Witness Name: Andrew Knight

Statement No.: 1

Exhibits:

Dated:

UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF ANDREW KNIGHT

I, **Andrew Knight**, of Care UK, Connaught House, 850 The Crescent, Colchester Business Park, Colchester, Essex, C04 9QB will say as follows:

1. Introduction

1.1. I am the Chief Executive Officer of Care UK. I make this statement in connection with the Rule 9 request made of Care UK, dated 9 May 2024.

1.2. Prior to joining Care UK, I held a number of leadership positions in the hospitality and consumer health sector, including as board director of Punch Taverns and Managing Director, UK of Weight Watchers. I was also employed as a non-executive director at Mid Staffordshire NHS Foundation Trust from 2009 to 2012, post the events which led to the Francis Enquiry.

1.3. I joined Care UK in 2014 as Managing Director of what was, at the time, the Residential Care Services Division, before moving to my current role as CEO of Care UK in 2018 following a restructuring of the company. I am also a Policy Board Member at Care England.

1.4. The information provided below is based on Care UK's specific experience of the Covid-19 pandemic. Care UK is fortunate to have had the benefit of private investor funding during the pandemic and to have had the strong central support functions that come with being one of the larger providers in the care home sector.

1.5. I am aware that some providers did not have access to the same funding or resources and so the experiences of those providers will have been different from ours. I believe it is very important that the Inquiry captures the views of small, medium, and large care home providers as well as those who are operated by private, public and charity providers. This is key to ensuring lessons are learned for the benefit of the entire sector.

1.6. Although Care UK had the benefit of private investor funding and was able to withstand the significant financial outlay prior to any Government funding being made available, the financial impact of the pandemic should not be underestimated. As Chief Executive Officer of Care UK, I was having weekly discussions at Board level about the financial sustainability of the company, given the costs being incurred and the reduction in income due to a drop in occupancy.

2. Care UK

History, background and values

2.1. Care UK is a provider of residential, nursing, and dementia care, respite services and palliative end-of-life care. More than 10,000 families trust us every day to deliver high-quality person-centred care for their loved ones.

2.2. Care UK started with a single care home on the Essex coast in 1982. Over the following four decades, we have grown to operate 163 care homes across the UK.

2.3. Prior to 2019, our experience in the health and social care sector also spanned various areas including primary GP care, home care, learning disability support, prison health services and mental health services. Our business strategy led to a consolidation to focus purely on care homes.

2.4. We have opened 65 new homes since 2010, which are helping to provide much-needed care home capacity for local communities across England, Scotland, and Wales.

2.5. At the end of 2021, Care UK took over the management of 26 homes that were previously branded Sunrise Senior Living and Gracewell Healthcare. In doing so, our portfolio was expanded by 20%. This acquisition included our first care home in Wales.

2.6. Colleagues across Care UK are inspired and guided by our core values of *Caring, Passionate* and *Teamwork* and an underlying company purpose of *Fulfilling lives*. These values underpin everything we do. For example, applicants for roles within Care UK are assessed against a values-based recruitment process which explores cultural fit as much as it does experience and capability. Colleague performance reviews take place twice annually and include discussions about if and how individuals are living the company's values. Our monthly colleague recognition scheme, entitled GEMs (Going the Extra Mile), recognises exceptional performance against each of the categories of Caring, Passionate and Teamwork.

2.7. The values also underpin our brand positioning of *Trusted to Care* which is supported by a number of proof points:

- More than 10,000 families trust us to care for their loved ones and our regular satisfaction surveys of both residents and relatives are at their highest ever level. This includes a resident Net Promoter Score of 55 which is considered excellent across any sector.
- We have the highest regulatory ratings of any of the large care home providers, with 93% of our homes rated 'Good' or 'Outstanding' in England and 100% compliance in both Scotland and Wales.
- We operate more 'Outstanding' rated homes than any other provider, by a significant margin.
- We have received the most awards of any care home provider for the last three years running, with more than 81 awards at an individual, care home and corporate level. These have included being named

Care Home Provider of the Year five times in the last three years by the likes of Laing Buisson, Health Investor and the Caring UK Awards.

- We have a 40-year heritage of providing high quality care to the people of the UK and the scale to ensure robust support and processes for each of our care homes.

2.8. In the last ten years we have seen a steady improvement in all areas of our balanced scorecard, with key performance measures for commercial delivery, quality of care, employee engagement and customer satisfaction all improving. I am confident in saying that Care UK is one of the most highly regarded care home providers in the UK.

Care UK's homes

2.9. As of 1 March 2020, Care UK owned or operated 122 homes across England and Scotland.

2.10. By 28 June 2022, Care UK owned or operated 153 homes across England and Scotland, as well as operating our first care home in Wales. During the pandemic, we had a number of care homes that had been in construction due to open, and we opted to continue with these openings as planned, despite the challenges of operating during the pandemic. We also sold some existing homes to other providers.

2.11. Care UK acquired the management contracts for 26 homes previously branded Sunrise Senior Living and Gracewell Healthcare at the end of 2021.

2.12. Care UK currently owns or operates 163 homes. This includes locations in England, Scotland and Wales.

2.13. A full list of current homes (as of September 2024), including location, is attached as **Exhibit AK/01 – INQ000509764**.

Services provided and range of recipients

2.14. Care UK offers a mixture of residential, nursing, and dementia care for older people, offered on a permanent or respite (short term) basis. We offer palliative end-of-life care and are specialists in the provision of high-quality dementia support.

2.15. Our offer also extends to those in the local community who may not require full-time care, with several of our homes offering day centres for those in need of additional social stimulation and support.

2.16. Care UK supports a mixture of local authority or NHS funded care and private paying residents.

2.17. Between 1 March 2020 and 28 June 2022, Care UK, in conjunction with local authorities and NHS continuing care, supported 5,053 individuals with residential care, 6,365 residents with nursing care provision and 84 residents with day centre access. This support was either fully, or in part, funded by local authorities or NHS continuing care. This does not include private-pay residents.

