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UK COVID-19 INQUIRY – MODULE 6

WITNESS STATEMENT OF JOANNA KILLIAN

ON BEHALF OF THE LOCAL GOVERNMENT ASSOCIATION

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I, **Joanna Killian**, Chief Executive of the Local Government Association, 18 Smith Square, London, say as follows –

Part 1 – Overview

Introduction

1. I am the Chief Executive ("**CEX**") of the Local Government Association ("**LGA**") of 18 Smith Square, London, SW1P 3HW, and I am authorised by the LGA to make this statement in response to the Covid-19 Inquiry's Rule 9 ("**Rule 9**") Request dated 18 November 2024 to the LGA for evidence in relation to Module 6 concerning the impact of the Covid-19 pandemic on the publicly and privately funded adult social care ("**ASC**") sector.

2. The way ASC was affected by the pandemic is a complex subject and the engagement of the LGA with this sector was very extensive. For these reasons, and because the Rule 9 Request includes some 41 questions (and many sub-questions) this statement is long. For brevity, I have frequently used acronyms, which are identified when first used, and also listed in full in Appendix 1.

3. To provide another perspective on the LGA's work over this period:

   - Appendix 2 sets out a timeline of the LGA's engagement with the most significant organisations for this Module;
   - Appendix 3 sets out a timeline of engagements with councils, such as events and webinars, hosted by the LGA;
   - Appendix 4 captures a selection of case studies, reflective of the lived experience of councils during the pandemic.
   - Appendix 5 – Detailed recommendations

4. The main body of the statement is in 19 Parts corresponding to the different groups of questions, as follows:

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5. To be of most use to the Inquiry, my statement is predominantly limited to the scope of the Rule 9 request, and to those matters of which the LGA had direct knowledge or involvement, including information it received from local authorities.

6. The will of the LGA to learn and develop its understanding relating to this period continues; it will listen intently and with full sympathy to the evidence of those who are well placed to speak to the tragic and wide-reaching impacts of the pandemic beyond this statement.

Condolences

7. I wish to emphasise, at the outset, that the LGA as an organisation, is very much aware of the effects of the pandemic on those connected to the ASC sector, including those who drew on care and support, their families and close friends, those who worked in providing care, those who died during the pandemic, or those who were impacted physically, mentally or emotionally by it, including those affected by long-Covid.

8. The LGA and its officers well-know nothing can fully comfort those who have suffered or been left bereaved, but I hope that, through my statement, they may gain some insight into the many steps that the LGA and local authority officers took to try to respond to this terrible event, and perhaps, as a result, they can obtain a degree of solace.

The basis of my evidence

9. The Inquiry will be aware that the LGA has previously given evidence to the Inquiry on several occasions, including most relevantly for this Module, the evidence of the previous CEX, Mark Lloyd, for Module 2 (**INQ000215538**); when I cross–refer to passages in his statement I shall refer to it as "**LGA/ML/M2**".

10. I took up my current role on 18 March 2024, having previously worked for many years on local government issues, including latterly between 2018 and the beginning of 2024 as CEX of Surrey County Council, between 2015 and 2018 as a Partner and Head of Local Government at KPMG, and between 2006 to 2015 as CEX of Essex County Council. Both councils had statutory responsibility for ASC services.

11. Accordingly, as I was not working for the LGA during the relevant period for Module 6, I cannot give first hand evidence of the issues confronting the LGA or the actions taken by it at that time. So, in making this statement I have had to rely on information provided to me by the LGA's officers who were involved over this period. My statement must therefore be read as representing the collective understanding and knowledge of the LGA in relation to the relevant period.

12. I am happy to place such reliance for three reasons -

    - *First* the LGA's officers are highly professional, and it is my belief that they have diligently and fairly reported to me the relevant information that I set out below, though I should note that certain senior colleagues (including the LGA's former CEX, Deputy CEX and Director of Policy) who were heavily involved in the LGA's pandemic response work have retired or moved on to new organisations. I should add that in preparing this statement, it has not been thought necessary for current LGA officers to seek input from those former colleagues, since sufficient memory resides in the senior officers who were central to the LGA's work during the pandemic and who remain at the organisation and worked closely with those who have since left the LGA.

      Of course, the LGA cannot now claim to know the content of every email, meeting and phone call between now-departed senior LGA officers and members, and senior Government figures, civil servants, councils and other partners. However, while the perspective of former colleagues would add nuance to this statement, I do not believe its absence creates a significant deficit.

- *Secondly*, the evidence I give below conforms to much of my personal experience as Surrey's CEX during this period, as well as to the information that I received from senior colleagues in other councils with whom I spoke during the period. `

- *Lastly* my statement proceeds from the general evidence that the Inquiry has already received on this topic. As to this the Inquiry will be aware that in November 2023, the LGA submitted to the Inquiry the "Covid-19 Inquiry Survey for Module 6: Research Report" (**Exhibit JK4/001 - INQ000400522**, referred to as the "**Module 6 Survey**"), which it had been asked by the Inquiry to undertake. This survey powerfully captures the voice of local government and its experiences during the pandemic related to ASC. It is not necessary for me to repeat this evidence in full, since it is already before the Inquiry, but I shall refer to it where relevant. More generally, the views of local government as expressed in this survey provide a general back to this witness statement, as does the evidence that the LGA has given in other Modules (including LGA/ML/M2, **INQ000215538**).

