

Witness Name: Paul Featherstone

Statement No.: 1

Exhibits: PF1

Dated: 28 January 2025

## UK Covid-19 INQUIRY - MODULE 6

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### WITNESS STATEMENT OF PAUL FEATHERSTONE

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I, Paul Featherstone, of: Personal Data will say as follows:

1. I make this statement as Chair and Founder of the National Association of Care Workers ("**NACAS**") in response to a Rule 9 request for evidence from the UK Covid-19 Inquiry (the "**Inquiry**") dated 29 July 2024 (the "**Request**").
2. I have been a care professional for the past 11 years. I have worked as a support worker for people with significant mental health and behavioural issues to enable them to live independently. I worked in the domiciliary care setting, with people with various health conditions and disabilities. I also cared for my mother, who was living with vascular dementia. My wife, Janet, also works in the social care sector.
3. This statement has been prepared on the basis of the following information:
  - a) my own knowledge and experience;
  - b) discussions which solicitors at Hogan Lovells International LLP and I have had with NACAS members; the NACAS Leadership Team; and the NACAS Board of Directors (described below at paragraph 10(a)-(i));<sup>1</sup>
  - c) responses provided by NACAS members to two surveys (the '**Surveys**', described below at paragraph 5);<sup>2</sup> and

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<sup>1</sup> Where there are quotations in this witness statement without an exhibit reference, these are taken from notes taken during discussions with NACAS members or from correspondence from NACAS members.

<sup>2</sup> Quotations from the Surveys have been amended for spelling and grammatical errors throughout this witness statement.

- d) additional accounts submitted by various NACAS members on 10 March 2024 in response to my request for further information on areas of concern amongst the membership in advance of the Preliminary Hearing on 19 March 2024.
4. I refer in this witness statement to a paginated bundle of documents which is exhibited to this statement at “PF1” and I refer to documents by tab number in the form of [PF1/[x]- INQ000000000].
5. Care professionals were on the frontline during the pandemic and have a unique understanding of the day-to-day support those in care settings received at a time when access to these individuals was limited. As a result, NACAS considered that it was vital to obtain the views of its membership to enable it to fully participate in the Inquiry. This was achieved primarily through the use of surveys; the first surveys (“**Survey 1a**” and “**Survey 1b**”) were completed between 22 February and 13 March 2024 and had 187 respondents. The second survey (“**Survey 2**”) was conducted from Friday 30 August 2024 to Monday 14 October 2024 and had 136 respondents. Survey 2 was conducted following receipt of the Inquiry’s Request and was designed to capture the views of the NACAS membership in relation to the specific issues raised in the Request. Respondents to one or both of the Surveys are referred to as the “**Survey Respondents**” throughout this statement.<sup>3</sup> The Survey Respondents predominantly work with adults in the settings outlined at paragraph 12 below.
6. Throughout this witness statement, the views expressed on behalf of NACAS reflect the organisation’s position. However, where I express my own views, I will make this clear; I express such views in a personal capacity.

#### **NACAS' role, aims, functions and membership**

7. It may be useful at the outset to explain the circumstances in which NACAS was created. In 2015, I realised that there was no single organisation that offered support for, or represented, care professionals. Although there were various trade unions, there was no organisation exclusively for care professionals and run by care professionals. As a result, for the following two years - while continuing to work as a care professional - I conducted research, spoke to local and national (Welsh) government along with the Care Quality Commission (“**CQC**”), and drafted a business plan and organisational policies. Following this, in March 2016, I set up the UK Support Worker Association (“**UKSWA**”). In June 2016, our first subscribing member joined and I began actively

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<sup>3</sup> Attempts have been made to ensure that this statement provides a representative view of all Survey Respondents, as well as the wider NACAS membership.

engaging with major social care stakeholders. In August 2016, the UKSWA was invited to become a strategic partner to represent the care workforce at Social Care Wales (formerly the Care Council for Wales). In mid-2017, the organisation was re-branded as NACAS.

8. NACAS was established as an independent social care stakeholder and professional body committed to advocating and providing a platform for care and support professionals to have a voice in the sector. It seeks to promote the recognition and value of the social care workforce and provides a wide range of education and other resources to its members, including access to best practice guidelines, training courses, facilitating access to legal advice and networking opportunities. NACAS is also dedicated to fostering growth and well-being among care and support professionals and offers support to help its members manage stress, learn new skills and advance their careers.
9. In addition, NACAS works alongside policymakers, employers, and other stakeholders to promote policies that support the needs and interests of care and support professionals and improve the quality of care provided to vulnerable individuals.
10. NACAS' leadership team and volunteer board is comprised of individuals with experience working within the adult social care sector:
  - a) Liz Blacklock has been the CEO of NACAS since 2021. She left her career as a Registered Nurse in the NHS 9 years ago and opened an organisation providing domiciliary care called Lapis Care.
  - b) Zoe Jones, NACAS' Operations Officer, is a former community care worker;
  - c) Andy Millbank is NACAS' Registration Director;
  - d) Pappy Akinyemi is NACAS' Business Development Director;
  - e) Kay Mumford is NACAS' Marketing Director;
  - f) Pamela Miller is NACAS' Membership Director;
  - g) Sally Rhodes is NACAS' Safeguarding Director;
  - h) Paula Cashmore is NACAS' RN Employer Director; and
  - i) Beth Hendy is NACAS' Operations Director.

11. In March 2020, NACAS' membership stood at approximately 4,000 across the United Kingdom. Since then, NACAS' importance and recognition in the sector has grown significantly and its membership currently stands at 15,097 across the United Kingdom. The majority of NACAS' members reside in England, with a reasonable number of members located in Wales and Scotland and a few members in Northern Ireland. NACAS' members come from various ethnic backgrounds and nationalities.<sup>4</sup>
12. NACAS represents individual care professionals (rather than care homes) who provide care and support to a vulnerable person, whether that is an adult or a child (although NACAS members predominantly work with adults). NACAS' membership covers a diverse range of roles across the profession, including those working in varied settings including domiciliary, residential and community care and nursing. Members of NACAS work in different employment settings, primarily in care homes, nursing homes, residential homes or in domiciliary care, and whether employed, self-employed, agency workers or individuals on zero hours contracts. I would estimate that 40% of NACAS members are self-employed care professionals. In this statement, I will refer to all forms of care and support workers collectively as "**care professionals**" unless stated otherwise.
13. As NACAS has grown, so has its role in supporting care professionals. During the Covid-19 pandemic, NACAS supported its members in a variety of ways:
  - a) With limited resources, and at the height of the PPE crisis, NACAS purchased 2000 disposable face screens and distributed them free of charge to our members on a first come first served basis to help mitigate the shortages of PPE [PF1/1 - INQ000518356] [PF1/2 - INQ000518367]. NACAS would have liked to provide more PPE but was unable to do so because of financial constraints.
  - b) NACAS approached major supermarkets [PF1/3 - INQ000518378] and asked them to accept NACAS membership cards as proof of a member's status as a frontline worker so that they were given priority access along with our NHS colleagues. This was positively received, and as a result, a NACAS membership card was accepted as proof of status [PF1/4 - INQ000518389].
  - c) NACAS highlighted the controversial practice of discharging Covid positive patients into care homes. We worked with Sky News by introducing them to a

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<sup>4</sup> NACAS does not collect data on the nationality and ethnicity of its members.

care home manager who was directly involved in this practice, which helped to highlight the story at a national level.

- d) NACAS introduced a "Social Care Worker On Call" windscreen sticker that members could display on their cars to give notice to the public that a care/support worker was active in the area [PF1/5 - INQ000518400].
- e) On behalf of NACAS, I undertook some limited media to raise the profile of the difficulties faced by NACAS members in their roles as care professionals.
- f) On 18 May 2020, NACAS contacted the UK Department of Health and Social Care ("DHSC") by email to make them aware of our existence and to offer support and services. However, DHSC did not publicise the support and services offered [PF1/6 - INQ000518411]. Beyond that, NACAS did not raise issues with any organisations during the pandemic. NACAS was a new stakeholder with very limited resources at that point in time. We now proactively engage with a number of organisations including Care England, the Home Care Association, the National Care Forum, Care Workers Charity and the CQC.

#### **Summary of NACAS' key concerns about the pre-pandemic workforce in the adult social care sector in the UK**

- 14. Before the pandemic, NACAS had significant concerns about the capacity of the workforce. NACAS is of the view that this problem was understood by government but had not been appropriately addressed before the pandemic. It resulted in limited capacity and diminished resilience to accommodate the shock of the pandemic. 72.39% of Survey Respondents also considered that before the pandemic there were existing problems in the care sector which impacted the sector's ability to respond to the pandemic [PF1/7 - INQ000518420]. NACAS considers that the key issues which affected the capacity of the workforce are as follows:

##### Poor remuneration

- 15. The principal reason for the constraints on the capacity of the workforce was low pay coupled with the demands of the role. This is the primary factor identified by Survey Respondents. By way of example, Survey Respondents have stated the following:
  - a) *"there's always a shortage of good staff and there's a high turnover of staff. Poor wages contribute to this issue. It can be hard work and the pay does not reflect that."* [PF1/7- INQ000518420]

- b) *“there has always been shortage of care workers due to poor pay but Covid has even made it worse.”* [PF1/7- INQ000518420]
- c) *“We never have enough staff due to the pay we receive.”* [PF1/7- INQ000518420]
- d) *“Lack of good staff due to the huge responsibility undertaken for very poor pay.”* [PF1/7 - INQ000518420]
16. In 2020, the mean hourly wage in the sector was £8.30 per hour or £307 per week (based on a 37-hour week) [PF1/8 - INQ000518421]. In 2022/2023, the median hourly rate for care workers only increased to £10.11. However, high inflation means that pay has fallen by 35p per hour in real terms [PF1/9 - INQ000518422]. The turnover for the adult social care sector has remained relatively stable since 2016/17; the turnover rate across all care jobs in 2016/17 was 27.8% [PF1/10 - INQ000518357], and in 2022/2023 it was 28.3% [PF1/9 - INQ000518422]. It is significant that turnover rates are lower for care professionals who are paid above the minimum wage and are higher for care professionals who are on zero-hour contracts [PF1/9 - INQ000518422].
17. In this respect, NACAS members have pointed to a lack of central and local government funding of the adult social care sector as the reason for the low wages. One member reported:
- “it is down to the government. I don’t consider social care a problem that needs a solution. It is all about government recognition. They give all the money to NHS. Social care is a huge part of people giving people safety, and it has a huge impact on the economy. I think the government doesn’t recognise it as being a value. It is last on their list of priorities.”*
18. The results from the Surveys indicate that this view is widespread, with one NACAS member stating that:
- “social care has been always forgotten. Local councils and authorities do very little to improve things on the ground level – quite the opposite, they look more for cuts in hours and support. All of that resulted in social care worker jobs being the least attractive for young people because they prefer for the same money to work normal hours and not being overloaded with millions of policies to follow and be responsible for someone else’s life.”*

Profit-making care homes

19. NACAS is of the view that different business and funding models for the care sector may have led to variable investment in staff and infrastructure pre-pandemic, with some profit-making homes investing less than their publicly funded equivalents. Some Survey Respondents supported this view and identified that the private care home system was a key concern as it put “*profit over people*” [PF1/7 - INQ000518420]. A Survey Respondent explained that this system was “*profiteering from low paid, vulnerable, overseas workers... enforc[ing]... 12-hour shifts... [which r]esults in high turnover and cycle starts again*” [PF1/7 - INQ000518420]. In discussions with NACAS members, several agreed with these comments and explained that their needs and safety were not protected or prioritised in private care home settings. One NACAS member stated that although: “*care homes are businesses and have to manage books, [...] at the end of the day it’s the carers that do the job, who are on front line, who look after residents.*” Another NACAS member stated:

*“I think it all comes down to money – if you are managing care home on a fixed budget, the people that bring in the money are the residents, they don’t think of staff. The carers are replaceable...”*

20. The extraction of profit that could be invested in the care sector was apparent during the pandemic. A report published by the Financial Impacts of Covid-19 on Care Homes (“**FICCH**”) found that in the first year of the pandemic, 122 larger, ‘for-profit’ care home companies were able to pay shareholders 11% more in dividends than the previous year. Despite the increased profits, many care home staff worked extra hours without extra pay [PF1/11 - INQ000518358]. This report found that “*the care sector’s aggregate profitability improved over the first year of the pandemic*” and “*the aggregate profit margin of the care home sector increased from 4% to 6% (a net increase of £194m)*”, whereas “*42% of respondents reported personal financial problems linked to working in care during Covid-19*” [PF1/11 - INQ000518358].
21. As a result, NACAS observes that it is unclear whether all of the emergency funding went to supporting frontline care professionals during the pandemic. Indeed, a report published by the Scottish Trades Union Congress in June 2022 found that “*at least five of the ten largest for-profit care home operators received £57 million of extra Covid funds in 2020 and 2021. One of these companies made a loss, but the other four made over three times as much profit as the Covid grants they received (over £108 million in profits in 2020 and 2021)*” [PF1/12 - INQ000518359].

