Witness Name: Oonagh Smyth
Statement No.: 1
Exhibits:
Dated:

**UK COVID-19 INQUIRY - MODULE 6**

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**WITNESS STATEMENT OF OONAGH SMYTH**

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I, **Oonagh Smyth**, of Skills for Care, West Gate, Grace Street, Leeds, will say as follows:

1 I make this statement, in relation to the impact of the Covid-19 pandemic on the publicly and privately funded adult social care sector, in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 31 October 2024, in relation to Module 6 of the Inquiry. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

2 I make this statement on behalf of Skills for Care and confirm that I am duly authorised to do so.

**Introduction and Background to Skills for Care**

3 Skills for Care is the strategic workforce development body for adult social care in England. Over a period of more than 20 years, we have built extensive networks and deep relationships, engaging with a majority of Care Quality Commission ("**CQC**") registered care providers, all local authorities and all Integrated Care Systems (ICSs).

4 Skills for Care is an independent charity. We act as a neutral and authoritative system leader, bridging the gap between the government and the adult social care sector. The majority of our funding comes from the Department of Health and Social Care (DHSC) in the form of a grant.

5 Our four strategic priorities are increasing workforce capacity, supporting workforce capabilities, supporting culture and diversity, and improving the social care system.

6 We operate the Adult Social Care Workforce Data Set (ASC-WDS), which currently holds data on over 650,000 social care staff in 20,000 care locations. Every autumn we publish our *State of the Adult Social Care Sector and Workforce in England* report. This report has been described by the Office for National Statistics as 'the most comprehensive publicly available source of workforce statistics for the adult social care sector in England'.

7 We work across the health and social care system to understand the key drivers of change in social care and the capacity, characteristics and skills that are needed in our workforce to meet people's future needs.

8 We use our intelligence and networks to identify the workforce's development needs, we use our expertise to develop the services and products to meet those needs, and we use our engagement channels to ensure uptake.

9 We manage and oversee the sector's learning and development landscape – the content, pathways and quality assurance.

10 We have led the development of a Workforce Strategy for adult social care which involved working with a wide range of organisations and people who have a stake in the future of the sector. This was published in July 2024.

**Skills for Care's geographical remit**

11 Skills for Care operates in England, although we do facilitate a wider alliance of organisations with a remit for adult social care workforce development or regulation across all four nations, called Skills for Care and Development. As

Skills for Care's own work, data and insight are focused on England, this information in the statement also focuses on England only.

**Skills for Care's data**

12 Skills for Care is commissioned by DHSC to collect data on adult social care providers and the staff they employ. We do this via an online data collection service called the Adult Social Care Workforce Data Set (ASC-WDS). ASC-WDS has been collecting data in this way since 2007. The collection covers the type of care setting, numbers employed, staff retention and turnover, staff demographics, staff pay, staff hours, staff qualifications and more.

13 It is by far the most robust and insightful source of data on the adult social care workforce and is relied upon by DHSC and other government departments.

14 The service is voluntary to use for independent sector care providers and mandatory for local authorities. The service holds data on 53% of all CQC regulated services, on all staff employed in social care by local authorities and overall holds data on over 700,000 individual staff members.

15 This level of coverage is very good for a voluntary service. Where providers do not use it, this can be due to lack of awareness, churn in the sector due to providers opening and closing – or providers preferring not to invest the necessary time.

16 It is by far the most robust and insightful source of data on the adult social care workforce and is relied upon by DHSC and other government departments.

17 Skills for Care publishes weighted estimates and insights on the sector and workforce at national, regional, local authority and Integrated Care Board (ICB) level.

18 Our data for the entire period between 1 March 2020 and 28 June 2022 includes the following:

a. average pay - by job role and care setting;

b. residents per provider – while the workforce is the main focus of ASC-WDS, we do collect data on capacity and current occupancy in care homes;

c. breakdown of the workforce by protected characteristic - covering, at a high level, gender, ethnicity and disability;

d. breakdown of the workforce by role; and

e. breakdown of the workforce between full-time employment, part-time employment and those on zero hours contracts - by job role and care setting.

19 I will summarise the data on these areas later in this statement, when I come to talk about the findings of our annual *State of the Adult Social Care Sector and Workforce in England* reports.

20 We do not hold data on vaccine uptake.

**Evolution and limitations of Skills for Care's data**

21 By 2020, Skill for Care's data collection existed for around fifteen years and was a mature dataset that had evolved to cover the areas DHSC and others needed data on for the adult social care sector and workforce. While it did not cover every care provider, this was not an issue because knowing about more than half the sector meant that Skills for Care was, and is, able to produce very reliable estimates on the size and structure of the workforce as well as on the issues it faces.

22 Prior to the pandemic, we reported our workforce statistics on an annual basis, which allowed for national and local workforce planning. During the pandemic, we identified the need for more frequent reporting, as statistics such as absence rates and recruitment and retention were changing at a much faster pace.

23 During the pandemic, DHSC quickly started to collect data from every care provider about vaccine uptake by staff, their access to PPE on a frequent basis.

24 ASC-WDS was judged not to be the best vehicle to collect data on vaccine status and PPE, as it was not a mandatory collection for care providers and Skills for Care did not have the necessary regulatory or statutory status to obtain this data from every care provider.

25 Throughout 2020 and 2021, we responded to the need for more frequent reporting of workforce numbers by adding monthly trackers to our website from May 2020. These trackers covered key statistics that we knew were changing quickly during the pandemic such as sickness rates, the number of filled posts and the number of vacant posts.

26 Skills for Care's role in terms of adult social care data is focused on understanding the size and structure of the adult social care workforce and the nature and scale of the issues affecting it. We therefore continually review the data collected within ASC-WDS and the analytical outputs we produce to ensure we meet the intelligence needs of DHSC, other government departments and the wider sector. We work to ensure ASC-WDS is reflective of the sector in terms of the job roles it collects data on, types of care setting and its scope in terms of emerging data needs, for example, the need to better understand the role of workers on a Health and Social Care visa was recently addressed.

27 We have continued to work on our ability to report data more frequently. Following the pandemic, we began integrating data engineering into our analysis work to allow us to report data faster and more frequently in the future. Our estimates of the size of the care home workforce are now produced in a few hours and are reported monthly rather than once per year. We continue to expand our work in this area to cover recruitment and retention and other workforce characteristics.

28 Our data engineering work means we will be able to report on key statistics immediately during a future pandemic. We will soon be able to immediately identify changes in areas including staffing levels, sickness and vacancy rates.

29 At the start of the pandemic, there was some duplication across datasets and confusion for care providers. We recommend that the Government should make a plan to understand what data they know they will want access to during a future

pandemic and which data sources they will use to cover these needs. This plan could also cover areas including what data is needed daily, weekly or monthly; which data needs a response from every care provider; and where it will be possible to use extrapolated data from a smaller sample.

**The role of Skills for Care during the pandemic**

30 At the onset of the pandemic our plan of work, funded by the DHSC, was in place and agreed. In partnership, we rapidly revised our plans, and continued to revise them throughout the pandemic, in response to the changing context. We focussed our core strengths as the established adult social care workforce body to provide as much support to the sector as we could, during a time when it so badly needed it.

31 An overview of our role is set out below, and is expanded upon throughout this statement.

Collection of data, and provision of Adult Social Care Workforce Intelligence

32 As already described.

Information and guidance

33 During the pandemic, we provided a number of self-help resources and hosted online information events aimed at social care leaders, managers and other key members of the workforce, including infection prevention and control leads, personal assistants and their employers. Some of the resources were new and developed in response to the pandemic, others were existing and re-purposed to provide support within the context of the pandemic. The range of resources are detailed in the sections below.

34 We restructured our website to create a dedicated COVID-19 advice and support section. The aim of this was to provide easy access to these resources alongside others from Government and other trusted sources.

Direct and peer support

35 During what was an incredibly challenging time for the social care workforce, we took a key role in developing interventions with the aim of providing wellbeing support. We convened key sector partners to develop guidance and advice which were delivered via digital resources and online seminars.

36 We supported managers via our Advice Line, text message services and WhatsApp groups. We provided personalised guidance and signposting to national and local resources, while our local teams offered region-specific assistance, including information on funding, training, and COVID-19 responses.

37 We facilitated peer support connections between managers by convening and leading Registered Manager Networks, WhatsApp groups, and the Social Care Manager Facebook Group, which expanded to non-network members during the pandemic. Across a number of platforms this enabled thousands of managers to share advice, strategies, and experiences, fostering a collaborative approach to addressing the challenges they were facing.

Learning and Development

38 Skills for Care led the development of revised learning and development programmes to enable the acceleration of induction and on-boarding of new or returning members of the adult social care workforce. We commissioned training providers, which were quality-assured by us, to deliver the programmes at scale and pace.

39 We also developed new learning programmes and principles to help those in social care and in learning and development provision to respond to the changed context. We repurposed the established Workforce Development Fund to ensure funding was targeted at Learning and Development most relevant to the context. In 2020/21, £3.6 million was ringfenced for rapid induction training for new staff, statutory and mandatory training and a volunteer programme.

Connections into the sector and into central government

40 One of the core strengths of Skills for Care is our reach and connections across the diversity of adult social care. This, alongside our position as a strategic

delivery partner for the DHSC, means we have a unique ability to connect the sector with policy makers and vice versa.

41 At the onset of the pandemic, we focused on this core part of our role, quickly pivoting from face-to-face convening to connecting and interacting online. This meant that we continued to collect high-quality data and live insight, to ensure that as many people as possible could access the resources and support available to them.

42 We formalised our provision of insight from the sector to colleagues within the DHSC, providing daily, weekly and then monthly reports of what we were hearing and experiencing on the ground.

43 The first issue of our Market Insight report (later renamed to the Sector Insights report) was published on 30 March 2020. Reports were published weekly until 14 July 2020. As the pace of change reduced, it became a fortnightly publication for 2 issues in July - and from September 2020 until the present day it has been a monthly publication (with some exceptions by mutual agreement).

44 We used the intelligence ourselves to respond directly to the sector, developed interventions in partnership with government and other key partners, as well as providing advice and appealing directly to government on key issues via written reports, discussion with policy leads and through membership of groups and taskforces. Examples of these are detailed below.

**An overview of Skills for Care's role in delivering training, guidance and support for the adult social care sector on specific topics during the pandemic**

45 Skills for Care responded to the COVID-19 pandemic by developing and updating a wide range of resources to address the unique challenges faced by adult social care providers. We worked to maximise their reach among adult social care employers in England, promoting national guidance, initiatives, and support aimed at keeping both the workforce and the people they cared for as safe as possible.

46 We used our fortnightly electronic newsletter to proactively share information and updates. During April, May and June 2021, the newsletter was produced weekly. Whilst this was more regular communication than usual, it helped avoid overwhelming frontline care managers and staff with too much separate information. It also enabled Skills for Care to curate and signpost the key changes relevant to adult social care employers.

47 We established a dedicated COVID-19 advice and support section on our website, providing a centralised hub for guidance from government and other trusted sources. This aimed to serve as a single, reliable resource for social care providers, offering regular updates and essential information during a rapidly evolving situation.

48 Whilst Skills for Care produced training, guidance and support on a wide range of topics, the information in this section is limited to the below areas of interest expressed by the Inquiry.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

49 The Care Quality Commission (CQC) published its report on Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPR) on 18th March 2021, *Protect, respect, connect – decisions about living and dying well during COVID-19* which contained a recommendation that clinicians, professionals and workers must have the knowledge, skills and confidence to speak with people about, and support them in, making DNACPR decisions. To do this, the CQC recommended that:

> *"…there needs to be clear and consistent training, standards, guidance and tools for the current and future workforce. This needs to be in line with a national, unified approach to DNACPR decision making. Providers also need to ensure that there is training and development available for all health and care professionals."*

50 This recommendation was for Health Education England and Skills for Care. I joined the Ministerial Oversight Group for this work alongside the then Head of Workforce Capacity and Transformation at Skills for Care, Jim Thomas. We

attended four meetings between June 2021 and July 2022. The group was closed by letter from the Minister for Patient Safety and Primary Care, Maria Caulfield in July 2022 **[OS/01 - INQ000553289]**.

51 Skills for Care worked with partners to develop a set of principles that support best practice around advance care planning, which includes and appropriately contextualises DNACPR decisions, underpinned by training standards. This included an Easy Read version. We promoted these, published a podcast with CQC on DNACPR, reviewed and updated core principles for end-of-life care and developed some more material to clarify roles. The materials that we developed are still available on our website. Our DNACPR webpage was published in September 2021 and received, on average, 100 page views per month between September 2021 and June 2022.

