Witnesses Name: Jonathan Marron and Michelle Dyson

Statement No: 5

Dated: 2 June 2025

UK COVID-19 INQUIRY

FIFTH WITNESS STATEMENT OF JONATHAN MARRON AND MICHELLE DYSON

MODULE 6 CORPORATE STATEMENT C - KEY ISSUES IN ADULT SOCIAL CARE

I, Jonathan Marron, Director General for Primary Care and Prevention, at the Department of Health & Social Care, 39 Victoria St, Westminster, London SW1H 0EU, will say as follows, and I, Michelle Dyson, Director General for Adult Social Care at the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

INTRODUCTION

1. We make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 5 June 2024 made under Rule 9 of the Inquiry Rules 2006 (the Request) asking for a corporate statement on behalf of the Department of Health and Social Care (the Department) providing information on the role it played with regard to the UK Government's response to the COVID-19 pandemic, as it pertained to the adult social care sector between 1 January 2020 and 28 June 2022.

2. As this is a corporate statement on behalf of the Department, it necessarily covers matters that are not within our personal knowledge or recollection. As a corporate statement involving many different areas of policy within the Department, information has been gathered from many sources. It has been reviewed by us and by a corporate team who have examined a very large number of documents. It has also been shared with Rosamond Roughton who was Director General for Adult Social Care from April 2020

until July 2020. This statement is to the best of our knowledge and belief accurate and complete at the time of signing, in line with responding as far as possible with the Inquiry's deadlines. Notwithstanding, it is the case that the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality, the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be.

3. As set out above, I, Jonathan Marron, am a Director General for Primary Care and Prevention at the Department. I am responsible for the sections of this statement relating to Spring/Summer 2020. I first joined the Department in 1994 and have subsequently held various roles both inside the Department and across the healthcare system. I am currently the Director General for Primary Care and Prevention, having been made a Director General in 2017, initially on temporary promotion. In my current role I am responsible for policy on primary care, mental health, women's health, secondary prevention, the joint Health and Work Unit and the Office for Health Improvement and Disparities Regional Teams.

4. As set out above, I, Michelle Dyson, am the Director General for Adult Social Care at the Department. I am responsible for the sections of this statement relating to the period from Summer 2020 onwards. I have been a civil servant since joining as a government lawyer in the Home Office in 1998. I have been a senior civil servant since 2007, holding a number of posts across government including in the Department for Education (DfE), Department for Work and Pensions (DWP) and the Ministry of Justice (MoJ). I have been the Director General for Adult Social Care in the Department since 17 September 2020, initially on an interim basis, and then appointed permanently in May 2021.

ASYMPTOMATIC TRANSMISSION AND TRANSMISSION ROUTES

5. The Department's evolving understanding of asymptomatic transmission and its changes in approach were in response to the new and developing scientific evidence. As scientific understanding changed, the Government's pandemic response, which balanced health, economic and societal factors, necessarily evolved. Measuring and understanding each of the factors in the context of transmission was a particular challenge in the initial stages as evidence and data was limited.

6. For clarity, the definitions of asymptomatic and presymptomatic, are set out below **(MD/JM5/1 - INQ000562884)**:

a. Asymptomatic - an asymptomatic case is one in which someone has laboratory confirmed SARS-CoV-2 infection but does not develop symptoms (i.e., fever, dry cough, fatigue). Asymptomatic transmission refers to transmission of the virus from a person who did not develop disease symptoms.

b. Pre-symptomatic infection - pre-symptomatic cases are those in which infection is detected before the person develops symptoms. Pre-symptomatic transmission is defined as transmission that occurs during the pre-symptomatic phase of the viral incubation period.

7. It is important to understand that asymptomatic infection (a person is infected without having symptoms) is different from asymptomatic transmission (a person with no symptoms can transmit to others). Pre-symptomatic transmission is where a person becomes infectious, and becomes symptomatic, but they are infectious for a period (hours or days) before the symptoms appear. In asymptomatic transmission, the individual can transmit the virus despite having no symptoms at any point.

8. There are important differences between pre-symptomatic transmission and asymptomatic transmission from a perspective of disease control. The most important is that in pre-symptomatic transmission the case will be identified and counted, and their contacts can be identified and isolated, relatively easily (albeit later than in symptomatic infection). In asymptomatic transmission, it is much less likely the initial case will be identified early enough to institute contact tracing unless they are by chance tested whilst infectious.

9. Once it was realised that asymptomatic transmission of the disease was possible, this understanding was central to the formation of policy. Specifically in health matters such as the NHS, care home management, capacity, infection control measures and Personal Protective Equipment (PPE) requirements. The same understanding fed into decision making for non-pharmaceutical interventions (NPIs).

10. On 10 January 2020, Public Health England (PHE) published '*Wuhan novel coronavirus (WN-CoV) infection prevention and control guidance, guidance for healthcare providers*' **(MD/JM5/2 - INQ000325222)**. This guidance outlined infection prevention and control (IPC) advice for healthcare providers assessing possible cases of Wuhan novel coronavirus (WN-CoV), subsequently renamed COVID-19, which at the time was considered a high consequence infectious disease (HCID).

11. On transmission this guidance states:

> *"As WN-CoV has only been recently identified, there is currently limited information about the precise routes of transmission. Therefore, this guidance is based on knowledge gained from experience in responding to coronaviruses with significant epidemic potential such as Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV). It is known that both SARS-CoV and MERS-CoV can transmit person to person; although this is not yet confirmed for WN-CoV, it is reasonable to assume that human-to-human transmission is possible.*
>
> *There is currently little evidence that people without symptoms are infectious to others."*

12. On 22 January 2020, a precautionary SAGE meeting on COVID-19 took place with actions for the Department to consider, jointly with the Chief Medical Officer (CMO) and PHE, how NHS primary care facilities might respond to an increase of cases and potential cases. It was also to consider how to work jointly with the CMO and the FCDO to ensure consistent messaging on travel advice to/from Wuhan) **(MD/JM5/3 - INQ000174700**. The initial understanding of COVID-19 was set out in the meeting, including that there was evidence of person-to-person transmission and an apparent incubation period of within 5 to 10 days with 14 days a sensible outer limit.

13. On 28 January 2020, SAGE, following the first COBR meeting and the official establishment of SAGE under the COBR structure, met for the second time in response to COVID-19 - with the Department providing an update on the number of declared cases, deaths and geographic spread **(MD/JM5/4 - INQ000057492)**. The understanding of COVID-19 at that time was set out, including evidence that suggested a single point zoonotic outbreak being sustained by human-to-human transmission with a reproductive number (R-number) estimated between 2 and 3, with a doubling rate estimated at three to four days. The R-number is the average number of secondary infections produced by a single infected person. The Department was advised in the SAGE meeting to use the existing planning assumptions for an influenza pandemic to develop a Reasonable Worst Case Scenario (RWCS) for COVID-19 in the UK.

14. Until 28 February 2020, when the UK reported its first case of unknown origin, case numbers remained small and all had known links to travel. It was considered very unlikely that people in care homes or the community would become infected given the community

transmission rates as understood at the time and the low chance of care home residents travelling abroad. By the end of February 2020, a cumulative total of 23 cases of COVID-19 had been identified in the UK. There were no reported outbreaks in care homes at this time.

15. On 4 February 2020, a paper by the PHE virology cell on asymptomatic transmission was presented to SAGE **(MD/JM5/5 - INQ000074909)**. This outlined that it would be reasonable to assume that the early stages of illness may have lower viral load. It also noted that whilst the then available data was not adequate to provide evidence for major asymptomatic transmission, SAGE advised that, "*Asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely*" **(MD/JM5/6 - INQ000608139)**. Whilst asymptomatic transmission could not be ruled out, there was no substantial evidence to support it. This was further confirmed in the paper on the 24 February 2020 by the PHE National Infection Service which confirmed "*there is very limited evidence of transmission from asymptomatic cases. It is assumed that the substantial majority of transmission is from symptomatic individuals with SARS-CoV-2*" **(MD/JM5/7 - INQ000325224)**.

16. On 25 February 2020, PHE published its '*Guidance for social or community care and residential settings on COVID-19*' **(MD/JM5/8 - INQ000325225)**. In this guidance document, PHE provided the following explanation of COVID-19 transmission routes:

> *"**4. How COVID-19 is spread***
>
> *From what we know about other coronaviruses, spread of COVID-19 is most likely to happen when there is close contact (within 2 metres) with an infected person. It is likely that the risk increases the longer someone has close contact with an infected person.*
>
> *Respiratory secretions containing the virus are most likely to be the most important means of transmission; these are produced when an infected person coughs or sneezes, in the same way colds spread.*
>
> *There are 2 main routes by which people can spread COVID-19:*
>
> - *infection can be spread to people who are nearby (within 2 metres) or possibly could be inhaled into the lungs*
> - *it is also possible that someone may become infected by touching a surface, object or the hand of an infected person that has been contaminated with*

respiratory secretions and then touching their own mouth, nose, or eyes (such as touching a door knob or shaking hands then touching own face). Our current understanding is that the virus doesn't survive on surfaces for longer than 72 hours.

There is currently little evidence that people without symptoms are infectious to others."

17. PHE advised care settings (at paragraph 17.1 of the guidance) that, in the case of asymptomatic individuals, there was "*no need to change [their] approach*".

18. On 10 March 2020, in response to a question from the RWCS Team on asymptomatic / pre-symptomatic individuals and potential infection, the Deputy Chief Medical Officer (DCMO) (Jonathan Van-Tam) advised:

    "The evidence that people shed virus and are infectious to others whilst in the pre-symptomatic stages is highly limited and inconclusive. It is not possible to say there are no cases ever of pre-symptomatic transmission, but in relation to transmission from people with established symptoms the force of infection from asymptomatic people is likely to be extremely low. I do not advise that we complicate our case isolation policy and, if we were to do so, the science on pre-symptomatic transmission would need re- visiting by SAGE and/or NERVTAG before we did so" **(MD/JM5/9 - INQ000151568)**.

19. On 13 March 2020, the Infection prevention control (IPC) guidance was updated, and a section titled *'Infection prevention and control guidance for pandemic coronavirus*' included revised text on the understanding of COVID-19 transmission characteristics **(MD/JM5/10 - INQ000325350)**:

    "Assessment of the clinical and epidemiological characteristics of SARS-CoV-2 cases suggests that, similar to SARS-CoV, patients will not be infectious until the onset of symptoms. In most cases, individuals are usually considered infectious while they have symptoms; how infectious individuals are, depends on the severity of their symptoms and stage of their illness. The median time from symptom onset to clinical recovery for mild cases is approximately 2 weeks and is 3-6 weeks for severe or critical cases. There have been case reports that suggest infectivity during the asymptomatic period, with one patient found to be shedding virus before the onset of symptoms. Further study is required to determine the actual occurrence and impact of asymptomatic transmission".

20. Similarly, the rationale for the guidance was given as follows:

> *"Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak. The initial phylogenetic and immunologic similarities between COVID-19 and SARS-CoV can be extrapolated to gain insight into some of the epidemiological characteristics. The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces."*

21. On 20 March 2020, a NERVTAG meeting took place and members noted that, whilst there was data for people testing positive for SARS-CoV-2 without symptoms, there was very little information regarding transmission and the data from sporadic reports of asymptomatic transmission was not convincing **(MD/JM5/11 - INQ000119619)**.

22. On 24 March 2020, version 7 of the PHE paper '*Are asymptomatic people with COVID-19 infectious?*' was produced. It described cases of asymptomatic infection but said that these "*do not provide evidence for asymptomatic transmission of SARS-CoV-2*" **(MD/JM5/12 - INQ000325259)**.

23. On 2 April 2020, the World Health Organization (WHO) said that there were "*few reports of laboratory-confirmed cases who are truly asymptomatic, and to date, there has been no documented asymptomatic transmission*". WHO additionally reported the presence of pre-symptomatic spread in a small number of case reports and studies **(MD/JM5/13 - INQ000325256)**.

24. This evolving understanding of asymptomatic transmission was reflected in draft guidance. On 2 April '*Admission and care of residents during COVID-19 incident in care homes*' was approved by the Department, PHE, and NHS England and NHS Improvement (NHSE/I) **(MD/JM5/14 - INQ000325255).** The guidance recognised the vital role of social care in the national effort to respond to COVID-19. Regarding patients being discharged from hospital, it noted *"that some of these patients might have COVID-19, whether symptomatic or asymptomatic, and that all of these patients can be safely cared for in a care home if this guidance is followed*." At the same time, IPC guidance was updated and published **(MD/JM5/15 - INQ000339138)**. The 'methods of transmission' text was updated to include information on case reports suggesting possible infectivity prior to symptoms. The qualifier of the need for further study to define impact and importance remains:

"Assessment of the clinical and epidemiological characteristics of COVID-19 cases suggests that, similar to SARS, most patients will not be infectious until the onset of symptoms. In most cases, individuals are usually considered infectious while they have symptoms; how infectious individuals are, depends on the severity of their symptoms and stage of their illness. The median time from symptom onset to clinical recovery for mild cases is approximately 2 weeks and is 3 to 6 weeks for severe or critical cases. There have been case reports that suggest possible infectivity prior to the onset of symptoms, with detection of SARS-CoV-2 RNA in some individuals before the onset of symptoms. Further study is required to determine the frequency, importance and impact of asymptomatic and pre-symptomatic infection, in terms of transmission risks."

25. A substantial evidence base for asymptomatic transmission began to build from the beginning of April 2020. This developed as follows:

    a. On 3 April 2020, a very significant study was published by the US Centres for Disease Control and Prevention (CDC), based on outbreaks in care homes in Washington (published as an early release on 27 March 2020. The "CDC Washington study" was the first reference to evidence of asymptomatic and pre-symptomatic transmission of the virus. The authors had published an earlier report (published 27 March 2020, pre-print 18 March 2020) on a care home outbreak and its effects on the care homes residents, but this did not mention asymptomatic and pre symptomatic transmission of SARS-CoV-2, focusing rather on limitations in infection control and prevention and limitation of staff movement. The 3 April 2020 study concluded that "*Although these findings do not quantify the relative contributions of asymptomatic or pre symptomatic residents to SARS-CoV-2 transmission in facility A, they suggest that these residents have the potential for substantial viral shedding."* This study increased the impetus for PHE to conduct its own studies in care homes, as soon as testing capacity became available to support this work **(MD/JM5/16 - INQ000348269)**.

    b. On 8 April 2020, a briefing note was published by the London School of Economics (LSE) citing the pre-print of the Wei et al (2020) study on pre-symptomatic transmission mentioned below, and the CDC papers mentioned above. This briefing note referenced the growing asymptomatic transmission evidence base **(MD/JM5/17 - INQ000325331)**. As with the CDC Washington

study this added further impetus for PHE to conduct its own studies and work started on this from 9 April 2020.

c. On 10 April 2020, a further study was published by the CDC, by Wei et al, 2020 (published as an early release on 1 April 2020). The study reviewed data from seven epidemiological clusters in Singapore and explored the issue of pre symptomatic transmission. The study concluded that, in combination with evidence from other studies, there was a "*likelihood that viral shedding can occur in the absence of symptoms and before symptom onset*", providing further weight to the evidence base for asymptomatic transmission **(MD/JM5/18 - INQ000325253)**.

26. From 9 to 13 April 2020, PHE identified testing capacity at Colindale Laboratory in London to allocate tests to a care homes study. PHE carried out two studies in care homes between 13 and 24 April 2020 **(MD/JM5/19 - INQ000325352; MD/JM5/20 - INQ000325353; MD/JM5/21 - INQ000325354)**. The first was an enhanced surveillance study and swabbing in 95 care homes (the "*enhanced care home outbreak study*"). The second was a whole genome sequencing study in six care homes (the "*Easter 6 Study*"). PHE was the first in the world to undertake these kinds of studies, which went significantly further than the research published by the CDC, by utilising whole genomic sequencing in studying both care settings with known outbreaks and those with no known cases. The purpose was to understand better the transmission of the virus in care homes and inform urgent public health interventions.

27. As part of these studies, PHE assessed SARS-CoV-2 positivity in residents and staff at the care homes and followed them daily for two weeks. The resulting data found that across the six care homes, 39.9% of residents (107/268) were SARS-CoV-2 positive. Of these only 27.1% were symptomatic at the time of testing, and 44.9% remained asymptomatic throughout. It was the largest international dataset and strongest evidence to date showing that it was likely that the virus was being transmitted asymptomatically and that staff played a key role as a vector of asymptomatic transmission. The available data was analysed, and preliminary findings shared with the UK Senior Clinicians Group and the Department as soon as these were available in the week commencing 13 April 2020. Similar studies seeking to explore asymptomatic infection were also underway during this period, including studies conducted on 440 individuals in a Military Barracks (the '*Barracks study*'), as well as screening of 5000 individuals across 11 hospitals **(MD/JM5/22 - INQ000325283)**.

28. Interim results and analysis from the enhanced *'care home outbreak study'*, *'the Easter 6 study'* **(MD/JM5/23 - INQ000120155)** and *'the Barracks study'* **(MD/JM5/24 - INQ000325272)** were presented at NERVTAG on 24 April 2020 **(MD/JM5/25 - INQ000325270)** and further analysis presented to SAGE on 12 May 2020. NERVTAG noted the evidence of the presence of virus was found in individuals without symptoms **(MD/JM5/26 - INQ000215622)**. NERVTAG concluded that there remained uncertainty around the level of transmissibility of asymptomatic cases and around cases that were truly asymptomatic, as distinct from pre-symptomatic or mildly symptomatic. However, scientific advisors recommended that steps should nonetheless be taken to protect vulnerable individuals in care settings from asymptomatic transmission.

29. The advice that scientists gave to Government on risk in care homes was updated in light of the international and national studies. From the publication of the CDC Washington study onwards, PHE applied a precautionary approach, and over the course of April, they began to advise that:

    a. There is likely to be a degree of asymptomatic transmission of COVID-19 in care homes in both residents and staff.
    b. By the time a single symptomatic case is identified in a home, the virus will probably already be circulating in the home amongst residents and staff. Temporary staff are likely to be vehicles for imported transmission with infections being imported into care homes and between care homes by staff, especially whilst the usual staff are self-isolating.

30. On 17 April 2020, '*How to work safely in care homes*' was published by PHE to provide guidance for care workers on the use of PPE, given that COVID-19 was circulating in the community at high rates and that symptoms can differ from person to person **(MD/JM5/27 - INQ000303275)**. A significant feature of the guidance was that it recognised that at the time, approximately one third of people who carry COVID-19 do so without having symptoms and so it recommended that PPE was used for all care, and not just for patients with symptoms. This led to huge implications on IPC measure in care homes, together with the volume and type of PPE that would be required.

31. The emerging evidence from the studies referred to above, was that outbreaks in care homes were being introduced into care homes by staff and that there were a high number of asymptomatic or presymptomatic cases in staff and residents. This was also an issue in homecare and on 27 April 2020 PHE published guidance for carers entitled: "COVID-

19: how to work safely in domiciliary care in England" **(MD/JM5/28 - INQ000325274; MD/JM5/29 - INQ000303276)**.

32. The Government's '*COVID-19: Care home support package*' published on 15 May 2020 **(MD/JM5/30 - INQ000325278)** made reference to the scientific evidence showing significant asymptomatic transmission of COVID-19 in care homes via both residents and staff, similar to transmission in the wider community. It explained that by the time a single symptomatic case is identified in a care home, the virus was likely to be already circulating amongst residents and staff.

33. Over the course of the summer 2020, studies continued to address this issue in the UK and globally, but still the evidence was mixed. SAGE and NERVTAG continued to consider the evidence.

34. On 3 July 2020, the '*Vivaldi 1: COVID-19*' study was published, based on analysis of survey responses from 5,126 out of 9,081 care homes for the over 65s in England **(MD/JM5/31 - INQ000106159)**. Analysis of test results from the Whole Care Home Testing Programme (of all 9,081 homes tested via pillar 2 between 11 May and 7 June), showed that:

    a. 2.4% of all tests were positive (9,674 out of 397,197)

    b. 3.9% of residents tested positive (6,747 out of 172,066)

    c. 3.3% of asymptomatic residents tested positive (5,455 out of 163,945)

    d. 80.9% of residents who tested positive were asymptomatic (5,455 out of 6,747)

    e. 1.2% of asymptomatic staff tested positive (2,567 out of 210,620).

35. It was not until 9 July 2020 that WHO published a report acknowledging asymptomatic transmission, but its conclusion was still that the scale of asymptomatic transmission remained unknown **(MD/JM5/32 - INQ000325284)**.

36. At a meeting on 4 September 2020, NERVTAG noted that the evidence of asymptomatic transmission was still very mixed between studies, showing a wide variation in the proportion of infections that are symptomatic across different studies **(MD/JM5/33 - INQ000220150)**.

37. Even at the end of 2020, understanding of asymptomatic infection and transmission continued to be explored, in terms of the scale of asymptomatic infection and its role in transmission.

INFECTION PREVENTION AND CONTROL (IPC) AND PPE FOR THE ADULT SOCIAL CARE SECTOR

38. IPC is a key component of normal healthcare and social care given the naturally frail nature of patients and residents within those environments, combined with the risk of spread of infection from person to person, including to and from caregivers. Consequently, there are regulatory requirements that underpin the need for employers to keep staff safe. These remained in place throughout the pandemic. The Department and wider government efforts were to assist in meeting these requirements within the pandemic but did not replace the employer responsibility to keep their employees, service users, and recipients safe.

39. The need to keep staff safe is an employer competency underpinned by the Health and Safety Act 1974 and regulated by the Health and Safety Executive (HSE). For Care Quality Commission (CQC) registered providers, providers are required to ensure that care and treatment is provided in a safe way, including in relation to IPC (see, regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Providers must also have due regard to the Code of Practice relating to healthcare associated infections (Health and Social Care Act 2008: code of practice on the prevention and control of infections) issued by the Secretary of State under section 21 of the Health and Social Care Act 2008 **(MD/JM5/34 - INQ000339344; MD/JM5/35 - INQ000130549)**. Accordingly, the prevention of nosocomial infection, i.e., infection originating in the hospital or care setting, to staff and patients is a core function of health and care providers.

40. IPC guidance and mitigations are based on the HSE's 'Hierarchy of Controls'. In order to protect against risks, HSE guidance **(MD/JM5/36 - INQ000339330)** states that these controls should be considered in the following order, from the most effective, to the least effective:

    a. Elimination – physically remove the hazard
    b. Substitution – replace the hazard
    c. Engineering controls – isolate people from the hazard
    d. Administrative controls – change the way people work

e. PPE – protect the worker with equipment.

41. PPE is the least effective of the mitigations available, with the highest risk of failure.

42. This section concentrates on IPC guidance as it relates to PPE, however paragraphs 191-- 483 of this statement sets out actions underpinned by IPC guidance to mitigate the risk of recipients of adult social care and staff contracting COVID-19 as part of the hierarchy of controls. These include, but are not limited to:

    a. Adult social care visiting policy – aiming to reduce the introduction of COVID-19 into care facilities from the community
    b. Adult social care testing policy – aiming to identify care staff and residents infected with covid-19
    c. NHS discharge and care home admission policies
    d. Reorganisation of care home layout to maintain social distancing

PPE

43. Identifying IPC mitigations needed to manage a particular risk was the responsibility of employers based on a risk assessment, including decisions on what PPE was required. In the NHS, assistance to support risk assessment was provided via central guidance from NHS England (NHSE) on approaches to IPC and this was incorporated into local policies. An example is the move to 'bare below the elbows' to facilitate effective hand washing and reduce microbial spread of infection from contaminated sleeves.

44. During the pandemic, guidance to support adult social care providers in making IPC risk assessments and decisions specific to COVID-19 was published by PHE. This guidance was created by representatives of the UK Four Nations IPC Cell (a group of NHS and PHE IPC clinicians tasked with creating IPC guidance during the pandemic). The Department was not involved in the formulation of IPC guidance. The consequential publications are provided where relevant below.

45. Guidance produced to support social care providers with IPC followed NHS best practice, for example a 2018 National Institute for Health and Care Excellence guide titled "Helping to Prevent Infection" for managers and staff in care homes mirrored the "bare below the elbows" advice **(MD/JM5/37 - INQ000576752)**. Similarly, guidance was provided by the Department and PHE to provide care home managers and CQC inspectors a common source of information on the prevention and control of infection in care homes, taking into account the differences between the NHS and the care sector.

What is PPE?

46. As part of broader IPC measures, several non-pharmaceutical interventions (NPIs) support the protection of patients and health workers (and others) from being harmed by avoidable infections.

47. NPI consumable items for use in healthcare settings as part of IPC measures are collectively termed PPE. PPE is defined under Regulation (EU) 2016/425 on personal protective equipment and repealing Council Directive 89/686/EEC as incorporated into UK law by the European Union (Withdrawal) Act 2018.

48. PPE includes the equipment an individual wears to protect themselves from risks to their health or safety, including exposure to infectious agents. The level of PPE required depends on the:

    a. Suspected or confirmed infectious agent;
    b. Severity of the illness caused;
    c. Transmission route of the infectious agent; and
    d. Procedure or task being undertaken.

49. The Department's pandemic response for using PPE was based on available guidance on IPC. Standard IPC precautions include PPE and are supplemented by specific transmission-based precautions as needed; further information is provided on both of these in the below sub-sections. This includes the use of respiratory protection, splash protection for the eyes, clothing, and hand protection **(MD/JM5/2 - INQ000325222; MD/JM5/38 - INQ000339301; MD/JM5/39 - INQ000339307; MD/JM5/40 - INQ000339306; MD/JM5/41 - INQ000339312; MD/JM5/42 - INQ000339302)**.

Standard Infection Prevention Control Precautions

50. Even when not dealing with pandemic conditions, infection prevention precautions are essential in health and care settings; some of the key measures are set out below. Hand Hygiene is considered one of the most important ways to reduce the transmission of infectious agents that cause healthcare associated infections.

51. Examination Gloves are worn where exposure to blood and/or other bodily fluids, non-intact skin or mucous membranes is expected. Gloves are changed after each patient and/or after each procedure, even if on the same patient. Gloves can be made of different materials, which have specific characteristics. Due to its strength and barrier properties

Nitrile is now usually the accepted material of choice for gloves used in healthcare, but vinyl gloves are also commonly used in care settings.

52. Aprons are worn where contamination of clothes is expected or likely. They are also changed between patients and/or after completing a procedure or task.

53. Eye or Face Protection is worn if blood or other bodily fluid contamination to the eyes or face is anticipated or considered likely, such as when performing aerosol generating procedures, such as airway suction.

54. Surgical face masks are classed as 'Type I' (minimum 95% bacterial filtration rates),'Type II' (minimum 98% bacterial filtration rates) or 'Type IIR' (minimum 98% bacterial filtration rates and additional fluid resistance). They are used as source control to protect the patient from the wearer during sterile procedures. When fluid resistant mask are used, they also protect the wearer when there is risk of splashing or spraying of bodily fluids onto the respiratory mucosa. They are also used as an element of respiratory PPE for droplet precautions. Surgical face masks come in a single size to fit all. A 'fit test' is not necessary for surgical masks which are secured with either tie back straps or elasticated ear loops, but masks must still be well fitting, covering both the nose and mouth.

Specific Transmission-Based Precautions

55. As well as products that are used for standard infection prevention measures, there are PPE products that are used specifically to reduce transmission risks as set out in IPC guidance.

56. Respiratory Protective Equipment (RPE) are tight fitting masks which include a filtering face piece (FFP). FFP2 masks have a filtration efficiency of approximately 94% for particles 0.3micron or larger. FFP2s are widely used internationally as RPE, however within healthcare in the UK the higher standard of FFP3 is preferred (excepting some FFP2 products that are used within dentistry). FFP3 masks provide a minimum filtration efficiency of 99% for 0.3micron particles. HSE requires fit testing for RPE to ensure adequate protection is provided as the effectiveness of these products relies on the mask being tight-fitting.

57. During the pandemic use of RPE was recommended by IPC guidelines for where aerosol generating procedures were being performed. These procedures are much less common outside of hospital settings, so accordingly the use of RPE was lower within care settings.

58. Prior to the pandemic, procurement of PPE was the responsibility of the individual employer. For community providers, including adult social care and GP's, private wholesalers were the main source of PPE. Overall, compared with other clinical consumables within health and care, the procurement of PPE was not high volume or high cost. Of the PPE used, aprons and gloves were the highest volume used, with high-grade respiratory PPE such as FFP3 masks used in low volumes in the NHS and hardly at all in adult social care, due to PHE and clinical advice that it was not necessary **(MD/JM5/43 - INQ000610083)**.

59. The devolved nature of procurement and logistics meant there was no centralised information on supply resilience in adult social care for PPE at the point of which the pandemic emerged.

60. In response to the threat from pandemic influenza in 2009, the Government had recognised the potential for supply chain disruption in clinical consumables and had created a stockpile, including PPE, held by each of the Four Nations. The Department funded the stockpile, but operational responsibility for procurement (and storage of England's portion) at the start of the relevant period was in the hands of PHE, and oversight of the stockpile was via the Clinical Countermeasures Board of which the Department was a member. It was built to respond to a RWCS influenza pandemic in which 50% of the UK population would become symptomatic, over a 15-week period. The PPE items within the stockpile, whilst chosen for influenza, were the same that were needed for COVID-19.

61. The stockpile was intended to supply PPE to health and social care providers to manage symptomatic patients with influenza. It was not designed to provide PPE to meet business-as-usual demands or a move to universal PPE within health and care settings for all episodes of care. At the point the pandemic began the stockpile was at a point where it was being replenished to replace stock which was becoming aged, to incorporate newly recommended items such as gowns or to seek to extend the expiry date of stock where safe to do so. Specifically the stockpile contained a quantity of masks that were undergoing quality assurance and shelf-life extension testing to determine whether these could be safely deployed, or if replenishment procurement exercises were required. This process was incomplete, but nonetheless the stockpile provided vital support as it was deployed to support health and care settings whilst the Department's procurement efforts to source PPE could take effect.

Supply and Adequacy of PPE for ASC Throughout the Pandemic

PPE Supply: Background

62. IPC preparations for potential outbreaks of COVID-19 in the UK began with the publication of guidance by PHE on 10 January 2020 **(MD/JM5/44 - INQ000339103)**, with further publications of guidance occurring regularly thereafter as further information became available to the NHS and PHE IPC teams working as the IPC Cell.

63. At this point any cases of COVID-19 were expected to be managed in specialist infectious disease centres pending characterisation of the virus and not in general health or care facilities. Accordingly, patient care demanded a higher level of PPE to be worn, including: FFP3 respirator masks; fluid-repellent disposable gowns; gloves with long tight-fitting cuffs; disposable surgical caps; and eye protection. Minor iterations this guidance remained in place until early March 2020.

64. Health and care organisations began bolstering their local reserves of PPE and other clinical products. They used their normal routes of supply via increased procurement directly with suppliers and wholesalers, and for NHS secondary care via NHS Supply Chain Coordination Limited (SCCL).

65. Healthcare continuity of supply was recognised as a key concern given the location of the primary outbreak in China (the country that manufactures the most PPE) and the resulting disruption to clinical consumables manufacturing caused by Chinese regional lockdowns, closure of international borders, and export controls introduced at the end of January 2020. The Department and the NHS responded by gathering representatives from the Department, NHSE, PHE, SCCL and Devolved Government officials to form the 'Supply Chain Cell' from 30 January 2020. The cell then coordinated the response to continuity of supply issues, including those relevant to social care as they arose and was active for the next six weeks, meeting daily. Throughout this period the Department's role was one of oversight and assistance with procurement, whilst the ongoing effort to buy PPE remained with PHE, SCCL, NHSE and individual providers of health and care.

66. In early February 2020, NHSE, SCCL and PHE reported that they had activated contingency procurements for PPE, including activating sleeper contracts to bolster the Pandemic Influenza Preparedness Programme (PIPP) stockpile and increasing procurements through existing framework agreements. The Department encouraged them to continue effective preparations for all items of PPE, including gowns (which there was a particular concern and concentrated effort in the Department to source given the

PIPP stockpile did not contain them). Throughout February 2020, as COVID-19 cases outside of China began to be detected, an international scramble to obtain PPE began. Despite the efforts of the Supply Chain Cell, it became increasingly clear that existing routes of procurement and distribution were unable to meet the demands of the system as the first wave of the pandemic approached. Contracts agreed were not being fulfilled, delivery schedules slipped and private wholesalers reported being unable to source PPE for community and social care providers.

67. By 27 February 2020, the WHO acknowledged the acute global shortage of PPE. On 3 March 2020, in response to the shortage of PPE endangering health workers worldwide, WHO issued a call for industry and governments to increase manufacturing by 40%. However, acute global supply issues persisted. One effect of this was that countries banned exports of PPE, such as France and Germany, which were two of the first to implement this policy, banning exports of PPE on 3 March 2020. China announced additional restrictions on exports at the end of the month, effective from 1 April 2020.

68. On 13 March 2020, PHE guidance entitled 'COVID-19: guidance on residential care provision' was published **(MD/JM5/45 - INQ000325233)** reflecting increased knowledge of the transmission of COVID-19 and the need to support local providers with COVID-19 IPC risk assessments given the continued increase in case numbers across the world. The guidance was aimed at local authorities, Clinical Commissioning Groups (CCGs) and registered providers of accommodation for people in need of personal or nursing care. This guidance included the following recommendations:

    a. When someone in a care home displayed symptoms of COVID-19, whilst care homes were not expected to have "dedicated isolation facilities", they were directed to implement isolation precautions in the same way that they would if someone had influenza (using the individual's own room, which should ideally have en-suite facilities).

    b. Staff were directed to use PPE for activities bringing them into close personal contact with symptomatic individuals, such as washing and bathing, personal hygiene and contact with bodily fluids (aprons, gloves and fluid repellent surgical masks, as well as eye protection where there was a risk of splashing), with new PPE being used for each episode of care.

    c. Advice was also provided on management of waste and laundry.

69. It was clear by mid-March 2020 that existing buying and distribution mechanisms were not coping and the Government decided to step in to buy and distribute PPE as a provider

of last resort. The Department sought assistance from the military and across government. Cabinet Office deployed central government procurement experts to the Department to assist in identifying opportunities for PPE and together with SCCL, NHSE/I and the military it was decided that a cross-government effort led by the Department to buy and distribute PPE directly was needed. Leveraging skills and resources from across government and the NHS, building on PPE expertise within SCCL transferred to the team and working with industry partners the Parallel Supply Chain was formed on 1 April 2020. The immediate aim of the Parallel Supply Chain was to stabilise supply to the NHS and adult social care as set out in the PPE Plan published on 10 April 2020 **(MD/JM5/46 - INQ000050008)**.

70. The Parallel Supply Chain prioritised buying from existing suppliers to the NHS and SCCL, but also sought opportunities with manufacturers identified by Foreign Commonwealth Office officials in China, directly with UK manufacturers and from those offering sourcing opportunities to the Government via their contacts with PPE manufacturers worldwide. The Department made the first agreement for PPE on 22 March 2020 and flights bringing in Department-bought PPE started on 3 April 2020. Deployment of stock from the PIPP stockpile provided a buffer whilst supplies were airfreighted in.

71. The Inquiry is examining PPE procurement in detail within Module 5, therefore further details on the procurement activities of the Parallel Supply Chain will be provided in Module 5.

72. PHE guidance entitled 'How to work safely in care homes' was published on 17 April 2020 **(MD/JM5/27 - INQ000303275)**, containing recommendations on the use of PPE for care workers working in care homes. This guidance also specified that it was relevant for those providing residential supported living services. It confirmed that, due to sustained transmission of COVID-19 across the UK, PPE use was now recommended "in general". Carers providing personal care that required them to be in direct contact with residents (or within two metres of a resident who was coughing) were directed to use disposable gloves, a disposable plastic apron, and a fluid repellent surgical mask. Carers who provided other services requiring no direct contact with residents (for example, performing meal and medication rounds, or working in communal areas) were directed to use surgical masks. Eye protection was advised in situations where there was a risk of contamination to the eyes (for example when undertaking prolonged tasks near residents who were repeatedly coughing or vomiting). The only exception to the general use of PPE was explained in circumstances where no resident had symptoms of fever or cough and where

no staff member or visitor had experienced these symptoms in the preceding 14 days, then PPE may not be required.

73. On 17 April 2020, in the light of the challenges in the continued supply of PPE (specifically the risk of gowns becoming out-of-stock), IPC clinicians in PHE and the NHS created the "Acute Shortage Guidance" **(MD/JM5/47 - INQ000106360; MD/JM5/48 - INQ000106357)** providing guidance on alternatives, reuse and sessional, rather than single, PPE use. The MHRA issued the guidance via a Central Alerting System (CAS) alert. The CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. This guidance was withdrawn in September 2020 when there were no longer acute shortages.

74. On 27 April 2020, PHE also published guidance titled "Personal protective equipment (PPE) – resource for care workers delivering homecare (domiciliary care) during sustained COVID-19 transmission in the UK" **(MD/JM5/49 - INQ000058827)**. This guidance was primarily for care workers and providers delivering care in the following contexts: visiting homecare, extra care housing, and live-in homecare. In light of sustained transmission of COVID-19, these types of care workers were advised to use a face mask regardless of whether the person they were caring for had symptoms of COVID-19 or not. When providing personal care requiring them to be in direct contact with residents (or within two metres of a resident who is coughing), they were also directed to use disposable gloves, a disposable plastic apron, and a fluid repellent surgical mask. As in care homes, eye protection was advised in situations where there was a risk of contamination to the eyes. Additional advice was also provided on the management of waste, and cleaning uniforms.

75. PHE also published "Guidance for care of the deceased with suspected or confirmed coronavirus (COVID-19)" on 31 March 2020 **(MD/JM5/50 - INQ000106313)**. This included dedicated guidance for residential care settings including care homes and hospices on IPC measures (including PPE use) in the event that a resident died of suspected COVID-19 in a residential care setting.

76. These updates to IPC guidance represented a significant change to PPE usage, increasing demand for PPE within the care sector beyond that planned for in the pandemic preparedness stockpile.

77. On 5 June 2020, the Secretary of State announced that all staff in hospitals should wear face masks continually to prevent further spread of COVID-19, and that this policy would be considered for social care **(MD/JM5/51 - INQ000106399)**. Subsequently, SAGE considered the policy for care homes and submitted a paper to the Department on 2 July 2020, that mirrored the recommendations for hospital staff. The SAGE paper, however, did not make recommendations for homecare settings **(MD/JM5/52 - INQ000327945; MD/JM5/53 - INQ000512948)**.

78. Although the SAGE paper did not refer to homecare, PHE provided updated guidance advising care homes and homecare providers which PPE would be needed in different scenarios. For example, there are different types of masks that are made to different specifications and have guidance attached to how and when they should be used. Type I and IIR masks were to be worn by all staff in communal areas (both in care homes and homecare), and in homecare head offices, where care and non-care staff could not be separated to prevent transmission, type I and IIR face masks were to be worn. The Minister of State for Care, Helen Whately, was sent the updated guidance from PHE following sign off from DCMO, prior to it being sent to the Cabinet Office for Triple Lock with No.10 **(MD/JM5/54 - INQ000327944)**. She cleared the guidance on 14 July 2020 **(MD/JM5/55 - INQ000327947)**.

PPE Distribution for the Adult Social Care Sector

79. The supply problem was in two threads:

    a. How the Government should prioritise the distribution of PPE across worker groups; and

    b. How pandemic stockpile and centrally sourced PPE could best be distributed to end user organisations to meet the needs of prioritised groups

PPE Supply: The Approach to Prioritisation of Distribution of PPE

80. In March 2020, there was concern from adult social care providers that PPE was being diverted from care homes to the NHS. Representative bodies for care providers raised concerns specifically about wholesalers prioritising the NHS over social care. The Department found no evidence at the time of any NHS or government policy or decision to divert supplies designated for adult social care to the NHS instead. Reports reflected the conditions of profound market failure for PPE at a time of numerous buyers chasing ever diminishing stock which resulted in items being sold internationally to the highest

bidder with gazumping rampant. These reports directly influenced the Government's decision to step in to buy and distribute PPE.

81. The COVID-19 Healthcare Ministerial Implementation Group (HMIG) met on 20 March 2020. One of its actions was for the Department and the NHS to ensure stocks and delivery of PPE took into account social care providers **(MD/JM5/56 - INQ000327783)**.

82. A Cabinet Office paper dated 27 March 2020 explained that supplies should be allocated to those whose health would most otherwise be endangered, and that prioritisation decisions would sit with the Department, supported by other government departments. **(MD/JM5/57 - INQ000551534)**.

83. On 31 March 2020, a prioritisation framework was discussed at a PPE Oversight Board, chaired by Professor Dame Jenny Harries, setting out priority groups for those to receive PPE based on risk of contact with those who had COVID-19, the closeness of contact if present and whether the workforce was defined as critical. The highest category being those performing aerosol generating procedures, followed by other workers in hospital and adult social care, hospices, ambulances, primary care, children's homes, funeral directors, prison wardens and the police **(MD/JM5/58 - INQ000551548)**.