2.18. Care UK worked with 232 local authorities and NHS trusts during the relevant period. A full list of local authorities and NHS trusts is attached as **Exhibit AK/02 – INQ000509765**.

Care UK's colleagues

2.19. It should be noted that as our company employs a high number of part time and flexible workers, we track most measures associated with our workforce in hours worked, rather than individual colleague numbers. The data provided as part of this response will be a mix of hours and colleagues but is signposted accordingly.

2.20. During the relevant period (1 March 2020 to 28 June 2022), Care UK employed a total of 25,860 individual people. This figure includes anyone who started or left work within this period. Our colleague base at any one time averaged around 12,000 people.

2.21. 23,298 (90.1%) had permanent employment contracts and 2,562 (9.9%) had bank contracts. Bank contracts are those which provide employees with flexibility in terms of the numbers of hours they work each week.

2.22. 25,249 colleagues worked within Care UK's homes and 611 within the company's central support teams. Some members of the central support teams continued to undertake essential visits to Care UK's homes during the pandemic as part of their role, though this was greatly reduced as much 'business as usual' activity was suspended.

2.23. Of the 25,860 colleagues employed by Care UK throughout the relevant period:

- 6,584 (25.4%) colleagues identified as being from a white background.
- 3,509 (13.5%) identified as being from Black, Asian or minority ethnic backgrounds.
- 15,679 (60.7%) colleagues did not record their ethnicity.
- 11 colleagues declared that they lived with some form of disability.

3. Advisory bodies, government departments and agencies with whom Care UK worked and communicated

NHS England

3.1. In March 2020, I was invited at short notice to attend an online meeting with NHS England. It appears from my records that this meeting took place on 12 March 2020. The meeting was led by Matthew Winn, Director for Community Health NHS England, and Simon Chapman of NHS England/NHS Improvement. I recall that other care provider leaders also attended.

3.2. I attended without any clear idea of what would be discussed. The focus of the meeting was to establish capacity levels within the care sector and how best care providers could support the NHS to free up capacity within hospitals. We discussed whether it would be feasible to set up suites or

whole care homes that would be focused on caring for individuals with Covid. Ideas were proposed such as payments coming from the NHS direct without the usual local authority processes to speed up the rate of hospital discharges.

3.3. While the care sector CEOs were doing what they could to help with NHS capacity, we were also conscious of what this would mean for the safety of our colleagues and for others already living in are homes. We were also concerned about regulatory issues and whether we would be operating within the remit of our registration, as well as whether we would have access to specialist equipment such as ventilators that was at that time only available in hospital settings.

3.4. Little, if any, discussion was centred around support mechanisms that might be needed for the care sector in terms of their existing resident base.

3.5. It appears from my records that a NHS/provider call also took place on 21 September 2020. Deborah Sturdy attended as the NHS representative.

Government departments

3.6. From around April 2020, I, along with other care provider leaders, attended meetings with the Minister for Care, Helen Whately. During these meetings, providers emphatically expressed the need for funding and greater support from the government and communicated that the sustainability of the sector was at risk. We asked for there to be greater communication and consultation and provided our views regarding key policy issues such as how testing was to be carried out and whether there should be a mandatory requirement for care home workers to be vaccinated. We were supportive of all measures that could be put in place to help us protect residents, as long as these were consistently applied across both health and social care settings.

3.7. Online meetings also took place with Dido Harding, Head of the NHS Test and Trace programme. From my records, it appears that such a meeting took place on 5 August 2020. It is possible that there is information missing from my records in terms of meetings attended.

3.8. The Department of Health held regular online meetings with care home providers to share updates regarding upcoming changes, particularly relating to Covid testing, vaccinations and PPE. These meetings were later run by the UK Health and Security Agency. Tony Weedon, Strategic Programme Director, attended these meetings on behalf of Care UK and I refer to his witness statement which sets out further detail.

3.9. I feel we took advantage of every available opportunity to engage with government and to influence policies relating to the social care sector. I recognise the government then had to consolidate views from a range of different stakeholders. While the input we provided did appear to focus the government's response around areas such as the availability of testing and PPE, this came very late in the day and it felt like there had not been much thought given to these areas in the early days of the pandemic.

Local authorities, health boards and social care trusts

3.10. Care UK's home managers worked with, and were in regular communication, with their local public health team (see list of care homes, with locations and list of care homes by region with local authorities and Trust, at **Exhibit AK/02 - INQ000509765**). These communications often related to the regional application of national guidance and approvals on a home's intention to open to visitors or new admissions.

3.11. Care UK issued centralised guidance to its staff members by way of a "Pandemic Event Plan" (as set out within the witness statement of Tony Weedon, Strategic Development Director) but regularly indicated within this guidance that staff members should liaise with local public health teams to understand the position in each region regarding any specific issues or guidance. Care UK considered it necessary to issue centralised guidance as this enabled home managers to focus on delivery of care and communications with relatives as opposed to having to try to interpret Government issued guidance. This also enabled a consistent approach to be implemented across all the company's homes and updates could be communicated to all relatives at the same time. Care UK's subject matter

experts were also able to review and interpret guidance once with centralised guidance then being created which was set out in language which could be easily understood by home managers, with processes being clearly explained and flowcharts included where that was considered to be helpful.

3.12. For the most part, our managers reported feeling supported by local public health teams. However, there were often disparities between national guidance and the application of the guidance by local teams which was challenging for Care UK's colleagues. For example, in the latter stages of the pandemic some public health teams remained resistant to opening homes to visits and admissions. There was also different guidance issued at different times in England, Scotland, and Wales which made things difficult for us as a national provider. For example, there were differences in terms of visitor arrangements and mandatory vaccinations. This was difficult because Care UK had to interpret the new guidance from each jurisdiction, update its own guidance and ensure that its homes were compliant with any changes.

