or social care provider as having run out of PPE, and that its approach to social care was to provide an "emergency top-up" to their usual supplies, obtained from wholesalers. I do not understand how the government could not be aware that our usual wholesalers were already providing all their stock to the government and not to domiciliary care providers.

43. Eventually, the government created the PPE portal which we were able to access in May 2020 and from which we could order PPE for free, which made PPE much easier to obtain and made me feel better supported by the government in terms of PPE provision. The PPE that I ordered and received from the government portal included: gloves; aprons; and hand sanitising gel. Later, we also received items such as masks, visors, and clinical waste bags. I always received the PPE that I had ordered via the portal, and it was always delivered promptly and in date. Overall, despite the initial delays, I agree with the government's decision to pool all the PPE and to provide this to care professionals for free.

Use of PPE and related guidelines

44. My employees and I found the face masks difficult to wear, particularly during the very hot summers, but we made sure to wear them despite our discomfort to protect our clients. I found that the guidelines regarding masks were quite difficult to follow, as there were different masks for different conditions, and it was not workable to have readily available a range of masks to choose from according to the different clients we were supporting. We also were not permitted to touch the masks once we had put them on. I felt that these rules were geared towards the use of masks in care homes, rather than use in domiciliary care. As described above in paragraph 24, I feel that this is a further example of the guidance not being suitable for domiciliary care workers, and demonstrative of both the lack of understanding within government as to how we operate and the extent to which domiciliary care workers were overlooked when such guidance was produced.

45. At all times, I maintained policies that were in accordance with the government guidance with regards to IPC measures and controls, and PPE. While I sought to ensure that my employees always complied with these policies, it would be impossible

for me to police this, and therefore I cannot guarantee that all my employees always complied strictly with requirements, such as mask wearing, although I believe they tried.

46. Several of our clients are hard of hearing, and therefore they struggled to understand us while we were wearing masks. Our clients with dementia also struggled to understand what was going on with the introduction of PPE which obscured our features and identities. We eventually received visors from the government, however my employees and I found these hard to work with because they were unfamiliar, uncomfortable to wear and steamed up with breathing. Masks became damp and uncomfortable over time and straps chafed the back of our ears.

Restrictions on staff movement

47. No restrictions were imposed by the government on my employees' movements during the pandemic, as we were domiciliary care professionals, and therefore key workers. In terms of staff movement therefore, we continued to provide care as we always had done. Those who worked in small groups continued to work in the same small groups, and there was already very little cross over between these groups. When support was required in meeting the care requirements of our clients, I substituted myself in. The government placed restrictions on movement between care homes, I think this was because there was potential for spreading the virus between locations by movement of staff, however, this could not and did not apply to domiciliary care professionals.

Impact of visiting restrictions

48. The impact of the visiting restrictions was devastating for many of my clients. One client who was shielding told me she felt like a prisoner in her own home.

49. I felt that my employees and I shouldered the emotional burden of the visiting restrictions. We are emotionally connected to our clients, and we were determined to support them. We really felt for them when they could not see their family members. For our clients who were shielding, we were the sole physical point of contact. I feel that we all did what we could to make each visit with our clients as meaningful as possible, and often stayed longer than we needed to with each client. My employees would also try to support our clients by assisting with extra tasks, such as doing their laundry or delivering groceries, which they or their family members could no longer do for them. This demonstrates the kind nature of my employees, who were determined to continue to provide the best care for their clients. There were financial consequences to these practices, however I was happy to support them. I paid my staff for this

overtime out of my own pocket, as my agency only receives funding from the local authority for contracted periods of contact time with each client.

50. I struggled to understand the logic regarding the visiting restrictions at times, as visitors would not catch Covid-19 from a housebound person, and if visitors used the correct PPE and IPC measures, there would have been no spread of the virus. As an IPC measure, my agency put PPE inside the front doors of each of our clients' houses, so we could put on fresh PPE inside each of our clients' homes. I felt that visitors of our clients could have used this to enable them to visit loved ones. If visiting had been permitted, I would not have restricted the use of this PPE to my employees only, as I understood that family visits would have made a significant difference to several of my clients, who I believe felt incredibly lost and lonely without contact with family and friends. We still make masks available to visitors of clients with COPD (chronic obstructive pulmonary disease) as they are vulnerable to chest infections, and we continue to wear masks for a variety of reasons, especially if we are aware of winter viral outbreaks.

51. My employees and I were not required to enforce the visiting restrictions, and in any event we did not have to. I think that the news reports encouraging people to stay at home, and fears about passing the virus onto a loved one, were enough to keep everyone at home.