52 The resources were designed to ensure that DNACPR practices align with the principles of dignity, compassion, and individual rights. The offer includes practical guidance, FAQs, and tools aimed at improving communication and decision-making around DNACPR orders, fostering a person-centered approach within care settings.

53 Central to the offer are film recordings featuring real-life scenarios and expert insights. These films cover key aspects of DNACPR, including ethical considerations, legal frameworks, and effective communication strategies. They provide social care workers with examples of how to navigate sensitive conversations with service users, families, and healthcare professionals. The recordings emphasise the importance of clarity, empathy, and collaboration in DNACPR discussions, ensuring decisions are well-understood and respected.

54 The resources also address common challenges and misconceptions around DNACPR, empowering care teams to advocate for individuals' rights while maintaining professional standards. By promoting knowledge and confidence in this area, Skills for Care supports the workforce in delivering high-quality, ethical care that honours the preferences and dignity of those they support. These resources are accessible on our website and are tailored for varied learning needs within the sector.

55 We cannot comment on the impact of the Ministerial Oversight Group or the resources because we do not track the appropriate use of DNACPR.

56 On 29 April 2022, we provided DHSC with an update paper **[OS/02 - INQ000553290]** on progress made against the CQC's recommendation to be reviewed at the Ministerial Oversight Group meeting on 17 May 2022. As part of the update, we recommended that government commission a mapping of the gaps in knowledge and understanding between healthcare and social care workers, set out a local model for the evaluation of learning and development interventions that commissioners can use to measure progress and ensure that DNACPR is in all local and national workforce plans. This work was not commissioned by the Department of Health and Social Care (DHSC) from Skills for Care but might have been commissioned from another organisation.

End of life care

57 Between March 2020 and July 2022, we developed a small suite of resources to enhance end of life care in adult social care settings. These resources aim to equip care professionals with the necessary skills and knowledge to provide compassionate and effective support to individuals nearing the end of life during the COVID-19 pandemic.

58 We provided resources for health and social care workers who may not specialise in end of life care but found themselves supporting those with deteriorating conditions. The adapted *Common Core Principles* outline essential competencies, knowledge, and values needed in end-of-life care. Additionally, the *End of Life Care Support* supplement applies these principles practically, drawing from the *Good and Outstanding Care Guide* to highlight best practices and offering key guidance points. It also includes useful links to COVID-19-specific end-of-life care resources, supporting quality care during challenging times.

59 In collaboration with NHS England, NHS Improvement, the Nursing and Midwifery Council and the CQC, we created resources to support the verification of expected death (VOED) with clinical remote assistance. This guidance aligns with the *Coronavirus Act 2020*, allowing non-specialist care providers to verify

deaths remotely in community settings, such as care homes or private residences. Resources include supportive guidance, a step-by-step infographic, and a pocket prompt card, designed to aid those involved in VOED while respecting that some may feel unprepared or uncomfortable with this responsibility. We also offer recorded webinars and a video with insights from Claire Henry, an end-of-life expert, to help Registered Managers and providers prepare for this task, ensuring that those managing end-of-life care have access to appropriate support and training.

60 During the COVID-19 pandemic, Skills for Care highlighted essential end-of-life training resources to help the adult social care workforce provide compassionate, high-quality care. These resources aim to equip care workers and managers with the skills and knowledge needed to support individuals approaching the end of life. Training materials, such as *Bounce Back Boy* and *Working Together to Improve End of Life Care*, offer practical insights, while specialised guidance for domiciliary care providers ensures tailored support for home care settings. The *e-End of Life Care for All* (e-ELCA) eLearning program further enhances learning opportunities, covering key competencies for end-of-life care. Managers are encouraged to ensure their teams have sufficient trained staff to meet the diverse needs and wishes of those they support. Skills for Care also provides guidance on finding high-quality training and offers funding options for ongoing professional development in this critical area.

61 Skills for Care also played a key role in highlighting the importance of advance care planning to support adult social care providers in managing end of life care with sensitivity and respect. Some of the resources we promoted included An Advance Care Plan (ACP), which allows individuals to outline their care preferences should they become too unwell to communicate or make decisions. This guidance helped care providers understand how to respect the rights and wishes of individuals regarding treatments, including 'do not attempt resuscitation' decisions.

62 Skills for Care also helped to promote the ReSPECT process, which further supported personalised recommendations for emergency care, ensuring that care aligned with the individual's values. These resources, including the NICE

Advance Care Planning quick guide and the Gold Standard Framework, empowered providers to facilitate informed, compassionate care discussions with service users and their families. This support aimed to reduce stress for both staff and families during difficult times, ensuring that care remained person-centered and respectful of individuals' end-of-life preferences.

Supporting employers and the care workforce relating to any unfair impact as a result of the pandemic arising from ethnicity, age, gender and underlying health conditions

63 During the pandemic, Skills for Care delivered a comprehensive range of resources to address the pandemic's disproportionate impact on minority communities within the adult social care workforce.

64 Recognising the unique challenges faced by Black, Asian, and minority ethnic (BAME) workers, who comprise one in five of the sector's workforce, we focused on Supporting Ethnic Minority Staff through targeted webinars, surveys, and peer coaching. These initiatives sought to uncover the specific barriers and health risks that BAME staff encountered, such as increased risks from COVID-19 and historical inequalities in workplace conditions.

65 Webinars led by experts in critical race studies and healthcare addressed various forms of discrimination, helping staff understand their rights and equipping them with strategies to counter bias and promote fairness in their workplaces. Skills for Care's collaboration with the Equality and Human Rights Commission further explored the experiences of BAME workers in lower-paid roles and gathering data to inform more equitable practices.

66 Leadership and Organisational Change resources were another key focus, encouraging organisations to adopt anti-racist practices and prioritise inclusivity. Through webinars such as "How to Become an Anti-Racist Organisation," Skills for Care provided guidance for leaders responsible for implementing anti-racist policies, highlighting ways to foster a culture that values diversity and equity.

67 Expert panels, including prominent figures in educational equity, mental health, and social work, shared insights on organisational transformation and accountability. Webinars on "Building Alliances to Support BAME Staff"

emphasised the importance of collaboration within and beyond organisations, encouraging leaders and staff to form networks that advocate for systemic change. This approach underscored that addressing discrimination in social care is a collective responsibility, not limited to minority staff alone.

68 Mental Wellbeing and Resilience resources were vital, considering the heightened stress and mental health challenges faced by minority ethnic staff during the pandemic. Skills for Care facilitated webinars that discussed the psychological impact of discrimination, social inequalities, and the compounded stress of COVID-19 on BAME communities. These sessions explored practical ways for organisations to protect the mental wellbeing of their staff, including risk assessments and support structures. Topics included managing stress from everyday discrimination and creating inclusive environments that support open conversations around mental health. By addressing these challenges, Skills for Care aimed to foster a supportive atmosphere in which minority staff felt valued and psychologically safe.

69 In addition to training and webinars, we shared insightful blogs from leaders and care workers who provided personal perspectives on working within the social care sector as part of a minority group. These blogs, such as "Black Lives Matter in Care Too" and "Lived Experience: Iron Boots Over My Shoes," highlighted the personal and professional challenges faced by BAME staff. Contributors reflected on the importance of embracing diversity, sharing their lived experiences of exclusion and intersectionality, and calling for meaningful change. These narratives emphasised that creating an inclusive workforce requires sustained action and a commitment to change from organisations across the sector.

Agency and zero-hours contracts workers

70 Recognising the increased level of risk faced by these workers during the pandemic, Skills for Care produced guidance that addressed employment rights, wellbeing and fair working conditions for temporary and flexible staff. Resources included best practice recommendations for managing zero-hours contract employees, emphasising the need for stability, fair treatment, and clear communication to ensure consistent, high-quality care.

71 In addition, we delivered webinars and learning materials focused on workforce resilience and retention strategies, helping employers understand the importance of supporting agency and zero-hours staff during challenging times.

72 These resources encouraged managers to provide adequate training, protective equipment and mental health support to all workers, regardless of contract type, ensuring that temporary staff felt valued and protected.

73 The resources also highlighted the legal and ethical considerations of zero-hours contracts, aiming to reduce the exploitation of flexible workers and promote fair pay and job security wherever possible.

74 We also signposted to support for both frontline care workers and their employers to aid financial difficulties.

Personal Protective Equipment (PPE)

75 During the pandemic, Skills for Care signposted to a wide range of resources and guidance on PPE to support adult social care employers and managers in navigating the challenges of infection prevention and control. Recognising the critical need for PPE, we directed managers to Public Health England's tailored guidance for care homes and domiciliary care settings. These resources outlined correct PPE protocols, including detailed FAQs addressing common concerns about its use and application. Complementary videos, such as NHS England's demonstration on safely putting on and removing PPE, offered practical visual aids, ensuring care workers could implement best practices effectively.

76 To address widespread supply challenges, we highlighted key government initiatives, including the COVID-19 PPE plan and the PPE portal, which enabled eligible care providers to order emergency stock. Managers were also encouraged to engage with Local Resilience Forums (LRFs) and the National Supply Disruption Response (NSDR) system for urgent PPE needs. By providing details on emergency contact channels and requirements for obtaining supplies, we helped managers to maintain essential stock levels. Guidance on optimising PPE use during acute shortages, approved by the Health and Safety Executive

(HSE), offered strategies for sessional use and safe reuse, ensuring adequate protection within health and safety regulations.

77 We facilitated peer-to-peer learning through virtual networks and the Social Care Manager Facebook Group, enabling managers to share real-time solutions for accessing PPE, interpreting guidance, and overcoming logistical hurdles. These forums created a collaborative environment where managers could exchange experiences and advice, enhancing their ability to navigate pandemic-related challenges.

78 Additionally, Skills for Care promoted resources such as the updated government PPE distribution plans, helping managers understand and anticipate changes in supply chains. Videos and step-by-step instructions provided further clarity on maintaining proper PPE practices, ensuring safety standards were met.

79 Feedback from the sector indicated that, although the guidance we published was up to date, it did not always match the type of PPE available to them in the workplace. We shared this feedback with DHSC through our insight reports.

Infection prevention and control (IPC)

80 During the pandemic, Skills for Care provided a wide range of resources to support adult social care employers and frontline managers in IPC. These resources were designed to equip managers with essential knowledge and practical guidance to protect staff and individuals receiving care.

81 We signposted to government and Public Health England (PHE) guidance on IPC, including the safe handling of the deceased, managing stepdown precautions, and discharging COVID-19 patients to home or care settings. Webinars tailored for care homes and domiciliary care addressed core IPC principles such as proper use of PPE, isolating residents, and minimising virus spread. These sessions provided actionable steps for daily care adaptations, ensuring consistent safety measures across diverse settings.

82 To assist domiciliary care providers, Skills for Care promoted recordings and FAQs addressing unique challenges in home care environments. The NICE

*Preventing Infection* quick guide supported care home managers in implementing proactive measures to safeguard residents and staff. These resources highlighted the importance of vigilance in shared living spaces where infections can easily spread.

83 The Care Certificate Induction (Standard 15), developed jointly by Skills For Care, Health Education England and Skills for Health, offered practical tools to train new staff in IPC during onboarding. For established teams, the *Good and Outstanding Care Guide* provided recommendations to maintain high standards, emphasising staffing levels and adherence to best practices.

84 We promoted the government's antibody testing service, allowing care workers to check for previous COVID-19 infections from home. While tests provided reassurance, guidance reinforced the importance of continued adherence to protective measures.

85 Our Registered Manager Advice Line provided a vital point of contact during the pandemic, guiding employers to essential IPC resources. This service connected managers with knowledgeable advisors who could signpost them to relevant guidance, webinars, and practical tools for tackling COVID-19-related challenges. Whether addressing specific queries about PPE, safe discharges, or adapting IPC practices, the advice line ensured that managers had tailored support to implement effective measures in their settings.

86 Additionally, the peer support virtual networks and the Social Care Manager Facebook Group offered invaluable opportunities for managers to share experiences and learn from one another. These platforms fostered collaboration, with managers discussing strategies for implementing IPC guidance, overcoming logistical challenges, and maintaining high care standards. By sharing real-world insights and solutions, participants gained practical knowledge from peers facing similar situations. Together, these initiatives enhanced collective learning, resilience, and consistency in IPC practices across the social care sector.