#### Staff Shortages

22. NACAS considers that the sector suffered from significant staff shortages which affected workforce capacity before the pandemic. One NACAS member referred to the *“the never-ending staff shortages going way back.”* This created a vicious circle; it exacerbated the demands of the job on care professionals which in turn led to some individuals deciding to leave the profession. Survey Respondents have mentioned feeling *“overworked”* and working *“unsociable hours”*, which led to *“high levels of stress, physical and mental strain”* [PF1/7 - INQ000518420]. One stated that care professionals were *“asked to work extra shifts regularly and nobody cared about a healthy work-life balance”* [PF1/7 - INQ000518420]. Another NACAS member stated that *“we never had enough staff before Covid, it was terrible we were so overworked. Spending days at work just because we had no staff.”*
23. The lack of permanent members of staff resulted in a reliance on agency workers. One Survey Respondent commented:
- “I found in most care homes that they had mostly agency staff and very few permanent staff members. I think it was because as agency staff we could choose when we worked and the pay was only slightly higher with fewer perks such as paid holiday and the hours were not always guaranteed. However, some places were in the middle of nowhere and they just could not find the staff to employ.”* [PF1/7 - INQ000518420]
24. It was not just the care professionals who bore the strain of the staff shortages; the recipients of care and their families also suffered as a result. Several Survey Respondents felt that these conditions affected the quality of the care being delivered. By way of example:
- a) One stated that the understaffing issues meant that care professionals were *“left to work with [the] wrong ratio [of] service users to staff even if this was putting carer safety at risk.”* [PF1/7 - INQ000518420]
  - b) Another stated they *“have witnessed 1 care worker to 8 people.”* [PF1/7 - INQ000518420]
  - c) Other Survey Respondents mentioned feeling *“rushed”* and that they did not have *“enough time with clients or [to] travel to clients,”* which was not only stressful for the care professionals, but resulted in *“paperwork getting missed or being completed too late.”* [PF1/7 - INQ000518420]

- d) Another stated that *"it is difficult to deliver quality care when you are given 15 minutes to support a slow elderly person who is in pain to get washed, dressed and settled. It was already difficult dealing with the demands of people in need and the balance of trying to maintain all the appropriate notes and keeping records up to date."* [PF1/7 - INQ000518420]
- e) Another witnessed *"service users going without care or carers coming in late / rushing as had too many service users in one day to do a competent job."* [PF1/7 - INQ000518420]

25. It is important to note that workforce capacity issues persist today. The pandemic, along with Brexit, have resulted in issues such as staff shortages only getting worse. Workforce vacancies in the adult social care sector exceeded 152,000 in March 2023, which represents a vacancy rate of almost 10% [PF1/13 - INQ000518360].

#### Public Perception

26. NACAS also observes that the public's perception of the adult social care sector also impacted the sector's workforce capacity. My view is that the public's general perception is that care work is carried out by those who cannot get a "proper" job and that anyone can do the job. This was confirmed by Survey Respondents who mentioned that the adult social care sector has *"always been under-represented"*, and feel as though the *"lack of recognition [and] lack of respect for care workers"* are reasons for the understaffing. Another Survey Respondent stated that *"care workers are seen as people who are desperate for a job and can't find work elsewhere"* [PF1/7 - INQ000518420].
27. Other NACAS members considered that the presentation of the adult social care sector in the media has contributed to workforce capacity issues. One Survey Respondent commented that the sector is *"undervalued"* and *"stigmatised... [as] you only see negatives on the media about social care workers."* Another agreed, stating that *"the media only talk about care homes where abuse has happened and not ever how hard people work and how they have to give up their personal lives to look after others, and how they work 12+hours 7 days a week, get called in to work on their annual leave and everything else."* As a result of this, one NACAS member commented that *"people are always negative towards social care workers"* [PF1/7 - INQ000518420].

**Other issues that impacted on the ability of the care sector to respond to the pandemic**

28. There are a number of other systemic and structural issues that impacted the ability of the care sector to respond to the pandemic, most notably: (i) a lack of care sector visibility and representation within government; (ii) unclear accountability; and (iii) inadequate regulation.

Lack of visibility

29. NACAS is of the view that, historically, social care has not been sufficiently prioritised within or understood by the UK government. This has led to a lack of visibility and representation of the sector at a senior level. By way of example, there was no Director General with responsibility for social care in the DHSC between 2016 and June 2020. NACAS agrees with the Nuffield Trust that there has been a *“historical low priority of social care within government, and a resulting lack of senior social care voices embedded within decision-making processes”* [PF1/14 - INQ000553858].
30. It is inevitable that the lack of voices at a senior level contributed to issues with the pandemic response in the care sector. If there had been better representation of social care, NACAS considers that it would have led to a better understanding by decision-makers of how the social care system operated, including the ways in which it is interconnected with the healthcare system and the community. That in turn would have led to better decisions and improved implementation, including in relation to the discharge of patients into care homes without testing.

Unclear accountability

31. NACAS is also of the view that there was, and remains, a lack of clear accountability for the care sector within local and central government. Responsibility for social care is diffuse and is split across several UK government departments (DHSC, Ministry of House, Communities and Local Government, Department for Work and Pensions), numerous arm's length bodies (e.g. CQC, UK Health Security Agency) and different commissioning bodies in local authorities and the NHS. Services are also generally provided by private organisations.
32. There is often a lack of integration and coordination between health and social care services and this fragmented structure led to confusion, including amongst care workers, as to which body or bodies were responsible for issues such as PPE procurement and distribution and the rollout of testing, which in turn led to delay. There was no equivalent of NHS England to coordinate the care sector pandemic response.

33. NACAS has advocated generally for greater regulation of the care sector as it serves to improve and maintain standards and enhance the recognition of the care profession. To that end, in October 2023, NACAS, in conjunction with the Institute of Health & Social Care Management (“IHSCM”) launched the ‘Voluntary Care Professional Register’ (“VCPR”). The VCPR is an independent and voluntary register guided by peers and rooted in shared values. Those who choose to register are encouraged to embody the professional standards and ethical behaviours expected in social care, follow a Code of Conduct, and commit to delivering high-quality care. The VCPR offers numerous benefits to both employers and care professionals, some of which are set out below:
- a) fostering a positive impact on the social care ecosystem;
  - b) streamlining the recruitment process, freeing up time typically spent verifying references and conducting DBS checks. This would allow employers to focus on evaluating candidate suitability, ensuring the right fit for their care teams; and
  - c) serving as a powerful symbol of the dedication of a care professional to their field and commitment to maintaining high standards of care provision.
34. In England, unlike in the devolved regions, there is currently no registration provision. Formal recognition through professional regulation would go some way to addressing the public perception of care professionals as low-skilled and has the potential to improve recruitment and retention. It would also improve the response to any future pandemic in other ways. For example, the absence of a register during the pandemic meant local authorities could not identify the workforce. This was a particular issue when seeking to trace at pace close contacts of care professionals in the event of an outbreak [PF1/14 - INQ000553858].

#### **Key decisions made by the UK Government and Devolved Administrations**

35. In short, NACAS’ view is that key decision-making by the UK government, including the issuance of guidance, was slow, piecemeal and paid insufficient regard to the impact on the social care sector.
36. Survey Respondents reported significant concerns in relation to the key decisions made by the government and the government guidance provided to the adult social care sector during the pandemic. When asked if they thought the government made the right decisions during the pandemic, of the 129 NACAS members who answered, 78.29% responded ‘No’ and only 21.71% responded ‘Yes’ [PF1/7 – INQ000518420].

37. In particular, several NACAS members reported that there was no long-term planning or strategy in government decision-making. One NACAS member reported that the government made *“ad hoc policies which had a detrimental effect on carers, their families and the people we support”* [PF1/7 – INQ000518420].
38. NACAS members highlighted the following examples as particularly affecting the sector: (i) the decision to discharge hospital patients to care homes without testing (see further paragraphs 40-48 below) and (ii) a lack of clear instructions, and rules around visits to care homes (see paragraphs 55-62 below). A significant number of Survey Respondents mentioned feeling that the care sector had been *“let down”* by the government during the pandemic, with one Survey Respondent stating that they considered the government:
- “let the care home industry down massively. No support, no guidance, no management guidelines, no protection for carers and no dignity for those who were suffering from Covid.”* [PF1/7 – INQ000518420]
39. At this point, it is convenient to address in further detail some of the key government decisions and guidance affecting the social care sector.

#### Discharge of residents from hospital to care homes without testing

40. On 17 March 2020, the UK government made the decision to discharge hospital patients into care settings without prior Covid testing (the **“March 2020 Discharge Policy”**) [PF1/15 – PHT000000024], resulting in the discharge of [25,000] patients into care homes without testing [PF1/16 – INQ000518363] [PF1/17 – INQ000518364]. This meant that, of the 6,435 people discharged from hospital into a care home between 19 March and 15 April 2020, two thirds had not taken a Covid test during their stay or prior to discharge [PF1/18 – INQ000518365].
41. One day before this decision was made, Professor Dame Jenny Harries stated that discharge to care homes, without testing and regardless of Covid-19 status, was *“...entirely clinically appropriate because the NHS will triage those to retain in acute settings who can benefit from that sector’s care. The numbers of people with disease will rise sharply within a fairly short timeframe and I suspect make this fairly normal practice and more acceptable, but I do recognise that families and care homes will not welcome this in the initial phase”* [PF1/19 – INQ000399544]. In contrast, Professor Sir Jonathan Nguyen-Van-Tam gave evidence that *“while it is true that testing patients prior to discharge could not guarantee that they would not be infectious on arrival at a*

care home, that is not a reason for not doing it" [PF1/20 – INQ000269203]. NACAS agrees.

42. The UK government issued guidance regarding the discharge of hospital patients into care homes without testing on 19 March 2020 (the "**March 2020 Discharge Guidance**") [PF1/21 – INQ000049702], suggesting they should discharge hospital patients who are medically fit to leave [PF1/21 – INQ000049702]. Consistent with the March 2020 Discharge Policy, there was no requirement to test patients in the guidance; instead, the guidance stated "*where applicable to the patient, Covid-19 test results are included in documentation that accompanies the person on discharge.*" Draft DHSC guidance issued in March 2020 shows that the reliability of testing before patients' transfer from hospitals to care homes was a point of debate at the time [PF1/22 – INQ000049477]. The National Care Forum, Homecare Association, and Care England submitted in Module 2 of the Inquiry that "*the decision to move towards mass discharge from hospital to care homes, without the necessary testing, clinical support or resources, and consideration of wider social care settings, was pushed by senior decision makers despite knowing the suspicions of asymptomatic transmission*" [PF1/19 – INQ000399544]. NACAS agrees.
43. The UK government subsequently issued guidance on 2 April 2020 that confirmed cases of Covid should be discharged to care homes, with "*negative tests [...] not required prior to transfer / admissions into the care home*" and recommended that patients who had tested positive be isolated (the "**April 2020 Admissions Guidance**"). In April 2020, Professor Sir Chris Whitty told Matt Hancock that there should be testing for "*all going into care homes*" [PF1/23 – INQ000518371]. Despite this, Matt Hancock's WhatsApp messages from the Top Team group dated 4 April 2020 indicates that government advisors were focused on optics, rather than the health risk of not testing recipients of care [PF1/24 – INQ000093254].
44. It was not until the UK government published the "Adult Social Care Action Plan" on 15 April 2020 that NHS hospitals in England were required to test all patients for Covid-19 prior to them being discharged or admitted into a care home and that care homes were advised that they "may wish" to isolate asymptomatic patients for 14 days [PF1/25 – INQ000233794].
45. NACAS is of the view that, prior to 15 April 2020, the UK government had failed to consider adequately the impact of asymptomatic Covid-positive patients being transferred into care facilities and the impact on staff and residents (and, as addressed at paragraph 118 below, failed to advise that on admission to care homes asymptomatic

patients should be isolated from other residents insofar as practicable which compounded the problem). The mistakes, and the delay in rectifying them, caused avoidable deaths of both residents and staff in care homes. Social care felt like an afterthought.

