Witness Name: Dr. Jane Townson OBE

Statement No. M6/HCA/01

Exhibits: 164

Dated: 23 May 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR. JANE TOWNSON OBE

I, JANE TOWNSON, Chief Executive of the Homecare Association, Mercury House, 117 Waterloo Road, London, SE1 8UL, will say as follows: -

Executive summary

1. The COVID-19 pandemic represented an unprecedented challenge for the UK homecare sector, testing its resilience and exposing long-standing systemic issues.

2. This statement draws on extensive data and experience collected by the Homecare Association throughout the pandemic, including member surveys, government consultation responses, and direct engagement with policymakers. Our evidence reveals four key themes:

    - First, the pandemic exposed critical gaps in understanding of homecare at senior government levels. Nearly one million people in the UK receive professional homecare - significantly more than in residential care. Despite this, homecare was frequently overlooked in the pandemic planning and response. Policy

decisions often failed to account for the unique challenges of delivering care in people's homes.

- Second, pre-existing structural issues severely hampered the sector's ability to respond effectively. Chronic underfunding, workforce shortages, and poor integration with health services created vulnerabilities that were exposed and exacerbated by the crisis. These challenges were particularly acute given homecare's vital role in supporting hospital discharge and preventing admissions.
- Third, inadequate communication channels and data infrastructure complicated effective response coordination. Unlike the NHS, homecare lacked coherent mechanisms for rapidly disseminating information to all providers. Local authorities typically only maintained contact with providers they contracted with directly, creating significant gaps in support distribution.
- Fourth, the pandemic revealed and intensified deep inequalities affecting both the workforce and people receiving care. Care workers, predominantly women and with high representation from ethnic minority communities, faced impossible choices between self-isolation and income maintenance. Those receiving care experienced widely varying access to support based on funding routes and geographical location.

3. Despite these challenges, our evidence also demonstrates remarkable resilience and innovation:

- Care workers showed extraordinary dedication, continuing to deliver essential support despite significant personal risk.
- Providers rapidly adapted service models and adopted new technologies.
- The sector developed stronger collaborative networks and more unified advocacy.
- Important lessons were learned about emergency response capabilities.

4. Looking ahead, this experience demonstrates the urgent need for fundamental reform rather than incremental change. Our recommendations focus on:

    - Establishing stronger sector leadership, governance and representation in emergency planning;
    - Reforming funding and commissioning mechanisms;
    - Developing comprehensive workforce strategies;
    - Improving data and digital infrastructure;
    - Strengthening integration between health and social care.

5. The pandemic has created a crucial opportunity to address long-standing issues in social care. This statement aims to ensure the lessons from this extraordinary period inform lasting positive change.

Introduction and background

Purpose of statement

6. I make this statement in response to a request from the UK COVID-19 Inquiry dated 10 June 2024 under Rule 9 of the Inquiry Rules 2006, asking for evidence regarding Module 6 of the Inquiry (ref: M6/HCA/01), which examines the impact of the COVID-19 pandemic on adult social care.

7. I was appointed as Chief Executive of the UK Homecare Association in May 2019, nine months before the COVID-19 pandemic started. As Chief Executive during this period, I led the organisation through one of the most challenging periods the social care sector has ever faced. Our members provide essential care services to hundreds of thousands of people across the UK, enabling them to live independently in their own homes. These services proved crucial during the pandemic, helping to keep older and disabled people safe while reducing pressure on the NHS.

8. The pandemic both exposed and exacerbated long-standing issues in social care. My aim in providing this evidence is to ensure the Inquiry understands the experience of those receiving and providing homecare services during this time. I want to give voice to the dedication of care workers who continued to deliver essential care in people's homes despite significant personal risk, particularly in the early stages when PPE was scarce and testing unavailable. Pre-existing challenges, such as underfunding, workforce shortages, and limited understanding of homecare's vital role, also tested the sector's resilience.

9. Throughout the pandemic, I witnessed both the very best of human dedication in our sector and the devastating impact of systemic failures to understand and support homecare services. I base the experiences I share in this statement not only on my personal recollections, but also on the Homecare Association's extensive work supporting providers during this time.

10. I hope this evidence will help ensure we learn lessons from the pandemic response, so homecare services are better understood, valued, and supported in the future. The sector's ability to withstand future crises depends on addressing many of the issues I outline in my statement.

Methodology and evidence base

11. This statement covers the period from 1 March 2020 to 28 June 2022, during which the Homecare Association gathered extensive evidence through multiple channels.

12. Our systematic data collection included:

- Regular member surveys examining key issues such as PPE access, workforce capacity, and financial stability;
- Continuous monitoring of provider experiences through our advice line;
- Weekly data gathering through provider forums and working groups;
- Direct testimonials from frontline providers.

13. Throughout the period, we maintained direct engagement through:

- Participation in at least 12 government working groups and decision-making forums (from paragraph 694);
- Regular meetings with civil servants and ministers;
- Ongoing consultation with local authorities and NHS bodies;
- Active involvement in sector-wide response coordination.

14. We developed a substantial body of documentary evidence including:

- Production of 20 consultation responses to government departments;
- Development of detailed analytical reports on sector impacts;
- Creation of regular guidance updates for providers.

15. Our evidence gathering focused particularly on:

- The practical impact of government decisions on service delivery;
- Financial consequences for providers and staff;
- Effects on care worker wellbeing and retention;
- Consequences for people receiving care;
- Systemic issues revealed by the crisis.

16. Throughout this statement, I draw on this evidence to illustrate key points and support our analysis. Given the volume of material relating to the pandemic, and lack of access to public funds to support me with my statement, I could not review all potentially relevant documents. While I have endeavoured to provide comprehensive coverage, I have necessarily focused on the most significant issues and illustrative examples. All referenced documents are provided in the accompanying exhibits.

17. The structure of this statement follows the chronological development of the crisis while addressing the specific topics identified in the Rule 9 request. Where appropriate, I have included relevant contextual information to help the Inquiry understand the sector-specific factors that influenced both the impact of the pandemic and the effectiveness of the response.

18. In my statement, I refer to domiciliary care as homecare. I include information about the Homecare Association, its members, and our role during this time. I discuss the experience of homecare providers in relation to the key policy decisions and the disproportionate impact on the sector. I provide reflections on the decisions made by the UK government and how well informed these were. I conclude by offering my thoughts on what lessons we should learn from the COVID-19 pandemic.

19. While the evidence, information, and statistics I provide in this statement relate specifically to homecare services for adults, unless otherwise stated, it is important to acknowledge that some of our members also deliver social care services that fall outside the scope of Module 6's investigation. I do not provide assessment of service provision outside the scope of the module's remit, however the challenges and themes closely mirror those I describe.

20. This statement is accurate and complete to the best of my knowledge and belief at the time of signing.

Homecare Association

21. The Homecare Association is the UK's leading membership organisation dedicated exclusively to homecare (also referred to as domiciliary care) providers. With over 2,200 members, it serves as a vital advocate and provides essential support to the sector.

22. As the sector's primary representative body for homecare during the pandemic, we were uniquely positioned to observe and document its impact across the UK. Homecare providers deliver care to nearly one million people in the UK, ranging from

the largest national organisations providing hundreds of thousands of hours of care weekly, to small local services. These members deliver a spectrum of care, from regular visiting care and support to complex clinical care, serving people of all ages with diverse needs including physical disabilities, learning difficulties, autism, and mental health conditions.

23. Our role during the pandemic centred on three key functions:

- Supporting providers with practical guidance, resources and real-time advice as they navigated rapidly changing circumstances;
- Representing sector interests to government, regulators and other stakeholders through direct engagement and policy advocacy;
- Gathering and analysing evidence about pandemic impacts through regular surveys, provider forums and systematic data collection.

24. This evidence base, combined with our continuous engagement with stakeholders across health and social care, enables us to provide the Inquiry with detailed insight into how the pandemic affected homecare delivery and what lessons should be learned. The findings and recommendations in this statement draw on extensive data collected throughout the crisis, including member surveys, consultation responses, and direct provider feedback.

25. Full details of the Homecare Association's history, structure, governance, membership, stakeholder relationships and activities during the pandemic can be found from paragraph 625 onwards. This includes comprehensive information about our consultation responses, submissions to parliamentary committees, and published reports. Where relevant throughout this statement, I reference specific documents and evidence from these sources to support key points.

26. It should be noted that 93% of our membership is based in England, and as such, my statement primarily reflects the experiences of homecare providers operating in England. However, where we hold relevant information or evidence from providers in

the devolved nations, I have included it. While the focus of this statement is on England, it is important to acknowledge that providers across the devolved administrations faced similar challenges, and their experiences are consistent with the themes I outline. When statistics relate specifically to countries in the devolved nations, I have specified.

27. The challenges our members faced during the pandemic were significantly shaped by pre-existing structural issues in social care, which I will now describe.

Pre-pandemic context

Out of sight, out of mind

28. As I outlined in my opening statement to Module 2 of the UK COVID-19 Inquiry:

- Social care was overlooked in key decision-making moments.
- Social care was misunderstood - it was seen as care homes for older adults, rather than a diverse system of care and support for all ages, with a workforce of 1.6m, larger than the NHS. [JT/001- **INQ000103565**]. .
- Social care was disadvantaged, especially in comparison to the NHS. Indeed, the focus of decision making appeared to be protecting the NHS rather than citizens in all communities.

29. The question is why. In this section, I explore potential reasons for the discrimination against social care, with particular reference to homecare.

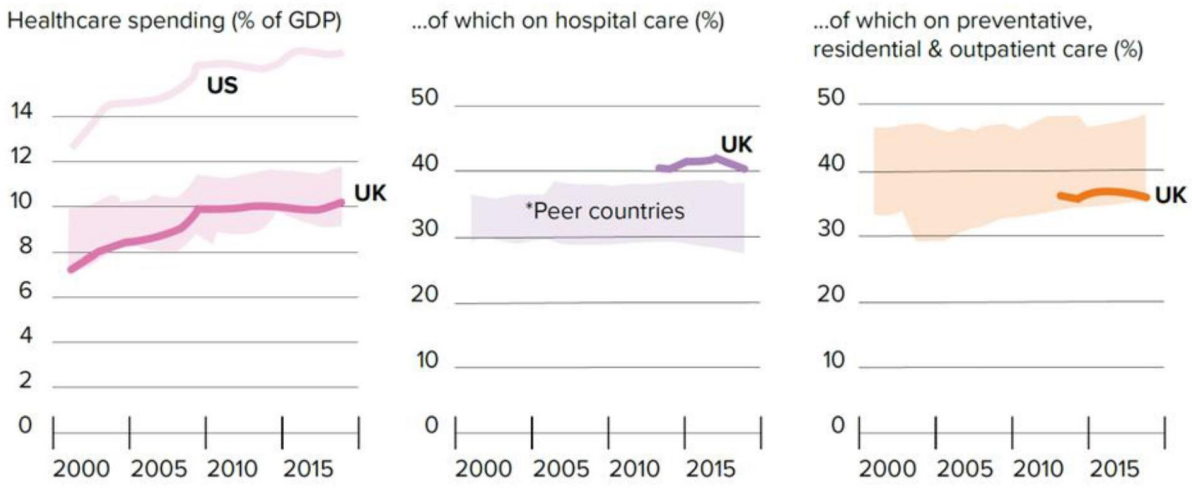
30. Some causes of discrimination against social care may relate to the nature of services themselves, which give rise to a “hierarchy of invisibility”. The saying "out of sight, out of mind" expresses the idea that people or things are easily forgotten or ignored when they are not visible or present. NHS hospitals, for example, are highly visible to the public and policymakers. This means hospitals naturally attract attention. NHS primary and community health services are less visible than hospitals, though many people have contact with their GPs and are aware of district

nurses and midwives. Community health services attract less public attention and money than acute hospitals.

31. Fewer people access social care than NHS services. This means social care is less visible to most people than the NHS. Within social care, care homes are more visible to people in communities than care behind the closed doors of people's own homes.

32. Visibility matters because it affects understanding and funding. The Organisation for Economic Cooperation and Development (OECD) data shows the UK spends a higher proportion of its budget on hospital care and a lower proportion on preventative and community care than peer countries (Figure 1) [JT/002-INQ000581867] .

Figure 1: UK spend on healthcare as % GDP (OECD, 2023)



*Austria, Canada, Denmark, Germany, Finland, France, Netherlands, Norway, Sweden, Switzerland, US
Source: OECD.Stat

33. The roots of this invisibility lie in the founding decisions that shaped our modern health and care systems. The structural separation between centrally managed tax-funded healthcare, mostly free at the point of delivery, and locally administered means-tested social care would have profound implications for decades to come, particularly during national emergencies like the pandemic.

Separate systems - NHS and social care

NHS and social care separated at birth

34. 1948 saw the creation of the National Health Service (NHS) in the UK. Households received through their letterboxes a leaflet from the Ministry of Health, launching the new NHS on 5 July, which read: “It will provide you with all medical, dental, and nursing care. Everyone - rich or poor, man, woman, or child - can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a ‘charity’. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.”

35. The same year, companion legislation in the form of the National Assistance Act, slid silently into statute. Its opening words, "An Act to eliminate the Poor Law," reflected its origins in Victorian welfare rather than modern public service.

36. Limited legal duties were placed on local authorities to ‘provide residential accommodation for persons who by reason of age, infirmity or other circumstances are in need of care and attention which is not otherwise available to them.’ The Act also included ‘welfare arrangements for blind, deaf, dumb, and crippled persons’, which was to underpin the core definition of disability in community care law until 2014. It was not until the 1970 Chronically Sick and Disabled Persons Act that councils were given the power to offer a wider range of support. Families were responsible for most caring needs and this remains the case today. State-funded social care is means-tested and those with assets over £23,250 must pay in full for their care, unless eligible for NHS funding.

Outsourcing of social care

37. Further change occurred in 1990 with the NHS and Community Care Act. This legislation aimed to drive competition, efficiency and innovation in social care by enabling councils to outsource services to independent providers. It sought to shift

power and resources closer to communities, reduce institutionalisation and build productive partnerships between the public, private and voluntary sectors.

38. In the three decades since, many providers have embraced this opportunity with creativity and commitment - developing new models of care, investing in facilities and technology, and driving up quality. At their best, they have combined an entrepreneurial mindset with a strong public service ethos.

A transformative vision for social care

39. The Care Act 2014 offered a transformative vision for adult social care in England, with high-quality, personalised support to enhance the wellbeing of older and disabled people. It recognised the value of a vibrant, diverse and sustainable market in fostering choice and stimulating improvement. The Act gave councils duties to shape local markets and ensure continuity of care if providers failed. It promised a fairer partnership between the state, individuals and families in sharing costs.

40. A decade on, it is clear that while the Care Act's principles were sound, the system has lacked the investment and policy architecture needed to realise them. Many of today's challenges - fragmented services, unstable markets, a struggling workforce - stem from failure to align resources and incentives with the Act's goals.

41. Successive UK governments have failed to acknowledge that life has changed dramatically since 1948. Back then, life expectancy at birth in the UK was just above the state pension retirement age of 65, and there were only 750,000 people over 80. Nobody imagined the remarkable progress that would follow. By 2020, average life expectancy at birth in the UK was 79 years for males and 82.9 years for females [JT/003-INQ000574124] , and there are now nearly 3.5 million people over 80 [JT/004-INQ000574125] .

42. Rising demand has put extreme pressure on NHS and social care services. Instead of minimising demand by encouraging early support and preventative services in the community, successive governments have poured most of the funds into crisis

management of hospitals. This has exacerbated demand, piling pressure on individuals, families, councils and the NHS, and trapping people in costlier services.

43. Meanwhile, spending on social care fell substantially in real terms between 2009/10 and 2019/20 [JT/005-INQ000574108] . Councils have had little choice but to squeeze fees, and short-term grant funding has failed to bridge the gap.

44. In many areas, the vision of a genuinely mixed market, with a range of quality options to suit different needs and preferences, has given way to a race to the bottom on price. The gulf between state-funded and self-funded care has widened to a chasm, worsened by a North-South divide in wealth, entrenching individual and regional inequalities.

45. Starved of resources, too many councils have fallen back on rationing, time and task commissioning, and buying care by the minute, rather than the system-wide, outcomes-based, person-led support envisaged by the Act. To save money, some councils are encouraging use of unregulated care and 'gig' economy models, risking quality, safety, compliance with tax law, and employment rights for care workers.

46. Providers in the state-funded part of the market find themselves stuck on a treadmill of inadequate fee levels, high staff turnover, and compromised quality. Practices like "call clipping" in homecare – rushing calls to cover payment for travel time - have increased as providers struggle with low margins.

47. While the Act promised a well-trained, professional workforce, care workers remain undervalued and underpaid. Zero-hours commissioning leads to insecure zero-hours employment and a lack of investment in the pay, training, development and support needed to recruit and retain talent. Most care workers love their jobs and the ability to improve lives. Too many, though, feel stretched by inadequate staffing and lack sufficient training to deal with increasing complexity of need.

48. As powerful monopsony purchasers, many councils are distorting care markets by failing to respond to rising costs, driving down prices, exploiting loopholes in

regulations, and turning a blind eye to poor practice. This means we have not seen the consistent innovation and efficiency gains that fair, well-regulated competition between high-quality providers should deliver.

49. In some places, cheap, poor-quality providers are winning most of the work, threatening the viability of good-quality ethical providers. This creates the conditions for labour exploitation, as well as risking quality and safety. Commissioners and regulators appear to lack the leadership, consistency, resources, or will, to enforce the rules and drive improvement effectively.

Attempts at reform

50. Over several decades, some of the finest minds have produced detailed analyses, argued cogently for reform, and legislated. The past 27 years have seen two government commissions, one government-commissioned review, three independent commissions, five white papers and 14 parliamentary committee inquiries on social care reform. Despite this, limited progress has been made. In January 2025, the Labour government announced yet another review of social care led by Baroness Louise Casey of Blackstock [JT/006-INQ000574109] .

Lack of sight and understanding

51. Central government has limited sight and understanding of social care. We suggest there are several reasons for this.

- First, the statutory responsibility for social care lies with local authorities. Local authorities commission, purchase and oversee operational delivery of social care services by independent providers. Whilst local authorities have sight of state-funded care services, their knowledge of the private-pay market is less detailed. This became an issue in the pandemic, which I will return to later.
- Second, central government responsibility for social care is split between departments. The funding for local authorities is the responsibility of the Ministry of Housing, Communities and Local Government (MHCLG). The policy for social

care is, however, led by ministers in the Department of Health and Social Care (DHSC), whose attention is often drawn to the NHS.

- Third, national communication channels and data for social care are weak. Unlike the NHS, there is no local authority regional structure for central government to engage with. Whilst there are regional groups for the directors of adult social services, they do not have full decision-making powers in councils, like the Chief Executive Officers. The value of the social care sector and what it means to those who receive and provide services is, therefore, not fully appreciated by government decision-makers. Social care and support services are hidden in plain sight. This is even more the case for homecare services, which are behind closed doors in people's own homes, and less visible in communities than care homes.

52. Prior to the pandemic, policy announcements felt disconnected from the realities experienced by providers. Escalating unmet need, staff shortages and funding deficits remained unaddressed despite increasing expectations from public bodies commissioning care.

53. There was grave concern about the sector's resilience, sustainability and ability to withstand and respond to an unexpected event such as a pandemic.

54. There was also a lack of confidence that central government understood the sector well enough to support it during a time such as this.

55. From the outset, political and administrative decision-makers lacked understanding about homecare services. They failed to consider the needs of the sector and of the people the sector cared for. It appeared to me that homecare, and other non-residential social care services, were an afterthought in government policy and guidance.

56. When provision or guidance was available for social care, there was a tendency to conflate the 'care home sector' with the 'social care sector'. Homecare was often overlooked in government thinking. This was a serious concern when home-based

social care involves half of the adult social care workforce [JT/001-INQ000103565] and hundreds of thousands of people.

57. The poor understanding of homecare by decision makers is key context for the disproportionate impact of the COVID-19 pandemic on the sector. Many of the experiences that our members, their staff and the people they cared for shared with us stemmed back to this fundamental issue.

58. The Homecare Association has worked hard to improve wider understanding of the homecare sector and to advocate on key issues affecting provision.

59. To help the Inquiry and provide further context to issues that arose during COVID-19, I summarise below key features of the homecare sector and expand on some of the pre-pandemic challenges.

Homecare sector

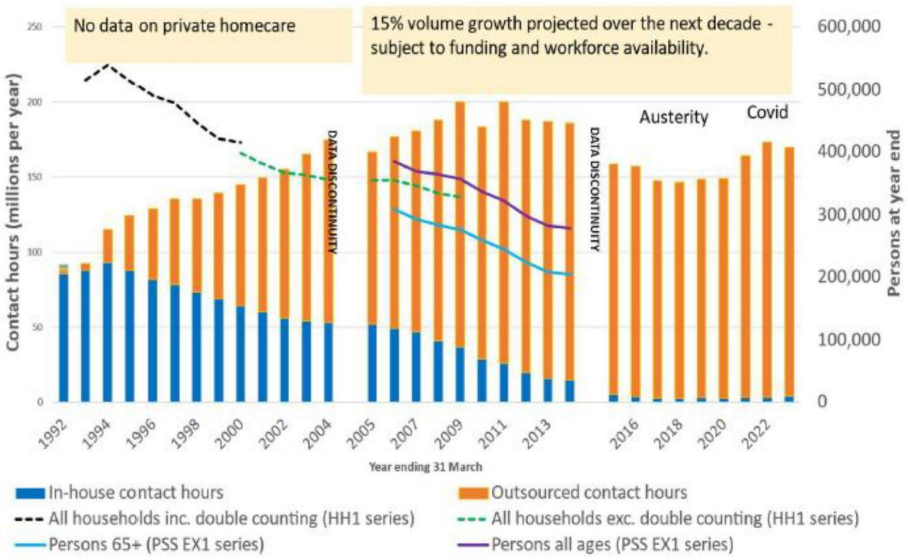
Structure, scale and funding

60. Our Homecare Association Market Overview 2024 provides a detailed analysis of the homecare sector in the four administrations of the UK [JT/007-INQ000571020].

61. Independent industry analyst LaingBuisson has produced a recent report on the scale, structure, funding and financial performance of the independent care sector [JT/008-INQ000574110].

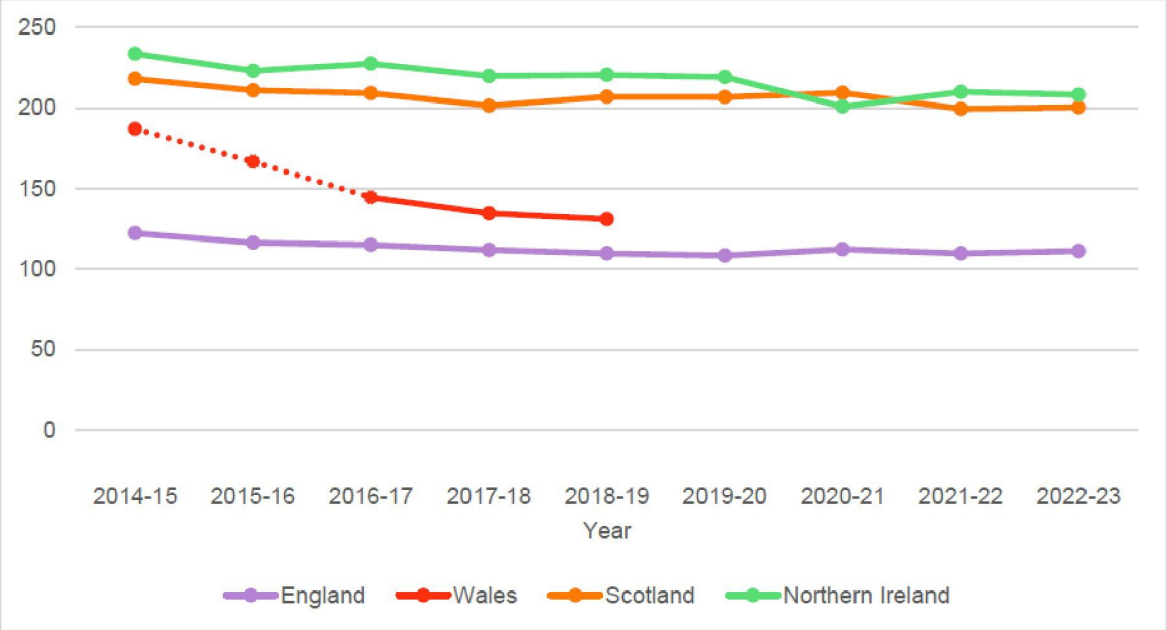
62. The UK homecare sector has undergone a fundamental transformation over the past five decades, evolving from a primarily public sector service to one dominated by independent providers (Figure 2). This shift reflects broader changes in delivery of social care in the UK. Today, the sector represents a substantial part of the UK economy, with the combined value of homecare and supported living services reaching £12.1 billion in 2022/23 [JT/008-INQ000574110] . Skills for Care reports that social care contributes £68.1 billion per year to the England economy [JT/009-INQ000572390]

Figure 2: Local authority commissioned homecare, England 1992-2023 (LaingBuisson, 2024)



63. The scale of homecare provision is significant, with professional providers supporting nearly one million adults across the UK at any given time. This exceeds the number of people in facilities-based care settings, which stands at 590,000. There is variation between the UK nations in the number of people per 10,000 population receiving state-funded homecare (Figure 3). It is important to note that regulated professional homecare provision represents only part of the picture. Skills for Care reports 123,000 jobs in unregulated homecare [JT/009-**INQ000572390** . Between 5.7 and 10.6 million unpaid carers provide essential support to people in their homes, highlighting the substantial role of informal care in the UK's social care system [JT/010-INQ000574126] . Despite this combined effort, unmet need remains a pressing concern, with an estimated 2 million people aged 65 and over in England alone lacking the care they require [JT/011-INQ000574111] .

Figure 3: Estimated number of adults receiving homecare funded by local authorities/HSCPs/HSC Trusts during the year per 10,000 population aged 18+



64. Homecare providers offer a diverse range of services to meet varying needs within their communities. These include regular visiting care where workers provide support through scheduled visits; extra care services in specially designed accommodation with 24-hour staff availability; and live-in care where care workers reside in clients' homes. The sector also encompasses supported living schemes, housing with care arrangements, and complex care services for those with long-term health conditions requiring specialised support. This variety of service models enables providers to support people with wide-ranging needs, from physical disabilities and learning difficulties to mental health conditions and chronic illnesses.

65. The market structure is notably fragmented, characterised by a large number of small and medium-sized enterprises (SMEs). 85% of homecare providers are SMEs with fewer than 50 employees [JT/009-**INQ000572390** . Industry analysis shows that the ten largest providers each hold only 1-3% of the market (Figure 4, [JT/008-INQ000574110] . The largest provider, City & County Healthcare,

generates annual revenue of £350 million, representing just 2.9% of the market. This fragmentation creates both benefits and challenges. While it promotes local responsiveness and competition, it can limit providers' ability to achieve economies of scale and build financial resilience.

Figure 4: Market leading independent sector providers of homecare and supported living services by turnover, UK, c. 2022/23 (LaingBuisson, 2024)

Operator	Principal Activity	Estimated annual revenue from homecare and supported living services in financial year 2022/23	Market share
		£ million	%
City & County Healthcare	Homecare	350	2.9%
Lifeways Group	Supported Living	227	1.9%
Bluebird Care (franchisor)	Homecare	223	1.8%
Home Instead Senior Care (franchisor)	Homecare	210	1.7%
Cera Care	Homecare	200	1.7%
Dimensions	Supported Living	194	1.6%
Clece Care Services	Homecare	180	1.5%
CareMark (Franchisor)	Homecare	130	1.1%
Community Integrated Care	Adult specialist	130	1.1%
Helping Hands	Homecare	128	1.1%
Other providers		10,108	83.7%
UK TOTAL		12,081	100%

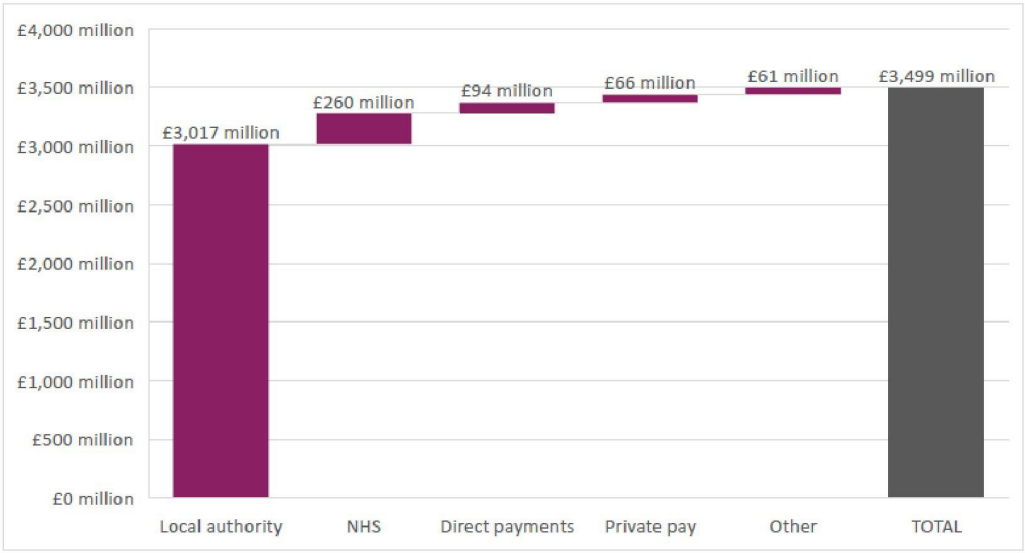
Source: LaingBuisson

66. The funding landscape reflects the sector's complex relationship with public services. Councils and the NHS purchase 79% of homecare (Figure 5) and 96% of supported living services (Figure 6), demonstrating the sector's heavy reliance on public funding. In England alone, local authorities spent £3.6 billion on homecare and £3.1 billion on supported living in 2022/23, with additional funding from the NHS and private sources [JT/008-INQ000574110] . The commissioning structure varies across the UK's nations, with different arrangements in England, Wales, Scotland, and Northern Ireland, adding another layer of complexity to the market. The following bodies commission and fund homecare in each UK nation:

- England: local authorities and Integrated Care Boards (ICBs).
- Wales: local authorities and Local Health Boards.
- Scotland: Health and Social Care Partnerships (HSCPs).
- Northern Ireland: Health and Social Care Trusts.

Figure 5: Sources of funding for homecare providers, England 2022/23 (LaingBuisson, 2024)

Figure 6: Sources of funding for supported living providers, England 2022/23 (LaingBuisson, 2024)



67. LaingBuisson estimates private-pay funding of homecare at 21% of the total (Figure 5), although this varies across the four UK nations. In England, those with assets over £23,250 may have to arrange and pay for their own care. Providers serving the private-pay market are acutely aware of cost-of-living pressures on older people who pay for their own care. The asset threshold to receive publicly funded care is so low that even those of modest means must pay for their care in full. If prices rise, many will reduce the hours of care, adding to the risk of avoidable hospital admissions.

68. While homecare is considered 'asset-light' compared to residential care, the sector requires significant investment in working capital, operational systems, and technology infrastructure. Private equity has played an important role in this regard, currently controlling 14 homecare or supported living groups with combined revenue of £1.2 billion, representing 12.2% of total independent sector revenue [JT/008-INQ000574110] . However, the need for investment in systems and service consolidation remains substantial.

Funding and costs of homecare delivery

69. Each year, the Homecare Association looks at the costs of homecare delivery to calculate a minimum price for homecare. This is the minimum rate a homecare provider needs to meet employment and care regulations, deliver quality services and operate sustainably. Staff costs include the National Living Wage (NLW) for all work hours (including travel), and statutory employment on-costs. These include statutory pension; national insurance; sick pay; holiday pay; training and travel time. The hourly rate also includes a contribution to other running costs. These include wages for the registered manager and office staff; recruitment; training costs beyond staff time; digital systems; telephony; insurance; regulatory fees; PPE and consumables; office rent, rates and utilities; finance, legal and professional fees; general business overheads; and a small surplus for investment.

70. In 2018, we calculated a minimum price for homecare of £18.01 an hour. We found that the average hourly price paid by councils was £16.12. This meant there was a

funding deficit of at least £402 million just to meet statutory requirements and ensure minimum wage compliance. [JT/012-INQ000571013] .

71. In 2018, our research [JT/012-INQ000571013] undertaken with local councils via Freedom of Information requests suggested that only 1 in 7 councils were purchasing care at or above the minimum price of £18.01 per hour. At that time, two local authorities were commissioning care at an average of less than £13.08 per hour (nearly £5 per hour less than our minimum figure). This was symptomatic of a wider picture.

72. In 2020, we calculated a minimum price for homecare of £20.69 per hour [JT/013-INQ000574127] .

73. The Association of Directors of Adult Social Services (ADASS) reported in 2019/20 that 35% of directors were fully confident that their budgets were sufficient to meet statutory duties, 59% had partial confidence and 6% had no confidence. By contrast, for 2020/21, 4% of directors were fully confident that their budgets were sufficient to meet statutory duties, 56% partial confidence, but 35% had no confidence [JT/014-INQ000574128] .