Navigating language barriers

87 We did not provide any specific training, guidance or support on this subject.

**Skills for Care's wider role in providing training or guidance for employers**

Recruitment

88 We provided support to the sector on recruitment and retention in social care, mostly in the form of convening and guidance. We also identified the systemic issues of recruitment and retention in social care.

89 Our Quarter 4 performance report in 2022 to DHSC on our grant talks about us setting up and running a Finding and Keeping Workers stakeholder group to understand the issues and act. This resulted in the following actions:

a. We set up an international recruitment webpage with guidance developed by subject matter experts.

b. Delivered Value Based Recruitment (VBR) online workshops.

c. A suite of careers and employment advisors specific VBR content were developed and launched.

90 The Think Care Careers webpage was revamped to provide improved content for teachers and careers advisors.

91 Skills for Care was asked by DHSC to put in place a 'single point of contact' to align the NHS Bring Back Staff process with social care and enable the deployment of returning registered nurses into social care. We represented social care in the regional planning and decision-making process and supported social care providers with information and advice on how to access returners through the NHS Bring Back Staff scheme. We gathered and collated intelligence from the social care leads in each region on how the scheme was working and fed that back.

92 We shared best practice on recruitment and retention with providers on our website and through a range of webinars that ran from 22 April 2020 to 28 March 2022. 3,473 care professionals registered for these webinars.

Rapid Response Programme (Rapid Induction, Essential Training, Volunteer Programme)

93 On 26 March 2020, Skills for Care was directly commissioned by the then Minister for Social Care, Helen Whately, to develop training programmes to support the rapid onboarding and induction of new staff into social care settings, as the shortage of care workers had impacted the sector at the start of the pandemic.

94 This commission was widened a week later to include a programme to recruit volunteers to support social care and a programme based on agreed relaxations to mandatory training which was called Essential Training.

95 All three learning and development programmes were to be delivered virtually, at scale and pace, through 12 of Skills for Care's endorsed learning providers.

96 The rapid induction programme content was based on the knowledge element of the Care Certificate, designed to give new entrants and returners to the workforce the essential knowledge to be able to start work, with employers then being responsible for the competence assessment in the workplace once work had started. This approach was agreed with CQC, as the regulator, and funding was agreed utilising a ringfenced proportion of the Workforce Development Fund as part of our grant agreement with DHSC.

97 The Essential Training programme, again in agreement with CQC, was a pared-down version of the Core and Mandatory training guidance for the sector covering the essential elements a care worker needed to be safe in the workplace, again with the responsibility passing to the employer to ensure that, over time, other elements of the core and mandatory training were being supplemented for each worker. The eight agreed programmes were assisting and moving people, basic life support, fire safety, food safety, health and safety awareness, infection prevention and control, medication management and safeguarding.

98 The Volunteer programme was the most challenging as, under CQC requirements, volunteers are not permitted to undertake any personal care for

people drawing on care and support. We therefore looked at other roles and functions which volunteers could undertake in the sector and developed a programme around isolation support, housekeeping and maintenance and wellbeing.

99 The three programmes were developed and launched, with funding attached, and formed a vital support for the workforce for the next four years, only being withdrawn by DHSC in 2024.

100 Of the three programmes, the rapid induction and essential training programmes were the most popular with the sector. The volunteer programme never gained traction as, during the pandemic there was a reluctance from people to volunteer to work in social care, and settings had to be cautious about who crossed their thresholds and interacted with staff and people drawing on care and support to prevent the spread of infection.

101 Funding for these programmes was from the already-agreed Workforce Development Fund as part of the Skills for Care grant agreement.

Guidance for Local Authorities and employers for care workers supporting people with Dementia

102 We communicated up-to-date guidance and support to care providers who were supporting people with dementia in line with the COVID-19 Ethical Framework for Adult Social Care. This included guidance and resources from the Care Certificate and the Dementia Training Standards Framework 2018, Tiers 1 and 2.

103 Skills for Care also worked with partners to develop additional guidance, including for Local Authorities, to ensure the rights of people with dementia to specialist care were being protected in line with the Care Act 2014 and the Human Rights Act 1998.

Learning from Events (initially called Learning Review)

104 A virtual learning programme for settings was developed to look at 'near misses' and 'accidents' and interrogate and learn from the process to avoid them happening again.

105 This programme was commissioned by DHSC as part of the Winter Plan 2020.

106 Based on similar programmes used within health, with support from the Behavioural Insights Team, Skills for Care developed the learning programme digital module, which was free to access for employers, and supported by an incentivised payment from the Workforce Development Fund of £100 to encourage uptake.

107 Funding for this learning was from the already agreed Workforce Development Fund as part of our grant agreement.

Assessment Principles for Learning & Development

108 Training provider staff from independent training organisations were no longer allowed to carry out face-to-face training at the height of the pandemic and so a series of adjustments were made to the assessment principles for qualifications.

109 Initially this took the form of a comprehensive risk assessment, based on the number of people who would be together, the health, risk level and characteristics of the people undertaking training and assessment, their vaccination status, the room where assessment would be carried out (whether there was adequate ventilation and social distancing) and the availability of PPE for participants.

110 As the pandemic progressed, guidance was that no one should undertake face to face training unless absolutely vital for the safety of people drawing on care and support - and guidance was produced to support virtual, digital assessment.

111 This was done with the agreement of the awarding bodies who were part of the Joint Awarding Body Quality Group (JABQG) and with the agreement of devolved nations' social care councils who were part of the Skills for Care and Development Joint Assessment Principles (Northern Island Social Care Council, Scottish Social Services Council and Social Care Wales).

Compulsory Vaccination and staff dismissal

112 Skills for Care signposted to guidance on the uptake of the vaccine and guidance to employers when DHSC made vaccination a condition of employment in social care settings **[OS/02a - INQ000571773]**.

**The Care Certificate**

113 In 2013, the Francis Inquiry into the serious failings at the Mid Staffordshire NHS Foundation Trust identified serious failures in healthcare provision. Camilla Cavendish was asked by the then Secretary of State to review and make recommendations on the recruitment, learning and development, management and support of healthcare assistants and social care support workers, to help ensure that this workforce provided compassionate care.

114 As a result, the Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health for use in England and is the minimum training, supervision and assessment that staff new to health and adult social care should receive as part of induction and before they start to deliver care out of the line of sight of more experienced workers.

115 There are fifteen standards **[OS/03 - INQ000553291]** that must be completed, involving knowledge learning, practical skills and workplace assessments. Completion of all standards is required to attain the Care Certificate.

116 The Care Certificate is aimed at workers joining a health or adult social care organisation without any past training or sector experience. However, employers are free to decide whether any other staff groups would benefit from undertaking some or all of the Care Certificate.

117 Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.

118 The Care Certificate is part of a structured induction but does not replace all of the learning required for staff induction. As well as the Care Certificate standards,

new staff will be expected to have information, knowledge and competences specific to the environment in which care will be provided. Other context-specific knowledge and skills would be related to the patient and service user groups the support worker will be supporting. The content of this remains the employer's responsibility.

119 For those individuals joining an employer with no past training and experience, each employer is likely to run a series of training sessions for their new workers. It is possible that these courses, sometimes referred to as "mandatory training", may cover some content of the Care Certificate.

120 To achieve the Care Certificate, the person must acquire knowledge and demonstrate competence in all 15 standards. The employer remains responsible for the decision to award the Care Certificate, irrespective of who undertakes the training, supervision or assessment.

121 For a full-time member of staff, the amount of time taken to achieve the outcomes of the Care Certificate should be around 12 weeks.

122 Employers should ensure that any skills and knowledge are current and can use the Mapping Document and Self-Assessment Tool produced alongside the Care Certificate standards to identify gaps or refreshers required in skills and knowledge. The employer would then arrange any additional training and/or workplace assessment needed. In some cases, this may mean that the employer will require the individual to complete the Care Certificate

123 The employer is responsible for assuring the quality of training, supervision and assessment of ability of their healthcare support and care workers. Providers of care have a duty to ensure that people are safe, and their health and welfare needs are met. They must ensure that their staff are competent to carry out their work and are properly trained, supervised and appraised.

124 Employers are responsible for assuring the quality of the teaching and assessment of the Care Certificate. It is expected that employers will use the standards to ensure that staff receive the training necessary so that they can

develop the knowledge and competences necessary to provide safe and compassionate care of the highest quality.

**Skills for Care's role in providing emotional or psychological support**

125 During the COVID-19 pandemic, Skills for Care played a vital role in supporting the emotional and psychological wellbeing of the adult social care workforce.

126 We galvanised key sector partners and convened a National Wellbeing Steering group, in collaboration with the Local Government Association, to provide a regular space to highlight challenges, develop and share resources and escalate concerns to DHSC.

127 Webinars addressed topics such as bereavement, managing mental health, and fostering resilience, offering practical strategies for coping with the pandemic's emotional toll.

128 We also highlighted resources from trusted partners, such as guidance from the British Psychological Society and Mencap, to support workers experiencing loss or supporting individuals with additional needs.

129 Peer support networks and the Social Care Manager Facebook Group created a safe space for care workers to share experiences and solutions, promoting collective learning and mutual encouragement. These efforts ensured that the workforce felt valued, supported, and equipped to manage the psychological demands of their roles.

130 The following sub-sections give more details on specific activities.

National Wellbeing Steering Group

131 The National Wellbeing Steering Group was formed in November 2020 and involved key partners including the DHSC policy lead for wellbeing, the Association of Directors of Social Services (ADASS), the Local Government Association (LGA), the CQC, Think Local Act Personal (TLAP), people with lived experience, the National Care Forum and the Care Workers' Charity.

132 The group met monthly throughout 2020-2022 and remains a strong connected group today. Members highlighted the concerns raised by the sector about the pandemic's impact on stress, mental health, burnout and trauma. Resources, webinars for a variety of audiences and workshops were developed by member organisations and shared via the group and respective websites. In January 2022, members of the group worked with the DHSC policy lead to influence and contribute to the wellbeing offer for the first People at the Heart of Care paper, from intelligence and insight gained from across the workforce. The wellbeing offer was removed from the second iteration of the white paper. The group raised concerns at the time that trauma, burnout and impact on the mental health of the workforce remained a priority.

Locality manager engagement with systems and care providers

133 Our network of locality managers worked with their local systems and providers to understand concerns, share and promote the Skills for Care offer and any local wellbeing initiatives, and establish links with the NHS wellbeing hubs.

134 Locality managers supported hubs to understand their local social care landscape and challenges with access, and suitability of the NHS wellbeing hubs to meet the needs of social care workers. We established a partnership in the Northamptonshire area with the NHS hub to deliver a series of workshops on compassionate leadership and established an NHS supported wellbeing network for registered managers.

Peer support and other assistance for frontline managers

135 During the pandemic, Skills for Care provided a range of support options and peer networks to help frontline managers navigate unprecedented challenges in managing adult social care services. These resources were designed to keep managers informed, connected, and supported in protecting people drawing on care and support and staff.

136 Skills for Care delivered weekly e-newsletters and continuously updated our website with the latest COVID-19 guidance, tools, and resources. These ensured managers had access to real-time information to make informed decisions.

137 We facilitated peer support connections between managers through Registered Manager Networks, WhatsApp groups, and the Social Care Manager Facebook Group, which expanded to non-network members during the pandemic. These platforms enabled thousands of managers to share advice, strategies, and experiences, fostering a collaborative approach to addressing challenges.

138 The Registered Manager Advice Line provided personalised guidance and signposting to national and local resources, while Locality Managers offered region-specific assistance, including information on funding, training, and COVID-19 responses.

139 Virtual networks allowed managers to connect at both national and local levels, offering opportunities to discuss best practices, hear from guest speakers, and access peer-led problem-solving.

140 These initiatives enabled managers to stay informed, access vital resources, and gain emotional and practical support, helping them lead their teams effectively during the crisis.

Telemarketing support

141 In addition to its other support initiatives, Skills for Care implemented targeted telemarketing activity during the pandemic to directly engage with frontline managers. This proactive approach aimed to provide emotional support and a listening ear for managers facing unprecedented pressures.

142 The telemarketing teams reached out to registered managers to check on their wellbeing, offer guidance on available resources, and ensure they were aware of peer support networks and the Registered Manager Advice Line.

143 These conversations also captured valuable insights into the ongoing challenges managers faced, such as staffing shortages, mental health strain, and adapting to rapidly changing guidance.

144 This feedback informed Skills for Care's ongoing development of tailored resources, ensuring that support remained relevant and responsive to the real-time needs of the sector. By combining practical advice with empathetic

engagement, Skills for Care helped managers feel less isolated and more equipped to handle the demands of their roles.