46. The UK government's decision to discharge residents from hospitals to care homes without testing was frequently cited by Survey Respondents as a key concern they had with government policy during the pandemic. 77.10% of Survey Respondents felt that discharging residents from hospital to care homes without testing was the wrong approach [PF1/7 – INQ000518420]. Several NACAS members mentioned feeling government decisions had not considered the risk that this posed to both care professionals or service users:

- a) *"[w]hen the government made this decision they did not think of the impact of what this decision could do to the patients, the families, staff and other patients at the care home."* [PF1/7 – INQ000518420]
- b) *"this decision exposed care staff and other vulnerable people to the virus and [...] highlighted that the government at the time did not consider these people (staff and elderly) important."* [PF1/7 – INQ000518420]
- c) *"Patients we're just being chucked out of the hospitals putting into care homes to die."* [PF1/7 – INQ000518420]
- d) *"the government treated the elderly and vulnerable as unimportant when it came to discharge of patients to care home that were infected with COVID 19 spreading the virus in homes that had not yet had COVID 19."*
- e) *"[the] most hurtful decision was not to test patients discharged from hospital into home care, which was sending a message that carers and nurses working in the Community are less worthy than the ones working in hospital or care homes."*
- f) *"the care sector experienced massive loses. Sending patients to care home with Covid 19 placed so many vulnerable older adults in jeopardy, ultimately ending in their deaths because of it."* [PF1/7 – INQ000518420]
- g) *"A terrible decision which resulted in early deaths for many residents."* [PF1/7 – INQ000518420]

h) *"It just issued a death sentence on the residents already in the care homes as they didn't know if these patients were clear, testing wasn't done correctly."*

**[PF1/7 – INQ000518420]**

47. Overall, Survey Respondents expressed a consistent view that at all times there should have been mandatory testing for all discharged hospital patients *"to ensure minimum risk to life for vulnerable people."* **[PF1/7 – INQ000518420]**
48. Graham Greenaway, the owner of Warberries Nursing Home, struggled with the decision to discharge Covid-positive patients into his care home. NACAS arranged for him to be interviewed by Sky news on 7 April 2020 and he said government policy had *"effectively imported death into the care homes"* **[PF1/26 – INQ000518374]**. This was an accurate reflection of my experience of what was occurring in the care sector at the time, and I was pleased that NACAS had a small role in bringing the issue of discharging Covid-19 patients into care homes into the public consciousness.

#### Lockdowns

49. NACAS has significant concerns about the UK government's timing and communication of the imposition of lockdowns during the pandemic.
50. NACAS' concerns are reflected by the membership. 57.03% of Survey Respondents felt that the government did not give enough notice before each lockdown. Some Survey Respondents reported that the government decision making around lockdown felt *"very last minute"*, and as a result the government did not *"give enough preparation time"* to those working in the adult social care sector. With successive lockdowns, there was limited pre-warning to the care sector which would have enabled better care. For example, one Survey Respondent commented that the lockdown announcement timings did not provide *"enough time to make appropriate care decisions that required planning"* and another stated that this *"created more stress leading to further staff losses and strain in clients"* **[PF1/7 - INQ000518420]**.
51. At the same time, there was a commonly expressed view that the initial lockdown was *"too late"*, with one Survey Respondent stating: *"it caused a lot of problems [because] Covid was well spreading by the time they took to make the decision"* **[PF1/7 - INQ000518420]**.
52. Lockdowns, in concert with the lack of notice of the lockdowns, significantly impacted the ability of care professionals to deliver care and perform their jobs. One Survey Respondent commented:

*"I feel I did not have enough time to explain to my client as to why I could not work the fulltime hours that my client was accustomed to, and it was so sudden that I was forced to only work only eight hours a week, which meant my client was not being supported for [an] extended amount of time, which I felt was a hazard to his health, especially living alone" [PF1/7 - INQ000518420].*

53. Care professionals were concerned about the detriment to their clients' wellbeing caused by the lockdowns. One Survey Respondent commented *"how I could leave my clients very lonely without help?"* Another stated *"we need to remember that each resident in a care setting (or indeed, at their own home setting), have their families and social connections what was interrupted and/or disrupted" [PF1/7 - INQ000518420].* In discussions with NACAS members, one domiciliary care worker described their service users as being *"vulnerable and isolated"* and commented that *"[y]ou would see people standing outside windows, but there is a need for human touch"*.
54. As with visiting restrictions (see paragraphs 55-62 below), the social isolation caused by lockdowns led to mental and physical deterioration in recipients of care. One Survey Respondent reported that *"people who could walk and drive pre Covid are in wheelchairs post covid, it deteriorated their quality of life dramatically" [PF1/7 - INQ000518420].* Another NACAS member explained the impact of 'shielding' on their clients with dementia as follows: *"clients couldn't understand where their family members were and why they weren't seeing them, leading to anxiety and depression in some instances."*

#### Visiting restrictions

55. NACAS considers that the rigid visiting restrictions imposed during the pandemic severely impacted care home residents, as explained below. NACAS recognises the importance of slowing the spread of the virus and preventing it entering vulnerable environments, but the impact on residents was so damaging that a blanket ban on families visiting in hospitals or care homes was, in NACAS' view, disproportionate.
56. This reflects the view of the wider membership; in response to the question "what was the impact of rules limiting or banning visitors for people you cared for?" of the 126 who responded, 120 mentioned the visiting restrictions as causing loneliness and/or having a physical and/or mental health impact on those in care [PF1/7 – INQ000518420]. Survey Respondents have reported as follows on the mental health impacts of visiting restrictions on their service users:

- a) One NACAS member commented that it led to *“significant decline in the mental health of people I cared for.”* [PF1/7 - INQ000518420]
- b) Another Survey Respondent stated that: *“it was very stressful, confusing and traumatic for the people I cared for. They did not understand why they could not see their loved ones and that impacted their health.”* [PF1/7 - INQ000518420]
- c) Another observed that *“visiting restrictions massively impacted care recipients in their mental and physical health.”* [PF1/7 - INQ000518420]

57. In addition, NACAS observes that the restrictions that were implemented during the pandemic differed between care settings. Following the first national lockdown on 23 March 2020, UK government guidance was published on 2 April 2020 which advised that family and friends should not visit care homes, except in exceptional circumstances such as end of life [PF1/27 - INQ000518375]. The government’s advice was subsequently revised on various occasions and was at times dependent upon the area in which the care home was located. For example, in October, limited visits to care homes were permitted for areas under the Medium (Tier 1) alert level, however visiting was not permitted for those in High (Tier 2) or Very High (Tier 3) alert level areas.

58. Visiting restrictions led to a noticeable deterioration in those residents living with dementia. One NACAS member went so far as to say that,

*“residents health and wellbeing declined, they failed to recognise loved ones when eventually allowed to see them. Social isolation further advanced cognitive and physical decline. The rules were an absolute nonsense...”*

59. Several NACAS members have commented on the devastating impact of visiting restrictions on the individuals who were dying and were prevented them from seeing their loved ones in their last moments. One noted:

*“It wasn't fair on elderly in care homes not to see any relatives especially if said client was ill or [a] dementia suffer[er], residents in care should been allowed immediate family to visit especially if they were coming to the end of their life. With the right safety measures it would been possible for people to visit and keep everyone safe. Staff were able to come and go in the homes.”*

60. In addition, the demands on care professionals increased significantly as a result of the visiting restrictions. Care professionals were often the only people interacting with their

service users during the pandemic, and therefore their reliance upon their carers grew. Survey Respondents have commented as follows:

- a) *“more emotional and physical support was needed from staff as the clients didn't have visitors to speak to or to do small things for them which would normally be carried out day to day by family members, neighbours etc. Clients were in a depressed state which in turn effected their general wellbeing and health.”* [PF1/7 - INQ000518420]
- b) *“literally their whole family support [was] taken away and strained carers [were] left to plug that hole.”* [PF1/7 - INQ000518420]
- c) *“[the] huge isolation issues, feeling of desperation and how they would manage, vastly increased pressure on carers to assist.”* [PF1/7 - INQ000518420]
- d) *“they didn't know how to use technology so communication was difficult. They relied on carers to help make contact.”* [PF1/7 - INQ000518420]
- e) *“it was devastating to my client as he required me to guide him to take him out and about in the community, and that suddenly ended and my client was stuck in his home for extended amounts of times, which subsequently affected his mental health and he became depressed and lonely.”* [PF1/7 - INQ000518420]

61. On a related note, one NACAS member added that, as a result of the visiting restrictions, there were *“lots of behaviour issues”*, and another remarked that as a result of the toll of separation from loved ones, those working in *“care homes got the abuse.”* This in turn could have a negative impact on the care professional. One Survey Respondent stated that *“being with someone who is challenging 24 hrs a day with little support had a big negative impact on carers”* [PF1/7 - INQ000518420].

62. Personally, as I was shielding during the pandemic, I was not able to visit my mother who has dementia. This meant the responsibility for her care fell entirely on my brother. My mother could not understand why I could not visit her, which impacted her mental health. On reflection, I think the restrictions were too rigid and the regulations and guidance should have allowed one or two family members to have contact with those in care homes. If other systems (for example, of testing, tracing and isolation) had operated effectively then it may have been possible to achieve this without it having an unacceptably high impact on the spread of the virus.

#### Vaccination as a condition of deployment

63. NACAS is of the view that the UK government failed fully to consider the practical consequences of employers dismissing individuals who decided not to be Covid vaccinated, including the knock-on impact on those professionals, increased staff shortages, and the resulting additional burdens on remaining staff.
64. The government issued guidance on vaccination as a condition of deployment on 22 July 2021, but it had not at that point conducted an impact assessment. The DHSC did not submit an impact assessment for Regulatory Policy Committee scrutiny until 18 August 2021 [PF1/28 - INQ000067307]. The basic rationale for imposing mandatory vaccination as a condition of deployment is understandable. Internal government exchanges reveal that the government was aware of the risk of care professionals leaving the sector as a result [PF1/28 - INQ000067307]. The government subsequently issued an impact statement on 9 November 2021 which predicted that as many as 38,000 people would not be able to be deployed in the adult care sector if vaccination became a condition of deployment and estimated the cost of replacing those individuals was an estimated £86 million [PF1/29 - INQ000518377].
65. Various studies have estimated that there was a reduction in care professionals of between 14,000 and 19,000 following the vaccination mandate coming into force [PF1/30 - INQ000518379]. However, the actual figure could be much higher given that these statistics were only a measure of the reduction in care home staff, which would not have accounted for staff that were replaced (as the change would be net zero in these situations) [PF1/31 - INQ000518380].
66. The vaccine mandate has had a lasting impact on workforce capacity levels within the care sector, even after it was lifted. By the start of June 2022, the total number of care professionals employed in elderly residential care was still about two per cent lower than just before the mandate was announced in the previous year. Although this represented a recovery in staffing numbers from when the mandate was in operation, it was driven almost entirely by agency workers [PF1/30 - INQ000518379].
67. A significant number of NACAS members expressed considerable frustration about requiring vaccination as a condition of deployment. Some Survey Respondents considered that they were discriminated against for not having the vaccine – one reported being “*marginalised and pointed at because I refused the vaccination.*” Several Survey Respondents reported feeling “*forced*” or “*bullied*” into having the vaccine. Some thought there should have been a choice, and that the vaccine should not have been a mandatory condition of deployment. That being said, there were differing views amongst Survey Respondents and some supported mandatory vaccination, believing

that “[the government] had to make it mandatory due to fearful...people”; another member said mandatory vaccination had “to be carried out to protect clients” [PF1/7 - INQ000518420]. I will explain the members' position on mandatory vaccination more broadly at paragraphs 193-198 below.

### **Summary of NACAS' views about the level of consultation and/or communication with the care sector about key central government decisions**

68. In NACAS' view, the level of UK government consultation and communication about key decisions affecting the care sector and care professionals was limited. That was a product of the low visibility and representation of the care sector in senior positions in government.
69. NACAS members have expressed the same view. Some Survey Respondents expressed the view that the government did not show an equivalent level of concern about care professionals as it did about other healthcare workers e.g., NHS employees, and some have reported feeling “abandoned”. Some Survey Respondents expressed the view that government guidance changed regularly and was not specific to care homes. This is indicative of there having been limited consultation with care home providers before the dissemination of government guidance [PF1/7- INQ000518420].
70. It appears that the government was aware of the care sector's concerns; draft guidance due to be published in May 2020 acknowledged a “need to make the sector feel fully supported” and noted “so far our stakeholders are positive but we need to convince them they are a priority” [PF1/32 - INQ000050377]. On the “handling” of guidance, an internal DHSC email from 14 May 2020 noted “sustained and vocal criticism of the Government on care testing still. Too little too late” and a fear of “add[ing] more fuel to the fire” [PF1/34 - INQ000049727].

### **Summary of NACAS' key concerns about the dissemination of government guidance to care professionals**

71. Initially, NACAS' perception with regards to the dissemination of guidance was that no guidance was shared by the government and that care homes and domiciliary care providers were providing their own internal guidance themselves. However, once the government realised that they had neglected the care sector, relevant guidance started to filter in.
72. An email exchange dated 17 March 2020 between Antonia Williams and Jonathan Marron (Director General of the DHSC) states that “I can't see any reference in

*Catherine F papers to social care. Was it discussed at [the] meeting?"* The email response explains there is no reference to social care because of the need to “*keep a very tight scope*” on guidance issued [PF1/34 - INQ000049727]. These emails are indicative of limited guidance tailored to the care sector at the start of the pandemic, which contributed to the feeling shared by care professionals that the care sector was not prioritised.