84. On 2 April 2020, the HMIG met and agreed on prioritisation as set out in the prioritisation framework **(MD/JM5/59 - INQ000083701)**.

PPE Distribution for ASC

85. From the outset of the response to the PPE supply crisis, the Department was concerned about the ability for smaller prioritised groups such as primary care, social care, and NHS community-based services (e.g. dentistry and community pharmacy) to access PPE.

86. By creating a Parallel Supply Chain, Government aimed to tackle not only the problem of securing supply, but also to tackling the challenge of distributing that supply to a hugely expanded operation of over 58,000 health and social care settings in the UK.

87. Existing supply to adult social care was via a network of wholesalers, so there was no single point of distribution that could be scaled up to meet demand. individual care homes typically placed much smaller orders than an NHS Trust making them unsuitable for existing NHS distribution systems.

88. The approach taken by the Department evolved over time to meet the diverse needs of the care sector. The response included:

a. A one-off direct supply to CQC registered care homes using stock from the PIPP stockpile;

b. Setting up an emergency response for PPE for when a provider had less than 72hrs of PPE remaining

c. Ongoing support by selling PPE to wholesalers to allow them to continue to supply care settings that used them – at the outset of the response this was envisaged to be the main route to support care providers;

d. Providing large volume PPE supply to Local Resilience Forums (LRFs) to be broken down into smaller units for onward distribution using their local knowledge of care providers in their community; and,

e. Developing a new direct small volume distribution channel for PPE – the e-Portal (sometimes referred to as the PPE Portal or the PPE e-portal).

PPE Supply: Emergency Supply Where Needed

89. As supply issues emerged in early March 2020, a decision was taken to distribute PPE directly to frontline health and social care facilities with the intent of bridging the supply gap whilst business as usual suppliers (private wholesalers) sourced additional PPE. Initially, as the fastest route to respond to urgent requests, the Department's National Supply Disruption Response (NSDR) Freight Team was reactivated to work with Military Aid to the Civil Authorities (or MACA, which is the operational deployment of the armed forces of the UK in support of civilian authorities, government departments, or the community) to compile emergency packs of PPE.

90. On 3 March 2020, a contracted delivery company, DPD Logistics, with support from the NSDR Freight Team, delivered 2.15 million Type IIR facemasks, 2.87 million aprons and 4.31 million gloves to 6,830 GPs from PIPP stockpiles. On 9 March 2020, a further 574,000 Type IIR facemasks, 2.29 million aprons and 2.29 million gloves to 11,480 community pharmacies **(MD/JM5/60 - INQ000496777)**. On 10 March 2020 officials discussed PPE requirements within adult social care **(MD/JM5/61 - INQ000608140)**. At that point the COVID-19 guidance for the adult social care sector did not recommend the use of PPE over and above that used in the usual care of patients, with the exception of providing any potential COVID-19 care with a face mask in advance of transfer. Guidance to the sector was updated and released on 13 March 2020 and on the same date 7.57 million Type IIR Facemasks were delivered to 25,245 care homes, homecare providers and hospices to meet the requirements of specific items of PPE to be used in adult social care settings included in the guidance.

91. On 16 March 2020, the Department, in response to continued supply chain distress, fully activated the NSDR. NSDR had three core functions to support delivery of emergency PPE:

    a. Operate a 24/7 helpline for providers who had an urgent requirement for medical products, including PPE. Call handlers would log details into a system that automatically prioritised cases in line with the information provided. The helpline's call volumes, as broken down by phases of the Department's response to the pandemic, (based on waves and related restrictions) were:

        i. January 2020 to the end of July 2020 = 36,277 (The NSDR call centre was operational from 16 March 2020 and call volumes were not recorded until 23 March 2020);

        ii. August 2020 to end of July 2021 = 7,690; and

        iii. August 2021 to 24 February 2022 = 355.

    b. Provide a case management function. The case management team accessed the cases directly via the system and worked through them in a prioritised process. This process involved triangulation of data including, for example, deliveries recently received by the organisation, the volumes requested and expected time of delivery; and

    c. Co-ordinate an express freight desk solution. Once the case was reviewed and approved by the case management team, the freight desk was instructed to pick, pack and deliver an allocation of PPE to the provider. Once a delivery was received, the NSDR case was closed.

92. NSDR was used to mobilise small priority orders of critical PPE to fulfil an emergency need; they did not have access to the full lines of stock held at other large wholesalers or distributors.

93. The NSDR helpline, which was operated by the NHS Business Authority on behalf of the Department, was introduced on 16 March 2020 and began operating as a 24/7 service on 21 March 2020. The helpline allowed health and care providers to report an urgent need for PPE, which they were unable to meet through their usual channels.

94. NSDR logged information concerning the requestor's supply needs, ensuring they had tried to use business-as-usual routes first, confirming that they provided care for COVID-19 patients, and that their current PPE stock levels and the amount requested were in line

with national guidance. This information was communicated to NHSE's Commercial Procurement Cell (CPC), that managed a system that automatically prioritised PPE provider requests via Robotic Process Automation based on reported urgency and need and coordinated urgent deliveries. Once a case had been reviewed and approved by CPC, NSDR arranged a PPE allocation for delivery to the provider. The NSDR focused on fulfilment of urgent requests, so prioritised shipping products which were available at the time of picking. Once a delivery had been received the NSDR case was closed.

95. Use of the NSDR system was a core component of the supply response during the period where there was acute constraint in supply of some product lines.

96. Providers with an immediate and urgent need for PPE - those at risk of running out of stock within 72 hours - which could not be remedied through other channels, could call the hotline to secure emergency supplies. As this was a direct distribution under the control of the Department at the direct request of a provider whose need had been verified by call handlers, the Department could be sure that these emergency deliveries were targeted to those most in need. The Department is not aware of any instances where it was unable to meet emergency supply requests.

97. There was an average of 1,084 daily contacts with NSDR in the first week data is available for (6 April 2020), reducing to 345 daily contacts in the week commencing 27 April 2020 and down to 64 daily contacts by 20 July 2020 reflecting a reduced need for emergency supplies as the efforts of the Parallel Supply Chain took effect **(MD/JM5/62 - INQ000551650)**.

98. In the first full week of operation (week commencing 30 March 2020), the NSDR dispatched 586,000 items of PPE. The maximum dispatched in a single week occurred in the week commencing 5 May 2020, when 1.14 million items were dispatched. In total, 15.8 million items of PPE were distributed by this route between the week commencing 25 March 2020 and the week commencing 5 October 2020 **(MD/JM5/63 - INQ000551674)**.

99. Of the cases raised between 25 March 2020 and 8 October 2020, 6,610 were with NHS Secondary Care, 14,049 were with adult social care, 6,135 were with Primary Care and 5,830 were with other settings such as dentists, pharmacies, local authorities and prisons **(MD/JM5/64 - INQ000551672)**.

PPE Supply: Use of Wholesalers to Support Adult Social Care, Primary Care and Other Community-based Providers

100. Prior to the pandemic, community providers obtained clinical consumables, including PPE, via a network of private wholesalers. At the point the pandemic was declared by the WHO, the Department had no visibility over which suppliers the community providers used, nor the PPE stock position of either the suppliers or community providers.

101. Minutes from the Supply Cell meeting on 5 February 2020 note that officials had discussed supply chain concerns with representatives from wholesalers. Wholesalers reported an inability to source PPE, particularly face masks, from the international market with extended delivery timelines of stock ordered at 6-8 weeks **(MD/JM5/65 - INQ000576751)**.

102. Officials and wholesalers discussed the potential to sell stock from the PIPP stockpile to support wholesalers to supply community providers. PHE led on this engagement and the Department understands that several contracts between PHE and wholesalers were started. It was reported to the Supply Cell meeting on 3 March 2020 **(MD/JM5/66 - INQ000339268_069)** that the first sale event to wholesalers was due to occur that day with 2-2.5 million face masks (Type IIR) to be sold from the PIPP stockpile. It was also reported in the same meeting that there would be contractual conditions about the stock provided, who it could be sold on to and that wholesalers would have to apply demand management to "prevent release of excessive stock into individual chains".

103. Subsequent sales events were arranged to occur on a weekly basis. There were also provisions put in place so that wholesaler margins could not increase. This was intended to keep pricing of PPE sourced by providers via this route competitive, compared to the open market where the supply/demand imbalance had driven price escalation.

104. Agreements were made with wholesalers for the onward provision of PPE into the following health and care sectors:

    a. Dentistry (four wholesalers);

    b. Primary Care (GPs) (two wholesalers);

    c. Social Care (12 wholesalers); and

    d. Community pharmacies (three wholesalers).

105. Wholesalers were able to access PPE 'Sale Events' if they could demonstrate regular business as usual sales into the appropriate sector, or sufficient current demand signals from those sectors. Additionally, they had to agree to supply data of their stock position on a weekly basis.

106. Initially only Type IIR Facemasks were supplied via these routes. From June 2020 onwards it included: Type IIR face masks, aprons and gloves. Gowns, visors and FFP2 Respirators were also made available in sales events to wholesalers supplying dentistry.

107. Early sale events were not run across dentistry or community pharmacies at the same rate as GPs and social care as these sectors saw a much-reduced demand associated with changes in business-as-usual operations due to lockdown restrictions.

108. The routes of supply to community providers, including the role of wholesalers, were communicated in the 10 April 2020 PPE Plan **(MD/JM5/46- INQ000050008)** and also in direct communications to providers, for example the 15 April 2020 communication to adult social care providers.

109. This communication stated that as of 8 April 2020, 25 million items of PPE had been sold to wholesalers supporting social care, including 11.4 million face masks (Type IIR), 9.8 million aprons and 1.7 million gloves **(MD/JM5/67 - INQ000050042)**.

110. On 22 April 2020, the Department began sharing details of care homes reporting critical shortages in PPE to assist wholesalers in prioritising their stocks of PPE to those most at need. This list was shared 3 times weekly during the first wave.

111. PHE managed sales events until 15 June 2020 with onward management then taken on by the PPE Parallel Supply Chain. Engagement with wholesalers included a ministerial round table held with representatives on 12 May 2020.

112. Distribution of items of PPE via wholesalers was continued until 24 January 2021. A total of 38 million items of PPE were distributed to wholesalers serving dentistry, 40 million to wholesalers serving GPs, 258 million items to wholesalers serving adult social care and 1.2 million items to wholesalers serving community pharmacies, totalling 337 million items **(MD/JM5/68 - INQ000234286)**.

PPE Supply: Use of Local Resilience Forums to Support Adult Social Care, Primary Care and Other Community-based Providers

113. Recognising that additional support was needed, the Department worked with the Ministry of Housing, Communities and Local Government (MHCLG) to engage the network of 37 LRFs to create a further temporary emergency channel for supply and to coordinate response to local supply issues. This was beneficial as it would have been inefficient to attempt to supply small providers, such as adult social care, in the same ways as hospitals.

114. Large volumes of stock were pushed to LRFs who acted as hubs for onward distribution at no cost to providers. The Department's Secretary of State was informed of the plan to use LRFs on 4 April 2020. This submission discussed the use of embedded military planning teams within LRFs to provide an advisory role to local public bodies to co-ordinate the collection, storage, accounting and delivery of PPE. The submission also set out the prioritisation of the distribution of PPE referencing the HMIG meeting where prioritisation of PPE to "those that are having close unavoidable contact with confirmed or suspected COVID-19 cases that include highly vulnerable groups" was agreed. The submission noted that decision making would be the responsibility of LRFs but would include "adult social care (including care homes and homecare), hospices, prison hospitals and local authority adult social care services for those most vulnerable to COVID-19. Other services with a high priority need for PPE included GPs, children's homes, secure children's homes, children's social care services in local authorities, prison officers, police and funeral directors."

115. On the same day Secretary of State agreed for the distribution to proceed, asking that LRFs be requested to report stock and distribution data and making it clear that LRFs were not to be used by NHS secondary care to obtain PPE, as there were other direct routes for them to be supplied. He also agreed to a further MACA request to provide additional military planning to support the distributions **(MD/JM5/69 - INQ000551555; MD/JM5/70 - INQ000608142; MD/JM5/71 - INQ000608141)**.

116. The first push through LRFs began on 6 April 2020 and at the peak of demand in April 2020 over 35 million items of PPE were delivered to LRFs in a single week.

117. The embedded military planning teams provided daily demand and stock reporting to the Department. Decisions on allocations of PPE via the LRF route taken alongside other routes were made at the 6pm allocation meetings. Stock and demand information from LRFs was also collated by MHCLG and provided via daily 'dashboard sit-rep' updates to senior leaders, including those in the Parallel Supply Chain and ministerial teams throughout April and May 2020.

118. Officials met regularly with MHCLG officials and LRF representatives. This included weekly meetings with LRF Chairs where PPE distribution was discussed.

119. From the start of May 2020, under the direction of LRFs, local authority public health departments and CCGs, CCG infection control nurses carried out "training the trainers" in

care homes on the recommended approach to infection prevention control, PPE usage and testing advice **(MD/JM5/30 - INQ000325278)**.

120. On 14 September 2020, with PPE supply stabilised, and the rollout of the e-portal ongoing, LRFs were stood down in some areas and their function replaced by local authority distribution. A total of approximately 637 million items were distributed via LRFs and local authorities by 31 March 2023 **(MD/JM5/72 - INQ000339145)**.

PPE Supply: PPE Supply e-Portal

121. There were logistical challenges with using wholesalers and LRFs to distribute PPE. The multiple routes to supply allowed the Department to engage with as wide a range of end providers as was necessary, however the multiple routes also risked providers being passed around the system when trying to obtain supplies. Multiple routes were also inefficient, requiring supply to be sub-allocated to routes ultimately aimed at the same end providers. The demand signal was also further away from the central allocation of stock, making it difficult to know how to divide out supply across the network. For these reasons, early in the response, it was decided to develop a central distribution mechanism for PPE to community-based providers. This became known as the e- Portal for PPE supply.

122. On 9 April 2020 the Department started the pilot phase of the e-Portal. The e-Portal was established as an online platform, developed and delivered through the Department partnering with eBay, Clipper Logistics, Royal Mail, the NHS, Volo, and Unipart to be an 'emergency top-up system' of PPE for providers, specifically for COVID-19 needs. It was established to take over from LRFs and central distribution to wholesalers as the route of choice for distribution to primary care, community providers and adult social care. Once an eligible provider registered with the PPE e-Portal, they could make weekly orders that would be dispatched by the PPE logistics team using Royal Mail.

123. Roll out of the e-Portal was staged to ensure the system was robust to deal with the volume of orders and ensure that supply was available to meet these orders whilst not undermining adequate provision via other routes, particularly emergency supply. Supply via NSDR, wholesalers and LRFs remained in place throughout the rollout to supply those not yet on the e-Portal and as emergency fallback routes. Roll out was tracked through the daily 6pm meeting to ensure that adequate supply was available to support the onboarding of providers.

124. By the 26 June 2020, 22,000 eligible GPs and smaller adult social care providers were registered with the e-Portal, and all community and care settings granted access by

September 2020. As additional need for PPE was identified, providers were registered with the e-Portal. For example, in September 2021 vaccination centres were able to source their PPE via the e-Portal.

125. The e-Portal continued to be developed to ensure it met the needs of its users in response to feedback. Plans to roll out an e-Portal 2.0 were launched in July 2020. The e-Portal remained in use until the end of the relevant period **(MD/JM5/73 - INQ000551643)**. From 9 April 2020 until 31 March 2023 10.6 billion items of PPE had been distributed via the e-Portal. PPE was provided via the e-Portal until 31 March 2024, or until Department stocks had depleted.

Decision Making on Distribution

126. On 18 March 2020, the Minister of State for Care, Helen Whately, approved a letter addressed to adult social care providers to encourage them to use the NSDR hotline, and to emphasise that wholesalers should not be prioritising the NHS over the care sector **(MD/JM5/74 - INQ000327780)**. The Department's approach to PPE supply for social care was set out in the "Coronavirus (COVID-19): personal protective equipment (PPE) plan" published on 10 April 2020 **(MD/JM5/46 - INQ000050008)**. The Department's Action Plan published on the 15 April 2020 also set out how the Government would support the adult social care sector specifically and included guidance on the use and distribution of PPE in social care settings **(MD/JM5/75 - INQ000325315)**.

127. The distribution of PPE to adult social care was publicised via a letter from the Department's Director of Adult Social Care, Ros Roughton, to relevant care representative groups **(MD/JM5/76 - INQ000106256)**. It was complemented by a further letter from the Chief Commercial Officer, Steve Oldfield on 1 April 2020 which also clarified that the NSDR was available to the adult social care sector **(MD/JM5/77 - INQ000107089)**.

128. Decision making on distribution to the NHS, wholesalers, LRFs and the e-Portal during the first months of activity of the Parallel Supply Chain was coordinated with procurement activity at a senior leadership level through the 8.30am and 6pm daily meetings. These were usually co-chaired by Dame Dr Emily Lawson and Director General Jonathan Marron. After the end of the first wave, operational decision making on supply - (where demand exceeded stock held) was formalised within the Parallel Supply Chain structure, though with improved stock positions by winter 2020 the Supply Chain had moved to full replenishment of actual demand.

129. In the early stages of the pandemic, primary care, community care and social care providers predominantly continued to obtain PPE through their usual routes of wholesalers.

130. As reported to the Prime Minister in May 2020, the Department surveyed 120 social care providers who reported that during the preceding 6-week period, approximately 85-90% of them had continued to obtain PPE via existing or new arrangements with wholesalers, including those wholesalers supported by central PPE releases by the Department. The remaining 10-15% came from emergency supply from NSDR or LRFs. The report also showed the reduction in call volumes to NSDR from social care providers as supply increased with the activity of the Parallel Supply Chain.

131. Engagement with adult social care stakeholders throughout the pandemic was primarily via an Adult Social Care PPE Task and Finish Group. Originally PPE was discussed at the National Adult Social Care COVID-19 Group, but given its priority a separate sub-group was created. The first of these meetings was held on 7 April 2020 and operated on a weekly basis until 22 July 2021. From 29 July 2021, the PPE stakeholder engagement meetings were combined with those for the Testing stakeholder engagement.

132. The Adult Social Care PPE Task and Finish Group considered issues related to PPE supply, distribution and guidance. This group was an important forum for gathering feedback from adult social care sector representatives and making improvements to PPE delivery and guidance to fit the sector's needs.

133. From 10 November 2020 until 20 April 2021, the Adult Social Care PPE Task and Finish Group was complemented by customer engagement panels, chaired by the Department's PPE Policy Team **(MD/JM5/78 - INQ000058924)**. Panels were held on a fortnightly basis, with separate forums for representatives of providers who were CQC registered and accessed the e-Portal, and those who were not CQC registered and therefore accessed PPE through local authorities and LRFs. The purpose of the panels was to discuss and resolve issues related to PPE, faced by providers. An example of an improvement that was made using stakeholder feedback was a change to ordering volumes on the PPE e-Portal where providers who were regularly ordering up to their limit on the PPE e-Portal were automatically moved up to the next provider size, allowing them to order increased volumes of PPE to meet their requirements.

134. Given the fragmented nature of the community provider sector, the Department did not have oversight of stock held by individual providers. However, feedback on the distribution and allocation of critical PPE was tracked via the following mechanisms:

a. Wholesaler feedback: the Department collected daily feedback from wholesalers on levels of demand from their customers including back orders placed.

b. LRF data returns: from 8 April 2020 the Department assessed LRF need through MHCLG-collated data returns from all LRFs (these were daily throughout the peak of the epidemic and then reduced to twice a week, as most LRFs stock position normalised). LRF stock position was RAG-rated across the following categories: those with fewer than 3 days of stock (red), those with 3-10 days of stock (amber) and those with 10 or more days of stock (green). LRFs in the red category were prioritised for urgent re-supply.

c. NSDR feedback: daily feedback from NSDR was collected on what types of providers had asked for emergency supply of PPE in the last 24 hours, and what types of PPE they have struggled to access via wholesale/LRF routes. For social care, the Department also used LRF data returns to monitor which service providers LRFs have supplied PPE to and compare this against the NSDR daily feedback and the social care business continuity tracker (which covered around 85% of the social care provider market).

d. Care home capacity tracker: from 2 April 2020 an existing NHSE capacity tracker for CQC registered adult social care providers was upgraded to collect data on their PPE stock needs on a daily basis. This showed which care homes were likely to have shortages in the next 48 hours or in the next 7 days. Recognising that wholesalers continued to be the main route for social care providers to obtain PPE, from 22 April 2020 wholesalers receiving centrally sourced stock were provided with a list of providers reporting critical shortages of PPE so they could be prioritised for supply. Over the course of May 2020, the tracker showed improving stock positions for PPE as reported to the Prime Minister.

e. Ready Reckoner: This was based on the estimated national demand and burn rate.

135. On 15 July 2020, a submission was sent to the Secretary of State and the Minister of State for Care from the Department's PPE Demand Team, proposing free distribution of PPE to frontline primary and social care services until March 2021 **(MD/JM5/79 - INQ000327950)**. The submission noted that although we had previously maintained emergency supply of PPE to social and primary care, there was now confidence in our inbound PPE supply. The Department was authorised by HM Treasury (HMT) to purchase £14 billion worth of PPE to distribute across the health and social care system (to date, the Department has distributed around £312m worth of PPE to social and primary care). The Secretary of State agreed to the free distribution policy on 20 July 2020 **(MD/JM5/80 - INQ000327954)**.

136. During the period 1 August 2020 to 31 July 2021 over 10.5 billion items of PPE were distributed to the health and care sector. The parallel supply chain that was established shortly after the outset of the pandemic ensured that acute shortages of PPE ceased during this period. The e-Portal ensured the supply of free PPE to over 50,000 social care and primary care providers.

137. On 28 September 2020, the PPE Strategy was published by the Department, reiterating the offer of free PPE until the end of March 2021 and providing confidence in UK supply of PPE **(MD/JM5/81 - INQ000234522)**. The strategy set out how the Government was moving beyond the emergency COVID-19 response to stabilise and build resilience through getting a clearer view of demand, developing a more resilient and diverse supply chain, and building up a stockpile of PPE. Amongst other things, the strategy outlined the steps the Department had taken to establish a strong domestic supply base through 'UK Make' and to create a four-month stockpile available across all categories of PPE to accommodate any future surge in place by December 2020.

138. In January 2021, the Department committed to providing free PPE to health and social care providers until 30 June 2021, with a review in April 2021 for provision beyond that date. On 18 March 2021, the Secretary of State and the Minister of State for Care received a submission for approval, that set out a number of options for how to extend provision beyond June 2021. The decision had to be announced in April 2021 to give providers enough lead time for any changes beyond June 2021 **(MD/JM5/82 - INQ000328084; MD/JM5/83 - INQ000328085; MD/JM5/84 - INQ000110871)**. On 24 March 2021, Ministers agreed to extend the provision of free PPE to 31 March 2022 **(MD/JM5/85 - INQ000328092)**.

139. In October 2021 there was a public consultation on whether to extend the central provision of free PPE to the health and care sector for a further year to the end of March 2023 **(MD/JM5/86 - INQ000257077; MD/JM5/87 - INQ000257078; MD/JM5/88 - INQ000257079)**. Overall, the consultation responses showed that the majority of health and care providers were strongly in favour of extending the provision of free PPE **(MD/JM5/89 - INQ000287729)**.

140. The "Adult social care: COVID-19 winter plan 2021 to 2022" (Winter Plan 2021/2022), published on 3 November 2021, contained a set of actions for care providers on IPC including that they should ensure all care staff had ongoing training on IPC, and ensure staff did not work if they had COVID-19 symptoms, or a member of their household had symptoms or a recent positive test, or if they had been told to isolate by NHS Test and Trace **(MD/JM5/90 - INQ000087232)**.

141. In January 2022, following the public consultation in October 2021 and careful consideration of the trajectory of the pandemic, the need to protect front-line health and care staff and the impact on businesses who operate in the PPE market, free PPE for frontline health and care staff was extended until 31 March 2023 **(MD/JM5/91 - INQ000257249)** and finally until 31 March 2024, or until stocks were depleted.

Unpaid or Self-funded Homecare

142. In March 2020, DCMO and PHE advice was that unpaid carers should not use PPE while providing care. They were concerned that unpaid carers would not necessarily use PPE properly and that without direct training and supervision, this could create additional risk and/or a false sense of protection. In addition, as unpaid carers were frequently members of the same 'household contact group', they would share transmission exposures in the same way that a family does, making PPE less effective in such circumstances. Given the uncertainty about PPE supply, environments in which the risk of transmission and the opportunities for mitigation were greatest were prioritised, particularly hospitals and care homes.

143. On 8 April 2020, the Department published "Guidance for those who provide unpaid care to friends or family" **(MD/JM5/92 - INQ000327821)**, which was based on the advice from DCMO and PHE. This guidance contained and signposted to general advice for unpaid carers on how to prevent transmission of COVID-19, including tips on how to help protect a vulnerable person living in their household (such as cleaning hands frequently with soap and water for at least 20 seconds, or using hand sanitiser), and steps to protect Clinically

Extremely Vulnerable (CEV) people. It contained the following paragraph on the use of facemasks:

> *"We do not recommend the use of facemasks as an effective means of preventing the spread of infection, unless advised by a healthcare professional. Facemasks play an important role in clinical settings, such as hospitals, where staff are trained in the use of personal protective equipment (PPE) but there is little evidence of benefit from their general use outside of these settings."*

144. Subsequently, understanding of how the virus was transmitted within the community evolved and the Department reviewed its position. The Scottish Government also reviewed its advice and recommended the use of facemasks for unpaid carers who were caring for someone who is shielding, or where carers, themselves, were shielding.

145. On 7 May 2020 PHE sent a paper to the Department. The paper identified three groups of unpaid carers and suggested some level of PPE should be worn by all three. This paper did not constitute formal advice and so, in light of the publication of the Scottish Guidance the Department asked PHE, on 26 May 2020, for updated advice **(MD/JM5/93 - INQ000608146)**. PHE subsequently advised that carers living in the same household as those they cared for should wear PPE if the cared-for person had COVID-19 symptoms; however, if neither the carer nor the cared-for person had symptoms, then PPE was not required **(MD/JM5/94 - INQ000050739)**. PHE advised that carers delivering care to another household (extra-resident carers) should wear PPE even when caring for someone without COVID-19 symptoms.

146. The Minister of State for Care asked for an update about this in July 2020, as reports were being received from MPs, the public and local authorities that family and unpaid carers were concerned that PPE was not being provided to them. The Minister of State for Care was sent a submission on 29 July 2020 recommending that the current policy should not change, and that unpaid carers did not need to wear PPE unless advised to by a healthcare professional **(MD/JM5/95 - INQ000051397)**. The position was to be reviewed as part of planning for a potential second wave, and advice was to be sought from the SAGE Social Care Working Group (SCWG). In the interim, the explanation in the unpaid carers' guidance was to be strengthened to give greater confidence to carers **(MD/JM5/96 - INQ000051396; MD/JM5/97 - INQ000051398)**.

147. Advice was accordingly sought from the SAGE SCWG on the effectiveness of PPE in reducing the transmission of COVID-19 in those delivering care within the same parameters as unpaid carers, to support a further review of this policy.

148. In a paper published on 23 September 2020 **(MD/JM5/98 - INQ000422314)**, the SAGE SCWG advised that:

    a. unpaid extra-resident carers should follow the same PPE procedures recommended for homecare workers[1], which aligned with PHE advice.

    b. PPE should be made available for co-resident unpaid carers (carers who live with the person they care for) who wished to utilise it, whilst acknowledging the impracticalities of co-residents wearing PPE at all times.

149. On 15 October 2020, the Minister of State for Care was informed that the policy ramifications of this advice would be rapidly worked through (taking into account issues of cost, supply, distribution, and lessons learned from devolved authorities) and an updated note would then be provided to ministers **(MD/JM5/99 - INQ000109853)**.

150. The Minister of State for Care was provided with a submission on 12 November 2020 proposing to trial a free PPE offer for unpaid extra-resident carers in five local authorities, with a view to rolling this out across the country by January 2021 **(MD/JM5/100 - INQ000328011; MD/JM5/101 - INQ000328012)**. The Minister of State for Care agreed to all the recommendations in the submission **(MD/JM5/102 - INQ000328015)**, as did the Secretary of State **(MD/JM5/103 - INQ000328016)**. The pilot commenced in the second week of December in Leeds City Council, Essex County Council, South Gloucestershire Council, North Yorkshire Country Council and Durham and Darlington. These local authorities were selected because they had high prevalence of COVID-19 in the community and provided a mixed sample of predominantly rural/ urban locations with a geographical spread.

151. On 13 January 2021, the Minister of State for Care received an update and proposal to rollout the pilot of PPE to carers nationally as soon as possible **(MD/JM5/104 - INQ000110355)**. Local authorities found the level of demand for PPE from carers was manageable from their existing stock. The national roll out offer was approved by both

[1] The current guidance to domiciliary care workers was that full PPE (type IIR mask, apron, gloves, eye protection if risk of droplets) should be worn when providing personal care, or if coming within 2m of someone who has a cough. When in a client's home, a type II mask should be worn if coming within 2m of the cared-for person, or a Type I or II if not.

the Secretary of State and the Minister of State for Care **(MD/JM5/105 - INQ000328040; MD/JM5/106 - INQ000328042)**.

152. On 25 January 2021, the Department sent a letter to local authorities and LRFs announcing that it was now extending nationally its offer of free PPE for COVID-19 needs to all extra-resident unpaid carers.

153. On 5 February 2021 'Guidance for unpaid carers', clarified that unpaid carers should follow the same guidance and PPE procedures for homecare workers: '*How to work safely in domiciliary care in England*' alongside a list of illustrative guides for wearing and removing *PPE* from PHE **(MD/JM5/107 - INQ000576742; MD/JM5/108 - INQ000061007; MD/JM5/109 - INQ000061008)**.

154. A '*Q&A on guidance for unpaid carers', annexed to the letter on 25 January 2021,* provided additional information about guidance on safe PPE usage centred on the following questions and topics: "*What sort of PPE should I order and how?", "How can I ensure I use PPE safely?", "When to wear PPE" and "Caring and Covid-19 symptoms"* **(MD/JM5/110 - INQ000059657)**.

155. The national rollout of free PPE to carers commenced on 5 February 2021. There was limited take-up across the country, as reported in an update provided to the Minister of State for Care on 19 May 2021. However, many local authorities who had emphasised the difficulty of identifying unpaid carers in the past reported that this offer had enabled them to identify and register additional resident unpaid carers in their locality, even if in relatively small numbers. This enabled local authorities to offer these carers further support, such as signposting to support networks, carers assessments and access to funding **(MD/JM5/111 - INQ000328126; MD/JM5/112 - INQ000328127)**.

IPC Funding Provision

156. Over the course of the pandemic over £2.9 billion was made available in specific COVID-19 funding to support the adult social care sector. A breakdown of the funding provided is exhibited here **(MD/JM5/113 - INQ000303274)**. £1.81 billion of this funding was for IPC. The provision of PPE was separately funded with procurement and distribution centralised through the parallel supply chain and PPE made available to the sector free of charge.

157. Initially, IPC funding was provided through the Infection Control Fund (ICF) and funding for testing was provided through the Rapid Testing Fund (RTF). From April 2021, these two funding streams were consolidated into one fund, the Infection Control and Testing Fund (ICTF).

Initial Response

158. On 11 March 2020, Budget 2020 was announced. Part of this budget was a £5 billion 'COVID-19 fund', which included the following:

    a. £1.6 billion to go to local authorities to help them respond to 'other coronavirus (COVID-19) pressures across all the services they deliver', including increasing adult social care workforce and for services helping the most vulnerable, including the homeless.

    b. £1.3 billion to enhance NHS discharge.

159. On 18 April 2020, the Secretary of State for MHCLG announced an additional £1.6 billion on top of the previous £1.6 billion committed to in March 2020, taking the total of emergency funding committed to combat COVID-19 to £3.2 billion **(MD/JM5/114 - INQ000106361)**.

160. In late April 2020, feedback from sector representatives such as the Association of Directors of Adult Social Services (ADASS) and the LGA was that the funding was not reaching the front lines quickly enough, was insufficient to cover the additional costs of providing care under the new guidance and was neglecting the self-funder market. The ICF was created to address these concerns and was designed to be more prescriptive to ensure that funding was passed to all providers. With the ICF, the Department was also more prescriptive about the pace at which funding needed to be passed on, and what it could be spent on, and imposed reporting conditions on these funds (as explained below at paragraphs 161 to 168).

Infection Control Fund (ICF)

161. On 13 May 2020, the Prime Minister announced the creation of the ICF, which was to be launched alongside the May Support Policy on 15 May 2020 **(MD/JM5/115 - INQ000050496)**. This was a new £600 million ring-fenced fund to tackle the spread of COVID-19 in care homes in addition to the £3.2 billion of financial support that had already been made available to local authorities to support key public services since the start of the crisis. In light of scientific evidence now showing significant asymptomatic transmission of COVID-19 in care homes via both residents and staff, care homes were now being asked to restrict permanent and agency staff to working in only one care home, wherever possible. The funding was used to meet the additional costs of restricting staff to work in one care home and pay the wages of those self-isolating.

162. In the ICF grant determination letter **(MD/JM5/116 - INQ000576723)**, local authorities had to pass (or 'passport') 75% of the funding straight to care homes within the local authority's area on a 'per beds' basis (based on the CQC Care Directory), including to social care providers with whom they did not have existing contracts. Local authorities then had the discretion to target the allocation of the remaining 25% of the funding to care homes or homecare providers and to support wider workforce resilience.

163. 09 June 2020, in response to questions received from local government and care providers, guidance on the ICF was published **(MD/JM5/117 - INQ000565715)**. It included the following clarifications regarding the distribution and required use of the fund:

    a. The funding would be paid in two tranches: the first had already been paid to local authorities on 22 May 2020, and the second would be paid in early July (provided that local authorities had returned a care home support plan by 29 May 2020).

    b. Local authorities had to ensure that 75% of the grant was allocated to support the following measures in respect of care homes: ensuring that staff who are isolating receive their normal wages; ensuring that members of staff only work in one care home; limiting or cohorting groups of residents; supporting active recruitment of additional staff and volunteers if needed to enable staff to work in one care home or in specified areas of a care home; limiting the use of public transport by staff; and providing accommodation for staff who choose to stay separately from their families to limit social interaction outside work.

    c. Pre-pandemic, completion of the Capacity Tracker was voluntary but after it was identified as the key data collection tool for gathering location level information, completion was made a condition for receipt of the ICF and subsequent funds. Residential care providers would be required to have completed the Capacity Tracker at least once, and commit to completing it on a consistent basis, to be eligible for the funding. Local authorities had to submit two high-level returns specifying how the grant had been spent. This helped to provide assurance that the funding was spent by care providers and local authorities on the correct measures.

164. Further detailed information on the grant conditions was set out in Annex C of this guidance, including reporting, and financial management of the grant **(MD/JM5/118 - INQ000576722)**.

165. The initial ICF was deliberately designed to only provide funding for four months and ran until 30 September 2020. This was to ensure that providers and councils used the funding to respond to immediate issues, but also because there was considerable uncertainty about how long the pandemic would last.

166. In September 2020, the Government announced that the ICF would be extended until March 2021, this became known as ICF2 **(MD/JM5/119 - INQ000235006)**. This additional £546 million made available through ICF2 included a number of structural changes to reflect feedback from stakeholders. Some of the major changes made were to include adult social care within the funds on a 'per user' basis, ensuring that care providers completed the Capacity Tracker at least weekly to be eligible to receive funding, and for local authorities to submit monthly spending reports to enable the Department to more closely monitor spend. ICF2 was paid in two tranches: the first on 1 October 2020 and the second in December 2020.

167. In April 2021, the ICF was consolidated with the existing RTF (explained below in paragraphs 169 - 173), to support additional lateral flow testing of staff in care homes, and enable close contact indoors visiting where possible.

168. The ICF was extended on two further occasions:

    a. In July 2021, the fund was extended until September 2021, with an additional £251 million of funding **(MD/JM5/120 - INQ000061246)**. This funding was paid to local authorities in July 2021 and included allocations for both IPC and testing.

    b. In October 2021, the fund was extended until 31 March 2022, with an additional £388 million of funding **(MD/JM5/121 - INQ000576743)**. This was labelled ICF3. The funding was paid to local authorities in two tranches: the first in October 2021 and the second in January 2022. This brought the total ring-fenced funding for IPC to almost £1.75 billion.

Rapid Testing Fund (RTF)

169. Following the introduction of lateral flow devices (LFDs), the Government announced the RTF on 23 December 2020 **(MD/JM5/122 - INQ000576734)**. This was another ringfenced grant, worth £149 million from December 2020 to March 2021 **(MD/JM5/123 - INQ000576744)**. Its main purpose was to support additional rapid testing of staff in care homes, and to support visiting professionals and enable indoors, close contact visiting

where possible. This included adult social care providers with whom the local authority did not have a contract.

170. This was a new grant, with separate conditions to the ICF grants. This additional funding brought the total ringfenced funding for care settings to £1.3 billion. It was paid in a single instalment in January 2021, and could be used to cover expenditure from 2 December 2020 to 31 March 2021 (any funding left unspent at that point had to be returned to the Department).

171. All funding had to be used to support increased LFD testing in care settings. As with the ICF, local authorities had to pass 80% of this funding to care homes within their geographical area on a 'per beds' basis. This included residential drug and alcohol services. The remaining 20% of the funding had to be used to support the care sector to implement increased LFD testing but could be allocated at the local authority's discretion. This could include supporting care homes or other providers that were experiencing an outbreak to ensure that they had the resources and equipment necessary to increase LFD testing, or supporting smaller homes and other eligible settings such as supported living and extra care settings to implement LFD testing.

172. The RTF could be spent on the following measures:

    a. paying for staff costs associated with training and carrying out LFD testing;

    b. costs associated with recruiting staff to facilitate increased testing;

    c. costs associated with the creation of a separate testing area where staff and visitors could be tested and wait for their result; and

    d. costs associated with disposal of LFD tests and testing equipment.

173. Providers could only receive funding from the RTF if they had completed the Capacity Tracker at least weekly; committed to continue to complete it at least weekly for the duration of the grant; and committed to provide their local authority with monthly reports on their spending against the grant. Local authorities were also required to submit monthly returns to the Department specifying how the grant had been spent. This information was gathered as part of spending returns for ICF2.

Infection Control and Testing Fund (ICTF)

174. The ICTF consolidated these two funding streams (the ICFs and the RTF), with an extra £341 million of funding until June 2021. This was announced on 29 March 2021, and

brought the total ring-fenced funding for IPC to almost £1.35 billion and support for lateral flow testing to £288 million in care settings **(MD/JM5/124 - INQ000576736)**.

175. The ICTF had three iterations and, like the ICFs and the RTF, required local authorities to directly pass on a proportion of their allocations to every care provider within their local area on a 'per bed' basis for care homes, and a 'per user' basis for CQC-registered community care partnerships (CCPs).

176. The ICTF's purpose was to support adult social care providers (including those providers with whom the local authority did not have a contract) to: reduce the rate of COVID-19 transmission within and between care settings through effective IPC practice and to increase COVID-19 and flu vaccine uptake among staff; and to support the conducting of testing of staff and visitors in care settings to identify and isolate positive cases and to enable visiting where possible. To ensure local authorities distributed all the available funding to all providers, regardless of their pre-existing commissioning arrangements, the ICTF grants included a number of conditions, not just about what the funding could be spent on, but also how it had to be dispensed and how quickly it had to be used. It was ring-fenced exclusively for actions which supported care homes and CQC-regulated CCPs to tackle the risk of COVID-19 infections and enable close-contact visiting and was in addition to funding already received.

177. On 27 July 2021, the fourth round of the ICTF was announced. This was a £251 million fund (£142.5 million for infection control, and £108.8 million for testing), provided to adult social care providers via local authorities to support COVID-19 related pressures for the three-month period July 2021 to September 2021 **(MD/JM5/120 - INQ000061246; MD/JM5/125 - INQ000256971; MD/JM5/126 - INQ000256969; MD/JM5/127 - INQ000256970; MD/JM5/128 - INQ000256965; MD/JM5/129 - INQ000256972; MD/JM5/130 - INQ000256973; MD/JM5/131 - INQ000256967; MD/JM5/132 - INQ000256968; MD/JM5/133 - INQ000256966)**.

178. On 30 September 2021, the fifth round of the ICTF was announced. This was a £388.3 million fund provided to adult social care providers via local authorities to support COVID-19 related pressures for the six-month period from October 2021 to March 2022. This fund included £25 million specifically to support care workers to access COVID-19 and influenza vaccines over the winter months **(MD/JM5/134 - INQ000066663; MD/JM5/135 - INQ000066747)**. The guidance that the Department published alongside this round made clear that in many circumstances the fund could be used to actively recruit new

staff, including returners to the sector, as well as hire agency staff where required to provide cover.