General summary of the LGA's role in the pandemic

Introduction

13. The Inquiry knows that the period covered by Module 6 was as challenging a period for good governance at both local and national levels as any since 1945. Decisions had to be made quickly and communicated well. Civil society, including local government, stepped up with a determined aim to make a positive contribution.

14. The goodwill, experience and expertise of local government was there to be harnessed in order to overcome the Covid-19 virus from the very start, and the LGA worked hard to ensure that the best use was made of these strengths throughout.

15. Alongside public facing work such as bulletins, Parliamentary briefings, and press releases, the LGA also communicated its members' and officers' views, needs and insights to national Government's political and administrative decision-makers. Some of this occurred through formal scheduled meetings with agendas and minutes, but there were also many short-notice informal meetings and discussions, at both the political and officer level, between organisations working at pace on a range of different difficult issues.

16. A key aim of the LGA in engaging with Government was to bridge the gap between policy and operation to help reduce the impact of the pandemic on communities. Much work focussed on sharing concerns about the impact of the pandemic on the ground, and in

communicating the detail of challenges councils faced in supporting their residents and communities. In this way it sought to help Government to develop policies, practice and approaches, which were operationally feasible, and made a positive difference to people's lives.

Limits to the work of the LGA

17. There were though, clear boundaries, to the work of the LGA.

18. It did not seek to influence the Government's science-led approach to making decisions about matters such as whether to impose lockdowns, the use of vaccines, social distancing requirements, or other restrictions. The LGA always recognised that to do so would have been inappropriate, since it did not have access to the scientific evidence and expertise that informed Government decisions.

19. Instead, the LGA's focus was on the implications that these decisions and related policies had for communities and local councils. The LGA's role was wide-ranging. In essence, the organisation sought to: capture the views and concerns of councils on the ground which were leading the local response; feed those into the Government's national policy-making machinery to best ensure guidance and policy reflected councils' experiences; and seek further views from councils on whether such guidance and policy was satisfactory. In short, the LGA played a critical role in providing a feedback loop between councils and Department of Health and Social Care ("**DHSC**") in the interests of national policy and guidance which was deliverable locally and addressed local needs.

20. Throughout the period from March 2020 to the summer of 2022, councils were often the first port of call for the public, businesses, and local agencies, simply because they are at the heart of their communities and closely involved in the delivery public services. Councils demonstrated flexibility, innovation, resilience, responsiveness and compassion, all of which enabled local government to play a critical role in responding to the pandemic and supporting and saving people's lives.

The LGA and councils: authenticity and establishing 'ground truth'

21. As a membership organisation that believes in the power of great local government to help transform lives and communities, councils will always be the LGA's primary stakeholder. This statement will detail at relevant points how the LGA worked with councils during the pandemic. All this work – whether in events, meetings, phone calls or emails – was about establishing what I shall describe as the "ground truth".

22. I use this term to describe the flow of information and its subsequent use, a process in which:

    - The LGA first captured the lived experience of councils "on the ground" through multiple forms of engagement;
    - then it fed this detailed specific knowledge into Government so that it might best understand the reality of what has happening in local communities;

      and

    - thereafter, the LGA did what it could to ensure that, government policies and decisions, reflected, and were informed by, this local reality.

23. A specific example of this kind of engagement and information flow may be helpful here: The LGA, together with its Care and Health Improvement Programme ("**CHIP**") (which was set up to help councils to improve the delivery of ASC, and both the public and Government to understand the related challenges), ran over 180 online events during the pandemic, attended by more than 30,000 council CEXs, leaders, other senior officer/political leadership, public health commissioners, heads of service, operational and practice staff, plus partners including NHS, providers, the voluntary sector and people with lived experience. My statement will discuss the work of CHIP in many places.

24. The LGA's work, throughout the pandemic, was rooted in the experience of councils. Councils' officers and members were regular speakers at many of these events and relevant issues emanating from these events were part of our ongoing feedback to Government. A detailed list of events, webinars and similar types of engagements for councils, hosted by the LGA, is included at Appendix 3. To exemplify the reality for councils when dealing with the issues that the pandemic threw up, a selection of case studies has been included in Appendix 4.

25. I must say now that the LGA and I are keen to pay tribute to council members and officers, because they went above and beyond with their time and dedication. Staff in every council in England – at all levels of seniority – led, coordinated, delivered, and supported, a truly immense amount of vital work to ensure ASC was as strong and as resilient as possible in the interests of everyone connected to the service.

26. I saw this first-hand as a council CEX at the time, particularly as staff pivoted from their usual roles to something very different, and I can only say that it was humbling to do so.

In my long professional life in local government, I cannot think of another time where councils have demonstrated the very best of themselves with such distinction. By so doing, they have demonstrated the extent to which they are an essential part of the fabric of our country.

27. Thus, though my statement may seem to be focussed solely or predominantly on what the LGA did, I also want to explain and give credit for the work of local government as a whole.

28. The work and commitment of my LGA colleagues must be acknowledged too. Everybody across the organisation played their part, whether they were current or former members, officers, leaders or more junior staff who moved from their existing roles to support different strands of LGA activity.

29. I believe that the Inquiry will readily understand that it was stressful and at times upsetting work. Many colleagues across the hierarchy regularly worked 12+ hour days and through the night to support the LGA's member councils and, in turn, local people and their communities. From speaking to colleagues when preparing this statement, I know that the LGA punched well above its weight and played a key role in our nation's response to Covid-19. The LGA is proud of the role it took on.