73. In addition, in discussions with NACAS members, one commented that at times the dissemination of advice could be confusing and overwhelming. They stated that they received different guidance from the government and/or local authorities via email “*two to three times per day. After a while, I couldn't respond to it all, [it] wasn't feasible. The government had best intentions, but without thinking how it could be implemented in reality.*”

### **NACAS' views and concerns regarding infection prevention and control (“IPC”) measures**

#### Ventilation in care settings

74. The fabric of care homes varies significantly, and ventilation can be poor. NACAS members expressed concerns that the government did not seem to understand this when issuing guidance; a number of Survey Respondents explained that ventilation was often very poor in care settings, particularly in washrooms and kitchens [PF1/7 - INQ000518420]. DHSC guidance on ventilation was only introduced on 4 March 2021 (subsequently updated on 13 May 2022) [PF1/35 - INQ000223595], and again on 31 March 2022 (subsequently updated in March 2024 [PF1/36 - INQ000518385] [PF1/37 - INQ000518386] [PF1/38 - INQ000553532]).

#### Isolation of recipients of care

75. NACAS' view is that the guidance to isolate recipients of care who had been discharged from hospital was issued too late and should have been expressed in mandatory terms.
76. 69.23% of Survey Respondents reported that residents were being admitted to care settings directly from a hospital from March 2020 onwards [PF1/39 - INQ000518387]. Despite this, care homes were not advised to isolate those that had been discharged, as explained above at paragraphs 42-43.
77. Covid-19 Professor Carl Heneghan from the University of Oxford's Centre for Evidence-Based Medicine confirmed in his evidence to the Inquiry that “*homes were also not advised to isolate patients discharged from hospital from other residents. By seeding Covid-19 into*

*care homes, government policy vastly increased the risk for the most vulnerable despite the known risk" [PF1/40 - INQ000280651]. NACAS agrees.*

Movement of staff and/or recipients of care within or between care settings

78. NACAS is also of the view that had care home professionals enjoyed better job security, with more permanent full-time jobs, there would have been fewer instances of care professionals working across multiple settings and the risk of cross-infection between homes would have been lower.
79. On 15 May 2020, the UK government introduced a policy to restrict the movement of care home staff between different care homes, by asking care homes to restrict permanent and agency staff to working in only one care home wherever possible, including staff who worked for one employer across multiple homes or members of staff working on a part-time basis for multiple employers [PF1/41 - INQ000518390] [PF1/42 - INQ000518391]. This policy required care professionals who typically worked across two care settings to be subjected to a 10-day interval between attending the two settings, and also required a negative test result prior to entering the second care setting. In NACAS' view, the late development of this policy is reflective of the lack of understanding of the care sector workforce by central government.
80. Survey Respondents expressed mixed views regarding the movement of staff between care settings. Some believed that care professionals should not have moved between care settings in order to reduce the spread of infection, whereas others said that although it was not ideal in terms of infection prevention and control, it was necessary and unavoidable. One care professional noted:

*"we did what was needed to be done. If care workers had withdrawn like everyone else in the country the most vulnerable people would not have survived. We did not have a choice, luckily most care workers are proficient in infection and control measures." [PF1/7 - INQ000518420]*

Other Survey Respondents reported that on some occasions care home management restricted care professionals from working in other care settings during the pandemic [PF1/7 - INQ000518420].

Staff training on IPC measures and guidance

81. In NACAS' view, staff training on IPC was often absent or inadequate. This is supported by the views of the membership; 52.83% of Survey Respondents reported receiving training about Covid-19 and the risk posed to care professionals during the pandemic,

however 47.17% of Survey Respondents reported that no training was provided [PF1/39 - INQ000518387]. Others considered that although they received training in accordance with government guidance, the training was insufficient, inconsistent and basic [PF1/7 - INQ000518420].

82. In addition, NACAS members had significant concerns regarding the training provided. For example, one Survey Respondent expressed that: “*we had training provided through [East Sussex County Council] which kind of had to be made up as it went along.*” As a result of the constant changes in regulation, Survey Respondents felt that the training was made-up and “*not sufficient*”. Whilst some Survey Respondents did acknowledge that training was provided, one stated that there was “*not enough training*” provided and another responded that they do not recall getting any training due to the guidance that kept “*changing daily*”. Many care professionals felt that they did not receive adequate training in response to new developments or when regulatory changes were made [PF1/7 - INQ000518420].
83. One NACAS member reported that care professionals were expected to monitor recipients of care for Covid-19 related symptoms without any training or guidance, in addition to carrying out key care tasks [PF1/43 - INQ000518392]. This is reflective of a wider concern shared by NACAS that during the pandemic the responsibilities of care staff were extended beyond traditional care work, into healthcare tasks (such as verifying deaths, dressing wounds, installing catheters and giving insulin), without any appropriate recognition [PF1/14 - INQ000553858].
84. One of the most common views reported by NACAS members in relation to the guidance and training on IPC measures was that it was difficult to keep up with the frequent changes to guidance. For example, one Survey Respondent stated: “*the rules kept changing daily, [it] was hard to keep up with them had to explain it to every single client was exhausting*” [PF1/7 - INQ000518420]. The impact of the changes caused a lot of confusion for both care professionals and recipients of care.
85. A number of Survey Respondents indicated that they felt the government was “*too slow to react to the pandemic*”. It was also noted by one Survey Respondent that an unspecified government member even “*ignored the rules.*” Such high-profile incidents of government figures failing to observe guidance on IPC undermined care professional confidence in the government [PF1/7 - INQ000518420].
86. Many Survey Respondents indicated that certain changes made things worse for care professionals, recipients of care and care providers. For example, the policy on

discharge of residents (discussed at paragraphs 40-48 above) was described by one Survey Respondent as a *“terrible decision which resulted in early deaths for many residents”*, by another as making *“things difficult for all”*. Survey Respondents were of the view that:

- a) *“All patients should have been tested before returning home”*; [PF1/7 – INQ000518420];
- b) *“There should have been mandatory COVID testing for all potential discharge patients to ensure minimum risk to life for vulnerable people”* [PF1/7 – INQ000518420]; and
- c) *“If any patient has any viral infections, flu, Covid, D&V etc, they should NOT be sent home to a care home.”* [PF1/7 – INQ000518420]

87. Many Survey Respondents also felt that the policy on visiting restrictions (discussed at paragraphs 55-62 above) made things worse for care professionals, recipients of care and care providers. One Survey Respondent stated that *“not allowing relatives to physically be with relatives was a wrong decision”*, and another reported that *“the lack of visits for people in care settings had a negative impact on people's lives”*. Several Survey Respondents also indicated that lockdown rules made things more difficult for care professionals, recipients of care and care providers. One Survey Respondent stated that *“the government made the situation worse as I could not take out my blind client for his daily walks for essential exercise, therefore he was isolated for extended periods of time, as my hours were drastically cut due to the lockdown, which severely affected my client's mental health. It took many months after the lockdown for my client to feel safe to go out in the community again”* [PF1/7 – INQ000518420].

#### **PPE**

88. A particular concern of NACAS and its members is that the adult social care sector was not prioritised when it came to the distribution of PPE, which exposed care professionals and care recipients to unacceptable risks to their health and safety.

89. 68.57% of Survey Respondents said that they felt care homes were forgotten about or de-prioritised in relation to PPE distribution. Several Survey Respondents reported that PPE was diverted to hospitals rather than care homes, with one member reporting that *“the hospital's seemed to get more priority”*, and another claiming that they felt this decision was made because *“it was expected that care home residents weren't worth saving.”* Another Survey Respondent stated that care home professionals were *“left to*

*fend for ourselves we were last on the list for information, PPE we weren't thought about at all" [PF1/39 - INQ000518387].*

PPE access and use

90. It has been widely reported that access to PPE was wholly inadequate, particularly at the beginning of the pandemic. That accords with NACAS' experience. 17.50% of Survey Respondents explained that, due to the lack of PPE provided by the government, care professionals were required to purchase their own PPE, sometimes use donations, or create improvised PPE. Furthermore, 11.43% of Survey respondents reported being given expired PPE, with one NACAS member stating they had been given PPE with an expiration date of 2017. Another NACAS member stated: *"at one point I had 300 masks for 50 staff, with no indications of when the next restock would arrive. I was told this quantity should last at least 3 days and I should manage the expectations of my staff by a local authority staff member"* [PF1/39 - INQ000518387].
91. Some NACAS members have reported that the uncertainty as to whether they would be provided with PPE negatively impacted their mental health – one Survey Respondent stated: *"since the PPE was substandard and there simply was not enough to go around for everyone it caused great panic among the staff, everyone felt stressed and tired"* [PF1/7 - INQ000518420].
92. In some cases, PPE shortages led to unsafe PPE usage or PPE not being used at all. One Survey Respondent reported that *"not all staff wore PPE"*, and another reported not being provided with any face covering PPE. 26.47% of Survey Respondents reported being told to re-use single use PPE. 5.88% of Survey Respondents reported being required to share PPE [PF1/39 - INQ000518387]. A NACAS member commented:
- "we had to get creative with PPE shortages. Some made their own masks or reused PPE when necessary. It was a challenging time, but we showed resilience by finding ways to protect ourselves and our patients despite the shortages."*
93. The government's failure to adequately supply the adult social care sector with PPE resulted in additional burdens being placed on some care professionals during the pandemic. A number of Survey Respondents reported an additional financial burden as a result of purchasing their own PPE. For others, searching for and acquiring PPE during the shortages added to their existing workload. One Survey Respondent reported that they *"spent several hours in April 2020 calling pharmacies & workwear*

*companies as we were running out of PPE with no deliveries available” [PF1/39 - INQ000518387].*

94. Access to PPE varied across the country and in different working environments. As a result, the experience of adult social care professionals was not uniform. One Survey Respondent reported that *“in central London none was available”* however *“in North Cornwall on live in care all available and stocked up”* [PF1/38 - INQ000553532]. Some NACAS members did not experience PPE shortages, with one stating *“I can never complain about lack of PPE, we were always provided with it, some were not using it, but that was their choice not because of lack of it.”*
95. Access to PPE also differed at various points in time during the pandemic; several Survey Respondents explained that the provision of PPE was most inadequate at the start of the pandemic, and then improved [PF1/7 - INQ000518420]. One reported *“at the start of lockdown we were advised by authorities to use one mask for a full shift, sometimes 12 hours. Hand sanitiser was not available, nor were aprons. We had a small stock of gloves but not enough.”* Another reported that there was a *“lack of PPE at [the] start.”* The point in time at which it was considered that the provision of PPE improved differed between Survey Respondents, with one reporting that *“full PPE was not in use until 29<sup>th</sup> April 2020 onwards”*, and another that *“by October 2020 the testing and PPE situation had drastically improved”* [PF1/39 - INQ000518387].

#### PPE guidance and training

96. In May 2021, the UK government issued guidance titled “PPE guide for community and social care settings including care homes: What PPE to wear and when – an illustrative guide” (the **“May 2021 PPE Guidance”**) [PF1/44 - INQ000518393]. One NACAS member stated that the guidance that was disseminated prior to this was focused on the NHS: *“NHS got the bulk of the support and attention [...] it was definitely tiered, NHS first, care homes second, domiciliary care third”*. My recollection is that the guidance on PPE changed almost every 2 to 3 months, with either new guidance being published, or existing guidance being updated.
97. As with access to PPE, whether or not training and guidance was provided in relation to PPE also differed significantly in different parts of the adult social care sector. 40% of Survey Respondents reported not receiving training on the donning (putting on) of PPE, and 42.86% of Survey Respondents reported not receiving training on the doffing (removing) of PPE [PF1/39 - INQ000518387]. Only 20.59% of Survey Respondents

reported being trained on appropriate sessional use versus single use of PPE [PF1/39 - INQ000518387].