74. We noticed similar issues in relation to Clinical Commissioning Groups (CCGs) and conducted a survey of our members on this issue in June 2020. We found that most CCGs were commissioning at rates below our published minimum price and that many CCGs were not uplifting their prices to account for inflationary increases (primarily - but not exclusively - driven by increases in the statutory minimum wage). 41% of CCGs had not increased their fee rates for over 2 years. We could only find one CCG who increased rates proportionately to the rate increase in the National Living Wage.

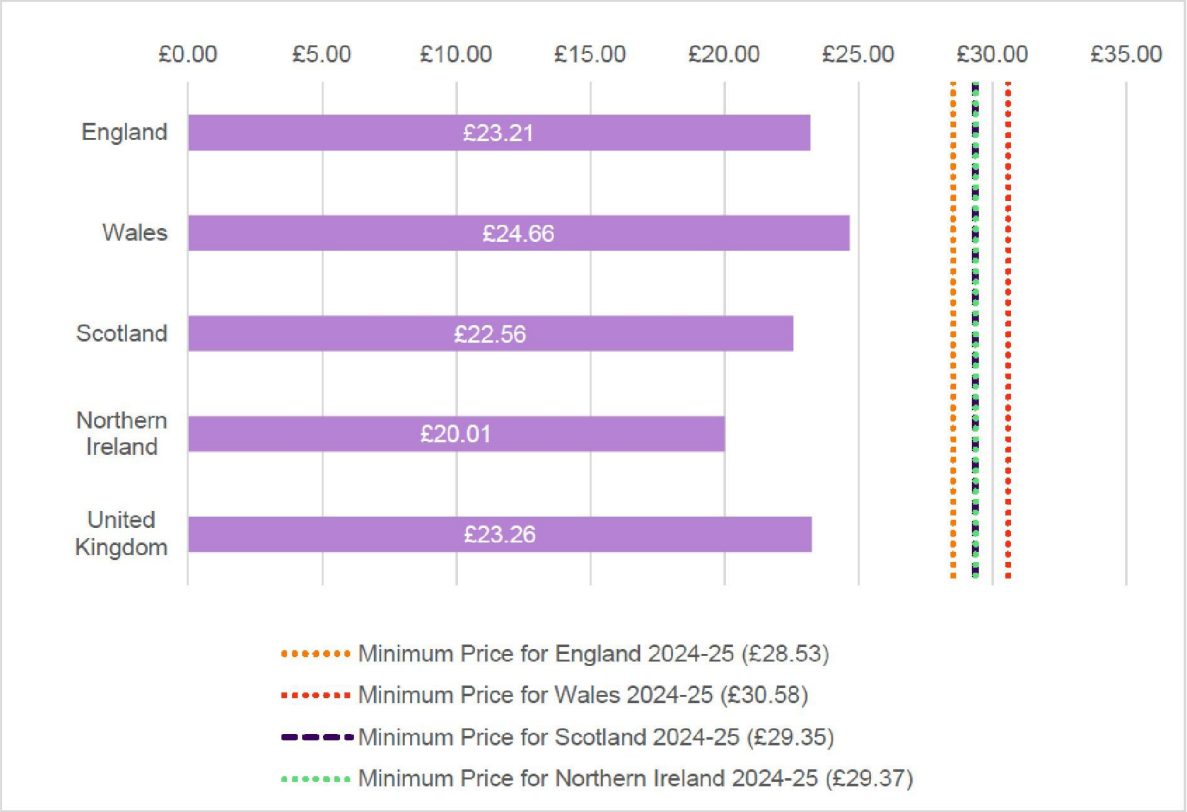
75. This represented something far more significant than a threat to profit margins and left significant questions over the sustainability of the state-funded part of the sector.

76. The December 2021 People at the Heart of Care White Paper raised concerns in the sector about the Government's intention to 'turn on' section 18(3) of the Care Act 2014. This would allow people who self-fund their own care to ask local authorities to arrange care in care homes for them at the local authority negotiated fee rate. Due to local authority fee rates being so low, this would effectively slash the financial sustainability of the self-funded part of the market. However, for domiciliary care, it was already possible for Councils to arrange care for self-funders at negotiated rates. We heard anecdotal evidence from providers in 2022 that Councils in some regions were already doing so and listing self-funded packages via their procurement portals. This began to introduce further control over market pricing in some regions and damaged some provider's ability to break-even, complicating the picture of market sustainability further.

77. Our research in 2023 showed only 5% of public bodies were paying rates that enabled full compliance with minimum wage legislation and care regulations [JT/015-INQ000571762] . More concerning still, some public bodies paid rates that fell below the amount needed to cover direct staff costs at minimum wage.

78. In August 2024, we published further research investigating fee rates for homecare after the minimum wage increased to £11.44 per hour on 1 April 2024. Only 1% of contracts with public bodies for regular homecare were paying the minimum price we calculated (then £28.53 per hour). Only 6% of regular homecare contracts with local authorities in England had a fee increase that kept pace with the NLW increase. In the United Kingdom, the average fee rate for regular homecare contracts with local authorities/HSC Trusts in 2024/25 was £23.26 per hour (Figure 7). Wales had the highest hourly average (£24.66). The average rate paid in England was £23.21 per hour – well below the minimum rate required [JT/016-INQ000571076] . We estimate that, in 2024/25, there is a £1.08 billion deficit to meet delivery costs at minimum wage in homecare alone. This rises to a £1.8 billion deficit for 2025/26. The minimum wage is not a fair wage for the skilled work required in care. If providers are to compete with supermarkets and hospitality, they need to offer more than the minimum wage.

Figure 7: Average 2024-25 fee rate per hour in each administration and the United Kingdom for regular homecare contracts with local authorities/HSC Trusts

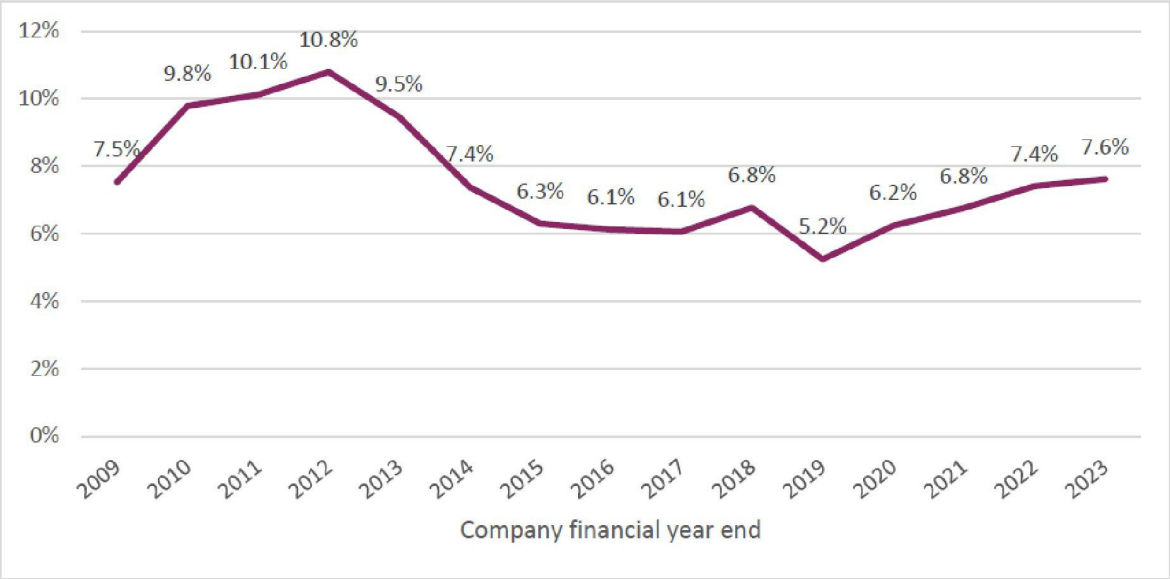


79. For the 2025/26 financial year, we calculate the Minimum Price for Homecare (in England) to be £32.14 (Figure 8, [JT/017-INQ000571077] . As shown in Figure 7, the current average hourly fee rate in England is only £23.21, with some councils and NHS bodies paying only £16-17 per hour.

Figure 8: Why regulated homecare costs £32.14 per hour in 2025/26 (Homecare Association, 2024)

80. The sector's financial performance reflects these challenging conditions. Analysis of statutory accounts reveals that average Earnings Before Interest, Tax Depreciation and Amortisation (EBITDA) margins have fluctuated significantly over time. They rose after the global financial crisis when pay was depressed, fell during years of austerity as local authorities held down fee rates, and have partially recovered in recent years. Current margins in homecare stand at an average of 7.6% for company financial periods ending in 2023, though this has not returned to previous peak levels (Figure 9). The average masks significant variation. Providers with high exposure to state-funding at low fee rates struggle to break even. Now providers face a 10% increase in employment costs after the Autumn Budget 2024 and extra costs from the Employment Rights Bill. Without additional government funding, many services risk failure. A reduction in access to homecare would increase unmet need and add pressure to the NHS. If we were to face another pandemic, we would be in an even worse position than before.

Figure 9: EBITDA margins posted by homecare and supported living groups, UK, company financial years ending 2009-2023 (LaingBuisson, 2024)



Source: Statutory accounts of companies large enough to post profit and loss
[1] EBITDA (Earnings Before Tax, Interest, Depreciation and Amortisation of goodwill..
[2] Homecare groups exclude those classified as Complex Care Groups, which offer typically nurse-led homecare services funded by the NHS

Commissioning and procurement

81. For many years, most public sector bodies have commissioned and paid for homecare on a zero-hours basis for client contact time only.

82. Local authorities and the NHS pay providers by the minute, often weeks or months after the care was delivered. Public sector bodies rarely provide extra funding to cover travel time for short visits or to encourage staff to work during unsocial hours.

83. Most commissioners offer no guarantee of hours of work to providers. Over the years, councils and NHS bodies moved away from block contracts, which offer some security of income, to spot purchase. In England, many commissioners establish framework agreements with providers registered with the Care Quality Commission (CQC). Providers must then bid for each package of work via dynamic purchasing systems. The lowest bidders usually win, though some local authorities set minimum

bid values. This encourages a race to the bottom on price. This increases the risk of labour exploitation and unsafe care. It also makes it hard for ethical providers, who invest in the workforce, quality and safety, to win work and remain viable.

84. Commissioning practices have been worsening for more than a decade. We produced a report as far back as 2012 highlighting our concerns that zero-hours commissioning at low fee rates results in zero-hours employment at low wage rates [JT/018-INQ000571014] .

85. Paying for care delivered in arrears means care providers are highly vulnerable to changes in business volume and cancellations. This makes business planning difficult and contributes to instability in the market. Many providers could not take on work for public sector organisations. When combined with the low hourly rates outlined in paragraphs 69, 73 and 74, some providers were forced to hand back public sector work because it was unviable. This had affected over 10,500 people in the year before the pandemic - something I highlighted in my 2019 blog post "CEO Blog - Homecare market and UKHCA priorities" [JT/019-INQ000587357 .

86. This became a significant issue early in the pandemic, as volumes of care commissioned dropped unexpectedly for some providers. I refer to this in more detail later in my statement.

Market instability

87. Prior to the pandemic, there was already a serious risk of provider failure.

88. In 2016/17, the CQC [JT/020-INQ000574130] noted substantial churn in the homecare market, with around 500 agencies registering each quarter and 400 de-registering. Meanwhile, in the CQC's 'State of Care' report for 2018-19, they expressed concern about the stability of the adult social care market [JT/021-INQ000574131] . In 2019, the CQC twice exercised a legal duty to notify

authorities there was a credible risk of service disruption because of potential provider failure.

89. Some providers were being forced to exit or considering exiting the market because of operating deficits. In 2019, Hft [JT/022-INQ000574132] found one in five providers had cut support in the last year because of financial pressures, with 95% citing rising wage bills as the main cause. They also found 45% of providers had to hand back contracts to local authorities at the time as a way of dealing with financial pressures.

90. In addition to this, in 2019, 79% of directors of adult social care were concerned about their ability to meet the statutory duty to ensure market sustainability within existing budgets [JT/023-INQ000574133] . In 2021/22, 82% of directors of adult social care said they were concerned about the financial viability of some providers since the outbreak of COVID-19 [JT/024 **INQ000514935**].

91. Analysis by LaingBuisson in 2020 suggested large providers exiting the market in the last five years were "triggered by austerity driven adverse trading conditions."

92. Market instability stems from a lack of financial sustainability. This is driven by inadequate funding, and poor practices in commissioning and purchase of homecare.

93. Funding availability for homecare services has been heavily affected by the financial restrictions faced by local authorities, which spend the largest proportion of their income on social care services. They are also the largest commissioners of homecare services (Figure 5).

94. In 2020, the Local Government Association [JT/025-INQ000574135] argued that local authorities had lost £16 billion in core funding over the last decade. The Centre for Progressive Policy [JT/026-INQ000574136] warned that 8 out of 10 local authorities may face bankruptcy. Social care funding via local authorities was not ring-fenced and consequently the wider financial position of local authorities was

directly impacting on social care providers. In 2017/18, for every pound spent on adult social care, five pounds were spent on health services.

95. The Health Foundation, estimated in 2019, before the COVID-19 pandemic, that £12.2 billion would be needed by 2023/24 to meet the existing funding gap, bring social care access and quality back to 2009/10 standards and allow for pay increases at the same rate as NHS staff pay increases [JT/027-INQ000590761] .

Workforce shortages

96. There had been long-standing issues with workforce shortages in homecare. This was because care providers could not make competitive employment offers compared with other sectors, such as retail and hospitality. As highlighted above, insecure zero-hours commissioning at low fee rates drives insecure zero-hours employment at low wage rates.

97. Prior to the COVID-19 pandemic, there was limited strategic planning at a national level on the social care workforce. Despite vacancy rates in homecare sitting at 10.0% in 2018/19 [JT/028- **INQ000103564** , compared to 2.8% for a national rate in the wider economy [JT/029-INQ000574141] , the sector had no workforce plan.

98. In our 2019 Manifesto [JT/030-INQ000571015] and in our response to the UK government's Spending Review in August 2019 [JT/031- INQ000598597] , we called for a workforce plan for social care. Aware of the potential impact of Brexit, we also called for a migration policy to be aligned with workforce planning for the sector [JT/031- INQ000598597] .

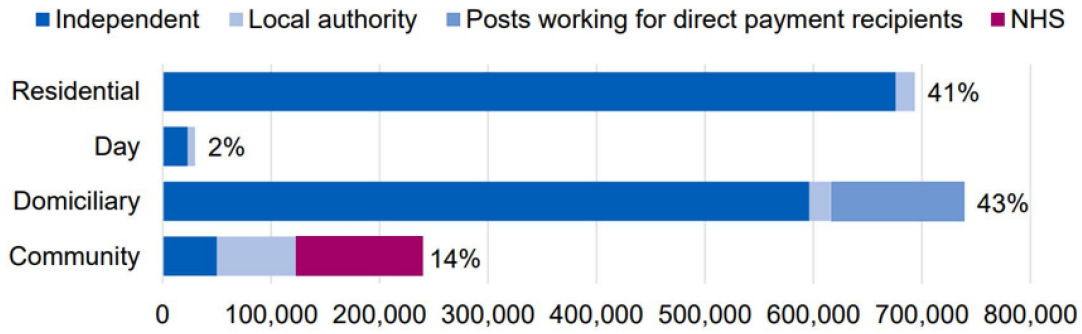
99. The Homecare Association does not hold the data in relation to the number or composition of our members' workforce. Skills for Care collect data on the size and structure of the Adult Social Care Workforce in England, which I will refer to.

100. As 94% of our members are based in England, I highlight key data from Skills for Care, where it relates to the homecare sector.

101. In March 2024, there were 10,850 non-residential PAYE employers, with almost 14,000 registered locations.

102. Skills for Care data show there are 740,000 filled posts in homecare in England, more than in care homes. This is 43% of the entire adult social care workforce (Figure 10). Most of these posts are in the independent homecare sector, rather than in services directly managed and delivered by public bodies. Added to this are 123,000 jobs in unregulated homecare [JT/009-**INQ000572390** .

Figure 10: Estimated number of adult social care filled posts by main care service group and sector, 2023/24 (Skills for Care, 2024)

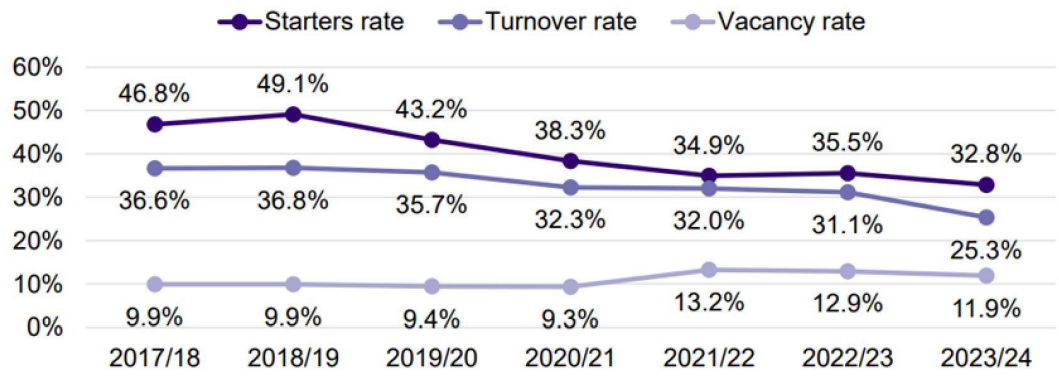


103. The homecare sector faces ongoing recruitment and retention issues. In 2023/24, the vacancy rate in homecare was 11.9%. This was the highest of all service types in adult social care. By November 2024, Skills for Care monthly tracking data show this had reduced to 9.8% [JT/032-INQ000574063] . The vacancy rate in the UK economy was around 2.5% in November 2024 [JT/029-INQ000574141] . This means the vacancy rate in homecare is nearly four times that of the wider economy.

104. The turnover rate for all employees in domiciliary care services was 25.3% in 2023/24 (Figure 11). This equates to about 131,000 workers leaving their role in the previous 12 months. Care workers had a turnover rate of 29.3%, which equates to about 116,000 leavers. Please note the turnover rate only includes services which were active in March during each period, and leavers from services that closed down

are not included, therefore the total number of leavers may be higher [JT/073-INQ000590763] .

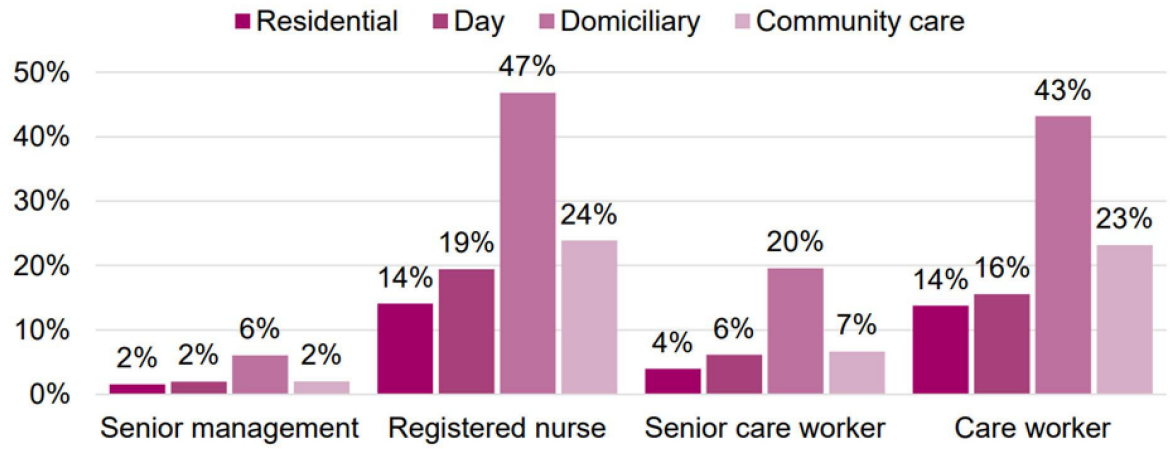
Figure 11: Starter, turnover and vacancy rate trends in domiciliary care services, independent sector only, 2017/18 to 2023/24 (Skills for Care, 2024)



105. The average hourly pay of a care worker working in homecare in 2023/24 was £11.30. The mean nominal hourly rate of care workers has increased every year from £7.92 in 2016/17 to £11.30 in 2023/24, an increase of 43% over the entire period [JT/009 **INQ000572390**

106. In the adult social care sector, homecare services have the highest number of workers on zero-hours contracts (Figure 12). Skills for Care estimates this is around 38%. This percentage is higher if you look specifically at care workers (43%) and registered nurses (47%) [JT/009 **INQ000572390** .

Figure 12: Proportion of workers in the adult social care sector on a zero-hours contract by service type and selected job role, 2023/24 (Skills for Care, 2024)

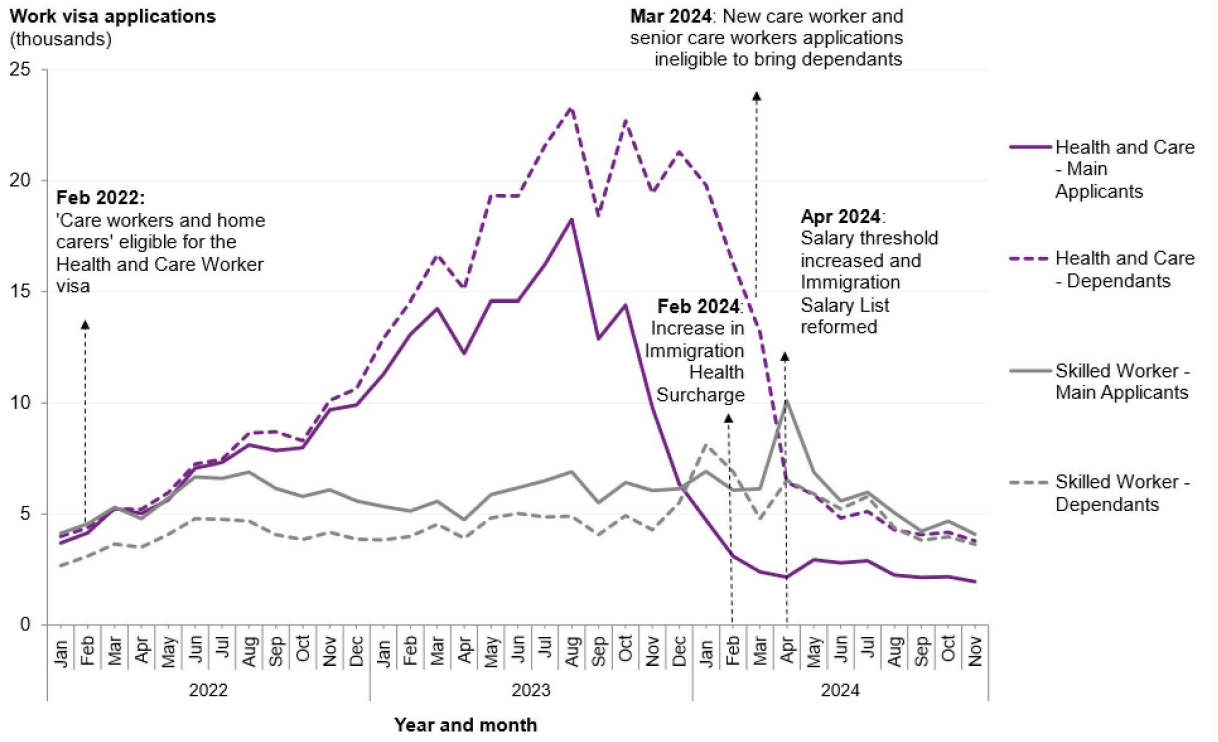


107. Around 79% of workers in domiciliary care services identified as female and 21% identified as male. The proportion of male workers was the same in managerial roles and direct care providing roles. This was also the same as the whole adult social care workforce [JT/009-**INQ000572390** .

108. Around 24% of the workforce were aged 55 and above in 2023/24, and this proportion has grown from 22% in 2017/18. The average age of workers in domiciliary care services in 2023/24 was 43. This is similar to residential care services [JT/009-**INQ000572390** .

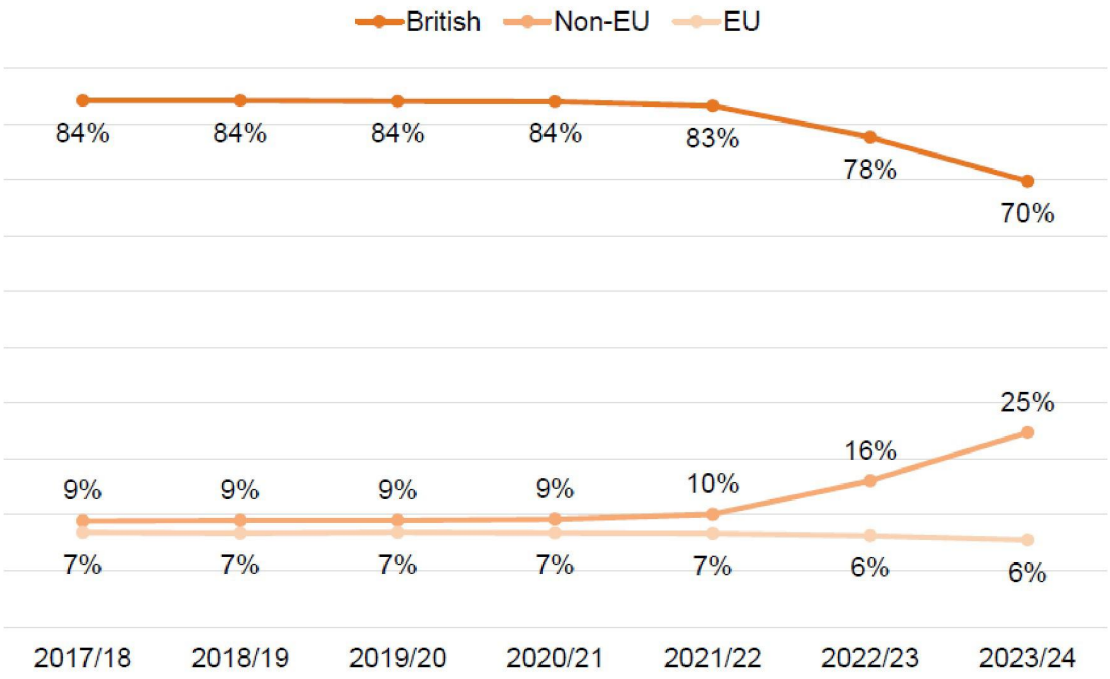
109. Challenges with domestic retention and recruitment have led homecare providers to become increasingly reliant on overseas care workers to meet demand. Changes in Home Office requirements have, however, led to a rapid fall in work visa applications (Figure 13), [JT/033-INQ000574114] . In the medium to longer-term, difficulty in recruiting both within the UK and from overseas risks a shortage of workers to meet rising demand for homecare.

Figure 13: Monthly applications for 'Skilled Worker' and 'Health and Care Worker' visas, January 2022 to November 2024 (Home Office, December 2024)



110. The nationality distribution of the workforce in domiciliary care services was 70% British, 25% non-EU, and 6% EU in 2023-24 (Figure 14). The proportion of British workers in domiciliary care services remained similar between 2017/18 and 2021/22. However, since 2021/22 the proportion of British workers has decreased from 83% to 70% in 2023/24. This equates to a decrease of around 35,000 workers. Over the same period, the proportion of non-EU workers increased from 10% to 25%, an increase of around 90,000 workers [JT/009- **INQ000572390** .

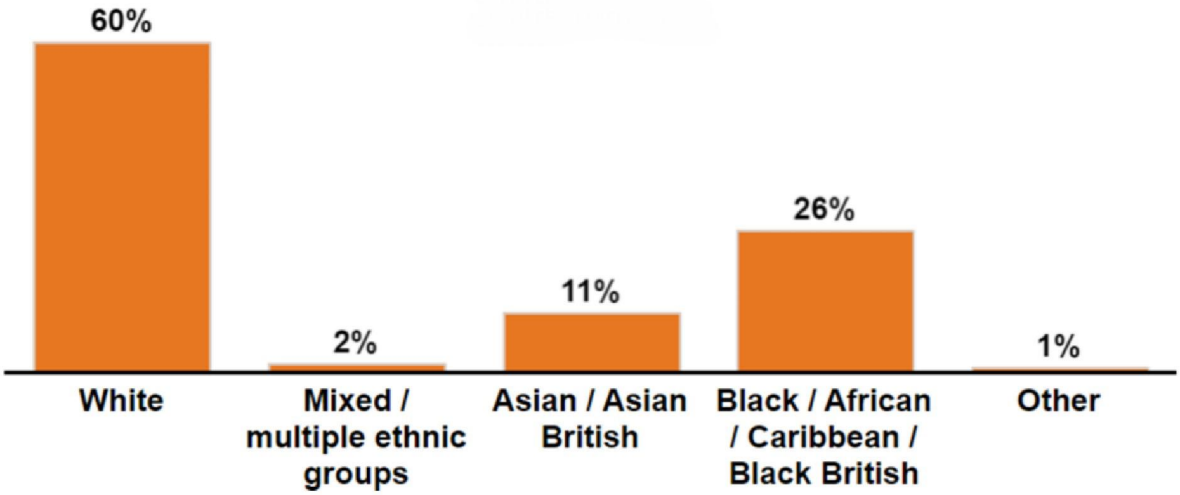
Figure 14: Estimated proportion of homecare workers by nationality, independent sector only, 2017/18 to 2023/24 (Skills for Care, 2024)



111. The adult social care sector was more diverse in 2023/24 than the population of England. In particular, there was a much higher proportion of people with a Black/African/Caribbean/Black British ethnicity within adult social care (18%) compared to the wider population (4%). The proportion of adult social care workers with a white ethnicity was 68% compared to 83% of the population in England [JT/009-**INQ000572390** .

112. This is even more the case in non-residential services, with a higher proportion of people with a Black/African/Caribbean/Black British ethnicity (26%) (Figure 15).

Figure 15: Ethnicity of the non-residential care workforce in 2023-24 (Skills for Care, 2024)



113. In 2023/24, Skills for Care estimated the proportion of workers recorded as having a disability in adult social care at 2%. This is much lower than the proportion of people in England with a disability according to the 2021 UK census (17.7%) [JT/009-**INQ000572390** .

Unmet need

114. In 2018, LaingBuisson reported there had been a drop of 3 million in homecare hours commissioned in the previous three years. . The combination of tightening funding for local authorities during austerity, increases in the minimum wage and an ageing demographic drove up demand whilst holding down capacity. Availability of homecare can also vary by complex regional factors such as rurality, workforce availability and rates of car ownership. This meant that access to care could vary depending on where a person was living.

115. In 2019, Age UK estimated 1.5 million older people in England had unmet care needs [JT/034-INQ000574064] . We highlighted this at the beginning of the COVID-19 pandemic, including in our response to the Spring Budget in March 2020 [JT/035-INQ000574092] . This meant that many people were entering a period of social isolation in the pandemic with inadequate support.

116. Shortage of funding for services also increased pressure on informal carers. According to Carers UK [JT/036-INQ000574139] , one in seven informal carers reported they, or those they support, received less care or support services than during the previous year.

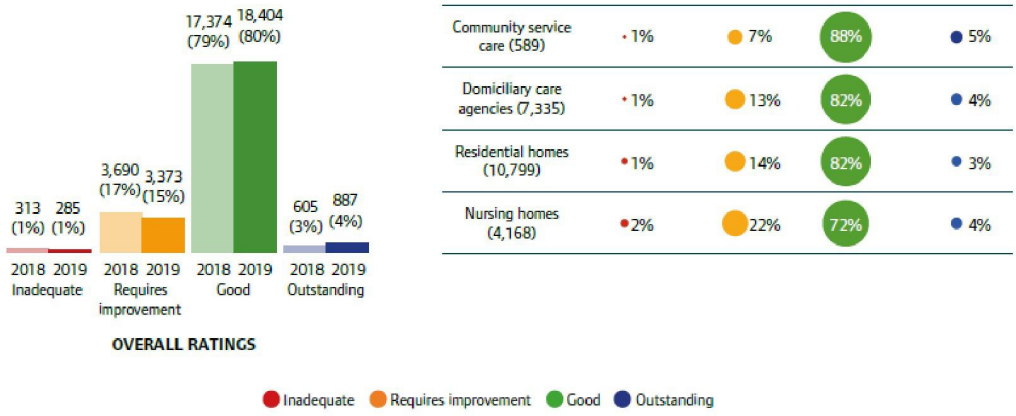
Regulatory environment

117. In England, the Care Quality Commission (CQC) independently regulates health and social care services, including registering providers and inspecting services. The devolved administrations have their own care regulators: the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland; Care Inspectorate Wales; and the Care Inspectorate in Scotland. Providers must register with the relevant regulatory authority to provide services.

118. In England, homecare providers must register with the CQC to provide the regulated activities of 'personal care' and 'Treatment of Disease, Disorder, or Injury' (TDDI). Care providers must pay registration fees to the CQC annually. For homecare, there is a flat fee per branch and a variable fee which depends on the number of people receiving regulated care. Regulators in the devolved administrations do not charge providers ongoing regulatory fees.

119. The CQC's ratings of care quality in 2018/19, before the COVID-19 pandemic, showed 86% of homecare services were assessed as "good" or "outstanding" (Figure 16), [JT/021-INQ000574131] . According to the CQC's own data, in 2019, they inspected one-third of all homecare services [JT/037-INQ000574097] . This meant they were on track to inspect every service at least once every three years, in line with their target.