179. By the end of March 2022, the Department had provided over £2.2 billion in funding for IPC and testing measures.

Adequacy of IPC Funding and Challenges Encountered

180. Providers communicated scepticism about the adequacy of the funding, and shared concerns about the additional reporting burden, and commented on whether the funding was sufficient to meet Winter Plan 2021/22 recommendations. These fell into three areas of concern:

    a. Monthly reporting – a lack of specificity meant it was open to interpretation by local authorities, some of whom were more demanding with proof of purchases than others. Some deadlines coincided with existing reporting timelines which could have created an unreasonable burden.

    b. Funding reaching providers was perceived as beneficial but raised the question of whether the amount was reaching where it was most needed. The funding being spread too thinly was also raised.

    c. Weekly capacity tracker – many care homes had not completed the tracker before and so there was concern some providers might be penalised.

181. Spending data from ICF1 showed that almost 99% of the funding provided was spent on the measures outlined in the grant conditions, with the remaining 1% returned to the Department unspent. The Department used the regular spending reports provided by local authorities, as well as Capacity Tracker data, CQC data and sector feedback, to inform future conversations with DLUHC and HMT around further emergency funding required.

182. In later rounds the majority of the funding was also spent. For example:

    a. ICF2: 97.7% spent
    b. RTF: 91% spent
    c. ICTF1: 94.9% spent
    d. ICTF2: 92.1% spent

183. There were other funding streams that ran in parallel to the ICTFs, such as the Workforce Capacity Fund and the Workforce Recruitment and Retention Funds. These funding

streams all shared the primary purpose of assisting local authorities in dealing with the impacts of COVID-19.

184. As for challenges encountered in relation to obtaining IPC funding, the primary concern was that the funding could not constitute 'state aid'. As a member of the European Union state aid was defined as "any advantage granted by public authorities through state resources on a selective basis to any organisations that could potentially distort competition and trade". The UK was subject to state aid rules until January 2021, when they were replaced by 'subsidy controls'. To balance the urgency of getting the funding delivered to the sector, the Department used its contractual rights to clawback mechanisms for unspent funds and gave clear guidance on how the fund ought to be spent; this also gave greater value for public money. Once these terms were established, the funds could be issued promptly for the benefit of the sector.

185. Another challenge encountered was meeting HMT's request to ensure value for money in everything that was spent. HMT had requested that the ICFs became more aligned with HMT's expectations, for example, that they had to be used for specific measures, that overcompensating providers should be avoided, and that the funding is recoverable. This was required anyway to deal with the state aid rules, but it shows that HMT was also concerned about value for money and making sure there was best use of the fund.

186. There were some challenges encountered in relation to the administration and distribution of IPC funding. As explained above, the ICFs included a large proportion of funding that had to be passed on by local authorities to care providers in their local area, including those that they did not have existing contracts with. ICF1 only included allocations for care homes, paid on a 'per bed' basis. From ICF2 onwards, adult social care providers were included in allocations, paid on a 'per user' basis. The Capacity Tracker and CQC data were used to generate the allocations for care homes and providers, but the data quality from these sources was poor, specifically around adult social care providers. Unfortunately, this was the best data available at the time to generate these allocations.

187. Also, technical issues with the Capacity Tracker meant that care providers were sometimes unable to complete the tracker, which put their allocations at risk. The Department asked local authorities to use their discretion in such cases, but it was made clear that the Capacity Tracker must be completed as soon as such technical issues had been resolved.

188. The Department was also contacted by some care providers asking how they could 'claim' the funding through the ICTFs, as they had not received any passported funds from their local authority. In these instances, the Department encouraged the provider to get in contact with their local authority and liaise with them to ensure that they were included within the passported funding pool.

189. The Department also received some complaints from local authorities that they were unable to pay out their funding to care providers in their local area until a number of weeks after the funds began. This was mainly because they needed to develop their own grant agreements with each individual provider, many of whom they did not have previous contractual relationships with. Having grant agreements in place between local authorities and care providers helped mitigate fraud risks and also meant that the local authorities could use these agreements to recoup any unspent funding at the conclusion of each fund.

190. In recognition of the work required to administer these funds, the grant conditions were changed from ICTF1 onwards to allow local authorities to use some of their total allocation for reasonable administrative costs associated with distributing and reporting on the funding. From ICTF3 onward, this was capped at 1%. Furthermore, the frequency of spending reports to be returned to the Department was reduced, from monthly reports in ICTF2, to three times in total, in January, February, and April bi-monthly reports in ICTF3.

HOSPITAL DISCHARGE POLICY

191. Throughout the pandemic the Department worked collaboratively with NHSE and PHE to create and implement hospital discharge policy. Policy was routinely reviewed and amended to ensure appropriateness and suitability.

192. In March 2020, the picture from certain other countries was one of hospitals being overwhelmed, spikes in deaths as the need for hospital beds exceeded supply, and people dying in hospital corridors or dying without, or before. coming to hospital. As a result, the Department had two emerging priorities that needed tackling. Firstly, to free-up the maximum possible in-patient and critical care capacity to prepare for patients who required respiratory support; this included older people and other vulnerable groups who were more likely to be hospitalised by COVID-19. Secondly to protect people, particularly older people, who would be at risk from an influx of COVID-19 patients, by arranging for them to be discharged, where clinically appropriate **(MD/JM5/136 - INQ000049702)**.

193. The hospital discharge policy was introduced in March 2020 to alleviate pressures on hospital beds and hospital staff. The priority was to move patients that had been categorised as medically fit, but requiring adult social care, into alternative settings - ensuring that funding was in place for them to receive ongoing support to recover.

194. To relieve pressures on hospital settings, changes to existing hospital discharge practices were necessary. Funding was used to establish the Discharge to Assess (D2A) model which mapped out different options for patients. The model identified four clear pathways for discharging patients, three of which relied on support from health and/or social care or a hospital setting[2]. The policy was based on existing best practice but formalised the roles of all stakeholders involved by establishing new routes of care for patients.

March Hospital Discharge Policy

195. The March hospital discharge policy, published on 19 March 2020, was developed and published by HM Government and NHSE to free up beds in acute and community hospitals. NHSE created the March hospital discharge policy to address the issue of bed capacity, whilst the Department played a key role in its implementation. This was made possible by supporting the movement of patients defined as clinically fit to be discharged. Patients in this category were discharged from hospital, subsequently freeing up beds, and either returned home or were relocated to alternative settings such as care homes. Some of those that returned home did so with individual care plans which included varying levels of health and social care support.

196. On 17 March 2020, policy options formulated by NHSE were presented to the Permanent Secretary and the Secretary of State. The preferred option stated the following:

> Selected option: Extending free care to speed up discharge to residential care homes was the preferred choice. Having referred to the workforce constraints and capacity in the social care sector, the note stated that "*We need a clinical decision on whether this is the right thing to do. The policy implies that emptying the hospital is more important than protecting residential or domiciliary care capacity to support people currently in the community. We would need this to be taken on a clinical basis.*" **(MD/JM5/137 - INQ000325232)**.

[2] The D2A guidance was based on four clear pathways for discharging patients**. Pathway 0** denotes simple discharge, no input from health/social care. **Pathway 1** support to recover at home; able to return home with support from health and/or social care**. Pathway 2** rehabilitation in a bedded setting**. Pathway 3** there has been a life changing event. Home is not an option at point of discharge from acute.

197. The premise of the note posed the question, "How can we free up hospital bed capacity by rapidly discharging people into social care?". It was estimated from delayed transfer of care (DTOC) data that there were approximately 1,000 patients in acute hospitals with a DTOC, who could be immediately and safely transferred into social care settings. In addition, it was estimated that there could be approximately 4,000 – 8,000 further beds occupied by people in need of adult social care and medically fit for discharge, but not yet reported as a DTOC. And a further 500 beds attributable jointly to adult social care and the NHS.

198. The note raised a concern about workforce constraints in adult social care and the RWCS that 11% of the workforce would be off work during the peak of the pandemic.

199. Prior to publication of the hospital discharge policy there were discussions between DHSC and NHSE/I relating to discharging individuals with symptoms of COVID-19 into care homes. On 12 March 2020, the Director of Adult Social Care, Ros Roughton, sent an email to an official at NHSE/I sharing the DCMO's approved position for press queries that, "*care homes should take the same steps to minimise the risk of transmission from the discharged patient, as they would with a resident with suspected Covid-19 within the home*" and that if there were an outbreak in a hospital, individuals could be discharged into community settings including care homes "*where it is safe to do so… with appropriate safeguards to minimise the risk of transmission*". At the time an NHSE/I official acknowledged potential risks to care homes and suggested that "*a priority should be to protect care home residents as a highly vulnerable population*", and "*where possible we should, for now, try to avoid discharging people presenting with possible C19 symptoms into care homes unless they have a negative test*" **(MD/JM5/138 - INQ000325237)**. However, it was also recognised that any intention to keep all COVID-19 patients away from care homes, whilst balancing pressures on hospitals would not be sustainable and "*will not hold for long*."

200. On 16 March 2020, in the context of the shielding policy to be introduced, the Director of Adult Social Care emailed DCMO and an official at NHSE/I, seeking views on what should happen if symptomatic patients were discharged into care homes with very strict infection control **(MD/JM5/139 - INQ000325241)**. DCMO agreed in an email on the same day that "*whilst the prospect is perhaps what none of us would wish to plan for*", in reality, this would be necessary, and it would be "*entirely clinically appropriate*" **(MD/JM5/140 - INQ000325243)**.

201. Whilst the Department was responsible for implementing hospital discharge policy, it did not have a role in clinical decision-making in respect of the appropriate discharge pathway for patients. The Department is not responsible for commissioning care homes places and did not have any role in monitoring the number of patients being discharged to care homes rated as 'inadequate'.

202. As set out in Statement A of this Module, the duty to plan and secure adult social care services rests on local authorities, who commission care predominantly from private sector and not for profit providers. In some cases, individuals self-fund their place in a care home, in which case they are responsible for selecting their provider. The NHS may also be responsible for commissioning care home places in certain circumstances. Where an individual is being discharged, the local authority would normally be responsible for commissioning a place for them.

203. As set out in a Social Care Institute for Excellence report on the 'Challenges and solutions: commissioning social care during COVID-19.' It highlighted that some areas had limited options for care facilities, making it challenging to avoid placing patients in homes rated as inadequate, particularly given the urgency of the situation and bed availability constraints. It highlighted that some areas had limited options for care facilities, making it challenging to avoid placing patients in homes rated as inadequate, particularly given the urgency of the situation and bed availability constraints **(MD/JM5/141 - INQ000576746)**.

204. During the pandemic the CQC increased monitoring and support for care homes, particularly those rated as inadequate or requiring improvement. The CQC conducted risk assessments, and in some cases, carried out inspections to ensure that homes could safely accommodate new residents **(MD/JM5/142 - INQ000235462)**. If CQC inspections identified issues in the delivery of care at a particular provider, a commissioner would choose to move care to another provider.

Impact of the March Hospital Discharge Policy

205. In the second witness statement of Matthew Style, the policy objective of the Hospital Discharge guidance is explained as follows:

> *"The policy objective of the guidance was to prevent critical care services becoming overwhelmed and to create hospital capacity, by enhancing existing discharge requirements. The guidance sought to ensure the timely discharge of those considered to be fit for discharge, based on the clinical assessment of clinicians, in line with existing good practice on discharge. Implementing the*

service requirements was expected to free up 15,000 beds by 27 March 2020.". That statement goes on to confirm that, "At a meeting with the Prime Minister on 29 March 2020, NHSE confirmed that 32,904 beds had been made available for COVID-19 patients".

206. The below is an assessment of the impact of the hospital discharge policy on care homes. The rationale for the discharge of people from hospitals to care homes is set out in the Fourth Witness Statement to the Inquiry by Professor Sir Christopher Whitty **(MD/JM5/143 - INQ000251645)**:

> ***"Specific issues at this time with regards to discharges from hospitals to care homes***
>
> *7.128. I was not closely involved in the decisions in relation to the need to free up hospital beds by way of discharging patients to care homes. I was aware of them however, and thought that the benefits of doing so outweighed the disadvantages. To that extent, I agreed with the decision even though the impetus for it came from the NHS. It might be worth me therefore laying out why I thought at the time, and continue to think, that this was a prudent decision in which there were both risks in doing nothing and risks in acting, but where doing nothing in my view carried the greater risks.*
>
> *7.129. The first group of people who would benefit from a swift move from hospital to care homes during a rapidly expanding wave of a new infection was the older and vulnerable people who were in medical beds in hospital but were fit for discharge (i.e. they no longer had any medical reason to be in hospital and could have received equally good care in a care or nursing home). The reason for this was that we were having an exponential rise in cases of COVID-19, and it was predictable that this would first manifest itself in hospitals where sick people come. I have already laid out how COVID-19 disproportionately affected the elderly above at paragraphs 5.59 to 5.60. Keeping such individuals in hospital unnecessarily therefore exposed them to a foreseeable risk of harm (from catching COVID-19) whilst conferring no benefit on them.*
>
> *7.130. Given that the doubling time of COVID-19 was measured in days, every additional day that a vulnerable person unnecessarily spent in hospital increased the daily risk that they would catch COVID-19 as a result of them being in that setting, even with the best care and infection control practices available. The idea that hospitals are uniquely safe places is a complete misunderstanding; nosocomial spread of infections in hospitals has always been, and remains, a risk*

for multiple infections everywhere in the world. Hospitals are far from an ideal place to be for someone who is vulnerable to an infection, if they do not need to be there for clinical care. The difficulties in preventing COVID-19 spread within hospitals became clear as our understanding of the virus and testing capabilities later increased, but were not surprising for a respiratory infection. Much (probably most) of the transmission of SARS and MERS occurred in hospital or healthcare settings.

7.131. Whilst the risk of importation of COVID-19 from hospitals to care homes was non-trivial from the time domestic transmission became established, this risk to other care home residents would only increase for every additional day that an elderly person from that care home remained in hospital during the exponential rise of cases in hospital before returning to their care or nursing home. I have previously commented on the scarce availability of COVID-19 tests early in the pandemic but also the slow turn around for those tests which were available. It was therefore, given the limited and slow testing, not the case that someone could have been tested prior to discharge and received the result in a timely manner, so as to allow their clinician to have confidence that the individual being discharged was not infectious.

7.132. A further group of people who benefitted from the discharge of medically fit individuals back to care or nursing homes were patients who became unwell, either from COVID-19 or another condition, and who required hospital beds. This included other people in care and nursing homes, who were at relatively high risk of needing hospital care compared to the general population. There was an obvious need to free up beds, increase hospital capacity and make staff time available for the potentially very large wave of hospitalisations which would occur due to COVID-19. This was a very important operational point for the NHS. We did not know in advance how big the wave was going to be, nor whether we would be successful in getting the epidemic first wave to turn over before the capacity of the NHS was overtopped. As was clear in Module 1 of this Inquiry, the relative lack of capacity in the NHS in terms of available beds was always going to limit our room for manoeuvre in a serious pandemic overall and compared to other nations.

7.133. Two things were obvious from mid-March 2020: that it would be ideal to test patients going from hospital (and indeed other settings) into care homes for COVID19; and that we did not have sufficient testing capacity nor was the turnaround time quick enough to achieve this. Over time the availability of tests

made it realistic - but it was not in March or early April. My advice from mid-April 2020 was therefore that testing should be undertaken **(MD/JM5/144 - INQ000236441)**, *but this was of course dependent on having sufficient testing capacity to achieve it, and a fast enough rate that someone would not be sitting in hospital for several days with the potential of becoming infected whilst waiting for a test result. These were operational questions."*

207. There has been much public discourse about the discharge policy and assumptions that deaths in care homes were as a result of hospital discharge. This topic is also covered in the UK CMO's Technical Report on the COVID-19 pandemic in the UK at Chapter 8.2 **(MD/JM5/145 - INQ000203933)** which states that:

> *"Outbreaks in care homes were closely correlated with community prevalence throughout the pandemic, and there is genetic evidence that the majority of outbreaks were introduced unintentionally by staff members living in the wider community.*
> *[…]*
> *Epidemiological and genetic evidence from across the UK suggests that for COVID- 19 while some care home outbreaks were introduced or intensified by discharges from hospital, hospital discharge does not appear to have been the dominant way in which COVID-19 entered most care homes. Prior to testing being widely available, the risk of keeping care home residents in hospital at a time of increasing nosocomial infection risk needed to be balanced with the risk that they might already have acquired COVID- 19 and introduce it to the care home. Nevertheless, hospital discharge to care homes connects 2 high-contact environments, and it was and should remain a high priority for preventive actions in similar pandemics."*

208. On 10 November 2020, the Department commissioned a consensus statement on the association between the discharge of patients from hospitals and COVID-19 in care homes. The SAGE SCWG published this report on 26 May 2022 **(MD/JM5/146 - INQ000215624)**, which found that discharge did not appear to have been the dominant way in which COVID-19 entered care homes:

> "*Any person infected with COVID-19 going into a care home could introduce infection into the care home. Hospital discharge to care homes connects 2 high contact environments, where contact rates with carers in the course of care are high, and potential consequences of COVID-19 in vulnerable populations severe.*

Overall, we interpret the identified studies as showing that at least some care home outbreaks were caused or partly caused or intensified by discharges from hospital. However, based on the very much larger associations between care home size (a proxy for all footfall) and outbreaks, hospital discharge does not appear to have been the dominant way in which COVID-19 entered care homes".

209. There were further reports and studies which set out that the Department's policies, which were and still are subject to legal challenge, were not a significant cause of deaths in care homes. Figures published by the Office for National Statistics (ONS) show that, between 2 March 2020 and 12 June 2020, there were 66,112 deaths of care home residents (wherever the death occurred) in England and Wales; of these, 19,394 involved COVID-19 **(MD/JM5/147 - INQ000325323)**. There has naturally been considerable public concern about the large number of people who died in care homes in the UK. Every decision-maker, official and scientist working on the pandemic response has been acutely aware that every death is a tragedy and has worked to mitigate the impacts wherever possible.

210. There have been some retrospective studies which looked specifically at the impact of discharge policies. The multiple available studies of this are in respect of England **(MD/JM5/148 - INQ000234332)**, Scotland **(MD/JM5/149 - INQ000325321)**, Wales **(MD/JM5/150 - INQ000213185)** and Northern Ireland **(MD/JM5/151 - INQ000325326)**, where parallel instructions were issued. Whilst there was slight variation to the policies implemented across the four nations and the evidence is not conclusive, the various studies have indicated discharge policies were not responsible for a significant number of outbreaks in care homes in the UK. A summary of these is outlined below.

211. In respect to England, an unpublished PHE study has explored the impact of discharge on care homes. The study was requested by the Department and a SAGE subgroup, to investigate care homes that received COVID-19 positive patients discharged from hospital and subsequently experienced an outbreak (herein referred to as "hospital associated seeding of care home outbreaks"). The report utilised laboratory data of confirmed COVID-19 cases and existing data to derive residential status. In doing so, it identified cases residing in care homes. Hospital discharge records were linked to these records to identify care home residents who may have acquired their COVID-19 infection whilst in hospital, and where their care homes experienced an outbreak of COVID-19 after their discharge. The report reached the following conclusions summarised below:

a. From 30 Jan to 12 Oct 2020, there were a total of 43,398 care home residents identified with a laboratory confirmed positive COVID-19 test result.

b. Of these, 35,760 (82.4%) were involved in an outbreak (two or more positive cases), equivalent to a total of 5,882 outbreaks.

c. 1.6% (n=97) of outbreaks were identified as potentially seeded from hospital associated COVID-19 infection, with a total of 806 (1.2%) care home residents with confirmed infection associated with these outbreaks.

212. The report findings went on to suggest that "*hospital associated seeding accounted for a small proportion of all care home outbreaks*".

213. The Scottish study concluded that it was the size of a care home that was the strongest predictor for an outbreak of SARS-COV-2. It said that *"after accounting for care home size and other care home characteristics, the estimated risk of an outbreak due to hospital discharge reduces."*. No statistically significant association was found between hospital discharge and the occurrence of a care home outbreak. *"However, due to the uncertainty observed, we cannot rule out a small effect, particularly for those patients who were discharged untested or discharged positive"* **(MD/JM5/149 - INQ000325321)**. Care home size was very strongly related to outbreaks. Of the care homes with 90 or more registered places, 90.2% had an outbreak, compared to just 3.7% of homes with less than 20 registered places.

214. The Welsh study found that the evidence did not support the hypothesis that the discharge instructions caused outbreaks. It demonstrated that SARS-CoV-2 outbreaks in care homes during the first pandemic surge correlated better with SARS-CoV-2 admissions rates during the same week than with the numbers of people discharged to care homes. In other words, they correlated with general community transmission and infection rate. The exposure to hospital discharge was not associated with a significant increase in the risk of a new outbreak. When stratified for care home size, the outbreak rates were similar for periods when homes were exposed to a hospital discharge, in comparison to periods when homes were unexposed.

215. In Northern Ireland, researchers concluded that there was no evidence to support a view that Ministerial or Departmental communications actually changed consultants' clinical decisions around discharge during the first pandemic surge, including decisions to

discharge people to care homes **(MD/JM5/151 - INQ000325326)**. Consultants indicated decisions were made based on a clinical decision, independent of any external influence.

216. An interim conclusion published by the SAGE SCWG on 23 September 2020, based on studies available at the time of the publication, stated that "*the weight of evidence is stronger in some areas than others, however evidence of staff to staff transmission has emerged in the genomic analysis (high confidence). Weak evidence on hospital discharge (…) does not suggest a dominant causal link to outbreaks from (this) source*". On 30 October, NHSE National Medical Director Professor Stephen Powis wrote to the Public Accounts Committee setting out some of the available evidence **(MD/JM5/152 - INQ000325330)**.

217. More broadly, evidence regarding causes of infection in care homes has demonstrated a direct correlation between care home incursions and community levels of infection **(MD/JM5/153 - INQ000325312)**. Whilst comparisons are difficult, international studies also show a clear correlation both in the UK and elsewhere between the levels of care home deaths and the levels of community deaths **(MD/JM5/154 - INQ000325346)**.

218. Significant measures were implemented during the course of the pandemic to mitigate the impacts of COVID-19 on individuals within care settings. This includes measures to protect against incursion from staff within care homes, including a wide range of staff testing programmes (as further explained in the Testing and Workforce sections of this Statement). Despite these measures, the impacts of COVID-19 continued to be experienced by those living within care homes. It is understood that while care homes continued to operate, despite all measures, they have remained susceptible to the experience of the wider population since the First Wave.

Updates to Hospital Discharge Policy and Funding

219. Between April 2020 and March 2022, over £3 billion was made available via the NHS to fund national implementation of the Discharge to Assess model through a standalone discharge fund known as the Hospital Discharge Programme (HDP). The funding was critical, especially in the early days of the pandemic, in enabling hospitals to free up beds for COVID-19 patients. In particular, the provision of national funding removed the need to agree the affordability or funding source for people's care upon discharge and ensured that funding was not a cause of delays in discharging people as soon as they were clinically ready to return to, or move into, new care packages. HDP focused on enabling

an individual to reach their optimum recovery at which point their long-term needs (including ability to pay) were assessed.

220. On 20 April 2020, a line was added to the "*Hospital Discharge Service Requirements*" guidance **(MD/JM5/155 - INQ000087450)**, indicating that it was being reviewed following the publication on 15 April 2020 of the Department's 'Action Plan for Adult Social Care'. New discharge guidance was published on 21 August 2020.

221. From March 2020 to August 2020, funding for care and support had been available for an indefinite period. The guidance was updated in August 2020 to reflect funding for a maximum period of six weeks for care and support for people discharged from hospital. Following that announcement, the Department updated the *"Hospital Discharge Service Requirements"* on , reiterating the use of the discharge to assess the model **(MD/JM5/156 - INQ000327958; MD/JM5/157 - INQ000327959; MD/JM5/158 - INQ000327975; MD/JM5/159 - INQ000327976)**.

222. NHSE was responsible for administering the discharge funding. The discharge funding went through NHSE to CCGs to be distributed to providers at a local level.

223. In July 2020, as part of the announcement of a new £3 billion funding package for the NHS, HMT committed to an additional £588 million to cover the immediate costs of care at home for those being discharged from hospital.

224. NHSE and MHCLG led on discharge funding, with the Department playing a supportive role. The Secretary of State had sight of decisions being made, and conversations were happening between NHSE, MHCLG and the Department regarding further funding for adult social care. Accordingly, NHSE is the best placed to provide an explanation of any challenges encountered in these respects.

Admissions and Care of Residents in Care Homes

225. From mid-March 2020, additional, bespoke guidance for care homes began to be developed to provide more comprehensive advice to providers and adult social care staff, regarding hospital discharge and infection control in care homes.

226. This bespoke guidance was first developed as two separate documents: PHE interim guidance on "Managing COVID-19 cases and outbreaks in care homes" **(MD/JM5/160 - INQ000325341)** and separate NHSE/I IPC guidance **(MD/JM5/161 - INQ000325324)**. However, following discussion with NHSE/I and the Department, it was agreed that the

work should be combined, and it should be co-badged to streamline the amount of guidance going out to the sector.

227. For the development of the PHE interim guidance, clinicians from PHE with expertise in the relevant area were consulted. The PHE interim guidance recommended that all symptomatic residents be isolated, that contacts of exposed residents be cohorted separately and that unexposed residents be cohorted in a third group. Transfers into a care home were to be undertaken on a case-by-case basis but the "threshold for transferring an unexposed person into a care home [sic] with a possible or confirmed outbreak of COVID-19 would have to be extremely high because of the risk that it poses to that individual and every attempt should be made to accommodate the individual somewhere else with co-ordinated action across all organisations". Correspondingly, individuals with confirmed COVID-19 were advised not to be transferred into a care home with no cases recorded. Moreover, PHE was advising that individuals testing positive for COVID-19 ought not to be discharged from hospital until they had been isolated for seven days and were free of symptoms.

228. Drafts of the PHE interim guidance were cross-checked with WHO guidance, dated 21 March 2020, "Infection prevention and control for long-term care facilities in the context of COVID-19" and relevant content from WHO guidance was referenced or included.

229. WHO guidance, dated 21 March 2020 stated, "*LTCFs (Long Term Care Facilities) should be prepared to accept residents who have been hospitalized with COVID19, are medically stable and are able to care for the patients in isolated rooms. LTCFs should use the same precautions, patient restrictions, environmental cleaning, etc., as if the resident had been diagnosed with COVID-19 in the LTCFs*". The guidance went on, in the case of previously positive COVID-19 patients, it stated that, "where testing is not possible, WHO recommends that confirmed patients remain isolated for an additional two weeks after symptoms resolve" **(MD/JM5/162 - INQ000325328)**.

230. There were concerns raised by NHSE/I and sector stakeholders regarding the discharge elements, outbreak advice and staff cohorting recommendations in the draft PHE guidance **(MD/JM5/163 - INQ000325313)**. NHSE/I was concerned that the guidance as drafted would concern the care home sector and create blocks in the system. It was felt that the overall balance should be about reducing the risk of care homes not taking back existing residents or new transfers. The feedback from NHSE/I considered that the greater risk at the time was of this population being stuck in hospital. Consequently, NHSE/I suggested changes to the wording and advice around discharge and the amended

document was circulated on 25 March 2020 **(MD/JM5/164 - INQ000325249)**. The amended advice did not advise against discharging COVID-19 positive individuals back to care homes. The CQC also signed off the discharge guidance.

231. Clinicians from PHE had also highlighted a need for a standardised process for the step-down of infection prevention control procedures with respect to patients who were COVID-19 positive, and with specific reference to those who were immunosuppressed. "Guidance for stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings" – was developed alongside the "Admissions and care of residents during a COVID-19 incident in a care home" and published on 9 April 2020 **(MD/JM5/165 - INQ000325262)**. This guidance aimed to complement existing infection control guidance to provide advice on appropriate infection prevention control precautions for COVID-19 patients recovering or recovered from COVID-19 and remaining in hospital or being discharged to their own home or residential care. It specifically provided clarity for clinicians around the necessary periods for isolation of COVID-19 positive cases and testing requirements.

232. On 31 March 2020, an official at the Department sent the latest version of the draft guidance for review by the Minister of State for Care **(MD/JM5/166 - INQ000325252)**. This set out a summary of the guidance as well as responses to queries from the Minister on 28 March 2020. The Minister of State for Care's office outlined her comment, "do we really want to be discharging patients with Covid into a care home unless it already has Covid cases? MSC is concerned that a patient will take Covid into a care home, and even with PPE that surely materially increases the risks to others in the facility." The response from officials was this was necessary due to capacity concerns in hospitals, "but we would expect care homes would do a risk assessment to ensure that appropriate isolation facilities are available...". In addition, the draft guidance advised staff immediately to instigate full IPC measures in these instances.

233. On 2 April 2020 "Admission and care of residents during COVID-19 incidents in care homes" was published by the Department, PHE, and NHSE/I **(MD/JM5/14 - INQ000325255)**. The guidance recognised the vital role of social care in the national effort to respond to COVID-19 and set out:

    a. The vital role in accepting patients discharged from hospital. The guidance recognised that some of these patients might have COVID-19, whether symptomatic or asymptomatic, and that all of these patients can be safely cared for in a care home if this guidance is followed.

b. Negative tests were not required prior to transfers/admissions to care homes.

c. In recognition of the vulnerability of care home residents, COVID-19 positive patients should be isolated for 14 days on a precautionary basis. Even if they become symptom free, patients with COVID-19 should complete their 14-day isolation before returning to normal care. Guidance was provided on single case isolation and the use of cohorting where not practical to isolate in single occupancy rooms.

d. As testing capacity increases, the Government aimed to offer a more comprehensive package to the sector. Testing may be offered in the case of a single symptomatic resident. If more than one symptomatic resident, the Health Protection Team should be informed, they would arrange for testing of up to 5 patients (to confirm a COVID-19 outbreak) and advise and support effective isolation and IPC measures.

e. Advice for staff included use of PPE when caring for possible or confirmed COVID19 cases. Staff who develop symptoms should not attend work and should self isolate for 7 days.

f. Family and friends were advised not to visit care homes, except next of kin in exceptional situations such as end of life. Alternatives to inpatient visiting should be explored including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.

g. Guidance also included infection prevention control practices, decontamination and cleaning, and on PPE supplies, including wholesalers supported by the Department and how to contact the NSDR for advice on obtaining supplies.

234. It was realistic to expect care homes to be able to conduct full risk assessments. Conducting risk assessments for outbreaks of infectious diseases (for instance, influenza and norovirus) has always been a very important element of running a care home, so it was reasonable to expect that care homes were able to fully risk assess outbreaks of COVID-19 using their existing risk assessment procedures, and with reference to national guidance.

235. The 'COVID-19: guidance on residential care provision' of 13 March 2020 *not expected to have dedicated isolation facilities for people living in the home*", they should "*implement isolation precautions when someone in the home displays symptoms of COVID-19 in the*

same way that they would operate if an individual had influenza". It also stated that if isolation was needed, *"a resident's own room can be used" and "ideally the room should be a single bedroom with ensuite facilities*." **(MD/JM5/45 - INQ000325233)**. The approach of isolating residents due to infectious disease was familiar to care settings. It involved ensuring that residents remained isolated in their own rooms with doors closed; rigorous hand hygiene and use of PPE before entering and when leaving the room; and additional measures in relation to the management of linen, waste and cleaning. It was therefore realistic to expect that care homes would be able to follow such an approach in the context of COVID-19.

236. The 2 April 2020 admissions guidance also signposted settings to a range of additional support including the local authority, IPC teams, and Health Protection Teams, who were available to support settings during that time to undertake risk assessments or provide practical advice on the application of guidance **(MD/JM5/14 - INQ000325255)**.

Updates to 2 April Admissions and Care of People in Care Homes, Throughout the Relevant Period

237. Updates to the 2 April 2020 guidance admissions and care of people in care homes included:

    a. Further advice on the admission and isolation of residents from a care facility. The guidance detailed the need for Polymerase Chain Reaction (PCR) testing and the time frames. The guidance also outlined specific criteria within an individual risk assessments that should be taken into account **(MD/JM5/167 - INQ000106486)**.

    b. Further guidance on residents' discharge from hospital. Including required isolation periods.

    c. Admissions guidance of residents who had tested positive for COVID-19 in the past 90 days.

    d. Admissions of new residents from the community.

    e. Urgent admissions from the community.

    f. Admission of residents who cannot be tested.

    g. Self-isolation in care homes.

    h. Self-isolation of residents following close contact with a confirmed COVID-19 case.

i. Cohorting residents during their period of self-isolation.

j. Self-isolation after international travel.

COVID-19: Our Action Plan for Adult Social Care

238. On 13 and 14 April 2020, Ministers discussed a proposed adult social care strategy and, once outstanding policy questions had been finalised, agreed to publish on 15 April 2020. On 13 April 2020, at the daily testing meeting, the prioritisation of care homes for testing was discussed and it was agreed to test people being discharged from hospital to care homes and to work towards testing all people before admission to care homes as testing capacity permitted.

239. On 15 April 2020, DHSC published "COVID-19: Our Action Plan for Adult Social Care" (the Action Plan) **(MD/JM5/75- INQ000325315)**. This brought together a comprehensive summary of the action the Government was taking to support social care. It also included significant expansion of testing, taking advantage of the additional testing capacity becoming available and new measures to support the workforce and ensure emergency supplies of PPE:

a. To support safe discharge a move to institute a policy of testing all residents prior to admission to care homes. This was to begin with all those being discharged from hospital. Guidance on isolation and care for both symptomatic and asymptomatic residents was provided.

b. A move to testing all symptomatic residents.

c. Testing for symptomatic care workers and their households.

d. Measures to support the workforce and to increase the social care workforce by 20,000 people over the next three months.

e. As well as continuing to supply LRFs with PPE to meet priority needs, the NSDR 24/7 helpline could provide PPE to providers with an urgent need.

Adult Social Care Insurance Pressures

240. The Department first became aware of insurance pressures in the adult social care sector in April 2020 via the National Care Forum and the CQC. The pressures took several forms, namely:

a. Providers being unable to renew their insurance policies (though on several occasions this was due to their CQC rating being "*requires improvement*" or "*inadequate*");

b. Significant increases in premia adding financial pressures on providers; and

c. New restrictions on cover for infectious diseases.

241. For context, all providers in the care sector must have insurance and suitable indemnity arrangements to cover potential liabilities arising from death, injury, or other causes, loss or damage to property, and other financial risks, in order to qualify for registration with the CQC **(MD/JM5/168 - INQ000576748)**. Providers must purchase insurance from the commercial insurance market, and supply evidence of both public and employer liability insurance cover when applying for CQC registration[3]. Since social care insurance is a private contractual arrangement between care providers and insurance companies, it is not a matter in which Government had direct involvement.

242. In April 2020, the Department began rapidly investigating and gathering evidence to monitor the adult social insurance market. For example, market insights were obtained from care and insurance industry stakeholders including the Association of British Insurers (ABI), the British Insurance Brokers' Association (BIBA) and care provider representatives such as the Care Provider Alliance (CPA). In 2020 and 2021, the Department also facilitated surveys (via the United Kingdom Homecare Association (UKHCA) and CPA) across provider representatives to understand the scale of the issue. It was estimated from the survey data that 75% of providers faced increases to the cost of insurance, with an average increase of 60% compared to pre-pandemic prices. There was also continuous joint working with CQC, ABI, BIBA and care provider representatives to monitor the situation, with regular updates provided to ministers **(MD/JM5/169 - INQ000576724; MD/JM5/170 - INQ000608148; MD/JM5/171 - INQ000608147; MD/JM5/172 - INQ000608156)**. The Department's monitoring showed that most care providers were still able to access some insurance, albeit at a higher cost, and insurance issues were not leading to widespread failure or exit from the sector. **(MD/JM5/173 - INQ000576719; MD/JM5/174 - INQ000576730; MD/JM5/175 - INQ000576731)**.

243. While the combined evidence base confirmed widespread increases in premia costs, evidence of providers having to stop operating because of insurance availability

[3] Public liability insurance covers eligible loss or damage sustained by third parties, i.e. those who are not directly employed by the care provider (which, in the adult social care context, includes care users, residents, their families and any visitors to a care service). Employer's liability insurance covers eligible loss or damage sustained by employees (for example, if an employee is injured at work).

constraints was lacking. Where the Department was made aware of a small number of providers considering ceasing operations due to lack of any available insurance, its follow-up found that the vast majority of providers had been able to secure cover, and, where this was not possible, other factors such as a low CQC rating also played a significant role. In the advice sent to ministers on 5 May 2020, it was recommended that "we don't provide indemnity yet due to lack of evidence that this is required. However, we should continue developing and costing options that meet the most significant risks".

244. On 4 June 2020, advice was sent to ministers which stated that **(MD/JM5/176 - INQ000576720)**: The Department had "received little new evidence of indemnity and insurance issues in adult social care. We have continued to develop a contingency plan in case coverage is widely withdrawn, but we do not think we have yet reached a trigger point for emergency measures. We will continue to monitor the situation, further refine our proposed indemnity solution and "stand ready" in case the further intervention is required". For example, "if we saw evidence of Covid Public Liability claims being formalised and being brought against providers or there was significant evidence of widespread impacts on behaviours – such as non-compliance with Government visiting guidance or impacts on admissions – and insurance was the dominant (rather than contributory) factor in this behaviour".

245. Overall, throughout the period of April 2020 – June 2022, the Department's monitoring showed that most care providers were still able to access some insurance, albeit at a higher cost, and insurance issues were not leading to widespread provider failure or exit **(MD/JM5/177 - INQ000576750)**. In response to the widespread increase to the cost of insurance specifically, DHSC successfully bid for funding in the 2020 Spending Review to help local authorities support providers: £95m was secured in response to the evidence of increasing insurance premia. This was un-ringfenced funding, as part of £1.6bn provided to local authorities for social care and other services over the Spending Review period: local authorities decided how to make best use of this funding, but were expected to take factors which were affecting the cost of providing care, such as increased insurance costs, into account when setting fees. Throughout the pandemic, funding committed to local authorities through un-ringfenced grants to tackle the impact of COVID-19 on their services, including in adult social care, rose to £6 billion.

246. Working closely with the CQC, care representatives, ABI and BIBA, the Department provided assistance to providers with finding alternative insurance cover wherever possible, although this frequently came with a higher premium and a COVID-19 exclusion (meaning there was no public liability cover in the event of a care user dying from COVID-

19 while in the provider's care). The Department also ensured that insurance premium increases were reflected in its assessments of overall pressures faced by the sector - and taken into account in decisions about sector funding.

247. On 19 January 2021, the Designated Settings Indemnity Support (DSIS) scheme, administered by NHS Resolution **(MD/JM5/178 - INQ000576733)** was introduced. 'Designated settings' were care homes assured by the CQC as safe to accept infectious COVID-19 positive patients from NHS hospitals, and further information is set out below. The DSIS scheme provided temporary, state-backed indemnity cover for designated settings which were unable to obtain sufficient insurance to operate this service. The DSIS offered indemnity cover for clinical negligence, public liability and employer's liability claims as needed. This indemnity cover did not replace existing insurance for designated settings but acted as a "gap-filler" to bring cover up to a sufficient level. The intention of the scheme was to help boost capacity in designated settings and support wider discharges by removing insurance as a barrier to their successful operation. The DSIS was extended several times and concluded at the end of March 2022, when the designated settings policy came to an end **(MD/JM5/179 - INQ000576749)**.

The Designated Settings Policy

248. The Department worked with the CQC to develop Designated Settings. Designated settings were specific care homes that had isolation facilities to house COVID-19 positive patients that had been discharged from hospital. The purpose of the settings was to restrict further spread of COVID-19. Patients were required to complete a period of isolation for 14 days before returning home or moving into a care home **(MD/JM5/180 - INQ000391363)**.

249. At its peak, during the second wave, there were 159 CQC approved designated settings, providing 2,169 beds. There were an additional 919 beds available through alternative arrangements: where some local authorities made arrangements with local partners to use NHS settings for the same purpose. The vacancy rate at the time, in January 2021 was 37.8%.

250. On 15 September 2020, the Cabinet Committee, COVID Operations (COVID-O) considered the Winter Plan 2020/2021 **(MD/JM5/181 - INQ000058272)**. It approved the publication of the plan **(MD/JM5/182 - INQ000090180)**. In light of a concerning uptick in positive cases in care homes and in response to a Prime Ministerial request of 14 September 2020, it also looked at more radical options going beyond the Winter Plan. Of

these, it agreed that the following should be implemented: further enforcement powers relating to care homes including on staff movement; strengthening of the CQC inspection regime; publishing data at an individual care home level on how much testing had been undertaken and how many of them were positive tests; and exploring a measure to ensure that no patient was discharged to a care home unless they tested negative (the existing policy was that those testing positive could be discharged to a care home if they were isolated). On this final point, following a discussion with the Prime Minister on 18 September 2020, it was decided instead to set up designated settings into which COVID-19 positive patients could safely be discharged **(MD/JM5/183 - INQ000325287)**. The 'Adult social care: coronavirus (COVID-19) winter plan 2020 to 2021' (Winter Plan 2020/2021) was published on 18 September 2020.