98. Several Survey Respondents reported that they received no training in relation to PPE whatsoever. One stated *"I don't recall getting any particular training? What happened was farcical as far as I remember."* Another stated: *"I didn't have any training, the rules kept changing daily, was hard to keep up with them had to explain it to every single client was exhausting"* [PF1/7 - INQ000518420].
99. For those who did receive training on IPC measures and PPE, it appears that the standard of training differed significantly across the adult social care sector; ranging from *"consistent"* and *"very good training"* to *"adequate"* to *"limited"*, *"very basic"*, *"not sufficient"* and *"not enough."* Some members reported that they *"received no extra training and was just told to keep a mask on and wash hands"*, that they were simply told to *"wash your hands, like we did not do that before"*, and that *"all we were told to is to wear aprons and gloves when assisting a client with covid"* [PF1/7 - INQ000518420].
100. Some NACAS members reported that training differed within the same organisation. One NACAS member explained that this is because, aside from mandatory training for all employees and workers, training is tailored depending on the relevant department.
101. Those who reported receiving no or minimal training and guidance in relation to IPC measures and PPE from their employer or agency reported needing to research this online. One member reported that their *"employer was almost dismissive. No training, I googled the guidelines to ensure my safety and that of my clients"*, and another stated *"we all had a choice to do our own research and empower ourselves without relying on our agency"* [PF1/7 - INQ000518420].
102. Several Survey Respondents have emphasised the difference between the experience of those who were self-employed, compared to those employed in care homes and other care settings. One Survey Respondent who was employed in a care home stated that the training that they received was *"as good as it could be in care homes based on the guidelines from Govt. But [it was] very hard for private carers who once again had to rely on their own resources!"* This view is shared by others, with one member stating that the *"self-employed had zero help"*, and that the training was *"rubbish for self-employer carers."* Another stated: *"I didn't have any help I was a private carer and I had 5 or 6 clients daily"* [PF1/7 - INQ000518420].

103. Some NACAS members working for agencies reported more positive experiences than their colleagues who were permanent employees in care homes. Indeed, one Survey Respondent stated that *“as an agency staff member, our employer made every effort to keep us up to date with the latest training to ensure that we remain fit and healthy for work. I felt that we were better trained than some of the permanent staff in some of the care homes as I noticed a lot of the permanent staff making serious errors with their PPE”* [PF1/7 - INQ000518420].
104. Another key issue that NACAS members have reported is the inconsistency in the guidance provided by the government, both generally and in relation to PPE. Several Survey Respondents reported that they felt the training and guidance: *“wasn’t consistent as the government failed to be consistent”, was “quite vague at times” and “was confusing, contradictive, stupid and didn’t make sense”* [PF1/7 - INQ000518420].
105. One of the reasons for this inconsistency appears to be the frequency at which the guidance changed. One Survey Respondent stated that *“training was whatever the latest government guidance was which changed so often it was hard to keep up”* while others stated that the guidance *“was disgraceful because it changed like the wind.”* The impact of this inconsistency was confusion with regards to rules and guidance concerning PPE use. One Survey Respondent stated that due to the *“rules about PPE changing every day, nobody knew in management what they were doing. Not out on the front line, had no idea.”* Another stated that *“training was a reflection of published guidelines and hence was erratic, unclear, ambiguous.”* One Survey Respondent commented, however, that the training and guidance *“followed government rules”* [PF1/7 - INQ000518420].
106. Another issue that a number of NACAS members raised is that their training was online, rather than face to face. While online training was a safer and practical mode of delivery, NACAS members found that it was not as effective as face-to-face training. One Survey Respondent stated that: *“all training went online which was a challenge to begin with but once we got used to it was OK but nothing beats face to face training”*. Another stated *“practical training was stopped which I felt may have put clients and care workers at risk and also contributed to feeling frightened and more stressed.”* Another also reported that it was a *“struggle to book onto the courses following covid to get up to date”* [PF1/7 - INQ000518420].

#### Suitability of PPE

107. Several NACAS members have expressed concerns regarding the suitability of the PPE that they were provided with. Survey Respondents have described the PPE as “*not up to standard*”, “*substandard*”, and another complained that the “*aprons were flimsy*.” Other Survey Respondents have reported that they “*don’t think PPE in care homes was adequate*” [PF1/7 - INQ000518420], and that “*being self-employed, they were not sure if it the PPE they were using was of correct standard*” [PF1/39 - INQ000518387].
108. The May 2021 PPE Guidance indicated that the following should all be worn when giving direct physical care within 2 metres of anyone: apron, gloves, fluid repellent Type IIR surgical mask, eye protection [PF1/44 - INQ000518393]. Survey Respondents reported being provided with the following items of PPE:
- a) Reusable respirators (5%);
  - b) FFP3 masks (10%);
  - c) FFP2 masks (12.5%);
  - d) Surgical masks (82.50%);
  - e) Visors (52.5%);
  - f) Goggles (27.5%);
  - g) Long non-surgical sleeved gown (7.5%);
  - h) Disposable cover-all (15%);
  - i) Apron (92.5%);
  - j) Gloves (97.5%);
  - k) Shoe covers (25%);
  - l) Hair net (7.5%);
  - m) Other face covering (including donated, home-made or improvised face coverings) (17.5%); and
  - n) Other PPE (including donated, home-made or improvised PPE) (12.5%).  
[PF1/39 - INQ000518387]

109. The lack of suitable PPE, or in some cases any PPE at all, led to some NACAS members purchasing their own PPE. One Survey Respondent stated that PPE *“was not adequate at all. During the middle of the pandemic the small face mask wasn’t designated to keep one safe at all. Care agencies, Homes ended up purchasing their own PPE. Where I was placed I ended up getting my own PPE which was stronger, safer and costly.”* Another NACAS member stated: *“it was difficult to get PPE. I bought mine but the price tripled during covid”* [PF1/7 - INQ000518420].
110. With regards to the use of FFP3 and FFP2 masks, only 5.71% Survey Respondents reported (i) receiving a fit test by a competent person prior to their first use of any new model or mask, or where there may have been a change of circumstance that may impact the mask fit and (ii) being informed of and trained on the importance of undertaking a fit test on each wear. 50% of Survey Respondents reported not receiving any training or guidance on being clean shaven when using FFP3 and FFP2 masks [PF1/39 - INQ000518387].

#### Impact of PPE on care professionals with disabilities

111. NACAS sought views from its members about their experiences of the impact of disabilities or diagnosed illnesses on their ability to wear PPE as part of the Surveys. 20.59% of Survey Respondents reported having such a disability or illness. In addition, 85.29% of Survey Respondents reported that their managers or occupational health departments did not help by way of reasonable adjustments or finding a safe solution that they were happy with. One Survey Respondent reported experiencing difficulty wearing PPE due to anxiety and not receiving support or reasonable adjustments from their employer: *“I have panic attacks all day on and off due to anxiety and wearing a mask and I get threatened with my job”* [PF1/39 - INQ000518387].

#### Impact of PPE on recipients of care with disabilities

112. NACAS members also reported concerns about the impact of wearing PPE on their clients, particularly those with dementia and learning disabilities, many of whom could not fully understand what was happening, nor why restrictions and mitigations were necessary.
113. Several NACAS members have commented that wearing PPE made communication with recipients of care much more difficult, and at times caused distress. One Survey Respondent reported that PPE made communication with people with hearing difficulties much harder:

*"I had to always wear facemasks when I went to visit my client, and it was extremely difficult to communicate with my client as the mask muffled the sound. Going to places that had plastic shields on, such as reception areas, made communication difficult and still causes a lot of problems for people with hearing difficulties."* [PF1/7 - INQ000518420]

114. One NACAS member, who has supported individuals with challenging behaviours and learning disabilities for the last fourteen years, reported:

*"A big problem for dementia clients was the wearing of a face mask by their carer as they couldn't understand why it was necessary, or in fact what Covid was. All of a sudden they were unable to read expressions and battled to understand what was, leading to challenging behaviour in some instances and extra stress on carer."*

115. In discussions with NACAS members, one commented that the "biggest challenge" with regards to wearing PPE "was on the dementia unit. If I was working in dementia and someone was experiencing delusions and they grab my mask, all of a sudden you are exposed. I think this why a number of residents went down within such a quick time." For this reason, they felt that PPE and IPC measures within care homes "weren't well thought through."

116. Another example of this is in relation to the disposal of PPE and test kits. One NACAS member stated: "I was managing residents with dementia who were picking things out of bins" and expressed frustration at incorrect disposal of tests, which they reported were occasionally "left on the side" after use and picked up by residents.

## **Testing**

### Requirements to test recipients of care

117. As explained above at paragraphs 40-48, the March 2020 Discharge Policy, March 2020 Discharge Guidance and April 2020 Admissions Guidance all allowed the discharge of hospital patients into care homes without testing. Only on 15 April 2020 did the policy change to suggest that testing of hospital patients discharged into care homes may be appropriate [PF1/25 - INQ000233794]. In NACAS' view this was a wholly inappropriate and ill-considered policy that not only led to the avoidable deaths of care recipients and professionals but is indicative of the way in which the care sector is perceived and treated by government.

118. Asymptomatic testing for all care homes was announced on 7 June 2020 but this was not fully rolled out until late September 2020 [PF1/19 - INQ0000399544]. In discussions with NACAS members, one stated that they felt asymptomatic testing was rolled out *"too slowly"* and another commented that this *"testing should have been rolled out as soon as humanly possible. There were a lot of people walking around that weren't sure about if they had Covid or not. It should have been rolled out as soon as possible as it could have prevented a great many deaths"*.
119. There was also a lack of information and clarity about the testing requirements that were put in place. For example, 69.23% of Survey Respondents reported that they were not provided with any guidance or training from their employers about the testing of residents for Covid-19 [PF1/39 - INQ000518387]. One reported that *"daily change of PPE and testing regulations and addressing any new changes on TV without previous consultation or information sent to care sector was frustrating and confusing"* [PF1/43 - INQ000518392]. Another commented that *"testing was organised, although it wasn't always made clear by my management team about how often or when residents should have been tested"* [PF1/7 - INQ000518420].

#### Requirements to test care professionals

120. 76.92% of Survey Respondents reported that regular testing of care professionals and recipients of care took place in their care setting [PF1/39 - INQ000518387]. The frequency of testing experienced by respondents varied. For example, one NACAS member experienced extensive testing requirements for every shift:

*"We had to test each and every time we arrived for a shift and were advised to arrive (unpaid, I must say!) 15 minutes before the shift to test, we weren't allowed to enter until the result was positive. Negative results would send one straight back home and we would spend a shift short staffed, to be fair, it would be until an agency staff arrived to cover (anything between 1 to 5 hours short staffed) on a 7 hour shift."*

121. 84.62% of Survey Respondents reported that the frequency of testing changed over time, [PF1/39 - INQ000518387] with many members reporting that testing was not available within care homes at the start of the pandemic [PF1/39 - INQ000518387] [PF1/43 - INQ000518392]. Survey Respondents reported significantly different experiences of how testing requirements changed during the course of the pandemic. Some stated that the frequency of testing decreased, with one reporting that testing went from three times per week to twice weekly, whilst others reported that testing

increased throughout the pandemic [PF1/39 - INQ000518387]. One Survey Respondent also reported that the frequency of testing appeared to be dependent upon outbreak numbers [PF1/39 - INQ000518387].

Availability of testing for care professionals and recipients of care

122. NACAS is of the view that testing for NHS staff was prioritised over testing for care professionals and recipients of care during the pandemic [PF1/19- INQ0000399544]. This is indicative of the second-tier status of the care sector and care professionals as compared to the healthcare sector and a lack of understanding as to the interconnectedness of the two systems.
123. The testing policy for care professionals and recipients of care announced by the UK government on 15 April 2020 initially only applied to symptomatic staff in care homes for over 65 year olds and up to the first 5 symptomatic residents [PF1/19- INQ0000399544]. On 11 May 2020, the policy was extended to one-off asymptomatic staff in care homes and residents in care homes for over 65 year olds, however the number of tests was capped at 30,000 per day [PF1/19- INQ0000399544]. NACAS is of the view that this was introduced too late. In addition, only 76.92% of NACAS members reported regular testing of staff and residents within their care setting [PF1/7 - INQ000518420].
124. In discussions with NACAS members, although one NACAS member felt that the requirements for testing care workers and recipients of care was a “*good plan*”, they also considered it to be “*quite onerous*” due to the administrative task of uploading test results.
125. A significant issue for Survey Respondents (ranked the second most important issue after the availability and adequacy of PPE) was the availability of testing for care professionals during the pandemic [PF1/45 - INQ000518395]. 83.33% of Survey Respondents reported that they received Covid-19 testing kits as part of their employment [PF1/39 - INQ000518387]. However, 34.78% of Survey Respondents reported that had they worked in care homes that had experienced a shortage of Covid testing kits during the pandemic [PF1/39 - INQ000518387]. One NACAS member commented that the “*government had a limited number of tests, so we had to ration what they had to make sure the most vulnerable got those first.*”
126. NACAS members have reported that care professionals were required to order their own test kits via the NHS website, and several appeared to face difficulties with this.

One commented that it *"could have been easier to order"* [PF1/39 - INQ000518387]. In discussions with NACAS members, one stated: *"we did not have easy access, we had to order them via the Government portal for ordering testing kits. We were well into the pandemic by then."*

127. Accessing government-provided lateral flow test kits ("LFTs") for our members was also a significant concern. NACAS could not obtain LFTs via the UK government portal because the portal only made LFTs available to those with direct involvement in the delivery of care. Despite advising the government that we intended to provide LFTs to members (who were directly involved in the delivery of care), ultimately NACAS was not successful in securing access to any LFTs.