IMPACT OF THE COVID-19 PANDEMIC ON MENTAL HEALTH AND WELLBEING

52. The pandemic caused a lot of fear among my employees, particularly at the beginning. I clearly communicated to my employees that we were key workers, and that the advice was that we should continue to provide care in the community. Most of my employees agreed with this approach and were determined to continue to care for their clients.

53. In terms of the impact of the pandemic on me personally, I felt permanently angry for months. I felt an immense pressure to hold everything together for the good of my agency, employees and clients, while shouldering the fears of my team and my own fears, and my responsibilities as a provider of care for those who need our services. It took a lot of effort, and I felt stressed and on heightened alert throughout. Throughout the pandemic I felt that domiciliary care workers were not properly supported by the government.

54. I also had to manage my employees' anxieties, which at times was very difficult. While I understood the genuine fears of the two employees to which I refer at paragraph 17

above, I had to make the difficult decision to let them go and cope with the consequences of being short staffed.

LONG-TERM IMPACT OF THE COVID-19 PANDEMIC

55. I think most of my employees felt exhausted from the pandemic and are glad that it is over, but I am not aware of them suffering any serious long-term impacts. I do not think that my agency or I are suffering from any long-term impacts from the pandemic either.

Access to medical care

56. The main long-term impact of the pandemic that I have noticed more generally is the relationship between domiciliary carers and doctors and nurses, which changed for the worse during the pandemic. It is only just recovering and becoming a working relationship again.

57. One of the reasons for this was that we experienced several issues in accessing medical care for our clients during the pandemic, particularly in relation to the testing of samples. Before the pandemic, my employees could get a urine or stool sample from a client checked by a GP quite quickly, for example. However, during the pandemic this was no longer possible. One GP receptionist informed me that any paperwork we provided would not be touched for five days, for fear that the virus was on the paperwork. I thought this was ridiculous, as a patient could die in the time it took them to review the paperwork and test a sample. My employees and I ensured that we firmly advocated for each of our clients when we thought they required medical assistance.

58. We also had difficulty getting in contact and communicating with NHS staff. We were encouraged to use NHS Digital by our local authority, and my agency was provided with an NHS email address to assist with these communication issues with the doctors and nurses. In practice, this did not resolve matters. I was told by a Community Matron that they did not even use the NHS email address, as they had their own internal communication systems. If we sent an email to the address provided, we would receive an automated response saying that we would receive a response in 5-10 working days. We needed responses faster than that to ensure that our patients were getting the medical care and attention they required.

59. I felt we received a very poor response from GP services, which were responding to a crisis of their own but failed to consider those of us working in the community. I feel

that this made life extremely and unnecessarily difficult for us. Call waiting times to make an appointment for our clients were regularly 45 minutes, and even after waiting there was no guarantee of an appointment. If a care call is 30 minutes long and you need to get to your next client in five minutes, a 45-minute wait time is not workable, as you cannot be on the phone or discussing a client's health needs when you are delivering personal care to someone else. I tried to support my staff by making calls for them where possible, but it is best that the person who is with the client makes the call (as they can describe the client's symptoms) rather than someone else calling from another location who has not even seen the patient. Some GP practices set up direct phone lines for care professionals, but when I tried to use one of these phone lines, I was told categorically that this was for care home staff only and that domiciliary carers were not allowed to use them. I felt this was unnecessary, unfair and clearly contrary to the expectation that carers and healthcare providers should work collaboratively. I was also informed by a GP receptionist that GPs would hold back appointments for care homes. I constantly had to have robust negotiations with GP receptionists to obtain the services needed for our clients, who often were GP surgeries' most vulnerable patients. This situation continued long after the pandemic was over.

60. GP receptionists often told us to ring 111, but this is not a practical option for domiciliary care, as the person making the call must remain with the patient to answer questions and often the call back times were much longer than the time slot for our care appointments. Some of our clients had no family members who could make these calls and enable us to get to our next care appointment, so we sometimes had to make the decision to call 999. We knew that ambulance services were under pressure and therefore we did not like doing this. We felt we had to choose between contributing to that burden or getting medical help and advice for our clients.

OTHER COMMENTS

CQC

61. I did not feel blamed or criticised for the spread of Covid-19, however I did feel bullied by the CQC. They are the sector regulator and carry out inspections and enforcement. Our agency must pay an annual fee to the CQC, but I have never felt supported as a result of that membership, just judged. Domiciliary care was swept up in the care sector more generally, and I felt forced to change our practices and adhere to arbitrary guidelines, often with little practical application to our work, and with little support.