Figure 16: Adult social care, overall CQC ratings 2018-2019 and by type of service 2019



120. During the pandemic, the CQC prioritised residential care at the expense of homecare. CQC inspectors stopped visiting homecare services, though did make phone calls to registered managers. Feedback from our members suggests regulators in the devolved administrations provided a much higher level of practical support to providers than the CQC. I will return to the impact of the changes to regulation later.

121. The homecare sector is complex and, while regulated homecare providers deliver most care in the home, some people access their care via other routes.

122. Before the pandemic, we saw an increasing number of people employing individual care workers working as sole traders (also called personal assistants) to deliver their care at home using direct payments or private pay. While this option increased some people's choice, we were concerned about reports that councils were encouraging the use of direct payments rather than usual homecare services to save money in their budgets. I discuss these concerns in my 2019 blog [JT/019-INQ000587357] .

123. Personal assistants were not (and still are not) regulated by the Care Quality Commission or the regulators in the devolved administrations.

124. We were also aware of the increasing numbers of introductory agencies offering the services of 'self-employed' care workers. Claiming self-employed status means lower employment expenses and regulatory costs. We raised this in our evidence on the Labour Market Enforcement Strategy in January 2020 [JT/038- INQ000571017]
.

125. In England, there is no professional register of care workers, unlike Scotland, Wales and Northern Ireland. Even in the devolved administrations, personal assistants are not registered, though Scotland has recently announced it will do so. This meant it was hard to identify all workers in the homecare sector.

126. Other regulators involved in homecare include His Majesty's Revenue and Customs (HMRC) and the Home Office UK Visas and Immigration (UKVI). HMRC is responsible for monitoring and enforcing minimum wage compliance. UKVI is responsible for monitoring and enforcing compliance with immigration rules. Like the CQC, HMRC and UKVI appear to lack resource or the will to perform their roles effectively. None of the regulators give adequate consideration to systemic factors affecting the ability of providers to comply with relevant legislation. We consider it scandalous that public bodies are allowed to purchase homecare at fee rates that fail to cover even direct staff costs at the minimum wage. Providers cannot charge higher fees because public bodies fix prices.

Communication and data

127. Limited digital capability had long hampered effective communication across the social care sector. Both the pre-pandemic digital capability of care providers and the central data held by central government on the sector were poor. This followed years of underinvestment in the sector both financially (which is necessary for investment in systems) and in terms of support for digital capability. The lack of digital infrastructure is evident in the 2021 People at the Heart of Care White Paper [JT/039-INQ000571019] that only 40% of social care providers were fully digital in 2021. Many were still using paper-based records. Most did not collect data digitally about their services.

128. Local authorities collect data for operational purposes on metrics such as waiting times for assessment and care; unmet need; number of hours of homecare purchased; and fee rates for care services. None of these data are available routinely in the public domain in England. They can only be accessed by freedom of information inquiries.

129. In England, the CQC holds the only comprehensive central register of all regulated care providers [JT/037-INQ000574097] . This can be filtered by local authority area. Local authorities typically only maintain records of contracted providers, creating significant gaps in their knowledge and ability to reach the full sector during emergencies. There is no register of unregulated homecare providers.

130. In the devolved administrations there are, as explained above, professional registers for care workers; and registers of regulated care providers. None yet have registers of unregulated homecare providers, though Scotland has now decided to do so.

Integration with Health Services

131. Despite caring for many of the same individuals, integration between health and social care remained poor. We consistently called for health officials to develop a stronger understanding of the social care sector and for improved communication and collaboration between health and care colleagues. To highlight funding challenges, we emphasised how underinvestment in social care services directly contributes to increased costs and pressures within healthcare settings.

132. Our 2017 manifesto [JT/040-INQ000571059] called on local authorities and NHS leaders to work more effectively together and to include people with care and support needs and their care providers in the development of plans for joined-up service delivery.

133. Prior to the COVID-19 pandemic, we highlighted our concerns about increasing complexity of need. While homecare services could support people to live well and

independently at home, the complex care requirements resulted in care workers being assigned more healthcare tasks than ever before. The need for joint working between health and social care was becoming increasingly important.

134. Data on delayed transfers of care immediately prior to the pandemic indicated a high level of delayed discharges from hospital because of people waiting for a care package in their own home. This accounted for around 20% of delays [JT/041-INQ000574143] and indicated the challenges of integrated working, and the fragility of the homecare sector.

135. By the start of the pandemic, we had seen no improvements.

Summary of pre-pandemic challenges

136. As described, the sector faced significant challenges that would later affect its ability to respond to the crisis. These pre-existing challenges created critical vulnerabilities that would be exposed by the pandemic. When COVID-19 emerged in early 2020, the sector faced a perfect storm:

- Financial fragility limiting ability to absorb unexpected costs;
- Workforce shortages restricting operational flexibility;
- Poor integration hampering coordinated response;
- Limited digital capability complicating rapid communication;
- Weak data infrastructure obscuring emerging trends.

137. The following sections examine how these underlying issues influenced both initial response capabilities and ongoing resilience throughout the crisis.

Impact of the pandemic

Early Pandemic Response (March-June 2020)

138. The initial months of the pandemic presented unprecedented challenges for the homecare sector. From March 2020, providers faced an extraordinary combination of operational, financial, and human challenges that tested their resilience to the limit. The sector's response demonstrated both remarkable dedication and the severe impact of the systemic vulnerabilities.

139. During the pandemic, we had an influx of members contacting us about their concerns and the impact of the COVID-19 pandemic on their services, care workers and the people they cared for.

140. They contacted us by email, on our advice line, in virtual webinars, informal conversations and other online meetings. I outline for the Inquiry below where the COVID-19 impact had the most impact to the best of my recollection.

People receiving care and support

141. The Inquiry has heard about the impact of the pandemic on older and disabled people from other organisations in detail. I offer some evidence and observations from the perspective of homecare providers.

142. Data from the Office of National Statistics (ONS) and the CQC showed that, even in the first wave of COVID-19 in 2020, when supplies of PPE were patchy, routine asymptomatic testing was unavailable for homecare, and vaccines had not yet been developed, deaths from COVID-19 of people receiving homecare were much lower than in care homes, and were similar to those in the wider population [JT/042-INQ000574115] . This is largely because homecare is not typically delivered in congregate settings. ONS data show the average household size in the UK is 2.4 [JT/043-INQ000574116] , so the risk of transmission was much lower than in a care home with 30 to 120 residents in close proximity. Among the homecare

workforce, evidence suggested the prevalence of COVID-19 was similar to that in the wider community [JT/044-INQ000574104] .

143. During the pandemic there was, however, a dramatic rise in the number of people dying at home in England and Wales:

- Between March 2020 and May 2021, over 59,000 (39%) more deaths occurred at home compared to the average number in 2015-2019 [JT/045-INQ000574106] .
- In 2020, deaths at home from all causes were one-third higher than the previous five-year average, with around 167,000 deaths compared to an average of 125,000 between 2015 and 2019 [JT/046-INQ000574117] .
- By July 2022, about 100,000 more people had died at home than expected, 33% above the five-year average for comparator years [JT/047-INQ000574118] .

144. The majority of excess deaths at home were not directly ascribed to COVID-19:

- Only 7% of the excess deaths at home involved COVID-19 [JT/046-INQ000574117] .
- Most excess home deaths were due to other causes such as dementia, Alzheimer's disease, heart disease, and cancer [JT/047-INQ000574118] .
- There were notable increases in deaths from specific conditions, including a 66% rise in Parkinson's disease deaths (616 excess deaths) and a 60% increase in diabetes deaths (894 excess deaths) at home [JT/046-INQ000574117] .

145. Evidence suggests many of these excess home deaths were cases that would typically have occurred in hospitals or other healthcare settings:

- The ONS data indicates the increased numbers dying at home were likely people who, in a non-pandemic year, would have died in hospital [JT/045-INQ000574106] .

- While home deaths increased, there was a corresponding decrease in hospital deaths from non-COVID-19 causes, with about 104,000 fewer people dying of non-COVID-19 causes in hospital by July 2022 compared to previous years [JT/047-INQ000574118] .

146. The shift in place of death raises questions about the quality of end-of-life care for those dying at home:

- Pre-pandemic surveys showed that while overall care quality was rated higher for home deaths, adequate pain relief was least frequently reported for those dying at home (19%) compared to hospitals (40%), care homes (43%), or hospices (64%) [JT/045-INQ000574106] .
- Evidence points to serious shortfalls in palliative and end-of-life care during the pandemic, with a survey of bereaved carers indicating that three-quarters of people who died at home may not have received the health and social care they needed [JT/045-INQ000574106] .

Access to care and support

147. The government's message to "Stay at Home. Protect the NHS. Save Lives" discouraged people from accessing health, care and support services. The fear of being a nuisance or the fear of infection contributed to this.

148. Many members raised concerns with us about the wellbeing of people accessing support. In many cases, people became increasingly isolated and dependent on care workers for social contact.

149. Research has subsequently shown that isolation at home had a severe impact on those with dementia. A study in eClinicalMedicine, 2021, summarising global research evidence on the effect of COVID-19 isolation measures on the health of people living with dementia found that, out of 15 studies, 9 reported changes in cognition and 14 worsening or new onset of behavioural and psychological symptoms [JT/048-INQ000574089] . A survey by the Alzheimer's Society on the

effect of the first lockdown found that people with dementia living alone were more likely to report an increase in symptoms, compared to those living with others. Only 1 in 5 reported having seen no difference to their dementia since lockdown began [JT/049-INQ000574090] .

150. Arguably, those receiving homecare and support services were more fortunate than those who did not. Homecare workers advocated for those they supported and did their best to ensure needs were met, including helping them to access GP, pharmacy, hospital and other services.

151. National guidance required minimisation of face-to-face contact of healthcare professionals with people. GPs, district nurses, social workers, housing managers and CQC inspectors were among the professionals who started working remotely in the pandemic. Homecare workers were often the only professionals going into people's homes to support them.

152. Our members raised concerns early in the pandemic that they could not access in person or virtual support and guidance from healthcare professionals in the NHS. The instant decision to withdraw community health services at the beginning of the pandemic brought significant risks to people's health and may well have precipitated a decline in their overall health and wellbeing.

153. One member told us a story of a district nurse throwing dressings over the threshold of a person's home and running away, leaving a homecare worker to do their work.

154. Some Clinical Commissioning Groups (CCGs) wrote letters to care providers, requiring them to take on responsibility for delegated healthcare tasks, such as wound care, insulin injections and verification of death (distinct from certification of death, which was still done by clinicians).

155. There was a general lack of support to ensure that providers and their staff were adequately trained, supported, and funded to complete these tasks. Getting sign off

on competencies by health professionals proved difficult, leading to unclear responsibilities and confusion regarding clinical care for homebound patients.

156. This was raised in the 2020 Social Care Taskforce chaired by David Pearson and is referenced in Recommendation 17 of that report [JT/050-INQ000574086] .

157. One of our homecare provider members was owned by a GP Federation. The GPs set up regular contact with homecare workers to ask for feedback about their patients at home. This became beneficial for the homecare workers because they had access to clinicians to raise concerns. This reduced risks for people at home and improved the professional security of the homecare workers, who usually bear a high level of responsibility in isolation. This was an exception rather than the norm.

158. Remote working by social workers in the COVID-19 pandemic resulted in a reduction in the number and quality of assessments of need. In April 2022, the Association of Directors of Adult Social Services reported a peak waiting list for assessment, review or the start of a service or direct payment of 542,000 [JT/051-**INQ000514939**]. A succession of ADASS surveys record between 400,000 and 500,000 people waiting for an assessment, review, direct payment or care package at any one time since 2021 [JT/052-INQ000581868] . Those waiting for assessment were at risk of deterioration and hospitalisation.

159. Delays in hospital discharges were also growing, with 24% of patients waiting for homecare during the winter months [JT/053-INQ000590762]. .

160. People whose care was being arranged by public sector bodies experienced significant delays in assessments of their care need. This meant homecare providers could not offer them packages of care until the local authority had assessed their need.

161. Members raised concerns with us about people's access to healthcare workers, and social workers. In particular, they were concerned about the quality of remote assessments by social workers and GPs. They felt that for many of the people they

cared for, who lived with communication difficulties or dementia, remote assessments were inaccurate. Packages of care were often inadequate, and it was only upon visiting a person's house for the first time that a care worker was able to determine this. For example, homecare providers were asked to start providing care and support for individuals without knowing, for example, that they were unable to mobilise or that they were hoarding. This meant care plans and assessment of time required were inaccurate.

162. At the beginning of the pandemic, our members notified us they were seeing a significant reduction in the number of care packages they were being asked to deliver. At the time, we were able to analyse the causes of this, and concluded that:

- Some councils chose to suspend care visits, to create more capacity in the community for hospital discharge, which did not materialise at scale.
- People shielding or self-isolating from the virus sometimes chose not to let carers in because care workers did not have appropriate PPE.
- Private clients chose not to continue with, or purchase, new packages of care. In some cases this was because family members were working from home or were furloughed and able to provide support for loved ones.

163. Data collected from a sample of providers in April 2020 suggested a negative impact of 15% on revenues of homecare providers as a consequence of this. (exhibit [JT/054-INQ000571018] .

164. As time went on, the demand for homecare services recovered. By late 2021/early 2022, our members became concerned that demand for their services was outstripping supply.

165. In large part, this was due to a shortage of homecare staff, which continued to escalate [JT/055-INQ000574059] . A number of central UK government policy decisions compounded this, which I will discuss later. These included ongoing underfunding of the sector, COVID-19 policies such as Vaccination as a Condition of

Deployment and competition from other sectors as the UK exited the European Union and the lockdowns lifted.

Nature and quality of care

166. Homecare providers continued to deliver in-person services throughout the pandemic. Homecare workers were often the only human contact for many older and disabled people living alone. They worked with extreme dedication to ensure safe and good quality care. Government guidance, especially in the first phase, was poor and confusing. It was hard for providers to gain answers to questions about policy and practice from the government, local authorities, the NHS or regulators. Many turned to organisations like the Homecare Association to help.

167. Homecare providers were also extremely concerned about the fact that the CQC paused and reduced its inspection activity. Homecare is a highly regulated sector and providers pay fees to be regulated by the CQC. The sector genuinely worried about the potential impact on care quality in some cases and lacked understanding about the reasons for the inspection pause. We challenged the CQC to continue with inspections. If broadcasters could speak to people at home via smartphone videos, why was the CQC not doing so?

168. We had little confidence that the CQC was focusing on inspecting homecare services, as they were diverting their attention to other services in the sector.

169. In contrast, members in Northern Ireland reported a high level of support from the RQIA. Providers felt they could ask colleagues at the regulator for practical advice on interpreting guidance and how to mitigate risk. Members in England reported experiencing only limited support from the CQC.

170. Although inspections of homecare services began to be phased back in during the time relevant to the Inquiry, satisfaction with the CQC dropped to an all-time low and has not recovered to pre-pandemic levels. The impact of the CQC's neglect of homecare services can be seen in their data. By August 2024, 60% of homecare

providers were either unrated (23%) or had severely outdated ratings (37%) [JT/056-INQ000571057] .

171. I outline in more detail later in my statement the change in regulatory approach and the impact this had on homecare providers (from paragraph 463).

Key worker status

172. Despite the vital services homecare workers were providing, the government did not prioritise them as key workers at the start of the pandemic. There was a disregard for people working in homecare. NHS workers were to take priority, and extending clapping to include social care workers did not shake this perception. Our members were deeply concerned about this as it had a detrimental effect on care workers' mental and physical health, and their ability to do their job.

173. Care workers feared for their own personal safety. Without key worker status, members told us that care workers were regularly being stopped by the police or vigilant members of the public. They assumed that care workers were breaking lockdown guidance by being out in public. Sometimes care workers were being verbally abused, and physically threatened because they were not at home. Care workers experienced this across the UK, feeling like an invisible force of front-line workers.

174. A member informed me about their work with the local authority to secure funding for private security in response to these concerns. This private security would escort care workers between homes while they were on shift.

175. Care workers were also unable to access priority shopping times or queues in supermarkets and other retail outlets. This had knock-on consequences for their ability to do shopping on behalf of the people they cared for and complete their visit schedule during a shift. This caused anxiety for care workers and safeguarding concerns for people who were being cared for. This issue extended into the personal lives of care workers, who could not shop for essential products in priority queues.

This meant some care workers went without food and essentials for themselves and their families.

176. Making the care workforce visible became an early priority, including via the distribution of the green 'CARE' badges. This served as the primary way care workers could identify themselves, although it's crucial to acknowledge that it didn't enjoy universal recognition like an NHS badge. Providers found it difficult to obtain badges. Initially this was due to technical difficulties with the website. Later, demand for the badges exceeded the number manufactured and production was discontinued.

Care workforce wellbeing

177. The wellbeing of care workers became an immediate and pressing concern. Care workers continued to enter people's homes despite having no clear understanding of the virus in the early days. Many experienced profound anxiety about potentially catching the virus or transmitting it to either the people they cared for or their own families. The burden of this responsibility, combined with the practical challenges of delivering care during a pandemic, placed unprecedented strain on the mental health of the workforce.

178. Senior staff and owners of homecare businesses faced immense pressure. Our member helpline received a surge of calls from worried managers trying to balance their duty of care to staff and service users while keeping their businesses viable as costs soared and essential supplies became scarce. The challenge of interpreting and implementing rapidly changing guidance, often published late at night or with minimal notice, created additional strain on already stretched management teams.

Workforce shortages

179. Workforce shortages threatened continuity of homecare delivery. Several factors contributed to this, including:

- Pre-existing workforce shortages arising from systemic challenges with retention and recruitment of care workers (from paragraph 96);
- Difficulty in accessing, purchasing and storing PPE;
- Lack of availability of testing;
- Self-isolation and access to the Infection, Prevention and Control Fund;
- Later, the policy of Vaccination as a Condition of Deployment.

180. During the peak of the COVID-19 waves, large numbers of homecare workers were self-isolating and unable to work. In some cases, our helpline was receiving calls where more than a quarter of the staff in an organisation were isolating. With the existing workforce shortages I outlined in paragraph 96 onwards, this became a serious issue for the continuity of homecare delivery. Many providers found it difficult to cover shifts, and because of a variety of reasons, staff could not take on extra work. These included caring responsibilities for children or other family members, health issues that limited their ability to work longer hours, and the need to balance multiple jobs or study commitments. In some cases, careworkers were also concerned that increasing their working hours could negatively affect their entitlement to benefits.

181. The lack of access to testing at the start of the pandemic and in later waves left providers unable to identify and isolate cases early, creating significant risks for both staff and those receiving care. I discuss this further from paragraph 202.

182. This had a huge impact on their mental health and wellbeing, causing many care workers to experience high anxiety and stress and change their family lives to protect others.

183. The compound impact of this was a substantial strain on staff during their usual shifts, and staff who were picking up additional hours to provide more care. Our workforce surveys (outlined in Annex D) showed that, during the time relevant to the

Inquiry, care worker exhaustion after the pandemic and work life balance were factors in care workers leaving the sector [JT/055-INQ000574059] .

184. The complexity of accessing funding via the Infection Control and Testing Fund, especially rounds two and three, added to financial pressures for care workers and providers. This fund was supposed to provide financial compensation for care worker testing. Care homes were given priority and homecare providers struggled to access funds.

Impact on care managers

185. Our members also raised concerns with us about the impact of the COVID-19 pandemic on registered managers of homecare services and other staff. These staff were under significant strain. They were having to manage staff shortages, ensure continuity of care, source PPE and communicate guidance changes, often at short notice late on a Friday night.

186. Little consideration appeared to be given by the central UK government to the practicalities of implementing measures and guidance when policy changes were being made (see paragraph 242 onwards for more on guidance). The central UK government did not develop guidance collaboratively, and people managing services often found themselves scrambling to understand complex guidance overnight. This came with acute levels of stress, worry, and concern about how to deliver services in a safe and compliant way.

187. Managers had to consider how they could protect care workers who were pregnant, or considered to be clinically vulnerable. For those staff, our members used the furlough scheme to support. Due to the nature of in-person care, it was not possible to redeploy care workers into other roles easily. To keep the services running during the worst staff shortages, many office-based staff were asked to provide care. These staff members took on roles they normally didn't do to make sure the people they cared for received support.

188. Although a relatively small number compared to other frontline professions, managers did need to consider the bereavement support some care workers needed. This is because care workers faced COVID-19 related deaths of the people they cared for and their co-workers. Our members were very concerned about the welfare of these care workers.

PPE shortages

189. Inadequate access to Personal Protective Equipment (PPE) emerged as the most urgent crisis. By early April 2020, our survey revealed that 80% of homecare providers lacked sufficient PPE [JT/057-INQ000581157] . The wholesale supply became almost impossible to locate as global shortages affected the health and care sector. When providers did secure orders, these were often commandeered at the point of delivery and redirected to the NHS, even when people had purchased supplies privately.

190. It is important for the Inquiry to understand that prior to the pandemic, face masks were not required for routine homecare delivery. Only gloves and aprons were used. FFP3 masks were worn in specific circumstances if supporting people with aerosol-generating procedures, for example, suction.

191. Prior to the pandemic, all homecare providers had regular orders and deliveries of gloves and aprons from business-as-usual suppliers of PPE. As explained in paragraph 65, 85% of homecare providers are SMEs with fewer than 50 employees. They typically operate from small offices with limited storage space. Most suppliers operate "just-in-time" deliveries, so few providers had stockpiles of PPE. When their regular orders did not arrive because they had been redirected to the NHS, there was no buffer.

192. A small number of larger homecare providers, which are part of international companies, had the resources and contacts to charter private jets to bring PPE from Asia to the UK in bulk. Their purchasing power meant they could negotiate lower

prices. For most small homecare providers, this was out of the question. They struggled with sourcing PPE and soaring costs.

193. At this time, the pressure on senior staff and owners of homecare businesses was huge. Worried homecare managers deluged our member helpline with calls, trying to keep their staff and service users safe, and their businesses afloat while costs rocketed and essential supplies like PPE were unavailable.

194. Care workers found themselves entering multiple homes each day without the protection needed. Some resorted to fashioning face coverings and other protective equipment from fabric, bin bags and other household items. A particularly memorable call to our advice line came from a provider who had finally managed to secure a limited supply of PPE from a veterinary supplier. This illustrated the extraordinary lengths providers went to in protecting their staff and clients.

195. We also saw significant issues where providers could not verify that PPE for sale met safety specifications. This put providers in an impossible position, potentially facing criminal liability for regulatory breaches if they worked without correct PPE, while being unable to source compliant equipment.

196. We experienced significant difficulty finding experts to talk to in the Health and Safety Executive about the correct specification required. Our enquiries bounced from one generic email address to another without being addressed. Colleagues at Public Health England (PHE) and DHSC were also slow to respond to our queries on these issues.

197. The lack of PPE provision to care workers who were directly caring for people with COVID-19 in March and April 2020 put care workers disproportionately at risk compared to health sector colleagues. The government redirected the supply of PPE for homecare, to the NHS. This left homecare workers without the equipment they needed.

198. In addition to this, homecare providers were disproportionately impacted by the rising costs of PPE. The Homecare Association sought to quantify this. In April 2020, we commissioned an independent analysis [JT/054-INQ000571018] of the additional costs that PPE and other infection control measures were adding to care delivery. This amounted to £3.95 per hour of additional COVID costs – a 25% increase on the median fee rate at that time [JT/058-INQ000574069] .

199. We raised attention to this in our blog [JT/058-INQ000574069] , wrote to officials at the Department of Health and Social Care and wrote to the Chancellor [JT/059-INQ000571074] . The first measure implemented was to provide temporary zero-rated VAT relief on PPE purchased for COVID-19. However, whilst this reduced costs, it did not resolve the fact that providers were still paying significantly more for PPE (and using more PPE) than they were pre-pandemic to deliver care. However, hourly rates for homecare remained the same. Zero-rated VAT did not resolve financial viability concerns.

200. Some free PPE became available via Local Resilience Forums from April 2020 but, in most regions, this did not meet providers' level of need. It wasn't until the PPE Portal began to operate in June 2020 that providers had better access to free PPE. In the early days of the Portal, providers also reported not being able to get sufficient PPE through that route to meet their needs. While the Infection Control Fund existed to cover some PPE related costs, local authorities mostly allocated these funds to care home providers. Some homecare providers did not receive any funding from this route during the first round. We raised concerns about this with the Chancellor in August 2020 [JT/059-INQ000571074] and with the Department of Health and Social Care in September 2020 [JT/060-INQ000571075] .

201. Eventually, the provision via the PPE Portal expanded to meet most providers' PPE needs, reducing additional costs. However, negotiations around the continuation of the PPE Portal raised doubt over how long this funding would continue and whether local authorities would increase hourly rates to fund PPE costs when it did not. Authorities typically made announcements regarding the

continuation of PPE funding in January, just after providers and commissioners commenced negotiations for the following financial year in December. The PPE Portal continued until 31 March 2024. Providers now pay for their own PPE. Arguably fee rates have not increased to compensate for this. Our research this year suggests only 1% of commissioners are covering necessary delivery costs in homecare [JT/016-INQ000571076] .

Testing issues

202. Access to testing emerged as a critical issue. Policymakers denied homecare workers routine testing for the first year of the pandemic. This increased their own personal risk, their family's risk and the risk to the people they cared for and those supporting them. The importance of testing people across social care did not appear to be recognised by policymakers.

203. The absence of testing for homecare workers created profound anxiety about asymptomatic transmission. Unlike NHS staff, homecare workers had no access to COVID-19 testing until mid-April 2020, and even then, only symptomatic testing was available. Asymptomatic testing would not be introduced until November 2020 and was not available in practice until January 2021. This left providers unable to identify and isolate cases early, creating significant risks for both staff and those receiving care. This had a huge impact on their mental health and wellbeing, causing many care workers to experience high anxiety and stress and change their family lives to protect others.

204. Members were really concerned about the risk of asymptomatic transmission to people being supported in their own home [JT/060-INQ000571075] . This was most severe with the highly transmissible Omicron variant in winter 2021/22. Although the policy changed to allow staff to return to work faster, there were shortages of lateral flow tests, making this difficult and causing some providers to struggle to secure tests. At the time, asymptomatic testing of care workers in the sector was via PCR test, so providers did not already have lateral flow stocks. I provide more detail on testing in paragraph 477 onwards.

205. When testing did become available, providers faced new challenges in managing the logistics of regular testing while maintaining service delivery. During periods of high staff absence due to self-isolation, many providers struggled to maintain adequate staffing levels, particularly given the pre-existing workforce shortages in the sector.

Hospital discharge policies

206. Hospital discharge policies compounded these challenges. The government's March 2020 directive to rapidly discharge patients without COVID-19 testing placed immense pressure on homecare providers. With no way to know patients' COVID-19 status, providers had to treat all new clients as potentially positive cases, further straining limited PPE supplies and complicating staff scheduling.

Insurance and public liability

207. This situation was also exacerbated by changes to insurance coverage. Insurers began adding exclusion clauses for COVID-19 to policies, leaving providers facing difficult decisions about accepting new packages of care for people with unknown COVID status. By early 2021, our survey revealed that 35% of providers had COVID-19 and/or other communicable disease exclusions from their Public Liability cover [JT/061-INQ000581159] .

208. Unlike other industries, the social care sector saw their insurance costs escalate and access to cover diminish. This disproportionately affected them. During this time, there were only two insurance companies willing to provide insurance products to the sector. In early 2021, we undertook a survey of our members [JT/061-INQ000581159] to understand this issue.

209. Our survey highlighted some serious concerns, including that:

- 72% of providers had seen their premiums rise.

- 35% of providers had COVID-19 and/or other communicable disease exclusions from Public Liability cover.

210. We discussed our concerns with the British Insurance Brokers' Association, HM Treasury and DHSC. We asked the government to consider agreeing to an indemnity scheme with the sector and create contingency plans in case the insurance market withdrew from the care sector completely. Neither of these materialised.

211. The impact of this was significant, and providers have now been left with much higher premiums; no, or extremely limited, Public Liability cover and only a few insurers to choose from. The loss of Public Liability cover created a high level of anxiety that providers would face future claims from employees and those in receipt of care who contracted COVID-19, compounded by the challenges of securing PPE, the delayed availability of testing for homecare workers and the lack of clarity in government guidance.

Financial pressures

212. The financial impact of these challenges was severe. Our analysis in April 2020 showed that COVID-19-related measures were adding £3.95 per hour to service delivery costs - a 25% increase [see my blog exhibited as JT/058-INQ000574069] . This included costs for PPE, higher staff absence rates, and enhanced infection control measures.

213. Simultaneously, revenues fell by approximately 15% as some clients cancelled services due to infection fears. The combined impact of rising costs and falling income created a 35-40% hit to most homecare businesses [JT/054-INQ000571018] . This proved particularly challenging given the sector's limited financial reserves, as detailed in paragraph 60 onwards. In 2018 [JT/012-INQ000571013] , we had estimated that only one in seven councils were paying a minimum rate for sustainable operations. Analysis of our initial data indicated that a 10-week outbreak

would equate to £273m in additional costs for the homecare sector. This meant that providers had low reserves and low resilience.

214. The Homecare Association worked with the Local Government Association and the Association of Directors of Adult Social Services to recommend changes to payment approaches by local authorities to help providers [JT/062-INQ000581358 . Many local authorities cooperated and started paying providers in advance for planned work, rather than in arrears for actual delivery. We want to express gratitude to many local authorities for this support, which was pivotal in sustaining services during the pandemic.

215. As public sector commissioners funded most homecare services at pre-agreed fee rates, providers could not cover increased costs by price rises. They did not have the ability, like other industries, to increase fees for their services. This left the sector disproportionately affected by rising costs but also disproportionately dependent on government intervention.

216. Decision makers took time to grasp how financial issues relating to the pandemic affected homecare providers. For example, decision makers initially assumed that homecare employers could cover the cost for the time staff spent testing, without any additional funds. It was clear to me that the financial predicament of the sector, which was not well understood prior to the pandemic, continued to be overlooked.

217. Additional funding for the sector was an urgent necessity, however it was slow to come. Although funding eventually arrived, it was often too late and only lasted for short periods. The systems for distributing and accounting for funds were bureaucratic and complex. With the stress of trying to ensure the delivery of compliant services, this complexity deterred some providers from accessing it, even when they desperately needed it.

Data

218. For many months, there was also a lack of quality and timely data on social care. With 153 different local authorities currently commissioning services in England, there were inadequate data on basics such as unmet need, waiting times for assessment and care, local authority expenditure and the number of people who received support. The lack of coordination in data collection led to providers receiving multiple data requests from local authorities, the NHS, DHSC, and the CQC.

219. For many providers, there was little perceived benefit in sharing data relating to service capacity as it did not result in any discernible change in support or decision-making. Nor did it help them with future planning. We have not addressed the issue of what, if any, impact this may have had on the number of homecare deaths or cases being reported, accurately or not. This is because, at the time of the COVID-19 pandemic, homecare providers did not need to report a death, unless the death may have been a result of the regulated activity or how it was provided. For example, if a person receiving homecare died after a heart attack at home or in hospital, it wass not necessary for a homecare provider to report this.

Government response and guidance

220. Our views on government guidance are discussed in more detail from paragraph 242. Early government guidance demonstrated limited understanding of homecare settings. Initial advice focused primarily on hospitals and care homes, with little consideration for the unique challenges of delivering care in people's homes. When homecare-specific guidance did emerge, it was often impractical or failed to account for operational realities. Initial guidance said there was no risk of community transmission from COVID-19 and that the risk of infection was very small, despite many thousands of people being cared for in their own home being required to shield or who were vulnerable.

221. The timing and communication of guidance created significant difficulties. New directives were frequently issued late at night or with minimal notice, leaving providers scrambling to implement changes. Our members reported particular stress around guidance published on Friday evenings, requiring managers to work through weekends to update procedures before Monday.

222. The complex structure of homecare services complicated the dissemination of guidance. Without a central channel for communicating with all providers, local authorities struggled to ensure consistent information reached those operating in their areas. This led to varying interpretations and implementations of national guidance across different regions.

Sector Adaptation and Coping Strategies

223. Providers demonstrated remarkable innovation in responding to these challenges. Many reorganised their workforce into separate teams - one caring for confirmed or suspected COVID-19 cases and another for those without symptoms. While this increased operational complexity, it helped manage infection risks with limited PPE supplies.

224. Digital capabilities evolved rapidly as providers sought new ways to support their workforce. Services that had previously relied on face-to-face supervision and paper-based systems quickly adopted remote working practices where possible. The Homecare Association's weekly webinars became a crucial forum for sharing emerging best practices and providing mutual support.

225. Care workers demonstrated extraordinary dedication during this period. Despite significant personal risk, particularly in the early stages when PPE was scarce and testing unavailable, they continued to provide essential care. For many isolated clients, these workers became their only human contact during lockdown, taking on an even greater emotional support role than usual.

226. The mental health impact on care workers was significant. Many experienced profound anxiety about potentially catching the virus or transmitting it to either the people they cared for or their own families. The burden of this responsibility, combined with the practical challenges of delivering care during a pandemic, placed unprecedented strain on the workforce.

227. The early pandemic response revealed both the sector's remarkable resilience and the devastating impact of systemic failures to understand and support homecare services. These initial months would set patterns of challenge and adaptation that would continue throughout the pandemic period, while exposing and exacerbating many of the pre-existing issues summarised in paragraph 136.