Registered Manager Webinars

145 The webinars offered by Skills for Care during the COVID-19 pandemic focused on key areas to support frontline managers in navigating unprecedented challenges. Staff Support and Wellbeing sessions, including topics on motivation, managing bereavement, delegation, and wellbeing for managers, equipped leaders with tools to maintain morale and resilience within their teams. Additionally, Human Resources and Recruitment topics, such as HR fundamentals, distance and safe recruitment, and DBS checks, helped managers adapt to remote hiring practices and ensure compliance.

146 Technology and Remote Support sessions covered using digital tools to support staff and those drawing on care, enabling managers to leverage technology effectively during remote operations. In terms of Health and Safety, webinars on infection prevention, risk assessment, and NICE guidance provided essential insights for protecting staff and people who draw on care and support in a health crisis.

147 For Leadership Development and Skills Building, sessions on time management, empowering staff, and contingency planning (especially regarding winter COVID demands) were important for maintaining service continuity. Managers also benefited from targeted support in Communication and Crisis Management, learning strategies for difficult conversations, COVID-specific HR practices, and adapting to recovery phases. Lastly, Quality and Improvement topics focused on driving improvements and leading meaningful activities, ensuring high standards of care even in difficult times.

148 Overall, these webinars supported frontline managers by offering practical, targeted guidance to navigate the pandemic with resilience, compliance, and a focus on the wellbeing of staff and people drawing on care and support.

Bereavement and loss

149 Skills for Care provided resources to support adult social care workers coping with bereavement and loss. Acknowledging the profound impact of losing colleagues, loved ones, or those drawing on care, these resources offered practical and emotional guidance. The *Supporting Yourself and Others* guide encouraged self-care and managing grief, while the British Psychological Society's *Continuing Bonds* leaflet suggested ways to honour and remember those who passed away when attending funerals was not possible.

150 For individuals with a learning disability or autism, tailored resources helped caregivers communicate and support understanding around illness and death. Tools included the *Beyond Words* guide for coronavirus-related deaths, Mencap's bereavement guidance, and the Cheshire and Wirral Partnership NHS Trust bereavement guide for carers. NHS advice on coping with bereavement further assisted workers in managing personal and professional grief. These resources supported care workers in navigating loss while fostering resilience and compassionate care for those they support.

Mental health

151 Skills for Care provided essential guidance on mental health support for the adult social care workforce through its Registered Manager Advice Line and dedicated website. These resources acted as an important hub for signposting to practical tools and one-to-one support options tailored to the unique challenges faced by care workers and managers. The advice line connected managers directly to knowledgeable advisors who provided personalised support and directed them to services such as the Samaritans' confidential listening line for social care staff and the Shout 24/7 crisis text service.

152 The Skills for Care website consolidated resources from trusted partners, including Mind and Every Mind Matters (NHS), offering tailored COVID-19 content. This included mental wellbeing advice, COVID-specific coping strategies, and tools such as the Mind Plan for managing anxiety and stress. By serving as a central access point for information and real-time guidance, Skills for Care ensured care workers and managers could easily navigate and access the

support they needed, fostering resilience and emotional wellbeing across the sector.

153 We developed a digital wellbeing card download hosted on our website with bite size information on how to access support from helplines, websites and the NHS wellbeing hubs. We updated the website with wellbeing sector stories, videos and podcasts, produced bite size guides to resilience and the Five Ways to Wellbeing guide for Registered Managers.

Wellbeing resource finder

154 Skills for Care launched a Wellbeing Resource Finder in June 2020 to support the social care workforce during the pandemic. This tool helps care workers and managers quickly locate trusted resources to support their own or others' wellbeing. It was developed to address the significant pressures experienced by care workers and managers, particularly during the pandemic.

155 Its key sections are: Mental Health Support; Physical Wellbeing; Financial Wellbeing; Bereavement Support; and Leadership and Peer Support.

156 The Wellbeing Resource Finder benefits adult social care workers by providing quick access to trusted, sector-specific resources tailored to their unique challenges. It saves time by consolidating reliable information in one place, reducing stress for care workers and managers. By addressing key areas such as mental health, physical wellbeing, financial support, and bereavement care, the tool empowers individuals to manage their wellbeing effectively. It also equips managers with strategies to support their teams, fostering a positive and resilient workplace culture. Overall, the Finder is designed to promote a healthier, more supported workforce, enabling care providers to deliver consistent, high-quality care.

BIT text message service

157 We developed a light-touch and easily scalable evidence based interactive text message intervention, working with the Behavioural Insights Team (BIT), to

improve Registered Managers' mental and physical health from November 2020 to February 2021.

158 The messages were designed to foster a sense of support, shared community and a collective sense of professional identity, and also to provide practical tips for how managers could look after themselves, manage stress and recognise the value their roles have.

159 Registered Managers received a text message once a week over a 15 week period, outlining tips on how to look after themselves. Themes included gratitude, dealing with difficult moments, using support networks, tips for looking after yourself and switching off, pride in your work and reflection on achievements.

160 There was an overwhelmingly positive response to the content of the messages, described as useful, relevant and well-adapted to specifically address the struggles of individual recipients.

Further wellbeing support

161 Skills for Care's additional wellbeing resources during the COVID-19 pandemic offered targeted support for employers, focusing on creating resilient teams and fostering a supportive workplace culture. These resources included tailored guidance on managing stress within teams, encouraging open conversations about mental health, and building resilience among staff. Practical tools such as templates and guides helped employers implement mental health strategies that aligned with their specific workplace needs, ensuring staff felt valued and supported during a challenging period.

162 Employers were also directed to funding opportunities and external resources, such as those provided by the Care Workers' Charity, to assist with financial challenges faced by their teams. We promoted structured approaches to balancing workload pressures and maintaining morale, helping employers mitigate burnout and retain their workforce.

The importance of this support

163 By focusing on both individual and organisational wellbeing, these resources enabled employers to create a healthier, more supportive environment, ensuring the sustainability of high-quality care delivery during the pandemic.

164 This multi-pronged approach to care workforce wellbeing support was highly valued during the pandemic and, since the pandemic, Skills for Care has continued to maintain our wellbeing support offer, signposting to wider support and sharing practical examples and recommendations to support frontline managers, regulated professionals and staff.

165 In terms of good practice, we found that organisations that took a compassionate and inclusive approach with targeted wellbeing initiatives shaped around the specific needs of their workforce led to team members feeling better-recognised and valued. This encouraged open conversations and empowered them to speak up during the pandemic.

166 We learnt that, when the NHS Wellbeing Hubs were mobilised, there were difficulties reaching the whole of the dispersed adult social care sector. This impacted engagement and uptake, with what appears to be many social care workers unaware of the offer of support available.

167 Whilst external support including helplines may have appeared useful, feedback implied that there was a lack of understanding of the challenges within adult social care from these services. This resulted in some disappointment at the assistance that was provided when services were contacted. In contrast, the value of the aforementioned peer support facilitated by Skills for Care was often more highly valued.

168 Central government funded support to sustain some of our own initiatives and much of the wellbeing assistance we signposted to was withdrawn soon after the pandemic. There has been a significant scaling back of wellbeing assistance in adult social care from central government.

169 We continue to hear about the long-term impact the pandemic has had on managers and the wider workforce. Anecdotal feedback through Skills for Care's insight-gathering includes regular concerns around mental health, reduced

resilience and burnout. Managers and staff say they're still feeling exhausted from the last few years, with a reduced love and enthusiasm for the work. We've been told that this has affected retention, with managers taking early retirement and feeling reluctant to recommend the role, or a reluctance among more junior staff to step up into a registered manager role due to a perceived lack of ongoing support.

170

171 The workforce in social care is key to good quality social care and their wellbeing is essential to ensuring that we have a good, stable workforce. It is the role of employers to support the wellbeing of their staff. Government can support this by highlighting the importance of wellbeing, sharing good practice and creating the right conditions for wellbeing by ensuring enough funding is in place for care providers to appropriately support their staff.

**The impact of financial support provided to the care workforce on their ability to self-isolate**

172 The Market Insights and Sector Insights reports produced by Skills for Care between 1 March 2020 and 28 June 2022 provided anecdotal evidence of the impact of financial support on the workforce's ability to self-isolate. These reports were the result of insights gathered through Skills for Care's contacts and networks across England. The audience for the reports was Skills for Care staff and key contacts at the DHSC.

173 From March 2020, there were consistent reports of concerns and issues being caused by staff needing to self-isolate due to COVID-19. These often related to confusion about the processes that should be followed when someone tested positive, or when they were identified through the 'test and trace' system, particularly as guidelines frequently changed. The impact of self-isolation on employers was also regularly noted, particularly when staff were not allowed to work in multiple settings to contain the spread and therefore the pool of available workers was smaller. Some employers reported concerns about the potential need to close services if staffing numbers fell to levels that would impact their ability to operate safely. Others later raised concerns about re-integrating staff

who had self-isolated with those who had continued working throughout the pandemic.

174 Government, and other, funding was available to support providers with COVID-related costs, including paying staff who were self-isolating. However, reports received indicated that this money was slow to trickle through and/or was not available in a consistent manner. We heard that the number of changes to guidance and the ability of providers to interpret it made it difficult for the sector to treat staff consistently with regards to self-isolation. In extreme cases we were made aware of this leading to employment disputes and the seeking of employment law guidance.

Sources of funding, financial context and funding concerns

175 In April 2020, the Care Workers' Charity set up a grant for UK carers who were self-isolating and who needed financial support. Over £1 million was awarded in this respect during 2020.

176 By the end of April 2020, we were hearing reports that businesses were struggling financially because of increased costs (PPE and staffing), a reduction in commissioned care packages and an increase in voids. The response by local authorities and Clinical Commissioning Groups (CCGs) was inconsistent – some made blanket payments, but others required providers to claim for grants and monies were slow to trickle through. When they were not paying in advance for packages of care, or funding for Discharge from Hospital to Home was delayed, providers experienced cashflow problems.

177 Some positive examples were shared of local authorities using Government funding to make one-off 'resilience' payments, agreeing a 5% annual uplift or guaranteeing the next three months payments based on the previous three months.

178 The £600m Infection Control Fund was announced on 13 May 2020, with payments being made in 2 tranches. The first one was on 22 May 2020 and the second in early July 2020. This was, amongst other things, designed to ensure that staff who were self-isolating in line with Government guidelines were paid

their usual, full wage whilst doing so. It could also be used to recruit additional staff and/or volunteers to ease capacity issues caused by self-isolation, thereby avoiding staff working in multiple settings. In the autumn of 2020, we were still receiving queries from providers who were unsure how to access funding to pay for staff who were self-isolating or what they should do when that funding ran out.

179 There was confusion about the applicability of furlough to staff who needed to shield. HM Revenue and Customs guidance in May 2020 indicated nursing staff could be furloughed on 80% of their salaries, but guidance for the care sector was less clear. We heard of some staff being paid Statutory Sick Pay (SSP) and others being forced to work despite their heightened risk.

180 Data from the COVID-19 ASC Tracker from mid-May 2020 indicated that 43% of employers were paying full wages to staff who were self-isolating following a positive COVID-19 test.

181 Research by LaingBuisson, commissioned by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS), working with the Care Providers Alliance, found that providers (care homes, homecare agencies and supported living providers) faced potentially increased staffing costs of £1.018 billion, due mainly to having to maintain safe staffing levels while staff were ill or self-isolating.

182 In March 2021 the Government announced a further £341m of funding for social care, over 12 months, however, providers were still voicing concerns about what would happen when this money ran out.

183 The Adult social care: COVID-19 winter plan 2021 to 2022 announced in November 2021 included a further £388.3m to support Infection Prevention and Control (IPC), testing and vaccination uptake in adult social care settings, including help for employers to pay staff normal wages if they are isolating.

184 In March 2022, a petition was issued to reinstate the Infection Prevention and Control (IPC) grant funding, specifically mentioning paying staff who needed to self-isolate. It gained almost 4,000 signatures but needed 10,000 to be considered for debate in Parliament. In June 2022, registered managers were

reporting concerns about the loss of Infection Prevention and Control (IPC) guidance and funding.

Confusion and concerns relating to self-isolation

185 In the early days of the pandemic, we were receiving queries from Registered Managers about whether staff who were self-isolating due to the health or other increased risk level of someone they live with should be paid, take annual leave or take paid leave. Guidance around eligibility for Statutory Sick Pay for those self-isolating or shielding was unclear, as was guidance on when people could return to work after a positive COVID-19 test. Others reported that staff were unable to work because they had not been granted key worker status and therefore had childcare responsibilities that prevented them from working.