62. Throughout the pandemic I received one phone call from my CQC inspector. This was intended to be a “support call”, however I considered it to be neither helpful nor supportive. I do not feel that they offered me any tangible support or acknowledged things we were doing well. All I recall receiving were several generic "thank you" letters from various other sources. I am sure I am not the only manager or carer within the care sector that feels taken for granted. Clearly our continued efforts throughout the pandemic were appreciated, but I think carers felt that the pandemic had highlighted our circumstances and that some action would be taken following it to address the sector's underfunding. Instead, all we got the after lockdowns were lifted was a notification from CQC that inspections would resume as robustly as before, which felt more threatening than supportive, particularly when what we needed was to rest and recover. At times throughout my career in care I have felt judged, threatened, bullied, and as though the future of my business was at the mercy of the CQC. This has always been a source of pressure and stress for me.

63. My view of the CQC more generally is that they are very inconsistent with regards to inspections and regulations, which impose a significant burden upon the care sector. Each inspection is different, which makes it difficult to prepare for them. We must be continually prepared for unannounced inspections with no idea what the CQC will be wanting to see.

64. By contrast, I feel that my local authority was and continues to be supportive, because I understand that they want the best care for their vulnerable residents and will support me in providing that care. They provide regular opportunities for meetings with contracts managers and officials, and they share information, feedback and best practice. Similarly, I felt supported by the government, through their provision of PPE, and did not feel blamed by them.

Recognition for the Care Sector

65. During the pandemic, everyone clapped on a Thursday at 8pm for key workers. I found it insulting. Care workers were referred to in government speeches and the like, but what they really needed was, and still is, increased pay and parity of esteem. The NHS has respect, while carers endure stigma. We are expected to work long hours, keep our training up to date, make health decisions on behalf of the people we are supporting, have complete responsibility for medication and endure continual supervision and monitoring, on minimum wage. Unlike the NHS we are unable to strike to draw attention to our plight.

66. During the pandemic, the DHSC set up a website for carers. It had a logo just like the blue NHS logo, but green saying '*CARE*'. There was also an enamel lapel badge that could be purchased. However, the website was taken down at the end of the pandemic and the badges are no longer available. Rather than the government taking positive action, yet another inquiry has started to investigate how to fix social care (the Health and Social Care Committee's inquiry into cost of inaction on adult social care reform) which I expect won't report for at least another year. Meanwhile extra funding has been handed to the NHS, with what feels like literally nothing by comparison for adult social care. The social care sector is just expected to carry on, and we will, without fail.

67. Unlike NHS workers, who receive a salary and benefits, and are motivated by career progression opportunities and have political respect and support, social care workers often work on zero-hour contracts for minimum wage, with limited to no career progression, or political or public acknowledgment. My agency pays our employees slightly above the Living Wage, but not all providers do so. Staff build tremendous relationships with the families of people being supported, but outside of this circle I feel that they are invisible. This can result in limited incentive for them to continue to work in the field and may provide some explanation for the low retention rates within the sector.

68. My personal experience as a manager of a domiciliary care agency is that the lack of recognition for care professionals and low wages make it difficult for me to enforce mandatory government guidelines or rules, as I worry that if my employees feel as though they are being forced to do something they do not want to do, they will simply leave their job.

69. My view is that the adult social care sector needs better representation and recognition. I feel that care professionals deserve better wages, but recognition of their hard work and skilled labour needs to go beyond this. I think there is a definite need for a collective body to represent care professionals, much like the NHS represents healthcare workers. I decided to pay for all my employees to become members of NACAS due to the benefits that NACAS provides (such as the ability to get a doctor's appointment, mental health support, legal advice and discounts for goods and services), but also due to the need for care professionals to feel as though they are represented by a collective body. I know that NACAS are an organisation that campaigns for change, but as with the Home Care Association, I feel as though no one is listening to them.

70. I also ensure that I repeatedly provide encouragement to my employees and remind them that they are skilled professionals who have undertaken lots of training and deliver high quality care, and that they are valued highly by me and by the people we support.

71. It is my view that the DHSC understands the healthcare sector but know very little about social care, and I attribute the confusing and impractical guidance that we received during the pandemic to this. Despite their lack of knowledge and understanding, they do not seem to listen to recommendations coming from within the sector, or indeed from previous inquiries.

72. Notwithstanding all the challenges we face and the lack of recognition, I believe that social care professionals worked with courage and tenacity throughout the pandemic and continue to do so.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **Personal Data**

Dated: 07-05-25