UK Health and Security Agency

3.13. As set out above, the provider meetings run by the Department of Health were later run by the UKHSA.

Care Quality Commission

3.14. Updates were occasionally received from the CQC but there was limited direct communication between Care UK and the CQC during the relevant period, save that remote infection, prevention and control visits took place for some of Care UK's homes. Further detail is provided in the witness statement of Rachel Harvey, Care, Quality and Regulatory Governance Director for Care UK.

Care England

3.15. Care UK continued to play an active role in Care England, a registered charity and representative body for independent providers of adult social care in England. I am a Policy Board Member of Care England.

4. Evidence, submissions and reports

4.1. Care UK reported Covid cases and deaths via the appropriate channels but did not otherwise provide any evidence, submissions or reports to Parliamentary Select Committees or other organisations.

4.2. Care UK's Suzanne Mumford, Head of Dementia, Care and Nursing, contributed to the article "*English care home staff morale and preparedness during the COVID pandemic: A longitudinal analysis*", published in the American Journal of Infection Control (**Exhibit AK/03 – INQ000509766**).

4.3. Care UK's Perry Manor home participated in the CHARM "Care Home Action Researcher-in Residence Model" research project. This mini research project focused on the impact on colleagues' feelings about their jobs, residents, relationships, teams, and their future, what had been learned about good person-centred care practice and how colleagues had moved forward form the outbreak and what their goals were for the future. See enclosed article *"Covid in a care home, The experience and impact of Covid-19 and a home's recovery from a staff perspective"*, published in the Journal of Dementia Care (**Exhibit AK/04 – INQ000509767**).

5. Pre-pandemic structure and capacity of adult social care

5.1. Due to my position on the Board of Care England and based on discussions with colleagues and peers, I can say that there is a shared belief in the sector that the social care system that entered the pandemic was underfunded, undervalued and already under pressure. Any response to the pandemic by the government would have needed to contend with legacy challenges associated with three key areas: local authorities paying a fair cost of care; challenges in attracting and retaining experienced staff; and a lack of partnership working from some public sector partners.

Challenges with funding

5.2. While Care UK has been able to build a successful business based on clear market strategy, I am aware that many smaller providers struggle with local

authorities who do not pay a fair cost of care or raise their fees in line with inflation and national living wage.

5.3. There has been an increase in life expectancy and, consequently, many more people are living for long periods with multiple and complex medical conditions and advanced dementia that require specialist nursing care and purpose-built environments with space for equipment such as lifts, hoists and generous-sized wet rooms.

5.4. Private sector providers are often the only organisations able to secure investment to develop new care homes to the appropriate standard and to provide much-needed capacity to the sector. Despite this, the valuable role they play in the UK health and social care economy is often overlooked. Care UK is one of few care home providers to have successfully brought together growth strategies across both public and privately funded care. As an example, our long-running partnership with Suffolk County Council involved us taking on a portfolio of council-owned care homes that were increasingly outdated and unfit for purpose, secured private investment and replaced them with ten newbuild homes that provided a much-needed expansion of capacity for both the council and for individuals who fund their own care.

Workforce challenges

5.5. There have long been challenges in the care sector in terms of recruiting and retaining staff.

- The fees paid in many public sector contracts at the time required tight cost control and limited the amount those delivering these contracts were able to pay their staff. In many markets, this challenge was exacerbated by strong competition from retail, leisure and hospitality sectors and a shortage of skilled and experienced care workers.
- There has been a long-standing shortage of qualified nurses in the UK as a consequence of a failure to provide sufficient nurse training places in the past. According to NHS figures as of 2024, there are

about 47,000 nursing vacancies in NHS England alone, accounting for over 10% of the total nursing workforce.

- Recruiting care staff from overseas is not only extremely complex, but the Government-mandated minimum salary for overseas workers means that overseas workers are often paid above UK workers which means it is not always sustainable to recruit them.
- The Government's recruitment campaigns have historically focused on recruiting to the NHS and do not often have a tangible benefit to the private adult social care workforce sector.
- There is an onerous CQC-mandated recruitment process which involves rigorous checking of references and DBS checks. This takes an average of 31 days for Care UK to process.

Opportunities to work more effectively with public sector partners

5.6. The processes required for individuals to secure and retain funding for adult social care in the UK are complex and often burdensome for families that are often facing an emotional crisis situation. This often results in delays or complications in discharging individuals from hospital into a care home environment and limits the amount of choice families have about where to place their loved ones.

5.7. The experiences of the pandemic, when these barriers were reduced, showed there are huge opportunities for hospitals to work more effectively with care home providers to ensure care is delivered in the most appropriate setting for the individuals in question.

6. Impact and experience of the pandemic

6.1. The mental health and wellbeing of Care UK's colleagues was significantly impacted by the pandemic. Colleagues were frightened about the risks of Covid-19 and were worried about the risk of exposing their family members to the virus. They also witnessed residents dying of Covid-19, without those residents having the comfort of being supported by family members or access to health care professionals.

6.2. The impact of the pandemic on Care UK's workforce cannot be underestimated. Care UK colleagues have recounted experiences consistent with varying degrees of post-traumatic stress following the pandemic. Care UK understands this to be a delayed reaction to the trauma experienced, the higher than ever number of resident deaths and the challenging circumstances in which they continued to work.

6.3. During the pandemic, Care UK's focus on providing a positive employee experience necessarily shifted to the fundamental challenges of keeping colleagues and residents as safe as possible. While this included a strong focus on mental health and wellbeing, the day-to-day experience of Care UK colleagues changed significantly as "nice to do" initiatives aimed at improving colleague engagement (such as team building, socialising with colleagues and activities for residents which were also enjoyable for colleagues, such as garden parties) were replaced with increased infection prevention and control measures, adapting to wearing PPE, and seeking to maintain contact between residents and their loved ones through the use of technology.

6.4. Due to absences, colleagues were often working additional overtime hours or with reduced staffing levels that allowed time to do what was necessary to ensure care for residents but did not allow for the quality social time that is key to both the wellbeing of residents and the job satisfaction of staff. Care UK was able, however, to meet regulatory requirements at all times.