186 The introduction of COVID-19 testing for those with symptoms who were living and working in care homes in May/June 2020 caused further issues for providers due to difficulties obtaining tests, the length of time for results to come back, changes to guidelines around how long people who tested positive would need to self-isolate and staff refusing to care for those who had tested positive. Providers continued to report uncertainty around supporting staff who were self-isolating, both whilst they were off work and when they were ready to return to work or when lockdown, shielding or travel restrictions began to be lifted. In April 2021, a Registered Manager noted that a staff member had accidentally reported a positive test result instead of a negative one, but still had to self-isolate for 14 days because the system didn't allow for results to be amended.

187 The 'test and trace' system caused further concerns for providers as the guidelines required people to self-isolate for 14 days each time they were identified as being exposed to COVID-19, which caused workforce shortages, particularly in smaller workplaces. Potential solutions mooted included sharing staff across services (which went against guidelines for containing the spread of COVID-19). In practice, we heard reports of Registered Managers working overtime to cover for staff who were self-isolating which was leading, in some cases, to reduced wellbeing, domiciliary care services closing and the quality of care being compromised.

188 In preparation for the second wave, providers reported increasing their pool of bank and agency staff as a potential mitigation for staff sickness and isolation, although agencies were also reporting high levels of staff shortages, so this wasn't necessarily a solution. It was also noted that managers lacked time to read and digest complicated guidance documents and keep up with changing requirements and that this was causing stress and, in some cases, leading to employment disputes and the need for legal advice on employment law because providers were unsure of how to apply the guidance in practice.

189 In November 2020, providers started to question whether staff needed to self-isolate if the contact with COVID-19 had happened in the workplace and all personal PPE guidelines had been followed. In January 2021, one Registered Manager reported providing tasks for staff who were self-isolating but not off sick (i.e. researching communication tools, activities, guidance, and policies). The benefits of this were taking pressure off the manager, making the staff feel useful during isolation.

190 When mass vaccinations were introduced in early 2021, providers faced new challenges with some staff being reluctant to be vaccinated and some experiencing side effects from the vaccination causing them to take time off sick. At this time providers were querying whether isolation applied to staff who were vaccinated, or what should happen if staff had isolated because of their positive test but subsequently another member of their household tested positive.

191 The reduction in self-isolation to 6 days in December 2021 caused concern for some registered managers who, unconvinced of the efficacy of Lateral Flow Device (LFD) tests, felt that staff might be returning to work too early, leading to further transmission of the virus.

192 Reports of staffing issues caused by staff self-isolating continued through to January 2022, with existing staff being negatively impacted by staff shortages and a negative impact on the quality of care provided.

**Sick pay provisions for the adult social care workforce**

193 Our workforce intelligence data provides evidence of the levels of sickness in the adult social care workforce and our Market Insights and Sector Insights reports provided anecdotal evidence of sick pay provisions and their impact.

194 The ASC-WDS data for March 2020 to July 2020 showed that rates of sickness, including shielding and self-isolation, were more than 3 times higher than pre-pandemic. 8.6% of shifts were lost between March and July 2020 compared to 2.6% pre COVID-19.

195 By late April 2020, workers who were shielding were eligible for Statutory Sick Pay.

196 The £600m Infection Control Fund was announced on 13 May 2020. The Statutory Sick Pay Rebate Scheme was announced on 19 May 2020.

197 A study by the ONS in July 2020 revealed that there was some evidence that in care homes where staff received sick pay, there were lower levels of infection in residents whilst, in September 2020, the Queens Nursing Institute published research undertaken with the Care Home Nurse Network which found that only 62 respondents (38%) stated that they could take time off with full pay, while some felt pressure not to take time off at all.

198 In January 2021, ASC-WDS data showed that sickness rates were 150% higher than pre-pandemic levels. The average number of sick days per head between April 2020 and March 2021 was 7.9, compared with 4.7 the previous year. We do not have figures for the number of staff off sick.

Concerns about the financial impact of sickness on care providers

199 Throughout the pandemic, sick pay was a significant cost for providers. Providers who turned to agency staff to cover staff sickness had higher wage bills.

200 Reports in June 2020 noted that registered managers were disappointed that the Infection Control Fund would not help with costs related to staff sick pay. There were also concerns about the Government's ability to claim back monies if they were not deemed to have been used appropriately, which was putting providers off from claiming.

201 The second wave of COVID-19 in the autumn and winter of 2020 saw more reports of increased levels of sickness among staff. This had knock-on effects for those who continued working and had to cover the work of those off. Providers struggling with a lack of nursing staff used agencies to get cover, which cost them more money.

202 In September 2021, concerns were raised about the affordability of Statutory Sick Pay once the Infection Prevention and Control (IPC) funding had run out.

203 On 1 April 2022, sector leaders wrote to Sajid Javid, Secretary of State for Health and Social Care **[OS/03a - INQ000571774]**, raising concerns about the impact of 'living with COVID-19', including the end of the Infection Control Fund, which had supported the payment of sick pay. They argued that this was unfair given staff were still expected to undertake asymptomatic testing but that this didn't apply to residents or visitors who could be bringing COVID-19 into the setting.

204 As late as June 2022, we were receiving reports that providers were concerned that COVID-19 cases amongst staff were high enough to be impacting on absence rates and the availability of staff to work. At this point we were starting to hear of issues relating to 'long COVID' and how this could push some staff into poverty if they had to rely on Statutory Sick Pay. Others queried whether long COVID would be recognised as a disability under the Disability Discrimination Act (DDA).

205 Providers expressed concerns that staff wouldn't disclose that they had tested positive for COVID-19 in order to remain at work and not lose pay, or that more care staff would be driven out of the sector which was already in the midst of a retention and recruitment crisis.

Confusion about sick pay policy

206 From March 2020 there were consistent reports of confusion around eligibility for Statutory Sick Pay and when to use furlough.

207 Legal guidance was welcomed (for example about whether it is preferable to furlough a member of staff who is shielding or not). Many people were unaware that staff on zero-hours contracts could be furloughed.

Skills for Care action on sick pay

208 Skills for Care signposted support for both frontline care workers and their employers to aid financial difficulties and also played a role in supporting DHSC guidance and policy development for the adult social care workforce.

209 We raised issues we were hearing about Statutory Sick Pay (SSP) for people self-isolating at the Task and Finish Group on the workforce in COVID in March 2020. These issues included the issue of whether SSP was available to workers who are self-isolating and the impact of pay security (including people only having access to SSP) on workforce capacity.

210 This led to guidance published by the Department of Health and Social Care (DHSC) clarifying the approach, published in May 2020. This has since been updated (in May 2022) but the original guidance in May 2020 stated:

> *"If you are unwell or someone in your household is unwell it is important that you feel able to self-isolate if you have symptoms of COVID-19 or live with someone who does.*
>
> *First check the Terms and Conditions of your pay with your employer.*
>
> *If they are unable to continue to pay you your full salary, you might be eligible for statutory sick pay (SSP). SSP will be available from day one and you must need to self-isolate for at least 4 days to be eligible. Those on zero-hour contracts will also receive SSP or will be able to claim Universal Credit, dependent on their circumstances.*
>
> *Those who are not eligible for SSP, are able to claim Universal Credit. Similarly, you can claim contributory Employment and Support Allowance (ESA). Most claims are for 'new style' ESA. You could get Universal Credit at the same time or instead of 'new style' ESA."*

211 Following a request from the DHSC, we carried out an analysis on the potential numbers of people that might be eligible to access the self-isolation funding for the DHSC to allow them to calculate the potential costs when calculating the funding needed from government for workforce capacity **[OS/04 - INQ000553292]**.

**The movement of the adult social care workforce between locations when providing care**

212 In the autumn of 2020, Skills for Care spoke to DHSC about the risks of staff movement in social care settings spreading COVID. DHSC asked for some analysis and advice on regulating against staff movement. In September 2020, we advised that a lot of employers were already restricting staff movement but that the practicalities would make it difficult to mandate **[OS/05 - INQ000553293]**.

213 On 2 October 2020, we had a request from DHSC to analyse staff movement, where people were working for more than one employer, demographics and agency workers. In response, we provided DHSC with data which showed that 1 person in 11 held more than one adult social care job, and these people were more likely than the average to be male, older, have a BAME ethnicity and have a non-British nationality. An estimated 15,000 care home staff were working in multiple locations, an estimated 16,000 care home workers also had jobs in other employment sectors, and an estimated 105,000 staff were on bank or agency contracts (where workers were more likely to work in multiple locations).

214 The following month, on 13 November 2020, the Government launched a consultation on restricting staff movement.

215 On 25 November 2020, Skills for Care provided DHSC with a more detailed report on the data indicating how many people were moving between settings and what employers told us about limiting staff movement **[OS/06 - INQ000553295]**. In this report, we raised concerns about increasing staffing pressures and workforce capacity more broadly, the impact of limiting staff movement on roles such as nurses in social care - because employers generally employed a small number of nurses - the impact on small providers and the

balance between providers being short-staffed and the risks around staff movement spreading COVID.

216 We advised that it was likely the proposal to ban staff movement would create an increased pressure on demand, as we estimated that 60,000 people per quarter started new jobs from elsewhere in the sector and there were 25,000 agency and 85,000 bank pool staff on any given day, whose movement would be restricted.

217 We fed back some suggested solutions, including a block contract with a select number of agencies so that they could have individuals working for agencies linked to specific services, and additional payments to existing staff to work overtime, compensation for staff who lost roles because they were working for more than one provider. We asked DHSC to consider some questions including how vacancies would be filled, how we could communicate the rationale for banning staff movement and other practical considerations.

218 On 1 March 2021, DHSC published guidance to restrict workforce movement between care homes and other care settings. There was a decision not to use regulation to restrict staff movement. Skills for Care kept the adult social care sector up to date on the need to limit staff movement through guidance on maintaining safe staffing levels **[OS/07 - INQ000553296]**.

**Personal Assistants and Individual Employers during the pandemic**

219 Individual Employers (IEs) are people who draw on care and support and directly employ people to support them. Personal Assistants (PAs) are the people who provide this support. In the year to March 2020, we estimate that there were 70,000 Individual Employers and 105,000 people were working as Personal Assistants.

220 Given the individual and personal nature of these relationships, experiences during the pandemic will have varied significantly depending on individual circumstances – ranging from Individual Employers who moved in with family members and no longer required support from Personal Assistants to Individual Employers who needed significantly more PA support.

221 During the COVID-19 pandemic, Skills for Care played an important role in supporting IEs, PAs – as well as User-led Organisations (ULOs), which are organisations run by and for people who draw on care and support.

222 Skills for Care developed and contributed to the following support and resources, as well signposting to resources to assist IEs, PAs and ULOs.

Developing DHSC guidance

223 Skills for Care worked in partnership with TLAP, the Local Government Association, NHS England and other key bodies to develop the content and promotion of government guidance for IEs and PAs. Updated guidance was hosted on our website, shared through our networks and forums and in our targeted newsletter for IEs, PAs, ULOs and those who support them.

224 Skills for Care was a member of a working group to support guidance and accessibility. As part of this, we insisted that IEs and PAs be included in the development of the guidance.

Website information pages

225 We made regular updates to our COVID-19 specific pages on the IE and PA information hub. Updates included:

a. guidance for care staff who are supporting adults with learning disabilities and autistic adults

b. antibody testing for PAs

c. flu vaccination for PAs

d. information from local support organisations

e. an 'access to work' factsheet

f. overview of adult social care guidance on COVID-19

g. self-isolating after returning to the UK: your employment rights

h. supporting people outside of their home

i. what to do if you are employed and you cannot work.

j. Vitamin D guidance

k. COVID vaccinations

l. updates to testing

m. access to PPE

n. guidance on essential training during restrictions and reintroducing face-to-face training as restrictions started to lift

o. access to rapid response training.

226 We promoted the Skills for Care digital wellbeing finder, which included resources specifically for people drawing on care and support, Individual Employers and their families and personal assistants.

227 We developed a digital pocket card to signpost PAs to wellbeing resources and helplines. Our locality managers were a key connection between personal assistants and the NHS health and wellbeing hubs to ensure that PAs could access support. This wasn't available across all hubs and some locality managers were instrumental in highlighting the needs of this part of the workforce for the hubs to open up access to include personal assistants.

228 The wellbeing of IEs and PAs was included and remains a priority for the National Wellbeing Steering Group, with IEs as members and influencers on the group.