### **Working conditions and infection prevention and control measures**

128. NACAS considers that the insecure nature of much care work and the absence or limited availability of occupational sick pay significantly impacted care professionals' ability to self-isolate and shield during the pandemic.
129. At an early stage, when the NHS was prioritised for testing, care professionals, like the public, were told to self-isolate. If they did so, care professionals on zero hours contracts, which accounts for just beneath a quarter of the adult social care workforce and over half of domiciliary care professionals [PF1/8 - INQ000518421], stood to lose their income and may not have been able to access sick pay. NACAS observes that if the care sector had been better understood by decision-makers perhaps this problem would not have been missed. As the Chief Medical Officer for England, Professor Chris Whitty, noted in December 2021: *"we didn't spot the effects of people not having adequate sick pay – it's one of those things that's obvious when you see it"* [PF1/46 - INQ000518396]. A UNISON Survey found that *"money worries was the reason given by more than one in ten (13%) care staff for working despite having possible Covid symptoms, and by 8% who continued going in when they should have been off self-isolating"* [PF1/47 - INQ000518397].
130. Survey Respondents confirmed that their employment status or the availability of sick pay affected their decision to test or self-isolate. One NACAS member reported that self-employed care professionals experienced financial insecurity as a result of zero hour contracts, and consequently many went to work even if they were infected with Covid-19. This was mirrored by another member who reported that they did not test because if they were Covid-19 positive, they would not have been paid. The same member went on to say that they would have only isolated had they felt very unwell.

Another Survey Respondent stated: "*I was self-employed... I have no sick pay so for me it was extremely important to self-test regularly but also [meant] that if I had to self-isolate I had no income and no protection of sick pay*" [PF1/7 - INQ000518420].

131. Many Survey Respondents reported that the availability and level of sick pay was poor. Others reported that they were ineligible or generally did not receive sick pay. This accords with NACAS' experience that some employed care professionals received only statutory sick pay while others received full pay. The availability of sick pay inevitably impacted on some members' ability to follow guidance. For example, one Survey Respondent reported that "*some of my colleagues said they wouldn't have been able to self-isolate for 10 days if they hadn't received sick pay*" [PF1/7 - INQ000518420].
132. Many NACAS members who worked for agencies reported an unequal position when it came to sick pay compared to counterparts employed as permanent staff members, with those hired by agencies not receiving sick pay in the event they had to isolate due to Covid-19. Some Survey Respondents reported that they felt they could not afford to get ill, and some suggested this led to a reluctance to test regularly, for example one NACAS member stated "*I know many people that did not test as they couldn't afford to be off*", and another "*I am self-employed and I know that testing for some wasn't done as they couldn't take time off as no sick pay*" [PF1/7 - INQ000518420].
133. Furthermore, care home staff could not apply for enhanced sick pay to a separate body but were dependent on their employers to use the funding from the Infection Control Fund [PF1/11 - INQ000518358]. This is a further illustration of the difference of treatment of care professionals and NHS workers, who could rely on more generous schemes. For example, NHS workers in England were provided with full pay for the time whilst off sick with Covid-19, which could be for an extended period beyond the 10-day period.
134. Infection rates were lower where care professionals were paid when they were sick. David Halpern, Chief Executive Officer of the Behavioural Insights Team ("BIT"), gave evidence that BIT found in July 2020 that "*care homes that paid sick leave immediately when someone had to self-isolate, had Covid case levels around 13% lower than care homes that did not*" and that this "*made the case for paying immediate sick pay for care home staff with possible Covid, and more generally for paying high risk, low income workers to self-isolate*" [PF1/48 - INQ000188738]. NACAS agrees.

#### Funding schemes and IPC measures

135. As a general comment, NACAS considers that the funding schemes introduced during the pandemic came too late and, when they did arrive, they were not well-understood by care professionals or sufficiently adopted by employers.
136. In May 2020, the Adult Social Care Infection Control Fund was introduced to support adult social care providers to reduce the rate of Covid-19 transmission in care homes by providing funding for care professionals to receive wages while self-isolating [PF1/49 - INQ000518399]. A survey by UNISON in October 2020 showed that only 25% of care home employers were paying staff who needed to self-isolate their full wages [PF1/50 - INQ000119075]. By 23 November 2021, 83% of care homes in England were paying their self-isolating, directly employed staff at a full wage rate. It is unclear why 17% did not do so [PF1/51 - INQ000518402]. Minutes from a DHSC testing meeting also noted that care home providers were refusing to sign up to the fund as they were concerned about it setting a precedent of *“paying staff in full for all future forms of sickness that lead to staff absences (not just COVID related) rather than just paying them statutory sick pay”* [PF1/50 – INQ000119075].
137. Those who tried to access the schemes faced barriers. In order to be eligible for the Covid-19 Statutory Sick Pay Enhancement Scheme, a PCR test was required to be submitted. One Survey Respondent reported that when they tested positive for Covid-19, PCRs were not available to order online which resulted in the member and her husband being short two salaries for one week [PF1/7 - INQ000518420]. Self-employed care professionals were also ineligible for the scheme, as reported by one NACAS member:
- “as self-employed carers we were left to be on our own to deal with that terrible situation...even if one had wanted to stay at home [for] any reason we couldn't because we could not be put on the government payments that others were getting from the government.”*
- Another member said *“I wasn't entitled to the government grant because I'd only started to be self-employed in February 2020. I got £500 when I had my first dose of Covid but that was it.”*
138. On 27 April 2020, the DHSC announced a new life assurance scheme for families of frontline health and care professionals in England [PF1/52 - INQ000518403]. On 20 November 2020, the government announced the Test and Trace Support Payment Scheme, which provided £500 lump sum payments to low-income individuals in England who were required to self-isolate but were unable to work during isolation

[PF1/53 - INQ000518404] [PF1/54 - INQ000518405]. However, as 75.76% of Survey Respondents indicated they were not aware of any government support funds [PF1/7 - INQ000518420].

How concerns about carer safety were treated in employment settings

139. NACAS members have raised fears about negative repercussions if they were to raise concerns about carer safety, for example disciplinary proceedings, having their working hours reduced or being allocated higher-risk roles more frequently.
140. 41.18% of Survey Respondents reported that safety concerns raised to management were not adequately addressed by their managers or agencies (although only 47.06% of Survey Respondents who responded to this question had indicated that they themselves had raised such concerns) [PF1/39 - INQ000518387].
141. A particular example highlighted by those who reported concerns being ignored or inadequately addressed was that safety concerns regarding a lack of appropriate PPE or being exposed to patients with Covid-19 (including when those individuals had health conditions such as asthma) were not adequately addressed. Some NACAS members put the lack of action down to staff shortages (*"concerns were ignored due to staff shortages"*) and others put this down to more general shortages of PPE (*"no fault to my manager, PPE was not available"*) [PF1/39 - INQ000518387].

The unequal impact of IPC measures on the adult social care workforce

142. Please refer to paragraphs 46, 79-80, 89, 102, 107, 122, 130-132, 137 and 183 for detail on the unequal impact on the adult social care workforce of infection prevent and control measures, particularly in respect of occupation. In addition, please refer to paragraph 111 for impacts on care professionals with disabilities and paragraphs 112-116 for impacts on care recipients with disabilities.
143. More broadly, NACAS members' experiences differed depending on whether they were employed in care home settings or were agency care professionals. The former generally reported having had a more structured experience, for example in relation to the provision of training, PPE and testing. By contrast, agency care professionals generally reported having to obtain information or supplies independently, including for example having to purchase adequate PPE themselves. For example, one member commented that *"working in the care home we were given PPE, trained, and assisted in infection control etc and far easier to practice testing, visiting restrictions etc. Absolutely left to own devices as a private carer"* [PF1/7 - INQ000518420].

144. Survey Respondents widely reported that employment status or the availability of sick pay affected decisions to test or self-isolate. Please see my response on sick pay at paragraphs 128-134 above, and 185-186 below.

### **The management of the pandemic in adult social care**

#### Access to healthcare and other services for recipients of care

145. Some NACAS members reported that understaffing across the NHS and other sectors increased the burden on care professionals within the adult social care sector (with understaffing amongst social workers and GPs specifically being cited). For example, Survey Respondents mentioned difficulties in finding available hospital and doctor appointments as a factor that increased their workload [PF1/7 - INQ000518420]. One NACAS member stated: *“Covid exposed the NHS being on its knees for years prior to the pandemic. The system could not care for patients way before Covid but the pandemic proved that if you are ill, you are a problem to eliminate, not to treat. At some point it was a super excuse to not provide immediate care.”* Another Survey Respondent commented that *“it was very stressful and difficult to get medication professional attention for clients. The lockdown was frustrating for care workers as it was extra time consuming and stressful in order to get the necessary and appropriate medical professionals to attend to clients’ needs”* [PF1/7 - INQ000518420].
146. One NACAS member who worked in domiciliary care stated that the pandemic made access to other services, such as health care professionals, *“complicated”* because *“GP surgeries stopped taking urine samples and if you put a paper prescription in the tray, it would be there for a week. Everything was in limbo until it was safe to touch things. We were not able to access primary care.”* This experience was not shared by all NACAS members; one member who worked in a care home said that: *“the doctors from the local surgery were coming in as far as can remember to do rounds as and when required. I can't think of any problems.”*

#### Restrictions on visits

147. I set out NACAS’ summary concerns about restrictions on visits for care recipients at paragraphs 55-62 above. In short, the blanket ban had a disproportionate impact on the physical and mental health of care recipients.

### **Do Not Attempt Cardio Pulmonary Resuscitation notices**

148. NACAS considers that end-of-life care and the use of “do not attempt cardiopulmonary resuscitation” orders (“DNACPRs”) pose significant challenges for care professionals.

To confirm, references in this statement to a DNACPR are to an advance decision that resuscitation measures will not be attempted if a person stops breathing or their heart stops beating and not, for example, to the withdrawal of any other medical care or treatment.

149. NACAS recognises that when used within a framework of appropriate safeguards and patient consultation DNACPRs are a valid and legal mechanism forming part of advance care planning. However, DNACPR is one of the most serious decisions that can be made within a care context. Issuing a DNACPR raises issues surrounding Articles 2 and 8 of the European Convention of Human Rights and, in many ways, goes against all instincts of a care professional wanting to do everything they can to help the person in their care.
150. A number of studies have been undertaken following the pandemic highlighting an increase in the use of DNACPRs. For example, one study of data from 23 English NHS Trusts cited a 30% increase in the issue of DNACPRs in the 'first wave' of the pandemic (23 March 2020 to 1 August 2020) and an 11% increase in the 'second wave' (1 October 2020 to 31 January 2021) as compared to equivalent pre-pandemic periods **[PF1/55 - INQ000518406]**.
151. A number of Survey Respondents expressed concerns about the pressure to use DNACPRs. One NACAS member said, "*they were being given and put on clients and their families as soon as they became unwell. There was a clear push to get them signed which was wrong and immoral.*" Similarly, others stated, "*In many cases this [DNACPRs] was forced upon patients*", and "*it was applied indiscriminately and unfairly*" **[PF1/7 - INQ000518420]**. A further member referenced a blanket DNACPR policy saying: "*I feel care homes were locked down in the expectation that most residents would not survive. GP services withdrawn. Told not to ring for an ambulance as they would not attend. Told to get DNACPR for all residents*".
152. The most common theme cited by Survey Respondents in relation to DNACPRs concerned issues of communication, including both communication to service users and/or their families prior to the issue of a DNACPR and communication with care professionals about what they needed to do in circumstances where a DNACPR was in place. For example, a NACAS member said:

*"In my experience, these were often put in place without consultation with clients or representatives, on discovering the DNACPR clients have been outraged and [lost] I of confidence in the treatment they might get, often describing this*

*to me as 'they've written off' 'I won't be treated fairly now, I'm too old' ' why don't they just give me a pill to get it over with if they can't talk with me about my own death'" [PF1/7 - INQ000518420].*

153. This was a common concern across our membership. Another NACAS member explained:

*"I was present when one of my clients was called at home by the GP. The client had her on speaker phone as she couldn't hear her well. My client answered a raft of questions and I was mortified when the post arrived to see that this had been turned into a DNACPR when at no point was that specifically discussed with my client. I advised her son of my concerns. How many people would have sleepwalked into that decision being made for them over that period?" [PF1/7 - INQ000518420].*

154. A further member of NACAS also recalled a client that she cared for, who had full capacity, having a DNACPR put in *"without any consultation with her. [...] It took a bit of messing to get it voided and she was extremely upset by this. It was put in place due to a hospital visit."*

155. In addition, one Survey Respondent noted that DNACPR decisions were *"often not communicated to carers"* [PF1/7 - INQ000518420]. A lack of understanding of a patient's resuscitation status could result in intervention that is not in line with patient wishes. At a time when patients were often isolated from friends and family due to lockdown rules it may also have been a missed opportunity to identify any DNACPRs that had been issued without appropriate and effective consultation, or for support on decision making to have been given by a care professional in their role as a health professional close to the patient.