6.5. I strongly believe that the impact and experience of the pandemic on care homes is best articulated via the stories of those who worked on the frontline of care during this period. For this reason, I attach personal accounts given by five of Care UK's home managers, setting out their experiences of the pandemic (**Exhibit AK/05 - INQ000509768**):

- Care Home Manager A, Home Manager of I&S I&S
- Care Home Manager B, Home Manager of I&S I&S

- Care Home Manager C, Home Manager of I&S I&S
- Care Home Manager D, Home Manager of I&S I&S
- Care Home Manager E, Home Manager of I&S I&S

6.6. The home managers set out the impact that the pandemic had on them personally and the impact that they witnessed events having on members of their team. The managers refer to colleagues having left the care sector altogether due to having been unable to recover from the loss of so many residents. Care Home Manager C sets out the ongoing impact of having had to inform her team that members of staff had passed away and how someone can feel that they are OK and then something happens to bring it all back. Care Home Manager B sets out a reminder that for those who comforted residents in their final moments, the pandemic is not over. Care Home Manager D speaks of how the hardest aspect emotionally was ensuring that residents were in contact with their loved ones when they passed away and describes staying with residents all night so that loved ones could tell them (via iPads) that they loved them as they took their final breaths.

6.7. I could not be prouder of the teams that worked for Care UK during the pandemic and the resilience, professionalism and commitment of everyone in the care sector who continued to work despite being scared and in many instances having to isolate from their own families. The whole experience was incredibly humbling for me and I was honoured to work with some exceptional people. If nothing else comes out of this Inquiry, I would like to see the frontline teams of the care sector recognised as the heroes they are for the outstanding role they played in protecting, supporting and comforting families who had loved ones in care.

6.8. Care UK experienced its highest colleague mental health absence levels between April and September 2020. I have set out below the number of mental health absence hours from January to September 2020 which

shows the increase in absence levels from April 2020 onwards. As previously noted, our company employs a high number of part time and flexible workers, so we track many workforce measures in hours, rather than individual colleague numbers.

Jan 2020: 7,206 hours

Feb 2020: 6,295 hours

Mar 2020: 5,947 hours

Apr 2020: 10,019 hours

May 2020: 14,820 hours

Jun 2020: 13,199 hours

July 2020: 12,088 hours

Aug 2020: 13,658 hours

Sep 2020: 10,621 hours.

6.9. There was a further peak the following Summer from May to September 2021, with absence hours ranging from 9,363 (in September 2021) to 11,558 (in August 2021).

6.10. These absence levels do not include colleague absences due to contracting Covid-19 and only include absences due to stress, anxiety, depression or other psychological conditions.

6.11. Although mental health-related sickness hours decreased immediately after the pandemic by an average 25%, this increased again by a further 20% between May and October 2023.It may be that this is due to colleagues beginning to process the trauma of the pandemic.

6.12. Care UK sought to provide mental health support in a centralised way during the pandemic by taking the following steps:

- Publishing a wellbeing newsletter (first circulated in April 2020).
- Introducing a dedicated wellbeing page on the company's intranet signposting colleagues to various resources including access to free counselling support.

- Sharing regular updates and recognition of colleagues' continued hard work.
- Recognising the extraordinary efforts of colleagues with a range of gestures, including 'Care UK Hero' badges, £100 gift vouchers after the first wave of the pandemic and again at Christmas, and a marketing programme that publicly thanked colleagues and recognised them as heroes in local advertisements and banners by each home's entrance.

6.13. Care UK was conscious that constantly changing guidance had the potential to overwhelm managers and individual colleagues and sought to alleviate some of these pressures by taking the following steps:

- Creating a specific pandemic email digest named "Coronavirus Update". This meant that home managers had one consistent source of guidance and support specifically related to Covid-19 which they could refer to as needed.
- Launching a new communication tool "Enboarder" in May 2020, which facilitated text communication direct to all colleagues.
- Categorising homes depending on their current situation; category 0 being the most severe. Communication with category 0 homes was limited to essential communication only. At key crisis points, this involved diverting all phone calls to a central support hub so colleagues could focus on delivering care while others fielded calls and provided updates to concerned relatives.
- Introducing monthly meetings between our executive team and our home managers so that any issues or concerns could be discussed.

6.14. Regional directors also provided support to care home managers. Regular Teams calls took place to ensure managers were kept up to date and that they had a chance to ask any questions or to share their own concerns.

6.15. Care home managers also provided a huge amount of support to colleagues working within Care UK's homes. They went above and beyond what could have been expected, including by working additional hours to

cover staff shortages, answering colleagues' questions and concerns about changes in guidance and providing emotional and pastoral support to their teams whilst working under extreme pressure. I refer to the experiences of the home managers set out within the reflective pieces at **Exhibit AK/05 - INQ000509768**.

6.16. In addition to the impact on colleagues' mental health, Care UK lost eight colleagues to Covid-19. One member of the company's extended leadership team was one of the first highly publicised cases and was hospitalised and in a coma for several months (thankfully, they recovered and remain with the company). All of this had a significant impact on the morale of colleagues across the business.

7. Disproportionate impact on adult social care sector

7.1. Care UK considers that the adult social care sector was disproportionately impacted by the pandemic in the following ways:

- Care home residents were particularly vulnerable to Covid-19 and were more likely to become seriously unwell or to die, due to their age and underlying medical conditions.
- As many hospitals were actively discouraging admissions from care homes, care home residents did not always have the same access to hospital care in the event they became seriously unwell either with Covid or unrelated medical conditions. This led to residents dying in care homes without access to ventilators which would have only been available in a hospital setting. On 25 March 2020, the British Geriatric Society published "Managing the COVID-19 pandemic in care homes" which stated "*Because most care home residents live with frailty and multiple medical conditions, there may be occasions where paramedics, general practitioners, or other healthcare professionals make decisions not to escalate their care to hospital. These decisions will not be taken lightly and care home staff must be prepared to work with healthcare providers to support families and residents if such difficult decisions have to be taken*" (**Exhibit AK/06 – INQ000336345**).