The LGA's other partners for ASC issues

30. Government too was of course a significant partner for the LGA, though it was by no means the only organisation with which the LGA worked closely. Indeed, it will be seen throughout this statement that the LGA engaged extensively with many other partners, such as:

- those organisations representing the voice of people drawing on care and support,
- those representing the workforce and those representing care providers,

  and
- the voluntary, community and charity sectors.

The LGA's relationships with these organisations had been built up over many years prior to the pandemic, and when it commenced, they proved invaluable for the LGA in seeking to understand the many different issues facing the ASC sector.

31. At the national level, the LGA and CHIP, worked closely with care provider umbrella bodies and representative associations. This was critical since high-quality care and support to meet people's needs holistically depended on an effective relationship between Local Authorities, as commissioners, and the providers of, ASC.

32. There was a particular aspect to this relationship caused by the history of austerity and financial strain in the years preceding the pandemic. In short, the commissioner-provider relationship was at times fraught. This was a result of the following factors -

    Providers facing rising costs which they expected to be met by raised fees from commissioners,

    and

    - commissioners facing significant downward pressure on their budgets for care as well as across other council services.

33. On the other hand, I should also mention a particular positive legacy emerging from the pandemic. In March 2020 the LGA set up and supported a forum - which continues to this day – in which provider representative organisations, together with local government, could respond to a fast-evolving set of events and Government policies.

34. As detailed below, the relationship between the LGA and care provider bodies stood up well from the early stages of the pandemic. Further – and though both sides did not always see eye to eye on every issue – in the LGA's view, both Government and the ASC sector benefited from a spirit of collaboration and constructive challenge from the national representative organisations of councils as commissioners and local care providers.

The LGA and the NHS

35. The LGA had a longstanding relationship with the NHS prior to the pandemic and worked closely with it at both a national and regional level in response to Covid-19 both:

    - At a national level, this was with NHS England ("**NHSE**") in particular, but also with organisations like the NHS Confederation and NHS Providers. The LGA ensured that it had officers who could engage with the NHS at the level of frequency required, notably but not exclusively the group established to support safe and timely discharge from hospital.

    - At a regional level, Care and Health Improvement Advisers ("**CHIAs**") who were senior officers involved in the work of CHIP work, were frequently and extensively engaged with NHSE regional structures. These were important places where the application of policy and guidance could be tested.

An introduction to the delivery of adult social care

The role of the Care Act 2014

36. The Inquiry may already be aware that the legal basis for the work of the ASC is primarily set out primarily in the Care Act 2014 ("**the 2014 Act**"), although other legislation also may a direct or indirect interface with these provisions.

37. Within councils both before, during, and after, the pandemic, each council's director of adult social services ("**DASS**") and lead/cabinet members for adult services, have oversight over the delivery of ASC in accordance with this legislation. Of course other senior council officers and members will work closely with them, including the directors and lead/cabinet members, for children's services, housing, and public health. Indeed, in some cases directors may have responsibility for more than service area, such as adult and children's services, or adult services and housing. Among these others, council directors of public health ("**DPHs**"), who are experts in population health and infectious disease control, played a particularly important role during the pandemic as I discuss in many places in this statement.

38. In outline (a more detailed description of these functions is set out in Overview of the roles and responsibilities of Local Authorities under the Care Act 2014) the 2014 Act placed statutory duties on councils for a range of issues concerning ASC, including:

- Assessing people's needs and determining their eligibility.
- Planning how those needs will be met and then meeting them through a local provider market, whose diversity and quality councils must promote.
- Assessing people's financial means to determine their contribution to the cost of their care.
- Keeping people safe from harm through safeguarding provisions.

39. These key points must be understood on the basis that:

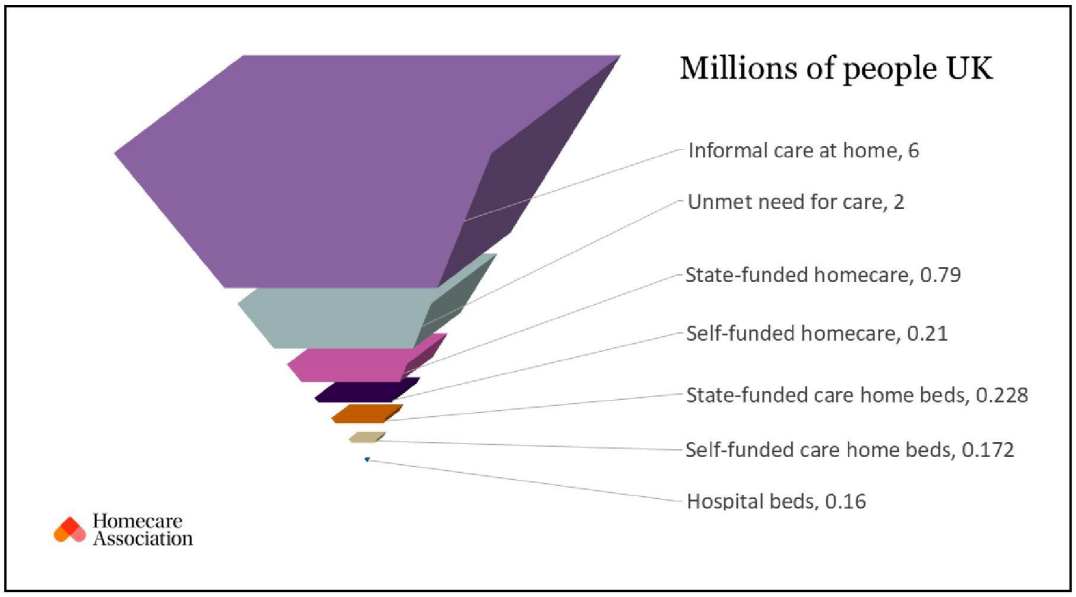
- Those in scope are adults of all ages;
- 'needs' relates equally to both people who access 'social care' and their family carers who access 'support';
- councils' duties on matters such as assessing need and care and support planning

apply equally to both those people whose care is funded in full (or in part) by their council and those who fund all their care themselves (self-funders);

and

- in addition to those over 65, a large proportion of people accessing ASC are individuals aged 18-64 who may, for example, be autistic, have a learning disability, and/or need mental health support.