251. An initial submission, explaining the different options and the potential benefits and challenges of an 'ASC post-discharge designation scheme' was sent to the Secretary of State on 23 September 2020, with a delivery plan submitted on 30 September 2020 **(MD/JM5/184 - INQ000109763)**. In annex B of that submission officials laid out the risks to consider with regards the possible introduction of any scheme. These included:

    a. The risk of functional decline from the continued risk of exposure to COVID-19 from a prolonged stay in hospital as well as the risk of functional decline associated with quarantine and isolation;

    b. The mental health and wellbeing impacts associated with social isolation; and

    c. The challenges associated with ensuring compliance with isolation were also explained.

252. In a letter sent on 13 October 2020, the Department required every local authority to identify sufficient designated accommodation to meet demand over winter (as soon as possible and ideally by 16 October 2020), and to have access to at least one designated location by the end of October **(MD/JM5/185 - INQ000234564)**. Each location was then assessed and approved by the CQC for use as a designated setting. The settings began operating in November 2020 and were funded through the £588 million discharge fund mentioned at paragraph 223. It was for local commissioners to determine appropriate fee rates for designated settings, with reference to their duties under the Care Act 2014 (the Care Act), and considering the additional costs to providers of those beds. The time spent by an individual within a designated setting contributed towards the 'up-to-6 weeks' funded care provided on discharge from hospital for new or additional care needs. In

practice, some of the funding for individual designated setting places may have come from other local authority and NHS budgets, depending on the circumstances and locally agreed arrangements.

Rollout, Implementation and Final Step Down

253. It took about two months, following the discussion with the Prime Minister on 18 September 2020, before the first designated settings began operating, with each having been approved by the CQC **(MD/JM5/186 - INQ000576728)**. By early January 2021 designated settings were available in 141 local authorities.

254. In order to set up and operate a designated setting, local authorities were asked to consult with care providers to identify a sufficient number of facilities within their local area to meet likely demand over the winter months. Local authorities then worked with local system leaders to ensure that the designated accommodation identified adhered to the standards set out in the CQC IPC protocol and wider requirements for registration. As part of this, local authorities had to ensure there were provisions for repeat testing, PPE, arrangements for staff isolation or non-movement, protection from viral overload, sickness pay and clinical treatment and oversight. Once local authorities had selected premises, the CQC inspected them against the IPC protocol and published their findings on their website. Following this, local authorities communicated to CCGs and providers when the new designation scheme was in place to commence its operation. **(MD/JM5/187 - INQ000391338)**.

255. Between October 2020 and May 2021, significant work was undertaken to monitor the uptake of designated settings across local authorities and the number of beds available. As designated settings were inspected and approved by the CQC, the CQC collected data on their location (including local authority), and the number of beds provided by each. The CQC began to report this data daily to the Department in late October 2020. By late November 2020, the CQC had built a dashboard, to which Department officials were given access, and which was refreshed daily. The dashboard included data on the number of CQC-approved settings, or alternative settings, and the total beds allocated in those settings. Some local authorities made alternative arrangements with local partners to use NHS settings for this purpose. Once designated settings became more established, additional functionality was added in December 2020 to the Capacity Tracker, that enabled designated setting bed vacancy information to be sourced when needed for discharge purposes. This also allowed the Department to highlight care homes that were

designated settings and identify the total number of designated setting beds, and importantly, the individual beds available, i.e. not occupied, on a day-by-day basis.

256. At a COVID-O meeting on 11 January 2021, it was confirmed that designated settings were available in 141 local authorities. Of the ten local authorities who did not yet have designated settings in place at that time, six were being prioritised by the Department's Regional Assurance Team, two were waiting CQC approval, and two were anticipated to be in place shortly **(MD/JM5/188 - INQ000325299)**.

Success and Data

257. As of 8 March 2021, according to triangulated data from the capacity tracker, the CQC and the regional assurance team, 151 local authorities had designated setting capacity and only two areas did not have designated settings in place **(MD/JM5/189 - INQ000576735)**. Capacity was closely monitored by the regional assurance team on a weekly basis. The average vacancy rate was 57%, and had been increasing since mid-January 2021, although it was noted that there was considerable regional and location variation.

258. The Department considers that the designated settings policy was a success and is a policy that would be considered in a future pandemic subject to clinical advice. The creation and implementation of the policy was essential for inspiring confidence in the care home sector. It allowed those providers that did feel confident to safely accept patients being discharged from hospital with COVID-19 to come forward and receive assurance from the CQC that they were able to do so. It also reassured other providers that they would not be required to accept patients being discharged from hospital with COVID-19, and hospitals that they could safely discharge people with COVID-19 when they were medically fit to leave. However, we recognise that there were concerns about the use of designated settings. Due to there being a limited number of designated settings available to each local authority, the provision of the placement may be less tailored to specific needs, including them being further away from family and friends. For individuals with cognitive impairments who normally would reside in a care home, moving to an unfamiliar environment could be distressing. The extent to which designated settings were used varied across the country, however. In some areas, such as London, designated settings were not used extensively because there was sufficient capacity within NHS beds that they were not required.

259. The Department doesn't hold the data that would be required to make a full assessment on the designated settings policy on infection rates, morbidity and mortality within care and residential homes, and accordingly no such analysis has been undertaken.

VISITING POLICY

260. When making decisions about visiting restrictions to care homes, the Department sought to balance the need to minimise COVID-19 risk to residents and staff with the need to protect residents' wellbeing. This balance was constantly reassessed to reflect the Department's increased understanding of COVID-19 and we consulted a wide range of stakeholders at every step. The goal throughout was to enable visits as much as possible in the context of the public health advice at the time.

February – July 2020

Key Decision-Making and Development of Visiting Policy and Guidance

261. The Department was concerned with visiting policies from an early stage. On 14 February 2020, Dr Nisha Mehta, Clinical Advisor to the CMO, emailed PHE with an urgent request for advice about adult social care planning for a RWCS **(MD/JM5/190 - INQ000562859)**. She attached a document with some of the questions the Department had received from the sector, including a question about whether providers should "*consider stopping visitors from coming in*" **(MD/JM5/191 - INQ000562860)**.

262. On 25 February 2020, PHE issued guidance covering care homes, including advice on managing visits where these were deemed necessary. This guidance had been shared by the Department in draft form with the four nations' CMOs and other stakeholders, including, among others, the Devolved Administrations, the Care Quality Commission, the Association for Real Change, and the National Care Forum **(MD/JM5/192 - INQ000502348; MD/JM5/193 - INQ000454118)**. The guidance provided advice on risk assessments for undertaking homecare visits or providing care in residential settings **(MD/JM5/8 - INQ000325225)**, and stated that: "*social, community and residential care staff should ascertain if a person is in self-isolation and if they are asymptomatic or symptomatic prior to their visit. If they are self-isolating and a visit is deemed necessary, then a full risk assessment should be undertaken with managers and infection control specialists to decide the best course of action*".

263. On 13 March 2020, PHE issued further guidance for residential care settings, supported living provision and homecare provision, advising providers to review their visiting policy. The guidance was shared in drafts with the National Adult Social Care COVID-19 Group

(NACG) who gave feedback **(MD/JM5/194 - INQ000562862)**. It was also reviewed by the Minister of State for Social Care, the Secretary of State and No. 10 officials **(MD/JM5/195 - INQ000562863)**. The guidance on residential care provision advised "*to minimise the risk of transmission, care home providers are advised to review their visiting policy, by asking no one to visit who has suspected COVID-19 or is generally unwell, and by emphasising good hand hygiene for visitors. Contractors on site should be kept to a minimum. The review should also consider the wellbeing of residents, and the positive impact of seeing friends and family.*" **(MD/JM5/45 - INQ000325233)**.

264. The dilemma on visiting was encapsulated in an email exchange between Rosamund Roughton and representatives of Care England, the National Care Association, and the Association for Real Change and the National Care Forum on 15 March 2020 **(MD/JM5/196 - INQ000562864)**. Rosamund laid out two options for visiting: "*1) Recommend that care homes close to all visitors if a resident is symptomatic for 14 days, with special discretion for family members to visit someone at the end of life with strict infection control etc. 2) Stick with current advice around isolate and good infection control.*" In response, the representative for the Association for Real Change replied, "*The issue is if care homes doors are closed, potentially for many months, then there are genuine social impacts for people. For people with Learning Disabilities and/or autism, isolation for some will lead to increased behaviours of concern and greater challenges for staff, increased staffing ratios will be required at a time when fewer staff are available etc. That said preservation of life is THE priority. Maybe there are opportunities for homes to better use technology to check in with their loved one as a counter to closures. Sorry this may not be terribly helpful, very difficult.*".

265. On 30 March 2020, the guidance for residential care settings, which had been published by PHE on 13 March 2020 was updated, at the request of No.10 and without consultation with the Department. The updated guidance advised that, "*Care home providers should stop all visits to residents from friends and family. Medical staff and delivery couriers can still visit, but you should leave a hand sanitiser by the entrance and ask them to wash their hands as soon as they enter the building*". This amendment was questioned by the Department, but not updated. On 2 April 2020, the guidance was withdrawn and replaced by the '*Admission and care of residents during COVID-19 incident in care homes*' guidance, further details of which can be found below **(MD/JM5/197 - INQ000562865)**.

266. On 2 April 2020 guidance on '*Coronavirus (COVID-19): admission and care of people in care homes*' was published by the Department, PHE, and NHSE/I **(MD/JM5/14 - INQ000325255)** which included reference to visiting**.** Reflecting a position agreed with

DCMO and the Minister of State for Care **(MD/JM5/198 - INQ000327807)**, the guidance stated that:

> "*Family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life. Alternatives to inpatient visiting should be explored including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.*"

267. The Department also regularly reviewed the impact of visiting restrictions on residents' wellbeing. For example on 13 May 2020, the Minister of State for Care asked departmental officials to consider concerns relating to support for care home residents, and emotional wellbeing in particular, when developing advice on visiting. The Minister engaged regularly with stakeholder groups, some of which represented care home residents and their families, including via a bi-weekly meeting. In addition, the Department set up a new strand of work focused on the user perspective and experience during the pandemic. The aim was to properly understand the range of issues and ensure they were considered and addressed in Government decisions relating to adult social care. The advice to the Minister noted that the Department had supported published advice on dementia, care homes and COVID-19, from the Social Care Institute for Excellence (SCIE) and National Clinical Director for Dementia **(MD/JM5/199 - INQ000562867)**. The advice included that the Department would:

    a. "*Deploy a lead official for user wellbeing. They will work with our Chief Social Worker and ASC policy leads to ensure wellbeing and user rights are considered when making decisions and issuing public statements about ASC and the pandemic.*

    b. *Consider and mention user wellbeing in key pieces of guidance to be updated or published, including for people with dementia, LD&A. In particular, in updated guidance for care homes, we will remind providers and others of their obligations to consider wellbeing under the Care Act 2014, the Ethical Framework for ASC and other equalities legislation.*

    c. *Include a fuller explanation of the visiting policy, including information about exemptions for some people with LD&A, in updated care home guidance (to be submitted for your steers, soon).*

    d. *Test more pieces of new guidance with trusted user representatives and people with lived experience – not just relying on the NACG at speed. Publish*

key pieces of ASC guidance in accessible formats including 'easy-read' for people with communication difficulties, audio and British sign language.

e. *Consider the case for a new 'Frequently Asked Questions' document on dementia and the pandemic."*

268. In June 2020, the Government began easing restrictions on the whole population and various exemptions from the need to remain at home were introduced. On 13 June 2020, The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 were amended to allow an individual to visit a person "*receiving treatment in hospital, or staying in a hospice or care home*".

269. On 12 June 2020, officials began to develop proposals to move to a local dynamic risk-based approach to visiting. This would be based on the circumstances of the individual care setting (including both residents and staff), the individual needs of the residents within that setting and the external COVID-19 environment. The adult social care sector influenced the decision to introduce local dynamic risk-based approaches. The advice noted that officials would seek CMO and DCMO agreement before publication of dedicated visiting guidance **(MD/JM5/200 - INQ000562868)**.

270. On 24 June 2020, a submission was sent to the Minister of State for Care setting out the risks and benefits of publishing dedicated visiting guidance. The submission said that the aim of the draft visiting guidance was to allow care homes to take a more flexible and local approach in setting visiting policy **(MD/JM5/201 - INQ000327932)**. The submission further said that the draft guidance was informed by the latest SAGE paper **(MD/JM5/202 - INQ000562877; MD/JM5/53 - INQ000512948)**, and that the Department had worked with the following stakeholders in the development of the draft: David Pearson (Chair of the Social Care Sector COVID-19 Support Taskforce), the National Care Forum, Care England, the Local Government Association, ADASS, Association of Directors of Public Health (ADPH), Think Local Act Personal, Learning Disability England and Alzheimer's Society UK. The advice noted that the proposed approach:

a. Would give care home providers much more flexibility to develop their own visiting policies, in collaboration with the local infection control lead from the CCG, the Director of Public Health (DPH) and the local PHE Health Protection Team;

b. Included guidance which had been developed with the sector and received broadly positive feedback. It had also been reviewed by DCMO who was

content. DCMO tested the draft guidance with CMO, in particular on whether he would support greater flexibility for care homes to set their own visiting policies. Both CMO and DCMO were content for the guidance to be in place.

Visiting Policy Between July 2020 and February 2022

Introduction

271. Over the period July 2020 to February 2022 there was continued focus on visiting in care settings. The Department was trying to balance the benefits of visiting in terms of a resident's health and wellbeing against the risk of disease coming into care settings. This was in the context of a fast-moving situation where national guidance was frequently changing in response to COVID-19 developments. The difficulty of striking the right balance between protecting residents' physical health and their mental wellbeing is illustrated by the fact that the Department was both judicially reviewed for failing to shut down visiting early enough in the first wave and received a number of pre-action-protocol letters in late 2020 challenging guidance for not allowing enough visiting.

272. There were frequent discussions between officials, the DCMO, PHE and the Minister of State for Care. In these discussions, the challenge was always whether changes could be made to visiting policy that would enable more frequent visits and an enhanced level of visits to take place, whilst still keeping residents safe. This, together with changes to national restrictions flowing from COVID-19 developments, meant that there were many changes to visiting policy during the period between July 2020 and February 2022, as set out below. Decisions went through collective agreement processes – normally COVID-O committee meetings to agree policy as part of wider discussions on national restrictions, and Cabinet Office/No.10 to clear publications.

273. The Department also sought to ensure visiting guidance did not hinder health and social care professionals from visiting residents in care homes. In all COVID-19 guidance on gathering and household mixing, there were exemptions which applied to medical professionals and others who might need access to a care home to deal with an emergency. This meant health and social care professionals were always able to visit residents in care homes and provide emergency care.

274. The Department also actively engaged with stakeholders. When making changes to the guidance, Ministers and officials drew on the insights of, for example, the Social Care Sector COVID-19 Support Taskforce (the Adult Social Care Taskforce), the National Care Forum, the Care Quality Commission, Care England, the Local Government Association,

ADASS, the ADPH, Think Local Act Personal, Learning Disability England and the Alzheimer's Society UK, to ensure the changes were informed as much as possible by views from across the sector.

275. Many stakeholders (providers as well as charities and families' representative groups) were broadly in favour of loosening restrictions. However, stakeholders were aware of the balance of risks involved and had a variety of views on where that balance should best be struck. Stakeholders (particularly providers) were concerned that any guidance should be clear, including clear policy and public communications, and that the guidance should be workable for staff and residents, and therefore the Department also worked very closely with them on how the guidance would be implemented.

July 2020 – August 2020

276. On 8 July 2020, officials proposed to the Secretary of State further changes to the draft visiting guidance to enable easier visiting in care homes. The advice noted that the care sector had been consistently calling for visits at this point, and some care homes had started facilitating visits with appropriate social distancing **(MD/JM5/203 - INQ000327941)**.

277. SAGE was consulted on the proposals, and it found that there was medium evidence to suggest that visits of a short duration, with appropriate social distancing and infection control, were likely to pose a lower risk to residents than infection from care home staff. The guidance was approved for publication and 'visiting arrangements in care homes' was published on 22 July 2020 **(MD/JM5/204 - INQ000109589; MD/JM5/53 - INQ000512948)**.

278. This 'visiting arrangements in care homes' guidance **(MD/JM5/205 - INQ000325285)** advised care home providers to develop a policy for limited visits from a single constant visitor per resident where community transmission rates were low. Where there was an outbreak, care homes could impose visiting restrictions but were required to consider alternative options to maintain social contact for residents and their families. Providers were advised that when establishing their visiting policy they should consider the cohort of residents, including whether "*their needs make visits particularly important (for example, people with dementia, a learning disability or autistic people may be permitted visitors when restricting visitors could cause some of the residents to be distressed)*". The guidance acknowledged the particular difficulties for individuals with dementia, and that

care workers should try to prepare the resident for a visit, "*perhaps by looking at photographs of the person who is due to visit, and talking to them about their relationship*".

279. This guidance also recommended that care homes take a personalised approach to visiting policy, stating that where "*care homes are proposing to take a bespoke approach to a specific resident, it should seek to engage family or other likely visitors, any 'residents and relatives' committee, and the resident to the fullest extent possible in this decision*".

280. This guidance also set out that in exceptional circumstances, a very small number of people might have great difficulty in accepting staff or visitors wearing masks or face coverings, which might place them, visitors, or the supporting staff at risk of harm. A comprehensive risk assessment was required to be undertaken for each person identifying the specific risks to them and others, including consideration of visors or clear face masks.

281. Alongside the discussions regarding care home visiting, ministers also regularly reviewed guidance on 'visits out' by care home residents. Several stakeholders, including the National Care Forum, said that such visits were an important part of many residents' lives. PHE advised the Department on 10 July 2020, that enabling such visits would require further consideration, as "*a trip out of the care home, especially with overnight/weekend stays, represents a very different level of risk to visitors coming into the home wearing appropriate PPE etc, and so needs risk mitigation to be thought through.*" **(MD/JM5/206 - INQ000562869)**. On 6 August 2020, a submission was sent to the Minister of State for Care outlining the approach to out of home visits **(MD/JM5/207 - INQ000562889)**. The submission recommended developing a risk assessment and locally based approach for visits out, as well as publishing the associated guidance as soon as possible. The guidance contained information and advice on visitors and support bubbles, which included points on limiting visits to care settings and the number of visitors, exploring alternatives to in-person visits, and the use of outside spaces where possible. An update to the guidance on visiting out was delayed until after the publication of the Adult Social Care Winter Plan, as previous guidance on infection control already included provisions on visiting out, and most of the interest from stakeholders was on visits into care homes. Guidance on visits out of care homes was published on 1 December 2020, as an update to the general visiting guidance for care homes.

September 2020 – December 2020

Development of the Winter Plan

282. In September 2020, following the rise in confirmed COVID-19 cases in care homes, the Prime Minister asked for advice on strengthening guidance for visits to care homes. On 12 September 2020, the Minister of State for Care updated the Prime Minister on the latest situation in care homes, including the threefold spike in infections since August. **(MD/JM5/208 - INQ000328156; MD/JM5/209 - INQ000328155)**.

283. Following meetings with officials to discuss options, the Prime Minister agreed to a policy of continuing to allow visits but tightening restrictions to ensure stronger IPC measures, as well as restricting visits in areas of high prevalence **(MD/JM5/210 - INQ000327990)**.

284. On 17 September 2020, the Secretary of State and Minister of State for Care decided on wording to go into the Winter Plan 2020/2021 following on from the Prime Minister's decision **(MD/JM5/211 - INQ000327989)**. The Minister wanted to clarify that the number of visitors would be limited to a single constant visitor per resident wherever possible, with an absolute maximum of two constant visitors per resident to limit the risk **(MD/JM5/212 - INQ000327991; MD/JM5/213 - INQ000608153)**. Those amendments were taken forward and the Secretary of State approved the wording on 17 September 2020 **(MD/JM5/214 - INQ000327992)**.

285. The Winter Plan 2020/2021 was published on 18 September 2020 **(MD/JM5/215 - INQ000234495)**. The Plan stated that care home providers should develop a policy for limited visits, as appropriate, in line with up-to-date guidance from their relevant Directors of Public Health (DPH) and based on dynamic risk assessments which considered the vulnerability of residents. This policy was expected to include both whether their residents' needs made them particularly clinically vulnerable to COVID-19 and whether their residents' needs made visits particularly important. Social workers could assist with individual risk assessments for visits and advise on decision-making where the person in question lacked capacity to make the decision themselves. The expectation was that policies should:

    a. Set out the precautions that would be taken to prevent infection during visits and ensure these were communicated in a clear and accessible way;

    b. Ensure the appropriate PPE was always worn and used correctly – which in this situation was an appropriate form of protective face covering (this may have included a surgical face mask where specific care needs align to close contact care) and good hand hygiene for all visitors;

c. Limit visitors to a single constant visitor wherever possible, with an absolute maximum of two constant visitors per resident to limit risk of disease transmission;

d. Require visitors to be supervised visitors at all times to ensure that social distancing and IPC measures were adhered to;

e. Wherever possible, provide for visits to take place outside, or in a well-ventilated room, for example with windows and doors open where safe to do so; and

f. Make provision to immediately cease visiting if advised by their respective Director of Public Health that it is unsafe.

286. To continue to support residents' wellbeing during continued visiting restrictions, as part of the Winter Plan 2020/2021, NHSX gifted 11,000 iPads to care homes to help residents receive ongoing care and stay connected to loved ones **(MD/JM5/216 - INQ000562890)**.

287. To reflect the changes to visiting restrictions throughout this period, the Department gave funding to help care providers ensure safe visiting. The ICF had been established in May 2020 with the primary aim of supporting adult social care providers to reduce the rate of COVID-19 transmission in and between care homes. In October 2020, the second round of the ICF was launched, with stakeholders informed that it could also be utilised to fund dedicated staff to support and facilitate visits, additional IPC cleaning in between visits, and making alterations to allow safe visiting such as redesigning a dedicated space.

288. New visiting guidance was introduced on 15 October 2020 to reflect the changes introduced in the Winter Plan 2020/2021 (as set out in para 285 above) and align the guidance with the tiering system. The guidance said that care homes in the lowest level of alert (Tier 1 - medium) should continue to allow visits, with appropriate use of PPE and social distancing, whilst care homes in Tier 2 or 3 (high and very high) should only allow visits in exceptional circumstances.

289. At a COVID-O meeting on 23 October 2020 **(MD/JM5/217 - INQ000090126; MD/JM5/218 - INQ000090293)** they discussed visiting policy and noted that options to permit more visiting were being worked up including through the use of testing of regular visitors. The paper also summarised a SAGE SCWG consensus statement from 1 November 2020 **(MD/JM5/219 - INQ000215625)**, on the evidence on visiting, covering beneficial impacts and the relative contribution of visiting in transmission risk citing evidence that isolation

had a strong negative impact on quality of life. Evidence was weaker on the risk of introduction and transmission of COVID-19 infection from visitors. Further work through the commissioning of new studies was needed. In the meantime, it concluded: "*there is no existing simple solution to balance quantifiably both harm and benefit to inform policy development*".

290. Following the Winter Plan 2020/2021 and the new guidance of 15 October 2020, the Department continued to work on options to further open up visiting. However, at the end of October/early November 2020 (particularly the weekend of 31 October and 1 November 2020), in the context of an impending four-week national lockdown, there was much consideration and debate as to how to balance the risks and wellbeing impacts in relation to visiting policy, as is set out below.

291. On 1 November 2020 a submission was sent to the Minister of State for Care, accompanied by an advice note setting out different options to enable visiting. This document went through several iterations as officials and Ministers considered different options that recognised that while infection risk would increase along with the numbers or frequency of visitors, there was a clear evidence base demonstrating the deleterious impact of visiting restrictions on residents' wellbeing. Views were sought from DCMO, and feedback provided by the Minister of State for Care and No 10 to prepare viable options for discussion at COVID-O the following day. Two options were confirmed for discussion: Option A – allowing in-person visits by one single visitor per resident, who would be frequently tested; Option B - allowing visits where visitors did not enter the building (e.g. "virtual visiting" using iPads, or "airtight" visiting through windows) **(MD/JM5/220 - INQ000562870; MD/JM5/221 - INQ000608157)**.

292. Option A was explained to be the higher risk option. The Department's recommendation was for Option B, however, there was concern that this would exclude significant numbers of residents, e.g. those who were bed-bound and unable to reach a window, or residents in care homes where there were no 'visiting pods' in place **(MD/JM5/222 - INQ000562871)**.

293. A COVID-O meeting on 3 November 2020 considered the paper prepared by the Department **(MD/JM5/223 - INQ000062849)**. The Prime Minister agreed with the Department's recommendation to implement option B (which centred on outdoor and airtight barrier visits) and move to option A (carefully managed indoor visits) when sufficient testing was in place **(MD/JM5/224 - INQ000562872)**. Visiting guidance was

therefore updated on 5 November 2020, when national restrictions were reintroduced in England (the second national lockdown) **(MD/JM5/225 - INQ000234603)**. The guidance:

a. set out the role of providers in assessing risk, subject to advice from local Director of Public Health; and

b. advised on options for safe visiting, which included the use of visiting pods, screens, windows, outdoor settings, and video calls.

294. This guidance again acknowledged the needs of some care home residents, such as those living with advanced dementia, which might make COVID-19 secure visits challenging. It provided further information on factors that providers should consider when making visiting decisions for particular residents or groups of residents, including the benefits of visiting to a person's wellbeing and the extent of the harm if this was stopped. Visiting was, however, expected to be stopped during an outbreak in all but exceptional circumstances. 'End of life' was considered to be one such exceptional circumstance.

295. A further COVID-O meeting was due to be held on 17 November 2020 **(MD/JM5/226 - INQ000562873)**. The paper prepared by the Department for this meeting provided the latest data on the state of COVID-19 in care homes; an update on the implementation of the Winter Plan 2020/2021 and visiting policies, including the paying out of the £546 million ICF which supported care homes to facilitate safe visiting; and the expansion of testing to visitors and visiting professionals such as CQC inspectors. The meeting was later cancelled.

296. The paper noted that the end of national restrictions meant more visiting and a return to the tiered approach. It said that the objective by Christmas was to enable each resident to receive visits including close contact through the rollout of testing, except where there was an active outbreak of COVID-19 in a home.

297. The paper described the tiered approach to visiting as:

> *End of national restrictions means more visiting simply from returning to the provisions in place over summer & autumn, provides for a tiered approach in line with local risk levels:*
>
> *I. Medium Risk areas - Indoor visits with up to 2 visitors – with PPE, social distancing and supervision*

II. *High & Very High Risk areas - Outdoor visits; indoor visits only with a screen and visitor enters from outside; window visits, pods etc.*

III. *In all places - Always support visiting in exceptional circumstances including at end of life.*

298. Guidance on visiting was again updated on 1 December 2020, to reflect the decisions described in paragraphs 295-297 above, at the end of the second national lockdown and the implementation of the tiering system. **(MD/JM5/227 - INQ000325292; MD/JM5/228 - INQ000325293)**. This guidance:

a. Set out the role of local DPHs and Directors of Adult Social Services (DASSs) in supporting visiting unless they determined that there was good evidence to take a more restrictive approach in a particular care home. It confirmed that the default position was that visits should be supported and enabled wherever it was safe to do so, and that the local DPH and DASS should ensure that could happen across their local area and provide advice to care homes accordingly;

b. Introduced testing for visitors prior to entry to the care home (alongside existing infection, prevention, and control measures);

c. Advised that working age residents could join their families in their homes subject to an individual risk assessment, negative test before leaving, and self-isolation upon return; and

d. Advised that working age residents could form a bubble with one other household (not including a three-household Christmas bubble).

299. Key messages included that all care homes regardless of tier, and except in the event of an active outbreak, should seek to enable indoor visiting if the visitor had been tested and returned a negative result, in addition to outdoor visiting and 'Screened' visits, as well as enabling visits in exceptional circumstances regardless of tier, such as end of life visits.

300. Also on 1 December 2020 the Department published new guidance, 'Arrangements for Visits out of Care Home'. This set out how care homes could support residents of working age on visits outside of the care home.

301. Alongside changes in guidance, the Government launched the RTF to provide funding to support costs associated with testing visitors. Funding could be used to support costs associated with testing visitors from 2 December 2020, when visitor testing was rolled out

with the increased availability of lateral flow tests. Testing was continually expanded in adult social care as availability increased, and to reflect testing needs and prioritisation of risk.

302. Visiting was discussed extensively at a Social Care Sector COVID-19 Stakeholder Group Meeting on 3 December 2020 **(MD/JM5/229 - INQ000582636)**. It was noted that work was underway to support care homes and local systems to put the guidance into place, enable care homes to feel confident to support the visiting that it described, and to communicate to residents and families issues such as the real value of testing and importance of delivering testing in line with other infection control measures. This discussion also noted the importance of balancing risks and noted the very real harm caused by residents unable to have contact with loved ones. The minutes record that there was a variation in practice nationally, with some providers offering safe visits extensively, and others not offering visits at all.

303. A further COVID-O meeting took place on 8 December 2020 **(MD/JM5/230 - INQ000091044; MD/JM5/231 - INQ000059200)**. The focus of this meeting was adult social care COVID-19 testing, including the use of LFD tests to support visits into care homes. The paper noted that the Department expected all care homes to be able regularly to test visitors by 18 December 2020, although the delivery was complex and there were many risks. The paper also noted that the tests would support working age adults to leave care homes to join their families for Christmas in support of the new guidance that had been published on 1 December 2020. Following the publication of guidance on 1 December 2020, millions of LFDs were sent to care homes during December 2020, to ensure that they could test residents and visitors. Further funding was announced on 23 December 2020, to further support the rollout and delivery of LFDs to care homes.

304. In December 2020, following a commission from the Cabinet Office, the Department consulted PHE and DCMO on what restrictions should apply in outdoor and indoor visiting in Tier 4. Consequently, visiting guidance was updated on 19 December 2020 with the creation of Tier 4 **(MD/JM5/232 - INQ000325296; MD/JM5/233 - INQ000234635)**. This guidance:

    a. Stated that all care homes, regardless of tier, and except in the event of an active outbreak, should seek to enable outdoor visiting and screened visits; and

b. Stated that care homes in tier 1, 2, or 3, except in the event of an active outbreak, should enable indoor visits where the visitor had a negative test result;

305. On 20 December 2020 the visiting out guidance was also updated in light of the new tier 4 restrictions. The guidance advised that individuals in tier 4, including residents in care homes, must stay at home and must not gather indoors unless one of the specified exemptions applies.

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306. Following the start of the third lockdown which took place on 6 January 2021, Ministers continued to be mindful of the need to balance minimising risk to residents and staff visiting while also supporting residents' wellbeing. Officials sought further advice from DCMO and PHE on what changes to the visiting guidance were needed. The subsequent submission to the Minister of State for Care was also informed by the views of a wide range of stakeholders representing care home providers, staff, and residents **(MD/JM5/234 - INQ000110288)**. As a result of this advice, visiting guidance was updated again on 12 January 2021 **(MD/JM5/235 - INQ000325221)**. This guidance:

a. Stated that all care homes, except in the event of an active outbreak, should enable outdoor visiting and screened visits, and visits in exceptional circumstances including end-of-life should always be enabled; and

b. Reflected the national stay at home guidance with visits out supported only in exceptional circumstances.

307. The guidance of 12 January 2021 also gave providers advice on establishing their own visiting policies. It explained:

a. *"Providers are best placed to design individual visiting arrangements that take account of the needs of their residents and what is possible within the layout and facilities within the home. In this context, the provider must develop a dynamic risk assessment that assesses how the care home can best manage visits safely, and how this is delivered.*

b. *This dynamic risk assessment should consider relevant factors relating to the rights and wellbeing of the residents. It may be appropriate or necessary for providers to apply different rules for different residents or categories of resident, based on an assessment of risk of contracting COVID-19 in relation*

to such residents, as well as the potential benefits of visits to them. This is further explained in the advice for providers when taking visiting decisions for particular residents or groups of residents section below.

c. *The risk assessment should also consider factors relating to the layout, facilities and other issues around the care home – to help determine:*

- *where visiting will happen – outdoors or in COVID-secure indoor rooms, the rooms in which visiting will happen, where and how visitors might be received on arrival at the home to avoid mingling with other visitors, staff or residents etc*
- *the precautions that will be taken to prevent infection during visits (including PPE use and hand washing).”*

308. It similarly gave advice about outdoor visiting using temporary outdoor structures known as ‘visiting pods’ or conservatories.

309. Throughout this period there were calls from residents, families, campaigners, and members of parliament, along with evidence from SAGE and Age UK, of the importance of visiting and contact for residents’ wellbeing. In February 2021, officials consulted DCMO and PHE on how opportunities for visiting could be developed in the near term and reconvened the stakeholder group chaired by Sir David Pearson. Following these discussions, officials consequently recommended to the minister taking a structured approach by introducing a ‘single named visitor’ to visit each resident, supported by testing and PPE. A paper was prepared by the Department in advance of a COVID-O meeting scheduled to take place on 10 February 2021 **(MD/JM5/236 - INQ000562876)**. It highlighted that some indoor visiting would open ahead of the lifting of national restrictions.

310. While the COVID-O meeting on 10 February was cancelled, **(MD/JM5/237 - INQ000325306)** the paper demonstrates the issues that the Department was grappling with at the time in question.

311. On 22 February 2021 ‘Spring 2021 – COVID-19 response’ was published by the Cabinet Office. It set out the Government’s four-step roadmap out of lockdown, confirming that Step 1 would be from 8 – 29 March 2021.

312. Ahead of that publication, the COVID-O meeting of 18 February 2021 **(MD/JM5/238 - INQ000091741; MD/JM5/239 - INQ000576737)** considered the care home visiting policy and other measures for inclusion in Spring 2021 - COVID-19 response. The paper set out

the existing guidance on visiting and the case for expanding visiting from 8 March 2021 to a single named visitor, as well as the risks of this. COVID-O agreed to the single named visitor proposal. It also agreed to taking a decision no later than mid-April 2021 as part of the next Roadmap stage, on whether to encourage providers to allow more visiting based on an assessment of the latest data at that point, and said that the Department should set out its criteria to enable more visiting in the 22 February 2021 publication.

313. Visiting guidance was updated at the start of 'step 1' of the national roadmap out of lockdown **(MD/JM5/240 - INQ000325310; MD/JM5/241 - INQ000325311)**. The guidance:

    a. Stated that every care home resident should be able to nominate a single named visitor to have regular visits;

    b. Advised on additional arrangements for essential care givers who would provide a greater degree of personal care; and

    c. Reflected national restrictions with regards visits out (i.e. that any such visits should be outdoors), and set out the need to self-isolate for 14 days upon return form a visit out.

314. Ahead of step two of the roadmap, officials worked closely with clinical colleagues and with a range of stakeholders, including providers, professionals, charities and groups representing residents and their loved ones, to review the existing guidance and consider what amends could be made to align with the wider easing of restrictions.

315. The 'Care Home Visiting Stakeholder Group', as it was later known, was informally established at this point. The membership included public health officials along with representatives from Care England, The National Care Association, Age UK, National Care Forum, Alzheimer's Society and Carers UK **(MD/JM5/242 - INQ000562879)**. The group met regularly with the Department throughout the period until March 2022 to discuss possible relaxations to visiting policy in advance of the roadmap steps, and to discuss amendments in response to new issues as appropriate. To align with step two, the visiting guidance was therefore updated again on 12 April 2021 **(MD/JM5/243 - INQ000234851; MD/JM5/244 - INQ000325320)**. The guidance increased the number of named visitors who could regularly visit from one to two. The Minister of State for Care approved the final draft guidance on 31 March 2021 **(MD/JM5/245 - INQ000328108; MD/JM5/246 - INQ000328109)**.

316. Following feedback from the Care Home Visiting Stakeholder Group, the Department produced supplementary guidance on the easing of restrictions to provide care home residents with the ability to vote in person in the 6 May 2021 local elections. After further discussion with clinical advisers, it was decided that this could be expanded to allow other low risk visits out to take place. These changes were introduced on 4 May 2021 in supplementary guidance **(MD/JM5/247 - INQ000325329)**. This guidance stated that residents could leave their care homes to spend time outdoors without the need to self-isolate on return **(MD/JM5/248 - INQ000562878)**.

317. On 17 May 2021 the visiting guidance was updated at the point of step 3 of the national roadmap out of lockdown. This increased the number of named visitors from two to five and stated that residents could go to medical appointments (excluding overnight stays in hospitals), a workplace, educational settings, and day centres without a period of self-isolation upon return **(MD/JM5/249 - INQ000325333; MD/JM5/250 - INQ000325332)**.

318. On 8 June 2021, the Secretary of State and Minister of State for Care received a submission setting out options for care home visiting and admission into care homes once 'Step 4' of the COVID-19 pathway had been reached **(MD/JM5/251 - INQ000608167)**. Option 1 involved a minimal change approach: existing freedoms would remain, but the limit on nominated visitors would be removed and guidance would be amended to encourage a more permissive approach to the nomination of essential care givers who could visit. However, officials recommended Option 2, which involved moderate changes so that residents' freedoms would be largely in line with the rest of society. The key changes in Option 2 included removing restrictions on the number of visitors allowed overall or on any one day, removing the requirement to isolate following admission to a care home from the community and removing the 14-day isolation requirement on return from a visit out. The Secretary of State agreed to most of Option 2, but did not agree to the removal of the requirement to isolate following admission to a care home from the community.

319. Following the response from the Secretary of State officials considered what additional mitigations could be put in place to allow admissions to care homes from community without the need to isolate. Officials proposed that in an enhanced testing regime could be added to the criteria already laid out in the guidance. This would consist of a PCR test in advance of admission, on admission (day 0) and after 7 days following admission (day 7). Additionally, the guidance would recommend LFD testing for 7 days. The Secretary of State approved this amendment and agreed to the removal of the requirement to isolate following admission to a care home from the community **(MD/JM5/252 - INQ000608168)**.

320. The guidance was updated twice. The guidance entered the Triple Lock process on 15 June 2021. The Minister of State for Care approved the guidance on 17 June, the same day as Triple Lock clearance was provided. The guidance was published on 17 June 2021 and applied from 21 June 2021 **(MD/JM5/253 - INQ000325337; MD/JM5/254 - INQ000325336)**. At this point the guidance was updated to reflect that:

    a. Care home residents should isolate following a visit only where it included an overnight stay in hospital, or was deemed high-risk following an individual risk assessment;

    b. Residents no longer should isolate on admission into the care home from the community; and

    c. Every resident could nominate an essential care giver.

321. On 19 July 2021 the visiting guidance was updated again at the point of step 4 of the national roadmap out of lockdown to remove restrictions on the number of visitors care home residents could receive overall or on any one day **(MD/JM5/255 - INQ000111556; MD/JM5/256 - INQ000325339; MD/JM5/257 - INQ000325338)**. On 16 August 2021 the visiting guidance was updated at the point of national changes to self-isolation regulations. This guidance update was conducted as part of changes to various pieces of guidance including visiting in, visiting out, and the admission and care of residents in supported living accommodation. The guidance stated that visitors to care homes should avoid visiting for the necessary self-isolation period if they were identified as a close contact of someone with COVID-19 **(MD/JM5/258 - INQ000325340; MD/JM5/259 - INQ000287661; MD/JM5/260 - INQ000111683; MD/JM5/261 - INQ000562883)** (national guidance at the time said fully vaccinated individuals would no longer need to self-isolate).

322. On 25 November 2021 the visiting guidance was updated to make it clearer and to align the advice on visits into care homes with visits out of care homes. Media attention and letters sent from groups such as Rights for Residents had challenged the Government's existing care home visiting guidance. There was interest from Members of Parliament, as well as stakeholders, in making it easier to facilitate visiting. The updated guidance emphasised that there were no national restrictions on visiting and providers should facilitate visits wherever possible, and advised on how care homes could support residents on visits out of the home.

323. On 14 December 2021 the visiting guidance was updated at the point of increased prevalence due to the Omicron variant This was in response to clinical advice on the

increased risk of visiting due to the Omicron variant but taking into account all the lessons that had been learned over the previous 21 months. The guidance reduced the number of visitors each care home resident could receive (not including essential care givers or preschool age children), required residents to test or self-isolate following visits out of the care home, and changed testing arrangements for staff and essential care givers **(MD/JM5/262 - INQ000287702; MD/JM5/263 - INQ000067612)**.

324. On 26 January 2022, a COVID-O paper was published **(MD/JM5/264 - INQ000091547)** which proposed the removal of restrictions in care homes and reducing isolation requirements in line with the latest evidence from SAGE, while ensuring wider protections remain robust **(MD/JM5/265 - INQ000608174)**. COVID-O agreed to the changes and the visiting guidance was updated on 31 January 2022 **(MD/JM5/266 - INQ000287738)**.