- Care homes had limited access to GPs during this time and no support from district nurses or mental health teams.
- Visitor restrictions remained in place within care homes long after restrictions for the general population had eased, leaving residents isolated and separated from their families. This had a significant detrimental impact on residents' wellbeing and physical and mental health.
- It was clear that there was a two-tier system, with the NHS being prioritised and the care sector coming second. For example, the NHS was prioritised in the distribution of PPE and other equipment. Insurance was also put in place for the NHS should any legal claims arise but no such protection was communicated to the care sector.
- The messaging from the Government was that the public must protect and applaud the NHS. It was not until the later stages of the pandemic that adult social care received anything approaching the same recognition.
- In the early stages of the pandemic, a significant number of individuals were discharged from hospitals to care homes to clear hospital capacity. In many cases, this was without testing for Covid-19, thereby potentially introducing Covid-19 into care homes where some of the most vulnerable members of society were being cared for. Care providers continued to experience pressure to accept admissions without evidence of a negative Covid-19 test, with the expectation that care homes would accept admissions to remove pressure from the NHS. I refer to the experiences of the home managers set out within the reflective pieces at **Exhibit AK/05 - INQ000509768**. While we recognise that hospitals were also under pressure at this point, this approach is indicative of a lack of partnership working and respect for the role the care sector plays in the overall health system and is an area that needs to be addressed as part of any attempt at reform.

- The Government introduced a mandatory requirement for care home workers to be vaccinated but did not introduce the same requirement for those working within the NHS. This disproportionately impacted the care sector as many individuals felt very strongly that they did not want to be vaccinated and this included colleagues who were opposed to the vaccine due to their religious or cultural beliefs. This particularly impacted colleagues from a black and ethnic minority background (see reflective piece of Care Home Manager E, care home manager of I&S I&S There appeared to be a lack of science behind this decision – for it to be effective, the government's approach to vaccinations needed to have been consistently implemented across all health and social care settings.

- There was a lack of access to the science behind many of the decisions being made which made it difficult for Care UK to understand the rationale for decisions and to be able to reassure the company's clinical teams.

8. Concerns regarding key decisions

The decision to discharge residents from hospital to social care settings without testing

8.1. On 17 March 2020, NHS England wrote to NHS trusts setting the aim of expanding critical care capacity to the maximum: freeing up 30,000 (or more) of the English NHS's 100,000 general and acute hospital beds and supplementing them with additional capacity. It was set out that trusts were to urgently discharge all hospital inpatients who were medically fit to leave and that for those requiring social care, emergency legislation would ensure that eligibility assessments did not delay discharge (**Exhibit AK/07 – INQ000509770**).

8.2. On the same day, Care UK's Pandemic Event Plan was updated and set out that from Care UK's perspective, it was essential that new residents being admitted had evidence of a negative test if transferring from hospital

or undertook a health screening and risk assessment process if transferring from their own home (see Pandemic Event Plan, version 2).

8.3. On 2 April 2020, the Department of Health and Social Care published "Admission and Care of Residents in a Care Home during COVID-19" which set out the following:

"The care sector looks after many of the most vulnerable people in our society… As part of the national effort, the care sector also plays a vital role in accepting patients as they are discharged from hospital – both because recuperation is better in non-acute settings, and because hospitals *need to have enough beds to treat acutely sick patients. Residents may also be admitted to a care home from a home setting.* ***All of these patients can be safely cared for in a care home if this guidance is followed…*** *Negative tests are not required prior to transfers / admissions into the care home"* **(Exhibit AK/08 – INQ000509771)**.

8.4. Care UK understood the reasoning behind the decision to discharge individuals from hospital. The company had significant concerns, however, about large numbers of individuals being admitted to care homes without testing. This decision is likely to have contributed to the transmission of the virus into care homes alongside the challenges of care teams without access to testing inadvertently bringing the virus into care homes. To protect those living and working in our homes, Care UK required negative Covid tests for all new admissions and isolated residents where such confirmation had not been provided.

8.5. Care UK found that even once testing was available, colleagues were regularly being put under pressure to accept admissions without confirmation of a negative Covid test in order to speed up hospital discharges. This continued to be the case even when government guidance evolved to suggest that all new care home residents should be tested before admission. Our care home teams experienced ambulances arriving at care homes outside of working hours (i.e., when home managers were less likely to be present) or with residents who had already been refused admission as they were known to be covid positive. They also experienced excessive pressure from NHS discharge teams to accept

admissions to free up hospital beds. Home managers felt that they had been given incorrect information about residents to make sure that admissions went ahead. I refer to the reflective pieces of Care Home Manager B, Care Home Manager D, and Care Home Manager E at **Exhibit AK/05 - INQ000509768**. Care Home Manager E sets out that there was a threat made by a local CCG at the time that if the home did not accept residents during that time period, no residents would be placed at the home in the future. Care UK adopted the position that the focus must be on protecting residents and that the safety of residents must be prioritised over occupancy levels and accepting new admissions.

The impact of shielding

8.6. Care UK supported the Governments decisions in respect of shielding and wished to protect its colleagues. This decision did, however, significantly impact on Care UK's available workforce at a time of extreme pressure.

The impact of lockdowns

8.7. Care UK considered the first lockdown to have been implemented too late. There were clear reports of the impact of the virus on care homes in Spain and Italy (See attached article "Coronavirus: Spanish army finds care home residents 'dead and abandoned', 24 March 2024, **Exhibit AK/09 – INQ000509772**). This type of media coverage made it very clear that there were likely to be significant challenges ahead for the care sector in the UK but still felt there were still significant delays before there was any consideration given to the care sector. With this in mind, our approach in the early stages of the pandemic was to assume that we had to be self-sufficient when it came to things like procurement of PPE and guidance to our care homes on best practice infection prevention and control. I am very conscious that as a larger care home provider with strong financial backing we were in a much stronger position to take this approach than a lot of smaller providers.