Evolving Crisis (July 2020-December 2020)

228. As the pandemic progressed beyond its initial acute phase, the homecare sector faced evolving challenges that tested its resilience in new ways. While some early issues began to resolve, other profound difficulties emerged or intensified, revealing deeper systemic vulnerabilities.

Development of response mechanisms

229. By July 2020, some improvements in PPE supply became evident through the PPE Portal, though access remained inconsistent. Local Resilience Forums had established supply chains, but our members reported vast variation in the amount of PPE made available to providers. Generally, the supply remained insufficient to meet their needs.

230. A significant issue arose on 29 September 2020, when new guidance required providers to switch from vinyl to nitrile gloves. This overnight change forced providers frantically to search for scarce and expensive nitrile gloves to comply with the new requirements. We later learned the guidance change was made in error and had not been approved through correct processes. Though reversed on 2 November 2020, providers had already incurred substantial costs.

231. Testing capabilities gradually expanded, though significant gaps remained. While symptomatic testing became available for care workers in April 2020, regular asymptomatic testing was not introduced until November 2020 and in practice until January 2021. This continued to create anxiety about potential transmission risks, particularly when supporting people who were shielding.

Financial Pressures and Market Stability

232. The financial impact on providers intensified during this period. Our sector surveys revealed a growing disparity between rising costs and static fee rates. Despite the pandemic increasing costs by £3.95 per hour (25%) and revenues falling by 15%, most local authorities had not adjusted their fee rates to reflect these pressures.

233. The Infection Control Fund, while welcome, heavily favoured residential care settings in its initial distribution. Some local authorities gave none of this funding to homecare providers, while others restricted it to providers with existing council contracts, excluding those serving self-funding clients or NHS-funded packages.

234. Insurance costs escalated significantly. By late 2020, providers faced a contracting insurance market with only two companies willing to provide coverage to the sector. This created additional financial pressure through reduced competition and rising premiums.

Workforce Challenges

235. Staff absence rates remained problematic throughout this period. Our helpline received regular reports of providers experiencing 15-25% staff absence due to self-isolation requirements. With pre-existing workforce shortages, this created significant challenges in maintaining service delivery.

236. The impact on care workers' wellbeing continued. Many reported high levels of stress and anxiety, particularly those supporting people with significant cognitive

impairments or communication difficulties. The use of PPE, especially face masks, created additional challenges in providing person-centred care.

237. We saw increasing concerns about the financial impact on care workers required to self-isolate. While the Infection Control Fund helped some providers maintain full pay for isolating staff, access to this support varied significantly by region and provider type.

Changes in Service Delivery

238. Providers continued to adapt their service models to manage infection risks. Many maintained separate staff teams for COVID-19-positive and negative clients, though this became increasingly complex as community transmission rates rose. Some providers reported having to reduce the frequency of visits for lower-priority care needs to maintain essential services with reduced staff availability.

239. The use of PPE in community settings created ongoing practical challenges. Guidance maintained that care workers providing personal care needed to wear masks, including when supporting people in public spaces. This brought unnecessary attention to people receiving care and felt disproportionate compared to guidance for the general public.

Regulatory changes

240. The Care Quality Commission's approach to regulation changed significantly during this period. The move to remote monitoring and risk-based inspection models proved particularly challenging to implement effectively in homecare settings. Unlike care homes, where remote monitoring could provide some insight into operations, the distributed nature of homecare services made meaningful remote oversight difficult to achieve.

241. Providers expressed serious concerns about the CQC's paused and reduced inspection activity. The sector worried about the potential impact on care quality in

some cases and lacked understanding about the reasons for the inspection pause. I discuss regulatory changes later from paragraph 463 onwards.

Government guidance and communication

242. The clarity and timing of government guidance remained problematic. Providers continued to receive updates late on Friday evenings, requiring managers to work weekends to implement changes. The guidance often failed to account for the practical realities of delivering care in people's homes.

243. Local variations in guidance interpretation created additional complexity for providers operating across multiple areas. Different public health teams often took varying approaches to similar situations, creating confusion and increasing the administrative burden on providers.

244. By December 2020, it became clear that the lack of a central channel for communicating with all providers was severely hampering effective response coordination. Many providers, particularly those serving self-funding clients, remained outside local authority communication networks.

Impact on care recipients

245. The prolonged period of isolation began to show concerning effects on people receiving care. Members reported accelerated cognitive and physical decline among some clients, particularly those with dementia. The suspension of day services and reduction in respite care created additional pressures on both formal and informal care arrangements.

246. Access to healthcare professionals became increasingly difficult. Our members raised serious concerns about the quality of remote assessments by social workers and GPs, particularly for people with communication difficulties or dementia. Care packages were often inadequate, and it was only upon visiting a person's house for the first time that care workers could determine true needs.

Later Pandemic Phases (2021-2022)

247. As the pandemic entered its second year, the homecare sector faced new challenges while continuing to manage ongoing pressures. The introduction of vaccines brought hope but also complex operational challenges, while workforce and financial pressures intensified in ways that would have lasting implications for the sector.

Vaccination Programme and Vaccination as a Condition of Deployment (VCOD) Policy

Roll-out of the vaccination programme

248. Priority was given to care homes for roll-out of COVID-19 vaccinations. Homecare providers initially struggled to access vaccines for their care workers. In January 2021, we asked the NHS to open the National Booking Service for homecare workers. They declined without providing a reason.

249. From 27-29 January 2021, the Homecare Association conducted a rapid survey of homecare providers' experience of vaccination of the homecare workforce [JT/063-INQ000574052] . The survey covered employers of staff who were in group 2 of the Joint Committee on Vaccination and Immunisation's priority list ("JCVI-2").

250. Responses were received from 379 providers and covered 111 (73 per cent) of the 153 Upper Tier authorities with responsibility for Adult Social Care in England. The sample represented employers of 27,210 homecare workers, the majority (95 per cent) of whom were in organisations mostly delivering "hourly" or "visiting" homecare. The remaining 5 per cent were working for "live-in" homecare providers, where homecare workers live full-time in the homes of the people they support.

251. Data indicated that around 32 per cent of the workforce in the sample already appeared to have been vaccinated. Given the numbers of staff involved and the extremely short period for these workers to obtain vaccination, it was to the immense

credit of everyone concerned, including local government, central government, the NHS, GPs, primary care networks and employers that this was achieved.

252. There was clear evidence of a strong willingness on the part of most homecare workers to be vaccinated.

253. This was an encouraging start. The data, however, showed a substantial variation in vaccination rates both within and between local authority areas. Some providers reported that almost all their eligible staff had been vaccinated whilst others reported none having received the COVID-19 vaccination.

254. This was a matter of timing; some local areas were well ahead of others, vaccinating members of the workforce even before the official "Standard Operating Procedure" was published. All local areas were progressing vaccinations.

255. Our data also showed that specialist providers of "live-in" care services faced additional challenges to obtain vaccinations for staff. This was because care workers were typically working with clients in a different local authority area from where their employers' office was based.

256. By 15 February 2021, the UK government aimed to have offered a first vaccine dose to everyone in the top 4 priority groups identified by the Joint Committee on Vaccination and Immunisation (JCVI):

- all residents in a care home for older adults and their carers
- all those 80 years of age and over and frontline health and social care workers
- all those 75 years of age and over
- all those 70 years of age and over and clinically extremely vulnerable individuals

257. Our findings suggested meeting the government target could prove a challenge given the rate of progress in some areas.

258. Skills for Care estimated there to be 715,000 jobs in homecare compared with 680,000 in care homes, so the homecare workforce was larger than the care home workforce and harder to reach because homecare workers are dispersed in their communities. This meant that effective communication between councils, employers and the workforce, as well as efficient organisation and logistics, was paramount.

259. Overall, 79 percent of responding providers had received contact from the councils where they were based. This was positive but, in many areas, there were challenges in ensuring that local authorities, the NHS and providers were in contact and working together. Feedback from our survey suggested that, in some areas, communication between councils and providers was not as easy or efficient as it could have been.

260. Examples of feedback from providers [JT/063-INQ000574052] included:

- *"We were missed off the initial email list as a private provider. It took me 6 days to find a contact who was responsible for the roll out for domiciliary care vaccinations. When I returned the forms I had to chase it up as they then stated they didn't receive my email although I attached delivery receipts to it and could see it had been delivered."*
- *"I had a phone call to send details over, but heard nothing… I sent them the details again, and a week later still nothing. At the beginning of the week I emailed the council and they were to let me know where we were at in the queue. Still nothing."*
- *"We received an email to send a spreadsheet of all staff eligible and their NHS numbers – we got it back to them within 24 hours – this was weeks ago and we have not heard anything since."*

261. Our findings showed that even in areas where councils were doing a really good job, a proportion of providers in the local area had not heard anything from their council. This was extremely frustrating for homecare workers and their employers.

262. The Homecare Association worked with colleagues in local government, central government and NHS England to ensure providers could identify themselves as having workers who need vaccinating.

263. We continued to lobby for the National Booking Service to be opened for homecare workers. This was eventually agreed after we published our survey in February 2021.

Vaccination as a condition of deployment (VCOD)

264. The announcement of Vaccination as a Condition of Deployment (VCOD) in 2021 created significant concern across the sector. Our survey in October 2021 [JT/064-INQ000574057] revealed that 65% of providers anticipated severe impacts on their businesses if the policy was implemented. Almost a quarter (23%) predicted they would lose 25% or more of their workforce.

265. The mere discussion of mandatory vaccination had immediate effects. During the five-month consultation period, the sector experienced a net reduction of over 18,700 staff (4%) (from data exhibited at [JT/065-INQ000574142]). This occurred at a time when providers were already struggling with unprecedented workforce shortages.

266. The policy particularly impacted London and other urban areas where vaccine hesitancy was higher. Some homecare businesses reported that over half their staff were unvaccinated. There was no government contingency plan for the loss of substantial numbers of workers.

267. The policy of Vaccination as a Condition of Deployment appeared to be pursued without regard to the scientific evidence available on the efficacy of the vaccine on transmission; or awareness of the fact that staff in the health and social care sector were effectively irreplaceable in those labour market conditions [JT/066-INQ000574073] .

268. From the outset, we strongly supported vaccination against COVID-19; there was clear evidence it helped to protect recipients from serious illness and death.

269. At the same time, we consistently argued that persuasion would likely be more successful than compulsion in achieving high vaccine uptake, especially among those with genuine fears. And we repeatedly stressed the need to balance the mitigated risk of infection with the risk of older and disabled people going without vital care.

270. In pressing ahead with regulations requiring vaccination as a condition of deployment in CQC-regulated wider care settings, including homecare, we believed the government had seriously misjudged this balance of risk.

271. We were deeply concerned that the safety and well-being of older and disabled people would be dangerously compromised by the loss of 15 to 20 per cent of the homecare workforce (75,000 to 100,000 careworkers, based on Skills for Care and DHSC data on workforce) as a result of these regulations. We believed the risk of hospitalisation and death from COVID-19 among people receiving homecare, particularly those who had been triple-vaccinated, was over-stated and unsupported by the evidence.

272. On 22 January 2022, we wrote to the Secretary of State, Rt Hon Sajid Javid, to urge the government to withdraw the regulations [JT/067-INQ000571058] . We exhibit his response as [JT/068-INQ000588680] .

273. As of 20 January 2022, 81.8 per cent of homecare workers had received two doses of COVID-19 vaccine, leaving over 18 per cent potentially ineligible for deployment after 1 April 2022. Further serious harm was likely to come to older and disabled people, their families and wider society if we were to lose 15 to 20 per cent of the homecare workforce (c. 75,000 to 100,000 careworkers) as a result of the VCOD regulations.

274. We questioned why the government would choose to force dismissal from 1 April 2022 of up to one-fifth of the homecare workforce, up to 100,000 careworkers, when there was already severely inadequate capacity to meet demand. There was no evidence of high death rates from COVID-19 in people's own homes and the scientific basis for justifying the regulations was weak.

275. There was also no contingency plan for loss of 10-20% of the homecare workforce overnight. This demonstrated a gross lack of understanding of the operations of the sector, working conditions or how fundamental care services are to people receiving support. The damage caused by this policy was disproportionate to the potential gain.

276. The UK government withdrew its policy of COVID-19 vaccination as a condition of deployment for health and social care workers on 15 March 2022 [JT/069-INQ000574120] .

Intensifying Workforce Pressures

277. By early 2021, workforce challenges had reached crisis levels. Our workforce surveys [JT/070-INQ000574058] , [JT/055-INQ000574059] painted an increasingly concerning picture:

- 91% of providers reported recruitment was harder than before the pandemic (July 2021)
- This rose to 95% by August 2021
- By November 2021, 98% reported increased recruitment difficulties
- 85% described recruitment as "the hardest it has ever been"

278. Staff turnover rates increased significantly during this period. Our surveys showed that 75% of providers reported more care workers leaving their roles than before the pandemic. Competition from other sectors, COVID-19 impacts, and migration policies all contributed to reduced workforce capacity.

279. The cost-of-living crisis began to affect retention severely. By March 2022, our survey revealed that 95% of providers were reporting staff anxiety about rising costs, particularly fuel prices. With 90% of homecare workers using their own cars to deliver care, the rapid rise in fuel costs created significant financial pressure.

Financial impacts and market stability

280. The ending of the Infection Control Fund in March 2022 had severe implications. Our April 2022 survey [JT/071-INQ000574061] showed that while 85% of providers had paid full wages to isolating staff while receiving the grant, this dropped to just 6% after the funding ended. Close to half (48%) of providers reported care workers seeking alternative employment due to issues regarding loss of pay while isolating.

281. By late 2021 [JT/070-INQ000574058] , 42% of providers reported having to hand back contracts to councils or the NHS due to insufficient staffing. A further 45% said they could not take on any new work. This created significant concerns about market stability and access to care.

282. The insurance market remained problematic. In early 2021 [JT/061-INQ000581159] , 72% of providers had seen their premiums rise, while 35% faced COVID-19 and/or other communicable disease exclusions from Public Liability cover. By 2022, the market had contracted to just two insurers willing to provide coverage to the sector.

Changes in service delivery

283. The emergence of new variants, particularly Omicron in winter 2021/22, created fresh operational challenges. Staff absence rates reached new highs, and a national shortage of lateral flow tests complicated the implementation of updated isolation guidance.

284. Digital transformation accelerated across the sector. Many providers who had previously relied on paper-based systems invested in new technology to support

remote working and improve communication. However, the 2021 People at the Heart of Care White Paper [JT/039-INQ000571019] noted that still only 40% of social care providers were fully digital.

285. Access to healthcare professionals remained problematic throughout this period. Our members continued to report difficulties securing support from mental health staff, social workers, physiotherapists, dentists and GPs. This often left care workers as the only professionals regularly visiting people in their homes.

Regulatory changes and oversight

286. Serious concerns remained about the Care Quality Commission's inspection regime.

287. The prolonged reduction in regulatory oversight created significant issues for providers:

- Difficulties demonstrating service quality to commissioners
- Challenges accessing insurance coverage with outdated ratings
- Challenges bidding for public sector contracts with outdated ratings
- Reduced ability to evidence improvements in quality
- Limited external validation of good practice

288. Our analysis of the CQC's data showed that by August 2024, 60% of homecare providers were either unrated or had severely outdated ratings. This included 23% of homecare locations that had not been assessed at all, and 37% with ratings that were 4-8 years old. I return to this in para 469.

Emerging inequalities

289. The pandemic's long-term impact revealed and exacerbated existing inequalities. Workers from ethnic minority backgrounds, who make up a significant proportion of

the homecare workforce, faced higher COVID-19 risks. Those living in multi-generational households experienced particular challenges with self-isolation requirements.

290. The financial impact on care workers became increasingly severe. With limited sick pay provision and high proportions of zero-hours contracts, many faced impossible choices between self-isolating when necessary and maintaining their income. This particularly affected workers with no recourse to public funds, who had limited access to government support schemes.

291. By mid-2022, these combined pressures had created a sector facing profound challenges to its sustainability. The pandemic had both exposed and deepened many pre-existing issues while creating new structural weaknesses that would require significant policy intervention to address. I discuss this further in the following section.

Disproportionate impacts

292. The pandemic's impact on the homecare sector was notably disproportionate compared to other sectors, exposing and intensifying existing inequalities while creating new ones. This uneven impact manifested across multiple dimensions, people receiving care, the workforce, and providers in ways that revealed deep structural vulnerabilities.

293. I discussed some disproportionate impacts on homecare in relation to PPE, testing and vaccination in earlier sections. I will now summarise key points and highlight some others.

Impact on care recipients

294. Policymakers lacked understanding of and failed to address the physical and mental health needs of people at home during the pandemic and the rising unmet need for health and care services.

295. The pandemic exposed and exacerbated existing inequalities across multiple dimensions. Those living in more deprived areas often had fewer choices about their care arrangements and less ability to supplement reduced formal care with private support. When services were reduced or suspended, these individuals were less likely to have alternative support networks to fall back on.

296. The impact on unpaid carers, who often supplement formal care arrangements, was particularly severe. The reduction or suspension of respite services and day centres left many managing increased caring responsibilities with reduced support. This disproportionately affected women, who make up the majority of unpaid carers.

297. Language barriers created additional challenges for both care workers and people receiving care from non-English speaking backgrounds. The rapid changes to guidance and infection control requirements proved particularly difficult to communicate effectively to these groups, potentially increasing their vulnerability.

298. The impact on people with dementia or cognitive impairments proved particularly severe. People with learning disabilities faced specific challenges. The use of PPE created significant communication barriers, and many had difficulty understanding the need for PPE. Changes to familiar routines and reduced social contact accelerated decline for many. Reduced access to community support services created particular stress. The inability to maintain familiar support patterns often led to increased anxiety and behavioural challenges. Research [JT/048-INQ000574089] summarized in EClinicalMedicine (2021) found that 14 out of 15 studies reported worsening or new onset of behavioural and psychological symptoms during isolation periods.

299. Digital exclusion emerged as a significant factor causing unequal impact. While some people receiving care could maintain social connections through technology, many lacked either the equipment or skills to do so. This digital divide particularly affected older people and those in more deprived areas, intensifying their social isolation.

300. Our Additional Closing Statement [JT/072-INQ000399544] on behalf of the National Care Forum, Homecare Association and Care England to the evidence of Dr Simon Case, in Module 2, paragraphs 3.1 and 3.2, refers to the lack of expert input to government committees on at-risk groups.

301. In his evidence, Dr Case accepted that the government committees formed to manage the pandemic had limited input from experts on at-risk groups. The Minister for Disabled People and the Minister for Equalities did not attend COVID-O and COVID-S meetings. They also ignored the heightened risk of domestic abuse during lockdown, which unequally affects women.

302. Dr Case admitted the government was slow to recognise and address the unequal impact of COVID-19 on ethnic minorities. They also ignored low-income individuals. These groups experienced higher mortality. The social care workforce has a higher proportion of people from minority ethnic groups than the general population. Many care workers also experience low and insecure income. It is clear that the government did not think enough about the experiences, rights, or needs of these groups during the pandemic.

Impact on workforce

303. The homecare workforce, already among the lowest-paid in the care sector, faced particularly severe challenges. The prevalence of insecure zero-hours contracts and limited sick pay provision meant many workers faced impossible choices between self-isolating when necessary and maintaining their income. This disproportionately affected those with no recourse to public funds, who had limited access to government support schemes.

304. Homecare workers were denied access to PPE and testing for longer than NHS and care home colleagues. Access to COVID-19 vaccinations for homecare workers was also slower than for NHS and care home staff.

305. The closure of the Infection Control and Testing Fund whilst care workers were still required to routinely test and self-isolate had a disproportionate impact on care workers. The Fund was used to pay care workers who were self-isolating their full pay [JT/071-INQ000574061] . When this ended, due to financial pressures, many employers reverted to paying care workers who were self-isolating statutory sick pay. At the time care workers knew people in other sectors of the economy that were working despite having COVID-19 and being paid; meanwhile they were required not to work (which was reasonable, given infection risk to clinically vulnerable people) and were not being paid full sick pay (which was disproportionate). This caused care workers to feel undervalued and consider working elsewhere for better pay.

306. Workers from ethnic minority backgrounds, who make up a significant proportion of the homecare workforce (for example, 26% of the workforce are people with a Black/African/Caribbean/Black British ethnicity, compared to 4% of the population in England), [JT/009 INQ000572390] faced higher COVID-19 risks. Those living in multi-generational households experienced particular challenges with self-isolation requirements, often lacking suitable space to isolate effectively.

307. Female workers, who comprised approximately 79% of the workforce [JT/073-INQ000590763] , faced additional pressures. Many found themselves managing complex competing responsibilities as schools closed and family care needs increased. Our members reported that female care workers often struggled to balance their professional duties with increased childcare responsibilities and caring for vulnerable family members.

308. The mental health impact on care workers was profound. Often the only professionals regularly visiting people in their homes, care workers took on additional emotional support roles while managing their own anxieties about virus transmission. The burden of this responsibility, combined with financial pressures and fear for their own families' safety, created unprecedented stress levels.

Effects on providers

309. The financial impact on providers proved particularly severe due to the sector's pre-existing funding challenges. Our analysis showed the pandemic increased costs for homecare providers by £3.95 per hour (25%) while simultaneously reducing revenues by 15% due to decreased demand [JT/054-INQ000571018] . This amounted to a 35-40% impact on business finances, which proved especially challenging given the sector's limited financial reserves.

310. Small and medium-sized providers, which comprise over 85% of the sector, faced the greatest challenges. Without the economies of scale or financial buffers of larger organisations, many struggled to absorb increased costs for PPE, staff absence, and enhanced infection control measures. The impact was particularly acute for providers serving predominantly state-funded clients, as public bodies rarely adjusted fee rates to reflect these additional costs.

311. Access to support funding revealed significant inequities. The distribution of the first round of Infection Control Fund heavily favoured residential care settings. Some local authorities gave none of this funding to homecare providers. Others restricted access to providers with existing council contracts, excluding those serving self-funding clients or NHS-funded packages. This created a two-tier system of support that disadvantaged many providers.

312. These disproportionate impacts have created lasting implications for the sector's recovery. They have highlighted the need for more targeted support mechanisms and a better understanding of how crisis responses can either mitigate or exacerbate existing inequalities. This learning must inform future emergency planning to ensure more equitable responses to future crises.

Analysis of key government decisions and their impacts

313. Analysis of the government's response to the pandemic reveals significant shortcomings in how the needs of the homecare sector were understood and

addressed. The absence of social care expertise in key decision-making bodies had profound implications for the quality and applicability of policy decisions throughout the crisis.

Use of PPE

314. Guidance for social or community care and residential settings on COVID-19 published on 25 February 2020 [JT/074 INQ000114411] stated: "During normal day-to-day activities facemasks do not provide protection from respiratory viruses, such as COVID-19 and do not need to be worn by staff in any of these settings. Facemasks are only recommended to be worn by infected individuals when advised by a healthcare worker, to reduce the risk of transmitting the infection to other people. It remains very unlikely that people receiving care in a care home or the community will become infected".

315. This decision revealed a lack of understanding of people receiving social care and the nature of care work. It made little scientific sense and placed those giving and receiving care at unnecessary risk.

316. Homecare providers chose to disregard this guidance and attempted to procure face masks, which were not routinely used in homecare before the pandemic. As already discussed, PPE was hard to obtain. Providers therefore went to extreme lengths to source masks and some had to make their own PPE.

317. The government withdrew this guidance on 13 March 2020.

Discharge from hospital

318. One of the most consequential early decisions was the March 2020 directive mandating rapid hospital discharges without COVID-19 testing. This placed homecare providers in an impossible position. They had to decide whether to accept people with unknown COVID-19 status while lacking adequate PPE and testing capability. The policy prioritised hospital capacity over the safety concerns of the social care sector.

319. In the early pandemic, April 2020, officials issued guidance for care workers to wear PPE when caring for someone with COVID-19. This meant care providers had to source significant amounts of PPE to enable safe discharge from hospital. However, providers were in many cases unable to secure it. When they could secure it, it involved long discussions with local hospitals and local authorities. We called for better access for testing in order to target PPE supplies [JT/075-INQ000574087] . As PPE supply became more readily available in the second phase of the pandemic, this issue eased.

320. This decision also affected the operational delivery of care services. This was because many providers had tried to reduce transmission with limited PPE. To do this, they separated teams, so one team of care workers provided care to people who had tested positive for COVID-19 and another to those who had not. Providers often called this "cohorting staff." When new clients had unknown COVID-19 status on discharge from hospital, this made risk mitigation such as the cohorting described difficult to implement.

321. In the section beginning at paragraph 207, I highlight our concerns about the reduction in available insurers and insurance for the homecare sector during the time the Inquiry is interested in.

322. This was a particular issue in relation to services accepting new packages of care for someone who tested positive for COVID-19. In this case, insurers were adding exclusion clauses to policies, which meant providers would not be insured for the care of those who tested positive for COVID-19.

Key worker status

323. The initial failure to recognise care workers as key workers had severe practical consequences (from paragraph 172). Unlike their NHS counterparts, homecare workers faced challenges accessing priority shopping, encountered police questioning while travelling to provide care, and struggled to access childcare. This

reflected a fundamental lack of understanding about the essential nature of homecare services.

Shielding

324. The Prime Minister announced the Government's plan to shield those with serious conditions who were particularly vulnerable to COVID-19 infection on 22 March 2020. Many people who were told to shield were recipients of homecare services. They already had health conditions that would put them at a very high risk of severe illness if they caught COVID-19. I discuss shielding for workers in more detail from para 526.

325. This guidance had an immediate impact on the availability of care workers and the delivery of homecare services.

326. Our Module 2 closing statement [see paragraph 2.12 of JT/072-INQ000399544] highlighted the lack of planning that the government undertook into the impact of shielding on the availability of social care. The government's planning focused on modelling NHS capacity, identifying potential breaches, and determining actions to prevent hospital overloads.

327. In his public evidence, Professor Neil Ferguson revealed that SPI-M-O had not modelled the impact on social care before 23 March 2020:

> 328. "*I mean, that's true, we modelled — all the models had age-related risk in them, and we were looking at shielding options for the elderly, but no models explicitly represented the care sector. They did represent hospitals, in some sense, but we didn't represent nosocomial — hospital-based transmission.*" 10 [17/169/1-7] Transcript of Professor Neil Ferguson

329. The implementation of shielding guidance demonstrated limited consideration of its impact on the homecare sector. While intended to protect vulnerable individuals, the policy created significant operational challenges for providers who had swiftly to

identify which staff and service users needed to shield, while managing the resulting workforce shortages.

330. The delayed inclusion of homecare workers in regular testing programmes proved particularly damaging. While NHS staff received priority access to testing from early in the pandemic, homecare workers did not receive access to asymptomatic testing in practice until January 2021. The policy change was announced in November 2020 but test kits were unavailable until January. This ten-month delay left providers unable to effectively manage transmission risks.

Care workers

331. Homecare providers undertook risk assessments of their highly vulnerable care workers to identify those unable to work as usual. Although the NHS was supposed to send letters to people informing them if they should be shielding, not everyone received a letter, and some of the data the NHS held was inaccurate. This made it difficult for homecare providers to assess which of their staff needed to shield.

332. Care providers resorted to the furlough scheme for their care workers required to shield as delivering personal care from home and behind a laptop was not possible.

333. Losing shielding care workers had a big impact on the usual delivery of care for many homecare providers. In the early stages there were reports of increased absence - up to 15% of staff in some cases, due to staff shielding or self-isolation. Registered Managers and Care Coordinators quickly had to revise rotas and people receiving care had a change of team. For those receiving care with more complex needs, it also required new care workers to be trained in the needs of that person. Recruiting additional staff was not an option for short-term cover.

334. When care workers were furloughed, staff had to revise rosters and inform clients if their usual care worker could not visit. Substitute staff had to be trained in the needs of recipients of care, which was challenging given that lockdown was in place by then.

People receiving care

335. Many people who were told to shield were recipients of homecare services. Providers had to identify which of the people they cared for may need to shield and understand how they could implement infection control measures to lower the risk of transmission.

336. Some people chose not to receive care during this period and cancelled their care packages. The risk of infection from visiting care workers scared them. The lack of PPE made available to social care made the situation worse. This meant people receiving care were living in fear. When their care workers turned up in bin bags, rather than aprons you can begin to understand why.

337. For those who continued with their care packages, their care workers became the only people they saw. This meant that care workers experienced an even greater emotional toll than usual. It also meant that these people became dependent on care workers for shopping and important services like obtaining medication. Local authorities did not always recognise this in their commissioning.

Availability of care

338. For some care providers, their clients shielding and cancelling packages had a significant impact on their financial viability. At a time when costs of delivering services were increasing rapidly, they found their income reducing and the very real threat of business closure. I outline earlier in my statement from para 69 the financial impact of the pandemic on providers. This was one element of this.

Lockdown

339. When the first lockdown began on 23 March 2020, homecare providers had to adapt rapidly to the consequences for our sector. Unlike many other industries, the social care sector could not shut down or reduce its services.

340. Back-office functions moved to remote operations, and methods of communication with health professionals and other important people in their clients lives changed. Earlier in my statement I outline the impact of these changes from para 147.

341. There was a significant change to the regulatory approach from the Care Quality Commission. The Care Quality Commission stopped inspections and started remote working for inspectors. This left many providers without practical support or advice. I outline more about the impact of the change of approach later in my statement. See from para 463.

Training

342. The lockdown had an impact on staff training and supervision. Providers moved meetings and group face-to-face activities to a remote setting. This meant training on topics like moving and handling of people, which traditionally involved face-to-face demonstrations, had to be moved online, which was not ideal. This also affected the use of PPE, for example, face-to-face fit testing of FFP3 masks where they had to be used.

Impact on care workers

343. As I outlined earlier in my statement (from para 172), people often assumed care workers were breaking lockdown rules when they were visiting people who needed care. Police were generally supportive once care workers explained their role, but the lack of an immediate way for care workers to be recognised as key workers was a problem in the early pandemic.

344. There was a lack of thought about the economic consequences on homecare services by government and decision makers. In paragraphs 4.1 and 4.2 of our joint Additional Closing Statement [JT/072-INQ000399544] , we refer to Dr Case's testimony which revealed the government had limited data and discussion about the economic consequences of lockdown measures, which likely exacerbated existing

inequalities. For the social care sector, which employs a significant proportion of low-income and ethnic minority workers, government failure to consider and mitigate the financial impact of the pandemic response was particularly damaging. Care workers lost income because of isolation requirements, without adequate government support or compensation.

Stopping care packages

345. I have outlined in my statement that some people who were advised to shield chose to cancel their care packages. This was also the case for people who were not advised to shield. Our members told us that many families were so scared about the transmission of COVID-19 that they withdrew from packages of care during lockdown. This was more evident in the early stage of the pandemic. Due to the complex nature of people's care, our members were concerned about whether family carers could provide the appropriate level care for their loved one. The numbers of withdrawals ranged from 4.6%, to 15% of service users.

Increasing need

346. Lockdowns also had profound effects on people receiving care. People receiving care had limited family support due to lockdowns. This placed additional strain on homecare services. Care workers were often the only people providing care and support in people's homes.

347. People could not undertake their regular outings to visit day centres, loved ones living in care homes, friends and family. Social isolation became a serious problem with adverse effects on people's physical and mental health. Many with conditions like dementia became worse, as they struggled to understand the changes in routine.

348. There was no extra support available to mitigate these effects. Homecare services were left to fill the gaps in service provision and do the best they could for the people they cared for.

Vaccination as a Condition of Deployment

349. The Homecare Association consistently supported vaccination against COVID-19, recognising the clear evidence that it protects recipients from serious illness and death (para 268). However, we took a strong position against making vaccination mandatory for care workers, based on our assessment of the risks and implications for the sector [JT/066-INQ000574073] . A key risk was the projected loss of 10-20% of the workforce.

350. It was our view that the policy appeared to be pursued without proper regard to two critical factors: first, the scientific evidence; and second, the fact that staff in the health and social care sector were effectively irreplaceable in those labour market conditions.

351. The UK government failed to consider the impact of introducing the VCOD policy on recruitment and retention in the sector. This was further compounded by exiting the European Union and more available work in other sectors such as retail and hospitality.

352. The mere announcement and consultation process had immediate negative effects on staffing levels. During the five-month consultation period, the sector experienced a net reduction of over 18,700 staff, representing 4% of the workforce [JT/065-INQ000574142] . This loss occurred at a time when providers were already grappling with unprecedented workforce shortages.

353. The impact was particularly severe in London and other urban areas where vaccine hesitancy was higher. Some homecare businesses reported that over half their staff were unvaccinated. Despite these concerning figures, the government failed to produce any contingency plan for the potential loss of substantial numbers of workers.

354. We consistently argued that persuasion would be more effective than compulsion in achieving high vaccine uptake, especially among those with genuine fears. We

repeatedly stressed the need to balance the mitigated risk of infection against the risk of older and disabled people going without vital care.

355. The lack of any contingency planning for an overnight loss of 10-20% of the homecare workforce demonstrated, in our view, a gross lack of understanding of the sector's operations, working conditions, and how fundamental care services are to people receiving support.

356. We believed the government had seriously misjudged the balance of risk. We were deeply concerned that the safety and well-being of older and disabled people would be dangerously compromised by the loss of such a significant portion of the workforce. The risk of hospitalisation and death from COVID-19 among people receiving homecare, particularly those who had been triple-vaccinated, appeared to be over-stated and unsupported by the evidence.