325. On 24 February 2022, updated visiting guidance was published which removed the limit on visitor numbers, removed the need for residents to test or self-isolate following a normal visit out, and advised that after an emergency hospital stay or high-risk visit out residents should self-isolate for 10 days, with testing arrangements to end isolation sooner **(MD/JM5/267 - INQ000562886)**.

326. On 22 March 2022 the visiting guidance was updated following the reduction in the duration of outbreak management in care homes from 14 to 10 days. **(MD/JM5/268 - INQ000564786)**. Visiting restrictions applied when there was an outbreak in a care home and so this reduction in the length of outbreak management meant that usual visiting arrangements could be restored earlier.

327. On 31 March 2022 visiting guidance was incorporated into the Department's IPC guidance **(MD/JM5/269 - INQ000562888)**, and the remaining self-isolation requirements were removed.

328. In terms of monitoring compliance with visiting policies, (beyond close engagement with stakeholders as described above) the CQC used a 'Care Home Visiting Concerns form', as a mechanism for people to feedback on concerns related to visiting. Summaries of these concerns would then be shared with the Department; however, the Department did not have any role in the development of this system, nor did it have direct access to the information from the forms. Only a small number of queries were raised using the form, and none were about genuine blanket bans on visiting. The majority of concerns raised in regard to visiting were due to miscommunication between the care home and the visitors, or the lack of understanding around visits being restricted in case of an outbreak.

Due to the Department's very limited involvement with this form, this is the fullest extent of our knowledge. Visiting was also monitored by the Department through the use of the capacity tracker. The Department asked questions to providers on visiting arrangements in care homes and used this data to monitor visiting trends **(MD/JM5/270 - INQ000061124)**.

Enhanced Health in Care Homes

329. In late March/early April 2020 many care homes were experiencing outbreaks. To support the sector, and particularly those care homes facing more acute pressures, the Department worked with NHSE to consider options to accelerate the implementation of 'Enhanced Health in Care Homes'. Enhanced Health in Care Homes was an existing NHSE programme to enhance clinical support in care homes. Prior to the pandemic, it had been intended that the full programme would be introduced in October 2020. On 25 April 2020 an NHSE options paper was circulated amongst officials in the Department and proposed the introduction of an interim service focussed on the support GPs could provide to care homes ahead of the full rollout in October **(MD/JM5/271 - INQ000562866)**. A letter was sent to primary care providers on 1 May 2020 from NHSE and the measures were detailed by the Department in the May Support Package on 15 May 2020.

330. On 15 May 2020 the Department published the "*Coronavirus Care Home Support Package* **(MD/JM5/30 - INQ000325278)**." This confirmed the accelerated measures from the EHCH programme:

> *"Primary care and community health services are key to ensuring care homes have the clinical support they need. The NHS has committed that all care homes will be supported via primary and community support, by 15 May.*
>
> *This will provide:*
>
> a. *timely access to clinical advice for care home staff and residents, including a named clinical lead for every care home and weekly check-ins;*
>
> b. *proactive support for people living in care homes, including through personalised care and support planning as appropriate;*
>
> c. *support for care home residents with suspected or confirmed COVID-19 through remote monitoring (and face-to-face assessment where clinically appropriate) by a multidisciplinary team where practically possible (including*

those for whom monitoring is needed following discharge from either an acute or step-down bed); and;

d. *sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit."*

331. As this was an NHSE programme, NHSE are best placed to address any questions on how successfully the measures ensured health care needs were met.

TESTING

Testing in the Adult Social Care Sector

332. This section of the corporate statement sets out the development of policy and guidance regarding testing within the adult social care sector throughout the relevant period; how testing policy in adult social care was operationalised; and how take up and turnaround times for results were monitored.

333. Testing was an important tool for controlling outbreaks within social care, although testing was not able to prevent all outbreaks. The most significant factor that limited testing in care homes was the overall testing capacity available for the UK, especially in the early months of the pandemic. Given the size of the adult care home sector in England (further details are provided in statement A of this Module), testing a population this size, even just once, requires very significant capacity, and regular testing even more so.

Testing Policy and Guidance

334. On 1 March 2020, Public Health England (PHE) produced an internal report titled "Laboratory testing capacity and prioritisation of testing" **(MD/JM5/272 - INQ000565758)**. This set out that current PHE laboratory demand was beginning to approach capacity level at several PHE laboratories. The report also stated that increases in testing capacity were likely to be slower than increase in demand. PHE began to develop an outline prioritisation approach in the event that capacity was reached, or turnaround times of testing declined. This was based on criteria established in the 2009-2010 influenza pandemic and using modelling data of likely demand. On 8 March 2020, PHE advised that demand for testing was projected to outstrip capacity within six to eight weeks (mid-April to May).

335. The projected increase in demand for testing, and the scale of testing required, meant that as the UK moved into the 'delay' phase, it would not be possible to test everyone with

symptoms. Therefore, guidance was issued to ensure testing resource was allocated appropriately, as testing supply was scaled up. Guidance continued to be updated, and new guidance was provided, as testing capacity increased. This was based on the available evidence on need and risk at the time, prioritising those where testing was required to support clinical management of the most vulnerable cases.

336. As of 14 March 2020, testing capacity reached about 3,000 tests per day but demand for tests far exceeded capacity. Consequently, a prioritisation process was established to determine how the limited supply of tests should be used. Patients were the first priority and PHE finalised the prioritisation draft on 11 March 2020, which was as follows:

    a. Group 1 (test first): Patient requiring critical care for the management of pneumonia, Acute Respiratory Distress Syndrome ("ARDS") or influenza like illness ("ILI"), or an alternative indication of severe illness has been provided e.g. severe pneumonia or ARDS;

    b. Group 2: All other patients requiring admission to hospital for management of pneumonia, ARDS or ILI;

    c. Group 3: Clusters of disease in residential or care settings e.g. long-term care facility, prisons, boarding schools;

    d. Group 4: Community patient meeting the case definition and not requiring admission to hospital – over 60 years or risk factors for severe disease (recognising that this is challenging); over 60s should be prioritised over other risk factors;

    e. Group 5: Community patient meeting the case definition and not requiring admission to hospital – under 60 years and no risk factors for complication.

    f. Group 6 (test last): Contacts of cases.

337. On 2 April 2020 "*Admission and care of residents during COVID-19 incident in care homes*" was published by the Department, PHE, and NHSE/I **(MD/JM5/14 - INQ000325255)**. The guidance recognised the vital role of social care in the national effort to respond to COVID-19 and set out:

> *"As testing capacity increases, the government will aim to offer a more comprehensive package to the sector. Testing may be offered in the case of a single symptomatic resident. If more than one symptomatic resident, the Health*

Protection Team should be informed, they would arrange for testing of up to 5 patients (to confirm a COVID-19 outbreak) and advise and support effective isolation and infection prevention and control measures."

338. As testing capacity increased, officials began to consider how key workers who were self-isolating should be prioritised for testing. On 7 April 2020 a submission was sent to Ministers with a proposed approach to keyworker prioritisation for COVID-19 testing. The submission provided a proposed prioritisation order for while testing was limited, and confirmed that testing should be offered to all keyworkers and eventually to the wider public as capacity increased **(MD/JM5/273 - INQ000562623)**. The prioritisation list was taken to HMIG for discussion on 9 April 2020 **(MD/JM5/274 - INQ000083645)** before being published on 15 April 2020 **(MD/JM5/275 - INQ000608144)**. This confirmed that as of 15 April 2020 "NHS and social care critical workers who are self-isolating because of coronavirus symptoms" were currently being tested. As capacity increased the list was added to.

339. On 14 April 2020, Departmental officials agreed the approach to draft guidance on testing all hospital patients ahead of discharge to a care home. This included patients who were not symptomatic **(MD/JM5/276 - INQ000565711)**.

340. On 15 April 2020, the Department published "*COVID-19: our action plan for Adult Social Care"* (Action Plan), which outlined steps to minimise infection in care homes **(MD/JM5/277 - INQ000233794)**. On resident and staff testing, it included the following:

    a. Resident testing*: "Testing is currently carried out on the first five symptomatic residents in a care home setting with an outbreak. We can now confirm that we will move to all symptomatic residents in care homes being tested"*.

    b. Staff testing*: "In order to support those working in the sector to return to work as soon as it is safe to do so, we will enable the testing of social care workers and those in their household who have symptoms consistent with COVID-19. Those who are COVID positive must continue to self-isolate but will know that they have had the disease when they return to work. We are rolling out testing of social care workers across the country with over 3,000 workers now having been referred to local testing centres. There is now capacity available for every social care worker who needs a test to have one, just as there is for NHS staff and their families*."

c. Patients discharged from hospital: "*We are mindful that some care providers are concerned about being able to effectively isolate COVID-positive residents, and we are determined to make sure discharges into nursing or social care do not put residents currently in those settings at risk. We can now confirm we will move to institute a policy of testing all residents prior to admission to care homes. This will begin with all those being discharged from hospital and the NHS will have a responsibility for testing these specific patients, in advance of timely discharge. Where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be.*"

341. On 23 April 2020, a ministerial submission was sent to the Secretary of State, the Minister for Social Care and the Parliamentary Under Secretary of State **(MD/JM5/278 - INQ000325273)**. Amongst other things, this recommended prioritising testing of asymptomatic staff and residents in care homes where an outbreak had been recorded within the past 14 days.

342. On 28 April 2020, the Government announced the further expansion of access to testing. With testing capacity rapidly increasing, the Government would be "*rolling out testing of asymptomatic residents and staff in care homes in England and of patients and staff in the NHS. This means anyone who is working or living in a care home will be able to get access to a test, whether they have symptoms or not* **(MD/JM5/279 - INQ000106391)**. Testing was carried out in the form of PCR tests, with other forms of testing becoming available later in the year **(MD/JM5/280 - INQ000475202)**.

343. Over summer 2020, as testing capacity increased, whole care-home testing was implemented. This is explained further below and at paragraphs 55 to 68 of Statement D of this Module.

344. On 7 June 2020, the Department issued a letter to DPHs, DASSs, chief executives, local NHS trusts and care providers to update on the decision that all care homes would be able to access whole care home testing for all residents and asymptomatic staff. This included adult care homes supporting adults with learning disabilities or mental health issues, physical disabilities, acquired brain injuries and other categories for younger adults under 65 years **(MD/JM5/281 - INQ000050842)**.

345. On 3 July 2020, it was announced that from Monday 6 July 2020, care home staff would be provided with tests every week, and residents would receive a test every 28 days **(MD/JM5/282 - INQ000565716)**.

346. On 22 July 2020, the Department published guidance on making arrangements for limited visits to care homes. The guidance outlined that DPHs should consider local testing data and frequency of testing when making a judgement in regard to visiting policy, and should consider results from weekly and monthly testing of staff and residents **(MD/JM5/205 - INQ000325285)**.

347. An overview of testing capacity is provided with reference to recipients of care between March to July 2020:

Date	Daily testing capacity	Groups reached by Track and Trace
14 March 2020	Approximately 3,000	Testing of patients requiring critical care for the management of pneumonia, ARDS or influenza like illness (ILI), or an alternative indication of severe illness has been provided e.g. severe pneumonia or ARDS. All other patients requiring admission to hospital for management of pneumonia, ARDS or ILI. Clusters of disease in residential or care settings e.g. long-term care facility, prisons, boarding schools. Where clusters arose, following 5 positive tests, any new symptomatic cases were assumed to be positive without conducting testing.
27 March 2020	10,949	NHS staff with symptoms and their symptomatic families
12 April 2020	27,947	Testing of all symptomatic care home residents (expansion from first 5 members of a cluster). Testing of all symptomatic staff in care homes and symptomatic members of their household (expansion from first 5 members of a cluster).
12 April 2020	27,947	Symptomatic NHS non-frontline staff and their symptomatic household members
15 April 2020	38,766	People being discharged from hospital to a care home, whether or not symptomatic.

24 April 2020	49,862	Symptomatic essential workers and their symptomatic family members
27 April 2020	73,400	All emergency admissions to hospital.
28 April 2020	77,365	Asymptomatic staff and residents of CQC registered care homes whose primary demographic is residents over 65 or those with dementia. Anyone symptomatic over 65, as well as symptomatic members of their households. Symptomatic workers who were unable to work from home.
18 May 2020	127,697	Anyone symptomatic across the population.
30 May 2020	205,634	Antibody testing launched for health and social care staff in England.
07 June 2020	186,455	Asymptomatic staff and residents of all remaining CQC registered care homes for adults.
10 June 2020	229,704	Asymptomatic people in high contact professions, e.g. taxi drivers.
06 July 2020	349,109	Regular retesting of care home staff (weekly) and residents (monthly)
13 July 2020	339,755	Outbreak testing guidance amended to include rapid response

348. A submission was sent to the Secretary of State, Matt Hancock, on 5 November 2020 to inform him of the plans for the trial of testing visitors to care homes and wider rollout **(MD/JM5/283 - INQ000058864)**. This submission outlined that the risks of transmission of COVID-19 from allowing visitors to care homes could be reduced by offering visitors access to testing; and that testing could enable care homes to factor in results when considering the admission of visitors, as part of a holistic risk-based approach to visiting. The pilot began in November, with care homes able to conduct PCR testing and lateral flow testing of visitors from this date **(MD/JM5/284 - INQ000565724)**.

349. On 17 November 2020, there was a paper prepared for a COVID-O meeting, that was cancelled. The focus of the meeting was an update on the implementation of the Winter Plan 2020/2021. With regards to testing, this paper provided an update on the expansion of testing to visitors, visiting professionals such as CQC inspectors, and to other parts of

social care e.g. homecare. This included how the Department planned to widen access to safe visits supported by testing.

350. On 20 November 2020, the Department published details of a new testing regime for homecare workers in England, including all carers in domiciliary care organisations **(MD/JM5/285 - INQ000565725)**. The new system involved weekly routine testing of homecare staff and other homecare workers in adult social care in England, using PCR tests. This regime extended to homecare workers in unregistered organisations, live in carers, and personal assistants. This system commenced from 23 November 2020.

351. From 9 December 2020, regular asymptomatic testing of staff using PCR tests was extended to extra care and supported living settings. Testing was again scaled up for staff and introduced for all visitors from 23 December 2020[4].

352. As explained at paragraphs 169 to 173 above, following the introduction of LFDs, the Government announced the RTF on 23 December 2020 **(MD/JM5/122 - INQ000576734)**. This was another ringfenced grant, worth £149 million from December 2020 to March 2021 **(MD/JM5/123 - INQ000576744)**. Its main purpose was to support additional rapid testing of staff in care homes by paying for staff time to undertake home testing at the care homes discretion (the process involved around 5 minutes to do the swabbing process, then 30 minutes to check the result) **(MD/JM5/286 - INQ000608162)** and to support visiting professionals and enable indoors, close contact visiting where possible. This included adult social care providers with whom the local authority did not have a contract.

353. On 16 February 2021 the Department published "Coronavirus (COVID-19) testing for personal assistants" and introduced weekly PCR testing for personal assistants. This was followed by "Coronavirus (COVID-19) testing for adult day centre workers, published on 18 February 2021 to set out how day care centres could order weekly PCR testing for their staff.

354. On 29 March 2021, the ICTF was launched. This is further explained in paragraphs 174 to 179 above. It consolidated the ICF with the RTF, with an extra £341 million of funding until June 2021.

[4] "Supported living" schemes provide personal care to people as part of the support that they need to live in their own homes. "Extra care" housing is purpose-built (or purpose adapted) single household accommodation specifically designed to facilitate the delivery of care to people.

355. Guidance was published on 24 March 2021, "Coronavirus (COVID-19) testing for adult social care settings." This brought together all the guidance previously published for specific adult social care settings into one place. This guidance was then updated through 2021 as appropriate. For example, it was updated on 17 August 2021 to reflect changes to self-isolation guidance that had come into effect on 16 August 2021.

356. On 25 November 2021, the visiting guidance was updated. This included a measure to enable an outbreak to be considered as finished (and therefore permitting indoor visiting to recommence) in seven to eight days, instead of fourteen days, following two rounds of whole home PCR testing four to seven days apart.

357. The adult social care visiting guidance was updated again on 14 December 2021 due to the new Omicron variant **(MD/JM5/262 - INQ000287702)**. The updated guidance required isolation or testing for residents who had been on a visit out of the care home and increased testing for staff and essential caregivers.

358. On 15 December 2021, testing was increased for staff in high-risk settings to three LFDs a week (in addition to one PCR test) **(MD/JM5/287 - INQ000608172)**. 'High risk' settings were defined as extra care and supported living settings which met both of the following two criteria: a) the setting was a closed community with substantial facilities shared between multiple people, and b) the majority of residents (more than 50%) received the kind of personal care that is CQC-regulated (rather than help with cooking, cleaning and shopping). Free PPE was also extended until 31 March 2024 **(MD/JM5/288 - INQ000339355)**.

359. On 31 January 2022, guidance was published to scale back the restrictions introduced with the emergence of Omicron and lower the self-isolation period for residents after admission to a care home, from fourteen to ten days for those who tested positive with COVID-19, with further reductions if they tested negative on days five and six.

360. The adult social care visiting guidance was updated again on 31 January 2022 to reduce restrictions. This included removing the need for residents to test after a normal visit out, and the need for isolation and testing for residents who had a hospital stay or other high risk visit out.

361. On 16 February 2022, all adult social care workers in England were moved to a new asymptomatic testing regime. Staff were no longer required to complete PCR tests but were subject to daily LFD tests on the days they were working, at the start of each working

day. This change applied to care homes, extra care and supported living, homecare, eligible day care centres and personal assistants.

The Operationalisation of Testing in Adult Social Care

362. This section sets out how testing was operationalised in adult social care. As testing volumes increased, it was possible to introduce progressively more testing for social care - building from the mid-March 2020 policy of testing care home residents with symptoms until five residents tested positive, to the rolling programme of weekly staff testing and monthly residents testing from July 2020 onwards.

363. The Department published its Testing Strategy on 4 April 2020 **(MD/JM5/289 - INQ000106325)**. The objective of the strategy was to ensure testing was available to anyone who needed it, as part of the wider government strategy to protect the NHS and save lives **(MD/JM5/290 - INQ000055915)** On 20 April 2020 officials met with MSC to discuss a plan on the rollout of testing within adult social care. The plan explained the proposed approach to testing care workers, people being discharged from hospital and new residents to care homes. It also included a communications plan that was in place and a graph to explain current capacity as well as projected testing capacity **(MD/JM5/291 - INQ000608145)**.

364. In recognition of the importance of supporting local authorities to address care needs, on 7 May 2020 the Minister of State for Care wrote to local authorities, setting out the steps the Government was taking to meet the Secretary of State's commitment to offer COVID-19 testing for all care home staff and residents **(MD/JM5/281 - INQ000050842)**.

365. On 11 May 2020 a bespoke website was launched allowing eligible providers across the UK to order, receive, register and report on tests **(MD/JM5/292 - INQ000325277)**. The portal also allowed the CQC to refer care workers for testing. Care homes were required to register online, using their CQC registration number, and were asked to confirm the number of residents and staff in the care home.

366. On 13 May 2020, the Director General for Adult Social Care wrote to local DPHs and DASSs, setting out how the new testing service would be rolled out in a phased approach **(MD/JM5/293 - INQ000106428; MD/JM5/294 - INQ000106425; MD/JM5/295 - INQ000106426; MD/JM5/296 - INQ000106424)**.

367. The Government also provided information to help staff decide if they or care home residents required a test and where such tests could be obtained **(MD/JM5/297 - INQ000106427)**.

368. By 6 June 2020, all eligible care homes with residents aged over 65 or with dementia had been offered enough testing kits to test all their residents and staff once, with or without symptoms. A million testing kits had been delivered to almost 9,000 care homes.

369. On 8 June 2020, the Government announced that all remaining adult care homes in England would be able to order the whole care home testing service for residents and staff, and that this service would benefit residents and staff in over 6,000 care homes. This included care homes for adults with learning disabilities or mental health issues, physical disabilities, acquired brain injuries and other categories for younger adults under 65 years. The overall testing capacity was 70 – 80,000 tests being made available to care home staff and residents each day. NTP processing capacity for pillar 2 (swab testing for the wider population) at this time was about 125,000 tests a day, of which 80,000 were going to care homes for asymptomatic testing. This figure indicates the commitment to adult social care testing as a proportion of overall available testing capacity. Additional symptomatic, and outbreak, testing was available through Health Protection Teams (pillar 1).

370. On 6 July 2020, regular repeat testing was rolled out to care homes for adults, starting first with care homes caring primarily for older people and those with dementia (9,000), and then rolling out regular testing to the remaining care homes for adults. This regular testing regime involved testing residents every 28 days and testing staff every week. This was in response to SAGE advice that the Department should aim to move towards re-testing care homes on a weekly basis.

371. In September 2020, work commenced to establish the Adult Social Care COVID-19 Dashboard. This dashboard brought together data from the Capacity Tracker (which included reporting from care homes). Data from the Adult Social Care COVID-19 Dashboard was central to discussions on adult social care testing at COVID-O. This is explained at paragraphs 50 to 54 of Statement D of this Module.

372. The visitor testing pilot (referred to above in policy section) began in November 2020, with care homes able to conduct PCR and LFD testing of visitors from this date **(MD/JM5/284 - INQ000565724)**.

373. To prepare for national rollout of visitor testing, guidance was issued to care homes on 7 December 2020 to explain how care homes could order tests and how testing of visitors should be conducted **(MD/JM5/298 - INQ000565728)**. A letter for visitors and a guidance pack was also issued.

374. On 8 December 2020, COVID-O had a meeting which was focused on adult social care COVID-19 testing. There were updates on action to drive compliance with the testing regime and a progress report on testing turnaround times. But the main focus was the ramping up of testing for adult social care from 120,000 tests to 776,500 tests per day to support all parts of the adult social care sector. An important part of this was LFD tests to support visits into care homes. The paper noted that the Department expected all care homes to be able to regularly test visitors by 18 December 2020, although the delivery was complex and there were many risks. The paper also noted that the tests would support working age adults to leave care homes to join their families for Christmas in line with the new guidance that had been published on 1 December 2020.

375. On 14 December 2020, national rollout of visitor testing went live, along with new guidance for care homes on testing visitors. Testing was introduced for all visitors from 23 December 2020 **(MD/JM5/233 - INQ000234635)**.

Overview of Care Home Compliance and Testing and Turnaround Times

376. The next section of this statement contains a summary and information on care home compliance with testing and the associated turnaround times. Significant emphasis was placed on testing as a critical tool in tackling COVID-19 in the adult social care sector and preventing outbreaks, particularly in the period before vaccines were available. Testing for COVID-19 in care homes, which was considered a high-risk setting, was prioritised and from the summer of 2020, regular testing had been offered to all care homes. Compliance with testing and turnaround times by care homes during this period was subject to much consideration in government.

377. COVID-O was a key decision-making body when it came to COVID-19 decisions, particularly testing. COVID-O meetings routinely discussed enforcement and action to drive local performance and progress with care home compliance with testing and testing turnaround times for care home staff and residents.

378. As explained above at paragraphs 371 to 375 On 15 September 2020, COVID-O met to discuss the Winter Plan 2020/2021 and as part of that discussed testing in care homes. In light of a concerning uptick in positive cases in care homes and in response to a Prime

Ministerial request of 14 September 2020, it also looked at more radical options going beyond the Winter Plan 2020/2021. With regards testing the discussion focused on the turnaround time for care home testing, and compliance with the testing regime. The paper, prepared for discussion at COVID-O explained that **(MD/JM5/299 - INQ000608152)**:

379. *Operational issues in the testing programme are hampering our ability to manage the virus in care homes. In the w/c 27th August nearly half of tests results were completed in over four days, and 8% of tests (for 25k people) were void due to lab issues. Work on improving them is ongoing. Slow turnaround times allow the virus to spread, and reduce adherence to the regime, as staff grow frustrated.*

380. These two points were then discussed in the meeting and explained further:

> *"in 46 per cent of cases testing turnaround in care homes was over four days. Of the 250,000 person testing capacity at the time, 110,000 of that was protected for social care testing, and this volume was being protected even as demand rose. The delay in testing beyond the 24-hour target was intentional. To ensure that testing was running at full capacity seven days a week, some test samples were being held for a number of days so they could be processed at the weekend. Symptomatic testing was being prioritised over asymptomatic care home tests, and so the latter were delayed. Public demand for tests was higher during the week, and care homes did not like to test at weekends. The Government was ready to override care home preferences in order to manage demand flow. This would be practically difficult as staff rotas meant those working on weekends may be different to those during the week"*
>
> *A major problem identified with testing of care home staff was that only 70% of the tests being sent to care homes were being returned* **(MD/JM5/182 - INQ000090180)**.

381. The note of the Covid-O meeting did not expand on why care homes preferred not to conduct asymptomatic testing at the weekend. The Department's understanding is that the reasons include that care homes have less staff at the weekend, so it is harder to arrange testing of all residents.

382. In a further discussion of testing on 29 September 2020, COVID-O noted that the median turnaround for tests in social care settings were coming down, and were now at 70 hours, down from 100 hours two weeks previously. Some of the extra testing capacity that was coming online would also be used to tackle turnaround times.

383. On 6 October 2020, at COVID-O the Executive Chair of NHS Test and Trace said that the programme had made material improvements in the turnaround times of tests for care home residents. The programme was targeting the turnaround of 90% of tests within 72 hours by the end of October 2020, and would be targeting a 48-hour turnaround time thereafter. In discussion, it was noted at the meeting that more could be done to improve testing in care homes; for example, to prioritise frequent testing over reducing turnaround times.

384. On 23 October 2020, at a COVID-O meeting, participants acknowledged the improvements in testing turnaround times. It was noted that achieving a 24-hour turnaround time for care home tests would remain challenging due to the additional logistical challenge of testing all residents and then sending tests through couriers. It was indicated that further work was underway to improve courier speeds, but a 48-hour target was a realistic immediate ambition given improved testing capacity. It was also reported at the meeting that the increased turnaround times in care home testing had also increased compliance with staff testing **(MD/JM5/300 - INQ0000090302)**. An update on the progress on care home compliance with testing and testing turnaround times was also provided in the paper prepared for the COVID-O meeting scheduled to take place on 17 November 2020 mentioned above, that was later cancelled.

385. On 8 December 2020, at COVID-O, the Minister of State for Social Care said that over 500,000 tests had been carried out in care homes in the previous seven days. It was reported that one of the biggest successes of the testing team had been the reduction in turnaround times of tests: over 90% of tests were now turned around within 72 hours. Furthermore, 70% of tests were now turned around within 48 hours **(MD/JM5/230 - INQ000091044)**.

386. At the same meeting, the Minister of State for Social Care said that the Department was seeing a drop off in the number of care home staff taking tests. There was no definitive reason for this, but it was noted that this could possibly be attributed to testing fatigue, in particular a resistance to the level of testing and the time it was taking.

387. On 11 January 2021, at COVID-O **(MD/JM5/301 - INQ000091795)**, the Minister of State for Social Care welcomed the significant volume of testing being administered in care homes. There had been 40,000 PCR tests administered in the preceding week. It was noted that there had been some logistical challenges with PCR test turnaround times, such as those experienced in the laboratories during Christmas and the New Year. Care home staff were being asked to take two LFD tests per week, in addition to a weekly PCR

test, with further testing required when a positive case was found in a care home. Whilst positive tests were required to be reported immediately, there was a lag in the data reporting for negative tests. Action points from this COVID-O meeting included increasing testing across the adult social care sector and addressing turnaround times.

388. On 20 January 2021, a ministerial submission was sent to the Minister of State for Social Care with an 'Adult Social Care Testing Update' **(MD/JM5/302 - INQ000059637)**. Amongst other things it was noted that '*testing is being used and having an impact'* in terms of care home compliance, therefore identifying positive cases more quickly. The following data was provided in support of this point:

    a. *"We know there is good compliance among PCR testing in care homes through our regular MI – there are on average 80,000 kits registered on average every day; 68% of staff have been tested in the most recent week, and we are targeting outbound calls to homes to drive compliance further.*

    b. *Over 95% of eligible care homes are testing with PCR and over 65% of eligible domiciliary care agencies have registered for testing with PCR.*

    c. *Care homes have had a two week reporting 'holiday' for LFD whilst they get used to the new kits but from January 16th, are required to register negatives as well as positives. We do know that around 30k LFD tests are being conducted per day in homes, finding around 600 positive cases daily which would either have been picked up more slowly (risking more onward transmission) or not at all".*

WORKFORCE: KEY DECISION-MAKING AND DEVELOPMENT OF POLICY AND GUIDANCE

389. The pandemic presented an enormous challenge to all those working in the adult social care sector, and involved having to balance many competing considerations, both ethical and operational, to try and protect those receiving care and support from the virus, whilst balancing their need to see friends, family and live as independent a life as possible.

390. The Department recognises the sustained pressure put on all those working in the adult social care sector in the response to the pandemic. The risks posed by COVID-19 for staff were extremely significant, especially as they worked in close proximity with those they were caring for. The workforce responded with dedication and compassion and provided support during the most difficult and emotional situations. In many cases this came at a

cost to workers' health and wellbeing including, tragically, some loss of life. The Office for National Statistics (ONS) reported that deaths involving COVID-19 among adult social care workers were higher than the rates of death involving COVID-19 among those of the same age and sex in England and Wales. This rate was also higher than the death rate for health care workers **(MD/JM5/303 - INQ000565778)**. Some also live with long-term physical and psychological conditions as a result of their role in the pandemic.

391. Actions were taken by the Department to address workforce challenges. For the purposes of this statement, those actions have been mapped to the following four objectives:

    a. Ensuring the sector had enough workers (workforce capacity);

    b. Supporting and recognising the workforce;

    c. Protecting the workforce from COVID-19, and

    d. Protecting recipients of adult social care from workers who had COVID-19.

392. These objectives were prioritised throughout the pandemic according to the pressures faced at the time and in response to the developing understanding of COVID-19. The following section considers each of these in turn for the whole of the relevant period to explain the actions taken by the Department. The final two objectives are combined, as the actions were interwoven.

393. Over the course of the pandemic over £2.9 billion was made available in specific COVID-19 funding to support the adult social care sector. It included £582.5 million specifically for workforce capacity **(MD/JM5/113 - INQ000303274)**.

Workforce Capacity

394. Throughout the pandemic there was an ongoing need to make sure the adult social care sector had enough workers, and the Department took a number of actions to support recruitment and retention. These are explained below, and include an explanation of the Workforce Capacity Fund (WCF), the Workforce Recruitment and Retention Fund, and the Omicron Support Fund.

395. In early 2020 there were real concerns about how an already overstretched adult social care workforce would manage in a pandemic, and immediate consideration was given to how to ensure the sector had enough workers. In the pre-pandemic period, the adult social care sector was under considerable financial strain, with a largely low-paid workforce with

high turnover rates, accompanied by a long-lasting and unresolved debate over adult social care reform. The CQC's 2018/19 annual report stated that: *"in adult social care, funding and workforce issues continue to contribute to the fragility of the sector."* In its 2019/20 annual report, the CQC maintained *"that adult social care remained very fragile ... any further shocks to the labour market would be expected to increase the existing level of market fragility and place more pressure on local authority finances."*

396. A Departmental note provided for the Permanent Secretary and Secretary of State for a meeting on 12 March 2020 with the Prime Minister reported that there were currently around 120k vacancies (8%) in the social care workforce and the Department's RWCS model would have another 11% off in the peak week of a pandemic, equating to an additional 176,000 staff. Furthermore, vacancy rates were significantly higher in the South-East and London **(MD/JM5/137 - INQ000325232)**. A small number of care homes were already reporting that they had reached critical staffing situations and it was clear that absences due to COVID-19 would make safe staffing difficult for care providers.

397. In March and April 2020, the Department worked to rapidly ramp up recruitment and training to provide extra care workers ready to be deployed expeditiously into adult social care. The Department also provided additional funding to support local authorities and care providers respond to the pressures facing the adult social care workforce.

398. On 13 March 2020, guidance commissioned by the Department on care homes, *"COVID-19: Residential care, supported living and home care guidance"* was published by PHE **(MD/JM5/304 - INQ000325236; MD/JM5/45 - INQ000325233; MD/JM5/305 - INQ000325235; MD/JM5/306 - INQ000325234)**. This guidance provided a number of recommendations for both NHS and local authority stakeholders to support care settings in resilience planning, looking at options in relation to outbreak, management support, and management of workforce issues. Care home providers, home care providers and providers of supported living were all advised to work with local authorities to establish plans for mutual aid, including sharing of the workforce between providers and with local primary and community health services providers, and with deployment of volunteers where it was safe to do so. This advice was later revised, in line with the Department's growing understanding of transmission. The Department's steps to limit staff movement is explained further below at paragraphs 453 to 456 and the understanding of asymptomatic transmission is explained in paragraphs 24 to 32 of this statement.

399. On 24 March 2020, the Minister for Social Care, Helen Whately, had a meeting with the CEO of Skills for Care (SfC) about a rapid induction training scheme for volunteers and

new/returning staff to be delivered by their endorsed national learning providers with the aim of making recruitment faster and more streamlined. The scheme would be managed by SfC and funded through the Workforce Development Fund **(MD/JM5/307 - INQ000327785)**, a long-established annual core grant that the Department allocates to SfC to support the continuing professional development (CPD) of staff. Adult social care employers can claim money towards the costs of workers completing a broad range of adult social care qualifications and learning programmes. The list of funded qualifications and learning in 2020/2021 is exhibited here: **(MD/JM5/308 - INQ000565779)**. Organisations must apply to access the funding by completing or refreshing an Adult Social Care Workforce Data Set (ASC-WDS) account, which is expected to be an accurate reflection of their workforce **(MD/JM5/309 - INQ000565780)**.

400. On 26 March 2020, the Minister for Social Care confirmed to the CEO of SfC that she was happy to proceed and scale up delivery as quickly as possible subject to agreeing the content of the training and delivery model **(MD/JM5/310 - INQ000327786; MD/JM5/311 - INQ000327787)**. The Minister for Social Care received further advice on 24 April 2020 on how this scheme would work in practice **(MD/JM5/312 - INQ000050177; MD/JM5/313 - INQ000050175)**. On 11 May 2020, the Minister for Care responded with questions about how the training being offered fitted across existing online platforms, and stated that she would like to review how training support packages were working in combination **(MD/JM5/314 - INQ000327879)**.

401. Following further work involving CQC, a new online platform called Join Social Care was launched together with the care company Cera Care, to fast-track recruitment into adult social care, supported by £3m of funding from the Workforce Development Fund **(MD/JM5/315 - INQ000327858)**. This recruitment platform allowed people looking for jobs in social care to record an interview and access free training supported by SfC before starting employment. It also helped adult social care employers to recruit more quickly as they were able to search for candidates in their local area, view their video interviews before starting Disclosure and Barring Service (DBS) checks and make jobs offers. The online platform was included in the Department's Social Care Action Plan and launched the following month alongside a new national adult social care recruitment campaign. Within a week of the platform going live approximately 220 people had started the induction training **(MD/JM5/316 - INQ000327924)**. By 16 June 2020 a total of 4382 candidates had registered, and also 1333 providers. 11% of these, or 471 people, had completed the training by this point. The Department does not hold data beyond this point.

402. On 15 April 2020, the Department published *"COVID-19: Our Action Plan for Adult Social Care"* (Action Plan) **(MD/JM5/75 - INQ000325315)**. This explained the actions the Government had been taking to help minimise the spread of infection within all care settings. These are further explained below in the 'protecting the workforce and adult social care users section' at paragraph 450. The Action Plan also highlighted the measures the Department had taken to increase the adult social care workforce by 20,000 people over the next three months. These recruitment measures included:

    a. Launching the Join Social Care platform, as well as a new national recruitment campaign to run across broadcast, digital and social media targeting returners to the sector and new starters who might have been made redundant from other sectors.

    b. Allowing individuals across the UK to undertake paid employment in adult social care while furloughed from other sectors.

403. The Home Office and DBS put temporary arrangements in place to support the swifter recruitment of staff by offering to fast-track the process of conducting Enhanced DBS checks free of charge. Individuals are required to undertake DBS checks if they are to provide care services for adults or children. DBS fast-tracked 24,175 enhanced checks related to the adult social care sector **(MD/JM5/317 - INQ000565776)**.

404. Social Work England invited previously registered workers in England, who had left the register since 18 March 2018, to return to practice if they wished to do so, aiming to support 8,000 social workers to return to the register.

405. On 15 May 2020, the Government published the "COVID-19: Care home support package" **(MD/JM5/30 - INQ000325278)**. The document set out the steps needed to keep people in care homes safe, and the support available to providers to put this into place. These steps are more fully explained below, in the 'protecting the workforce and adult social care users section'. With regards to the workforce capacity, the package reiterated the steps explained above as included in the Action Plan.

406. The Care Home Support Package was accompanied by a letter from the Minister for Social Care to Council Leaders, Local Authority Chief Executives, DASSs, DPHs, Care Home Providers and CCG Accountable Officers **(MD/JM5/115 - INQ000050496)**. This letter briefly set out what was contained in the May Support Package and how government would work with local authorities to support care homes.

407. As explained in statement A of this Module, on 8 June 2020 the Adult Social Care Taskforce was established, alongside eight advisory groups. The Adult Social Care Taskforce meet throughout Summer 2020 and published its final report on 18 September 2020. The report considered workforce capacity and gave a range of recommendations including: 'Recommendation 14' (that the Government should set up a short-term workforce planning group to further address workforce capacity issues likely to arise over the next six months); 'Recommendation 15' (that the Government should keep under review vacancies and absence levels and consider further measures to improve recruitment and retention if existing strategies did not fill the gap); and 'Recommendation 16' (that there should be a review of wellbeing services available to social care staff) **(MD/JM5/318 - INQ000058246)**.

408. In parallel to supporting the Adult Social Care Taskforce to reach its conclusions and produce its final report, officials were tasked on 17 July 2020 by the Secretary of State to work on a Winter Plan 2020/21 for adult social care. The Winter Plan 2020/2021 considered the recommendations from the Adult Social Care Taskforce and intended to translate them into an operational plan. As set out in Statement A of this module, the implementation and delivery status of these recommendations was not formally tracked or reported against, so there is no record of whether they were met. However, in November 2021, in his review of the Winter Plan 2020/21, Sir David Pearson concluded that the majority of the Taskforce recommendations had been included in the Winter Plan or had been subsequently implemented. In addition, it provided a framework to bring together elements of the adult social care COVID-19 response that had been published separately up to that point into one coherent document.

409. COVID-O considered the Winter Plan 2020/2021 on 15 September 2020 **(MD/JM5/182 - INQ000090180)**. It approved publication and the Winter Plan 2020/21 was published on 18 September 2020 **(MD/JM5/319 - INQ000090012)**. The plan set out the Government's priorities for adult social care and detailed key elements of national support available for the adult social care sector for winter 2020/21. With regards to workforce capacity, it reiterated the measures outlined above that were already in place and confirmed the Department's intention to continue to monitor workforce capacity throughout winter 2020/2021 **(MD/JM5/320 - INQ000565720)**.

The Workforce Capacity Fund (WCF)

410. In response to ongoing workforce capacity concerns, a submission was sent to the Minister for Social Care on 6 January 2021 recommending a bid to HMT to fund a £120

million ringfenced grant to local authorities (**MD/JM5/321 - INQ000328030)** On 16 January 2021, the Department announced the £120 million WCF.

411. Following negotiations with HMT the £120 million fund was introduced with the expectation that it would be used to improve workforce capacity and help to alleviate some of the staff shortages identified in the sector. It was intended to maintain the provision of safe care in response to staff shortages and to address adult social care workforce capacity pressures. Local authorities could use the funding to deliver measures to help all providers of adult social care in their geographical area, or to pass funding directly to providers.

412. On 20 January 2021, officials set out the final grant design for the fund in a submission to the Minister for Social Care and sought ministerial clearance of the guidance and grant documents. Funding would be paid out as a grant, ring-fenced exclusively for actions which enabled local authorities to supplement and strengthen adult social care staff capacity. This included both increasing the use of the existing workforce and increasing the size of the workforce in care homes and domiciliary care **(MD/JM5/322 - INQ000110419; MD/JM5/323 - INQ000110421).** This was a new grant, separate to the ICF2 and RTF (explained in paragraphs 174 to 179), and would be paid directly to local authorities in England. Funding had to be spent by 31 March 2021.

413. On 26 January 2021, the Minister for Social Care gave her formal approval to clear the guidance, grant determination letter and the letter to the sector **(MD/JM5/324 - INQ000328053)**. The guidance and accompanying documents were then published on 29 January 2021 **(MD/JM5/325 - INQ000502378; MD/JM5/326 - INQ000565734; MD/JM5/327 - INQ000565735; MD/JM5/328 - INQ000565736; MD/JM5/329 - INQ000565737; MD/JM5/330 - INQ000059679; MD/JM5/331 - INQ000565733)**. The WCF ran from January to March 2021. As part of the funding conditions, local authorities had to complete returns setting out how this money was being used, and what impact they expected on the availability of care provision and on staffing capacity.