40. The Homecare Association has produced an illustration showing the different categories of people who have cause to draw on care and support and where that support is provided (Email from Homecare Association to LGA dated 11 February 2025, **Exhibit JK4/002 - INQ000581275**):



ASC in practice

41. The Inquiry will want to drill down into how this worked in practice. On this point I refer to a helpful description by The King's Fund (King's Fund "Key facts and figures about adult social care" (1 July 2024), **Exhibit JK4/003 – INQ000581203**) -

> *"…Adult social care covers a wide range of activities that help people who are older or living with disability or physical or mental illness to live independently and stay well and safe. It can include 'personal care', such as support for washing, dressing and getting out of bed in the morning, as well as wider support to help people stay active and engaged in their communities. Social care includes support in people's own homes (home*

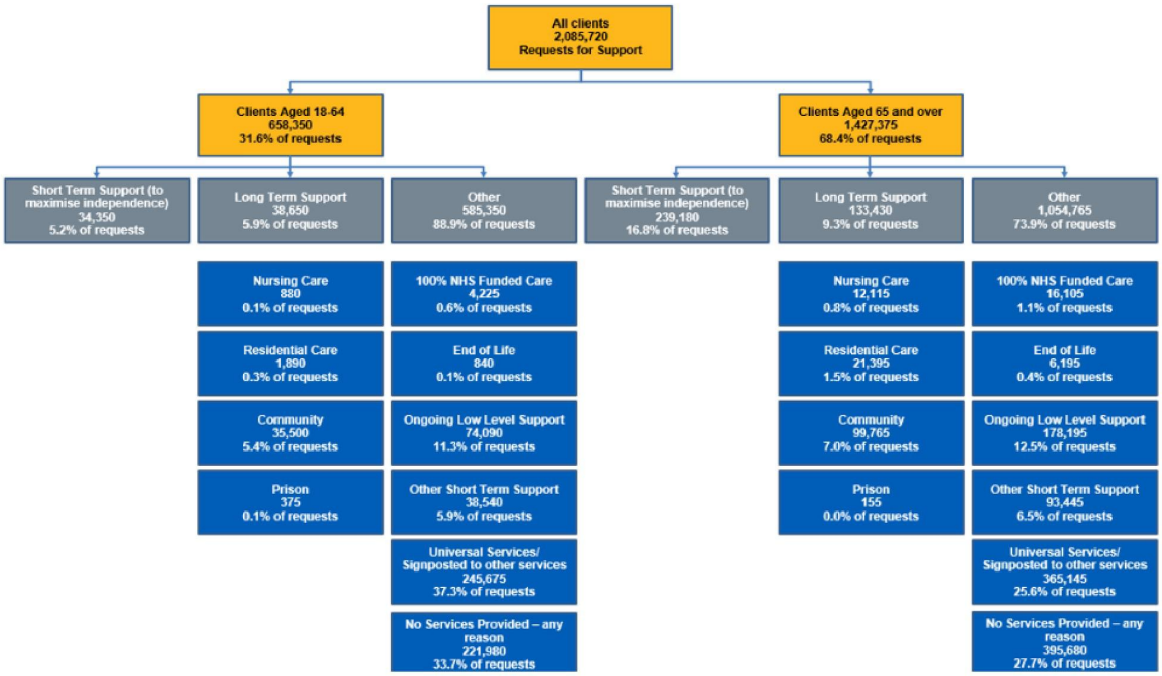
care or domiciliary care); support in day centres; care provided by residential homes and nursing homes (care homes); reablement services to help people regain independence; the provision of aids and adaptations for people's homes; information and advice; and support for family carers.

Social care is often broken down into two broad categories of 'short-term care' and 'long-term care'. Short-term care refers to a care package that is time limited, usually with the intention of maximising the independence of the individual using the care service and eliminating their need for ongoing support. Long-term services are provided on an ongoing basis and range from high-intensity services such as nursing care to lower-intensity community support. Both long-term and short-term care are arranged by a local authority and could be described as 'formal' care…"

42. The data of ASC activity and finance, published annually by NHS Digital provides, further helpful information to illustrate the size and scale of the service. The most recent publication is (NHS England "Adult Social Care Activity and Finance Report, England, 2023-24" dated 31 October 2024, **Exhibit JK4/004 - INQ000581347**).

43. In 2023/24, councils received just under 2.1 million requests for support from new clients (0.66 million requests from people aged 18-64 and 1.43 million requests from people aged 65+). This is the equivalent of 5,715 requests per day.

44. The outcome for those requests is illustrated in the table take from the most recent edition of this publication (**Exhibit JK4/004 - INQ000581347)**.