357. Also, I have previously outlined in my statement (see from para 121), the sector is complex and the VCOD policy did not cover the whole homecare sector. This was because it was not being applied to those delivering unregulated care such as personal assistants or to others visiting people's homes who were not performing regulated activities.

358. The damage caused by this policy was, in our assessment, disproportionate to any potential gain. This view was ultimately validated when the UK government withdrew its policy of COVID-19 vaccination as a condition of deployment for health and social care workers on 15 March 2022.

Funding for the sector

359. During the time relevant to the Inquiry, the UK government made funding available for the social care sector. This included a series of three Infection Control Funds which were aimed at supporting the sector with some of the impacts previously described in my statement. Local authorities distributed these funds in

June and October 2020 and October 2021. While these funds were welcome, their accessibility was problematic for the sector.

360. Decisions to fund the sector seemed to mirror the wider lack of understanding of the sector as I outlined in the section beginning at para 51. Homecare was not adequately or fairly treated in accessing these funds, and the funding heavily favoured residential care settings.

361. 75% of the first Infection Control Fund went to care homes. Local authorities distributed the remaining 25% based at their discretion. Homecare services received roughly half of the remaining 25%. Some local authorities gave none of this funding to homecare. Others gave it only to providers who contracted with them [JT/076-INQ000571021] . This meant that many homecare providers did not receive any funding from the Infection Control Fund, or a limited amount.

362. As a result of our lobbying, the second and third Fund allocations reached homecare services more consistently than the first. Access to these funds was important to support providers with the additional cost of testing and self-isolation for their staff.

363. During 2022, the UK government decided to end the Infection Control Fund. This was despite continuing to require homecare staff to undertake asymptomatic testing and to not attend work when they tested positive for COVID-19.

364. This came at a significant price to homecare providers and their care workers. We understood from our members they had no choice but to make substantial reductions in the sick pay that care staff received when they were self-isolating/off work because of COVID-19 [JT/071-INQ000574061] .

365. During the third Infection Control and Testing Fund, 85% of members responding to our survey said they were paying full wages to staff who were self-isolating due to COVID-19 when they were accessing the fund. When the funding ended, this reverted and homecare providers were only able to pay Statutory Sick Pay. This

raised significant concerns. Feedback from members [JT/071-INQ000574061] included:

- "Care workers are asking for holiday so that they have some income whilst they are required to isolate as they cannot afford the loss of income."
- "We, like others in the sector, are concerned that without the ability to pay full sick pay, staff will not register positive test results and may choose to leave the sector for industries where they can work if well enough to do so following a positive test."
- "We cannot sit back and not support the staff who are isolating. We are juggling finances around to ensure we top up their wages for this period, but this is not sustainable moving forward. We are using reserves to do this, but the government has to support the sector, otherwise it will be financially not sustainable, staff will leave, or we will not be a financial position to continue."
- "We are very worried about how we will survive whilst paying people to be off sick (some managers paid full pay) and paying full pay for carers to cover. We cannot take on new service users as we are terrified [that] staff will be isolating and we won't be able to cover."

Understanding of the homecare sector

366. The pandemic exposed critical gaps in understanding of homecare at senior government levels, which significantly impacted policy decisions and their implementation. Our direct experience engaging with ministers and civil servants revealed concerning limitations in their grasp of how homecare services operate, the people they support, and the sector's vital role in the wider health and care system.

367. When the pandemic started, the Minister for Care, Helen Whately MP, had only been in role for about one month and had not had time to build relationships or sector knowledge. Minister Whately worked hard to rectify this. We want to put on record our thanks for her diligence in seeking to master her brief and being willing to

listen and act. As a junior minister and not a Secretary of State, it is likely she was excluded from key government decision-making meetings to advocate for the social care sector.

368. When the Minister for Care started, the civil service team responsible for Adult Social Care in DHSC had only 50-60 FTEs and no Director-General. The most senior role was a Director. Invitations to important government decision-making meetings included only the most senior-ranking civil servants. This meant social care had no voice in important discussions involving civil servants in Whitehall. This was rectified in June 2020 when the Director was promoted to Director-General.

369. At the outset of the pandemic, some of the civil servants with most experience of adult social care in DHSC were moved elsewhere. I recall there being only one director, two deputy directors and just over 50 FTEs. There was inadequate experience and resource to cope with the scale of the challenges we faced. In June 2020, three new Directors joined the adult social care team in DHSC. There was then rapid expansion of civil service teams. DHSC will provide the Inquiry with details. My recollection is that the number of civil servants in the adult social team at DHSC increased from just over 50 FTEs to over 350 FTEs in subsequent months. For many, it was their first experience of adult social care.

370. The Homecare Association and our partners spent considerable time providing informal inductions to officials about basic sector operations. This included explaining fundamental aspects like how services are commissioned, the relationship between fee rates and workforce pay, and the practical realities of delivering care in people's homes. Even after these efforts, we saw little evidence of improved understanding reflected in subsequent guidance. This was not helped by many new recruits and high turnover in civil service teams.

371. The lack of understanding manifested in several ways. First, homecare was frequently overlooked in initial pandemic planning and response. Despite supporting nearly one million people - significantly more than in residential care - homecare was often treated as an afterthought in policy development. When provision was made

for social care, there was a persistent tendency to conflate 'care homes' with the entire 'social care sector', leading to guidance and support mechanisms that failed to account for the unique challenges of delivering care in people's homes.

372. The distributed nature of homecare services, with care workers travelling between multiple households daily, created distinct operational challenges that policy often failed to address. For example, early PPE guidance demonstrated limited understanding of how care is delivered in community settings. The initial February 2020 guidance stating there was "no risk of community transmission" and that facemasks were unnecessary during "normal day-to-day activities" revealed a fundamental misunderstanding of the close personal care provided by homecare workers.

373. Communication mechanisms revealed fundamental misunderstanding of sector structure. Unlike the NHS, homecare lacked coherent channels for disseminating information quickly to all providers. The government's reliance on local authorities to distribute information and resources proved problematic, as many only maintained contact with providers they contracted with directly.

374. There were some improvements in understanding as the pandemic progressed. Through persistent engagement, we developed stronger relationships with civil servants in the DHSC. However, the initial lack of social care expertise in key decision-making bodies like the Scientific Advisory Group for Emergencies (SAGE) and Public Health England had far-reaching consequences for policy development and implementation.

375. The timing and method of guidance distribution revealed systemic problems in understanding sector operations. New requirements were frequently issued late at night or before weekends, demonstrating limited grasp of how providers manage service delivery and implement changes. The personal liability carried by Registered Managers for regulatory compliance created additional stress when trying to interpret and implement rapidly changing guidance.

376. Financial support mechanisms demonstrated limited understanding of sector economics. The routing of emergency funding through local authorities failed to account for providers serving self-funding clients or NHS-commissioned care. The complex distribution of the Infection Control Fund created unnecessary barriers to accessing vital support, particularly for smaller providers with limited administrative capacity.

377. Decision-makers showed limited understanding of workforce dynamics in homecare. The delayed recognition of care workers as key workers had serious practical implications, including difficulties accessing essential supplies and services. The implementation of Vaccination as a Condition of Deployment (VCOD) policy demonstrated insufficient grasp of existing workforce pressures and likely impact on service delivery.

378. The government's focus on protecting NHS capacity often came at the expense of understanding social care needs. The March 2020 hospital discharge policy, mandating rapid discharges without COVID-19 testing, showed limited appreciation for the challenges this created for homecare providers already struggling with PPE shortages and workforce pressures.

379. The experience in devolved administrations varied. In Northern Ireland, for example, the Regulation and Quality Improvement Authority demonstrated better practical understanding of homecare operations and provided more hands-on support to providers. This contrasted with the experience in England, where the Care Quality Commission's approach suggested limited appreciation of the risks in homecare.

380. Looking ahead, this experience demonstrates the critical importance of ensuring social care expertise is embedded in emergency planning and response mechanisms. Future preparedness requires a much deeper understanding of the homecare sector's unique characteristics, operational realities, and vital role in supporting independence and wellbeing in communities.

Engagement, consultation and communication

381. The government's engagement and consultation with the homecare sector during the pandemic was often inadequate, poorly timed, and demonstrated limited understanding of operational realities. While some improvement occurred as the crisis progressed, initial communication channels proved insufficient for the scale and urgency of the challenges faced.

382. The Director for Adult Social Care in DHSC, Rosamond Roughton, worked in a highly collaborative and supportive manner during her tenure, which ended in June 2020. We want to record our thanks to her. The situation would have been much worse without her thoughtful and inclusive approach.

383. The Director for Adult Social Care at the DHSC stood up a National COVID-19 Planning Group, which first met on 6 March 2020. Key representatives from across the social care sector were invited to participate. Quite quickly, though, it became apparent that separate working groups were needed to deal with the multiple issues arising. We were involved in at least 12 groups and many meetings on a range of topics, including:

- Workforce
- Care recipients and informal carers
- PPE
- Financial sustainability
- Insurance
- Collecting and using the right data
- Emergency coronavirus legislation
- System assurance and regulation
- Hospital discharge

- Developing practice guidance
- Testing
- Vaccination (COVID-19 and influenza).

384. On 17 March 2020, Lord Agnew, Minister responsible for procurement in the Cabinet Office, made contact with me [JT/077-INQ000571078] . He wanted to know how much PPE was needed and how to distribute it to care providers. It appeared the government had no detailed emergency plans for social care. We, therefore, had to help officials and ministers with emergency planning and logistics on the hoof. I wrote to Lord Agnew on 17 March 2020 to explain the issues [JT/078-INQ000573879] . Because of a lack of involvement of anyone from social care provision in SAGE, we had no sight of scientific modelling or access to relevant data and were left to guess requirements.

385. In the early stages of COVID-19, there seemed to be no project management or coordination of government efforts in key areas. With PPE, for example, well-meaning civil servants in different government departments, including the Foreign Office, Department for Business and Trade, DHSC and the Cabinet Office, contacted us asking for meetings and offering help. Later, appointment of a PPE "Tsar" improved communication and coordination. There was also insufficient resource to investigate and manage offers of PPE supplies from around the world. Our over-riding experience was of chaos and frustration.

386. Early pandemic decision-making revealed significant gaps in consultation processes. Critical decisions affecting homecare were often made without meaningful sector input. For example, the February and March 2020 guidance on PPE use was developed without consultation with homecare providers or representative bodies, leading to impractical recommendations that failed to account for how care is delivered in people's homes.

387. We made repeated efforts to get PPE guidance altered when it was inappropriate or lacked clarity for the homecare sector. We raised concerns at DHSC's Adult

Social Care Personal Protective Equipment (PPE) Task and Finish Group, when guidance was inappropriate or lacked clarity for the homecare sector. These requested changes did not happen.

388. We warned [JT/066-INQ000574073] that implementing a policy of vaccination as a condition of deployment in homecare risked the loss of 15-20% of the workforce [JT/067-INQ000571058] . Initially, the government disregarded our views and continued to implement the policy. As I outline in para 264, by the time this decision was made, the sector had already suffered a serious loss in its workforce.

389. The quality of engagement varied significantly across different government departments and agencies. The DHSC gradually developed more effective consultation mechanisms as the pandemic progressed, particularly through groups like the Adult Social Care COVID-19 Support Taskforce, established in June 2020. However, other organisations crucial to the pandemic response, such as Public Health England, maintained that social care fell outside their remit.

390. Communication with other agencies was also challenging. The Health and Safety Executive was particularly difficult to engage with, and the Care Quality Commission demonstrated limited responsiveness during this period. While we did have some engagement with HM Treasury regarding insurance-related issues, this did not lead to any meaningful action.

391. Public Health England's position that social care fell outside its remit created significant gaps in public health expertise and support. Witness Statement of Professor Yvonne Doyle CB, Medical Director and Director for Health Protection INQ000273878_0020, dated 17 October 2023, paragraph 56, states 'PHE had no formal remit for the social care sector.' This artificial separation between health and social care hampered effective response coordination and left the sector without crucial public health guidance tailored to its needs. The delayed creation of the SAGE Social Care Working Group, which did not appear on public lists until January 2021, further demonstrated the initial exclusion of social care expertise from key decision-making bodies.

392. When consultation did occur, it was often rushed or superficial. The implementation of Vaccination as a Condition of Deployment (VCOD) typified this approach. Despite the sector raising serious concerns about workforce implications, the policy proceeded without adequate consideration of operational impacts or contingency planning for potential staff losses. Our survey in October 2021 [JT/064-INQ000574057] showed 65% of providers anticipated severe business impacts, yet these warnings went largely unheeded until the policy was eventually reversed.

393. The timing of communications proved particularly problematic. Guidance was frequently issued late at night or immediately before weekends, leaving providers and Registered Managers scrambling to interpret and implement changes. One particularly challenging example occurred in September 2020, when guidance requiring providers to switch from vinyl to nitrile gloves was issued without warning, forcing providers to frantically search for scarce supplies. The guidance was later revealed to have been published in error.

394. Documentation and clarity of communication also proved challenging. Guidance was often lengthy, complex, and failed to account for the practical realities of service delivery. The frequent need for sector bodies like the Homecare Association to interpret and explain guidance highlighted weaknesses in direct communication from government to providers.

395. Communication channels between central government, local authorities and providers were inadequate. Unlike the NHS, which had established mechanisms for disseminating information, social care lacked coherent systems for reaching all providers quickly.

396. It was even difficult for the DHSC to access decision-making levels in local authorities quickly and easily. This is because there was no regional structure or routine meetings for council decision-makers in place. The government's reliance on communicating with Directors of Adult Social Services (DASSs) in local authorities as primary channels had limitations. Directors have fewer decision-making powers than local authority Chief Executives. Most local authority adult social care

departments maintained contact only with providers they contracted with directly. This meant they had limited or no contact with other providers, such as those serving self-funding clients or providing unregulated care.

397. Regional variations in communication and engagement created additional difficulties. Local authorities often interpreted national guidance differently, leading to inconsistent implementation across areas. Providers operating across multiple regions faced challenges managing these variations, especially when local interpretations conflicted with each other or with national guidance.

398. The Homecare Association worked to bridge these communication gaps, participating in numerous government working groups and decision-making forums. In time, we came to be regarded as a trusted and expert voice on the homecare sector. We used these relationships to raise awareness of the impact of policy decisions with core decision makers and civil servants.

399. We also worked with colleagues in the LGA and ADASS to try to address problems arising between local authorities and providers because of variation in guidance or poor communication.

400. The creation of the Social Care COVID-19 Support Taskforce in June 2020, led by Sir David Pearson, while it helped to coordinate a response, came too late.

401. We co-chaired the Workforce Advisory Group, which was a sub-group of this Taskforce. The government simply ignored many of the recommendations made by this sub-group, especially those regarding financial support for the care workforce

402. 'Top priority' recommendations made by the Workforce Advisory Group [report exhibited as JT/079-INQ000532336]), that were not fully implemented included:

- Implementing measures to retain experienced staff (e.g., a loyalty bonus);

403. Reviewing and implementing a new career-based pay and reward structure for social care;

- Providing a loyalty bonus for workers remaining in one location;
- Investing in occupational health services;
- Mental health first-aid; and bereavement services;
- Promoting a positive view of occupational health;
- Providing training for employers on managing sickness/absence, prioritising campaign planning;
- Ensuring free vaccinations for the social care workforce, which was partially implemented.

404. Of the 'Highly Important' recommendations from the Workforce Advisory Group that were not implemented, or not fully implemented included: rapidly assessing staffing needs of the social care sector; addressing barriers to enabling nurse returners and nursing students to join the social care workforce; reinforcing development of extended or delegated roles through training and support; providing temporary arrangements to mitigate the impact of the points-based migration system (changed were not made until 2022); and maximizing the use of available volunteers. It was not clear to us whether the Government had a strategy to increase take up or amend ineffective initiatives.

405. We shared our concerns in 20 government department consultations and made 13 written and oral submissions to Parliamentary Committees and APPGs from 1 March 2020 (see Annex A and Annex B). In each case, where appropriate, we explained how the pandemic affected the homecare sector and offered recommendations to make the proposals in the relevant consultations practical for our sector and the people who receive homecare services.

406. We attended over 12 different working groups, providing rapid feedback on policy proposals and highlighting operational implications. However, our ability to influence outcomes was often limited by the speed at which decisions were being made and the lack of established processes for incorporating sector feedback.

407. There were some positive developments in engagement as the pandemic progressed. The creation of regular stakeholder forums provided opportunities for more structured feedback, and relationships with civil servants strengthened through sustained interaction. However, these improvements came too late to prevent many of the early challenges faced by the sector.

408. Providers' experience in the devolved administrations varied. Civil servants in Wales had more experience and knowledge of adult social care than those in England. In Northern Ireland, for example, engagement with the Regulation and Quality Improvement Authority proved more constructive, with regulators providing practical support and guidance to providers. This contrasted with the experience in England, where the Care Quality Commission's engagement was more limited.

409. Looking forward, this experience demonstrates the need for more robust engagement mechanisms between government and the homecare sector. Future emergency planning must include established channels for two-way communication, proper consultation processes, and recognition of the sector's operational expertise. This should include both formal structures for engagement and informal channels for rapid feedback on emerging issues.

Guidance – clarity, consistency, timing, applicability

Guidance for care and support services

410. Homecare providers sought to deliver safe, effective and high-quality care despite significant challenges during the pandemic. As COVID-19 was a novel infectious agent, there was initially high uncertainty about appropriate Infection Prevention and Control (IPC) guidance for homecare settings. While homecare

workers routinely wore gloves and aprons for personal care pre-pandemic, masks were only used in specific situations like aerosol-generating procedures.

411. The guidance development process had several persistent flaws:

- Content was typically written for NHS services without consideration of homecare's unique circumstances
- Publication often occurred late at night or before weekends, creating implementation challenges
- Changes frequently came with minimal notice and unrealistic implementation deadlines
- When we requested simple changes to guidance, it took a significant amount of time and effort to gain agreement and enable implementation
- Local variations in interpretation created additional complexity for providers operating across multiple areas

412. The first major guidance failure came on 25 February 2020, when guidance for social care settings stated: "During normal day-to-day activities facemasks do not provide protection from respiratory viruses, such as COVID-19 and do not need to be worn by staff in any of these settings." This guidance, which no homecare providers found credible, also claimed it was "very unlikely that people receiving care in a care home or the community will become infected." This demonstrated a fundamental misunderstanding of the close personal care provided by homecare workers who entered multiple households daily.

413. In some cases, providers told us that guidance made it very difficult to deliver high-quality care for people with significant cognitive impairments and/or communication difficulties. The use of PPE was significantly inhibiting people's ability to lip-read or read non-verbal communication. For others they were very frightened, especially when they did not understand the reason for its use. While discussions about using transparent facemasks started early in the pandemic, a

technical specification wasn't published until 2021 [JT/080-INQ000574078] . Even then, providers struggled to procure them. Guidance on risk-assessing PPE use in such situations was inadequate, particularly as it placed responsibility on to managers - often without clinical or infection control expertise - to make complex judgements about infection risk. It was unclear what kind of risk assessment would be considered legally or professional robust in the event of liability claims, should a careworker, or person receiving care suffer harm due to infection. Without clear guidance on which factors reduced infection risk and to what extent, many managers may have felt ill-equipped to assess risks to both staff and those supported. Furthermore, there was little clarity on how to appropriately balance infection control considerations with an individual's communication needs, leading to uncertainty in decision making.

414. This early failure reflected deeper structural problems in how guidance was developed. The Scientific Advisory Group for Emergencies (SAGE) initially excluded scientific and operational expertise in social care. SAGE first met, in response to COVID-19, on 22 January 2020, and its participants were first publicly listed on 4 May 2020 [JT/081-INQ000574093] . The SAGE Social Care Working Group does not appear on a public list until 29 January 2021 [JT/082-INQ000574094] .

415. Public Health England maintained that social care fell outside its remit. In her witness statement, Professor Yvonne Doyle said, "PHE had no formal remit for the social care sector" [INQ00273878/21]. She later described PHE's role in creating infection control guidance for care settings. This suggested PHE did, after all, have a formal remit for the people served by social care.

416. As discussed, civil servants demonstrated limited understanding of the sector. The Homecare Association and partners spent considerable time providing informal education to officials about basic sector operations. However, this rarely translated into improved guidance. The situation raised serious concerns about the quality of advice being given to Ministers.

417. When problems with guidance were identified, corrections were slow to materialise. For example:

- It took months of concerted engagement between ourselves and Public Health England to get the main guidance on PPE for homecare in England: "Personal protective equipment (PPE): resource for care workers delivering domiciliary care during sustained transmission of COVID-19 in England" [JT/083-INQ000581864] , updated to include a section on care workers undertaking 'live-in' care.
- A September 2020 directive requiring providers to switch from vinyl to nitrile gloves overnight was later revealed to be published in error, but not before providers incurred substantial costs seeking scarce supplies. It often took months of sustained engagement to achieve even simple clarifications.

418. These issues particularly affected Registered Managers, who carry personal liability for regulatory compliance. Care coordinators who typically work Monday to Friday had to work additional hours, often late on Friday nights, to implement urgent changes before the weekend. The highly regulated nature of social care meant that poor timing of guidance updates had disproportionate impacts. For example:

419. 12 April 2020 Guidance: The COVID-19 personal protective equipment (PPE) [JT/084-INQ000574095] guidelines were amended to include reference to 'sustained community transmission', an escalation in the measure of transmissibility of COVID-19. This immediately required providers to follow Table 4 [JT/085-INQ000574096] and use significantly more PPE when delivering care. This change happened in the middle of an Easter bank holiday weekend, with no time for providers to implement it. The situation was exacerbated by a lack of clarity about the meaning of the change, and poor communication to the sector.

420. As described in the previous section, the communication chain between government and providers was problematic. Local authorities, often responsible for disseminating guidance, typically only had contact with providers they contracted

with directly. While the CQC had access to all regulated providers, unregulated parts of the sector remained harder to reach. This fragmented communication meant some providers regularly missed important updates.

421. Local interpretations of national guidance created additional challenges, particularly for providers operating across multiple regions. When NHS PPE rules were relaxed in September 2022 [JT/086-INQ000581865] , for instance, district nurses no longer needed to wear face masks while homecare workers still did, creating confusion for both staff and people receiving care.

422. The Homecare Association's role in supporting members to understand and implement guidance became a full-time activity. Our advice line was inundated with providers struggling to interpret requirements that clearly had not been designed with homecare in mind. This applied particularly to guidance on PPE use, infection prevention and control, isolation requirements, and visiting policies.

423. These challenges reflected a broader pattern of social care being overlooked in pandemic response. Guidance designed primarily to "protect the NHS" often failed to consider its impact on community care services. When social care guidance did emerge, it frequently came later than NHS equivalents, despite both sectors caring for the same vulnerable populations.

424. This meant that homecare providers were disproportionately impacted by having to deliver services that were compliant with guidance that did not work for them. The slow response of the UK government to amend guidance simply prolonged issues for providers unnecessarily.

Management of the pandemic

425. The pandemic response revealed significant shortcomings in how support was provided to the homecare sector. While various measures were introduced, their design and implementation often failed to account for the sector's unique characteristics and needs.

Access to healthcare professionals and other support services

426. As discussed in the section beginning para 147, access to healthcare professionals and support services proved particularly challenging. Our members reported that many healthcare professionals withdrew from providing in-person support, leaving homecare workers as often the only professionals visiting people in their homes. Some Clinical Commissioning Groups attempted to transfer additional healthcare responsibilities to care workers, such as wound care and insulin injections, without adequate training or support.

427. Reduced oversight of service quality due to suspended CQC inspections added to risks for people drawing on services.

428. Families and providers experienced challenges obtaining vaccinations for housebound individuals.

429. As highlighted in para 296, the impact on unpaid carers, who often supplement formal care arrangements, was particularly severe. The reduction or suspension of respite services and day centres left many managing increased caring responsibilities with reduced support. This disproportionately affected women, who make up the majority of unpaid carers.

Financial support mechanisms

430. Financial support mechanisms proved poorly aligned with sector needs. The Infection Control Fund, while welcome, heavily favoured residential care settings in its initial distribution. Some local authorities gave no funding to homecare providers, while others restricted access to those with existing council contracts. This created a two-tier system that particularly disadvantaged providers serving self-funding clients or NHS-funded packages.

431. The government introduced several support measures in England, including:

- Additional funding for local authorities

- Temporary VAT changes
- Three rounds of Infection Control Funding
- Hospital discharge support funding
- The Adult Social Care Omicron Support Fund
- The Workforce Capacity Fund
- The Workforce Recruitment and Retention Fund

432. However, these measures often proved difficult to access or insufficient for sector needs. The routing of support through local authorities created inconsistent access and added administrative burden at a time of crisis. Many providers, particularly smaller organisations, struggled to navigate complex application processes.

Support for workers

433. Support for workers proved particularly inadequate. The lack of comprehensive sick pay provision left many care workers facing impossible choices between self-isolation and income maintenance. The furlough scheme had limited applicability to homecare services, which needed to maintain operations throughout the pandemic. Only 0-0.5% of social care employees were furloughed, yet providers received little targeted support for maintaining services with reduced staff availability.

434. The devolved administrations took different approaches to worker support, offering one-off bonus payments:

- Scotland: £500 in November 2020
- Wales: £500 in March 2021 and £1,000 in February 2022
- Northern Ireland: £500 in February 2022

435. However, these payments proved less beneficial than intended due to tax implications and impacts on benefits. The complex structure of the workforce,

including unregulated workers like personal assistants, also created challenges in distribution. Scotland experienced an eight-month delay while developing a system to identify eligible workers.

436. The experience in Wales showed some variation, with Social Care Wales developing additional support including remote counselling and advice for care workers. However, uptake remained low despite serious concerns about worker wellbeing, suggesting potential issues with service design or accessibility.

437. The Coronavirus Life Assurance Scheme, launched in 2020, allowed bereaved families of front-line workers to claim £60,000 following COVID-19 deaths. However, uptake remained low, suggesting communication barriers between policy intent and implementation. By June 2023, the DHSC was still requesting help promoting the scheme [JT/087-INQ000571062] .

Implementation of Care Act easements

438. We provided insights and expertise to government officials on drafting of the emergency COVID-19 laws, including Care Act easements.

439. We proposed that central government should have more control over local government than usual. This was because we expected problems with variations in approach by the 153 councils with responsibility for social care. In short, we worried that localism could cost lives. In an emergency, clarity of communication and control is vital, and we thought reducing local variation would help. We were unsuccessful. We worked to encourage consistency between the 153 local authorities. When, inevitably, local authorities chose individual approaches, we helped members understand the variation in requirements.

440. The Care Act easements introduced in England during the pandemic had far-reaching consequences for homecare provision. While these measures were designed to help local authorities manage unprecedented pressures, they created

significant challenges for providers and raised concerns about the long-term implications for care standards.

441. Although only eight out of 153 local authorities formally implemented easements, our evidence suggests their impact extended far beyond these areas. Members reported similar reductions in service provision across both easement and non-easement areas, indicating a de facto relaxation of Care Act duties even where formal easements were not triggered.

442. The practical effects of these changes manifested in several ways. Local authorities postponed needs assessments and care reviews, altered care arrangements without full consultation, and prioritised support to meet only the most urgent and acute needs. This created significant uncertainty for providers trying to maintain consistent service delivery while managing reduced care packages.

443. For homecare providers, the easements created substantial operational challenges. Many reported difficulties in adjusting service delivery when care arrangements were changed with limited notice or consultation. This was particularly challenging given the already complex operating environment created by the pandemic.

444. The impact on people receiving care was especially concerning. Our members reported instances where essential support was reduced or withdrawn without adequate consultation or consideration of the consequences. This often resulted in increased pressure on family carers, who found themselves having to fill substantial gaps in formal care provision.

445. We observed concerning trends in the wellbeing of people receiving reduced services. Members reported accelerated cognitive and physical decline among some clients, particularly those with dementia, highlighting the vital importance of consistent care provision. The suspension of day services and reduction in respite care created additional pressures on both formal and informal care arrangements.

446. The long-term implications of the easements remain a significant concern. While intended as temporary measures, there is evidence suggesting they may have set a precedent for diminished provision under the Care Act. This raises important questions about the future interpretation and implementation of statutory duties in social care.

Sector sustainability and longer-term implications

447. By late 2021, these cumulative policy shortcomings had created a sector facing severe sustainability challenges. Our research [JT/070-INQ000574058] showed 42% of providers were handing back contracts due to insufficient staffing, while 45% could not accept new work. These outcomes directly reflected the inadequacy of government support measures.

448. Looking ahead, this experience demonstrates the need for more targeted and accessible support mechanisms that recognise the sector's distinct operational characteristics. Future emergency planning must ensure more equitable distribution of resources and better coordination between health and social care services.

Matters relating to end of life care

449. The pandemic created unprecedented challenges around end-of-life care at home, though these manifested differently from issues faced by residential care services. Our evidence suggests three key areas of concern: the use of DNACPRs, provision of palliative care, and data collection regarding deaths at home.

Do Not Attempt Cardiopulmonary Resuscitation Orders (DNACPRs)

450. Unlike other parts of the social care sector, we did not receive a high volume of queries from members regarding DNACPRs. The reasons for this are unclear. Homecare providers deliver substantial end-of-life care. They routinely discuss and record people's preferences for resuscitation when developing care plans. DNACPRs are particularly relevant for care at home when supporting someone to

access health services, or when providing emergency first aid while awaiting ambulance arrival.

451. When media reports emerged about blanket use of DNACPRs across care settings, we took immediate action as part of the Care Provider Alliance. Our statement condemned any blanket application of DNACPRs and emphasised the importance of tailoring advance care planning to individual circumstances [JT/088-INQ000574105] . This position reflected our commitment to person-led care and respect for individual choice in end-of-life decisions.

452. We actively supported the Care Quality Commission's review of DNACPR use during the pandemic, keeping our members informed through regular communications. This engagement helped ensure homecare providers understood their role in supporting appropriate use of DNACPRs while protecting individual rights.

Palliative and End-of-Life Care

453. During the pandemic, we observed a significant shift in place of death, with many who would typically have died in hospital instead dying at home [JT/045-INQ000574106] . This created unprecedented pressure on community palliative care services and primary care teams, as documented by Marie Curie and other organisations ([JT/089-**INQ000348998** .

454. Our members reported increasing responsibility for delivering delegated healthcare tasks, including those related to end-of-life care. The widespread withdrawal of healthcare professionals from community settings meant care workers often found themselves undertaking more complex tasks without adequate training or support. This raised serious concerns about both worker wellbeing and quality of care.

455. Pre-pandemic surveys [JT/045-INQ000574106] had shown that while overall care quality was rated higher for home deaths, adequate pain relief was least

frequently reported for those dying at home (19%) compared to hospitals (40%), care homes (43%), or hospices (64%).

456. The pandemic exacerbated these challenges, with reduced access to specialist palliative care support creating additional pressures on homecare workers and families.

457. 70% of palliative care services in London, the region with the highest COVID-19 death rates, reported being busier since the pandemic [JT/090-INQ000590764] . At King's College Hospital, London: "Between 03 February 2020 and 10 May 2020, 632 patients were referred to the palliative care team. Weekly referrals increased from a mean of 39 in February, to 75 at the peak. Two-hundred and twenty-one patients with confirmed COVID-19 were referred. The number of patients on the palliative care caseload who died increased from a mean of 13 per week in February to 52 per week at the peak" [JT/091-INQ000590765] .

Data collection and monitoring

458. The early stages of the pandemic revealed significant gaps in data collection and monitoring of deaths at home. Limited testing availability meant we couldn't always determine whether deaths were COVID-19 related. By spring 2020, we had identified a concerning 51% increase in death rates at home, which we believed partly resulted from people avoiding seeking care or healthcare due to infection fears [JT/058-INQ000574069] .

459. Subsequent research by the King's Fund confirmed our concerns about displacement of deaths from hospital to home during the pandemic [JT/045-INQ000574106] . Their analysis showed that:

- Between March 2020 and May 2021, over 59,000 (39%) more deaths occurred at home compared to 2015-2019 averages
- Only 7% of excess deaths at home involved COVID-19

- The majority of excess home deaths were due to other causes including dementia, heart disease, and cancer

460. The data infrastructure around deaths in homecare settings proved inadequate for monitoring the pandemic's impact. Several factors contributed to this:

- Deaths in hospitals are not reportable to the CQC by homecare providers
- NHS records often don't identify when a person is receiving homecare services
- No systematic collection of data about major health interventions in homecare settings
- Limited integration between health and social care data systems

461. These data limitations hampered effective response planning and resource allocation. Without accurate, timely data about deaths in homecare settings, it proved difficult to identify emerging trends or target support effectively. This experience highlights the urgent need for better data collection and sharing mechanisms across health and social care settings.

462. Looking ahead, this experience demonstrates the need for:

- Better integration of health and social care data systems
- Improved tracking of homecare service users across different care settings
- More robust monitoring of deaths in community settings
- Enhanced support for palliative care delivery in home settings
- Clearer protocols for delegating healthcare tasks to care workers

Changes to the regulatory inspection regime

463. The pandemic prompted significant changes in regulatory oversight from the Care Quality Commission (CQC) that had far-reaching implications for the homecare sector. As we explained in our Module 2 closing statement [JT/072-

INQ000399544] , providers experienced a frustrating relationship with the CQC due to its slow response to unfolding events and apparent reluctance to advocate for the sector despite its position and oversight role.