414. As for the efficacy and impact of the WCF, the following points were summarised in an October 2021 report on the fund's outcomes and findings **(MD/JM5/332 - INQ000328150)**:

    a. £7.7 million of the WCF was recorded as unspent, representing 6% of the £120 million fund.

    b. 39,047 staff had been recruited using the funding, and 7.3 million hours of additional work were generated by the funding.

c. The majority of the 59 local authorities who responded to an online survey of their experience agreed that the fund did help support staffing capacity over winter 2020/2021 and supported reducing staff movement between care homes and other health and care settings. Local authorities reported funding measures including overtime, recruitment support initiatives, engaging agencies and other temporary staffing, emergency support measures and recruitment campaigns.

d. Local authorities and the sector reported that they needed more time to prepare to receive and disseminate the funding, and that this was a key driver in the level of unspent monies reported.

e. Local authorities felt that the reporting requirements for the fund incurred a high administrative burden and that this acted as a disincentive for effective use of the funding.

f. The feedback received would be used to make improvements to future funding streams, notably the Workforce Recruitment and Retention Fund (for instance, allowing local authorities more time for planning and utilisation of the fund, and developing a more proportionate reporting framework).

415. Further assurance of the WCF identified that local authorities had additional underspend which needed to be returned to the Department as per the grant conditions. The Department has since recouped £8.3 million of unspent WCF funding. Until recently, the Department was still claiming back unspent portions of this fund from local authorities. The maximum amount of funding still outstanding is £800k split across five local authorities **(MD/JM5/333 - INQ000576745)**.

Use of Military Personnel and Volunteers

416. In addition to the WCF the Department looked for other options to address the staffing shortages in the sector. On 18 January 2021, the Department sent the Minister for Social Care a submission advising that it was exploring options to source additional staff capacity in adult social care quickly and temporarily **(MD/JM5/334 - INQ000059610)**. These options complemented the WCF, which could pay for additional staff. The advice recommended the following:

a. Use of military personnel. It was considered that the best use of military support would be for large-scale transportation and logistics for safe visiting (where allowed) and administering tests and vaccinations, which would free

up adult social care staff currently performing those tasks. It was noted that the military did not have any available capacity within its clinical staff or medical technicians.

b. Standing up a national paid volunteer scheme using HMRC and DWP employer databases and networks to attract furloughed and redundant staff into social care for a limited period.

417. Following various discussions between the Minister for Social Care, the Department and the Ministry of Defence (MoD) team, the Department concluded in February 2021 that military assistance was not appropriate for the staffing shortages within adult social care as there was no demand for it from local authorities **(MD/JM5/335 - INQ000110738)**.

418. On 4 August 2020, guidance on redeployment of staff and use of volunteers was published on the SfC website which provided practical advice on how adult social care employers could safely redeploy workers and involve volunteers where necessary to ensure service delivery **(MD/JM5/336 - INQ000565719)**.

The Workforce Recruitment and Retention Fund

419. In light of the ongoing challenges with workforce capacity across the care sector, on 3 September 2021 the Department bid for urgent further funding (£240 million over six months) to help enable local authorities and providers to retain and enhance the capacity of their existing workforces **(MD/JM5/337 - INQ000111773; MD/JM5/338 - INQ000111774; MD/JM5/339 - INQ000111775; MD/JM5/340 - INQ000111776; MD/JM5/341 - INQ000111779; MD/JM5/135- INQ000066747)**.

420. On 24 September 2021, the Chief Secretary to the Treasury (CST) decided not to approve the bid at that time, but noted the significant concerns raised around workforce issues in the sector. HMT asked the Department to increase monitoring of labour market conditions in the sector and continue to work with departments across Government to mitigate these risks, including considering how to utilise the end of the furlough scheme to encourage more people into employment in the adult social care sector. On 1 October 2021, the CST advised that he was willing to consider further advice on the Workforce Recruitment and Retention Fund (WRRF) within the next two weeks and set out what that advice would need to show **(MD/JM5/342 - INQ000565759)**.

421. Following this feedback from the CST, the Department submitted a revised bid to HMT on 7 October 2021 (in advance of the next Covid(O) meeting on 20 October 2021), providing

detail on what the funding would buy, evidence that it had been successful previously, a range of scalable grant options, and how the fund would be targeted **(MD/JM5/343 - INQ000067214; MD/JM5/344 - INQ000067215; MD/JM5/345 - INQ000067216)**.

422. This bid was approved at the next COVID-O meeting on 20 October 2021, when the Winter Plan 2021/2022 was discussed and agreed **(MD/JM5/346 - INQ000092237)**. The WRRF was announced on 21 October 2021 **(MD/JM5/347 - INQ000257083)**.

423. The WRRF was used to support local authorities to urgently address adult social care workforce capacity pressures in their geographical area through recruitment and retention activity, allowing local authorities to decide the best way to do so through engagement with care providers. Compared to the original WCF, this fund included more proportionate reporting requirements, allowing local authorities more time for planning and utilisation of the fund, based on previous feedback as highlighted above (paragraph 420). The fund also utilised better data on workforce retention and the labour market to continue to target these areas, which was one of the purposes of the WCF.

424. The WRRF was a ring-fenced grant of £162.5 million paid in two instalments to local authorities, the first instalment in November 2021, and the second in January 2022 provided local authorities had completed a return to the Department by 14 January 2022. Local authorities were expected to work closely with providers to determine how funding should best be spent, including passporting funding directly to providers where appropriate. Examples of measures that it could be used to fund included: supporting payments to boost the hours provided by the existing workforce (including childcare costs and overtime payments); occupational health and wellbeing measures; incentive and retention payments; and local recruitment initiatives.

425. On 10 December 2021 a £300 million extension to the WRRF was announced.

426. As for the efficacy and impact of the WRRF, the Department published a report on the fund's outcomes and findings on 26 January 2023 **(MD/JM5/348 - INQ000565775)** which noted the following:

    a. £450.9 million of the total funds were spent.

    b. The funds had a small but positive impact on the number of hours worked (they were responsible for an estimated 2.9 million additional staff hours).

    c. The funds helped support short-term stabilisation of staffing capacity over winter 2021/2022. There was an estimated net growth of 33,000 staff,

driven by increased retention. Feedback highlighted that the fund was most effective when used on retention methods or investments in the existing workforce such as overtime, childcare costs and bonuses, which boosted staff morale. Feedback suggested that the funds were a "lifeline" and helped local authorities and providers "get through" a particularly challenging period. However, most of the measures that they supported were temporary, and the funds were less successful in creating longer-term benefits.

d. The funds did not have a measurable positive or negative impact on overall recruitment during the funded period (although they may have had an impact later on). Feedback highlighted that the lead-in time or fund period was too short to have a tangible impact on recruitment activities.

427. As for challenges in administering the WRRF, the Department was informed of several issues encountered by providers. These were summarised in the above report. For example, late payments (with some local authorities paying both rounds in December 2021, which limited time to plan and spend the funds); restrictive spending conditions imposed by local authorities in line with their own strategic priorities; and some providers not receiving any funds at all or not being consulted about the funding.

428. Local authorities and providers reported that they needed more time to plan and then distribute the funding. This meant that local authorities were unable to spend the funding in time which was the main reason for the level of unspent funding. As part of further assurance of the funds, additional unspent funding was uncovered from local authorities which needed to be returned to the Department as per the grant conditions. The Department subsequently recouped £12.6 million in underspends from local authorities. Until recently, the Department was still claiming back unspent portions of this fund. The maximum amount of funding still outstanding across 9 local authorities is £2.6 million (which includes amounts confirmed as underspend and in dispute amounts which are unconfirmed spends).

The Adult Social Care Omicron Support Fund

429. At the end of November / beginning of December 2021, the Department became very concerned about the spread of the Omicron variant. In addition to concern around the direct risk to care users, there was increasing concern about the indirect risk to care users

flowing from the impact on the workforce and likely staff absences. The Omicron impact on the workforce was against the backdrop of already acute workforce pressures.

430. On 22 December 2021, a submission was sent to Ministers asking them to agree to a bid to HMT for funding for further measures to manage the risks to adult social care resulting from the Omicron variant of COVID-19 **(MD/JM5/349 - INQ000112047)**. On 17 December 2021, the Government had committed funding for adult social care over the winter period, including a £388.3 million extension to the ICTF, £437 million on hospital discharge, free PPE until March, and the second round of the WRRF (explained above). Whilst there was a considerable amount of funding already in the adult social care system, the Department remained concerned about the impacts of Omicron on the workforce and those receiving care (in particular, due to staff absences and self-isolation requirements). It was thought that the Omicron variant could be expected to have a significant impact on workforce absence, and this was supported by modelling data from SPI-M. There were also concerns that, in addition to costs directly related to workforce absence, providers might have to undertake additional measures to prevent or contain any outbreaks when there would be higher community transmission of COVID-19 **(MD/JM5/350 - INQ000067707)**.

431. Ministers agreed to the bid and on 24 December 2021, HMT agreed to provide £60 million for this funding stream, to be spent on the following measures: IPC funding relative to workforce operations (sickness and self-isolation pay and limiting staff movement); backfilling staff absences; ventilation; and unpaid carer support measures. The Department's bids for further recruitment and retention funds and for a civil service volunteer scheme were not approved **(MD/JM5/351 - INQ000576741)**. The Adult Social Care Omicron Support Fund was then announced on 29 December 2021 **(MD/JM5/352 - INQ000257228)**. The Department had to ensure that the funding was sent out to local authorities with speed and minimum burdens but also needed to make sure that it was used in the best way. Ultimately the Department agreed to a non-ringfenced fund, as this was the fastest way to get the money to local authorities and providers, with minimal additional burdens on conditions and reporting.

432. Guidance for the fund was published on 10 January 2022 **(MD/JM5/353 - INQ000257240; MD/JM5/354 - INQ000565768**; **MD/JM5/355 - INQ000565769)**. The purpose of the fund was to support the sector with measures already covered by the IPC allocation of the ICTF (round three) to reduce the rate of COVID-19 transmission within and between care settings through effective IPC practices. Among other things, the fund could also be used to pay for temporary staffing to cover increased staff absence caused by COVID-19 and maintain staffing levels and workforce capacity.

433. The funding was paid in full in January 2022. Since the Department wanted local authorities to make use of it as quickly as possible, it minimised conditions and reporting restrictions. Local authorities had discretion to use the funding as they needed locally to support the adult social care sector to cope with increased challenges posed by Omicron. The guidance gave examples of appropriate uses of the grant (such as paying for temporary cover for staff who had COVID-19 or were isolating, and limiting staff movement). Local authorities were advised that, ideally, they should not provide direct funding to a provider unless they had complied with the grant conditions from previous funds, except where the local authority had sufficient assurances from that provider. They were only permitted to pass funding onto providers who had completed the Capacity Tracker at least twice consecutively, and who committed to completing it at least once per week until the conclusion of the fund.

Consideration of Further Interventions in Winter 2021/2022

434. On 17 November 2021, the Department sent advice to the Secretary of State entitled 'ASC Workforce Capacity – Monitoring and Further Actions', setting out plans for monitoring the impact of interventions to date as well as options for further actions in the event that improvements were not forthcoming **(MD/JM5/356 - INQ000565762; MD/JM5/357 - INQ000111971)**.

435. Further workforce interventions were explored and implemented, including to encourage great use of overseas recruitment. Following the Migration Advisory Committee's recommendation, on 24 December 2021 the Government announced changes to the immigration system to make it easier, quicker and cheaper for care providers to recruit care workers from abroad (collectively agreed by COVID-O: **(MD/JM5/358 - INQ000104597)**. The changes came into force on 15 February 2022 and included:

436. Adding care workers to the Shortage Occupation List, meaning employers could employ overseas workers at an annual salary minimum of £20,480, below the general threshold of £25,600 for occupations not on the list.

437. Care workers were also brought within the scope of the Health and Care visa. This meant applicants and their dependents could benefit from fast-track processing, dedicated resources in processing applications and reduced visa fees.

Supporting the Workforce

438. Alongside the work to increase capacity within the workforce, the Department was also mindful of the need to recognise the work and commitment of the adult social care workforce. On 28 March 2020, a letter was sent from the Secretary of State to adult social care providers and the social care workforce, thanking them for their work during a difficult time **(MD/JM5/359 - INQ000608164)**.

439. Over the relevant period the Department introduced a number of measures to support care workers.

The CARE Brand and Application

440. In a submission to the Minister for Social Care, dated 3 April 2020, officials set out recommendations for establishing a unified identity for the adult social care sector to generate a greater sense of value. The 'CARE' brand was recommended as a unifying visual logo for the adult social care workforce. The submission also included a proposal to establish a mobile application equivalent to the COVID-19 Employee App in production for the NHS workforce, to enable access to the latest updates and guidance.

441. On 6 May 2020 the Care Workforce App (the App) for the adult social care workforce in England was launched to support staff through the pandemic. The App brought together 1.5 million care workers across approximately 18,000 care provider organisations (**MD/JM5/360 - INQ000509517**).

442. The App, developed alongside NHSX and the NHS Business Services Authority, was introduced under the new CARE brand, and acted as a one-stop-shop providing users within the sector with the latest guidance, wellbeing support and advice to protect themselves from COVID-19 and keep themselves well. Users of the app were able to:

    a. Access learning resources on areas such as IPC;

    b. View offers available to NHS and social care staff, including free car parking and discounts through organisations and initiatives like Discounts for Carers and the Blue Light Card; and

    c. Be signposted to free access to wellbeing apps such as Silvercloud, Daylight and Sleepio.

443. The App was available until March 2021, when it was closed due to relatively low uptake, high per-user cost and non-compliance with the Government Digital Service code.

Wellbeing and Wider Support

444. On 11 April 2020, the Department sent a submission to the Minister for Social Care, containing an update on wellbeing work impacting the social care workforce, which included setting out a plan for extending the helpline service, established by the NHS in partnership with Samaritans and Hospice UK, offering support to NHS staff to the social care workforce **(MD/JM5/361 - INQ000050011)**. The submission acknowledged that the social care workforce was likely to be particularly at risk, given they were responsible for caring for a significant section of the population most at risk from COVID-19, and that it was vital to prioritise their wellbeing.

445. On 11 May 2020, the Department published guidance on the health and wellbeing of the adult social care workforce **(MD/JM5/362 - INQ000574712)**. This guidance included advice to help employers protect the mental health of frontline staff; and advice to staff on how to protect their own mental wellbeing. The guidance advised that employers should create wellness action plans; and set out case studies from Skills for Care on workplace stress and how to build resilience.

446. There was also financial support for families of NHS and social care staff who had died from COVID-19 at work. This was called the NHS and Social Care Coronavirus Life Assurance Scheme and was in place from April 2020. The scheme paid a lump tax-free sum of £60,000 to the family of the deceased and was administered by the NHS Business Services Authority.

Support to Staff Particularly Vulnerable to COVID-19

447. As the pandemic spread, we learnt that COVID-19 was more dangerous for people with impaired immunity, underlying health conditions, learning disabilities and disabilities, and individuals from Black Caribbean, African, Pakistani, Bangladeshi and other minority ethnic communities.

448. In May and June 2020, the Minister for Social Care had several meetings with the NHS Chief People Officer on how to better support and protect these communities and staff from being disproportionately impacted by COVID-19 **(MD/JM5/363 - INQ000327871; MD/JM5/364 - INQ000050906)**.

449. The Department subsequently developed the Adult Social Care Risk Reduction Framework to be used in all social care settings or social care interventions. This

framework provided guidance for employers on how they should support workers who were more vulnerable to infection or adverse outcomes from COVID-19, including risks by ethnicity. The framework was published on 19 June 2020 **(MD/JM5/365 - INQ000303267)**.

Protecting the Workforce and Adult Social Care Users from COVID-19

450. Alongside these efforts to increase recruitment and support staff, the Department was also focusing on protecting the adult social care workforce and adult social care users from COVID-19. This included making sure care workers were prioritised for COVID-19 testing and financially able to self-isolate, and that staff movement between settings was understood and appropriately limited.

451. On 4 March 2020, the Government announced that statutory sick pay would be available for the whole working population from day one (rather than day four) when isolating. This provided some support for the adult social care workforce to isolate and the Department continued to consider how to further support self-isolation as explained below in paragraph 461.

452. As explained above, *"COVID-19: Our Action Plan for Adult Social Care"* (Action Plan) **(MD/JM5/75 - INQ000325315)**, published on 15 April 2020, detailed the actions the Government had taken in the early stages of the pandemic to help minimise the spread of infection within all care settings. Actions included:

    a. Publishing guidance for providers on how to minimise the risks of transmission;

    b. Providing £1.6 billion of additional funding to support local government in meeting some of the rising costs providers were facing and additional pressures on adult social care;

    c. Explaining the intention to roll out of testing of adult social care workers across the country. When capacity allowed, tests would be available for every worker who needed to have one, in line with policy for NHS staff and their families.

    d. Measures to support unpaid carers, which included signposting published guidance on providing unpaid care **(MD/JM5/92 - INQ000327821)**.

453. As explained in paragraphs 24 to 32 of the Asymptomatic Transmission section the emerging evidence in April 2020 from the surveillance studies captured a growing

understanding that one third of people who carried COVID-19 did so without showing any symptoms (asymptomatic). The movement of temporary staff and general movement of usual staff to and from the community, was likely to have contributed towards the prevalence of COVID-19 within care home settings.

454. At a meeting on 22 April 2020, discussing managing and preventing outbreaks in care homes, the Minister for Social Care agreed to move forward with policies including restricting movement of staff between care homes **(MD/JM5/366 - INQ000325269; MD/JM5/367 - INQ000595310)**. The Department and PHE worked with care provider bodies and local government to consider how best to support care providers in making changes to workforce rotations. This was an extremely complex issue which required Government to consider the impact of restrictions on the ability to provide safe levels of care in care homes, as well as agreeing funding to provide support to providers and staff who needed to change working practices and patterns.

455. On 27 April 2020, there was a meeting with Ministers. Following the meeting, the Department was asked to come up with proposals relating to restricting care home workers to working in one home and ensuring that those workers were free from the virus whilst working.

456. On 28 April 2020, Ministers agreed to all of the recommended actions set out in Annex 3 of the Department's slide pack "Social Care: Update and Next Steps", including asking care homes to restrict permanent and agency staff to working in only one care home and mandatory isolation of new residents to care homes **(MD/JM5/368 - INQ000325275; MD/JM5/369 - INQ000109303)**.

457. As explained above, on 15 May 2020, the Government published the “COVID-19: Care home support package” **(MD/JM5/30 - INQ000325278)**. This was backed by the £600 million ICF. Further detail is provided in paragraphs 461 to 464 below. The document set out that scientific evidence shows significant asymptomatic transmission of COVID-19 in care homes via both residents and staff, similar to transmission in the wider community. By the time a single symptomatic case was identified in a care home, the virus was likely to be already circulating amongst residents and staff. In light of this new understanding, guidance for the adult social care workforce was given on:

458. The importance of infection prevention control – continuing to observe guidance set out by PHE on preventing and controlling infections, including the use of PPE, isolation practices and decontamination and cleaning processes.

459. Restricting workforce movement – taking all possible steps to minimise staff movement between care homes. Subject to maintaining safe staffing levels providers should employ staff to work at a single location. A check-list of actions care homes should consider taking was provided.

460. Comprehensive testing – The Department made testing available for all residents and workers in care homes. Tests were available for booking via a digital portal, which was intended to make it as easy as possible for care homes to arrange tests and register directly for delivery and collection of kits. Further details are provided in paragraphs 332 to 388. This measure was implemented to limit transmission of the virus, and to enhance workforce capacity by enabling those who were COVID-19 negative to go back to work.

461. The ICF was announced on 15 May 2020. This fund was worth £600 million, and its primary purpose was to support adult social care providers, including those with whom the local authority did not have a contract, to reduce the rate of COVID-19 transmission in and between care homes and support wider workforce resilience. Guidance on the use of the fund was published on 9 June 2020 **(MD/JM5/117 - INQ000565715)**. This explained that funding could be spent on measures such as:

    a. Ensuring that staff who were isolating in line with Government guidance receive their normal wages while doing so. This enabled providers to utilise the funding to uplift the pay of those who needed to isolate and who would normally only have been entitled to Statutory Sick Pay. This avoided staff facing a financial penalty for isolating in line with Government guidance.

    b. Limiting or cohorting staff to individual groups of residents or floors/wings

    c. Ensuring, in so far as possible, that members of staff only worked in one care home

    d. Supporting the active recruitment of additional staff and volunteers

    e. Steps to limit the use of public transport by members of staff

    f. Providing accommodation for staff who proactively chose to stay separately from their families in order to limit social interaction outside of work.

462. Following the publication of the initial guidance document the Department wrote to providers and local authorities to reiterate the importance of supporting staff to self-isolate **(MD/JM5/370 - INQ000576726)**.

463. Subsequent iterations of the ICF ran from October 2020 to March 2022 and provided almost £1.7 billion of dedicated grant funding. Further details on the ICF are included at paragraphs 161 to 168 of this statement (IPC section).

464. Following the publication of the May Support Package and the announcement of the ICF the Department continued to work with the sector to understand the ongoing risk posed by staff movement and to consider next steps.

465. On 23 July 2020 the Minister for Social Care met with members of the Adult Social Care Taskforce, including the chair Sir David Pearson and asked for a briefing on how staff movement could be restricted **(MD/JM5/371 - INQ000327960)**. A submission was produced in response on 29 July 2020 following two workshops with the care sector **(MD/JM5/372 - INQ000327965; MD/JM5/373 - INQ000327966; MD/JM5/374 - INQ000327967)**. The submission advised the Minister for Social Care that: *"National and international research has demonstrated that a significant risk factor in outbreaks of Covid-19 in care homes* is *staff movement"*. It made recommendations on limiting staff movement but advised against legislating to stop staff movement. In response on 4 August 2020, the Minister for Social Care asked for further advice on practical actions to reduce staff movement such as requiring care homes to have staff dedicated to a single site except in emergency situations **(MD/JM5/375 - INQ000327971)**. This position was reiterated in the Adult Social Care Taskforce's final report, when it was published on 18 September 2020.

The Winter Plan 2020/2021 and Proposal to Regulate Staff Movement

466. As explained above, COVID-O considered the Winter Plan 2020/2021 on 15 September 2020 and approved publication for 18 September 2020. The plan confirmed provision of over £500m of additional funding to extend the ICF to March 2021, to help the care sector restrict the movement of staff between care homes to stop the spread of the virus, was also included. This had been announced on 17 September 2020 **(MD/JM5/320 - INQ000565720)**.

467. At the meeting on 15 September 2020 COVID-O discussed a proposal to legislate to stop staff movement **(MD/JM5/182 - INQ000090180)**. This discussion was the result of a request from the Prime Minister on 14 September 2020 (explained at paragraph 250) to consider more radical solutions than those included in the Winter Plan 2020/2021 in response to an alarming uptick in cases. Considering legal options was taken forwards as an action for the Department from the meeting **(MD/JM5/319 - INQ000090012)** and a

submission was sent to the Secretary of State and the Minister for Social Care on 18 September 2020 setting out two potential legal routes to stop staff movement **(MD/JM5/376 - INQ000109760)**.

468. The first legal route proposed used amendments to regulation 18 of the CQC Regulated Activities Regulation to mandate restrictions on staff movement. At the request of the Minister for Social Care further advice on how effective the mechanism might be was provided in a submission on 24 September 2020 **(MD/JM5/377 - INQ000109793)**. Given the implementation challenges, the Minister for Social Care specifically requested for the policy to be developed with the sector **(MD/JM5/378 - INQ000109792)**. Further advice on 14 October 2020 set out the scope of regulations to limit staff movement **(MD/JM5/379 - INQ000109851; MD/JM5/380 - INQ000109852)**, and on 21 October 2020, a further note was sent to the Minister for Social Care advising of the need for more time to consult on the policy properly with stakeholders on developing the staff movement regulations **(MD/JM5/381 - INQ000058605; MD/JM5/382 - INQ000058606)**. The Minister for Social Care subsequently agreed on 5 November 2020 to holding a consultation **(MD/JM5/383 - INQ000576729; MD/JM5/384 - INQ000608161)**.

469. The consultation was held between 13 and 23 November 2020 **(MD/JM5/385 - INQ000328144; MD/JM5/386 - INQ000328145)** and proposed to amend regulations to:

    a. Create a temporary requirement that CQC registered care home providers should not deploy staff to provide personal or nursing care if they were, or had in the previous 14 days, been carrying out a regulated activity in another health or social care setting (further details on which groups are excluded is set out in this document).

    b. Provide a limited temporary exception to the requirement so that care home providers could continue to ensure enough staff are available to care for service users safely. This would allow providers to use people who were also being deployed in another health or social care setting, but only for a reasonable period of time to allow the provider to make other arrangements to enable them to comply with the requirement.

470. A submission sent to the Minister for Social Care on 3 December 2020 advised that the staff movement consultation responses were 86% against introducing the regulations. Themes in the responses included:

    a. Concerns about the inclusion of settings for working age adults;

b. The impact on staff well-being and the risk of burnout; and

c. Insufficient funding to compensate staff hours, which would lead to financial hardship for care workers. **(MD/JM5/387 - INQ000328025)**

471. The Department made the case to HMT that any staff movement restrictions should be accompanied by furlough payments for staff and/or financial support to compensate for lost earnings. On 18 December 2020 HMT rejected the proposals to compensate staff through the furlough scheme but said that they would be open to considering extending the ICF or a new fund to support the regulation **(MD/JM5/388 - INQ000328026; MD/JM5/389 - INQ000328027)**.

472. The regulations were then discussed at a COVID-O meeting on 22 December 2020. An action from that meeting was for further work to identify a way to compensate care staff which would not amount to a furlough payment - with a view to implementing the policy from 4 January 2021 **(MD/JM5/390 - INQ000091096)**.

473. The proposed compensation scheme did not obtain HMT approval - and instead the HMT steer was to make an alternative proposal which would increase the supply of care workers **(MD/JM5/391 - INQ000576732)**. This alternative solution was the establishment of the WCF, further details of which can be found above at paragraphs 410 to 415.

474. On 5 January 2021 the Minister for Social Care received a submission recommending that she agree not to pursue the staff movement regulations given acute problems with staff capacity across the sector and HMT deciding not to fund a compensation scheme **(MD/JM5/392 - INQ000328029)**. On 7 January 2021, the proposal was dropped **(MD/JM5/393 - INQ000328031; MD/JM5/394 - INQ000328032)**.

475. Following the decision not to legislate on staff movement, on 1 March 2021, the Department published *'Restricting workforce movement between care homes and other care settings'* guidance for care home providers **(MD/JM5/395 - INQ000502379)**. Prior to publication this guidance was approved by the Cabinet Office, PHE and No.10 **(MD/JM5/396 - INQ000565744; MD/JM5/397 - INQ000565745)**.

476. The aim of the guidance was to:

a. reinforce the continued importance of restricting routine staff movement to care home providers;

b. confirm that staff sourced through agencies, staff banks and other temporary sources should, wherever possible, also be subject to efforts to reduce staff movement between settings; and

c. set out those exceptional circumstances in which staff movement could still take place and give advice on the use of lateral flow testing to manage the associated risks.

COVID-19 Positive Working

477. In early January 2021, the Department's Social Care Regional Assurance Team became aware of incidents involving staff in care homes not self-isolating after testing positive for COVID-19. Information was not routinely collected on the reasons why people were continuing to work, but the Department understood that a significant factor was acute staff shortages, where there were limited alternatives to safely staff care homes (further details on the Regional Assurance Team are provided in paragraph 83 in Statement A of this Module) **(MD/JM5/90 - INQ000087232; MD/JM5/398 - INQ000565732)**.

478. On 20 January 2021, the Department also received a query from Cambridgeshire County Council asking for clarity on the legal position with regards to individuals refusing to self-isolate **(MD/JM5/399 - INQ000565740)**.

479. The Department worked closely with relevant stakeholders to understand the extent of the issue and on 27 January 2021 issued a joint statement with CQC, Association of Directors in Public Health (ADPH) and PHE to say that under no circumstances should care workers work whilst COVID-19 positive **(MD/JM5/400 - INQ000565771)**. Following this, an update was sent to the Prime Minister from the Minister for Social Care as part of a wider note. This was cleared by the Secretary of State, with the suggestion of police investigation for any possible offences **(MD/JM5/401 - INQ000565738; MD/JM5/402 - INQ000110579)**. On 10 February 2021, advice was sent to the Secretary of State and the Minister for Social Care on steps to address COVID-19 positive staff working in care settings **(MD/JM5/403 - INQ000328062)**. The submission set out how the CQC were responding, where they had identified instances of COVID-19 positive staff working in care settings and advised on additional potential actions including police investigation of potential offences **(MD/JM5/404 - INQ000328063)**.

480. Between April 2021 and July 2021, the Department continued to consider how best to address this issue **(MD/JM5/405 - INQ000328135; MD/JM5/406 - INQ000328136)**. Further advice was provided to the Minister for Social Care which detailed work the

Department was undertaking with the CQC and local authorities to consider the option of police involvement **(MD/JM5/407 - INQ000111003; MD/JM5/408 - INQ000565748)**. It was proposed that local authority safeguarding teams should give urgent and careful attention to both historical and future known cases of COVID-19 positive working as these would likely meet the bar for statutory safeguarding measures to be triggered. It was also suggested that the CQC be notified once the local authority had concluded safeguarding enquiries and that the CQC be given overall responsibility for making sure that all COVID-19 positive working was referred to the police for investigation. The CQC expressed concerns that this policy would set a precedent for Government intervention and potentially risk the CQC's independence. The Minister for Social Care then wrote to Peter Wyman, chair of the CQC, asking the CQC to ensure that local authorities had referred any substantiated cases of COVID-19 positive working to the police; and, where the police had not been involved, that CQC refer these cases back to the Department to pass onto the police **(MD/JM5/409 - INQ000576738)**. In his response, Peter Wyman reiterated that the CQC could not undertake such a role as it had no responsibilities under legislation to monitor local authority safeguarding processes. He also said changes would need to be made to provider fees to allow this scheme to be administered, which would take until early 2022 to be implemented **(MD/JM5/410 - INQ000061314)**.

481. The Minister for Social Care met with Kate Terroni, the Chief Inspector of Adult Social Care at the time, on 8 July 2021 and confirmed that she understood the CQC's position and was content not to pursue the matter further **(MD/JM5/411 - INQ000576740)**.

482. On 22 July 2021, the Minister for Social Care received a further submission on this topic, advising that the police did not have sufficient resources to investigate all cases of COVID-19 positive working and that the CQC had written to confirm that they would not follow up on cases - but that local authorities would continue to consider cases through safeguarding processes. The recommendation was that she agree to no further action with the CQC, and that she consider whether: (i) to write to local authorities reiterating that they should refer substantiated cases to the police via safeguarding processes; or (ii) make it clear in the forthcoming Winter Plan 2020/2021 that COVID-19 positive staff must self-isolate and that COVID-19 positive working and CQC local authorities were responsible for investigating individual breaches **(MD/JM5/412 - INQ000328147)**.

483. The Minister for Social Care responded to the submission on 28 July 2021, agreeing to set clear expectations and guidance in the Winter Plan 2020/2021 **(MD/JM5/413 - INQ000328148)**. The Winter Plan 2021/2022 was published on 3 November 2021 and confirmed the Department's position that "COVID-19 positive working is not acceptable in

any circumstances, and local authorities should ensure any confirmed cases of COVID-19 positive working are considered through local safeguarding processes, including referring to the police if appropriate" **(MD/JM5/90 - INQ000087232)**.

VACCINES WITHIN THE ADULT SOCIAL CARE SECTOR

484. The Department's role in the development and deployment of vaccines was to support the Government and Secretary of State in planning for and delivering a successful vaccination programme in response to COVID-19. As work on potential vaccines progressed, the Department began to plan for deployment of a vaccine, including consideration of who should be prioritised to receive it.

485. Decisions on vaccine prioritisation are taken by government ministers of UK health departments. In England, they are taken by the Secretary of State for Health and Social Care on the advice of the Joint Committee on Vaccination and Immunisation (JCVI), a statutory standing advisory committee constituted for the purpose of advising the UK health departments on the provision of vaccination and immunisation services. The Secretary of State is not statutorily obliged to accept JCVI advice or recommendations, but when presented with a recommendation from the JCVI based upon a coherent strategy, careful consideration of relevant evidence by experts, and detailed modelling, there would need to be a compelling reason not to accept it, particularly in the unprecedented circumstance of a global pandemic.

Prioritisation

486. From May 2020, the JCVI met regularly to consider COVID-19 vaccination. The JCVI considered the emerging clinical and epidemiological data with a view to provide advice on COVID-19 vaccination. It met twice weekly (compared with twice annually pre-pandemic), reviewing emerging evidence on a rolling basis to give advice on approaches on vaccination well in advance of vaccine authorisation, allowing timely recommendations. Weighting of JCVI's usual priorities in decision-making also evolved, with vaccine supply, procurement and delivery capacity becoming higher priority considerations than usual, and programmatic cost a lower priority than usual.

487. On 18 June 2020, JCVI published interim advice **(MD/JM5/414 - INQ000106485)** on priority groups for vaccination including the priority vaccination of frontline health and care workers and those at "increased risk of serious disease and death from COVID-19 infection stratified according to age and risk factor". The JCVI considered frontline health and care workers to be the highest priority for vaccination due to their increased personal

risk of exposure to infection with COVID-19 and of transmitting that infection to patients vulnerable to COVID-19 in health and social care settings. Their vaccination would also help to maintain resilience in the NHS and for health and social care providers. The JCVI then prioritised vaccination using a mortality risk-based approach as the then available evidence "strongly indicates that the risk of serious disease and death increases with age and is increased in those with a number of underlying health conditions".

488. In response to a submission dated 12 June 2020 **(MD/JM5/415 - INQ000106484; MD/JM5/416 - INQ000608149)**, outlining key developments on a potential COVID-19 vaccine and Vaccination Programme, the Secretary of State was content with the publication of the prioritisation list. However, he commented that the progress to date from the Vaccine Taskforce (VTF), a joint taskforce between the Department and the Department of Business, Energy & Industrial Strategy, which was set up in April 2020, was too slow. The Secretary of State said that the dosage aim was too small and that there needed to be an aim for the whole of the UK to be vaccinated, rather than just 30m doses. He also commented that he would like to be closely involved in the next stage of prioritisation.

489. On 25 September 2020, JCVI published updated interim advice advising that older adults resident in a care home, and care home staff, receive vaccines first, followed by people aged over 80 and health and social care workers, before rolling out to the rest of the population in order of age and risk. The JCVI's recommendations were established using mathematical modelling based upon evidence which firmly indicated that, because age was so strongly associated with COVID-19 mortality, offering vaccination to older age groups first was the optimal strategy for both minimising future deaths and minimising quality adjusted life year losses. It suggested that an age-based programme would likely result in faster delivery and better uptake in those at the highest risk, though whether health and care workers should be prioritised above, alongside, or below, persons at highest risk from COVID-19 "would depend on the characteristics of the vaccines when they become available and the epidemiology of disease at the time of delivery **(MD/JM5/417 - INQ000070847)**."

490. In a paper to the COVID-O committee in November 2020, the Department advised that JCVI's approach would save lives, reduce hospitalisation, and protect the NHS and social care system **(MD/JM5/418 - INQ000060716)**. On 13 November 2020 the COVID-O committee agreed in principle the JCVI recommendations on prioritisation, subject to further consideration of provision for CEV individuals. At this meeting the COVID-O

committee also agreed that the PM would take the final decision on Phase 1 prioritisation **(MD/JM5/419 - INQ000090898; MD/JM5/420 - INQ000401301)**.

491. On 2 December 2020 a submission was sent to the Secretary of State on the JCVI's recommendation and advice for Phase 1 prioritisation for the Pfizer vaccine **(MD/JM5/421 - INQ000234198; MD/JM5/422 - INQ000234199)**. It set out that this vaccine should be given to older adult care home residents and staff first, followed by individuals over 80 and health and care workers, then to the rest of the population in order of age and clinical need. The Secretary of State accepted this recommendation.

492. On 29 December 2020 the Secretary of State received a submission about the JCVI advice on Phase 1 advice for the AstraZeneca vaccine **(MD/JM5/423 - INQ000401314; MD/JM5/424 - INQ000501434; MD/JM5/425 - INQ000489936; MD/JM5/426 - INQ000489937)** which he accepted on the same day **(MD/JM5/427 - INQ000401318; MD/JM5/428 - INQ000059390)**. On 30 December 2020, the JCVI provided its final advice on Phase 1 prioritisation **(MD/JM5/429 - INQ000059401)**. This advice also noted that priority group six also contained those in receipt of a carer's allowance, or those who were the main carer of an elderly or disabled person whose welfare might be at risk if the carer fell ill.

493. On 30 December 2020 the UK's four CMOs gave joint clinical advice that delivery plans should prioritise delivering first vaccine doses to as many people on the JCVI Phase 1 priority list in the shortest possible timeframe **(MD/JM5/430 - INQ000059403)**.

494. Further to the CMOs' joint letter on 30 December 2020, an update to the COVID-19 vaccine guidance was issued on 7 January 2021 **(MD/JM5/431 - INQ000565741)**. This provided additional operational guidance on the immediate requirement to vaccinate frontline health and care workers ensuring maximum uptake of vaccination and timely, equitable access across staff groups.

495. On 10 February 2021, the Department advised Ministers on the proposed method of implementation for COVID-19 vaccination for group six, including the definition of unpaid carers, who were also included in group six, and settings of multiple occupancy **(MD/JM5/432 - INQ000059858)**. The Secretary of State approved this submission on 11 February 2021 **(MD/JM5/433 - INQ000401337)**.

Availability of Vaccines

496. There was understandable concern about the effect of constrained supply for the vaccination programme. The issues involved were considered by the UK Health Security Agency (UKHSA) and JCVI and included in formal advice to ministers and often in the daily ministerial calls. In the event, due to the whole of government approach, the programme was able to proceed at a very fast pace, using the very substantial supply of millions of doses in the first few months and then ongoing for each rollout. This was the result of very substantial work and resourcing in effective development and manufacturing. Through the VTF, the Department was able to secure access to promising vaccine(s) for the UK population.

497. The Department undertook substantial work so that vaccine deployment could happen as soon as vaccines received regulatory approval. Vaccines were purchased before authorisation, and plans for deployment readiness began before we knew there would definitely be an approved vaccine. This substantial pre-planning required careful coordination across a wide range of bodies but meant that the UK was ready to deploy as soon as vaccines were available. There was a well-established system of advice, approvals and distribution for national vaccine programmes which could be built on and scaled effectively. Before the pandemic, the Department had already done a significant drive every year to promote flu vaccination in adult social care, including CMO writing directly to provider representatives to encourage take up **(MD/JM5/434 - INQ000565691)**. This provided an effective base upon which to build.

The Vaccine Rollout for Recipients of Care: Successes

498. The NHS began vaccinating people against COVID-19 on 8 December 2020. It was the start of the biggest immunisation programme in UK history. Within the first month of deployment more than 1 million people in England had received their first dose of the COVID-19 vaccine and, by 18 July 2021, the vaccine programme had met its target of offering a first dose of a COVID-19 vaccine to all adults aged 18 and over **(MD/JM5/435 - INQ000234326)**.

499. SAGE had advised that the safe level of vaccination in each care home was 90% for residents. This threshold was met within 8 weeks of the beginning of the vaccination programme. As of 9 March 2021, 91.7% of eligible care home residents had been vaccinated (as seen in the table below)

500. NHSE&I visited care homes to administer vaccines on site, operating a four-visit schedule for each home **(MD/JM5/436 - INQ000565750)**. Local primary care networks were

responsible for providing vaccination to residents. The Department and NHSE/I had sent a series of communications directly to staff in the sector and through partner channels to remind residents about how to book a vaccination.