Recorded webinars

229 We recorded and hosted on our website a series of webinars covering a range of topics to support individual employers, PAs and supporting organisations with best practice. Topics included Wellbeing, Recruitment and retention, digital, learning and development and Managing PAs. Overall, these webinars supported

IEs, PAs and family members by offering practical, targeted guidance to navigate the pandemic with resilience, compliance, and a focus on wellbeing.

PA Framework steering group

230 The PA Framework steering group continued to meet virtually during COVID and was an essential source of information and insight on issues affecting IEs and PAs, which fed into the development of DHSC guidance.

Information line and email queries

231 We regularly answered telephone and email queries and concerns via our advice line and PA-specific email inbox, as well as signposting to resources from other organisations to support IEs, PAs and ULOs.

Workforce Development Funds

232 The User Led Organisations (ULOs) reported difficulties during this time and had to make changes to training delivery to ensure that IEs/PAs could still access training opportunities during the time period.

Lessons learned

233 The importance and value of involving and consulting with PAs, IEs and user groups on official guidance development became extremely apparent. This allowed individuals within these roles to share understanding of the main issues and ensure an effective and appropriate response, including support for local authorities' direct payment teams.

234 We heard anecdotally that the impact of the pandemic on IEs and PAs included a feeling of uncertainty, worry, lack of consistent care and an inability to access essential services they needed. Some PAs were told not to turn up for work as the person's family would be able to care for them if they were isolating or furloughed, which had an impact on income and job security.

**Skills for Care's role in developing and/or feeding back on the UK Government's adult social care plans**

235 As the workforce development body for adult social care in England and a key DHSC partner, Skills for Care's insight and feedback was already regularly sought by DHSC in the development of adult social care plans prior to the pandemic.

236 Feedback can be both ad hoc, through the proactive or reactive sharing of data with DHSC policy leads, and/or regular, which could be through policy submissions to DHSC, and frequent contact with DHSC stakeholders. Below I set out the role played by Skills for Care in supporting the development of adult social care plans produced by the UK Government between 1 March 2020 and 28 June 2022.

COVID action plan

237 On 15 April 2020, the Government published the Adult Social Care COVID action plan. DHSC sent Skills for Care a draft of the plan on 11 April 2020 and we provided some feedback to the DHSC policy team **[OS/08 - INQ000553297]**. Our comments focused on the purpose, language and clarity of the document and they were, in our view, addressed to an extent. In our view, there was still no long-term plan for social care as promised in this document.

COVID winter plan

238 On 18 September 2020, the Adult Social Care Coronavirus COVID-19 Winter Plan 2020 to 2021 was published. Prior to publication, on 7 August 2020 we had a request from DHSC to look at winter pressures during a "normal" winter. We provided DHSC with the relevant data we had, which showed social care tended to have a higher vacancy rate in winter. We also highlighted that the data didn't look at sickness in the same way and so we could not offer that analysis **[OS/09 - INQ000553298]**. On 11 August 2021 we sent a document proposing more action that Skills for Care could undertake to support the sector in winter **[OS/10 - INQ000553299]**.

239 Specifically, we:

a. Recommended supporting employers to protect staff and people they supported with taking up vaccines (including additional financial support).

b. Flagged the significant systemic issues in social care recruitment and retention with poor perceptions of the role and poor pay and terms and conditions.

c. Recommended joining up the guidance and legislation that was being announced, recognising how overwhelmed managers were. We suggested that government think about how to maximise engagement.

d. Recommended that government do more to support the wellbeing of staff in social care.

*240* We also attended a DHSC winter planning meeting on 11 August 2020, and we discussed issues around workforce capacity, wellbeing and the market. We did not know whether our recommendations were taken up, but the Winter Plan which was then published did include workforce capacity, wellbeing and the market.

*People at the Heart of Care* white paper

241 Skills for Care sent various reports and proposals to DHSC (some of which are reflected in the *People at the Heart of Care* White Paper published in 2021) on what needs to change for the Adult Social Care Workforce to have the right number of people, with the right values and skills. I have summarised these below along with our sense of whether they have been implemented or are being implemented.

*The need for a national adult social care infrastructure and workforce strategies (nationally and locally)*

242 At the beginning of COVID, there was no national social care workforce strategy aligned with local workforce strategies and the NHS. There were several government departments, 152 local authorities and more than 18,000 care providers. There was also no mechanism or infrastructure to pull all of these

bodies together so that they were all pointing in the same direction. More broadly, there was a lack of infrastructure for the social care workforce. For example, unlike the other UK countries, England does not have an arm's length body which has a mandate to support workforce development. While Skills for Care provides that infrastructure in practice with our national and local presence, that mandate is not as clear for Skills for Care which means the roles and accountabilities were not clear for us and the sector.

243 In Skills for Care's evidence review **[OS/11 - INQ000553300]** which informed our own strategy which we published online and shared with DHSC on 15th February 2021, we identified the lack of a national social care workforce strategy noting:

> *A broad consensus is emerging across political parties, campaigners and think tanks that social care needs to be reformed. Eight reports published in the last two years highlight the lack of a social care sector workforce strategy, and three refer to the lack of the promised Green Paper. All of these issues were also raised within stakeholder consultations. (Page 10)*

244 Further to that, in our recovery report **[OS/12 - INQ000553301]**, which we developed internally and shared with DHSC, we had a recommendation that DHSC fund Skills for Care to:

> *Develop a consistent approach to developing a local offer with local partners to ensure all local areas have a workforce strategy for social care which is informed by our intelligence.*

245 We have seen some change in this since COVID where DHSC commission Skills for Care to support ICSs and integration partners to develop improved understanding, knowledge and engagement with adult social care. Additionally, Skills for Care delivers activity to ensure leaders and managers in adult social care recognise and understand the integration agenda.

246 Skills for Care is now engaged with all 42 ICSs and represented on 78% of ICS People Boards/Workforce Steering Groups, which is an increase of over 25% since 2021/22. The overall purpose of the People Board is to bring together systems partners to manage and oversee system wide workforce planning,

development and wellbeing across the whole ICS in line with the 10 people function outcomes.

247 There were various attempts to build more consistent infrastructure in social care within the inquiry's scope which appear to have been paused or cancelled, including:

a. A discovery process which we led for on behalf of DHSC to explore the creation of a voluntary register in April 2021, which was designed to allow national government to be able to contact people working in social care directly. We advised that a voluntary register could be seen as a first step towards registration, and have some longer-term benefits, but this would need to be accompanied by clear incentives and long-term investment.

b. A proposal which Skills for Care delivered for DHSC on the creation of a Skills Passport, which was an initiative we had discussed with DHSC at different times since 2016. The Skills Passport was intended to support the building of more infrastructure in social care to support learning and development and reduce repeated training and inefficiency. An Alpha stage was carried out by contractors Olive Jar for DHSC in early 2022, but the work did not proceed to Beta stage. We had proposed that we use ASC-WDS as the basis for a Skills Passport, and proposed more significant infrastructure so that we could reach people working in social care more directly.

c. A discovery and Alpha stage which Skills for Care led looked at the creation of a hub for social care in June 2021. The Care Workforce Hub was developed to address key challenges in the adult social care sector, including communication, recognition, and retention, which were all existing issues for the sector intensified by the pandemic. The platform was designed to provide support, foster engagement, and promote recognition for social care workers. We recommended the hub should continue to evolve, have clear communication regarding purpose and conduct ongoing engagement and initiatives. We also highlighted that a robust verification system should be tested in Beta phase, and that sustained funding and support would be

crucial for the ongoing success of the hub. We advised that the Care Workforce Hub should align with a broader social care digital strategy, and that data privacy and consent processes should be regularly reviewed, with reverification every two years to ensure the hub remained current and effective. A key concern for the development of the hub was the need for significant user demand to ensure it is regularly used. To address this, it was recommended that the Care Workforce Hub be integrated into a larger ecosystem, including complementary services, such as the Skills Passport and Job Board.

d. The hub was reflected in the commitment in the People at the Heart of Care White Paper to set up "…a new digital hub for the workforce to access support, information and advice, and a portable record of learning and development" which was intended to "… allow staff to easily identify themselves as working in care, signpost the new support available for the workforce and allow all care workers to more easily find resources to help them in their careers."

248 Social care is very large, fragmented and, critically, diverse sector. In 2019/20, there were 25,500 CQC regulated locations. This has since grown to 29,000 by 2023/24.

249 Interconnections between organisations, which can bring about benefits such as collective bargaining and transfer and scale of innovation, are less developed than we see in other sectors including the NHS. Barriers to entry and exit - particularly in homecare - are arguably lower too, so there is relatively high flux in the organisational make-up of the sector. This translates into how the workforce is overseen, managed and what people working in social care experience. In many ways, the sector exists as thousands of separately managed workforces. This in turn means there are very few strong levers available to drive change and improvement at scale.

250 Skills for Care is a long-standing and well-recognised body within the sector, and as such provides much of the workforce infrastructure that does exist. However, this is done without a clear mandate and is funded on a year-by-year basis. We

would advise that we should build on the success of ASC-WDS and the Care Workforce Pathway to develop a deeper and shared understanding of the workforce across all sector stakeholders. In this way we can start to develop a national inter-organisational career infrastructure, with a clearer articulation of expectations and routes to development and progression, which in turn will drive improvement in recruitment and retention which remains an issue for most providers. At a macro level we will then have an improved ability to assess workforce capacity and skills gaps. This improved infrastructure could also be designed in such a way to allow more immediate or even direct contact with care workers in the event of another pandemic.

251 In order to overcome the limitations and realise the opportunities we have identified, we would argue that, in England, we need a body with a formal mandate for workforce development in social care, which the other three UK devolved nations already have.

252 We would also argue that a key learning point from the pandemic is the need for longer-term planning in adult social care, with a roadmap for implementing reforms over a number of years. This is not yet happening. The Workforce Strategy that Skills for Care developed in collaboration with the adult social care sector provides much of the evidence and recommended actions to support this.

*Concerns about the systemic issues of recruitment and retention in social care*

253 We tracked and identified capacity issues through our data and engagement. For example:

a. We highlighted issues about workforce capacity to DHSC through the data reports I have previously referred to.

b. We highlighted the need for more roles in the future. The Skills for Care evidence review highlighted the need to consider what adult social care should look like post-pandemic and that "*If nothing else changes we will need another 520,000 people working in social care by 2035 and we need to be planning now to either fill those roles, or to think about how we provide social care differently*". The evidence review also highlighted the need for

upskilling of roles related to COVID-19, including infection control, PPE, positive behavioural support, clinical skills, end-of-life care, supporting people's mental health, communication and decision-making skills.

254 Some systemic issues were addressed when care workers were added to the shortage occupation list in February 2022, leading to a significant increase in international recruitment in social care, and a reduction in workforce capacity pressures as we began to see capacity improvements in our 2022/23 statistics.

255 Other systemic issues have yet to be addressed, with social care having three times the national vacancy rate. More recently, we are starting to see international recruitment reduce and domestic recruitment reduce too. According to Skills for Care's latest tracking data, an estimated 10,000 new international recruits started between July and September 2024, compared with an average of 26,000 per quarter in the year to March. We might expect a Fair Pay Agreement and tackling poor terms and conditions to help with these systemic issues.

256 Recruitment and retention are also positively impacted by learning and development. While there was a commitment in the White Paper to additional investment in learning and development, this has since been removed and learning and development funding has remained broadly the same for adult social care since before COVID.

*Concerns about staff wellbeing*

257 Skills for Care sought to provide the range of initiatives to support staff wellbeing, which I have outlined in section 9 of this statement, along with our recommendations for the future.

258 We highlighted concerns from care providers about staff wellbeing through our sharing of insights with DHSC and in chapter 3 of the evidence review for our strategy in February 2021.

259 Skills for Care was part of the conversations with the national steering group and DHSC on what the *People at the Heart of Care* White Paper needed to include. In total, there were nine wellbeing commitments in the original White Paper,

including Occupational health support, which were all removed and deprioritised by the Government.

*The need for more digital skills*

260 In May 2021, the then NHSX commissioned Ipsos MORI and the Institute of Public Care (IPC) at Oxford Brookes University to conduct two related reviews. The first focused on the adoption and scalability of technology innovation in the adult social care sector. The second, which was conducted jointly with Skills for Care, looks at the digital capabilities of the adult social care workforce.