8.8. There was a very strong public narrative in the early stages of the pandemic that the Government's primary focus was to protect the NHS. While we were initially very supportive of this focus and looked for ways we could

alleviate the pressures on the NHS, it soon became clear that the government's narrow focus meant that these protective measures may come at the expense of care home safety. An example of this would be the decision to move Covid-positive individuals into care homes that were full of frail and vulnerable elderly people.

Vaccination as a condition of deployment

8.9. The Government introduced a mandatory requirement for care home workers to be vaccinated but did not introduce the same requirement for those working within the NHS. Some colleagues left the care sector due to the mandatory vaccine requirement and chose to work in the NHS instead. Other members of staff ultimately went ahead with vaccination but were very unhappy about this. I refer to the reflective pieces of the home managers at **Exhibit AK/05 - INQ000509768**. In particular, Care Home Manager E, care home manager at I&S sets out that 90% of her staff were unhappy about having a Covid vaccine. Care UK took the view that it was right to require colleagues to be vaccinated but found this was challenging to manage, particularly given the same rules did not apply to the NHS nor to care settings in Scotland. This was a further example of the NHS and adult social care being treated differently.

9. Whether the adult social care sector was adequately understood and considered by core political and administrative decision makers

9.1. Care UK does not consider that the core political decision makers adequately understood the breadth and diversity or needs and circumstances of those working in and using the adult care sector.

9.2. Most notably, the Government did not appear to understand the way in which guidance would need to be interpreted and implemented within care homes. In the early stages of the pandemic, changes to guidance were initially announced publicly before the detailed guidance was shared with care home providers (for example, in relation to care home closures, the distribution of PPE and the introduction of testing in care homes). In later months, we would more often receive the detailed documentation several hours before it was announced (for example, in relation to changes to

visiting restrictions) which was not sufficient time to rework guidance into policies and procedures that would make sense in the context of a care home environment.

9.3. Other examples of there being a lack of understanding include:

- The decision to only mandate Covid vaccinations for those working in adult social care and not those working for the NHS failed to account for the interconnectedness of health and social care settings. For example, Care UK has a number of resident movements between its care homes and hospital settings (i.e. admissions or discharges) each month.
- The initial arrangements for Covid testing involved attending a drive through testing centre, which did not take into account that many care workers do not have easy access to a car. There was then a lack of testing kits for care homes.
- At one point, guidance to care homes suggested restricting the provision of personal care to 15 minutes. This demonstrated a lack of understanding of the practicalities of providing personal care to elderly care home residents, particularly those living with dementia and other complex health conditions.
- It was virtually impossible to achieve social distancing within care homes, particularly for residents living with dementia. Care UK had to adapt broad guidance and implement cohorts of residents and a policy specifically relating to residents with dementia "walking with purpose". This policy set out the reasons that residents with dementia may walk with purpose and the importance of understanding the different ways that people communicate their needs, with practical guidance as to how to support residents. The policy emphasises the importance of understanding each resident as an individual in order to meet their specific needs and minimise the need for pharmacological interventions. This policy is included within **Exhibit AK/09a – INQ000515877** (also attached to Tony Weedon's statement as TW/07) from pages 98-104.

10. Views about the level of consultation and communication with the adult social care sector

10.1. Care UK recognises that feedback was sought from the sector and that attempts were made at communication and consultation. We believe, however, that there should have been greater involvement of the social care sector in planning and decision making via more structured consultation and transparency regarding when and why suggestions from the sector were not progressed. This should also have involved engaging with the appropriate sector associations and providing opportunities for direct discussion with relevant individuals at the NHS, DHSE and ADASS.

10.2. We believe the Government's approach to the pandemic could have been significantly improved with consultation about key decisions affecting the care sector. This would have ensured decisions taken were practical, impactful and sustainable in a care home environment.

10.3. As set out above, I attended meetings with the Minister for Care which enabled me to communicate Care UK's concerns about key issues and decisions. Tony Weedon also attended provider meetings with the DHSC and latterly the UKHSA but these meetings primarily involved updates being communicated to care providers as opposed to there being meaningful consultation. During these meetings, providers raised various issues but there was no indication that these concerns were being actioned.

10.4. Communication could also have been significantly improved. Communication of decisions taken was often done publicly at the same time or immediately after it was shared with care home providers, giving insufficient time for the care sector to take the steps needed to implement changes safely and effectively. This was most notable in respect of changes to visitor restrictions.

10.5. We recognise that it would have been challenging for the Government to identify the key stakeholders to communicate and consult with due to the highly fragmented nature of the sector, as compared to the NHS. In future,

we would recommend making more use of sector bodies such as Care England who can facilitate meaningful engagement across the sector.

10.6. The Government sought feedback from the care sector but Care UK found that this feedback was not always acted upon. For example, Care UK raised concerns regarding the timing of information being shared with the care sector, in that insufficient time was allowed for care providers to implement any changes, but information continued to be shared in the same way. There was therefore a concern that participating in this process was potentially a waste of resources at a time when the sector was under an incredible amount of pressure.

Views about the guidance regarding key decisions

10.7. While we recognise the pandemic brought with it unprecedented challenges, Care UK and others in the care sector, feel the Government lacked the foresight to anticipate the risks associated with the a pandemic or to develop a plan to support care homes early on in the pandemic. To those working in social care, media coverage of the devastation caused in care homes in Spain and Italy in the weeks leading up to the first case in the UK provided a clear indication of the challenges ahead (see **Exhibit AK/09 - INQ000509772**). Care UK immediately started its own pandemic planning at this point, as the Government's primary focus appeared to be on protecting the NHS.

10.8. In the first few months of the pandemic, the Government completely underestimated the impact of the virus on care homes and as such, early guidance fell well short of what was required.

10.9. As matters progressed, guidance improved. Care UK, however, makes the following observations:

- Guidance was being issued by multiple bodies in respect of the same issue, for example by the Department of Health & Social Care, Public Health England and the CQC. Guidance was also frequently being updated. It was therefore necessary for care providers to track, cross-check and consolidate the guidance

relating to all issues affecting care homes originating from all sources.