501. The table below summarises the success of the programme with regards to priority groups 1 and 2 in particular and gives the percentage vaccinated with one or two doses by each step of the Government's Roadmap for exiting lockdown. **(MD/JM5/437 - INQ000257491; MD/JM5/438 - INQ000257499; MD/JM5/439 - INQ000257500; MD/JM5/440 - INQ000257501; MD/JM5/441 - INQ000257502; MD/JM5/442 - INQ000257504; MD/JM5/443 - INQ000257503; MD/JM5/444 - INQ000257505; MD/JM5/445 - INQ000257506; MD/JM5/446 - INQ000257507; MD/JM5/447 - INQ000257508; MD/JM5/448 - INQ000257492; MD/JM5/449 - INQ000257495)**

JCVI priority groups	Priority group coverage	Dose	% vaccinated by 09/03/2021	% vaccinated by 30/03/2021	% vaccinated by 13/04/2021	% vaccinated by 18/05/2021	% vaccinated by 20/07/2021
1	Older adult care home residents	1st dose	91.7	93.4	94.0	94.9	95.9
		2nd dose	N/A or not reported	N/A or not reported	N/A or not reported	82.5	93.4
	Older adult care home staff	1st dose	73.4	77.7	79.5	82.6	87.1
		2nd dose	N/A or not reported	N/A or not reported	N/A or not reported	60.5	77.2
2	All over 80s	1st dose	93.4	94.3	94.7	95.0	95.3
		2nd dose	15.5	40.5	74.5	91.1	93.3
	Trust health care workers in the ESR*	1st dose	80.5	84.9	86.2	87.8	91.0
		2nd dose	10.0	39.1	62.1	78.3	85.7

**ESR: electronic staff record*

502. The Department produced a lessons learnt report in June 2021 **(MD/JM5/450 - INQ000111468)**. The report summarised the work of the Department's adult social care vaccines team and the Adult Social Care Taskforce (the establishment and role of the

Adult Social Care Taskforce is fully explained in statement A of this Module) on the COVID-19 vaccination rollout, and lessons learned during the rollout. The report included data on how many workers had received their first dose, and said that ways of working had also proved successful, with a small core virtual team working at pace to engage the sector, draw on expertise, and produce, with partners, a positive outcome for frontline care workers and those they support. Webinars and "roundtable" discussions had enabled broad engagement and problem solving, while regular calls with the NHS programme team had provided an invaluable opportunity to understand the wider issues across the programme. It was reported that the commitment of local authorities and their vaccination leads to support the sector had also been invaluable.

503. Positive feedback in March 2021 also came specifically from HC-one on the rollout to adult social care, and they reported there were 'huge reductions in colleague and resident cases' that may indicate less outbreaks and meant the care home could be open for admissions and visiting **(MD/JM5/451 - INQ000565746)**. This also included praise for the programme overall with over 92% of residents having had their first vaccines and many taking up their second one too. They reported that at the start large numbers of residents and colleagues had received the vaccine mostly through vaccine clinics at the care homes and that these were well planned and attended.

504. In addition to the take-up figures, the Minister of State for Social Care Helen Whately in her Module 2 witness statement dated 30 October 2023 highlighted the "successful collaboration" between local authorities, care providers and local NHS teams.

> "*I feel a real sense of pride in the vaccination programme, and particularly in how the DHSC, the NHS, local authorities and social care providers all worked together with the common aim of getting the COV-19 jab to as many care home residents and staff as quickly as possible".*

The Vaccine Rollout for Recipients of Care: Challenges

505. There were challenges regarding the rollout of the vaccine to recipients of care. The following are explained in more detail below:

    a. storing the vaccines and ensuring they were kept at the right temperature;

    b. ensuring primary care sites could prioritise care homes;

    c. ensuring NHS England had sufficient expertise in the adult social care sector

d. identifying people with learning difficulties and reaching those who were housebound.

506. A letter from the Minister of State for Social Care, Helen Whately, to care homes for older adults, local authority chief executives and DASSs on 4 December 2020 mentioned that "*getting the Pfizer-BioNTech vaccine to care home residents is challenging because of the requirements for transporting it and the temperature at which it is stored*" **(MD/JM5/452 - INQ000503970)**. This meant it required maintenance of cold chain transport. In contrast, the Oxford/Astra Zeneca vaccine could be stored at fridge temperatures, between 2 and 8 degrees, making it easier to distribute to care homes. Vaccines being taken directly to care homes was a joint effort between the care homes and the primary care network vaccinating teams. Packing down the vaccine into allocations of 75 doses had enabled efficient use in large care homes with over 50 beds. Deliveries of vaccines to large (over 50 beds), medium (25 to 49 beds) and small (under 25 beds) care homes were underway from December 2020.

507. Further to this, a meeting on vaccine deployment took place on 12 January 2021 **(MD/JM5/453 - INQ000565731)**, where the Prime Minister met with the leadership of the NHS Vaccine programme (Simon Stevens, Dame Dr Emily Lawson, Brigadier Phil Prosser, and Dr Nikki Kanani), the Health Secretary, the Minister for Vaccine Deployment, the Defence Secretary, Chief Defence Secretary, CMO, Chief Scientific Advisor and others to receive an update on vaccine deployment to date and scrutinise further plans for rollout. The group discussed the rate of care home vaccinations and the NHS explained that "*some [primary care] sites had prioritised their over 80s rather than care homes",* along with noting that "*there may be challenges in care homes with a significant outbreak*".

508. The lessons learned report from June 2021, referenced in paragraph 502 **(MD/JM5/450 - INQ000111468)**, found the need for "*a more prominent social care influence within the programme itself, and by increasing the interactions at more levels of seniority between the Department, NHSEI and stakeholders*".

509. In terms of those with learning disabilities, the JCVI advice that all people on the GP Learning Disability Register should be invited for a COVID-19 vaccination in priority group six was accepted by the Government **(MD/JM5/454 - INQ000489943; MD/JM5/455 - INQ000608163; MD/JM5/456 - INQ000354486).** It was noted however, that GP systems might not have always captured the severity of someone's disability, meaning some adults who were more severely affected by learning disabilities might not have been invited for

vaccination, alongside people with other long-term health conditions. To address this, the NHS worked with local authorities to identify working age adults in residential and nursing care, and those who required support, for example as part of assisted living in the community, and those who were in shared accommodation with multiple occupancy. This meant that at least 150,000 more people with learning disabilities were offered the vaccine more quickly. The Vaccine Delivery Plan, published on 11 January 2021 **(MD/JM5/457 - INQ000399454)**, made provision for those who were housebound, residents of care homes or who would otherwise struggle to travel. The report said "*Local vaccination services could coordinate and deliver vaccination to people who were unable to attend a vaccination site, including visiting care homes, the homes of housebound individuals and other settings such as residential facilities for people with learning disabilities or autism*." Each of the UK nations had plans to scale up vaccine delivery and the plan set out the deployment plans of the NHS in England. Whilst exact models differed slightly from region to region, all four nations' plans involved a mixture of delivery models which included mobile teams visiting care homes, large sites at hospitals, and primary care-based delivery. Local vaccination services mobilised general practice, working together in groups of primary care networks, plus large and small community pharmacy sites. These services provided the largest number of locations and were well placed to support the individuals most vulnerable to COVID-19, many of whom already had a trusted relationship with their local health services. They also coordinated and delivered vaccinations to people who were unable to attend a vaccination site, including visiting care homes, the homes of housebound individuals and other settings such as residential facilities for people with learning disabilities or autism and prisons, as well as vulnerable groups such as those experiencing homelessness.

Take-up of Vaccination Amongst the Workforce, and Vaccination as a Condition of Deployment (VCOD)

510. As set out in paragraph 494, from very early on there were concerns about vaccine uptake within the social care workforce. For example, on 9 March 2021 (see table above (paragraph 501) rates amongst staff adult care home residents were recorded at 91.7% whereas vaccination rates amongst adult care home staff were only 73.4%.

511. On 22 January 2021, Ministers received a submission **(MD/JM5/458 - INQ000328047)** on increasing vaccine uptake amongst care workers. This advice detailed ongoing work as well as options to go further, covering communications, examples of good local practice and the work of the Task and Finish Group set up to address vaccine hesitancy **(MD/JM5/459 - INQ000325302)**. This submission also included options for mandating

vaccination but advised that an approach based on persuasion and incentivisation should be pursued and kept under review.

512. Ministers at the COVID-O meeting of 10 February 2021 received a paper noting that the proportion of vaccinated staff lagged behind that of residents, particularly in London **(MD/JM5/236 - INQ000562876)**.

513. On 25 February 2021, the Minister of State for Social Care wrote to the Prime Minister setting out the latest data on vaccine take up; measures that the Department was taking to make it as easy as possible for care workers to access the vaccine; and approaches to address fear and hesitancy.

514. The Minister's letter to the Prime Minister also highlighted that some staff were "reticent about being vaccinated, others are worried or genuinely frightened.". The number of people reporting they intended to take the vaccine was lower amongst women, ethnic minority communities and people under 55. These groups made up a significant proportion of the care home workforce. The letter noted anecdotal evidence that younger women were worried about its impact on fertility and some ethnic minority communities were particularly worried about Pfizer, for example due to its implications on fertility.

515. The Minister's letter to the Prime Minister highlighted actions the Department had taken to increase uptake. It noted that many care workers worked long hours on low pay and relied on public transport, and so the best way to reach them was to revisit care homes and offer staff vaccinations at work. As a result, the Department requested all NHS Clinical Commissioning Groups and Primary Care Networks ensure that all care homes with staff or residents yet to be vaccinated, were revisited by the end of March. The Department had also emailed all care homes with clear guidance on how their workers could book a vaccination via the National Booking Service, which opened to care home staff on 11 February 2021, or their local GP. The Department had also sent follow-up emails to those care homes with the lowest staff vaccination rates. NHSE/I worked on a programme of follow-up visits to older adult care homes, with each care home due to have a minimum schedule of four visits (two to administer the first dose and two to administer the second dose).

516. The letter also set out the option to use secondary legislation to make vaccination a condition of deployment (VCOD) in care homes. It highlighted that the DCMO Jenny Harries, had warned that mandating vaccination could undermine trust and confidence in the vaccine programme. The letter continued to state that, if the Department was to go

down this route, it would be best to do it as part of a drive to raise appreciation of care workers e.g., guaranteed sick pay, which would have cost implications. Consideration was also given to the option of extending the requirement to the NHS and wider social care, and at least to those NHS staff visiting care homes such as nurses and GPs. Finally, the letter referred to exploring enforcement options other than new regulations, for example using statutory guidance. At this time an extensive programme of work was also underway to address fears about vaccination. This included webinars for the care sector, educational materials sent to providers and broader work to build trust amongst hesitant communities. The Department shared blogs and videos of care workers from ethnic communities receiving the vaccine, explaining how they had overcome their own vaccine hesitancy and why they would encourage their colleagues to be vaccinated. The letter noted that *"(t)he consistent message is that staff are most likely to be reassured by respected colleagues."* **(MD/JM5/460 - INQ000325309)**

Vaccination as a Condition of Deployment (VCOD)

COVID-O Meeting of 17 March 2021

517. VCOD was discussed at a COVID-O meeting was on 17 March 2021 **(MD/JM5/461 - INQ000092064; MD/JM5/462 - INQ000325316)**. The paper noted that the Prime Minister and the Secretary of State had discussed this issue several times and wanted to put in place legislation to require vaccination among the care workforce, in order to reach a position of much greater safety for care recipients. The paper considered how to implement this policy through secondary legislation, including the need for consultation. Reference was also made to the fact that there were moves by some larger care providers to require staff to be vaccinated and that the public/media was increasingly supportive of a requirement for vaccination. The Secretary of State's view was that the focus should first be on staff in older adult care homes and later broaden to other care workers and health care workers.

518. The paper noted that the SAGE had advised that the safe level of vaccination in each care home was 90% for residents and 80% for staff and these levels had not been reached, particularly in London. The proposition was therefore to create a legal requirement for vaccination to become a condition of deployment, whilst continuing to pursue all other softer levers (detail on the significant programme of work to improve access to vaccines and address vaccine hesitancy was provided in the annex). The rationale for this was not only the lagging uptake of the vaccine but also:

"(1) the vulnerability of care home residents, considered by the Joint Committee on Vaccinations and Immunisations (JCVI) along with their carers to be the top priority group for vaccination (2) the fact that most care home residents were in their final years of life and stood to lose what remaining time they had left and (3) the nature of care homes, as closed environments where COVID-19 could spread rapidly with devastating consequences."

519. COVID-O agreed to the proposals to introduce secondary legislation in relation to those working in older age residential care homes, noting that they were in JCVI's priority cohort one and had had access to the vaccine for the longest time. As well as scope, the paper also dealt with the development of a Public Sector Equality Duty impact assessment, and the ethical risks associated with the policy. On this last point, the paper proposed that the issue be brought before the next meeting of the Moral and Ethical Advisory Group (MEAG) on 31 March 2021. At this meeting, officials presented a paper to MEAG members requesting their views on the proposed consultation document **(MD/JM5/463 - INQ000325318)**. MEAG Members, considered a range of related issues and noted that the ethics of mandating vaccinations for staff was in part contingent on the scale of the risks to care home residents and the effectiveness of this approach at mitigating these risks. They also noted that there were regional, local and community differences in vaccine uptake which concentrated the risks. The MEAG recognised the merits of a targeted approach but also expressed concern about the disproportionate impact to care home staffing in targeted areas, as well as the negative perceptions and resistance among communities who may feel specifically targeted. They noted that the policy also raised significant risks to civil liberties, which should be investigated further as it was likely to impinge on the autonomy and privacy of care home staff, could lead to bullying and would disproportionately affect women, ethnic minorities and those on a low income. The MEAG raised possible mitigations to some of these impacts such as furloughing staff and offering staff a choice of vaccine, and stressed the importance of clarifying and justifying the scope of the proposals **(MD/JM5/464 - INQ000401347)**. These views were then considered by officials during formulation of policy and in development of the questions being asked in the consultation.

520. Following the COVID-O meeting on 17 March 2021, on 24 March 2021 the Chancellor of the Duchy of Lancaster (CDL) wrote to the Prime Minister setting out COVID-O's proposals, together with the risks of proceeding with VCOD. As explained in this letter, as older-age individuals in residential care homes were "*the highest priority cohort identified by the JCVI, it is imperative to do everything we can to protect this extremely vulnerable*

group" **(MD/JM5/465 - INQ000234310)**. It was therefore agreed to run a public consultation on the proposals.

521. On 25 March 2021, the Minister of State for Social Care received a further submission, setting out the plan to ensure that an announcement on VCOD to be introduced to older adult care homes could be made by 5 April, and to draft and put the regulations in place by the time that Parliament went into recess in the summer of 2021 **(MD/JM5/466 - INQ000328093; MD/JM5/467 - INQ000328094)**.

522. The Secretary of State provided his comments on the submission on 26 March 2021. He wanted the consultation document to be published on 5 April and agreed to running the consultation until 21 May 2021. This was later extended to 26 May 2021 as requested by No 10, to allow enough time for a public announcement and publication of the official response. On the scope of the consultation document, he agreed to the preferred policy position that regulations would apply to older age homes, all staff who worked on site and all without a medical exemption. In order to move as fast as possible, he suggested a mid-June 2021 deadline **(MD/JM5/468 - INQ000328096)**.

523. The Minister of State for Social Care Helen Whately also provided comments on 26 March 2021. She agreed with the scope of the consultation but thought there needed to be a caveat around access so that, if staff were unable to access the vaccine, the stipulation should be disapplied in order to avoid vaccine supply causing workforce issues. She also wanted some consideration of boosters, requiring staff to have winter jabs or new variants if necessary, and did not think that requiring two doses was practical for newly recruited staff, as it could add significantly to an unvaccinated person starting work. She suggested a requirement for a window in which staff had to receive two doses, but that they could start working after the first dose. The Minister for Vaccine Deployment agreed with the scope of the consultation and its launch shortly after 5 April 2021 if that was the Secretary of State's preference, "*noting the risks that officials have outlined*". These risks concerned the need to reach a wide audience for the consultation, quality assurance of the consultation itself and the statutory requirement to publish the proposed changes to the code of practice on the prevention and control of infections **(MD/JM5/469 - INQ000328095)**.

524. A further draft consultation document was shared on 26 March 2021 along with a draft 'write round' letter to gain collective agreement on the publication of the consultation **(MD/JM5/470 - INQ000328097; MD/JM5/471 - INQ000328098; MD/JM5/472 - INQ000328099)**. A 'write round' is a mechanism where the responsible Minister will write

to other Ministers on a particular Cabinet Committee of central government to provide comments and/or be informed of legislation or policy which will impact them, and ask for comments or views.

Consultation on Making Vaccination as a Condition of Deployment in Older Adult Care Homes

525. The Department ran its consultation between 14 April 2021 and 26 May 2021 **(MD/JM5/473 - INQ000256957)** on the proposal to require older adult care home providers, with at least one resident over the age of 65, to deploy only those staff who had received the COVID-19 vaccination unless they had a medical exemption.

526. More than 13,500 consultation responses were received. On 27 May 2021, advice was sent to the Secretary of State, summarising high-level findings from the consultation **(MD/JM5/474 - INQ000328130; MD/JM5/475 - INQ000608166)**. Views were divided, with 57% not supportive and 41% supportive of the proposal. Health care providers, care service users and front-line care staff were mostly unsupportive, while care home providers and managers and directors were overall supportive. The submission reported that the majority of people opposed the policy being applied only to older people's care homes, but this was because a large number of those were against the policy in general.

527. Concerns were raised around the potential risks of the policy. These included; the impact on staff retention and recruitment, as well as the impact on morale, infringement on the human rights of the workers affected, infringement on freedom of choice and bodily autonomy, and concerns about the morality of the policy. The NHS and local authorities expressed concerns about the impact on retaining staff and the impact on staff who would feel compelled to leave due to implementation. The consultation also showed that respondents were concerned about impacts on protected characteristics and staffing levels from this policy.

528. Three in five respondents (61%) agreed with a specific list of exemptions, with one in five (22%) against **(MD/JM5/476 - INQ000325334)**. A significant proportion, particularly but not exclusively those supportive of the proposals, felt that there should be no exemptions and all visitors to care homes should be vaccinated. Other groups mentioned included those with allergies or medical exemptions, those who were pregnant, breastfeeding or hoping to conceive and exempt on religious grounds. There were also calls for exemptions for visiting emergency services.

529. The submission also included statistics on the possible impact of the policy on the workforce. Officials estimated that 14,000 - 33,000 workers would leave their jobs if VCOD applied only to care homes registered with CQC as caring for older adults. The estimate was that 18,000 - 42,000 would leave their jobs if it applied to all CQC-registered care homes and 20,000 - 47,000 would if it applied to all care homes **(MD/JM5/477 - INQ000565749)**. Details on the impact of vaccination as a condition of deployment are included at paragraph 532 below including the impact on workforce numbers.

530. A further submission was sent to the Secretary of State on 4 June 2021, asking ministers if they were content to proceed with VCOD, subject to the amendments set out below, content with the draft Statutory Instrument (SI), and content with the next steps on parliamentary handling, stakeholder engagement and consultation response. The Secretary of State confirmed he was content with the scope, with an amendment that it should be defined as anyone who came into contact with the resident, and that he agreed with the SI, subject to an amendment to state that the term "vaccinated" currently meant two doses **(MD/JM5/478 - INQ000565752; MD/JM5/479 - INQ000325335; MD/JM5/480 - INQ000328133; MD/JM5/481 - INQ000328151)**.

The Government's Response to the Consultation

531. The COVID-O meeting of 15 June 2021 was focused on VCOD in adult social care and health settings **(MD/JM5/482 - INQ000092238; MD/JM5/483 - INQ000091970)**. The Minister of State for Social Care highlighted that SAGE recommended a threshold of 80% of staff and 90% of residents should have had at least one vaccination to avoid outbreaks. Despite efforts to incentivise uptake, only 64% of care homes had met the dual threshold across both staff and residents for the first dose, with numbers in London being significantly lower at 44%. For second doses, only 39% of care homes were reaching this 80-90% level of coverage and in London, there were only 21% of care homes reaching the staff-resident dual threshold.

532. Given the responses to the consultation, the paper proposed changing the scope of the policy to cover all care homes, not just those with residents over the age of 65, and to include a wider range of people coming into care homes, although not visitors. The paper noted the preparation of an Equality Impact Assessment, to be addressed in paragraphs 536 to 537 of this statement. It also discussed the workforce risk and the assessment, based on survey data, that 3-7% of the workforce would leave because of the vaccine requirement and ways of mitigating this. COVID-O agreed that the Department should proceed with the proposed regulations.

533. The Minister of State for Social Care also presented a second paper considering launching a further consultation on extending the vaccination requirement to all CQC regulated settings, to be addressed in paragraphs 555 to 563 of this statement. There was a desire from No.10 to expedite the policy to ensure readiness by winter 2021/2022. For both policy proposals, they discussed the impact on women and minority ethnic staff.

534. COVID-O agreed that the Government's proposed consultation response should be published on 17 June 2021, and regulations laid on 21 June. It also agreed for the Department to launch a future consultation on extending VCOD to social and health care settings for COVID-19 and flu vaccination.

535. In response to the consultation, three key changes to the policies were announced **(MD/JM5/476 - INQ000325334)**:

    a. The scope would be extended to all CQC registered care homes in England. Regarding policy scope, the consultation showed that the initial definition of including only CQC-registered care homes with at least one older (65+) adult would be extremely challenging to implement, for example, a birthday or death could see a home moved into or out of scope, respectively. This might mean that not all residents who were clinically most vulnerable to COVID-19 were protected, and might give rise to unintended consequences (for instance, the risk of someone turning 65 being moved, to avoid a home falling within scope of the policy).

    b. The condition of deployment would be extended to all people who entered a care home regardless of role, excluding residents, family and friends and emergency services. This was due to there being significant support to broaden the scope of the policy to include these groups, as respondents were not in favour of the baseline approach to include only paid staff deployed in the care home and volunteers deployed to carry out regulated activities. There was also some support for broadening the policy to all health and social care staff, in any setting.

    c. A policy on exemptions would be introduced. This was due to the majority of respondents agreeing with the proposal to grant exemptions on medical grounds, as well as calls for exemptions to visiting emergency services, to women of childbearing age, those who were trying to get pregnant, or were pregnant or breast feeding. There was also a call to ensure that the system

for demonstrating vaccination status or exemption from vaccination would be as simple and clear as possible.

Public Sector Equality Duty and Equality Impact Assessment

536. In considering these policy changes, Ministers had to comply with the equality legislation, including the Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010, their general duties under the National Health Service Act 2006, and the Family Test. Under the PSED, Ministers must have due regard to the impact of decisions on those people with the protected characteristics, which are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

537. An Equality Impact Assessment (EIA) was published on 16 June 2021 **(MD/JM5/479 - INQ000325335)** as part of the outcome of the consultation. It reported that:

a. The policy was likely to have a significant positive impact on staff and residents with disabilities if a greater number of their colleagues were vaccinated and therefore provided them with some protection. However, some disabled staff without a medical exemption might have clinical concerns that could make them less willing to be vaccinated or prevent them from having the vaccine, or face access issues to being vaccinated.

b. The policy was likely to have a significant impact on women, due to many more women than men being in the social care workforce. There was some evidence that women had higher rates of vaccine hesitancy than men and might also face more barriers to accessing the vaccine.

c. Determining the full impact of the policy on LGBT people was a challenge due to having no evidence available on the demographics of the adult social care workforce regarding sexual orientation or the prevalence of vaccine hesitancy by sexual orientation. However, surveys indicated that some LGBT people avoided treatment for fear of discrimination on the grounds of sexual orientation and therefore might be less likely to have already been vaccinated.

d. The policy was likely to have a significant impact on ethnic minorities. One in five members of the social care workforce were Black, Asian or from another ethnic minority, compared to the overall population of England of one in seven (14%). Evidence suggested that vaccine hesitancy was highest among Black

people, people of Pakistani and Bangladeshi heritage, and non-UK/Irish White ethnic groups.

e. The policy was expected to have a positive impact on older residents and staff, due to increased protection from COVID-19. However, around 15% of the workforce was made up of women under 30. This group might be particularly vaccine hesitant, specifically related to fertility concerns, and thus could be significantly affected by the policy.

f. Determining the impact on transgender or gender non-conforming people in the workforce was a challenge due to lack of data. There was no evidence that this group experienced higher levels of vaccine hesitancy but there was some evidence they were more likely to have negative interactions with healthcare staff and so less likely to seek testing or treatment for COVID-19.

g. The policy was likely to have a significant impact based on religion or belief as some staff may be opposed to vaccination in principle due to their beliefs, either religious or non-religious.

h. The policy was likely to have a significant impact on pregnancy and maternity as the majority of the workforce was female. There was a serious risk of discrimination against those who did not wish to take the vaccine e.g. such as pregnant and breastfeeding employees. As routine vaccination during pregnancy had not been advised until 16 April 2021, pregnant and breastfeeding employees might have been less likely to have already been vaccinated against COVID-19 and a requirement to do so would be likely to cause significant anxiety.

i. There was no current evidence that making the COVID-19 vaccination a condition of deployment would have a greater or lesser impact depending on marital and partnership status.

Legislative Process

538. The Department laid the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 before Parliament on 22 June 2021. There was full Parliamentary scrutiny of the changes brought in by the Department. The Minister for Vaccine Deployment provided oral evidence before the Secondary Legislation Scrutiny Committee on 13 July 2021 and a debate took place in the House of Lords on 20 July 2021. The regulations were made on 22 July 2021 and came into effect on 11 November

2021, following a 16-week grace period, making vaccination a condition of deployment in all CQC registered care homes.

Preparations and Roll Out of VCOD

539. To prepare for the deadline of all older adult care home workers to receive two COVID-19 vaccinations, and to minimise negative impacts, regular stakeholder engagement took place with the sector in the preceding months **(MD/JM5/484 - INQ000086799)**. Meetings were held with representatives of residents, patients, their families and carers. One-to-one calls took place with groups including the National Care Association, ADASS, Care England and the National Care Forum. For example, a stakeholder engagement event with the Local Government Association, Care Association Alliance, the National Care Forum and Care England took place on 17 May 2021 **(MD/JM5/485 - INQ000060944; MD/JM5/486 - INQ000060943)**. This included discussions on the sector's views on VCOD, how it would be implemented, what would be the best way to implement it, and how to mitigate impacts on the workforce. Another meeting took place on 1 July 2021, where sector representatives met with the Department to discuss the upcoming VCOD guidance and the best way to draft it. **(MD/JM5/487 - INQ000565777)**. The Department also facilitated several webinars with the DCMO (Jonathan Van-Tam), NHSE, UKHSA and CQC to address vaccine hesitancy and support uptake.

540. The Department worked closely with UKHSA, NHSE, ADASS, LGA, CQC and sector representatives, to make available a range of bespoke resources to support care homes and local authorities engage with their staff, residents and families. Guidance was co-produced with a stakeholder working group including representatives of the LGA, ADASS, CQC, care home representative organisations, large national care home chains, NHSE, unions, and clinicians, and others **(MD/JM5/488 - INQ000565755; MD/JM5/489 - INQ000565756; MD/JM5/490 - INQ000503940; MD/JM5/491 - INQ000565757)**. The guidance was published on 4 August 2021 and included details of the 16-week grace period, a summary of how the regulations applied to care homes and how providers could check and record an individual's vaccination status. A letter from the Department's Director of Adult Social Care Delivery and COVID-19 Response was sent to providers on 27 August 2021, urging them to encourage their workforce to get vaccinated, before VCOD came into force **(MD/JM5/492 - INQ000066763)**. This included advice to reach out to unvaccinated agency staff and ensure they were aware of the potential limitations on their future deployment. The letter also highlighted making use of the Vaccines Communications Toolkit for Adult Social Care, which contained resources that could be used in conversations with staff to help build their confidence in the vaccine. The

Department also hosted a webinar for 1,700 participants on 17 August 2021 and joined a webinar organised by the Care Provider Alliance on 27 August 2021.

541. On 1 September 2021 officials produced a submission summarising the work on VCOD. This explained that the Department was working with Skills for Care and ACAS to ensure that resources such as guidance and best practice were available to support providers and local authorities with capacity and workforce planning, recruitment and well-being **(MD/JM5/493 - INQ000608169)**. Officials had also delivered a programme of work to support vaccine uptake amongst adult care workers, working with national and local stakeholders, including care home managers and agencies. Regional assurance leads were in regular contact with local authorities to understand their situation and ensure they had support to encourage vaccine uptake. The submission also suggested a temporary exemptions process ahead of the permanent process being introduced at the end of September.

542. The VCOD communications plan of 1 September 2021 **(MD/JM5/494 - INQ000066781)** detailed further steps being taken to minimise impacts on the workforce. The Department then launched an extensive communications programme to encourage vaccine uptake in adult social care homes in November. This included:

    a. bespoke communications materials (posters, videos, leaflets, and shareable social media assets) shared across the Department's CARE App (a dedicated app for the adult social care workforce which had been launched in May), weekly newsletter, and adult social care and the Department's social channels;

    b. a paid advertising campaign targeting care workers with digital advertising to build vaccine confidence and encourage booking on the National Booking Service;

    c. the launch of the stakeholder toolkit updated on a weekly basis (this included frequently asked questions, guidance and communications materials);

    d. positive messaging using influencers, leaders and care home workers who had already been vaccinated to boost confidence and tackle misinformation; and

    e. letters to all older adult care homes in the bottom quartile of staff vaccination rate.

543. The Department also discussed workforce impacts from VCOD and mitigation via its Workforce Advisory Group. The Workforce Advisory Group was first established as a sub-group of the Adult Social Care Taskforce and is further explained in paragraph 407- above (workforce section).

Continued Monitoring of Vaccination Uptake and the Potential Impact of VCOD

544. Ahead of implementation of VCOD the Department very closely monitored the take up of vaccinations and the potential impact of VCOD on the sector. Vaccination uptake was monitored through the CT using first and second dose data **(MD/JM5/495 - INQ000111753)**. In October 2021, to enable additional monitoring of staff exempt from VCOD new fields were added to the Capacity Tracker covering: staff fully vaccinated abroad, staff with self-certified medical exemptions, staff with NHS COVID-19 pass medical exemptions and staff aged under 18.

545. Monitoring the data enabled the Department to gain a very clear picture of the numbers of workers not yet vaccinated, and the likely number who would be unvaccinated by 11 November 2021. To fully understand the potential impact of VCOD the Department also worked through the Regional Assurance Team to build an understanding of the situation at a local level, with the key question being how many care homes are at risk of having to close. They worked with local authorities to offer support in relation to ensuring contingency plans were in place to deal with workforce shortages, such as by redeploying staff from their own or other services or relocating residents in the event of service closures. Further details on the Regional Assurance Team are included in statement A.

546. During Autumn 2021 and in the run up to implementation of VCOD on 11 November, there was significant focus on VCOD in regular meetings between the Secretary of State and the Director General of Adult Social Care. The Director General prepared notes ahead of these meetings, and these detailed the numbers vaccinated and an update on the picture on the ground, based on departmental intelligence. On 15 September, this stated that "as things stand, 92% care workers in older people's homes and 89% care workers in under 65 care homes have had the first jab, and it looks as though approximately 38k workers will need to leave frontline work on 11th November. The situation on the ground may not be as bleak as this suggests because some of this group will be exempt on medical grounds, care homes may have been able to find replacements (either permanent or agency staff) or they may be able to manage it through under occupancy **(MD/JM5/496 - INQ000610084)**." The impact of VCOD was also contextualised in these notes, to provide detail of the wider workforce concerns at the time. Potential mitigations were explained,

including the introduction of a new fund to manage workforce capacity. This was ultimately introduced as the Workforce Recruitment and Retention Fund and explained further from paragraph 419 to 428 within this statement.

547. On 28 September 2021 the briefing stated that "we are still seeing an increase in staff taking up their 1st jab and a proportion of this number will be able to take advantage of the exemptions procedure, either because they are medically exempt or because they have been vaccinated abroad. We may not have comprehensive quality data on this before mid-October but we are gathering informal intelligence in the meantime. Also there will be some care homes that have plans to replace their unvaccinated staff or can do without them because of under-occupancy levels. In older-age care homes for example, occupancy is running at 77% compared to 83% before the pandemic. The key question is how many care homes are at risk of having to close because of this policy, which we would otherwise have liked to see continue operating. We can only tell this by speaking to each local authority in order to obtain a sense of the local picture and their plans to manage it **(MD/JM5/497 - INQ000610085)**".

548. On 6 October 2021, the Department sent a note to No10 with its assessment of adult social care workforce capacity risk and actions underway to address it. The Department was concerned with the size of the workforce shrinking and understood that this was likely due to a combination of factors. The note explained that "the sector historically experiences high rates of turnover (e.g. in 2019/20 annual staff turnover was 30.4%). It is likely that structural factors are contributing to high turnover. For example, most staff are on or just above National Living Wage, 1/3 are on zero hours contracts and c.1m jobs are care worker roles with relatively flat structures." In addition, a growing pay gap between social care and other comparable sectors of the economy, staff fatigue and the ongoing challenges the sector faced were at play. All these factors were concurrently happening at a time when VCOD was being introduced and changes to the economy were coming into effect, including the reopening of hospitality and retail sectors.

549. On 8 October 2021 the Director-General sent a note to the Secretary of State to provide an update on VCOD in care homes and the related workforce issues **(MD/JM5/498 - INQ000565760)**. The view at the time, was that VCOD risked exacerbating these workforce pressures, but "local authorities are telling us that the vaccine policy will not result in care home closures that would not have happened anyway and that pressures from staff leaving can be managed at least in the short term". There were concerns in particular local authorities and the plan was for the regional team to focus on supporting those areas. Local authority feedback continued to indicate that the greater workforce

pressure was in the homecare market which was not affected by VCOD at this time. In addition, "conversations with stakeholders broadly support the local authority insight". Although there was huge concern about workforce shortages generally, "one care home association lead described the "vaccine policy as a 'contributory factor' in care homes but no more."

550. On 26 October 2021, the Director General provided the following update to the Secretary of State "There is little movement on data on VCOD in care homes. The number of those who have not had their first jabs remains at around 30k and those who have not had their second jabs remains at over 60k. Exemption numbers are low (around 2k) - only 9% of care homes have provided exemption data and analysts are trying to establish whether the remainder are effectively nil returns or those who have yet to provide data. But it remains the case that all our intelligence suggests that the impact of VCOD in care homes is manageable at local system level and that wider workforce pressures are a much greater concern **(MD/JM5/499 - INQ000610086)**".

551. Progress was also reported via the Adult Social Care Situational Report (SitRep) **(MD/JM5/500 - INQ000565782; MD/JM5/501 - INQ000565785)**. On 5 November 2021, the SitRep stated that increased coverage was expected as the 11 November 2021 deadline was approaching, and that communications and operational plans may be revised if necessary, depending on data showing the progress of VCOD **(MD/JM5/502 - INQ000608159)**.

552. Progress was discussed and monitored at the Adult Social Care Vaccines Stakeholder Group (convened to coordinate the vaccine rollout with the NHS). At the meeting held on 10 November 2021, the progress of VCOD was discussed, including exemptions; if any care homes might be at risk of closure as a result of VCOD; and delays to updating vaccination records **(MD/JM5/503 - INQ000067399)**.

Additional Funding to Support Access to Vaccinations and to Alleviate Possible VCOD Pressures

553. On 30 September 2021, the Department provided £25 million specifically to support care workers to access COVID-19 and influenza vaccines as part of the third round of the ICTF. Further details on the ICF is included at paragraphs 174 to 176 (in IPC section).

554. On 21 October 2021, the Department announced a £162.5 million Workforce Retention and Recruitment Fund. This was intended to help the adult social care sector with

workforce pressures including those which resulted from the VCOD policy. The Workforce Recruitment Fund is fully explained at paragraphs 399 to 401 (workforce section).

Extending VCOD Across All CQC Regulated Settings

555. The strong feedback from social care stakeholders to the first consultation was that, if the rationale for introducing VCOD for care homes was to protect those most vulnerable to COVID-19, it should be extended more broadly to the health and wider social care sector. At a meeting on 15 June 2021, COVID-O had agreed with the Department's proposal to launch a consultation on extending the VCOD regulations to all CQC registered settings, and to flu **(MD/JM5/482 - INQ000092238)**. It was noted that the risk of outbreaks was much lower in other care settings than in care homes and that the workforce implications were likely to be greater.

556. The Department ran a public consultation from 9 September 2021 to 22 October 2021 regarding whether to make COVID-19 and flu vaccination a condition of deployment within all CQC registered settings **(MD/JM5/504 - INQ000480664)**. This consultation received 34,929 responses, which were carefully considered by the Department.

557. The consultation found that 65% of respondents did not support vaccination as a condition of deployment within all CQC registered settings **(MD/JM5/505 - INQ000257101)**. The main concerns raised during the consultation concerned workforce impacts, the proportionality and evidence for the policy and inequalities and impact on individuals and their rights. Several stakeholders from responding organisations reflected that there was a lack of consensus within their membership towards the policy. Some reported feeling split between their central objective to improve patient care or provide care and support to vulnerable individuals but recognising the policy would likely be divisive amongst the workforce and counterproductive if leading to retention challenges. However, all organisations supported the objective to maximise vaccination rates irrespective of their view of the policy.

558. The Secretary of State wrote to the Prime Minister on 28 October 2021 saying that, having carefully considered the response to consultation and advice from officials, his view was that VCOD across all CQC registered settings, and for flu, was essential as part of confidence in health and care services **(MD/JM5/506 - INQ000325343)**. COVID-O considered the issue on 9 November 2021. The paper stated that the basis for the policy was evidence that vaccination reduced the likelihood of infection and therefore helped break chains of transmission. The paper noted that the Department was recommending proceeding with VCOD in all CQC registered settings in relation to COVID-19 but not flu

(MD/JM5/507 - INQ000092154). The change to remove flu vaccination from the proposal between the letter to the Prime Minister and the COVID -O paper was explained as being due to 1) stakeholder concerns, 2) timing of the flu programme 3) stock availability and 4) provider accountability. The paper also noted the proposed scope of the policy; the proposed implementation date; and risks around workforce and potential mitigations.

Engaging Stakeholders for Extending VCOD Across All CQC Regulated Settings

559. Further stakeholder engagement was conducted on extending VCOD to all CQC regulated settings. This engagement was done through webinars, direct discussions with stakeholders, including providers and sector actors, and through an engagement session with local authorities. Throughout December 2021, the Department held engagement sessions with care homes, homecare, assisted living (extra-care housing) and local authorities, in order to learn lessons from the policy in care homes and to try to work towards smooth implementation of the extension to all CQC regulated settings **(MD/JM5/508 - INQ000565763; MD/JM5/509 - INQ000565764; MD/JM5/510 - INQ000565765; MD/JM5/511 - INQ000565766)**.

Public Sector Equality Duty and Equality Impact Assessment for Extending VCOD

560. The EIA for the extension of VCOD to all CQC registered settings was published on 9 November 2021 **(MD/JM5/512 - INQ000092156)**. It included analysis, as of 4 November 2021, showing that the average uptake of vaccination by NHS staff was at 92.9% for the first dose and 89.9% for the second dose. The document noted that while these headline figures for uptake were high, they masked significant variations in uptake across organisations and hospital trusts. In adult social care, 83.7% of homecare staff had received one dose of the vaccine and 74.6% had had a second dose.

561. The EIA reported that that the effects of the policy could be significant, as it could lead to the redeployment or dismissal of staff working in health and social care settings who refused to be vaccinated or result in these workers feeling pressured to have vaccinations when they would not have done otherwise. However, it would have a positive impact on service users, predominantly vulnerable individuals, as it would provide them with greater levels of protection. The EIA noted that, in the case of disability, and pregnancy and maternity, the impacts were centred on access and medical exemptions to the vaccine. However, VCOD might also have a significant benefit for them by potentially reducing the transmission of COVID-19 within the workplace.

562. Overall, the EIA noted that there were multiple groups with protected characteristics who might be disadvantaged by VCOD in all CQC regulated settings, either through redeployment or dismissal. However, it stated that "this must be balanced against the public health benefits of maximising vaccine uptake in the health and care workforces, and the benefits this will bring, specifically to elderly and vulnerable people who face a high risk of serious complications from COVID-19."

563. The Government laid regulations to amend the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations to introduce COVID-19 vaccination as a condition of deployment across all CQC regulated settings. The regulations were approved by Parliament on 14 December 2021 and made on 6 January 2022. A 12-week grace period was imposed to allow time for providers to engage with their staff and the plan was that regulations would not come into force until 1 April 2022.

Revoking Vaccination as a Condition of Deployment

564. This initial decision to extend VCOD was kept under review and, in the event, the revised policy was not pursued due to the changing evidence available to Government. When VCOD was first introduced in care homes, it was supported by the clinical evidence and based on the severity of the dominant variant of COVID-19, the Delta variant. The changes in the pandemic as a result of the emergence of the Omicron variant of COVID-19, which was intrinsically less severe, as well as the continued success of the vaccination programme, with many more people protected, meant that the balance of costs and benefits needed to be reconsidered.

565. On 20 January 2022, preliminary evidence from UKHSA was considered by the Secretary of State showing that the effectiveness of all vaccines against symptomatic infection was lower in all periods against the Omicron variant, compared to the Delta variant and waned rapidly. Vaccine efficacy against mild disease with Omicron largely disappeared by 20 weeks after 2 doses. The preliminary data therefore showed that after a relatively short time, a full primary course of an approved vaccine no longer provided the intended longer-term public health protection against the spread of COVID-19. The Secretary of State concluded that it was no longer proportionate to require VCOD in care homes and all other health and care settings, and that all VCOD regulations should be revoked, subject to consultation. The consultation ran between 9 and 16 February 2022, with 90% respondents supporting the revocation of VCOD. The outcomes report said that it was right that the Government responded to the changing landscape of the pandemic and highlighted that the intended benefits of the policy must be balanced against the existing

and predicted impacts, including workforce capacity. In relation to this latest scientific evidence and having considered the views received as part of the consultation, as well as an analysis of equalities impacts, the Government decided to bring forward regulations to revoke VCOD. Regulations to revoke VCOD were made 1 March 2022, taking effect from 15 March 2022 **(MD/JM5/513 - INQ000325344; MD/JM5/514 - INQ000091599)**.