156. NACAS considers that a uniform system of documenting the DNACPR process may assist in this respect. In October 2020, the DHSC commissioned the CQC to conduct a review of DNACPRs. A final report was released in March 2021 (the **"CQC Report"**) [PF1/56 - INQ000518407]. The CQC review into DNACPRs published in March 2021 found that *"poor record keeping and lack of audits meant that [they] could not always be assured that people were being involved in conversations about DNACPR decisions, or that these were being made on individual assessments."* In response to a Freedom of Information request as part of one study, one NHS Trust in England was unable to share DNACPR data as *"a manual check of paper clinical records would be required"* [PF1/55 - INQ000518406]. The use of paper records rather than centralised

electronic patient records on an issue such as this is surprising. NACAS fully supports a requirement to formalise the DNACPR process to ensure a consistent and accountable approach, preventing the concerns expressed by NACAS members on this issue arising again in general practice or any future pandemic and/or lockdown situation.

157. NACAS also supports “*clear and consistent training, standards, guidance and tools for the current and future workforce*” as recommended in the CQC review [PF1/56 - INQ000518407]. This should be freely available to all care professionals across the whole range of health and social care settings through a centralised source.

### **Regulatory inspection regime**

158. NACAS has particular concerns about the decision to pause in-person inspections and the impact it had on protecting vulnerable people from harm.
159. There are distinct regulatory inspection regimes for health and social care for each of the four nations within the UK. The four authorities/inspectorates that oversee the regimes are the CQC (England); the Care Inspectorate (Scotland) (“**CIS**”); the Care Inspectorate Wales (“**CIW**”) (Wales); and the Regulatory and Quality Improvement Agency (“**RQIA**”) (Northern Ireland).
160. A significant change made to the regulatory inspection regimes during the pandemic was the pause of in-person inspections between March to May 2020 and the reduction in routine inspection frequency for the rest of the pandemic. All four inspectorates paused routine in-person inspections between March to May 2020. The CQC, CIW and RQIA provided inspections at the outset of the pandemic only for the most urgent and serious cases of concern. For example, the CQC continued to inspect in response to immediate risks and concerns about safety as identified by staff or members of the public, but this totalled just 50 inspections between 16 March 2020 to July 2020 [PF1/57 - INQ000518408]. The oversight role of the inspection regimes was less effective without routine in-person monitoring of care homes, particularly where effective IPC practices within care homes were paramount to the safety of the residents.
161. NACAS has particular concerns about the CIS’ response to the pandemic in terms of its approach to inspections. In April 2020 there were no inspections; and in May just twenty inspections were completed [PF1/58 - INQ000518409]. In addition, fewer complaints to the CIS were the subject of in-person full investigations – of the 2316 complaints received by the CIS from relatives in 2020-2021, just 122 were the subject

of a full investigation, compared to 600 in previous years. The CIS altered its approach to rely on more “*dialogue and mediation*” rather than care home visits [PF1/59 - INQ000518410]. Such changes to the inspection regime at the outset of the pandemic inevitably placed care home residents at greater risk of harm at a time when they were particularly vulnerable.

162. However, the care inspectorates continued to offer an important outlet for care professionals’ concerns and handled a higher call volume than usual, signifying an increased reliance on the regulators as a reporting mechanism for concerns. This accords with NACAS’ experience of increased reporting by care professionals during the pandemic. Between 2 March 2020 to 31 March 2020, there were 2,612 calls to the CQC from adult social care staff, which was a 55% increase from the same period in 2019 [PF1/60 - INQ000398848].
163. An independent review lead by Dr Penelope Dash into the CQC found significant internal failings within the CQC [PF1/61 - INQ000474296]. One of the emergency findings listed in the interim report is in relation to the CQC’s poor operational performance, which the report concluded “*is impacting CQC’s ability to ensure that health and social care services provide people with safe, effective, compassionate and high-quality care and is negatively impacting the opportunity to improve health and social care services*” [PF1/61 - INQ000474296]. As part of this, the review found that only 7,000 inspections and assessments were carried out between 2023 and 2024, compared to more than 16,000 inspections conducted in 2019 to 2020. This falls below half of the target number of assessments for the period 2023-2024 (which was set at 16,000) [PF1/61 - INQ000474296].

### **The deaths of care professionals and care recipients**

164. NACAS is devastated that so many sector colleagues lost their lives during the pandemic. The mortality rates for those employed in health and social care were among the highest by occupation in the UK [PF1/62 - INQ000518414] [PF1/63 - INQ000518415]. In the period 9 March 2020 to 28 February 2022, the deaths of 1,290 social care professionals (which, based on ONS occupation categories, encompasses the majority of NACAS member roles) in England and Wales involved Covid-19. The mortality rates were significantly higher as compared to the general population; for example, between 9 March 2020 and 25 May 2020, the ONS reported mortality rates for ‘care workers and home carers’ of 71.1 (males) and 25.9 (females) per 100,000 as compared with rates in the general population of 19.1 (males) and 9.7 (females) per 100,000.

165. Mortality rates were not even across all sections of the workforce; reports indicated a disproportionately raised risk of death in the UK among minority ethnic staff compared with those of white ethnicity, accounting for 67% of all health workers' mortality [PF1/9 - INQ000518422], despite making up only 22.3% of the total health and care workforce in 2020 [PF1/64 - INQ000518416]. The increased risk of death shows how the pandemic exacerbated existing societal inequalities. As is well known, the care workforce consists overwhelmingly of persons of lower socioeconomic status and women and there is a high proportion of staff from minority ethnic backgrounds [PF1/65 - INQ000235497].
166. Care professionals experienced significant distress due to the death of clients they cared for, and with whom they had built close relationships over prolonged periods, particularly as a result of lockdowns. One Survey Respondent explained: "*the death of these people we support took a toll on the mental health of a lot of carers including myself. They were like our families at the time*" [PF1/43 - INQ000518392]. This was exacerbated by the fact that in many cases the families of people receiving care could not be with them at the end of their lives and care professionals were sometimes the only individuals present when they died.

#### **Allegations that care professionals spread the virus**

167. NACAS observes that the suggestion that care professionals were responsible for the deaths of care recipients has been particularly hurtful and disrespectful. In particular, Matt Hancock commented in his Pandemic Diaries that "*the vast majority of infections were brought in from the wider community, mainly by staff*" [PF1/66 - INQ000518418]. NACAS considers that this is an attempt to distract from the UK government's disastrous discharge policy and inaction to address the risks to the care sector. Care professionals had no choice but to provide care and it was foreseeable that there would be community transmission into care homes, yet the government failed to address the situation with the urgency it required.
168. Survey Respondents generally reported that allegations in the media that they were responsible for spreading Covid-19 made them feel "*angry and upset*" and "*not valued*" [PF1/7 - INQ000518420]. Other Survey Respondents have stated the following:
- a) "*personally, in my view how dare 'they' attempt to blame carers who, by and large, are female and an under represented profession. Angry and indignant might describe how I feel.*" [PF1/7 - INQ000518420]

- b) *"we were a target of abuse and negativity, feeling degraded and dirty."* [PF1/7 - INQ000518420]
- c) *"it was very traumatising and stressful and degrading for all the care workers."* [PF1/7 - INQ000518420]
- d) *"made to feel like a leper. That we were a risk to people."* [PF1/7 - INQ000518420]
- e) *"the criticism of care workers who spread covid was made by cowards who would not have worked an hour of their life in the health sector and is not worth listening to. From the professional, appreciated and respected person you thought you were to being blamed for something that was not caused or perpetuated by you is a humiliation that we do not deserve."* [PF1/7 - INQ000518420]
- f) *"it was depressing. There was a lot of criticism. We were trying to do our best in very difficult circumstances. To some we were respected to others we were part of the problem."* [PF1/7 - INQ000518420]
- g) *"I stopped watching the news to be able to maintain my mental health we both did that as the news agencies reports."* [PF1/7 - INQ000518420]

169. Survey Respondents reported feeling discriminated against as a direct result of these allegations. One stated: *"there was so much discrimination experienced working during the pandemic especially when you're out going to work on the bus in the shops walking on the street leaving the care home after you finish work some people will be running away from you and blaming the care workers for the covid."* Another NACAS member stated: *"I do know colleagues that had verbal abuse by the public and some were not feeling safe to be in public even though they needed to be to carry out their job"* [PF1/7 - INQ000518420].

170. A number of Survey Respondents observed that media reporting about the risk posed by care professionals negatively impacted their clients', and clients' families', perception of them. For example, one NACAS member reported that *"clients were fearful"*, another that *"some service users didn't want us to go to others because they were afraid of catching or spreading [Covid]"*. One Survey Respondent stated that *"some families of clients were quite hostile"*. One member even reported that in their experience, the negative criticism of care professionals and the risk that they had

spread Covid-19, led to private patients dismissing their care professionals and relying on family members instead [PF1/7 - INQ000518420].

171. However, this experience was not shared by all NACAS members. One stated that their *"clients were eternally grateful we were still supporting them"*. Another Survey Respondent wrote that they *"did not receive any criticism because my clients were extremely happy I could continue to provide vital services"* [PF1/7 - INQ000518420].
172. Survey Respondents have contrasted their own treatment with that of NHS workers who had a similar risk-profile, but who they considered were afforded greater respect by the public. One Survey Respondent stated that *"care workers were ostracized during covid, while we watched as nurses and doctors were given huge appreciation and applause."* Another stated: *"in my opinion it is ironic and amusing that people didn't feel the same about hospital workers! Difference: hospital workers have respect of the whole community. Care workers' respect is very limited, only to the ones that care for and/or their families. For the wider community the care worker position doesn't mean much at all"* [PF1/7 - INQ000518420].

#### **Discrimination in the adult social care sector**

173. NACAS considers that the pandemic had unequal impacts upon black and ethnic minority care professionals.
174. In response to a question as to whether ethnicity, heritage, immigration status or discrimination were a factor in their or their colleagues' experience of working during the pandemic, a number of Survey Respondents reported experiencing or witnessing discrimination. Survey Respondents stated: *"I suffered racism"*, *"my partner received discriminatory comments"* and that *"a lot of discrimination took place"* [PF1/7 - INQ000518420]. A number of Survey Respondents have indicated that race, ethnicity and immigration status in particular were factors for discrimination:
- a) *"Black and Ethnic minority health and care workers were treated unfairly during the pandemic. Most times sent to the battle front despite the carers health issues. If you say 'No' you will find it difficult in subsequent rotas."* [PF1/43 - INQ000518392]
  - b) *"a lot of Africans were exposed to risky working areas or people who had severe covid 19."* [PF1/7 - INQ000518420]
  - c) *"there was great fear amongst ethnic colleagues."* [PF1/7 - INQ000518420]

- d) *"immigrants were treated differently, they were made to feel like they brought covid in England."* [PF1/7 - INQ000518420]
- e) *"when offering cares some patients and clients wouldn't want to be attended by you saying you are the once who are bringing covid in this country."* [PF1/7 - INQ000518420]
- f) *"I once made a phone [call] for a certain service, nothing to do with my line of work, and I was asked "what job do you do? Which country do you come from?""* [PF1/7 - INQ000518420]
- g) One Survey respondent commented that care workers generally were discriminated against, but *"especially minority nationalities."* [PF1/7 - INQ000518420]

However, one Survey Respondent commented that these problems were present before the pandemic, stating that they were *"a factor in care work throughout. Not especially Covid"* [PF1/7 - INQ000518420]. It is worth noting that these experiences were not shared or acknowledged by all NACAS members.

175. There was a lack of awareness and support for enhanced risks for ethnic minorities. 52.83% of Survey Respondents reported having received training on risks posed to them as care professionals during the pandemic, of which 86.67% reported that their training did not feature any information on any potential enhanced risks to ethnic minorities. Of the 13.33% of Survey Respondents who reported receiving such information, only 29.55% of Survey Respondents reported receiving information from their employer on higher risks to ethnic minorities. The majority of Survey Respondents received this information from non-training sources, such as media reporting (36.36%), word of mouth (18.18%) or other sources (15.91%) [PF1/39 - INQ000518387].

#### **Overall impact of the pandemic on care professionals**

176. I have addressed the impact on the mental health care professionals throughout this statement: see paragraphs 91, 166 and 168 in relation to access to and suitability of PPE, deaths of their service users and allegations that care workers spread the virus. In this section, I deal with some additional points about the toll of the greater responsibility upon care professionals during the pandemic, deaths of service users, fear of catching and transmitting Covid-19 to service users and loved ones, the imposition of DNACPR orders, loneliness and financial worries.