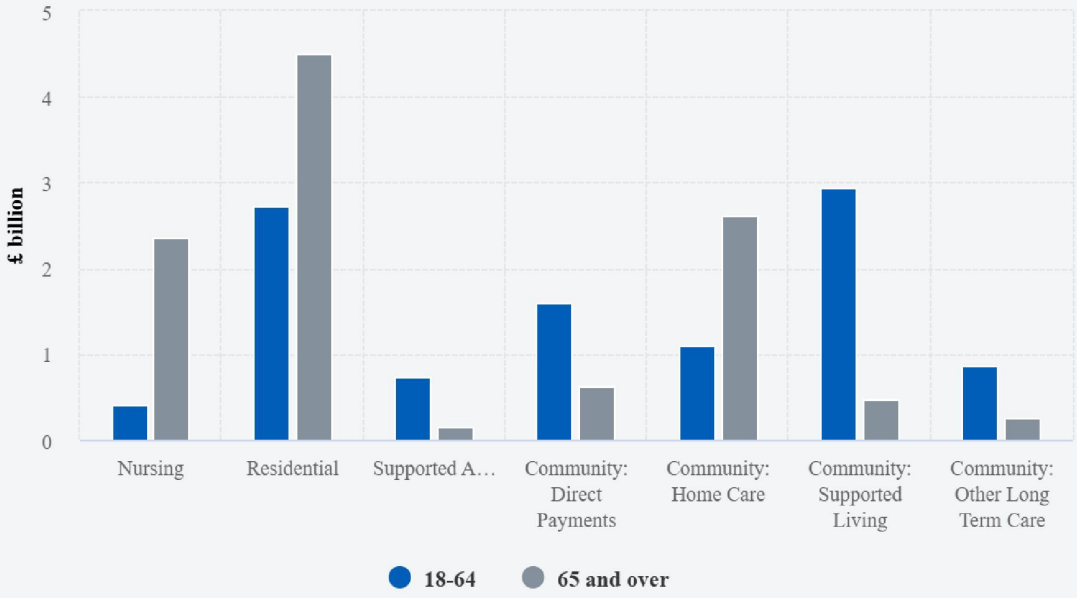


45. To set the scene further, it is helpful to be clear about spending on short- and long-term care in 2023/24. NHS Digital use the measure of gross current expenditure, which is total expenditure less charges and less all income except for client contributions. Its figures show:

- For short-term care, £983 million was spent. This is 3.6% of gross current expenditure on adult social care. This comprised £215 million spent on people aged 18-64 and £768 million spent on people aged 65+.

- For long-term care, £21.4 billion was spent. £10.4 billion was spent on people aged 18-64, while £11 billion was spent on people aged 65+. The breakdown of spend on long-term care by age group and setting can be seen in the table below.

Figure 18: Gross current expenditure on long term support by support setting and age group, 2023-24



Motivation and ambition within the ASC sector

46. The Inquiry may also be helped by considering the ASC sector's wider sense of motivation and ambition. This existed before the pandemic but was further shaped by it. In my and the LGA's view, seeing ASC through this type of lens is crucial given the potential impact the Inquiry's conclusions and recommendations may have for shaping the wider debate about the future of care and support.

47. In this sense, the LGA takes the view that ASC is more than merely services or processes and is a matter of common humanity in which services and processes are a vehicle for enabling people to "live a good life".

48. In its campaigning work the LGA has articulated this as follows (LGA Campaign "The future of adult social care", **Exhibit JK4/005 - INQ000581294**):

> *"[ASC]…is not simply a set of services; it is about supporting people to live the lives they want to lead. It is used in every community when needed to enable adults of all ages to grow and sustain their wellbeing.*
>
> *Everyone should be able to live the life they want to lead; to feel human.*
>
> *In this way, social care is common to us all.*

Adult social care is fundamentally about people's rights and relationships. At its best, it helps ensure that everyone is able to pursue the things that matter most to them, irrespective of their age or conditions."

49. This approach is by no means unique to the LGA. For instance, in recent years, much of the sector – including many councils – has coalesced around the following broadly similar vision for ASC developed by Social Care Future (a people-powered movement seeking changes in how people drawing on care are supported) (**Exhibit JK4/005 - INQ000581294**):

> *"We all want to live in the place we call home, with the people and things we love, in communities where we look out for each other, doing the things that matter to us. That's the #SocialCareFuture we seek."*

The LGA is committed to reimagining ASC in this more ambitious and people-centred way; it believes that this would be a strong and positive legacy of the pandemic.

50. The work of the ASC sector has sometimes been viewed as being concerned purely (or primarily) in terms of older people in care homes. This is neither true nor appropriate and that is why the LGA has long been and continues to be, determined to educate and rebut such a limited stereotype. So, reframing the aims and purposes of ASC, as discussed above, is an ongoing process, which the LGA considers to be essential if greater public and political support for the service is to be built up.

51. Of course, older people in care homes are important, but to limit the concept of ASC in this way is a mischaracterisation that ignores many other groups including:

52. The many thousands of working-age people who draw on care and support, including people with a learning disability and/or autism, a physical disability, a mental health problem, and unpaid carers;

53. The many other settings in which 'care and support' takes place, such as -

- people's own homes,
- respite settings,
- different housing settings providing a combination of accommodation and/or care and/or support with daily living,
- day centres and other community locations,

and

- the many partners of councils, particularly from the voluntary, community and faith sectors, which help deliver services and support.

54. During the pandemic, national media, and sometimes even national Government, appeared to succumb to this mischaracterisation, losing the appropriate human–centred focus and ignoring the full breadth of ASC that I have described above. I and the LGA therefore encourage the Inquiry, at every stage of this Module, to keep in mind the sheer breadth, purpose and value of adult social care, and its linked importance to people and communities.