- There was a significant volume of guidance being produced throughout the pandemic by the UK Government, the Scottish Government and the Welsh Government with variations between the positions adopted in each jurisdiction – at times these were minor, at other times quite significant. As Care UK is a national provider, the company needed to issue separate guidance to its homes within the different jurisdictions. The guidance from the various administrations was also issued at different times, further increasing the administrative burden of implementing changes.
- Some guidance contained internal inconsistencies and so it was not always straightforward to interpret the intention behind the guidance and understand how it should be implemented. I recall the executive team having conversations regarding inconsistencies and interpretation of guidance but I cannot give specific examples due to the passage of time.
- The guidance often consisted of a significant number of pages of text and was not written in language or set out in a way which could be sent straight to care home colleagues to follow. For example, I refer to the document "Admission and Care of Residents during COVID-19 Incident in a Care Home", dated 2 April 2020 (**Exhibit AK/09b – INQ000325255**) which consists of 28 pages and required distilling into Care UK guidance. I also refer to the Care UK therefore developed guides and flow charts for home managers and other staff so that those working in the homes would be able to follow the new guidance to reduce the risk that lengthy and complicated guidance notes would be misinterpreted. There appeared to be a lack of appreciation that this work would need to be caried out or that many of the changes required significant planning to implement effectively as little, if any, time was allowed for care homes to interpret changes prior to those changes being communicated to the public. It may be that smaller care providers

would not have had the resources to carry out the work that Care UK did in terms of interpreting and distilling guidance for staff members.

- Guidance was regularly sent to care providers late on Friday afternoons, placing providers under pressure to interpret guidance and to communicate changes to those working in care homes over weekends. While we recognise that in some cases this was unavoidable in moments of peak crisis, it happened so regularly that it felt as if the government was working to 'end of week' deadlines that did not factor in the time required to implement guidance changes. Although our care homes are staffed and supported seven days a week, receiving guidance on a Friday meant we were not always able to engage with public sector partners in putting together our guidance and did put additional pressure on management teams working long hours through the week to then spend the weekends implementing new policies and procedures. I refer to the reflective piece of Care Home Manager C (**Exhibit AK/05 - INQ000509768**) within which she says that her and her team knew that when new guidance was issued, they would be "ambushed" the following day and that someone would always find a loophole and interpret the guidance differently.

- There was some guidance issued which appeared to lack logic and demonstrated a lack of understanding of the realities of how care is provided to care home residents. For example, the guidance that personal and intimate care should be limited to 15 minutes which is not feasible for many care home residents who need multiple carers to support them, require hoists for lifting and who have complex care needs. Furthermore, those living with dementia will often only accept support for personal care where this process is taken slowly to build trust and rapport. The time required for personal and intimate care depends on the individual's specific needs but it is likely that it would take at least an hour for one such interaction to be completed.

- Guidance and Government communications referred to whole home Covid testing being made available from 6 July 2020 but this was not consistently available to Care UK homes until August 2020. There was therefore a difference between what was being communicated to the public and the reality of the care home experience. This made it very challenging for care home teams to manage the expectations of relatives and Care UK ultimately had to write to relatives to explain that some of the statements made on the nightly news broadcasts about testing in care homes were not correct.

10.10. Care UK considers that a more centrally coordinated approach, better consultation with the sector, a clearer articulation and more timely issuance of communication would have greatly reduced the amount of unnecessary stress being placed upon the sector.

11. The extent to which Care UK felt or was supported

11.1. At the beginning of the pandemic, Care UK was required to source and finance its own PPE. This involved the company spending over I&S upfront and taking on the risk that the I&S companies that Care UK was entering into contracts with may not deliver on those contracts. Had the Government been able to source and secure PPE earlier in the pandemic and make it available centrally, this would have significantly reduced the pressure on care home providers.

11.2. Care UK later received financial support from the UK Government via the Infection Control Fund. The fund was specifically to support providers with the additional costs incurred in effectively managing the pandemic and complying with the Government's guidance on infection prevention and control with respect to Covid-19. Care UK was also able to make use of the furlough scheme. Funding was also put into the care sector by central Government which enabled local authorities to increase the fees paid to care homes which brought local authority funded fees more in line with a realistic cost of care.

11.3. Although financial support was provided, there were other issues in terms of the Government's approach to the care sector which I have addressed within other sections of this statement.

11.4. Care UK did not feel supported by the Scottish Government. The Scottish Government required any death related to Covid-19 be reported centrally. The Government subsequently launched Operation Koper which involved a Crown Office unit being set up to establish whether criminal prosecutions should be brought following on from deaths that had occurred in Scottish care homes (see enclosed article "Covid in Scotland: More than 400 care homes investigated over deaths", BBC News, 22 January 2021, **Exhibit AK/10 – INQ000360115**). This placed a huge amount of pressure on Care UK's colleagues in Scotland and reinforced feelings of guilt and trauma.

11.5. Care UK found that some local authorities were supportive and sought to work together and to collaborate, whilst others did not seem in a position to do so. Some local authorities were proactive and came up with helpful initiatives, while with others Care UK had to push to receive financial support.

12. Impact of easements to the Care Act 2014

12.1. The easements to the Care Act 2014 took effect on 31 March 2020 and enabled local authorities to reduce their usual duties in certain circumstances. This included removing the requirement for local authorities to carry out detailed assessments of people's care and support needs or to carry out detailed financial assessments.

12.2. These easements removed some of the bureaucracy associated with public sector funded residents being placed in care homes and enabled a much smoother admission process for those individuals. This was welcome relief, particularly at a time when the care sector was under extraordinary pressure to accept new admissions.

12.3. The DHSC issued guidance regarding the easements, dated 1 September 2020, which stated the following:

"Local authorities and care providers are already facing rapidly growing pressures as more people need support because unpaid carers are unwell or unable to reach them, and as care workers are having to self-isolate or unable to work for other reasons. The government has put in place a range of measures to help the care system manage these *pressures"* **(Exhibit AK/11 – INQ000509774)**.