Changes to inspection approach

464. In March 2020, the CQC fundamentally altered its regulatory approach by suspending on-site inspections and moving to remote working. While this shift to a risk-based model was understandable given infection risks, it effectively resulted in the withdrawal of meaningful oversight from homecare services for much of the pandemic.

465. We lobbied the CQC to conduct remote inspections of homecare services during COVID-19, after they initially stopped inspections. We argued that if journalists could speak to people drawing on services and care workers, so could the CQC. They started a pilot with 100 volunteer providers and devised a method for regulators to stay connected with and inspect homecare providers during COVID-19. Regrettably, though, CQC's focus was mainly on care homes and other services, where the isolating impact of the pandemic created a greater risk of closed cultures.

466. When some on-site inspections resumed in 2020, we identified additional concerns. Despite the known risk of asymptomatic transmission, CQC inspectors were not required to undergo regular COVID-19 testing when visiting services, creating unnecessary anxiety for providers and people receiving care.

Impact on care recipients

467. The reduction in regulatory oversight had significant implications for people receiving care. The public could no longer be confident that CQC ratings accurately reflected current service quality, as many providers went uninspected for extended periods.

468. The CQC's ratings of care quality in 2024 suggested 86% of services were "good" or "outstanding" (Figure 17), which was the same as their assessments before the pandemic (para 119, Figure 16).

Figure 17: Adult social care, CQC ratings by service type, 2024 (Care Quality Commission, 2024 – [JT/092- INQ000598598]

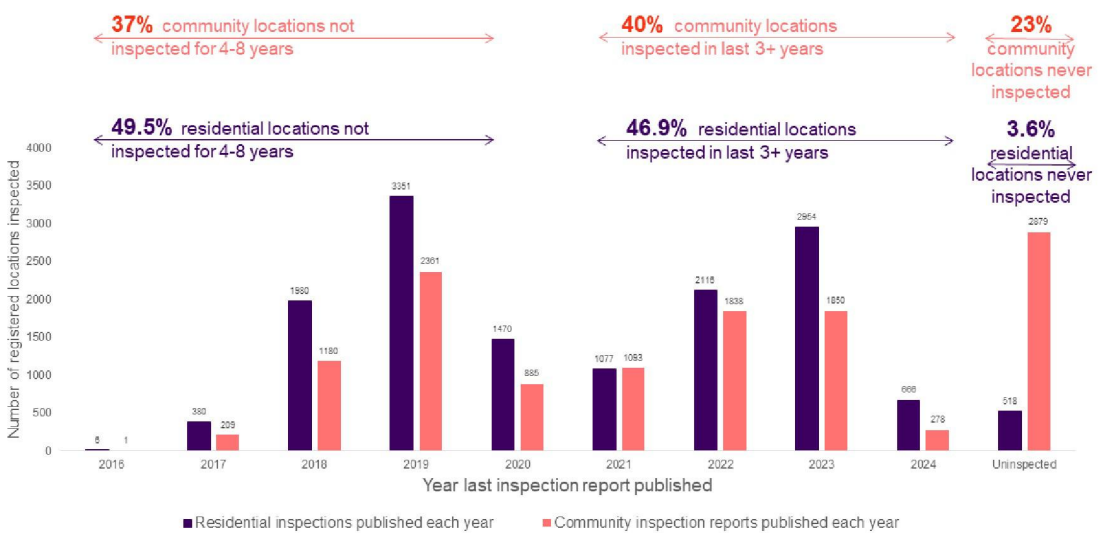
)

Source: CQC ratings data, 1 August 2024
Note: 2024 ratings include 'insufficient evidence to rate' for 19 homecare (domiciliary care) agencies (0.21% of total ratings) and 1 residential home (0.01% of total ratings).

Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

469. By June 2024, 23% of homecare locations remained unassessed, while 37% had ratings that were 4-8 years old (Figure 18) [JT/093-INQ000574123]). This calls into question the accuracy of the CQC's published ratings.

Figure 18: Aged ratings - year of last published CQC report (Homecare Association, 2024 – [JT/093-INQ000574123]).



470. The CQC appeared slow to act on serious concerns affecting service users. For instance, on 31 March 2020, the CQC signed a joint statement on advance care planning and DNACPR with the Care Provider Alliance, British Medical Association and Royal College of General Practice but it took until March 2021 for CQC to publish the result of its investigations into the practice. Similarly, the CQC seemed to give limited consideration to the experiences of people discharged from hospital during the pandemic.

Impact on providers

471. For providers, outdated ratings created significant practical challenges. Many reported difficulties accessing insurance coverage and securing public sector contracts due to their inability to demonstrate current quality ratings. This issue persists, with 60% of homecare locations still lacking up-to-date ratings in 2024 (Figure 18).

472. Providers faced particular challenges reconciling conflicting regulatory obligations. Many found themselves choosing between competing requirements under the Health and Safety at Work Act 1974 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The PPE shortage exemplified this

dilemma, forcing providers to balance infection risks to staff against service users' care needs without clear regulatory guidance.

Data collection and monitoring

473. The CQC's approach to data collection during the pandemic raised additional concerns. Despite being the only body holding data on care home deaths, the regulator initially appeared not to make this information accessible. Considerable resources were spent developing competing data collection systems with the NHS and NECS Capacity Tracker, rather than focusing on service quality and safety monitoring.

Long-term implications

474. Our analysis suggests the pandemic marked the beginning of a concerning trend in homecare regulation. The CQC's decision to prioritise residential care oversight at the expense of homecare has had lasting consequences. While the regulator's ratings suggest 86% of services were "good" or "outstanding" in 2024, the high proportion of outdated or missing ratings calls this assessment's validity into question. The CQC also has a backlog of uninvestigated safeguarding alerts. Harm to people may therefore be undetected. The CQC has said it will take them three to four years from now to catch up.

475. Looking ahead, this experience raises important questions about the regulator's role in emergency planning and response. Given its practical knowledge and statutory powers, the CQC might have played a more proactive role in developing sector guidance. The detailed guidance issued by the Health and Safety Executive stands in marked contrast to the CQC's limited input on reconciling competing regulatory requirements during the crisis.

Infection Prevention and Control Measures

476. I have highlighted issues related to Infection Prevention and Control throughout this statement to show their significance in relation to the chronology of events. This section brings it all together as requested by the Inquiry.

Testing

477. There were three main areas where availability of testing was an issue. Firstly, homecare workers experienced delayed access to both symptomatic and asymptomatic testing at the start of the pandemic. Second, there were difficulties around people being discharged from hospital to the community without being tested–causing issues with how to use scarce PPE supply. Last, there was a national shortage of lateral flow tests during the Omicron wave. This affected homecare workers.

Availability of testing

478. Testing was vital to the ongoing delivery of safe homecare services. I have outlined in my statement in para 320 how providers used different staffing models to reduce the transmission of COVID-19 across staff and the people they care for.

479. At the start of the pandemic, officials prioritised the limited testing capacity for hospital staff and seriously ill patients. It then expanded to cover outbreaks in residential care settings. Although many people receiving care at home were shielding, or vulnerable to the effects of COVID-19, the sector did not initially receive testing.

480. This was a particularly acute challenge for providers who were being asked to step in and support increased numbers of people being discharged from hospital as I outlined in para 318.

481. By mid-April 2020, the Social Care Action Plan announced that all social care staff would be able to access symptomatic testing [JT/094 **INQ000325315** . This

included homecare workers. We welcomed this announcement but also called for testing to be made available for the people being cared for at home [JT/095-INQ000574103] . These people were eligible in May 2020 as PCR testing became available to everyone with symptoms.

482. While this was a welcome policy decision, this did not address the significant risks associated with asymptomatic transmission. The policy did not make asymptomatic testing available for homecare services. In July 2020 DHSC published the results of a study [JT/044-INQ000574104] which showed the prevalence of COVID-19 amongst homecare staff was in line with the general population. This was used to argue that asymptomatic testing was not required in homecare services and that residential care settings and hospitals needed to be prioritised.

483. While we were pleased that the prevalence of COVID-19 in homecare staff aligned with the general population, this did not reassure the people being cared for. As I outlined earlier in my statement (para 336) many people decided to cancel their care packages which had a detrimental effect on their mental and physical health. This was because they were scared about catching COVID-19 from their care workers. Asymptomatic testing of homecare staff was not announced until November 2020 and was not available in practice until January 2021.

484. In December 2021, there was a national shortage of lateral flow tests. At that point, providers were already routinely testing homecare workers for COVID-19 without symptoms, by using weekly PCR testing. To support providers with workforce shortages, and maintain continuity of care, the government advised staff to access lateral flow tests to reduce self-isolation periods as quickly as possible.

485. Access to lateral flow testing for homecare staff was the same as the route for the public (only PCR tests were available via the testing portal). Consequently, there was a period where staff could not get tests to support release from isolation. In a survey of our members undertaken in January 2022, 60% of providers had some issues accessing tests. 19% said staff were rarely able to access tests and 8%

hadn't been able to get hold of lateral flow tests at all [JT/055-INQ000574059] . This exacerbated workforce shortages at a critical period.

Requirements for testing

486. Frontline care workers were the main target for homecare testing requirements. While it was an important element of delivering safe care, decisions made about the requirement to test did not consider the financial costs to homecare services, or additional burden on staff time.

487. There was an unrecognised cost to the introduction of weekly asymptomatic PCR testing of homecare staff announced in November 2020. Care workers who tested positive for COVID-19 were not allowed to attend work. Not attending work either led to sick-pay costs for the employer or lost earnings for the care worker (or both, depending on the contractual arrangement).

488. Many care businesses operate on tight margins and could not easily budget to increase sick pay expenditure. They had also lost business, and many providers were seriously concerned about their financial sustainability as I outlined in the section beginning para 212.

489. Government funding to support the impact of this cost came from the initial Infection Control Fund and the Adult Social Care Rapid Testing Fund. These funds were primarily targeted at care homes and covered mainly lateral flow testing. Neither fund was, therefore, accessible to homecare providers.

490. After representations, the guidance for the Adult Social Care Infection Control and Testing Fund of March 2021 was adjusted to clarify that homecare providers could access financial support from it for testing costs.

491. This was vital, however, access to the Fund varied by local authority area and some providers were still unable to access support. Access to the Fund was also a defined amount of funding and not based on demand. Some homecare providers who had high levels of staff self-isolation found they ran out of funding rapidly.

492. The Fund ended in March 2022. Our survey in April 2022 [JT/071-INQ000574061] showed how important the Fund was. 85% of respondents paid full wages to staff self-isolating when in receipt of the grant. This dropped to 6% after the grant ended. When providers could not pay staff full wage when they were off sick, this was often because the grant had run out (42%) or because of uncertainty around the funding (26%).

493. In February 2022, the Government changed the asymptomatic testing method for homecare workers from weekly PCR tests to daily lateral flow tests. This was a significant concern for our members as it entailed substantial additional time to a care worker's day. We estimated it took about 2 hours per week per care worker over and above the time required by previous testing arrangements. It was also significantly more testing than that being required of frontline workers in the NHS. They tested twice weekly with lateral flow tests, not every day.

494. At the same time, the government announced the Living with COVID-19 Plan. This included the removal of asymptomatic testing for the public. This caused significant confusion in the sector, given they were being asked to test every day.

495. We wrote to the Minister of State for Care and Mental Health in early March 2022 to highlight that guidance for the sector was inconsistent with the public and causing great concern about capacity [JT/096-INQ000571073] .

496. Feedback from members [JT/096-INQ000571073] at this point included:

- "We can expect more challenges to retention if daily testing goes ahead. We have already attempted daily testing for unvaccinated staff and had a number of leavers due to this strategy. Care workers are exhausted, we need to sensibly support them to do their jobs, keep them and SU's safe but keep it proportionate to the risks"
- "the recording of weekly tests requires two full time staff. So with daily tests, we need another 3 full time administrators."

497. Unlike care homes, there was no requirement by central government for homecare services to test homecare recipients. Occasionally, providers were asked by the people they supported to assist them to test themselves. Different people would require different kinds of support with self-testing and providers approached support with this according to the person's needs, their own risk assessments and their staff training.

PPE

498. The provision and use of PPE during the pandemic created significant challenges for the homecare sector. These issues stemmed from inadequate initial guidance, limited access to supplies, and poor understanding of homecare's specific needs.

499. The Homecare Association had no means of systematically monitoring the use of PPE during the time relevant to the inquiry. My comments are based on feedback from members and survey work we conducted.

Guidance on PPE

500. PPE requirements for the homecare sector did not feature in guidance to sector at the start of the pandemic. Although many people were shielding or vulnerable to the effects of COVID-19, there was no clarity on what PPE was required. This did improve, but as I have outlined already, it was still very complicated and often overlooked homecare.

501. I would like to draw the Inquiry's attention to a particular issue with PPE guidance and live-in care. This is the provision of care, in someone's home 24 hours a day. A care worker lives in the person's home for an extended period before changing shifts with another in the care team. Over the course of the pandemic, PPE guidance failed to take account of this type of service. Guidance maintained that any care workers providing personal care needed to wear masks for example. This meant that care workers, living in the same household as the person they cared for, spent several weeks wearing masks all day. Although we and other stakeholders

eventually persuaded the government to change its guidance, this situation illustrated the lack of understanding about social care in central government and decision-making bodies, as I have previously mentioned.

Access to PPE

502. At the pandemic's start, PPE requirements for homecare were not addressed in sector guidance, despite providers supporting many vulnerable and shielding individuals. When guidance finally emerged [JT/097-INQ000571069] , the government had not established mechanisms to ensure providers could access the required PPE.

503. Access proved particularly challenging in the pandemic's early stages. Unlike healthcare settings, homecare providers had limited pre-pandemic PPE stocks. Face masks were not routinely used in homecare before the pandemic. Care providers normally receive PPE from their business-as-usual suppliers in "just-in-time" deliveries. Most homecare offices are small and have limited storage space for PPE and consumables. When guidance required increased PPE use, providers faced severe difficulties sourcing supplies.

504. The wholesale supply was difficult to locate and high in cost due to shortages and when it was available, it was being commandeered at the point of delivery and given to the NHS. Even when people had purchased supplies privately (exhibit [JT/098-INQ000571063] .

505. Our members reported spending significant time attempting to secure PPE through any available means [JT/099- INQ000598599] . When supplies could be located, they were often:

- Prohibitively expensive due to global shortages
- Commandeered at delivery points for NHS use, even when privately purchased [JT/098-INQ000571063]

- Of uncertain quality with no way to verify safety specifications [JT/100-INQ000571064]

506. This situation placed providers in an impossible position, potentially facing criminal liability for regulatory breaches if they operated without correct PPE [JT/101-INQ000571065] . Many homecare managers spent most of their time attempting to source supplies rather than managing services.

Distribution systems

507. The introduction of Local Resilience Forums (LRFs) as PPE distribution points created new challenges. Many local authorities lacked contact details for all providers in their area, making equitable distribution impossible. The Homecare Association did everything it could to assist in improving the communication flow between LRFs and providers, sharing the contact details of LRF colleagues with our members. When providers could access LRF supplies, quantities varied significantly and were generally insufficient [JT/102-INQ000050008 .

508. It was clear to the Homecare Association and providers that a well-coordinated national system to supply the health and care sector was required. Development of an online PPE portal was slow and suffered delays. The national media reported this [JT/103-INQ000574100] .

509. The PPE Portal, launched in June 2020, initially proved inadequate due to ordering restrictions. While we worked with civil servants to increase limits, specific needs like FFP3 masks for Aerosol Generating Procedures (AGPs) remained unmet until late 2020 [JT/104-INQ000571068 . This particularly affected providers performing delegated healthcare tasks.

Financial impact

510. The rising costs of PPE created significant financial pressure. The Homecare Association quantified the rising costs of PPE to secure funding and stabilise the

sector. I detail this in para 212. We raised our concerns with key stakeholders in DHSC and wrote to the Chancellor [JT/059-INQ000571074] .

511. While the government introduced temporary zero-rated VAT relief, this did not address the fundamental issue of unfunded costs. Providers were receiving inadequate income from low fee rates and paying substantially more for increased PPE usage. The Infection Control Fund, intended to help with costs, primarily benefited care homes, with some homecare providers receiving no support in the first round. We raised concerns about this with the Chancellor in August 2020 [JT/059-INQ000571074] and with the Department of Health and Social Care in September 2020 [JT/060-INQ000571075] .

512. Even after the PPE Portal expanded coverage, uncertainty about its continuation complicated provider planning. The government's practice of announcing PPE funding decisions in January, after the December start of fee negotiations for the following year, created additional challenges. Current research shows only 1% of commissioners now cover necessary delivery costs in homecare [JT/016-INQ000571076] .

513. The PPE Portal continued until 31 March 2024. Providers now pay for their own PPE. Arguably fee rates have not increased to compensate for this. Our research this year suggests only 1% of commissioners are covering necessary delivery costs in homecare [JT/016-INQ000571076] .

Suitability and use

514. PPE guidance often failed to account for homecare's specific circumstances. The requirements particularly impacted live-in care workers, who were initially required to wear masks continuously while living in service users' homes. This demonstrated fundamental misunderstanding of different care models.

515. Changes to PPE requirements often came without warning or proper process. A September 2020 directive requiring providers to switch from vinyl to nitrile gloves

overnight exemplified this problem. Though later revealed as an error [JT/105-INQ000571070] providers had already incurred substantial costs sourcing new supplies.

516. In a minority of cases care workers were required to undertake Aerosol Generating Procedures. This required different PPE, including FFP3 facemasks. Our members found it extremely challenging to source FFP3 facemasks. At the time, it appeared that LRFs were not supplying PPE for AGPs [JT/104-INQ000571068] , and the PPE portal did not initially allow care providers to order it. This was despite the use of FFP3 masks featuring in government guidance. It was not until the end of 2020 that providers could secure PPE for AGPs from the PPE portal. The Homecare Association had to make significant representations which were not actioned quickly enough to achieve this change.

Impact on safety

517. Limited PPE supply forced some care workers to deliver care without appropriate protection. We received reports of workers:

- Operating without all recommended PPE
- Using makeshift protection like bin liners instead of aprons
- Reusing single-use PPE
- Working with PPE that may not have met safety specifications

518. The lack of reliable COVID-19 prevalence data in homecare settings makes it impossible to quantify the impact of limited PPE access on infection rates. However, the situation created significant anxiety for both care workers and those receiving care.

519. The implications of potential future variants raised additional concerns about PPE adequacy. Questions about whether Type IIR masks would remain sufficient

highlighted ongoing challenges around fit-testing requirements and the lack of clear data about the workforce requiring protection.

520. Looking ahead, these experiences demonstrate the need for:

- Better understanding of homecare's specific PPE requirements
- More robust supply chains and distribution systems
- Clearer guidance accounting for different care models
- Sustainable funding mechanisms for ongoing PPE costs
- Improved workforce data to support emergency planning

Movement of staff between care settings

521. The movement of care workers between care settings was more complex for homecare. Due to the nature of the work, care workers had to deliver care in multiple people's houses during a shift. As I outlined in para 320, some providers tried to minimise the movement between different settings by cohorting staff, but this was not possible for all.

522. We expressed our concerns when the guidance restricting movement between care settings was introduced [JT/106-INQ000574101] . We were concerned that this guidance could impact on the availability of care workers who held jobs in both residential and homecare services [JT/107-INQ000571022] .

Training on IPC for care workers

523. Infection Prevention and Control has always been a core part of training for social care staff. Providers expanded their training during the pandemic to comply with relevant guidance and ensure their staff felt confident in the use of PPE.

524. Poor communication and government decisions to publish guidance late at night or at short notice made providing guidance, training and advice to homecare workers

extremely difficult. As I outlined earlier in my statement, see paragraph 185, Registered Managers frantically tried to interpret guidance, with no time to consider how to implement it or communicate it to their staff.

525. The complexity of guidance compounded this for Registered Managers. We repeatedly pointed out that the PPE guidance wasn't written in plain English [JT/108-INQ000571071] . This impacted how easy it was to translate the guidance into training. Unlike healthcare professionals, most homecare staff do not have clinical training or expertise. This meant guidance that used technical language was difficult for them to understand. The guidance frequently assumed readers possessed existing knowledge of infectious diseases for completing risk assessments. Unlike other care settings, care workers delivered care on their own, in people's homes, and would be trying to make risk assessments every hour of their shift.

Impact of working conditions - self-isolation and shielding

526. The ability of homecare workers to self-isolate or shield during the pandemic was significantly impacted by pre-existing employment conditions and commissioning practices. These structural issues created particular hardships for certain worker groups and exposed deep inequalities within the sector.

Employment terms and commissioning impact

527. The fundamental challenge stemmed from the way state bodies commission and purchase homecare services. Local authorities typically purchase care by-the-minute and pay in arrears, rarely offering guaranteed hours or additional funding for travel time and unsocial hours. This commissioning and contracting model drives employers to use zero-hours contracts, creating inherent financial insecurity for workers [JT/018-INQ000571014] . This type of commissioning is long-standing. We have campaigned against such practices as long ago as 2012 [JT/018-INQ000571014] and continue to do so.

528. Skills for Care research [JT/109-INQ000598600 revealed the financial precarity of the workforce. While the average hourly pay rate for care workers rose from £9.43 in 2020/21 to £9.79 in 2021/22, this represented only a marginal increase above the National Living Wage (£8.72 and £8.91 respectively). This minimal buffer left workers particularly vulnerable when faced with income loss due to isolation requirements.

Financial impact of self-isolation

529. Our independent analysis in April 2020 [JT/054-INQ000571018] showed COVID-19 increased provider costs by approximately 25% against median fee rates. For councils paying as little as £14 per hour [JT/012-INQ000571013] , this represented nearly a 30% cost increase. The analysis estimated additional costs of £3.95 per hour, including £1.08 per hour for statutory sick pay, reflecting approximately 15% of staff being sick or self-isolating.

530. In a blog [JT/058-INQ000574069] , I detailed the limitations of the government's assistance to homecare providers in relation to sick pay. Providers faced dual financial pressures when workers needed to isolate:

- Covering sick pay for isolating workers
- Paying overtime rates to available staff covering additional shifts due to workforce shortages [JT/058-INQ000574069]

531. The government's support proved inadequate in several ways:

- SSP cost coverage only applied to employers with under 250 staff, excluding many care providers
- The Coronavirus Job Retention Scheme had limited applicability, with only 0-0.5% of social care workers being furloughed
- Very few providers could offer occupational sick pay schemes beyond statutory requirements

532. Funding was needed to ensure homecare providers could replace the income of care workers needing to self-isolate or shield.

533. Very few homecare providers were able to offer occupational sick pay schemes. While statutory sick pay existed, not all workers qualified, and it did not provide full income replacement. As the pandemic worsened, we became increasingly concerned about financial pressures on care workers.

Impact of government support measures

534. The Adult Social Care Infection Control Fund (Round 2) introduced later in the pandemic [JT/110-INQ000581866] temporarily improved the situation. Our survey [JT/071-INQ000574061] showed 85% of employers used the Fund to provide full pay for isolating workers. However, when the Fund ended on March 31, 2022, this dropped dramatically to 6%.

535. The consequences were severe:

- Nearly half of surveyed members reported workers seeking alternative employment due to isolation pay issues
- 59% expressed concern that staff might work while COVID-positive due to financial pressure
- 37% identified poor pay and conditions as the primary factor affecting staff retention [JT/111-INQ000574054]

Disproportionate impact on specific groups

536. Homecare workers were disproportionately affected by lack of access to sick pay when self-isolating, and in some cases the need to shield. The homecare workforce disproportionately comprised women and people from Black, Asian and minority ethnicities. These groups already faced structural disadvantages in the labour market:

- Lower average salaries limiting ability to build financial reserves
- Higher likelihood of living in multi-generational households complicating isolation
- Increased risk of serious illness from COVID-19
- Greater likelihood of having no recourse to public funds limiting access to support

537. These care workers held jobs in a sector where funding was poor, and financial sustainability low. In general, they were on low salaries and did not have savings to withstand time out of work.

538. Women, who comprise approximately 82% of the homecare workforce, faced particular challenges during the pandemic. Many found themselves managing complex competing responsibilities as schools closed and family care needs increased. Our members reported that female care workers often struggled to balance their professional duties with increased childcare responsibilities and caring for vulnerable family members, creating additional stress and financial pressure.

539. Research by Dr Aldridge at UCL [JT/112-INQ000581162] highlighted how these inequalities manifested during the pandemic: "Our findings support an urgent need to take action to reduce the risk of death from COVID-19 for BAME groups. Actions to reduce these inequities include ensuring an adequate income for everyone so that low paid and zero-hours contract workers can afford to follow social distancing recommendations."

540. The intersection of these factors created compound disadvantages. For example, female workers from ethnic minority backgrounds on zero-hours contracts faced multiple layers of vulnerability - increased health risks, greater caring responsibilities, and financial insecurity. Our surveys indicated that these workers were more likely to report anxiety about continuing to work during the pandemic but felt they had no choice due to financial pressures.

541. While providers recognised the importance of supporting workers to self-isolate and attempted to mitigate risks where possible, the sector's underlying financial

constraints severely limited their ability to provide adequate support without government funding.

542. These inequalities extended to people receiving care. Those in more deprived areas often had fewer choices about their care arrangements and less ability to supplement reduced formal care with private support. When services were reduced or suspended during the pandemic, these individuals were less likely to have alternative support networks to fall back on.

543. Digital inequality emerged as a significant issue during the pandemic. Some care workers struggled to access online training or guidance due to limited digital skills or lack of appropriate technology. Similarly, people receiving care who lacked digital access found it harder to maintain social connections or access remote support services during periods of isolation.

544. The pandemic also highlighted geographical inequalities in service provision. Rural areas faced particular challenges in maintaining service delivery due to longer travel times between clients and difficulties in staff recruitment. These areas also experienced greater challenges in accessing PPE supplies and testing facilities during the height of the crisis.

545. The government's response to these inequalities was insufficient. While the Adult Social Care Infection Control Fund provided some support, its distribution did not adequately account for the additional challenges faced by workers experiencing multiple disadvantages. The lack of specific support for workers with no recourse to public funds created particular hardship for this vulnerable group.

546. Looking forward, these experiences highlight the urgent need for policies that address structural inequalities within the sector. This includes ensuring adequate sick pay provision, addressing the prevalence of zero-hours contracts, and developing targeted support for workers facing multiple disadvantages. Without such measures, the sector remains vulnerable to similar disproportionate impacts in future crises.

547. This experience demonstrates how pre-existing structural inequalities in employment terms and conditions created disproportionate impacts during the pandemic, particularly affecting the sector's most vulnerable workers. The temporary nature of government support measures failed to address these fundamental issues, which continue to affect the sector's resilience.

Systemic issues revealed

548. The pandemic exposed fundamental systemic weaknesses in how social care, particularly homecare, is understood, organised, and supported within the UK's health and care infrastructure. These structural issues not only hampered the immediate pandemic response but revealed deeper problems that require strategic intervention to address.

Understanding of the sector

549. The pandemic starkly demonstrated how poorly understood homecare services were by senior decision-makers. Despite supporting nearly one million people - significantly more than in residential care - homecare was frequently overlooked in early pandemic planning and response. This reflected a deeper issue where homecare's vital role in supporting independence and reducing pressure on other services was not fully recognised.

550. When provision was made for social care, there was a persistent tendency to conflate 'care homes' with the entire 'social care sector'. This resulted in guidance and support mechanisms that failed to account for the unique challenges of delivering care in people's homes. The distributed nature of homecare services, with care workers traveling between multiple households daily, created distinct risks and operational challenges that policy often failed to address.

551. The complexity of homecare provision was particularly poorly understood. Policy makers demonstrated limited grasp of how services operated across multiple funding streams (local authority, NHS, and private), or how providers managed the

intricate scheduling required to deliver person-centred care with a mobile workforce. This lack of understanding manifested in impractical guidance and poorly targeted support measures.

Communication channels

552. The pandemic exposed serious weaknesses in communication infrastructure between central government and the homecare sector. Unlike the NHS, which had established channels for disseminating information, social care lacked coherent mechanisms for reaching all providers quickly. This became particularly problematic when rapid implementation of new guidance was required.

553. Local authorities, tasked with being the primary communication channel to providers, often had incomplete knowledge of services operating in their areas. Many only maintained contact with providers they contracted with directly, leaving those serving self-funding clients or NHS-commissioned care outside primary communication networks.

554. The timing and method of guidance distribution revealed systemic problems. Late-night or weekend publication of new requirements demonstrated limited understanding of providers' operational realities. The frequent need for sector bodies like the Homecare Association to interpret and explain guidance highlighted weaknesses in direct communication channels.

Data and evidence gaps

555. Significant gaps in data collection and sharing hampered effective response planning. The lack of comprehensive, real-time data about service capacity, staffing levels, and COVID-19 impact meant decisions were often made without full understanding of ground-level realities. This reflected a longer-term underinvestment in digital infrastructure across social care.

556. Limited digital capability across the sector created additional challenges. The 2021 People at the Heart of Care White Paper noted that only 40% of social care

providers were fully digital, with many still using paper-based records. This technological gap complicated data collection and the government's ability to response rapidly to changing circumstances.

557. The absence of a central register of care workers made workforce planning and support particularly challenging. Unlike other UK nations, England lacked a professional register of care workers, making it difficult to identify and reach the full workforce during the crisis.

Funding mechanisms

558. The pandemic exposed fundamental flaws in how social care is funded. The relationship between public funding and provider sustainability became particularly evident as additional pandemic-related costs could not be absorbed within existing fee structures. Our analysis showed that by 2024 [JT/016-INQ000571076] , only 5% of public bodies were paying rates that enabled full compliance with minimum wage legislation and care regulations.

559. The mechanisms for distributing emergency funding proved inadequate for the sector's needs. The routing of support through local authorities created inconsistent access and added administrative burden at a time of crisis. Some providers, particularly those serving self-funding clients, found themselves excluded from vital support.

560. The longer-term implications of inadequate funding became increasingly apparent. By late 2021 [JT/070-INQ000574058] , 42% of providers reported having to hand back contracts to councils or the NHS due to financial unsustainability. This highlighted how pre-existing funding challenges had left the sector with limited resilience to handle additional pressures.

Workforce sustainability

561. Deep-seated workforce challenges severely compromised the sector's resilience during the crisis. Pre-existing issues of low pay, limited career progression, and poor

terms and conditions were exacerbated by the additional pressures of pandemic response. Greater parity of pay and terms and conditions with NHS staff of an equivalent skill set was needed. The prevalence of zero-hours contracts and limited sick pay provision created particular vulnerabilities.

562. The pandemic highlighted the precarious position of many care workers. Despite being essential workers, many faced impossible choices between self-isolation and income maintenance. The sector's reliance on workers from disadvantaged groups, including those with no recourse to public funds, created additional vulnerabilities that policy responses failed to address.

563. The lack of a comprehensive workforce strategy became increasingly apparent. The sector's ability to recruit and retain staff deteriorated significantly, with our surveys showing 98% of providers reporting increased recruitment difficulties by late 2021. This reflected both immediate pandemic pressures and longer-term failures to address workforce sustainability.

564. These systemic issues reveal the need for fundamental reform rather than incremental change. The pandemic has demonstrated how structural weaknesses in understanding, communication, data, funding, and workforce sustainability create vulnerabilities that compromise the sector's ability to respond effectively to crises while maintaining essential care services.

Lessons learned

565. The pandemic experience has provided crucial insights into both the resilience and vulnerabilities of the homecare sector. Analysis of the response reveals important lessons that must inform future policy and practice to build a more robust and sustainable care system.

Positive reflections and successes

Workforce dedication and innovation

566. The most remarkable aspect of the pandemic response was the extraordinary dedication and adaptability shown by the homecare workforce. Despite facing significant personal risk, particularly in the early stages when PPE was scarce and testing unavailable, care workers continued to deliver essential support. This demonstrated both the sector's fundamental commitment to those it serves and the resilience of individual care workers.

567. Care workers often became the only human contact for many isolated individuals, taking on expanded roles in emotional support and advocacy while managing their own anxieties about virus transmission. Their commitment to maintaining essential care services, even in extremely challenging circumstances, highlighted both the professionalism of the workforce and their deep dedication to supporting vulnerable people.

Provider adaptability and innovation

568. Homecare providers demonstrated impressive agility in adapting their service delivery models. Many organisations rapidly restructured their operations, implementing innovative approaches such as:

- Creating separate staff teams (cohorting) to manage infection risks
- Developing new protocols for safe care delivery
- Adopting remote working practices where possible
- Implementing enhanced infection control measures

569. These adaptations were particularly noteworthy as they were achieved despite limited resources and support, demonstrating the sector's capacity for innovation under pressure.

Digital transformation

570. The pandemic accelerated digital transformation across the sector. Many providers successfully transitioned from paper-based systems to digital solutions, including:

- Remote working capabilities for office staff
- Virtual training delivery
- Digital care planning and monitoring systems
- Enhanced communication platforms

571. Our own organisation successfully pivoted to delivering virtual support, training and webinars, allowing us to reach more members than ever before. This demonstrated the sector's ability to embrace technological change when necessary.

Improved sector collaboration

572. The crisis fostered stronger collaboration across the social care sector. Organisations like the Care Provider Alliance facilitated improved coordination between different parts of the care sector, while relationships with civil servants in the Department of Health and Social Care, though sometimes challenging, created enduring communication channels.