Delivering ASC in the pandemic: emotional context

55. It is important to recognise also that people working in the ASC sector did sometimes feel let down and sidelined by the Government's approach. Thus, like the population at large, local government colleagues (and their ASC partners) sometimes felt concerned and distressed at unfolding developments. Crucially, the very people that councils and the ASC sector were seeking to support - people drawing on care and support and their loved ones - also felt let down.

56. Many, whether drawing on care or working on the frontline, suffered real distress when exposed to avoidable risks or those they worked with or for sadly died. In addition to the heartbreaking grief endured by the bereaved, who have my full and sincere sympathy, I cannot overstate the impact this also had on council members and officers in terms of the difficulty of their work and their morale. The same can be said for LGA members and officers. Some examples of moments when these feelings came to the fore include:

- Government messaging, quite early into the pandemic, to the effect that social care had been protected from the outset. This was helpfully explored by the Inquiry during the Module 2 evidence hearings, with Mr Keith KC, Lead Counsel to the Inquiry, referring Matt Hancock to the fact that (Hearing transcript dated 30 November 2023, **Exhibit JK4/005a – PHT000000052**):

  > *"On 15 May you said at a Downing Street press conference: "right from the start it's been clear that this horrible virus affects older people most. So right from the start, we've tried to throw a protective ring around our care homes".*

- Mr Keith underlined the point when he said:

"In Parliament – and I breach no Parliamentary privilege rule by stating as a matter of fact, because I'm not addressing the merits of what was said in Parliament, you [Matt Hancock] said, "We absolutely did throw a protective ring around social care".

- On the ground, this notion of a 'protective ring' was known to be simply not true. This caused deep concern and distress for families, as well as for sector professionals seeking to perform their duties to very clinically vulnerable individuals. In the aforementioned Module 2 hearing, the former Secretary of State accepted that the processes put in place for the care sector did not constitute an 'unbroken circle'.

- According to LGA research, the Government's Number 10 daily briefings did not have a predominant and specific focus on ASC until 15 April 2020, coinciding with the launch of the Government's ASC Action Plan (Transcript of speech "Health and Social Care Secretary's statement on coronavirus (Covid-19): 15 April 2020", Exhibit **JK4/006 – INQ000581277**). And even that briefing opened with the then Secretary of State for Health and Social Care saying, "At the core of our plan is to protect the NHS from being overwhelmed".

- The next notable focus on social care was 8 June 2020, announcing the creation of the Social Care Sector Covid-19 Support Taskforce, chaired by Sir David Pearson (Transcript of speech "Health and Social Care Secretary's statement on coronavirus (Covid-19): 8 June 2020", **Exhibit JK4/007 – INQ000237366**). Again the former Secretary of State missed an opportunity to shine a light on the breadth of ASC, focussing his opening remarks just on care homes and concluding (following an announcement that all care homes would receive sufficient tests for care home residents and staff) that, "It'll mean that right across adult social care, everyone will have the certainty and confidence of a high quality coronavirus test". "Right across adult social care" in the context of tests for all care homes, did a disservice to the many thousands of people accessing and deliver ASC in other settings. It is not difficult to imagine that the lack of profile for ASC in these significant daily televised public briefings caused a sense of abandonment and deprioritisation for those drawing on or working in ASC, including frontline care workers.

57. The Module 6 Survey showed how 44% of councils (or care providers) experienced personal protective equipment (**"PPE"**) orders for ASC being diverted to the NHS in the first six months of the pandemic (20% experiencing this 'very often' and 24% experiencing this 'fairly often') (**Exhibit JK4/001 - INQ000400522**). Anecdotally, the LGA is aware that

some care workers had little choice but to use their own home-made makeshift PPE (Marshall et al. (BMC Geriatrics, 2021) research article "Care homes, their communities, and resilience in the face of the Covid-19 pandemic: interim findings from a qualitative study", **Exhibit JK4/008 – INQ000581168**).

58. There were also harrowing experiences of family members being unable to visit relatives in care homes, or having to do so on a restricted basis, because of guidance on infection control measures. A February 2024 study of family carers' experiences of care home visiting provides a stark and deeply upsetting picture (Dixon J, Stubbs E. (Ageing and Society, 28 February 2024) "Family carers' experiences of care home visiting restrictions during the Covid-19 pandemic: a relational autonomy perspective", **Exhibit JK4/009 – INQ000581255**):

> *"He [resident's spouse] was two metres behind the screen at one side and she [the resident] was two metres at the other and the staff just popped her in, left her and walked off, and she just cried the whole time."*
>
> *"He [registered blind resident] wasn't allowed to touch me and I wasn't allowed to touch him. I shall probably cry now – he'd sometimes put his hand out to touch me and they'd pull, you know, the care assistant, not nastily, they'd just move it away."*
>
> *"Whatever carer told you was the rules, whoever you spoke to on the phone, none of them really knew, they were just guessing."*
>
> *"For goodness' sake, we had gloves. They can smother her in gel if that's what they need to do. Touch, sometimes it's all people have left. That should've been thought about."*

59. Likewise, the sense and level of neglect was almost unimaginable, when care workers, who had been working with unwavering commitment, and at great personal risk, were forced to leave by 'no jab, no job' policies. As Unison's Head of Care said in 2022 (The Guardian article, dated 1 March 2022, "Mandatory Covid jabs for healthcare workers in England to be scrapped", **Exhibit JK4/010 - INQ000581307**):