177. A significant number of care professionals reported a negative impact on their mental health as a result of the pandemic. This was often due, at least in part, to the “*greater weight of responsibility*” that they felt, as discussed at paragraphs 60-61, 83, 93, 113-116 and 176 above. One Survey Respondent reported that they “*had to stop working at one stage because I felt like I was having a mental breakdown from all the stress and worry*”, and another stated that they “*have been suffering ever since from mental health issues.*” Another Survey Respondent stated that “*both clients and workers health deteriorated. Depression was rife and morale extremely low*” [PF1/7 - INQ000518420].
178. Another commented that “*staff were overworked, not having breaks, working extra and double shifts, made to cover larger areas and not given the time needed with the client. Staff were completely mentally and physically exhausted, some were crashing cars falling asleep at the wheel, others had physical problems such as back pain, others on medication for various reasons*” [PF1/7 - INQ000518420].
179. A number of Survey Respondents reported that the pandemic increased their workload which impacted their wellbeing. This was exacerbated by the fact that many found themselves working in settings which were understaffed and poorly resourced. One NACAS member explained that: “*terrible staff shortages meant that there were two carers and one nurse on night shifts for forty-eight residents. For more than a year me and many others worked on this ‘ratio’.*”
180. As noted above at paragraph 166, the impact on care professionals of the deaths of care recipients was severe.
181. NACAS members feared the risk of Covid-19 not only to their own lives, but also to the lives of friends and family to whom they could inadvertently transmit the virus, and to the lives of those in their care. One Survey Respondent explained: “*I have never seen deaths like that in my life. Covid made me feel helpless let alone fearing for my life*” [PF1/7 - INQ000518420].
182. A number of Survey Respondents explained that they experienced emotional distress as a result of the imposition of DNACPR orders, many of whom wrestled with the ethical dilemma of implementing them. One NACAS member said:

*“during the pandemic, as a nurse, I've witnessed the significant impact on the care workforce, especially those caring for individuals with specific medical conditions like Learning Difficulties, Mental Health difficulties, physical difficulties, dementia, and multiple or complex needs. It was a challenging time,*

*requiring us to be creative and adaptable in providing care while prioritising safety. We had to find new ways to support our patients and ensure their well-being despite the challenges brought on by the pandemic. We had to manage increased workloads and find innovative ways to provide care while maintaining the well-being of those they cared for... During the COVID times the addition of [DNACPRs] to a person's care plan had a significant impact on the care workforce. For example, a patient with a [DNACPR] experienced a sudden decline in their condition. As a nurse, I had to respect their wishes outlined in the care plan, which meant refraining from initiating resuscitation efforts. It was emotionally challenging, but it highlighted the importance of honouring the patient's autonomy and decisions regarding their care."*

183. A number of care professionals described feeling isolated, particularly those who were self-employed and in circumstances where guidance was perceived to be inadequate. One NACAS member explained that it was: *"very difficult as a private carer - there was no guidance given that I know of, so the burden of responsibility was entirely ours and our only lifeline was 999. Being a self-employed can be a very lonely career!"*
184. The experience of NACAS members is in line with research on the impact of the pandemic on the sector. In the social care sector, Hussein et al. 2020 examined the impact of Covid-19 on frontline workers in the UK through a survey of 296 participants in July to August 2020 [PF1/67 - INQ000518419]. Their analysis highlights significantly increased workload and working hours and a decline in reported job security among all workers since the onset of the pandemic. Nearly half indicated their general health worsened, 60% reported an increase of incidents where their work had made them feel depressed, gloomy or miserable since the pandemic, and over half reported a reduction in the level of their enthusiasm and optimism at work. In many cases, the pandemic also had a negative financial impact on care professionals. Despite organisational and governmental processes in place, some care professionals, particularly those on zero hours contracts, who took sick leave, self-isolated or were stopped from working as a measure to control infection, reported that they did not receive any pay, adding to the financial challenges already faced by low-paid staff. Those on zero hours contracts felt the financial pressure to go to work even if they were ill or had coronavirus.
185. Although many members identified financial concerns due to a lack of sick pay, they elected to test anyway due to the vulnerabilities of those under their care. One Survey Respondent stated that the question of finances did not impact their decision to test

and/or work because *"it's not morally acceptable to visit a clinically vulnerable person with COVID"* [PF1/7 - INQ000518420].

186. However, a number of Survey Respondents confirmed that employment status or lack of sick pay did affect their decisions on whether to test and/or self-isolate. For example, in confirming how this was an influence, one member said: *"nobody could survive with £56 a week"* and another member said: *"Yes I wouldn't of got paid so I wasn't ever going to test and would of only isolated if I was very unwell. If I had a cold I told clients and asked if they wanted me in or not so the choice was theirs."* In this way, the workforce experienced unequal impacts of the pandemic [PF1/7 - INQ000518420].
187. The financial impact on self-employed care professionals was particularly acute, as they had to cover the extra costs of PPE, as discussed above at paragraph 90, 109 and 143. One NACAS member reported purchasing a car to reduce the risk of infection from public transport and felt as though *"this extra cost was not always appreciated."* In addition, some domiciliary carers reported losing work where families of clients were unhappy with allowing a care professional to come into their loved one's home after having visited another client. One NACAS member explained:

*"sanitising as a domiciliary carer meant having to literally change clothes, etc. between clients, extra time pressure, the large expense of PPE and shortage thereof – we were not given any special preference at suppliers who advised us to 'wait like everyone else', putting extra stress on us. If we were unable to secure it, we were forced to resort to homemade masks instead of government mandated masks. Care homes were given a 'mandate,' we were given nothing, yet we were dedicated throughout the Lockdown period. We would hear about the pressure on the NHS, etc. but nothing about self-employed carers..."*

### **Mental health support for care professionals provided by the UK Government and Devolved Administrations**

188. As discussed at paragraphs 60-61, 83, 93, 113-116 and 176 above, the demands on care professionals increased significantly during the pandemic, yet NACAS members felt that there was a severe lack of mental health support for care professionals during the pandemic, which resulted in a Survey Respondent feeling as though care professionals were *"not cared about"* [PF1/7 - INQ000518420].
189. A number of Survey Respondents reported feeling *"abandoned"*, with one Survey Respondent reporting that care professionals were *"abandoned in every side [...] I left my family at home without seeing them for weeks before they find cover. We only have*

*PPE and useless clapping every night at number 10.” Another Survey Respondent stated: “as a care worker this was the most difficult time. No support provided, either emotionally or financially.” Another member stated that there was “no support for staff who were drained physically and mentally” [PF1/7 - INQ000518420].*

### **Key-worker status for care professionals**

190. Despite their fundamental role in ensuring the health and wellbeing of some of the most vulnerable individuals, care professionals were not initially considered as key workers. One NACAS member commented that *“at the start [of the pandemic] we weren't seen as key workers even though we continued going into our clients' homes and supporting them.”* The delay in including care professionals in the key worker category resulted in complications for several NACAS members which easily could have been avoided. One Survey Respondent commented that: *“before the keyworker scheme was set up to allow our children in school I was having to leave my children at home to go and care for others, it was an impossible and scary situation” [PF1/7 - INQ000518420].*
191. One NACAS member commented that care professionals *“didn't need the government to say that we were key workers: we already knew we were key workers. A lot of our patients are bed bound, if we weren't able to see them how would they get food and medication? We still would have gone if the government said that we weren't key workers, the NHS weren't going to look after them. Their families couldn't either [...] 99% had no intention of not coming to work – we are hostages to love and care so much. No way they were going to be abandoned.”*
192. Key worker status resulted in some care professionals not being eligible for furlough, which placed some care professionals under pressure to continue working. One NACAS member stated that care professionals were *“told we were key workers with no option of furlough”* and that this meant she needed to tell her staff: *“you had to decide if you want to go to work. If you don't want to be there, we aren't going to force you. There is no furlough, if you don't come to work you don't get paid.”*

### **Mandatory vaccination**

193. As with the population at large, NACAS members are divided in their views of mandatory vaccination.
194. Several NACAS members regard the vaccination programme positively. One Survey Respondent reported: *“I had no issue about it and had mine straightway, to protect my clients, as well as my family, although some people had issues for reasons only they*

can explain, and in my work place back than 2 walked out because they would not have the vaccine" [PF1/7 - INQ000518420]. Another NACAS member reported: "I must state that we both were lucky enough to have had our Vaccines as soon as it was released (me because of my minority ethnic background is my best guess? + I was one of the most reliable staff they had); and my husband because he was over 60 years old and working at an NHS setting. The only staff at our setting who refused to have the Vaccine left because of that." Several recognised that it was a necessary measure, with one stating that it had "to be carried out to protect clients" and another saying that it "did save a lot of lives" [PF1/7 - INQ000518420].

195. At least one NACAS member received legal advice about a mandatory vaccination requirement that was being imposed on them. Specifically, in December 2021, NACAS was contacted by a member who had been promoted following completion of a probationary period. A condition of this promotion was that they had the Covid-19 vaccination, notwithstanding that this was not a part of their new contract. This requirement was maintained by the employer following removal of the government policy on mandatory vaccination. As the member did not want to have the vaccine, they were dismissed by their employer on the basis that they did not pass the probation period by declining the vaccine. As their period of employment was less than 2 years, options to challenge this decision were limited.
196. A notable number of Survey Respondents opposed mandatory vaccination. Language such as "forced", "manipulation", "bullied" and "blackmailed" appear across a number of responses from the Survey Respondents [PF1/7 - INQ000518420]. A number of Survey Respondents considered that mandatory vaccination was contrary to their human rights.
197. Some Survey Respondents reported that they were reluctant to take the Covid-19 vaccine but felt they had to do so because they could not forgo their income. One member stated, "I left my job" and "lost all my life savings" because they did not want to have the vaccine [PF1/7 - INQ000518420].
198. Survey Respondents reported that mandatory vaccination led to many care professionals leaving the industry; indeed, some NACAS members who refused to have the Covid-19 vaccination reported being dismissed from their employment. Some Survey Respondents felt that mandatory vaccination policies exacerbated existing staff shortages. One stated that two people from their workplace "walked out because they would not have the vaccine." Another stated: "that was a joke. That ruined the care sector even more because the people that didn't want to be vaccinated then lost their

*jobs so everyone was even more under staffed which put a lot more pressure on everyone else then they got fed up and left too” [PF1/7 - INQ000518420].*

**Areas or aspects of the response to the pandemic that NACAS considers went well or was a success in how the adult social care sector responded during the relevant period.**

199. During the pandemic, the UK government introduced a fast-track Barred List check service for healthcare and social care workers in England and Wales. NACAS is of the view that this was a positive and welcome service which reduced the time it took for individuals seeking work or employment in the adult social care sector to access the work force. The fast-track service was free of charge and provided individuals with a DBS check within one to two working days, as opposed to 14 working days using the standard service. This enabled providers to onboard new staff much more quickly.
200. When asked what they thought the government had done well in responding to the pandemic, one NACAS member commented that policies such as lockdown and furlough were a good decision, as they *“kept a lot of people safe”*. Another NACAS member commented that the roll out of the vaccines was a success as it *“it was really fast and organised”*.
201. What was clearly demonstrated during pandemic and was a positive was that it enabled the general public to see how skilled and dedicated the workforce are. As one Survey Respondent commented, *“I think all professionals did their best considering the situation and I hope lessons were learnt particularly in Care Homes, allowing major events to take place and delaying to implement measures to protect people” [PF1/7 - INQ000518420]*. Unfortunately it was short lived and, once the pandemic was over, social care found itself once again on the sidelines.

**Recommendations**

202. The pandemic shone a bright spotlight on the work of the phenomenal individuals working in the social care system and highlighted how crucial their hard work and dedication is both day-to-day and in times of crisis. To ensure lessons learnt from the pandemic are translated into improvements, NACAS has two key objectives which it would encourage the Chair of the Inquiry to consider when formulating recommendations:
- a) **Establish parity of esteem between the NHS and the social care sector.** To achieve this, there should be social care voices embedded at a senior governmental level to inform decision-making which impacts the sector. In addition, the social care

sector must have equivalent access to essential resources, including PPE and testing.

- b) **Recognise social care as a skilled profession.** To achieve this, the profession should be regulated and there should be mandatory registration for social care professionals. The training of care professionals should be the responsibility of a regulator or professional body to ensure consistency of training. There should be a national recognised care work curriculum that is applicable across the UK. In addition, recognition should include improved remuneration and working conditions to increase workforce capacity and care professionals should be recognised as frontline key workers from the outset of any future pandemic.

203. In addition to these two objectives, NACAS invites the Inquiry to consider the discrete suggestions made earlier in this witness statement at paragraphs 33-34, 47, 75, 134 and 156-158.

**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.

**Personal Data**

Signed:

**Dated:** 28 January 2025