573. The sector's ability to present a unified voice through bodies like the Care Provider Alliance and Care and Support Alliance strengthened our collective advocacy and influence on policy decisions.

Enhanced recognition and visibility

574. The pandemic brought unprecedented public awareness to the vital role of homecare services. While it took longer than it should have, the recognition of care workers as key workers marked an important shift in public perception. The

introduction of the green 'CARE' badges, despite its limitations, helped make the care workforce more visible in communities.

Positive policy changes

575. Some beneficial changes in commissioning practices emerged during the crisis. Most notably, the shift by local authorities to paying providers for planned rather than actual care delivered provided greater financial stability. This demonstrated that alternative, more sustainable approaches to commissioning were possible and beneficial. Now, unfortunately, most have reverted to pre-pandemic commissioning practices.

576. The establishment of the PPE Portal, once fully operational, proved that centralised support mechanisms could work effectively for the sector. While its implementation took time, it ultimately provided a more reliable supply chain for essential equipment.

Strengthened sector voice

577. The pandemic strengthened the Homecare Association's role as an authoritative voice for the sector. Our evidence-based approach, including regular surveys and data collection, helped us effectively represent members' interests and influence policy decisions. The relationships built during this period have enhanced our ability to advocate for the sector's needs going forward.

578. The combination of increased public awareness, stronger sector collaboration, and enhanced representative voices has created a stronger platform for addressing long-standing challenges in social care and pushing for necessary reforms.

Legacy benefits

579. While these positive developments do not diminish the serious challenges faced during the pandemic, they provide important foundations for future emergency planning and sector reform. The crisis demonstrated both the fundamental resilience

of the homecare sector and its capacity for positive change when properly supported.

Areas requiring improvement

Understanding and representation of the sector

580. The pandemic exposed critical gaps in how the homecare sector was understood and represented at senior government levels. The exclusion of social care expertise from key decision-making bodies had far-reaching consequences for policy development and implementation.

581. The absence of sector representation in bodies like SAGE and Public Health England meant that policies and guidance often failed to account for the practical realities of homecare delivery. The belated creation of the SAGE Social Care Working Group in January 2021 highlighted this systematic oversight and its impact on the sector's ability to respond effectively to the crisis.

Communication and coordination

582. Communication mechanisms between central government and the sector proved fundamentally inadequate. Key weaknesses emerged, including:

- Lack of direct channels between central government and providers
- Over-reliance on local authorities who had incomplete provider knowledge
- Inadequate engagement and poor timing of guidance publication, often late at night or before weekends
- Poor cross-government coordination and project management

583. The fragmented nature of communication was particularly problematic during emergencies. The absence of a comprehensive list of all regulated and unregulated care providers hampered effective information dissemination and support coordination.

584. Local variations in guidance interpretation created additional complexity for providers operating across multiple areas. Different authorities often took varying approaches to similar situations, creating confusion and increasing the administrative burden on providers.

Financial support and funding

585. The mechanisms for distributing emergency funding proved poorly aligned with sector needs. Key issues included:

- Complex distribution through local authorities creating inconsistent access
- Short-term emergency funding creating uncertainty and administrative burden
- Support often failing to reach providers in time
- Some providers, particularly those serving self-funding clients, being excluded from support

586. The pandemic highlighted how years of underfunding had left the sector vulnerable to crisis. The absence of a sustainable funding settlement for social care, including fair pay for care workers (that had greater parity with NHS staff) and adequate fee rates for providers, undermined sector resilience.

Workforce support and recognition

587. The delayed recognition of care workers as key workers had serious practical implications for service delivery. Care workers faced unnecessary challenges in:

- Accessing essential supplies
- Travelling to provide care
- Obtaining priority access to services
- Securing childcare and supporting their own families

588. The impact of policy decisions on workforce capacity required more careful consideration. The Vaccination as a Condition of Deployment policy demonstrated insufficient understanding of the sector's staffing challenges and existing pressures.

Data and digital infrastructure

589. The pandemic exposed significant weaknesses in data collection and sharing across the sector. Critical gaps included:

- Inability to quickly identify all providers
- Limited tracking of workforce capacity
- Poor monitoring of service pressures
- Inadequate digital infrastructure for rapid response

590. Many providers were still using paper-based systems when the pandemic began, limiting their ability to adapt quickly to new requirements and share critical information.

Key lessons for future crisis response

Central government

591. Future emergency planning must:

- Include social care representatives from the outset
- Ensure policies and guidance are workable for all care settings
- Establish clear frameworks for identifying and supporting essential workers
- Implement testing and PPE distribution systems more efficiently
- Conduct thorough impact assessments of policy changes

Local authorities

592. Local authorities need to:

- Develop better relationships with all providers in their area
- Reform commissioning practices to support provider sustainability and support better systems-wide outcomes
- Ensure consistent interpretation of national guidance
- Improve data collection and sharing capabilities
- Develop more robust contingency plans
- Strengthen partnerships with NHS bodies

Service providers

593. Homecare services need to:

- Develop robust business continuity plans
- Maintain strong local networks and partnerships
- Invest in digital infrastructure where possible
- Establish clear communication channels with all stakeholders
- Build financial reserves where funding allows

Regulation

594. Regulators need to:

- Develop protocols for remote and hybrid inspection models
- Ensure continuity of quality monitoring during emergencies
- Maintain regular contact with providers even when physical visits aren't possible
- Improve coordination between regulators

- Establish clear protocols between CQC, HMRC, and UKVI
- Create formal mechanisms for information sharing
- Develop joint approaches to systemic issues affecting provider compliance
- Enhance focus on commissioning oversight
- Implement systematic monitoring of local authority commissioning practices
- Review impact of fee rates on provider sustainability
- Assess relationship between commissioning approaches and care quality

Integration and coordination

595. The artificial separation between health and social care sectors must be addressed through:

- More coordinated approaches to service planning and commissioning
- Better integration of health and social care data systems
- Clearer protocols for service coordination during crises
- Joint workforce planning mechanisms

Looking forward

596. These lessons must inform both immediate reforms and longer-term planning to ensure the homecare sector is better supported and more resilient to future challenges. A comprehensive approach to sector reform should address:

- Structure and communication channels
- Sustainable funding mechanisms
- Workforce development and support
- Regulation

- Digital transformation
- Integration with health services
- Emergency preparedness
- Market oversight and regulation

597. Without such fundamental changes, the vulnerabilities exposed by the pandemic will persist, leaving the sector ill-prepared for future crises.

Recommendations for future

Overview

598. The pandemic exposed fundamental weaknesses in how social care is organised, funded, and delivered in the UK. Our recommendations address both immediate operational needs and essential long-term strategic reforms. They are drawn from direct experience of the pandemic response and reflect the sector's collective learning.

Governance and leadership

599. The pandemic highlighted fundamental questions about where responsibility for social care should sit within government. The current arrangement, where policy sits within the Department of Health and Social Care while funding flows through the Department for Levelling Up, Housing and Communities, creates unnecessary complexity and potential misalignment of priorities.

600. There is a strong case for considering whether social care needs its own dedicated Secretary of State with a specific focus on the sector's unique challenges and requirements. This would help ensure social care receives appropriate attention at Cabinet level and isn't overshadowed by NHS concerns.

601. Equally, given local authorities' central role in commissioning and overseeing social care services, there are arguments for locating primary responsibility for social

care within the Ministry for Housing, Communities and Local Government. This could support better integration with other local services and more coherent funding arrangements.

602. Whichever departmental structure is chosen, it is essential that social care has strong, dedicated leadership at the highest levels of government with sufficient authority and resources to drive necessary reforms.

Funding and commissioning reform

603. A complete overhaul of social care funding and commissioning mechanisms is essential. The current system, characterised by inadequate fee rates and unstable funding streams, undermines service quality and sector sustainability. We recommend establishing a national contract for care services, with a mandatory minimum rate for state-funded care that reflects true delivery costs, including staff wages, training, travel time, and organisational overheads.

604. Ring-fenced funding must be established for workforce development and digital infrastructure. This should include dedicated resources for staff training, professional development, and technology implementation. Without protected funding streams, these crucial areas will continue to be underprioritised.

605. New mechanisms for deploying emergency funding must be developed that can reach all providers quickly and efficiently. The pandemic demonstrated that routing support through local authorities creates delays and inequities. Direct funding channels should be established for future crises.

606. The funding system must recognise and support homecare's vital role in preventative care. Investment in high-quality homecare services can reduce hospital admissions and delay the need for residential care, creating system-wide cost efficiencies.

Workforce development

607. Implementation of a comprehensive national workforce strategy is urgently needed. This should address recruitment, retention, career progression, and professional development. The strategy must be expert-led and developed in consultation with the sector.

608. Minimum employment standards must be established, including adequate sick pay provision and regular hours contracts. The pandemic highlighted how zero-hours contracts and limited sick pay created vulnerabilities for both workers and service users. This requires adequate funding, which is lacking at present.

609. England should follow other UK nations in creating a professional register for care workers. This would support workforce planning, enable better communication during crises, and enhance professional recognition.

610. Significant investment in training and career development is essential. This should include:

- Standardised induction and core skills training
- Specialist skills development programs
- Leadership and management training
- Clear career progression pathways

Collaboration and coordination

611. Practical steps must be taken to achieve meaningful collaboration between health and social care. Social care expertise must be included in key health planning and decision-making bodies from the outset, not as an afterthought.

612. Shared data systems between health and social care must be developed. These should enable real-time information sharing about service users, capacity issues, and emerging risks while maintaining appropriate privacy protections.

613. Clear protocols for service coordination during crises need establishing. These should cover:

- Hospital discharge processes
- Access to clinical support
- Medicine management
- End-of-life care

614. Joint workforce planning mechanisms should be developed between health and social care, recognising their interdependence and shared workforce challenges.

Regulatory reform

615. The regulatory framework for homecare requires modernisation. The CQC's inspection approach should be reviewed to ensure it remains appropriate for current service models and can adapt during emergencies.

616. Quality assurance mechanisms need to be more proportionate and responsive. This includes developing better ways to monitor service quality during crises without compromising safety.

617. Clear frameworks must be established for delegating and monitoring healthcare tasks in community settings. The pandemic highlighted confusion about responsibilities and competencies for clinical care. Enhanced responsibilities require enhanced training and funding.

618. Requirements for digital record-keeping should be updated, with support provided to help providers transition from paper-based systems.

Operational improvements

619. Several practical enhancements are needed immediately:

- Establishing robust communication channels between all stakeholders

- Creating standardised data collection systems
- Investing in digital infrastructure and skills
- Developing clear protocols for emergency supply distribution

620. Service delivery improvements should focus on:

- Supporting technology adoption
- Developing flexible staffing models
- Enhancing infection control procedures
- Improving coordination with informal carers

Emergency preparedness

621. Future crisis planning must be more comprehensive and better tested. This includes:

- Maintaining detailed provider registers
- Establishing emergency funding mechanisms
- Stockpiling essential supplies
- Regular scenario planning exercises

622. Providers should be supported to develop robust business continuity plans that:

- Address various emergency scenarios
- Include staff deployment strategies
- Cover supply chain resilience
- Consider service user prioritisation

Implementation

623. These recommendations require sustained commitment and investment from government, alongside meaningful engagement with the sector. Without comprehensive reform, the vulnerabilities exposed by the pandemic will persist, leaving the sector ill-prepared for future challenges.

624. Implementation should be phased but urgent, with clear timelines and accountability for delivery. Regular progress reviews and adjustments will be essential to ensure reforms achieve their intended outcomes.

Homecare Association – background information

History, mission, aims and functions

625. The Homecare Association is one of the largest care associations and is the UK's leading membership organisation dedicated exclusively to homecare (also referred to as domiciliary care) providers. It serves as a vital advocate and provides essential support to the sector. A group of 75 homecare providers established the United Kingdom Homecare Association (UKHCA) in 1989 as a not-for-profit private company limited by guarantee. The founders' initial aims were to advocate for the sector, develop quality standards, and campaign for regulation. In September 2021, we changed the legal name to the Homecare Association and stopped using the acronym UKHCA. All other aspects of the Association's remit and activities remained the same.

626. Our mission is to ensure society values homecare, and invests in it, so we can all live well at home and flourish in our communities. We lead the way in shaping homecare and provide representation and practical support for our members.

627. The Homecare Association has four primary functions:

- **Representation**. We advocate for our members' interests to the central government; local government; the NHS; regulators; the media; the public; and other stakeholders. We work with partners across the health and care sector, including other care associations and representative bodies; unions; charities; academic researchers; and think tanks. This includes listening; researching; developing evidence-based positions on key sector issues; communicating and contributing to policy development at national and local levels to make an impact.
- **Thought leadership**. We use our trusted voice to shape and advance homecare policy, practice, and innovation.
- **Quality improvement**. We develop and maintain quality standards for the sector. Our Code of Practice was the only quality standard in homecare until 2003.
- **Member support.** We provide practical tools, resources, and hands-on assistance to our members. This includes guidance on regulatory compliance, business operations, and service delivery.

Organisation and governance

628. The Homecare Association has 17 full-time equivalent employees, of which four are engaged in work on policy and practice in homecare.

629. A board of directors governs the Association [JT/113-INQ000598601] . The board has 16 places: two for executive directors and 14 for non-executive directors. Non-executive directors are all homecare providers, elected by the members. There are 11 board seats for England members and one each for Scotland, Wales and Northern Ireland. For England, six represent small providers with 1 to 3 registered locations; two represent medium-sized providers, with 4 to 20 registered locations; and three represent large providers with 21+ registered locations, of which at least one must be state-funded and one private-pay funded. This structure aims to ensure fair representation of the providers in the market.

Geographical remit

630. The geographical remit of the Homecare Association includes England, Scotland, Wales, and Northern Ireland.

Membership

631. The Homecare Association has 2236 members as of 13 November 2024. Homecare Association members include most of the largest providers of homecare, some of which deliver 100,000 to 400,000 hours of homecare per week; and over 1000 SMEs, over 85% of which have fewer than 50 employees. We also have 34 affiliate members, who are organisations or groups that provide goods, services and consultancy to homecare providers.

632. 93% of our members are based in England, 3% in Scotland, 3% in Wales, and >1% in Northern Ireland.

633. Our members represent the full diversity of the regulated homecare market. They include small, medium and large organisations; state-funded and private-pay funded; generalist and specialist; start-ups and mature businesses. Providers include independent owners; franchise networks; corporate chains; buy and build' operators which grow by acquisition; not-for-profits, including charities and employee-owned; and public sector organisations.

634. By *generalist* homecare services, I refer to those that provide personal care to individuals with a broad range of needs, including assistance with washing, dressing, meal preparation, and medication administration. In contrast, *specialist* homecare services support people with specific or complex conditions. These include, but are not limited to, services for individuals with dementia and learning disabilities, spinal injuries, stroke, multiple physical disabilities, sensory impairments, mental health conditions, eating disorders and substance misuse.

635. Local authorities, health bodies or private individuals purchase care from providers.

Range of services provided by members

636. Members of the Homecare Association provide a range of homecare services, including:

- Regular visiting homecare (also called domiciliary care), which is the delivery of care to a person in their own home through regular visits.
- Extra care, where a person has an option to receive care from a designated care provider (with staff on site up to 24 hours a day) in self-contained accommodation that is occupied under, say, a tenancy agreement and is part of a block of similar properties.
- Live-in care, where a live-in care worker lives in a client's home and is on hand 24/7. They may be on call instead of working for a portion of this time.
- Supported living, which refers to schemes that provide personal care to people as part of the support that they need to live in their own homes. A separate contract handles the provision of personal care, separate from the person's housing contract. Although residents often share accommodation with a small group, they can also live in a single household.
- Housing with care, which encompasses both supported living and extra care housing, and can also include shared lives (where people live in accommodation under an occupancy agreement, with an approved person owning or renting the premises as a carer).
- Complex care, which is nursing support provided to someone with long-term health issues (who thus requires extra help). NHS continuing healthcare refers to complex care that the NHS solely funds. Those providing complex care may require additional skills or training.

637. Members support children, adults under 65, and older people. Members help to meet the needs of individuals in our communities, from cradle to grave.

638. People drawing on homecare and supported living services have a wide range of health and care needs. These include:

- physical disabilities
- learning difficulties
- autism
- mental ill-health, and
- physical ill-health

639. The Homecare Association does not hold data in relation to regulated and unregulated homecare providers across the UK; people at home across the UK with unmet care needs; staff working and staff absences in domiciliary care; COVID-19 related excess deaths in private homes; and COVID-related excess deaths of staff working in domiciliary care.

640. Various bodies across the UK have published data on the homecare sector, and I summarise this in later sections.

Homecare Association's stakeholders

641. In addition to our members, the Homecare Association routinely engages with a wide variety of stakeholders. These include:

- **Central government**. Ministers and civil servants in the Department of Health and Social Care (DHSC); Ministry of Housing, Communities and Local Government (MHCLG, formerly the Department for Levelling Up, Housing and Communities, DLUHC); HM Treasury (HMT); Home Office (HO); and Department for Business and Trade (DBT). We also engage to a more limited extent with their equivalents in the devolved administrations.
- **Local government**. The Local Government Association (LGA); the Association of Directors of Adult Social Services (ADASS); national and regional

commissioning networks; and directors and commissioning teams in individual local authorities on an ad hoc basis.

- **NHS**. NHS England (NHSE) senior leadership and operational teams.
- **Regulators.** The Care Quality Commission (CQC); Regulation and Quality Improvement Authority (RQIA); Social Care Wales (SCW); Care Inspectorate Scotland; His Majesty's Revenue and Customs (HMRC); and the Home Office UK Visas and Immigration (UKVI).
- **Researchers, academics and think tanks**. For example, universities; Health Innovation Networks (HIN); National Institute for Health and Care Research (NIHR); King's Fund; Nuffield Trust; Health Foundation.
- **National and regional media outlets**. For example, BBC; ITV; Sky News; Channel 4; The Times; Financial Times; Guardian; Observer; Daily Mail; Daily Express; Daily Mirror.
- **Care sector partners**. Other members of the Care Provider Alliance; the Care and Support Alliance; Scottish Care; Care Forum Wales, Independent Health and Care Providers Northern Ireland; care associations in the Republic of Ireland; Skills for Care; Social Care Institute for Excellence.

Homecare Association's work in the pandemic

642. The Homecare Association supported and represented homecare providers in England during the COVID-19 pandemic. We provided information, resources and advice to our members, who were struggling to understand government guidance or access the necessary equipment to enable them to follow guidance and regulations.

643. We also supported members in Wales, Scotland, and Northern Ireland through our helpline and regular communication. We maintained COVID-19 web pages for each nation, with updated links to important guidance for care providers.

644. In Wales, the Homecare Association and Care Forum Wales funded a Policy Advisor specialising in domiciliary care. Their role was to provide practical support for homecare providers and represent their interests in the COVID-19 pandemic.

645. Since Scotland largely adopted UK government guidance, we didn't offer the same level of specific practical support or representation for members. Scottish Care undertook most representation work for homecare providers in Scotland during this time.

646. Due to limited capacity within our team, we could not offer the same level of support to our members in the devolved administrations.

647. We worked hard to ensure policymakers in central and local government in all UK administrations, Public Health England (PHE, now UKHSA), the NHS, regulators, the media, and the public, understood the issues and challenges faced by homecare providers and the people they support.

648. We represented members' concerns to the civil service and ministers in DHSC, MHCLG, and HMT; NHS; PHE; HSE; and the care regulators, influencing and campaigning persistently on a wide range of topics. We gave quick feedback and shared our views with government officials to help them understand the effects of policies. We also highlighted the importance of funding and resources when necessary. In this section, I give some specific examples of this.

649. Later in my statement, I provide more detail about the working groups and decision-making forums that the government established and invited us to be involved with.

650. We worked closely with colleagues in the LGA and ADASS to share intelligence and co-produce guidance to support local authorities and providers.

651. During the time relevant to the Inquiry, we also represented the views of homecare providers through the Care Provider Alliance. Representatives of the Alliance, including myself, were members of several working groups and decision-

making forums. The Alliance is unincorporated and comprises ten trade associations. These associations represent care and support providers, which are organisations that offer care and support services to various client groups. These groups include adults with physical, sensory, and learning disabilities, individuals with mental ill-health, and older people.

652. We also worked as members of the Care and Support Alliance. This Alliance represents over 60 of England's leading charities campaigning for a properly funded care system alongside the millions of older people, disabled people and their carers who deserve decent care.

Homecare Association publications

Consultation responses, written submissions and reports to government departments and ALBs

653. We submitted 20 consultation responses to government departments. Some of these consultation responses directly addressed government decisions during the COVID-19 pandemic, while others focused on broader policy decisions that impacted homecare services. In Annex A, I have tabled a chronological list of all our responses.

654. Besides the responses outline in Annex A, I contributed evidence to the National Audit Office (NAO) twice .

Submissions to Select Committees and APPGs

655. I also provided written and oral evidence to several select committees and APPGs. This includes evidence about the impact of the COVID-19 pandemic on homecare services. In Annex B, I have tabled a chronological list of all responses.

Homecare Association Reports

656. As part of our routine policy work, the Homecare Association generated reports in response to the key issues affecting homecare providers during the time relevant

to the Inquiry. In addition, we commissioned reports from expert third parties on issues relating to homecare. We shared these reports with our members and the stakeholders I have outlined in my statement in paragraph 641. In Annex C, I have tabled a chronological list of all reports.

657. The most relevant of these reports to the inquiry is our financial assessment of COVID-19's impact on the homecare sector in the UK. This report found the pandemic put a significant strain on the UK homecare sector's finances. Increased costs and reduced revenues posed severe risks to small businesses and their ability to deliver care. It called for immediate and coordinated action from local authorities, regulators, and central government to sustain the sector and support the broader system during the period relevant to the inquiry.

Key blogs, articles and webinars of the Homecare Association

658. We developed helpful documents and updated our website to support members in understanding government guidelines appropriate for homecare services.

659. During this time I published several blogs for our members to read. I used these blogs to communicate what we understood the key issues to be for homecare providers. I have provided a chronological list of all out blogs in Annex D.

660. I also published articles in magazines where homecare providers are the key audience. These were not specific to the COVID-19 pandemic, but relate to the fragility of the sector at the time. I have provided a chronological list of these in Annex F.

661. At the start of the pandemic, we hosted free weekly webinars to inform all members about ongoing developments. We could also gather high level feedback from providers, which we subsequently shared with central and local government. As time passed, these reduced in frequency to monthly and then after 2 years, quarterly.

662. We established a smaller group comprising board members and larger members to conduct weekly calls aimed at providing updates on guidance and addressing key issues. This allowed us to gather valuable provider intelligence concerning operational challenges such as staff absence, COVID-19 positive cases among staff and clients, fatalities, and access to personal protective equipment, tests, and vaccines.

663. We also held online masterclasses for our members during this time, covering important issues relevant to our members and homecare providers. We invited industry experts to help our members improve their recruitment practices and support the wellbeing of their workforce. Since many of our members had to deal with increased media and press coverage about their services, we also offered masterclasses on confidently handling the media, delivering a positive message about services, and managing business reputation. We delivered these webinars alongside Anthony Collins Solicitors, Towergate Insurance and other policy, business, technology and regulation experts.

664. To support the inquiry, I have provided a chronological list of all webinars in Annex E. Most of these webinars related to COVID-19.

665. We also prepared a number of advice notes for homecare providers with our partners Anthony Collins Solicitors. These notes aimed to explain the legal implications of specific COVID-19 related guidance. This includes quarantine restrictions, and self-isolation requirements. I have provided a chronological list of these advice notes in Annex G.

Homecare Association Surveys

666. We conducted regular surveys to understand key issues faced by homecare providers during the time relevant to the Inquiry. We used our research data to get journalists and broadcasters interested in important issues related to homecare. This led to national coverage on various topics. This reinforced our influencing work with

Ministers and civil servants. We achieved extensive coverage in the media on many issues pertinent to homecare providers.

PPE

667. COVID-19 PPE survey - 31/03/2020-09/04/2020; 490 respondents; [JT/057-INQ000581157] . The COVID-19 PPE survey highlighted that 80% of homecare providers did not have sufficient PPE. We conducted the survey of our members in collaboration with the BBC to draw attention in the national news [JT/114-INQ000574062] to the ongoing difficulties homecare providers were facing that were impacting their ability to secure PPE and deliver care.

668. PPE Usage survey - 02/10/2020-06/10/2020; 618 respondents; [JT/115-INQ000581158] : this survey was a response to a change in guidance to use nitrile, neoprene or latex rather than vinyl gloves. The survey identified the quantities of gloves needed to inform the PPE Portal about the sector's PPE requirements following the policy change. The survey results informed engagement with both the PPE Portal team and those working on the policy guidance.

Vaccination of homecare staff

669. Progress of vaccination of homecare workers against COVID-19 - 27/01/2021-29/01/2021; 379 respondents; [JT/063-INQ000574052] . The survey found that 32% of the workforce had already been vaccinated. It also showed that only 79% of providers had received contact from their local council about vaccination arrangements. The survey was used to draw attention to the need for good communication about vaccination and how best to ensure care workers had access to vaccination. The National Booking System later became available to care workers, eliminating the need to rely on local authority communication.

670. Vaccination against COVID-19–should it be compulsory for homecare workers? - 23/03/2021-26/03/2021; 579 respondents; [JT/116-INQ000574053] : our first survey on compulsory vaccination helped us to consider how to respond to the initial

policy suggestion that vaccination would become mandatory for those working in the health and social care sector. We found that 70% of respondents supported compulsory vaccination at that stage. However, we were aware there were a range of strongly held views. The overall position changed quickly when the staffing implications in the wake of Brexit and the end of furlough/the lockdowns became clear as employment opportunities in the wider service sector picked up.

671. Who will care? Risks of making vaccination a condition of deployment in homecare - 08/10/2021-15/10/2021; 150 respondents; [JT/064-INQ000574057] : Our later survey on compulsory vaccination in October 2021 highlighted that, by that stage, over two-thirds of respondents thought that mandatory vaccination would have a severe effect on their business. The impact varied significantly across different businesses. Some businesses had high levels of staff vaccinated, others would have lost large numbers of care workers. A quarter of survey respondents thought they would have to close the business. This survey was used to inform our consultation response on making vaccination a condition of deployment in the wider health and social care sector.

Workforce recruitment and retention during the pandemic

672. We undertook a series of four surveys on workforce recruitment and retention in July (08/07/2021; 140 respondents; [JT/111-INQ000574054] August (05/08/2021-10/08/2021; 843 respondents; [JT/117-INQ000574055]) and November 2021 (02/11/2021-10/11/2021; 339 respondents; [JT/070-INQ000574058]) and again in January 2022 (10/01/2022-24/01/2022; 296 respondents; [JT/055-INQ000574059]). From mid-2021 until the addition of care workers to the Shortage Occupation List in early 2022 there was a severe shortage of care workers and recruitment and retention became significantly challenging. This appeared to peak at the end of 2021. Findings included:

- Most homecare providers said recruitment was harder than before the pandemic or harder than it has ever been (July: 91%, Aug: 95%; Nov: 98%; Jan: 97%)

- Most respondents were saying more care workers were leaving than before the pandemic (July: 66%; Aug: 65%; Nov: 75%; Jan: 63%)
- Most providers stated demand had increased (July: 75%; Aug: 89%; Nov: 93%; Jan: 91%)
- All four surveys reported that pay and conditions were the greatest challenge to recruiting and retaining care workers.
- A substantial number of providers were very concerned about their financial viability (Nov: 44%; Jan: 24%) and were handing back contracts to Councils or the NHS (Aug: 30%; Nov: 42%)
- A substantial number of providers said they could not take on any new work (Aug: 38%; Nov: 45%; Jan: 28%)
- In November 2021 we found that 76% of providers in England reported that vaccination as a condition of deployment would decrease their ability to recruit care workers.
- In January 2021 over half of respondents (58%) stated that their local authority had not consulted them about the use of the Workforce Recruitment and Retention Fund.
- In January 2021 only two-thirds of providers (63%) claimed that their staff were either sometimes or usually able to acquire lateral flow tests over the previous four weeks to help facilitate a return to work.

673. These surveys helped us to represent members' interests and highlight current issues and trends (which were worsening throughout 2021) in letters to Ministers, stakeholder engagement meetings, the media, consultation responses and more.

Insurance for homecare providers

674. Homecare Insurance Survey - 16/02/2021-24/02/2021; 150 respondents; [JT/061-INQ000581159] : the Insurance Survey was used to inform discussions between the British Insurance Brokers' Association, Homecare Association and HM Treasury, as well as conversations with DHSC, about the difficulties that providers were having securing adequate public liability insurance. Key findings from the survey were:

- There were, currently, only two companies providing services to the sector - a cause for concern.
- 10% of providers had less cover than before.
- 35% of providers had COVID-19 and/or other communicable disease exclusions from Public Liability cover.
- 72% of providers had seen their premiums rise.

The cost of fuel

675. Fuel availability and fuel costs - We undertook two surveys on fuel availability in October 2021 (*30/09/2021-01/10/2021; 108 respondents; [JT/118-INQ000574056]*) and March 2022 (*11/03/2022-21/03/2022; 627 respondents; [JT/119-INQ000574060]*). In October 2021 there was a national fuel crisis due to a shortage of HGV drivers. Our first survey highlighted that 73% of providers were having trouble finding fuel and the impact this had on their ability to deliver care. In March 2022 we highlighted that 90% of homecare workers use their own cars and 95% were expressing anxiety about fuel price rises. The survey explored how homecare employers were responding to support their staff and helped us to engage in discussions about the funding situation. Both surveys were used to attract national media attention to the sector's challenges. We discussed the survey results with relevant staff at DHSC. This was part of our efforts to ensure care workers have

priority access to fuel in emergencies and to ensure that there is adequate funding for the sector.

End of the Infection Control Fund

676. Shortage of homecare and unmet need–impact of cost of living and removal of COVID-19 grants–11/04/2022-26/04/2022; 292 respondents; [JT/071-INQ000574061] : our April 2022 survey highlighted the impact of the end of the COVID-19 Infection Control Grant. Staff were still required to test and self-isolate when positive. The survey suggested that 85% of employers were paying full pay to care staff on sick leave whilst isolating when they were in receipt of Infection Control Funding and that this dropped to 6% when the grant was removed. Close to half (48%) asserted that care workers were seeking alternative employment due to issues regarding loss of pay while isolating. 59% of the sample expressed anxiety that staff would come to work after testing positive for COVID-19. We shared the survey with DHSC officials to outline the impact of not renewing funding.

Homecare Association Training

677. The Homecare Association delivered a range of training events for our members and other homecare providers during the pandemic. As a team, we were constantly trying to unpick and understand the guidance and subsequent changes so we could update our training and information in accordance with changing COVID-19 regulations and guidance.

678. We held online, full day workshops. We used a variety of methods to deliver these workshops, including 'Train the Trainer,' which enables those in training to pass on their expertise to other colleagues in their organisation. We allowed most homecare providers to book our training workshops. Not just Homecare Association members.

679. The training sessions include:

- Care Quality Commission–Proving compliance

- Registered Managers–Being Well Led
- Dementia Care–Train the Trainer
- End of Life Care–Train the Trainer
- Care Coordinator responsibilities
- Medication–Train the Trainer
- Safeguarding for homecare providers
- How to Grow your Homecare business

Homecare Association involvement in working groups and decision-making forums

680. My team and I actively took part in multiple working groups established by the UK Government, NHS England and Improvement and by other sector colleagues. In these groups, we worked in close collaboration to represent the concerns of the adult social care sector, and for us homecare services in particular.

681. My team and I were also in regular communication with civil servants in DHSC, and other government departments via telephone, email, and in one-to-one meetings about a range of topics, including those I listed earlier in my statement.

682. It was our role as an organisation to represent our members' concerns on a wide range of topics. Our involvement in the various working groups included influencing, understanding and amending guidance being issued, which was often initially inappropriate for homecare settings. It also meant providing feedback at pace, sharing our informed views with government officials on the implication of policy development and implementation.

683. The Department of Health and Social Care (DHSC) invited the Homecare Association to become a member of the National COVID-19 Planning Group. This group met for the first time on 6 March 2020. The National COVID-19 Planning

Group created over ten working groups, which met regularly, to tackle the key issues. These included:

- Workforce support
- Impact on care recipients and informal carers
- PPE
- Financial sustainability
- Insurance
- Collecting and using the right data
- Emergency coronavirus legislation
- System assurance and regulation
- Hospital discharge
- Developing practice guidance
- Testing
- Vaccination (COVID-19 and influenza).

684. The DHSC also organised a COVID ASC Working Group of Stakeholders (CAWGS). The key issues covered in these meetings, relating to homecare providers, included:

- Transparent facemasks.
- Contingency planning for new variants, including consideration of FFP3 masks and fit testing.
- Omicron and its impact on homecare capacity.
- Pay for self-isolation and testing of homecare staff.
- The Infection Control and Testing Funds.

- Issues with introducing the daily testing regime for staff.
- Continuation of free PPE for homecare providers.
- Flu and winter planning.
- Issues with access to tests for staff and homecare providers.
- Homecare providers being provided without-of-date test kits for staff.
- Guidance on 'Vaccination as a Condition of Deployment' and issues such as exemptions for care workers and implications for capacity in the sector.
- COVID-19 treatments and access to these.
- Concerns about risk assessment and clinical expertise of homecare staff to interpret guidance; clarity and plain English.