> *"…There were always better ways of upping the jab rate in care. Making the vaccine mandatory meant thousands of experienced staff quit care homes. These were workers that the struggling sector could ill afford to lose. Many won't go back, either. The have found better paid, less*

stressful work elsewhere…"

60. Clearly, the most stark and upsetting situation that families, loved ones, councils and their partners had to deal with was deaths, both of those in receipt of care and members of the ASC workforce. There were many such instances. Looking just at deaths in care homes, the Office for National Statistics ("**ONS**") has reported that, between week ending 20 March 2020 and week ending 21 January 2022, there were 43,256 deaths in care homes in England where 'novel coronavirus' appeared on the death certificate (ONS research article dated 28 February 2022 "Deaths involving Covid-19 in the care sector, England and Wales: deaths registered between week ending 20 March 2020 and week ending 21 January 2022", **Exhibit JK4/011 - INQ000581240**). Total deaths were a staggering 43.9% higher than the five-year average for the first wave. The ONS also provides data showing that, between 9 March 2020 and 28 February 2022, there were 1,228 deaths involving Covid-19 among social care workers aged 20-64 (362 men and 866 women) (ONS analysis dated 10 March 2022 "Deaths involving coronavirus (Covid-19) among health and social care workers (those aged 20 to 64 years), England and Wales, deaths registered, 9 March 2020 to 28 February 2022", **Exhibit JK4/012 - INQ000518415**).

61. The facts and information provided above make for extremely difficult reading. They also barely even scratch the surface of the level of upset and distress experienced by people drawing on or working in ASC. I hope that detail my statement will provide can play a part in ensuring that, in the future, the problems faced by the ASC sector in the pandemic, and which resulted in so much pain and suffering, can be avoided.

The pre-pandemic challenges to the national provision of Adult Social Care

62. In order to answer the questions posed by the Inquiry, I must first set out the context within which the ASC sector found itself immediately prior to the pandemic. There were four key challenges that had beset ASC in the decade to 2020, which, because of their impact on the resilience and preparedness of the ASC sector, were incredibly important in determining how the sector fared during the pandemic.

1 - Acute financial pressure

63. *First*, prior to 2020, the ASC sector had been under acute financial pressure for many years. No reliable observer of the ASC system could suggest that overall funding was, or had been, sufficient for many years. This inadequate funding had (and continues to have) real consequences, including:

- care provider instability,
- deleterious impacts on the nature and quality of provision,
- serious detrimental impacts on recruitment and retention issues for the care workforce (linked in large part to poor pay),
- greater strain on unpaid carers,
- inadequate investment in prevention,

and

- high levels of unmet and under-meet need.

My statement discusses these issues, in detail, in many places – see in particular Part 3 - LGA concerns for ASC sector pre-pandemic and action taken.

2 - Government understanding, and public perception of the ASC sector

64. *Secondly*, the public perception of ASC was significant because of its effect on a) the framing of the issues in ASC by opinion formers and politicians, and b) the public's willingness and capacity to understand the other issues I have mentioned.

65. The fact is that the media, successive governments, and sometimes the ASC sector itself, often framed the ASC sector in negative terms. Such a narrative – particularly when dominant – has not merely shaped public perception of the sector, it has impeded the necessary drive and ambition to address the problems the ASC sector has faced. Research conducted by Survation, and led by the Social Care Future ("**SCF**"), in partnership with Equally Ours (the only UK-wide pan-equality and human rights network) has noted how (Social Care Future report "How to build public support to transform social care" (April 2021), **Exhibit JK4/013 - INQ000581352**):

> *"Prior to being exposed to [the Social Care Future narrative], people tended to think of social care as being about looking after vulnerable people who cannot look after themselves, and they characterised social care as broken and in crisis…Many didn't identify social care as being part of their lives and a positive part of communities".*

66. This matters because, as the American political strategist and communications expert Anat Shenker-Osorio has said (Anat Shenker-Osorio report "A Brilliant Way of Living Our Lives: How to Talk About Human Rights", **Exhibit JK4/014 - INQ000581191**):

"People are more motivated by creating something good than ameliorating harms…enumerating massive problems makes people shut off and look away".

67. As to the second part there can be no doubt that there was a deep deficit in public understanding of ASC before the pandemic. Research conducted by Britain Thinks in 2018 on behalf of the LGA found that (BritainThinks insight report "Local Government Association: Adult social care & wellbeing research" (October 2018), **Exhibit JK4/015 - INQ000581173**):

    - Nearly half of respondents (48%) to a public survey of more than 1,700 people had little to no understanding of what 'social care' meant;
    - forty four per cent believed social care to be provided by the National Health Service ("**NHS**");
    - twenty eight per cent believed social care to be free, paid for through taxation;
    - in some cases, even those who had interacted with ASC, were not aware that they had done so.

68. In the LGA's view, public understanding of an issue, and interest in it, are often a pre-requisite for national government prioritisation of that issue. The LGA believes that this Module presents an important opportunity for the nation to spotlight ASC, to improve the public's understanding of the true nature of ASC, to empower media and politicians understanding of its critical importance to the lives of all, and – in so doing – to help build momentum for significant action by government to address the needs of the sector comprehensively and effectively.