566. Notwithstanding the revocation of VCOD, the Department continued to take steps to increase vaccine uptake amongst the NHS and social care workforce, as well as the wider public.

The Impact of VCOD on the Workforce

567. Following the introduction of VCOD in care homes on 11 November 2021, the Secretary of State asked for information on the known impact of it. In a VCOD Impact Analysis note to the Secretary of State on 25 January 2022, it was explained that "on the basis of information we currently collect, it is not possible to make direct causal links between staff leaving the workforce and VCOD" **(MD/JM5/515 - INQ000565770)**. The note went on to explain that "We use the Capacity Tracker to monitor the adult social care sector. This enables us to track live employee numbers and therefore the net change in staff employed over time. However, we do not systematically collect data on the reasons why or how many people leave the sector." and "Because Adult Social Care workforce data is not collected at an individual level, unlike the NHS Electronic Staff Record (ESR), we cannot definitively say how many staff have left the workforce using the data available to us." The note said that, whilst the VCOD Impact Assessment estimated that "around 37,000 additional staff might leave the care home workforce as a result of implementing VCOD", in practice, "the size of the care home workforce has reduced by far less than estimated since the regulations were introduced" and "Capacity Tracker data shows that the size of the workforce fell by 19,300 between July and December 2021". Finally, the note said that "In a survey of providers in Autumn 2021, only one in seven care home providers quoted "do not wish to be vaccinated" as the main reason for staff leaving".

568. The Cabinet Office conducted a rapid research activity on the impact of VCOD for all CQC registered care homes on social providers and the workforce in December 2021, to inform the then anticipated implementation of VCOD for all CQC registered settings. Specifically, it considered experiences around all CQC registered care homes, the approach of sector organisations and views regarding implementing VCOD and perspectives on central government's approach to implementation. The researchers conducted interviews with

ten Care Associations, eight individual Care Home Managers, ran a group session with seven Care Associations/providers and spoke to three other leading sector organisations.

569. The interviews with Care Associations and care home providers indicated that the disparity in the timing of VCOD for all CQC registered care homes had caused distrust in the care home sector and led to some staff moving to the wider health sector, with more attractive packages and benefits. Five care homes reported they had had staff leave their posts due to VCOD, however there could be many different factors leading to staff leaving their posts. The research found that many chose alternative career paths with less responsibility but more pay, such as retail or hospitality. The report found that Care Associations believed VCOD for all CQC registered care homes was effective overall in achieving increased vaccination rates but that the guidance could have been clearer and easier to interpret and been timelier, while they had also found the exemptions policy and process confusing. Providers felt that targeted local approaches were key to increasing uptake, alongside minimising barriers for a busy/tired workforce.

Adult Social Care Vaccine Booster Taskforce

570. The Department used all possible levers to drive the uptake of vaccine boosters. On 6 January 2022, the Department set up the Adult Social Care Vaccine Boosters Taskforce (the Vaccine Boosters Taskforce), chaired by Sir David Pearson, to drive the uptake of boosters across the sector **(MD/JM5/516 - INQ000257243; MD/JM5/517 - INQ000257241)**. This brought together senior representatives from the NHSEI Vaccination Programme, the Department's Adult Social Care Vaccines team, LGA, ADASS, provider representatives, ICS representatives and communications colleagues, to share best practice and drive the uptake of influenza and booster vaccines by adult social care staff and recipients of care. The Vaccine Boosters Taskforce met for the final time on 24 February 2022, having met initially twice a week and then weekly. The consensus view of Sir David Pearson, Dame Dr Emily Lawson (National Director Vaccine Deployment at NHSE/I) and Michelle Dyson was that the work of the Vaccine Boosters Taskforce should come to an end at the end of February 2022 **(MD/JM5/518 - INQ000068013)**. This culminated in a report to ministers setting out the work the Taskforce had completed, its successes, and recommendations for future vaccines work. The consensus to end the work of the Vaccine Boosters Taskforce was on the basis that it had fulfilled its aim to bring a focus to booster data, communications and operations; and that beyond this, any returns or value would diminish. The report states that by the end of February 2022, 88% of all care home residents were reported to have received a

booster. This was an increase of 4 percentage points from December 2021 **(MD/JM5/519 - INQ000287747)**.

CARE ACT MODIFICATIONS

571. Section 15 of The Coronavirus Act 2020 (the Coronavirus Act) modified the statutory obligations on local authorities under the Care Act, allowing them to streamline assessment arrangements to prioritise care so that the most urgent and acute needs were met. Whilst these measures were formally known as modifications to statutory duties under the Care Act, officials in the Department and others in the adult social care system often referred to them as "Care Act easements".

Rationale for the Modifications

572. The overarching objective of the Coronavirus Act was to enable the Government and public services to respond to and manage the effects of the COVID-19 pandemic. It was expected that a severe pandemic would lead to a reduced workforce and increased pressure on health services and death management processes.

573. In 2018, the Department had produced a paper that set out the key options and considerations to support and augment the community health care and adult social care sectors' response to an extreme influenza pandemic **(MD/JM5/520 - INQ000057494)**. In February 2020, this initial planning was reconsidered with reference to COVID-19. Officials worked with the Chief Social Worker (CSW) and discussed planning with stakeholders. At a meeting on 11 February 2020 the Permanent Secretary confirmed that the default position should be that any emergency powers that might be deemed necessary, including the possibility of relaxing duties under the Care Act in anticipation of an RWCS, should be included in the draft Coronavirus Bill **(MD/JM5/521 - INQ000049363)**. He also asked for an ethical framework to be produced, which is explained fully in Statement D of this Module.

574. On 12 February 2020, a submission was sent to the Minister of State for Care, explaining that "*early rapid work on the implications of the RWCS for ASC had identified the possible need for a number of extra measures*" to be included in the Coronavirus Bill. The submission explained that, in a RWCS, the Department anticipated a rapid increase in demand for care, at the same time as a significant reduction in capacity in the system, due to workforce shortages. In such circumstances, local authorities would be likely to struggle to discharge their duties under the Care Act to assess care needs and provide services for those who are eligible. If local authorities needed to prioritise, then permissive

powers or flexibilities in existing duties on local authorities under the Care Act might be needed **(MD/JM5/522 - INQ000049364)**. At the time the President of ADASS communicated their organisation's support of this approach to Ros Roughton, former Director General Adult Social Care **(MD/JM5/523 - INQ000565693)**. To support local authorities to meet the most urgent and acute needs, the Government proceeded with provisions in the Coronavirus Bill.

575. Officials advised the Minister of State for Care in a submission on 16 March 2020 **(MD/JM5/524 - INQ000565699; MD/JM5/525 - INQ000565702)** that:

> *"Local Authorities' duties under the Care Act 2014 are incredibly important, and we know that Local Authorities and providers will do everything they can to continue to meet all needs in line with the Care Act. However, in the event of the peak, they may need to be able to focus their resources on meeting the most urgent needs and prioritising accordingly, even if this means not meeting some of their duties. These measures make it possible for Local Authorities to do this*."

576. That submission included ten case studies of how the easements might be used in practice. Three of these case studies were:

a. *A small unitary authority receives up to 200 new assessment referrals each week. With 20% of its staff unavailable, this temporary change to legislation eases pressure on assessments and enables professionals to put in services quicker for those most in need.*

b. *The financial assessment team and social work team are 20% staff reduced. Financial assessments will not need to be completed under the temporary change to legislation, reducing pressure and freeing up those staff who are well to support in other areas. People who need services quickly will not have to complete the financial assessment forms, easing stress on individuals*

c. *The social work team have to urgently recommend residential care or home care support for those who require it. The easements mean care plans can be produced quicker and without normal processes and formats. Current Care Act legislation provides a duty on Local Authorities to provide care and support plans for all, even if not eligible for services. This temporary legislation will support more people, and much quicker. It will also enable capacity within the workforce.*

577. The proposed modifications were in addition to already existing flexibilities. The Care Act and Statutory Guidance allow some flexibilities for local authorities in how they meet needs while still complying with their legal duties. Section 19(3) of the Care Act gives local authorities a power to meet urgent needs without assessment, allowing for some prioritisation, but they must continue to meet all eligible needs **(MD/JM5/526 - INQ000608171)**. These flexibilities lie within four main areas; how an individual's support is delivered, how individual needs are assessed and reviewed, the time it takes to change individual support plans, and an understanding that Local Authorities will not be able to discharge their wider duties during pressured periods.

Care Act Modifications Provisions

578. The key changes, outlined fully in the Care Act modifications guidance document explained at paragraph 592 below were:

a. Local authorities would still be required to assess what care a person needed but these assessments would no longer need to be detailed;
b. Local authorities would not have to carry out financial assessments and they would have the power to charge people retrospectively for the care and support they received during this period;
c. Local authorities would not have to prepare or review care and support plans; and
d. Local authorities would still be expected to take all reasonable steps to continue to meet care and support needs but, in the event that they were unable to do so, they were allowed to prioritise the most pressing needs and temporarily delay or reduce other care provision.

579. The modifications were time-limited and intended to be used as narrowly as possible. A local authority could only exercise them when the workforce was significantly depleted or demand on social care had increased to an extent that it was "*no longer reasonably practicable for it to comply*" with the usual Care Act duties, and where to do so was "*likely to result in urgent or acute needs not being met, potentially risking life*" **(MD/JM5/527 - INQ000327802)**.

580. If the impact of the pandemic meant a local authority was considering utilising a Care Act modification, the relevant local officials first had to consult the Principal Social Worker and, as far as possible, set out the following:

a. the reason the decision needs to be taken and steps taken to mitigate the need to use the Care Act modifications;
b. the impact of the decision on the people who ordinarily use the service;
c. the impact of the decision on families and carers of people who ordinarily use the service; and, potentially,
d. the possible alternative sources of care and support and the likelihood of this being available.

581. Once the Principal Social Worker was satisfied that the Care Act modifications needed to be enacted, a final decision was required by the local authority Management Board, which should have been informed by engagement with local NHS Leadership. If a local authority decided it needed to prioritise care services, an emergency decision meeting between the Principal Social Worker and DASS took place to discuss how to prioritise care across adult social care services. Sufficient care and support were to remain in place at all times. Local Authorities had to inform the Department using the 'Care Act easements notification form' once a decision had been made. Any decisions taken to prioritise or reduce support had to be reviewed every two weeks, with the aim of restoring full services as soon as reasonably possible.

582. The Coronavirus Act received Royal Assent on 25 March 2020 and the Care Act modifications took effect from 31 March 2020.

Consultation and Stakeholder Engagement

583. Officials advised the Minister of State for Care in the submission of 16 March 2020 **(MD/JM5/524 - INQ000565699)** that the modifications were expected to be contentious.

> "*While the reasoning is entirely sound, an argument that we are allowing Local Authorities to do less than currently expected because the alternative is worse and less efficient is not easy to get across. We expect care user groups to be understandably concerned. Careful handling ahead of introduction, including explanation to influential partners and user representatives will be critical.*"

584. Accordingly, the Department consulted a broad range of stakeholders regarding both the introduction of the Care Act modifications and the accompanying guidance. Senior sector partners on the NACG – ADASS, LGA, CQC, provider bodies – supported the proposals and were willing to support the Department with Parliamentary, public, and sector handling **(MD/JM5/528 - INQ000565694; MD/JM5/529 - INQ000565696; MD/JM5/530 - INQ000565695)**.

585. The Department engaged in particular with the Think Local Act Personal (TLAP) network, a government-funded group of individuals and organisations working to make care and support more personalised, and of which the Department is a member. Other members include the NHS, local government, carers, providers and community organisations.

586. On 17 March 2020, TLAP recommended that the modifications should be reviewed at regular intervals to avoid them being kept in force for longer than strictly necessary and to avoid short-term decisions leading to permanent arrangements **(MD/JM5/531 - INQ000565703)**. It highlighted that the spread and impact of COVID-19 might be uneven and so "*a graduated response by area might work better, although we appreciate the need to avoid over complicating arrangements.*"

587. The Department also engaged with stakeholders on the guidance for local authorities on using the modifications. This guidance was developed rapidly, so that it could be published on the same day as the modifications commenced.

588. The Department established a Task and Finish group to deal with issues relating to the modifications, with representatives from the NACG amongst others. As set out in statement A of this Module, the NACG was convened on 6 March 2020 to advise on the action to be taken nationally to support local authorities and providers to respond to the pandemic, act as a conduit for communications from the sector into Government and vice versa, and provide specialist expertise as necessary. The Task and Finish Group drafted early sections of the guidance and commented on several drafts.

589. Once brought together, the group worked collaboratively and at pace to ensure concerns raised by stakeholders, such as managing risks to providers and adult social care users, were sufficiently addressed and covered in the draft guidance. As part of this, there was significant input from the CSW, with the guidance referring to, and drawing on, the Ethical Framework, which was published on 19 March 2020, and is explained in more detail in Statement D of this Module.

590. In a submission, dated 27 March 2020, officials sent the draft guidance to the Minister of State for Care **(MD/JM5/532 - INQ000327791)**. The submission explained "*There is still real concern among user / carer groups that this is an excuse to strip back an already limited care service. We have made clear in the guidance that the easements will be 'switched off' when appropriate after the emergency period.*"

591. In the submission, officials proposed that the guidance should state that local authorities should notify the Department when they decided to use the modifications and explain why

the decision had been taken. It was also explained that NACG supported this approach and that this guidance had been produced with a group of representatives from user and carer organisations and that stakeholder engagement would be ongoing.

592. The guidance, '*Coronavirus: Changes to the Care Act 2014*' was published on 31 March 2020. Following publication, the guidance was discussed at a NACG meeting on 1 April 2020 **(MD/JM5/533 - INQ000565712)** which outlined the next steps following publication:

    a. That the CSW would work to support Principal Social Workers [the lead social workers in each LA] to understand the guidance.

    b. That the focus should now move to measuring and monitoring the impact of the guidance. It was confirmed that TLAP and CQC were leading this work, and that it was already underway.

Implementation of the Care Act Modifications

593. In a submission dated 18 May 2020, officials provided the Minister of State for Care with an update on the Care Act modifications. Officials reported that six local authorities, all in the West Midlands area, were applying the modifications, with a further two having stopped using them. The Department's initial assessment suggested that the local authorities operating under the Care Act modifications as of 15 March 2020 had followed the guidance and the local authorities stated that they had not received complaints from local stakeholders. Two local authorities reported that local residents and service users "had been complimentary about the response."

594. The submission said that the CSWs had met with six of the Principal Social Workers (PSWs) of the local authorities using the modifications, and corresponded with a seventh, to ensure that the correct processes had been followed. Officials provided an update on the discussions between the CSWs and PSWs and told the Minister of State for Care that the Department needed to balance "ensuring we can account for the use of the easements nationally, and not scrutinising the local authorities as though they have taken poor actions. The Coronavirus Act introduced easements as a positive option for local authorities." Officials proposed three options to support ongoing monitoring of the use of the modifications **(MD/JM5/534 - INQ000327904)**:

    a. continue to rely solely on the findings from the conversations between the CSWs and PSWs which provided an anonymous snapshot of why the LAs were using the modifications;

b. have the CSWs build on their initial conversations with PSWs or commission a learning review;

c. facilitate a meeting between the Minister of State for Care and the DASSs of local authorities operating under the modifications. This option also recommended asking the Association of Directors of Adult Social Services (ADASS) to form a view on the reasons why the six local authorities using the modifications were all located in the West Midlands area.

595. In a further submission, dated 25 June 2020, it was recorded that the Minister of State for Care had agreed to use ADASS, TLAP, and the CSWs to understand the use of modifications, and review the guidance through a CSW-led review process using information already available to the Department. In the submission, officials reported that eight local authorities had used modifications and, as of 24 June 2020, only Solihull Metropolitan Borough Council was still doing so. Officials stated that this was "*testament to the progress made overall in addressing COVID-19 in the care sector, and the commitment of local authorities to providing the best care and support to their residents under the Care Act*". Officials told the Minister of State for Care that, as CSWs had good oversight of Solihull and it had an exit plan in place, monitoring of the overall system should remain light touch and efforts should be focussed on a lessons learned exercise **(MD/JM5/535 - INQ000327933)**.

596. Officials recommended in a submission dated 12 November 2020 **(MD/JM5/536 - INQ000565723)** that the powers in the Coronavirus Act should be retained in the light of the national restrictions which had taken effect on 5 November 2020. They also recommended a communications plan should be developed to allay concerns among people with care and support needs, and to provide support to local authorities who might need to use the powers but felt anxious that they would not be supported in the event of challenges to their decision. The Minister of State for Care agreed both recommendations.

597. Officials reported on 6 January 2021 **(MD/JM5/537 - INQ000565730; MD/JM5/538 - INQ000565730)** that no LAs had used the modifications since 29 June 2020. However, officials told the Minister for Social Care that ongoing pressure on the workforce, including capacity, burnout and sickness, could trigger some local authorities to use them in the following few weeks and therefore recommended keeping the legislation in place. The submission also stated that, using evidence from TLAP, ADASS and other stakeholders, officials had not found evidence of any negative impact on individuals. There was,

however, a communications issue as some people thought that changes to their care were due to modifications, even in areas which were not using them.

Withdrawal of Care Act Modifications

598. In a submission dated 2 March 2021 **(MD/JM5/539 - INQ000110791)**, it was recommended that the powers introduced in Section 15 and Schedule 12 of the Coronavirus Act were withdrawn. Officials reported, following engagement with the Department's Regional Assurance Team and external stakeholders, that there was strong support for withdrawal of the Care Act modifications from stakeholders and groups representing people who needed care and support. CSWs advised that:

> "*There is strong reluctance to use easements among LAs and they have managed significant pressures without their use since last June. Local planning and wider support systems have developed significantly since the easements were first devised in response to an emerging and unprecedented situation. While some stakeholders have said that COVID-19 presents an ongoing risk and favour suspension as a cautionary approach, on balance, CSWs have noted the anxiety the provision has caused among people who need care and support, the strength of their view that they should be withdrawn and the ongoing challenge of communicating the purpose of the easements and how they should be used. For these reasons the CSWs recommend that the provision for easements should be withdrawn.*"

599. The CSWs advice drew, in part, on an informal online survey distributed in February 2021 to the PSW Network and to TLAP's Self-Directed Support Group which consisted of user groups and carers. The survey asked for views on barriers or challenges with keeping, suspending or withdrawing the 'easements' and any wider suggestions or comments. 31 responses were received from PSWs and 33 responses from TLAP's Group. At the time, the CSWs also requested advice from LGA and ADASS on the need to retain the modifications provision **(MD/JM5/540 - INQ000565783; MD/JM5/541 - INQ000565784)**.

600. The one-year debate on the temporary provisions in the Coronavirus Act took place on Thursday 25 March 2021, and regulations to expire the Care Act modifications provision were laid on 21 April 2021 using the draft affirmative procedure.

601. The CSWs wrote to DASSs and PSWs on 28 April 2021 to communicate expiry of the Care Act modifications provision in the Coronavirus Act. The letter set out that the Ethical

Framework remained in place to continue to support local response planning and decision making during the pandemic **(MD/JM5/542 - INQ000608165)**.

Impact of Care Act Modifications

602. In addition to the ongoing work of the CSWs and the Department's Regional Assurance Team, as explained at paragraph 598 to 601 above, it was agreed that CQC and TLAP would lead work to measure and monitor the impact of the guidance. TLAP set up the TLAP Insight Group (TIG) to collate findings on the experience and impact on people accessing care and support, and unpaid carers, during the first phase of the pandemic. In a rapid evidence review published in October 2020 **(MD/JM5/543 - INQ000509867)**, TIG reported that it was not possible to establish a comprehensive picture of the impact of modifications, known then as the Care Act Easements (CAE), stating that:

> *"Eight local authorities introduced CAE but in different ways over different timeframes, and not all across the whole of adult social care […] Some introduced focussed, streamlined assessments and support planning or suspended reviews. Others adapted particular areas of service, for example deploying staff to different workstreams, depending on specific capacity gaps or pressures.*
>
> *Furthermore, feedback from work with Directors of Adult Social Services undertaken through the auspices of the TIG suggested that certain changes introduced by CAE councils were not noticeably different to the changes introduced by councils that did not introduce easements. This created a very grey line between CAE implementation and other local authority responses to Covid-19. There was some sense that CAE councils were unduly susceptible to criticism for triggering CAE when their actual practice was not substantially different to non-CAE councils. Indeed, Healthwatch also noted that some of the councils that enacted easements seemed to do so in preparation of potential capacity issues, which then didn't always materialise."*

603. TIG also noted that there was little data looking at the specific impacts of the modifications on people who accessed care and support, but the available data *"highlighted the difficulties of attributing change to CAE directly, as opposed to the wider impact of Covid-19*". However, the report found concern over how decisions to use modifications were communicated locally whilst those councils using them felt singled out for criticism.

604. A report on the "Impact of Care Act Easements under the Coronavirus Act 2020 on co-resident older carers of partners with dementia" was commissioned by the National Institute for Heath and Care Research (NIHR), which is funded by the Department. The

findings were published by the University of Manchester in November 2022 **(MD/JM5/544 - INQ000492905)**. The project investigated the impacts of Care Act easements on older carers of people living with dementia at home to make recommendations about the operation of this legislation now and in the event of another wave or similar pandemic. The report found that carers and the family members they were supporting "*experienced significant changes from their usual care and support, which in many cases resulted in lower wellbeing and unmet need*". The report also set out that:

> *"Although the experiences were similar across the local authority areas in this study, easements were differentially implemented, soon revoked, and not in force for any local authority beyond July 2020. There appears to have been little consequence – whether political, legal, or regulatory – for local authorities that did not invoke easements. However, for the local authorities that did, there was considerable pressure from lawyers, NGOs, lobby groups and adverse media attention."*

605. In October 2020, ADASS published a report that outlined "Themes and Learning from ADASS Members on the Local Response to COVID-19 in Spring and Early Summer 2020." The report found that Local Authorities were operating with easements in very limited ways such as: using streamlined templates for assessments, conducting assessments in a virtual capacity, and postponing and rescheduling reviews to a later date. These actions would have fallen within scope of the existing Care Act flexibilities and therefore local authorities not using easements were not disadvantaged **(MD/JM5/545 - INQ000103777)**.

Reconsideration in Response to Omicron

606. In December 2021, following the emergence of the Omicron variant, the Department considered measures to support local authorities to manage Omicron-related constraints, including the reintroduction of Care Act modifications for adult social care. As the provision had been expired in March 2021, the Department sought views from key stakeholders on whether reintroduction (via new legislation) would be necessary. Whilst there were some calls for the reintroduction of modifications to allow local authorities some flexibility in meeting their statutory responsibilities without the risk of legal challenge, engagement with DASSs, led by LGA and ADASS, found there was limited enthusiasm, because they found the previous process too rigid and bureaucratic. It was noted that local authorities were better prepared to manage pressures than at the start of the pandemic, using existing flexibilities in the Care Act, so were unlikely to rely on modifications. Additionally,

modifications were unlikely to be introduced quickly enough to have an impact on the immediate crisis, as even a rapid bill was likely to take at least two months.

607. A submission to the Secretary of State on 22 December 2021 advised that, taking into consideration feedback from stakeholders, the previous use of the modifications and the context of the crisis at the time, reintroducing modifications would not be appropriate or helpful to manage the situation. Instead, it was recommended that the department write to local authority leaders, via the CSWs, directing them to use existing Care Act flexibilities where necessary to assess, review and prioritise services while still fulfilling statutory duties **(MD/JM5/526 - INQ000608171)**.

608. The letter, sent on 29 December 2021, made clear that where these flexibilities are used, local authorities should be satisfied that the action is an appropriate, proportionate, and effective way of meeting needs and care must be taken to ensure that the process is person-centred. Local authorities were also directed to use the Ethical Framework that was published in response to the pandemic, which provides a checklist for local authorities when considering decision-making and policy responses to COVID-19 **(MD/JM5/546 - INQ000608173)**.

609. Though this approach would not provide local authorities with the same level of legal certainty as the Care Act modifications, it was considered to be the most appropriate approach given the context. The fact that local authorities would be expected to seek their own legal advice as usual regarding any specific measures to ensure they continued to comply with their legal obligations, including those under the Care Act 2014.

610. As the Department made clear at the time, modifications to the Care Act were a backstop: they were deliberately time-limited and intended to be used as narrowly as possible. The fact that they were not used to a significant degree is not an indication that they were unnecessary. In the event of a future pandemic or emergency, it would be appropriate for the Department to consider using them again, but whether it would implement such modifications would depend on the nature of the issue and the anticipated impact on the provision of adult social care.

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION ('DNACPR')

611. The following section sets out the Department's understanding of and involvement in the issue of potentially inappropriate use of DNACPR orders and decisions around their use during the relevant period. This section also provides information related to DNACPR notices for COVID-19 patients, including the development of policy and guidance, and

actions taken by the Department and relevant stakeholders, in response to concerns within the social care sector. It should be understood that the Department can provide an understanding of DNACPR processes, but NHSE would be best placed to provide a comprehensive answer.

612. A DNACPR decision is an instruction not to attempt cardiopulmonary resuscitation (CPR). DNACPRs are designed to protect people from the unnecessary suffering of receiving CPR that they do not want, that may not work or where the harm outweighs the benefits **(MD/JM5/547 - INQ000235491)**.

613. The Department did not receive evidence of inappropriate and blanket use of DNACPRs. However, from early April 2020, the Department was made aware that allegations of instances of inappropriate use of DNACPR procedures had been made **(MD/JM5/548 - INQ000381137; MD/JM5/549 - INQ000381138; MD/JM5/550 - INQ000381139; MD/JM5/551 - INQ000381140)**. Around the same time, guidance was circulated within the sector by other stakeholders **(MD/JM5/552 - INQ000565698; MD/JM5/553 - INQ000089652)**.

Concerns Over Blanket Application and Misuse

614. This subsection sets out a chronology of when the Department became aware of concerns from stakeholders regarding the potential blanket applications or misuse of DNACPRs; the Department's response; and action taken.

615. On 30 March 2020, the CQC, the British Medical Association (BMA), the CPA and the Royal College of General Practitioners (RCGP) wrote to adult social care providers and GP practices with a joint statement on the importance of Advance Care Planning stating that DNACPRs should not be applied to groups of people, and should continue to be made on an individual basis according to need **(MD/JM5/554 - INQ000192689)**. The Department became aware of this communication on the day it was circulated to the sector **(MD/JM5/555 - INQ000565705)**.

616. On 3 April 2020, a meeting of the Learning Disability and Autism COVID-19 Task and Finish Group took place, which Departmental officials attended. The NHSE representative at the meeting raised growing concerns regarding clinical decision making and inappropriate use of DNACPRs **(MD/JM5/556 - INQ000049998)**.

617. On the same day, 3 April 2020, the National Director for Mental Health, the National Clinical Director for Learning Disability and Autism, and the Medical Director for Primary Care from NHSE wrote to all Acute Trusts chief executives, Community Trust chief

executives and to Primary Care contacts about this same issue. The letter reiterated the same position as above, and emphasised that it was imperative that decisions regarding the treatment of people with learning disabilities and/or autism were made on an individual basis **(MD/JM5/557 - INQ000216427)**. On 4 April 2020, officials from the Department engaged with the CSW for Adults and shared the letters above so they could be circulated across social worker networks to raise awareness of the points, along with supplementary information from NHSE for people with disabilities **(MD/JM5/558 - INQ000565709; MD/JM5/559 - INQ000565708; MD/JM5/560 - INQ000565707)**.

618. On 7 April 2020, NHSE's Chief Nursing Officer, Ruth May, wrote to all NHS Trusts, CCGs, GP practices, primary care networks and community health providers reiterating the same message **(MD/JM5/561 - INQ000192705)**.

619. On 11 April 2020, the Department received email correspondence from the Registered Nursing Home Association. The email set out concerns that there was a perception that care home residents with COVID-19 symptoms should 'automatically' be deemed palliative (i.e. receiving care to treat the symptoms of an incurable medical condition) **(MD/JM5/562 - INQ000565710)**, which the Registered Nursing Home Association likened to the concerns regarding blanket DNACPRs.

620. On 15 April 2020, the Department published its 'Coronavirus (COVID-19): adult social care action plan' (Action Plan), which was cleared by Number 10 **(MD/JM5/75 - INQ000325315)**. The paper stated that it was "unacceptable for advance care plans, including DNACPRs, to be applied in a blanket fashion to any group of people.". It also set out that personalised decision making should be accompanied by the necessary legal support.

621. On 29 April 2020, a pre-action protocol letter was issued to the Department regarding the lack of emergency national directions on DNACPR decisions **(MD/JM5/563 - INQ000339300)**. Pre-action protocols set out what must be done before court proceedings are issued for particular types of civil claims.

622. On 20 May 2020, in the Department's fortnightly meeting between the Minister of State for Care and officials from the Learning Disabilities and Autism team, officials set out that the reporting of potentially inappropriate DNACPRs that increased at the start of the pandemic was now returning to a pre-pandemic level. Where instances of inappropriate use had been made, these were resolved and relevant support was made available to families **(MD/JM5/564 - INQ000565714)**.

623. On 20 May 2020, following discussions with leading figures from the disabled rights movements, voluntary sector organisations and specialist clinical directors, NHSE issued a joint statement with Baroness Campbell of Surbiton, DBE, which restated that blanket application of DNACPRs "is totally unacceptable and must not happen" **(MD/JM5/565 - INQ000339275)**.

624. In September 2020, the Minister of State for Care, requested a submission on action being taken on the inappropriate use of DNACPRs **(MD/JM5/566 - INQ000058389)**. The submission identified the difficulties in being able to determine the scale of the problem. NHSEI at the time advised that they were not in a position to comment on individual cases or to access individual patient records. Furthermore, to assess whether a DNACPR was inappropriate or not, there would need to be a clinical assessment of the individual patient's situation, the nature of the discussion, who was involved and how a decision was arrived at and communicated. The submission also set out plans to prevent inappropriate DNACPRs through:

    a. Revised guidance to be published by NHSEI;

    b. Communications with stakeholders;

    c. The Adult Social Care Winter Plan 2020/2021 which reinforced the guidance;

    d. And pointing to powers available to the CQC to raise instances of inappropriate use of DNACPR with relevant bodies, including professional regulators and to take action where registered providers are responsible.

625. In March 2021, NHSEI wrote to all CCGs, Trusts, and primary care leads to reiterate the position that people should not have a DNACPR on their record just because they have a learning disability, autism, or both **(MD/JM5/567 - INQ000339282)**. On 10 March 2021, NHSEI published public-facing guidance on DNACPR decisions on NHS.UK **(MD/JM5/568 - INQ000339118)**. NHSE's 2020/2021 General Medical Services contract Quality and Outcomes Framework (QOF) guidance also included a requirement for all DNACPR decisions for people with learning disabilities to be reviewed **(MD/JM5/569 - INQ000339326)**.

CQC Reports

626. An Oral Parliamentary Question was tabled for 1 October 2020 in the House of Lords to address the question of what assessment had been made of the use of DNACPRs at hospitals and nursing homes since March 2020 **(MD/JM5/570 - INQ000339273)**. In the debate, Lord Bethell informed the House that the Minister for Patient Safety and Mental

Health would be writing to the CQC requesting that it investigate and report on DNACPR issues **(MD/JM5/571 - INQ000339272)**.

627. On 7 October 2020, the Department commissioned the CQC, under the instruction of Nadine Dorries, the Minister for Patient Safety, Suicide Prevention and Mental Health, to conduct a special review, under s48 of the Health and Social Care Act 2008, of DNACPR decisions during the COVID-19 pandemic. The purpose of the review was to identify factors that had impacted DNACPR decision making at the beginning of the pandemic, and to ensure that best practice guidance had been applied. A key part of the review was to analyse the implementation of best practice DNACPR guidance in organisations across the sector, care homes, primary care and hospitals **(MD/JM5/572 - INQ000235490)**.

628. The review was split into two parts. An interim report named 'Review of Do Not Attempt Cardiopulmonary Resuscitation decisions during the COVID-19 pandemic: interim report' was published on the CQC website on 3 December 2020 **(MD/JM5/547 - INQ000235491)**. A final report named 'Protect, respect, connect: Decisions about living and dying well during COVID-19' was published on 18 March 2021 on the same platform.

629. The interim report identified the following key findings:

    a. There was confusion and miscommunication about the application of DNACPRs at the start of the pandemic, and a sense of care providers being overwhelmed;

    b. There was evidence of unacceptable and inappropriate DNACPRs being made at the start of the pandemic;

    c. There was a quick response from multiple agencies to highlight the issue. There were differing views on the extent to which people were then (i.e., in November 2020) experiencing positive person-centred care and support in relation to the issue; and

    d. It was possible that in some cases inappropriate DNACPRs remained in place.

630. The final report in the CQC's review of DNACPR decisions was published on 18 March 2021 **(MD/JM5/573 - INQ000235492)**. The report identified that decisions made in the early stages of the pandemic, when healthcare services were under unprecedented pressure, exposed and highlighted underlying problems that were in urgent need of attention. It summarised that focus was needed on three key areas:

a. First, information, training and support: it was noted that people's experiences of DNACPR decisions varied and that the training and support that staff received to hold these conversations was a key factor in whether they were held in a person-centred way.

b. Second, the need for a constant national approach to advance care planning: it was noted that there was a need for a consistent use of accessible language, communication and guidance to enable shared understanding and information sharing amongst commissioners, providers and the public. The report identified that many types of advance care planning were in use, each with different approaches and different types of forms and documentation. The lack of consistency could affect the quality of care received by a person.

c. Third, improved oversight and assurance: it was concluded that there was an urgent need for regional health and care systems, including providers, CCGs (now ICBs) and patient representative bodies, to improve how they assure themselves that people are experiencing personalised and compassionate care in relation to DNACPRs.

631. The CQC made several recommendations in its reports. It directed the following recommendations to the Department:

a. DNACPR decisions need to be recognised as part of wider conversations about advance care planning and end of life care, and these decisions need to be made in a safe way that protects people's human rights. To do this, a new Ministerial Oversight Group should be set up to look in depth at the issues raised in our report. That group, which should include partners in health, social care, local government and voluntary community services, should be responsible for overseeing the delivery and required changes of the recommendations of this report.

b. People, their families and/or representatives, clinicians, professionals and workers needed to be supported so that they all share the same understanding and expectations for DNACPR decisions. To do this, system partners across health and care needed to work with voluntary sector organisations, advocacy services and people to establish and assure a national unified approach to policy, guidance and tools that supports a positive experience of DNACPR decisions for people.

632. A further recommendation was addressed jointly to the Department and NHSE:

a. People, their families and representatives needed to be supported, as partners in personalised care, to understand what good practice looks like for DNACPR decisions. This should include what their rights are and how to challenge and navigate experiences well. In addition, there needed to be a positive promotion of advance care planning and DNACPR decisions, as well as a more widely publicised and accessible information available via a national campaign ad in partnership with the voluntary sector and advocacy services.

Formation and Work of Ministerial Oversight Group

633. In response to the CQC recommendation, the Ministerial Oversight Group (MOG) was established and first met on 8 June 2021. The MOG met a further three times: 20 October 2021, 9 February 2022, and 17 May 2022. The secretariat was led by officials from the Department. The purpose of the group was to oversee the delivery of the CQC's recommendations on DNACPR decisions. The terms of reference were set out in a document dated May 2021 **(MD/JM5/574 - INQ000339339)**.

634. The role of the MOG was to bring together the key bodies responsible for delivering the recommendations, and to receive updates on the progress of said recommendations. It was chaired by the relevant Departmental minister, initially Nadine Dorries MP and subsequently Maria Caulfield MP. The composition of the MOG included senior level representatives from the organisations referred to in the CQC report with responsibility for action. These were:

a. The Department

b. NHSE

c. NHSX

d. CQC

e. Providers

f. Health Education England

g. Skills for Care

h. National Guardian's Office

635. Membership was also extended to a range of other stakeholders:

a. The BMA;

b. The Royal College of Nursing;

c. The Resuscitation Council;

d. NHS Digital;

e. The General Medical Council; and

f. The Local Government Association.

636. At the first meeting on 8 June 2021 **(MD/JM5/575 - INQ000398642)**, discussion focussed on the following topics:

a. Information, training and support for the sector in relation to DNACPRs guidance;

b. The development of a unified approach to policy tools and guidance across the sector;

c. Digital compatibility and data quality in relation to care plans that contain DNACPR information; and,

d. Speak up mechanisms and quality assurances across social care.

637. At the second meeting on 20 October 2021, members discussed the ongoing development of a set of Universal Principles that would accompany DNACPR decision making **(MD/JM5/576 - INQ000339327)**. The Universal Principles are six high level criteria that should be considered in the Advance Care Planning process in England. Stakeholders attending the meeting also provided updates on different topics relating to DNACPRs including digital compatibility, data quality and record keeping. The meeting also discussed speak up mechanisms and quality assurances. The CQC updated members that concerns relating to DNACPRs had reduced in number, with no new concerns relating to 'blanket' applications **(MD/JM5/577 - INQ000398643)**.

638. The third meeting took place on 9 February 2022 and presented the final version of the Universal Principles for Advance Care Planning (UPACP) **(MD/JM5/578 - INQ000398644)**. The document was a collaborative effort amongst 27 partner organisations, with the aim of ensuring that high quality care planning filtered down to all health and social care settings. Consensus amongst the group acknowledged the

complexities within the health and social care system and agreed that engagement at a local level would be key to successful implementation.

639. At the final meeting on 17 May 2022, a summary of progress was tabled which went through each recommendation, identifying the lead responsible body and setting out progress to date, along with actions that were required on an ongoing basis to ensure DNACPR decisions continue to be applied in a consistent personalised way and were recognised as part of wider conversations about advance care planning **(MD/JM5/579 - INQ000339341)**. Attendees were informed the CQC had developed a new assessment framework which included DNACPR as a section and published further guidance for providers on what was expected in Advance Care Planning **(MD/JM5/580 - INQ000398645)**.

Universal Principles for Advance Care Planning

640. One of the key outputs of the MOG was the joint publication of a set of Universal Principles for Advance Care Planning, which was first published in March 2022 by a coalition of partners[5] **(MD/JM5/576 - INQ000339327)**. The document – which was intended to facilitate a consistent national approach to 'what good looks like' in Advance Care Planning in England in clear alignment with human rights law and the Mental Capacity Act 2005 – set out six high level principles:

    a. The person is central to developing and agreeing their Advance Care Plan, including deciding who else should be involved in the process;

    b. The person has personalised conversations about their future care focused on what matters to them and their needs;

    c. The person agrees the outcomes of their Advance Care Planning conversation through a shared decision-making process in partnership with relevant professionals;

    d. The person has a shareable Advance Care Plan which records what matters to them, and their preference and decisions about future care and treatment;

[5] This included the following organisations: NHSA, BMA, Age UK, the Association of Palliative Medicine, Association of Ambulance Chief Executives, APCOPC, ASPCP, Care England, College of Healthcare Chaplains, Compassion in Dying, Faith Action, Hospice UK, Macmillan Cancer Support, Marie Currie, Motor Neurone Disease Association, National Bereavement Alliance, National Guardian, Nurse Consultant Group, National Voices, PCPLD Network, The Queens Nursing Institute, Resuscitation Counsel, Royal College of General Practitioners, Royal College of Occupational Therapists, Royal College of Physicians, Skills for Care, Social Care Institute for Excellence, Sue Ryder.

e. The person has the opportunity, and is encouraged, to review and revise their Advance Care Plan; and,

f. Anyone involved in Advance Care Planning is able to speak up if they feel that these universal principles are not being followed.

641. To ensure the principles were observed in practice, the Universal Principles for Advance Care Planning were incorporated into the CQC's new single assessment framework **(MD/JM5/581 - INQ000608176)**. This framework includes the evidence required to demonstrate how care users' rights are being protected in relation to DNACPRs and help providers manage and maintain effective oversight of DNACPR decisions.

642. In June 2023, a submission was sent to the Maria Caulfield, Minister for Mental Health and Women's Health Strategy, recommending that the MOG secretariat write to members to formally stand down the group. The Minister agreed with the recommendation on 4 July 2023 and communications were sent to members of the MOG on 14 July 2023, thanking them for their input and standing them down from the group.

Acute Care Toolkit

643. The acute care toolkit is an informative paper published periodically by the Royal College of Physicians and the Society for Acute Medicine (SAM) that provides comment on acute settings. In the version "Acute care toolkit 16: Acute medical care for people with a learning disability" published in April 2022, the paper commented that clinicians are not obliged to administer a futile treatment, but reiterated that DNACPR decisions must never be made on the grounds that a person has a learning disability **(MD/JM5/582 - INQ000565781)**.

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:

Date: 2 June 2025

Signed:

Date:2 June 2025