685. The Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) organised meetings regarding funding, between May 2020 and July 2020. The key issues covered in these meetings, relating to homecare providers, included:

- The cost of PPE and funding required by local authorities to meet this.
- Payment on planned rather than by the minute in arrears as a way of supporting homecare businesses in turbulent times.
- A decrease in commissioning during the early stages of the pandemic, leading to a reduction in income for homecare providers.
- The first Infection Control Fund and its distribution, especially the 25% not allocated to care homes.

686. The Care Quality Commission (CQC) set up an External Advisory Group on COVID-19. The key issues covered in these meetings, relating to homecare providers, included:

- The CQC's response to the pandemic and their transitional/recovery inspection arrangements.
- Understanding DNACPR decisions as homecare workers.
- The Emergency Support Framework.

687. The DHSC organised a Capacity Tracker Data Advisory Group. The key issues covered in these meetings, relating to homecare providers, include:

- Provider access to data on Capacity Tracker.
- Who benefits from the data on Capacity Tracker, as homecare providers could not see the input data.
- Which questions to ask providers on the Capacity Tracker.
- The high volume of data request homecare providers received from different parts of the public sector.
- Quality and interpretation of data by government.
- How DHSC could incentivise good quality data input.
- The Capacity Tracker Operational Change Advisory Board organised by DHSC. The key issues covered in these meetings, relating to homecare providers, include:
- The optimum way to collect and use data on the Capacity Tracker.
- The need to prioritise homecare data, alongside care home data.
- The type of questions, and consistency of questions asked of providers across regions in England and impact of variation on national providers.
- Provider engagement and support for user testing.

688. The DHSC organised an ASC Stakeholder Vaccines Group. The key issues covered in these meetings, relating to homecare providers, included:

- Vaccination as a condition of deployment and implications for homecare providers.
- Uptake of vaccines and booster vaccines in the social care sector.
- The Flu Vaccinations Working Group organised by DHSC. The key issue covered in these meetings, relating to homecare providers, was the access, delivery and communications around flu vaccinations during winter 2020/21.
- The Vaccines Booster Taskforce organised by DHSC. The key issues covered in these meetings, relating to homecare providers, include:
- Data on vaccination in social care, including via Capacity Tracker
- Effective ways to address hesitancy in the homecare workforce, including local approaches
- The impact of vaccine side-effects and time off work on capacity in homecare

689. The DHSC organised a Customer Engagement Panel for the Personal Protective Equipment (PPE) Portal. The key issues covered in these meetings, relating to homecare providers, included:

- Order limits placed on homecare providers, including that they were too low to meet their demand in some cases.
- Communication of PPE guidance to homecare providers.
- The significance of personal protective equipment (PPE) guidance for homecare providers in relation to insurance access.
- Access to free PPE for homecare providers.
- Links to Capacity Tracker data.

690. The DHSC Adult Social Care (ASC) Stakeholder Working Group created a PPE Task and Finish Group. The key issues covered in these meetings, relating to homecare providers, included:

- Difficulties accessing support via Local Resilience Forums in some places.
- Issues with providers using the PPE portal, including getting deliveries of PPE.
- The change in guidance away from vinyl glove use and the implications of this.
- Transparent facemasks.
- Aerosol Generating Procedures and access to appropriate PPE in the community for homecare workers.
- The roll out of the Test and Trace app.
- Reviewing guidance, which was specifically for homecare. Including guidance on PPE when homecare staff are out and about supporting people.
- Recommending the use of plain English, tables, infographics and clarity of guidance.
- PPE guidance, including live-in care services.
- Concerns around the timing of publication of guidance.

691. Ministers formed an Adult Social Care Taskforce, chaired by Sir David Pearson. DHSC created workstreams to tackle the key issues as DHSC saw them. The Policy Director of the Homecare Association co-chaired the workstream focused on the ASC workforce. The key issues covered in these meetings, relating to homecare providers, included:

- Pay and recognition of social care staff.
- Safety, health and wellbeing of social care staff.
- Funding for self-isolation to support social care staff.
- Flu vaccine uptake across the sector.
- Workforce planning and contingency arrangements for short-term capacity issues.

692. The DHSC organised a Task and Finish ASC workforce and COVID-19 group. The key issues covered in these meetings, relating to homecare providers, included:

- Death in service scheme.
- HSE reporting.
- Test and trace, including app development.
- DBS checks for care workers.
- Care workers traveling from home and need for ID in lockdown if stopped by police.
- CARE badges, brand and identification.
- Bereavement resources.
- Access to symptomatic testing early in the pandemic.
- Use of volunteers to increase capacity.
- Furlough of workers and shielding.
- Recruitment into the sector during the first lockdown.
- Supporting minority ethnic workers who may be at higher risk.

693. The DHSC organised a Testing Task and Finish Group. The key issues covered in these meetings, relating to homecare providers, included:

- Pay for care workers to undertake testing.
- Pay for care workers when testing positive and use of the Infection Control Fund for this.
- Changing guidance on what care workers needed to do if they were contacts of known COVID-19 cases and isolation rules.
- Issues with the access care workers and providers had to tests.

- Distribution of, and access to, the Infection Control Fund.

694. NHS England organised a Home Care Sector Stakeholder Group. The key issues covered in these meetings, relating to homecare providers, included:

- Winter planning.
- Flu vaccinations.
- COVID vaccination uptake and addressing hesitancy.
- Availability of testing.
- NHS at home.
- Test and trace.
- PPE guidance.
- Insurance issues.
- Continuing Healthcare assessments being put on hold.
- Availability of NHS community services.
- Infection Control Fund distribution to community care.
- Supporting service users to test themselves for COVID-19.
- Home First / Discharge to Assess policies.

695. NHSX organised a Digital Social Care Advisory Group. The key issue covered in these meetings, relating to homecare providers, was the use and uptake of Digital Social Care records.

696. Our partnership with the British Insurance Brokers Association involved advocating for DHSC and Her Majesty's Treasury (HMT) to create a contingency plan that would address the potential unavailability of insurance for the social care sector. This was something we were deeply concerned about, as many insurance providers left the market.

697. In Wales, the Homecare Association and Care Forum Wales funded a Policy Advisor specialising in domiciliary care. Their role was to provide practical support for homecare providers and represent their interests in the COVID-19 pandemic, mainly to the Welsh Government. They joined the Expert Reference Group on Domiciliary Care, organised by the National Provider Forum, to share their expertise in homecare.

698. The Association attended regular meetings with the Welsh Government to represent members' interests and engaged with Welsh regulatory bodies on specific policy concerns, such as temporary funding grants.

699. Some of our work with the UK Government had direct effects in Wales. The analysis we commissioned on costs of the pandemic to homecare providers helped secure funding for social care quickly. The UK Government's decisions on testing and funding affected what the Welsh Government could do.

700. The Association talked to the Welsh Government about important issues like access to sick pay and funding for the workforce. The results of our work sustained the sector during and after the pandemic.

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: PD

Dated: 23/05/2025

Annex A–consultation responses to government departments

Date	Consultation responses to government departments	Exhibit
24 June 2020	UKHCA's response to the Migration Advisory Committee's (MAC) review of Shortage Occupation List (SOL) 2020. In response to the MAC's request for employer feedback, we emphasise the importance of allowing social care to recruit workers from abroad. We recommend that care workers, senior care workers, care coordinators, and registered managers remain on the Shortage Occupation List (SOL) to help address recruitment challenges in the sector.	JT/120-INQ000571046
17 July 2020	UKHCA's response to the Low Pay Commission's consultation on minimum wage rates from April 2021. In our response, we warn that raising the National Living Wage without sustainable funding for the homecare sector could destabilise the market. This is because local authorities are already paying providers below the minimum price needed to cover costs and comply with regulations.	JT/121-INQ000571047
24 September 2020	UKHCA's response to HM Treasury consultation on the Comprehensive Spending Review of 2020. In our response, we call for urgent increased funding and policy changes to stabilise the homecare sector. Key recommendations include a mandatory minimum rate for state-funded care, ending by-the-minute commissioning, addressing unmet care needs,	JT/076-INQ000571021

	changing VAT application, and exempting homecare businesses from business rates. We highlight the pandemic has resulted in PPE costs of up to £2.20 per hour and how many providers have received little to no financial support with these additional costs.	
13 November 2020	UKHCA's response to Social Care Wales priorities 2021-2026. In our response, we recommend that Social Care Wales adopt a more ambitious approach, especially in supporting the workforce, developing career pathways, promoting integration with healthcare, and fostering innovation. We highlight that low commissioning rates, worsened by COVID-19 cost pressures, make it hard for providers to improve wages.	JT/122-INQ000571048
23 November 2020	UKHCA's response to DHSC's consultation on staff movement between care settings 2020. In our response, we oppose the proposal to limit staff movement between health and social care settings during the COVID-19 pandemic. We highlight it is likely unworkable and could disrupt homecare provision when staff vacancies, sickness levels, and turnover rates are at their highest.	JT/107-INQ000571022
25 November 2020	UKHCA's response to the Welsh Government's consultation on market stability reports 2020. In our response, we support producing regional market stability reports on a 5-year cycle, but raise concerns about local	JT/123-INQ000232385

	authorities reporting on their own commissioning practices, emphasise the need to consider workforce issues and cost pressures (including those related to COVID-19), and recommend careful data governance to avoid unnecessary burdens on providers.	
1 December 2020	UKHCA's response to Welsh Government's Health, Social Care and Sports Committee inquiry into the impact of the COVID-19 outbreak, and its management, on health and social care in Wales. In our response, we recognise the Welsh Government's £40m fund for social care but express concern over delays in accessing the funds. We also note that the pandemic has shown how vital social care is in Wales and exposed its weakness because of long-term underinvestment.	JT/124-INQ000232389
21 January 2021	UKHCA's response to HM Treasury consultation on the Spring Budget 2021. In our response, we highlight that the social care sector, especially homecare, is severely underfunded and struggling with extra financial pressures from the COVID-19 pandemic. Without substantial government funding and support, providers may fail, putting care services at risk.	JT/125-INQ000571023
22 March 2021	UKHCA's response to CQC's consultation on flexible regulation 2021.	JT/126-INQ000571049

	In our response, we support CQC's plan for more flexible regulation but raise concern about frozen ratings during COVID-19. This has disadvantaged providers who have improved but can't get their ratings updated.	
5 April 2021	UKHCA's response to Welsh Government's White Paper on rebalancing care and support 2021. In our response, we stress the need for a balanced approach to addressing challenges in the social care sector. We call for reforms in commissioning practices, changes to the structure of Regional Partnership Boards, and the establishment of a strong national framework to ensure fair and sustainable care. We also emphasise that sustainable funding and strategic use of data are essential for achieving the goals set out in the White Paper.	JT/127-INQ000232386
19 May 2021	UKHCA's response to DHSC's consultation on vaccination as a condition of deployment (VCOD) in care homes and whether proposals should extend to other parts of the social care and health system. In our response, we caution against implementing VCOD and suggest that if mandatory vaccination is extended to homecare, we should only require vaccination for care workers who provide direct care or have close contact with service users. This requirement should not include administrative staff and senior managers without direct contact.	JT/128-INQ000571024

1 July 2021	UKHCA's response to Low Pay Commission's consultation on minimum wage rates from April 2022. In our response, we call for sustainable funding for homecare, a workforce development strategy and a fee structure that reflects actual regulatory costs. We highlight that these are essential for the long-term stability of the homecare sector.	JT/129-INQ000571050
5 August 2021	UKHCA's response to Social Care Wales draft Workforce Plan 2021. In our response, we support the draft Workforce Plan, calling for equal treatment with the NHS, addressing workforce shortages, professionalising the workforce, and addressing issues like qualifications, part-time work, staff retention, and recognition. We point out that these issues are even more urgent during the pandemic, as the sector is crucial for supporting people in the community and helping hospitals by enabling quick discharges.	JT/130-INQ000232387
1 October 2021	Homecare Association's response to HM Treasury consultation on the comprehensive Spending Review 2021. In our response, we stated that the homecare sector is unsustainable, with 70% of its income from the public sector and 87% of commissioners paying below the minimum required rate for compliance. Staff shortages, low pay, and limited workforce capacity are major problems. We highlight the need for an extra £1.7 billion per year to cover commissioners' rates, infection control, and PPE costs. We urge the government to fund sector reforms and VCOD.	JT/131-INQ000571016
22 October 2021	Homecare Association's response to DHSC's consultation on making vaccination a condition of deployment (VCOD) in health and the wider social care sector. In our response, we strongly support vaccinating homecare workers and highlight public expectations for this. We share	JT/132-INQ000571026

	concerns that VCOD could lead to a significant loss of workers in an already struggling sector with high demand and recruitment challenges. This could risk leaving older and disabled people without the homecare they rely on.	
29 October 2021	Homecare Association's response to the Migration Advisory Committee's call for evidence on the impact of the end of freedom of movement on the social care sector. In our response we highlight serious challenges in recruiting and retaining care workers across the UK, made worse by the COVID-19 pandemic and post-Brexit migration changes. We report that 95% of surveyed members find recruitment harder than before the pandemic. With some providers struggling to fill vacancies, take on additional work, or keep existing care packages. Without significant government investment in pay and working conditions, we highlight that the sector's long-term sustainability is at risk.	JT/133-INQ000571051
29 October 2021	Homecare Association's response to DHSC's consultation on extending free PPE to the health and care sector. In our response, we support the continuation of the PPE Portal for a further year. Our most significant concern is that the closure of the Portal would mean that providers could have difficulties funding the additional PPE that they require for COVID-19 related infection control.	JT/134-INQ000571027
15 February 2022	Homecare Association's response to DHSC's consultation on reversal of Vaccination as a Condition of Deployment (VCOD) regulations consultation. In our response, we argue that the risk of losing vital homecare staff outweighs the benefits of mandatory vaccinations. We call for ending the VCOD policy and suggest other ways to boost vaccine uptake and protect vulnerable people. We stress the importance of clear policies, workforce investment, and evidence-	JT/135-INQ000571028

	based infection control to keep both care workers and recipients safe.	
22 April 2022	Homecare Association's response to the CQC Local Authority Oversight Consultation In our response, we emphasise the importance of independent providers and care workers' voices in local authority and Integrated Care System commissioning practices. We suggest that commissioning and procurement of care significantly influence outcomes. In our response, we highlight that the voices of service users are important in evaluating Local Authorities' social care performance. However, the perspectives of independent providers and care workers are equally crucial to understand how Local Authority and ICS commissioning affect user experience and the market. We suggest that the care workforce, which influences care quality, seems overlooked in CQC's approach. We also suggest that it's unclear if CQC has considered what good commissioning looks like or how it affects outcomes.	JT/136-INQ000571052
20 June 2022	Homecare Association's submission to Low Pay Commission 2022. In our response, we advise the Commission to be cautious with future rate increases because of the challenges in the homecare sector. We are concerned that raising the minimum wage to £10.32 in 2023 and £10.95 in 2024 could harm the sector's financial stability unless the Government provides several billion pounds annually to support this increase and adjust provider fees accordingly.	JT/137-INQ000571056

Annex B - Written and oral submissions to committees and APPGs

Date	**Submissions to House of Commons Select Committees, House of Lords Committees and APPGs**	
23 June 2020	House of Commons Health and Social Care Select Committee: Oral evidence, given by me, on social care funding and the workforce in England.	
7 August 2020	House of Commons Health and Social Care Select Committee Inquiry into Workforce burnout and resilience in the NHS and social care: Written evidence by the Adult Social Care Taskforce Workforce Advisory Group & National Care Forum, Adult Social Care Taskforce Workforce Advisory Group and United Kingdom Homecare Association (UKHCA).	
13 August 2020	House of Commons Health and Social Care Select Committee Inquiry into social care funding and workforce in England: Written evidence by UKHCA.	
4 September 2020	House of Commons Health and Social Care Select Committee Inquiry into Workforce burnout and resilience in the NHS and social care: Written evidence by UKHCA.	
13 October 2020	House of Lords Health and Social Care Committee and Science and Technology Committee: Oral evidence, given by me, on Coronavirus lesson learned.	

13 April 2021	House of Commons Housing, Communities and Local Government Select Committee Inquiry into Long term funding of adult social care: Written evidence by UKHCA.	
25 October 2021	House of Commons Housing, Communities and Local Government Select Committee Inquiry: Oral evidence, given by me, on long-term funding of adult social care	
20 January 2022	House of Commons Health and Social Care Select Committee Inquiry into Workforce Recruitment, Training and Retention Inquiry: Written evidence by the Homecare Association.	
6 May 2022	All Party Parliamentary Group on Dementia Inquiry into building a social care workforce that can meet the needs of people living with dementia. Written evidence by the Homecare Association.	
13 May 2022	Health and Social Care Committee's Expert Panel on Workforce. Written evidence by the Homecare Association.	
27 May 2022	House of Lords Adult Social Care Committee Call for Evidence relating to the Invisibility of Adult Social Care. Written evidence by the Homecare Association.	

Annex C–Homecare Association Reports

Date	Reports	Exhibit
25 April 2020	UKHCA Financial Assessment of COVID-19's impact on the homecare sector in the UK. Commissioned by United Kingdom Homecare Association from independent analysts, Accenture. This report found that the COVID-19 pandemic significantly strained the UK homecare sector financially, with increased costs and reduced revenues posing severe risks to small businesses and the ability to deliver care. It calls for immediate and coordinated action from local authorities, regulators, and central government to sustain the sector and support the broader health system during the COVID-19 crisis.	JT/054-INQ00057 1018
23 Septemb er 2020	Impact Report 2019-2020 This report summarises UKHCA's work on behalf of members and activities during 2019-2020. This includes how we represented our membership at the beginning of the COVID-19 pandemic.	JT/138-INQ00057 1031
15 October 2020	Retaining homecare workers in the independent and voluntary sector. Authored by Talent for Care and UKHCA. This is a report based on a survey of 234 UK homecare providers conducted in December 2019. It highlights the significant challenges providers face in retaining homecare workers, with two-thirds experiencing staff turnover exceeding 15%. It emphasises the need for innovative approaches to improve retention, including flexible working hours, personal development opportunities, and increased use of technology.	JT/139-INQ00057 1032

17 December 2020	A Minimum Price for Homecare (April 2021 to March 2022) In this report, UKHCA sets a minimum price of £21.43 per hour for homecare services from April 2021, to ensure compliance with the National Living Wage and sustainable quality services for local authorities and the NHS. It includes equivalent calculations for the voluntary UK Living Wage, the Scottish Living Wage, and the London Living Wage between November 2020 and October 2021.	JT/140-INQ000571033
22 April 2021	Care is not a Commodity This report contains the first results from the analysis of our comprehensive survey of how homecare local councils and NHS Trusts commission services. 739 providers responded to our survey across the UK. It highlights critical issues in the commissioning practices of homecare services by local councils. We warn that the emphasis on cost-cutting over quality poses significant risks to the safety, dignity, and sustainability of homecare services. We set out immediate actions required from both local authorities and government to address funding shortfalls, ensure fair commissioning practices, and maintain the viability of homecare providers.	JT/018-INQ000571014
28 May 2021	An Overview of the UK Homecare Market This report provides a detailed summary of the homecare market in the United Kingdom. This includes recent market trends, such as how many people receive homecare, the number of hours of homecare provided and the funding received by the sector.	JT/141-INQ000571035
13 September 2021	Impact Report 2020-2021 This report summarises the Homecare Association's work (as UKHCA) on behalf of members and activities during 2020-2021. This includes how we represented our membership during the COVID-19 pandemic.	JT/142-INQ000571036

01 October 2021	What if you need care at home and there's no one to provide it? Authored by Age UK and the Homecare Association. This report highlights the workforce pressures within homecare, and the adverse effects on older people in need of support at home.	JT/143-INQ000571037
25 October 2021	The Homecare Deficit 2021 Homecare Association reports on a comprehensive enquiry to 340 public organisations in the UK, which purchase homecare across the UK, consisting of local authorities, Health and Social Care (HSC) Trusts in Northern Ireland and NHS bodies. Our research revealed a continued funding deficit for homecare services and highlighted the need for proper investment to address unmet needs and reduce inequalities.	JT/144-INQ000232402
17 December 2021	A Minimum Price for Homecare (April 2022 to March 2023) In this report, the Homecare Association sets as a Minimum Price for Homecare of £23.20 per hour for homecare services from April 2022, to ensure compliance with the National Living Wage and sustainable quality services for local authorities and the NHS. This is based on the UK's statutory National Minimum Wage and National Living Wage increase. The rate includes the minimum legally compliant pay rate for care workers, travel time, mileage, and wage-related on-costs.	JT/145-INQ000571039
08 February 2022	Homecare in Northern Ireland: The current state of play. Authored by the Homecare Association and Independent Health & Care Providers (IHCP). The report recommends supporting and strengthening Northern Ireland's independent homecare sector. This includes ongoing financial support so homecare providers can pay their staff improved wages, funding for HSC Trusts and a requirement to pay a fair price for care, and improved commissioning practices.	JT/146-INQ000571040

7 October 2022	Impact Report 2021-2022 This report summarises the Homecare Association's work on behalf of members and activities during 2021-22. This includes how we represented our membership through the COVID-19 pandemic for a further year.	JT/147-INQ000571034

Annex D–Homecare Association blogs

Date	Blogs	Exhibit
26 April 2020	United Kingdom Homecare Association (UKHCA) blog on homecare at the time of coronavirus. This blog calls for urgent government investment in homecare services at the start of the COVID-19 pandemic. It argues that supporting people at home could prevent unnecessary admissions to hospitals and care homes. It also highlights the need to avoid multiple homecare provider failures because of rising costs and falling revenues.	JT/058-INQ000574069
13 August 2020	UKHCA's blog on funding and workforce. We call for funding to address issues like workforce retention, fair pay for care workers, and quality of care delivery.	JT/013-INQ000574127
15 December 2020	UKHCA's Minimum Price for Homecare for April 2021 to March 2022	JT/148-INQ000581160

	This blog reports on our new Minimum Price for Homecare of £21.43 per hour, effective from April 2021. Further details are in our 'A Minimum Price for Homecare (April 2021 to March 2022)–Report ' (JT/077).	
2 February 2021	UKHCA's blog on progress of vaccination of homecare workers against COVID-19. This blog discusses the progress of COVID-19 vaccination roll out among homecare workers in England. It covers survey results showing that about 32% of homecare workers had received vaccinations, with significant variations observed across the country. We call for improved communication between local authorities and care providers to ensure all eligible workers can access vaccinations.	JT/063-INQ000574052
23 March 2021	Vaccination against COVID-19–should it be compulsory for homecare workers? This blog discusses the debate surrounding the potential compulsory vaccination of homecare workers against COVID-19 and our concerns about this.	JT/149-INQ000574079
25 March 2021	National Audit Office (NAO) Value for Money Report on Adult Social Care in England	
19 July 2021	UKHCA's blog on shortage of care workers in homecare This blog focuses on our concerns about inadequate workforce capacity to meet demand for homecare. It highlights that 91% of	JT/111-INQ00

	members surveyed said recruitment was harder than before COVID-19. Two-thirds reported more care workers were leaving their roles than before the pandemic. Competition with other sectors, COVID-19 and migration policies were affecting capacity, requiring urgent policy changes.	0574054
3 September 2021	Funding for social care–UKHCA response to news reports This blog, written by UKHCA's CEO, Dr Jane Townson, welcomes the Prime Minister's intention to address social care funding and reform, emphasising the need for investment in home-based care, community support, and the homecare workforce to help people live well at home.	JT/150-INQ000574081
8 September 2021	Health and Social Care Levy–UKHCA view on government announcement about funding for health and social care This blog post criticises the UK government's announcement of a new Health and Social Care Levy, arguing that the proposed £5.4 billion allocated for social care over three years is insufficient to address existing problems in the sector or implement meaningful reforms.	JT/151-INQ000574082
13 September 2021	Homecare Association blog on homecare workforce shortages continue. This blog concerns a second Homecare Association member workforce survey which revealed that 95% of homecare providers are facing increased recruitment difficulties, 65% are experiencing higher care worker turnover rates, and 89% are witnessing a surge in demand for homecare services, with key challenges	JT/117-INQ000574055

	revolving around pay, terms of employment, and workforce capacity. 78% described recruitment as the hardest it has ever been.	
2 October 2021	Fuel availability–impact on homecare delivery This blog describes a survey conducted by the Homecare Association in October 2021 which revealed that 73% of homecare providers were still experiencing negative effects from fuel shortages a week after the fuel crisis began. This led to late, reduced, or missed care calls for vulnerable older and disabled people, while providers struggled with inadequate support from government and local authorities.	JT/118-INQ000574056
12 October 2021	Homecare Association blog on homecare needs recognition not rationing. This blog discusses the challenges facing the homecare sector in the UK, including staff shortages, low wages, and inadequate government funding, while emphasising the need for better recognition and support for care workers who provide essential services to older and disabled people.	JT/152-INQ000574071
1 November 2021	Homecare Association blog on who will care? Risks of making vaccination a condition of deployment in homecare. This blog describes member survey results which found that 65% of members anticipated severe impacts on their businesses if vaccination against COVID-19 was a condition of deployment. 30% thought they would be able to continue business. 64% thought it was unlikely. Most members predicted increased recruitment costs, more difficult recruitment, dismissals, employee relations issues, reduced weekly hours, hand backs or closures.	JT/064-INQ000574057
1 December 2021	Homecare Association blog on people at the Heart of Care - our views on the White Paper.	JT/153-INQ00

	This blog discusses the Homecare Association's views on the UK government's Adult Social Care Reform White Paper. While the author, Dr. Jane Townson, welcomes the paper's vision for home-based support and care, she expresses concerns about inadequate funding and systemic issues that may prevent the aspirations from becoming reality.	057407 2
15 December 2021	Homecare Association blog on homecare workforce shortages deepen. In a third workforce survey of members, described in this blog, 98% of providers said recruitment was harder than before the COVID-19 pandemic, with 85% stating it was the hardest it has ever been. 75% of providers reported more care workers leaving their jobs than before the pandemic, and 93% of providers stated service demand had increased or significantly increased. Pay and terms and conditions were the greatest challenges.	JT/070-INQ00 057405 8
17 December 2021	Homecare Association Minimum Price for Homecare 2022-2023 This blog announces the Homecare Association's new calculation for the Minimum Price for Homecare of £23.20 per hour, effective from April 2022, which represents the amount required to ensure legally compliant pay rates for care workers, cover operational costs, and maintain a financially sustainable care business. This refers to the report: 'Homecare Association Minimum Price for Homecare 2022-2023' (JT/083).	JT/154-INQ00 058116 1
21 January 2022	Homecare Association blog on risks of ridiculous regulations. This blog argues against regulations requiring COVID-19 vaccination as a condition of deployment for homecare workers in the UK. While strongly supporting vaccination in general, Dr. Jane Townson contends that the regulations are based on questionable	JT/066-INQ00 057407 3

	scientific evidence and could lead to the loss of up to 100,000 homecare workers at a time of already high unmet need, posing significant risks to those receiving care.	
25 February 2022	Homecare Association blog on continuing lack of homecare workers. The Homecare Association's fourth workforce survey of members in January 2022, described in this blog, reveals ongoing challenges in recruiting and retaining homecare workers, with 97% of providers reporting harder recruitment than before the pandemic, despite some easing of pressures since November 2021.	JT/055-INQ000574059
13 April 2022	Fuel costs and homecare–impact on service capacity. This blog looks at results of a Homecare Association survey which reveals that rising fuel costs are severely impacting homecare services in the UK, with 95% of providers reporting staff anxiety about cost-of-living increases, 92% concerned about financial viability, and many struggling to maintain adequate mileage reimbursement rates, leading to staff retention issues and potential service disruptions.	JT/119-INQ000574060
22 May 2022	Homecare–the need to change public opinion This blog discusses the challenges facing the homecare sector in the UK, including workforce shortages, funding issues, and the need to change public perception to prioritise social care alongside healthcare.	JT/155-INQ000574083
1 June 2022	Shortage of homecare and unmet need–impact of cost of living and removal of COVID-19 grants	JT/156-INQ00

	This blog presents findings from a Homecare Association survey conducted in April 2022, highlighting the severe impact of removing the Infection Control and Testing Fund on homecare workers' pay, workforce capacity, and ability to meet care demands, ultimately affecting the well-being of older and disabled people needing homecare services.	057406 1
10 June 2022	Fuel costs hit homecare hard This blog discusses how rising fuel costs in the UK have significantly impacted the homecare sector, with providers spending an estimated £75 million more on fuel annually compared to the previous year, leading to concerns about financial viability and staff retention.	JT/157-INQ00 057408 5

Annex E–A list of Homecare Association run webinars

Date	**Webinar**
18 March 2020	COVID-19–Update webinar for UKHCA Members
24 March 2020	COVID-19–Update webinar for UKHCA Members
1 April 2020	COVID-19–Update webinar for UKHCA Members
9 April 2020	COVID-19–Update webinar for UKHCA Members
23 April 2020	COVID-19–Update webinar for UKHCA Members
6 May 2020	COVID-19–Update webinar for UKHCA Members

20 May 2020	COVID-19 Webinar - Risk, indemnity, insurance and mitigating legal liabilities for homecare services - to discuss the impact of coronavirus on insurance for homecare services. Webinar by our insurance partner, Towergate Insurance, and legal partner, Anthony Collins, and CQC.
3 June 2020	COVID-19–Update webinar for UKHCA Members
17 June 2020	UKHCA Members' Webinar: Future of homecare - COVID-19 and beyond–to consider the future of homecare, reflect on how staff teams have responded to the pandemic, and the lessons learned. Webinar with DHSC, LaingBuisson and expert providers.
22 July 2020	UKHCA Members' Webinar: The role of technology in homecare and supporting integration with health services–including data collection, digital transformation and home-monitoring. Webinar with technical and practitioner experts.
6 August 2020	Webinar: Campaigning for Zero-Rated VAT for Social Care–information about a campaign to lobby for a change to the current VAT regime for social care]
17 September 2020	COVID-19 update for UKHCA Members
15 October 2020	UKHCA Members' Webinar: The future of the homecare workforce - to consider the future of homecare workforce, reflect on how staff teams have responded to the pandemic, and the lessons learned. Webinar with Liz Kendall MP, Shadow Minister for Care, Skills for Care, and others.
16 December 2020	Webinar - COVID-19 and beyond - Update for UKHCA Members

30 March 2021	Webinar - COVID-19 and beyond: Members' update
28 April 2021	Webinar: Homecare futures - Homecare around the world in COVID-19 and beyond - an opportunity to hear the experiences of different countries in responding to COVID-19 and what this might mean for the future role of homecare. Webinar with an academic and international practitioner panel.
16 June 2021	Insurance market update, plus advice on preparing for renewal and risk management - free webinar. Webinar with Towergate Insurance Brokers, DHSC and others.
8 July 2021	Webinar - COVID-19 and beyond: Members' update
8 December 2021	Member's update webinar via Zoom
14 December 2021	Vaccination as a condition of deployment Webinar by partner organisation, Anthony Collins Solicitors LLP, looking at the legal aspects of this proposed policy.
21 April 2022	Webinar: How to approach your CQC inspection Webinar by partner organisation, Anthony Collins Solicitors LLP.

Annex F–Magazine articles

Date	**Magazine articles**	**Exhibit**
4 June 2021	Care Markets: Dr. Jane Townson "Homecare fees 'glaringly short' of the amount required." This article describes a campaign launched by the Independent Health & Care Providers (IHCP) and UKHCA to improve hourly rates for homecare workers in Northern Ireland. This aims to end	

	15-minute visits and £15 per hour fee rates, which are leading to low pay for care staff. Northern Ireland has the highest level of 15-minute visits in the UK, with over 30% compared to 3.5% in England. The campaign seeks fair contracts and rates for the sector.	
October 2021	Care Management Matters: Dr. Jane Townson 'Straight Talk,' on "Homecare workforce: inadequate capacity to meet rising demand and potential impact of vaccination as a condition of deployment." The article discusses severe staff shortages in the UK home care sector, with 95% of providers reporting harder recruitment compared to pre-pandemic levels and 89% experiencing increased demand for services. Dr. Jane Townson calls on the government to provide better funding, fair pay for care workers, and to develop a long-term workforce strategy for social care.	JT/158-INQ000574074
March 2022	Homecare magazine, March 2022 edition, Homecare Association's magazine for members.	JT/159-INQ000571041
June 2022	Homecare magazine, June 2022 edition, Homecare Association's magazine for members.	JT/160-INQ000571041

Annex G–Advice notes on C19 guidance for members

Date	**Advice notes for members**	**Exhibit**
31 July 2020	Briefing note on travelling abroad and quarantine restrictions, commissioned from Anthony Collins Solicitors LLP.	JT/161-INQ00

		0571043
15 February 2021	Self-isolation requirements for live-in care workers who have tested positive for COVID-19, commissioned from Anthony Collins Solicitors LLP.	JT/162-INQ0005710444
19 February 2021	Advice note in relation to live-in care workers who test positive for COVID-19, commissioned from Anthony Collins Solicitors LLP.	JT/163-INQ0005710445
Updated 25 June 2021	Costing Model we designed to assist members (and others) calculate a fair price for homecare services. This contains a figure for standard PPE costs, which increased in the pandemic. We excluded PPE specifically required for COVID-19 from the calculations. This public document is also available for commissioners to use.	JT/164-INQ0005740911