261 The project sought to determine national policy priorities and guide the adult social care sector on where to focus its efforts in relation to digital technology and skills. The research aimed to cover the significant evidence gap around the digital capability of the social care workforce, including current levels of digital skills, understanding of future need, and current provision and outcomes of training available. It was also envisaged that the research would provide a more comprehensive body of evidence to help NHSX plan their future strategy. Skills for Care also supported the scoping exercise for the work by undertaking evidence reviews to summarise existing knowledge and to help scope other aspects of the reviews.

262 The People at the Heart of Care White Paper sought to build on the findings, stating:

> *"Our ambitions for a digitally enabled care system cannot be realised without a workforce that is skilled and confident in the use of technology. Building on the findings from the recent digital skills baseline report, we will provide a comprehensive digital learning offer that includes accessible training and online resources to build transferrable digital skills as well as practical guidance on using technology in all care settings. This will include targeted digital leadership support for decision-makers who can drive cultural change at a senior level."*

263 The Digital Skills Review identified a number of gaps in digital skills which led to a number of initiatives which I detail below.

264 Between 2020 and 2022, Skills for Care undertook the critical task of developing the initial draft of the Digital Skills Framework to support the digital transformation of the adult social care sector. The framework was designed to provide a clear, structured pathway for social care organisations and their staff to improve their digital skills, ensuring that both the workforce and the sector as a whole could effectively adapt to rapidly evolving technological demands.

265 The development of the framework was based on extensive consultation with care providers, technology experts, and key stakeholders in the sector. This process ensured that the framework was tailored to meet the specific needs of the adult social care workforce, taking into account the diverse range of roles, skills, and digital maturity levels across different organisations. Research was conducted to understand the challenges that social care providers face in terms of digital adoption, such as limited access to technology, varying levels of digital literacy, and the need for practical, accessible training solutions.

266 The framework was structured across different levels of digital competency, from entry-level staff to senior leaders. This tiered approach allowed social care organisations to tailor training and development based on the specific needs of their staff members, from those requiring basic digital skills to those at a more advanced level.

267 To support the framework, Skills for Care provided a variety of practical resources and training tools, including e-learning modules, workshops, and guides. These resources were designed to be accessible, helping staff at all levels to develop their skills and apply them directly in their daily work. The framework also highlighted the importance of continuous learning, encouraging the workforce to keep up with evolving technologies and digital practices.

268 Working with the National Care Forum, Skills for Care also designed and delivered a four-day digital leadership learning programme. The programme aimed to give managers the basic digital understanding to underpin skills, knowledge and models of digital leadership that can be practically applied when implementing technology in a care service and promote best practice. The aim of all this work was to improve confidence in identifying how digital technology that

supports the delivery of quality care and enables managers to identify technology in the market, understand the barriers to technology adoption and how an organisation may choose to address them. This programme started the initial conversation with the NHS Transformation Directorate about the level 5 digital leadership in adult social care award.

269 Skills for Care developed and delivered digital learning resources to help adult social care workers improve their digital skills. This included online training, e-learning modules, and toolkits for social care providers to better integrate technology into their services.

270 Skills for Care also supported social care providers in adopting new technologies and digital tools. We offered practical advice, case studies, and guidance on integrating digital technologies into care settings, with a focus on improving service delivery and care outcomes. We also collaborated with key stakeholders to help social care organisations develop digital strategies that could improve operational efficiency and care quality.

271 With the ongoing staffing challenges in the social care sector, Skills for Care created tools to help employers with digital recruitment processes. This included support for improving job advertisement strategies and digital platforms to streamline the hiring process.

272 Skills for Care worked with partners across the health and care sectors to promote the integration of digital technologies that support care delivery. This included supporting the implementation of electronic care records and other digital tools that help streamline communication and data sharing between social care and healthcare providers.

273 Skills for Care addressed challenges related to digital access, especially in rural and remote areas where internet connectivity may be limited or expensive. We worked on providing resources and support to ensure that social care workers in these areas could also benefit from digital tools and training.

*The need for more consistent approaches to the development of skills*

274 Skills for Care had a plan to develop a knowledge and skills framework in our work programme for DHSC for delivery in 2020, which followed a number of draft outlines sent to DHSC following discussions we had since 2016. We were in policy discussions about a knowledge and skills framework for a number of years, where we explored how it could look and how it would be implemented, and we developed a few models. It was not commissioned as part of our work programme and remained as policy discussions.

275 The knowledge and skills framework was finally included in our work programme for 2020/21, but this was paused due to COVID.

276 In 2021, *People at the Heart of Care* committed to the development of this knowledge and skills framework - and that has since resulted in the launch of the first stage of the Care Workforce Pathway in January 2024.

277 We have yet to hear exactly how the Care Workforce Pathway will be rolled out and implemented in social care but, if implemented, and linked with pay, it could provide much-needed career development infrastructure in social care.

Health and social care integration

278 On 9 February 2022, the White Paper on health and social care integration was published. Skills for Care had a number of inputs into this White Paper, including a stakeholder engagement opportunity with DHSC, Number 10 and Health Education England in November 2022, which I attended. I made a number of suggestions at the meeting, focused on how the forthcoming White Paper could mitigate the issue that ICSs are being set up through a health infrastructure and how integration could be built in.

279 We recommended:

a. Integrating learning terms and conditions across health and social care.

b. More networks and engagement with social care from ICSs, either formally mandated or funded.

c. The development of a system communication fund so that social care can be more consistently engaged by ICSs.

d. Training and development of NHS staff in strengths-based model of care and support and personalisation.

e. Ensuring funding flows for delegated healthcare interventions.

f. DHSC should consider how to incentivise and fund the work that social care does on prevention and reablement.

280 Some of these recommendations are happening in pockets, but none of it is happening consistently, based on the feedback we get from stakeholders. The White Paper did make reference to the Skills for Care-developed principles of workforce integration.

281 DHSC commissions Skills for Care to support ICSs and integration partners to develop improved understanding, knowledge and engagement with adult social care. Additionally, Skills for Care deliver activity to ensure leaders and managers in adult social care recognise and understand the integration agenda.

282 Terms and conditions are still quite variable between health and social care staff. According to our latest State of the Adult Social Care Sector and Workforce in England report, healthcare assistants in the NHS are paid on average 67p per hour more than a care worker when they start, and this gap increases when a healthcare assistant has been in post for two years.

283 As I have previously mentioned, work is ongoing within the Care Workforce Pathway to explore the development of an Enhanced Care Worker role category. The intention here is to recognise and formalise the practice that is happening in pockets across the sector where people receive more holistic care and support because care workers take on more clinical tasks and/or other specialised duties. This Enhanced Care Worker role category is being tested with sector stakeholders, and improved recognition of the role is acknowledged as important.

284 However, even when the role category is finalised and published, there will still be barriers that prevent this role from being mainstreamed and widely adopted. These include funding not flowing from the NHS into social care to deliver the tasks, which adds additional pressure on social care providers and not enough nurses and clinical staff to direct and supervise treatment.

285 The Care Workforce Pathway with the Enhanced Care Worker role category is an important step in more formally recognising this practice. Testing work and iterative publication of the Pathway should continue. Government should make use of the Care Workforce Pathway as a vehicle to surface and address issues and opportunities in the workforce, but also to identify solve barriers and blockers in the wider system.

The need for more clinical skills in the social care workforce during COVID

286 In July 2020, we highlighted to DHSC the need for more clinical skills among care staff, because care staff were on the ground being asked to carry out clinical health tasks without appropriate training or support. We developed and published two short guides to support delegated healthcare activity in the absence of national guidance, as well as the resources I have previously mentioned to support the delegation to social care of remote verification of expected death.

287 Skills for Care delivered a programme of work to support delegated healthcare, and this is ongoing including the publication of principles of delegation published in May 2023. Work is ongoing on the Care Workforce Pathway to explore the development of an Enhanced Care Worker role which could take on more clinical tasks.

288 However, there are still barriers to delegated healthcare, including funding not flowing from the NHS into social care to deliver the tasks, which adds additional pressure for social care providers, and not enough nurses and clinical staff to direct and supervise treatments. If another pandemic happened where we needed social care staff to carry out more clinical tasks as they did during the last one then in our view the infrastructure, clinical capacity and incentives are not yet in place to ensure that this could happen safely and consistently.

**The risk reduction framework for social care**

289 *Coronavirus (COVID-19): reducing risk in adult social care* **[OS/13 - INQ000553302]** was a framework for how adult social care employers should assess and reduce risk to their workforce during the coronavirus pandemic. It was first published on 22 June 2020.

290 The intended aim of the framework was to support managers to make an assessment of personnel factors which should be considered as part of risk management and reduction, following contemporary research findings on the increased risk of COVID-19 to particular groups, and in the social care workforce.

291 The guidance included:

a. A risk framework

b. A tool for discussion of individual risk

c. Signposting to relevant existing guidance

d. Guidance on implementation including guidance to support employers to sensitively discuss and manage risks to their staff. This includes risk by ethnicity, but also age, gender and underlying health condition.

Skills for Care's role

292 On 11 May 2020, DHSC initiated a discussion about the application of the Risk Reduction Framework, developed for use in the NHS, to Adult Social Care. The NHS framework had been developed and published by the research group of NHS professionals and was linked to from the NHS Employers website.

293 Skills for Care worked closely with members of the DHSC Social Care policy team to develop a resource for use in the Social Care sector. Our support included:

a. Providing advice and brokering contact with sector stakeholders to ensure a reasonable level of sector representation - drawing on our insight from across the sector.

b. Convening and participating in meetings and discussions to test the guidance with sector representatives.

c. Working in close partnership with the DHSC colleagues to respond to comments and challenge from sector stakeholders, NHS colleagues, and colleagues in other DHSC departments, and iteration of the framework and supporting documents.

d. Providing advice on options and recommendations on solutions.

e. Highlighting potential points of tension beyond our remit, including HR legal issues as an unintended consequence of factoring risk avoidance into recruitment, deployment and furlough decisions.

f. Presentation, turning available guidance and evidence into accessible, usable guidance and linking to other relevant sources of information and guidance.

g. Promotion and profile - using our existing channels and reach to promote and signpost to the guidance.

h. Contributing to subsequent updates, for example factoring in new clinical evidence or guidance.

**The Care Management Matters COVID-19 Survey**

294 Care Management Matters conducted a survey in March 2020 asking adult social care providers about the impact of COVID-19 on absence rates, absence reasons and recruitment and retention.

295 This questionnaire covered many of the things we wanted to know about the workforce. We agreed with Care Management Matters that we would publish

data from their survey rather than issuing a survey ourselves and adding more burden on providers.

296 The key findings were as follows:

a. On average, providers reported around 15%-25% of their workforce currently absent due to COVID related issues. The most common reason was self-isolation due to symptoms or living with someone with symptoms. Other workers were absent due to concerns about catching the virus, shielding or due to childcare issues.

b. The majority of providers reported that most of their staff (but not all) were receiving key worker exemption allowing them to keep their children at school.

c. 34% of providers reported they urgently needed more staff.

d. Most providers noted an increase in applications and were taking on temporary staff. There was little evidence of a reduction in the quality of applicants yet.

e. Providers also noted volunteers coming forward – although many were not sure how best to utilise them yet.

**Skills for Care's workforce intelligence reports**

297 We have provided the full *State of the Adult Social Care Sector and England* reports for 2019, 2020 and 2021. The reports can be summarised as follows.

2019 report **[OS/14 - INQ000553303]**

298 The information in this report came from data collected prior to the pandemic with most of the data referring to March 2019.

299 The main findings were:

a. The number of adult social care jobs in England increased by around 1.2% (19,000 jobs) between 2017 and 2018, from 1.6 million to 1.62 million.

b. 48% of the workforce usually worked full-time and 40% usually worked part-time – with 12% being recorded in this report as not having set hours. Around a quarter of the workforce were recorded as being employed on a zero-hours contract (24%, or 370,000 jobs). Domiciliary care services had the highest proportion of workers employed on zero-hours contracts (43%), especially among care workers (58%).

c. The three most common job roles were 'care worker' (840,000), 'jobs working for direct payment recipients' – for example, Personal Assistants – (145,000) and 'other care providing job role' (93,000). There is a full breakdown of job roles on page 28 of the report.

d. The staff turnover rate of directly employed staff working in the adult social care sector was 30.8% in 2018/19. This equates to approximately 440,000 people leaving their jobs over the course of a year.

e. 7.8% of roles in adult social care were vacant, equivalent to 122,000 vacancies at any one time. This was highest amongst registered managers at 11.4%. The vacancy rate increased by 2.3 percentage points between 2012/13 and 2018/19.

f. Mean hourly pay for care workers in the independent sector was £8.30. Mean hourly pay for personal assistants was £9.27.

g. 83% of the workforce was female and 17% of the workforce was male. The three most common ethnicities were White (79%), Black/African/Caribbean/Black British (11%) and Asian/Asian British (7%). 2% of the workforce was recorded as disabled.

h. The report showed that around 84% of the adult social care workforce were British, 8% (115,000 jobs) had an EU nationality and 9% (134,000 jobs) had a non-EU nationality. It also highlighted concerns raised by the Cavendish Coalition around the implications of a 'no deal' Brexit.