12.4. Care UK's experience is that the easements did generally reduce the administrative burden associated with care home admissions, although the emphasis was on reducing the obligations placed on local authorities. Unfortunately, there has now been a return to the bureaucratic pre-pandemic admission processes. Care UK would encourage the Government to learn from the effectiveness of these more streamlined processes in smoothing the transition between hospital and care settings.

13. Working conditions

13.1. Care UK paid all colleagues who had received a letter advising them to shield, in accordance with Government policy.

13.2. Care UK regularly use bank workers to cover shortages due to holidays, illness or challenges associated with fully recruiting in highly competitive local markets. Bank contracts are those which provide colleagues with the flexibility to change the hours they choose to work week to week. Bank workers were included in the furlough scheme if they met the criteria (clinically vulnerable and clinically extremely vulnerable or shielding with someone in the home with someone that was CV/CEV). The calculation of their furlough payment was based on average earnings within the period specified by the Government so if they had worked hours in the period, they received furlough pay.

13.3. Temporary Covid sick pay was launched and took effect from 4 June 2020. This ceased as of 1 April 2022.

13.4. Throughout the relevant period, Care UK had a total of 528 colleagues on furlough, broken down as 328 shielding and 200 for reasons of low occupancy in the care home where they worked.

13.5. Care UK is not aware of any unequal impact or discrimination experienced by workers. All Care UK colleagues are DBS checked and have a confirmed Right to Work in the UK which meant the criteria for sick pay and furlough were applied equally to all.

14. Surveys conducted by Care UK

14.1. Care UK ordinarily carries out an annual colleague engagement survey covering a range of issues relevant to its workforce. The survey asks colleagues about their level of satisfaction with all areas of their role, such as how satisfied they are with communication within the company, whether they consider that they are receiving the right level of development, whether they feel supported by their line manager and how they rate the pay and benefits provided. The colleague engagement survey was postponed during 2020 and 2021 as carrying out the survey would have put additional pressure on home managers and Care UK recognised that the company's focus needed to be on providing colleagues with mental health support as opposed to seeking feedback in this particular way at this time. I consider that the impact of postponing the colleague engagement survey was limited as additional channels of communication had been put in place to enable colleagues to raise any queries or concerns that they had.

14.2. Care UK recommenced the survey in 2022 and added two statements to the survey relating to Covid-19. The statements are set out below, along with the percentage of colleagues who agreed or strongly agreed with the statements (being a percentage of the individuals who completed the survey):

- "Care UK was supportive of the challenges posed by Covid-19" - 85% agreed or strongly agreed.
- "I believe the organisation took all reasonable steps to keep colleagues and residents safe during the pandemic" - 88% agreed or strongly agreed.

14.3. Suzanne Mumford, Head of Dementia, Care and Nursing at Care UK, co-authored an article in the American Journal of Infection Control, titled

"English care home staff morale and preparedness during the COVID pandemic: A longitudinal analysis", 2022 (**Exhibit AK/03 - INQ000509766**). This article was based on an online structured survey targeted at LTCF workers administered at 3 points (November 2020-January 2021, August - November 2021 and March-May 2021). These surveys related to the sector as a whole and were not specific to Care UK's staff members.

15. Campaigns that Care UK was involved in

15.1. Care UK actively sought information regarding the safety of Covid-19 vaccinations and ran an internal campaign to raise awareness amongst colleagues of the importance of getting vaccinated. Care UK shared information with colleagues by way of webinars, Government-produced educational material and posters produced by Care UK posters.

15.2. Care UK continued to work with Care England to support carers being afforded the same status and recognition as NHS workers.

16. Aspects of response to the pandemic that went well

16.1. Without a doubt, the most impressive response to the pandemic came from individuals working within care homes. There was an initial concern that care home staff would feel too frightened to go to work but from a Care UK perspective, individuals continued to go above and beyond to support residents. This included exceptional actions such as carers staying in care homes overnight or for extended periods of time to cover staff shortages and because they did not want to leave residents or to risk spreading the virus; individuals giving up the option to spend Christmas with their family as they supported residents through the short Christmas window when isolation restrictions were eased; and carers moving into temporary accommodation away from their families so that they did not expose family members or residents to unnecessary risks. If it had not been for that resolve and determination, care providers would have been in a very different position. I refer to the home manager reflective pieces contained at **Exhibit AK/05 - INQ000509768** which expand on the huge sacrifices

that care home workers made during the pandemic and the acts of kindness and compassion demonstrated by their team members. The managers also describe the way in which teams pulled together and supported each other.

16.2. I am always proud of the work we do at Care UK, but never more so than during the pandemic. The teams working in our care homes would consistently go above and beyond to minimise any distress caused to residents by extended lockdowns. I am deeply humbled to work alongside individuals who very bravely faced their own fears and put the needs of residents above all else during such a challenging time and I cannot praise their efforts enough.

16.3. At a leadership level, care providers worked together as part of the Care England network, to collaborate and to test their understanding of the guidance. There was no sense of competition between care home providers. Everyone instead worked together to try to work on solutions.

16.4. Care UK was able to adapt from business as usual to pandemic crisis management, sourcing PPE, trialling lateral flow tests, and adapting homes so that family visits could take place.

16.5. The Government also introduced some positive changes such as allowing someone to start a new role either with a DBS check or references, rather than both and providing funding which enabled local authorities to increase local authority funded care home fees to levels more closely aligned with the real cost of care.

17. Inequality issues affecting care providers, workers and recipients of care

17.1. As set out above, care home residents were disproportionately impacted by the pandemic as they were actively discouraged, and at times prevented, from accessing a full range of health services due to their age.

17.2. Further, care home workers, many of which are from black and ethnic minority backgrounds, were required to accept Covid vaccines which

went against some people's religious and cultural beliefs when this policy was not applied to those doing similar roles within the NHS.

Statement of Truth

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

Signed: Personal Data

Dated: 29th Jan, 2025