2020 report **[OS/15 - INQ000553304]**

300 The information in this report came from data collected prior to the height of the pandemic. It therefore acted as a baseline for the position prior to COVID-19. However, there were some provisional statistics included using data collected between April 2020 and August 2020 to monitor the impact of COVID-19 on the sector and workforce.

301 The main findings were:

a. Sickness rates increased substantially. The percentage of days lost to sickness was around 7.5% between March and August 2020, compared to 2.7% pre-COVID-19. Sickness days will include those self-isolating and shielding, as well as those who were unwell (including COVID-19 and non-COVID-19 related illness).

b. The staff vacancy rate of employers updating ASC-WDS data between March and August 2020 was 7.0%. This figure was lower than before COVID-19 when the rate for these employers was around 8.6%.

c. The occupancy rate fell from 87% to 79% in care homes with nursing and from 87% to 82% in care homes without nursing between April and August 2020.

d. Over the same period, there was no evidence of the number of staff employed falling overall. It could be the case that the fall in the occupancy has served to reduce the shortfall in workforce supply rather than impacting staffing numbers (see the fall in the vacancy rate). Market Intelligence collected by Skills for Care from employers also found that some care homes were maintaining staff levels to cover sickness as well as to carry out new work now associated with running a safe service.

e. 50% of the workforce usually worked full-time and 50% usually worked part-time. 24% of the workforce was recorded as being employed on a zero-hours contract (375,000 jobs).

f. The three most common job roles were 'care worker' (865,000), 'jobs working for direct payment recipients' – for example, Personal Assistants – (135,000) and 'other care providing job role' (95,000). There is a full breakdown of job roles on page 32 of the report.

g. Mean hourly pay for care workers in the independent sector was £8.80. Mean hourly pay for personal assistants was £9.53.

h. 82% of the workforce was female and 18% of the workforce was male. The three most common ethnicities were White (79%), Black/African/Caribbean/Black British (12%) and Asian/Asian British (7%). 2% of the workforce was recorded as disabled.

i. There was evidence of a reduction in the number of non-British people arriving in England to work in adult social care jobs since the start of the pandemic. This is mostly likely a result of less travel taking place over the period.

j. There was no evidence, from the data available at the time, of any other substantial changes in workforce composition.

2021 report **[OS/16 - INQ000553305]**

302 This report was able to use a full year of data since the beginning of the pandemic to evidence changes in the sector and workforce over the period.

303 The main findings were:

a. Levels of staff sickness nearly doubled over the course of the pandemic (an average of 9.5 days lost were lost to sickness in 2020/21 compared to 5.1 days before the pandemic).

b. Occupancy levels in care homes decreased by August 2021 – to 76% in care homes with nursing and 81% in care homes without nursing. There were a high number of deaths among care home residents in 2020/21 as well as a shift in demand away from residential care and towards domiciliary care, both contributing to the decrease.

c. The shift in demand away from care homes and towards domiciliary care was seen in the change in the number of jobs (filled posts) in the two service types. Between 2019/20 and 2020/21 jobs in domiciliary care increased by 40,000 (a 7% increase).

d. ASC-WDS data collected between March 2021 and August 2021 shows a decrease in jobs (filled posts). Overall, the decrease was around -1.8%, and was higher in care homes (-2.2%) than in domiciliary care (-0.8%).

e. A decrease in jobs in the sector is unusual. The number of jobs over the previous several years had consistently increased to keep up with the rising demand for care due to the aging population. Given the vacancy rate had also risen over the same period, this pointed towards recruitment and retention difficulties for the sector rather than a decrease in demand with employers not being able to find and recruit the staff they need.

f. The decrease in jobs (filled posts) coincided with the announcement of the mandatory vaccination policy for care homes which may be putting some people off joining the sector and contributing to others deciding to leave. Market intelligence gathered from employers suggests that this was already the case for some staff who were already leaving to take up roles in the NHS or other sectors where vaccination was not required.

g. Vacancy rates fell during the start of the pandemic, potentially due to fewer jobs being available in the wider economy during this period. Vacancy rates steadily increased again as the wider economy opened back up. As of August 2021, vacancy rates were back above their pre-pandemic levels. This trend matches feedback we had from employers who advised that recruitment and retention has been especially problematic as other sectors such as hospitality and tourism have opened back up.

h. 50% of the workforce usually worked full-time and 50% usually worked part-time. 24% of the workforce was recorded as being employed on a zero-hours contract (380,000 jobs).

i. The three most common job roles were 'care worker' (895,000), 'jobs working for direct payment recipients' – for example, Personal Assistants – (130,000) and 'other care providing job role' (99,000). There is a full breakdown of job roles on page 38 of the report.

j. Mean hourly pay for care workers in the independent sector was £9.29. Mean hourly pay for personal assistants was £9.95.

k. 82% of the workforce was female and 18% of the workforce was male. The three most common ethnicities were White (79%), Black/African/Caribbean/Black British (12%) and Asian/Asian British (7%). 2% of the workforce was recorded as disabled.

l. New immigration rules came into place in the UK on 1 January 2021. The new rules effectively meant that people could not come to the UK to take up care worker roles (people could still arrive to take up some regulated professional roles). Data collected after March 2021, as was expected given the new rules and COVID-19 travel restrictions in place, showed a sharp drop in the number of people arriving in the UK to take up adult social care jobs.

2022 report **[OS/17 - INQ000553306]**

304 This report mostly uses data from March 2022 and highlighted recruitment and retention challenges faced by the sector following the pandemic.

305 The main findings were:

a. The report showed a 50,000 decrease in filled posts (3%) in 2021/22. This was the first decrease in filled posts since records began in 2012/13.

b. The vacancy rate also rose over the same period to the highest rate since records began ins 2012/13. The number of vacant posts increased by 52% in 2021/22 (by 55,000 to 165,000 vacant posts).

c. The UK vacancy rate (the wider economy) increased rapidly in 2021/22. This increase created competition for staff and contributed to the increase in the adult social care vacancy rate over the same period.

d. It was reported to Skills for Care that some care providers were able to respond to rising staff vacancies by increasing wages to attract and retain more staff. This was also reflected in the statistics.

e. 51% of the workforce usually worked full-time and 49% usually worked part-time. 24% of the workforce was recorded as being employed on a zero-hours contract (358,000 jobs).

f. The three most common job roles were 'care worker' (860,000), 'jobs working for direct payment recipients' – for example, Personal Assistants – (120,000) and 'other care providing job role' (100,000). There is a full breakdown of job roles on page 42 of the report.

g. Mean hourly pay for care workers in the independent sector was £9.66. Mean hourly pay for personal assistants was £10.21.

h. 82% of the workforce was female and 18% of the workforce was male. The three most common ethnicities were White (77%), Black/African/Caribbean/Black British (12%) and Asian/Asian British (7%). 2% of the workforce was recorded as disabled.

i. International recruitment was providing an additional option for employers to recruit care workers after they were added to the shortage occupation list. It was estimated (using ASC-WDS data) that approximately 10,000-15,000 people had moved to the UK to take up care worker roles since the start of 2022.

j. Occupancy levels in care homes increased between August 2021 and July 2022 – to 79% in care homes with nursing and 84% in care homes without nursing. These were still lower than March 2020 levels of 86% and 88% respectively.

**Skills for Care's investigation into the issues facing the BAME workforce and the impact of COVID-19**

306 As part of our work on understanding the impact of COVID-19 on the care workforce, we launched a survey in July 2020 to better understand and respond to the experience of workers from black, Asian and minority ethnic (BAME) backgrounds, who account for 1 in 5 of the adult social care workforce in England.

We already knew many workers from BAME backgrounds experienced racism and discrimination in the workplace and faced barriers to progression (Skills for Care, 2020; Public Health England, 2020). Feedback from our networks was indicating during the pandemic that people – both workers and those who were drawing on care and support – from BAME backgrounds had been disproportionately more likely to become ill or die. The DHSC COVID-19 Taskforce BAME Advisory Group reported in 2020 that BAME workers were also more likely to report a lack of access to PPE and to experience unfair treatment because of their ethnicity.

307 To help us gather more information about the issues facing BAME leaders and managers across the adult social care workforce as a result of COVID-19, we launched a survey.

308 The survey asked three questions:

a. What are the top challenges facing BAME staff in social care?

b. What else could Skills for Care do to support BAME staff and communities in the adult social care sector?

c. What other relevant topic areas should be covered in future webinars about inequalities within the BAME workforce?

309 Over 500 social care workers responded and highlighted significant concerns about racism, inequality, equality, progression, representation and health.

310 There were three main themes that came out of the question 'what are the top challenges facing BAME staff in social care?':

a. Racism - this came through as the major challenge cited by respondents and included institutional racism and systemic racism from and within organisations, management and peers, as well as racism from service users.

b. Progression and representation – closely linked to racism, respondents felt that there are barriers that prevent BAME staff from progressing in the workforce, particularly into leadership and management positions.

c. Health issues – respondents were anxious about the increased risks faced by BAME staff in relation to COVID-19, and often felt that they were not being sufficiently protected at work. Mental health issues were also a concern, linked to the frustration and resentment of experiencing racism and anxiety about the COVID-19 risk.

311 Other issues frequently identified included pay gaps, lack of confidence, lack of understanding and support, and issues around acceptance, recognition, respect and being valued.

312 In response to the question, what else could Skills for Care do to support BAME staff and communities in the adult social care sector?' we noted the following:

a. It was clear from the results that the strongest support Skills for Care could provide was around training. This included training for managers of BAME staff on understanding health risks, training for BAME staff on areas such as leadership, resilience, assertiveness and dealing with racism and training for all social care staff on areas such as cultural awareness, diversity unconscious bias and practising anti-racism.

b. Respondents wanted Skills for Care to collaborate more with the BAME communities in designing the organisation's approach, and to make resources more accessible. They wanted wider support including support for

progression, mentoring schemes, networking programmes and support around health and wellbeing.

313 In response to the question, what other relevant topic areas should be covered in future webinars about inequalities within the BAME workforce?':

a. Respondents wanted webinars on racism (particularly institutional and systemic racism and how to overcome it), organisational policy and practice, equality and inequality, including pay and discrimination, issues around progression and representation and Black Lives Matter.

b. To address the findings of the survey and to support BAME workers impacted by COVID-19, we offered training including a series of pre-recorded webinars on our website, and developing a suite of guidance based on the three challenges identified by the survey.

c. The Social Care Workforce Race Equality Standard (SC-WRES) collects data from local authorities on nine race equality indicators. The data informs an annual report and provides an evidence base for the social care sector. Skills for Care continues to fund local authorities to implement the WRES and market-test the viability of rolling out SC-WRES to all employers. In the Workforce Strategy for adult social care, we recommend that DHSC, the Ministry of Housing, Communities and Local Government and DfE should mandate and fund implementation of the SC-WRES across all local authorities - and the CQC should work towards integrating SC-WRES into its assessment framework in a way that aligns with the development of SC-WRES nationally.

**Closing Remarks**

314 I would like to thank the Inquiry Chair, on behalf of Skills for Care, for the opportunity to provide evidence in relation to Module 6 of the UK Covid-19 Inquiry.

315 In the face of extreme challenge, the social care workforce responded with courage and resilience. However, the pandemic exposed gaps in terms of preparedness, levers for change and ability to rapidly deploy interventions across the whole sector.

316 The composition and infrastructure of adult social care limits the levers available to drive change at scale and respond at pace. We have highlighted in this submission that the interconnections between organisations in adult social care are less developed than we see in other sectors - and we have consistently argued that there is a need for longer-term planning in adult social care with a roadmap for implementing reforms over a number of years.

317 On review of the interventions during and following the pandemic, it is clear that the issue is not with the interventions themselves - and we have highlighted examples of where these were successful - but the need for a long-term plan and the capacity to oversee, manage and rapidly implement change overall.

318 Skills for Care is committed to working with the Inquiry throughout its investigations and we are happy to assist with any further requests.

**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**: _____

**Dated**: 14 February 2025