69. Such needs were often complex and meeting them required a broad vision and great care. Councils were alert to the need to give attention to different 'at risk' groups, such as people with learning disabilities, autism, mental ill health, or substance misuse. Yet, sometimes, national policies were designed largely with older people in mind, reflecting a failure to fully comprehend that adult social care is about adults of all ages supported in a range of settings and not just care homes. Consequently, national guidance was in some cases updated frequently as the centre's understanding of ASC grew. For instance, guidance on the admission and care of people in care homes was updated 11 times between June and December 2020.

70. A related issue was that, as the pandemic progressed and social care became more of a priority, there was too strong a focus on overseeing the sector, rather than working with it.

71. Understanding the reality on the ground was crucial. For this, better coordinated data was required, yet too much effort was expended on establishing new data collections, and, at times, these duplicated long-standing arrangements that councils already had in place. This led to councils being asked to stand down their own tried and tested arrangements.

72. It is perhaps a paradox that it was through often harrowing media coverage, that the pandemic demonstrated to a wider audience that ASC is not simply a set of services some people need because of age or disability, but a key means by which adults of all ages are supported to live a full life, whatever their circumstances. If so, it is a welcome one since such greater understanding had long been missing and long been necessary.

73. That support, spanning different organisations and different people, showed itself to be inherently local, with councils playing an important role in local leadership and coordination.

74. The experience also showed the consequences of the often-hidden nature of social care, historically being 'done behind closed doors'. The tragic situation in care homes, the disproportionate number of deaths by people with learning disabilities, and the similarly disproportionate mortality of the black, Asian and minority ethnic ("**BAME**") care workforce, are just some of the ways that a historic lack of national attention played out in local communities.

75. One example of this, which is discussed in detail in this statement, is the Government's decision to implement a policy of discharging people from hospital back to the community, particularly care homes, without first being tested.

76. In hindsight, and even immediately after implementation, the disastrous consequences of this policy were apparent. Had the UK been better prepared ahead of 2020 to respond to the pandemic, and had it better understood and listened to the ASC Sector, the LGA believes this costly mistake could have been avoided. I cannot overstate the level of sympathy the LGA and local government holds for those who lost loved ones in this way, nor the toll it took on council colleagues and sector partners. I shall have much to say about this policy.

3 - The lack of parity of esteem as between the NHS and ASC

77. *Third*, for reasons explored in greater detail later in this statement (but often returning to

the inevitability of political expediency), the fortunes of the NHS have, for a long time, tended to be prioritised over the fortunes of ASC by successive governments. This was the case long before the pandemic, continued during it, and has remained so since. My statement will set out several examples of this inequality in policy and delivery.

78. Linked to this, whether as a cause or a consequence of social care's second order priority status, the fact is that the DHSC demonstrated a lack of operational experience and understanding of social care, early in the period in question. Linked, it is notable too that, for four years prior to June 2020, the DHSC had no director general for adult social care.

79. In the early phase of the pandemic, the ASC sector suffered from delayed and then short-term national action. While urgent plans were developed for the NHS, the then Government's national plan for ASC was not published until 15 April 2020, nearly a month after social distancing measures had been introduced. In the same early period, decisions were being made, and actions were being taken, nationally, without the time, knowledge or expertise, needed to achieve best results.

80. With such a heavy focus on the NHS, many people also felt (and still feel) that ASC was seen first and foremost as a release valve for pressures in the health service, rather than a vital public service in its own right. Hospital discharge into social care settings is a prime example of this.

81. The service of many people in need of, or concerned with, ASC felt very much like an afterthought. This had practical consequences (such as reduced access to PPE) and decision-making consequences (such as there being no ASC representatives on the Scientific Advisory Group for Emergencies ("**SAGE**") in the opening weeks of the pandemic.

82. It also had presentational consequences, for instance, to the best of the LGA's knowledge, of the 92 daily briefings from Number 10 between 16 March and 23 June 2020, only one had a dedicated focus and sector expert on adult social care (8 June, Sir David Pearson, announcement of the ASC Taskforce).

83. The LGA believes that the Inquiry will readily see how these matters damaged the morale and resilience of those working in the ASC sector. in April 2021, at the conclusion of his time as President of ADASS, James Bullion summed this point up nicely saying (Local Government Chronicle article dated 28 April 2021 "Bullion: Social care 'felt like an afterthought' during crisis", **Exhibit JK4/016 – INQ000581300**):

"…The fact that the Government did things later for social care always meant that you were on the backfoot…social care workers were made to feel like an afterthought, they felt this unequal status with the NHS…All the way through the pandemic you felt like [DHSC] was forever playing catch up, even though they had been given recommendations from us and others about what to do…"

4 -The deficit in Government commitment to, and reform of, the ASC Sector

84. *Fourth,* the failure properly to fund and reform ASC, the consequential negative public perceptions and misunderstandings of ASC, and the subsequent entrenchment of a lack of parity of esteem between the NHS and ASC, have created the conditions in which ASC has become seen by successive governments as too difficult a problem to address.

85. In theory, every prime minister, secretary of state, and minister for care, may have wanted to address policy on ASC, fully and once and for all, but for the reasons summarised above it just has not happened. Governments have just not been willing, to take the practical steps necessary, to prioritise the ASC sector to the level needed.

86. The last two decades have seen many failed attempts at change ASC policy. Green and white papers have come and gone; legislation on charging reform emanating from the 2010 Commission on Funding of Care and Support (frequently referred to as the Dilnot Commission after its chair, Sir Andrew Dilnot) has been delayed and postponed on several occasions; and sector proposals on much-needed improved support for the care workforce have never properly enjoyed deep political consideration and progress.

87. There is a further and connected point relating to planning for emergencies.

88. Local councils have duties to plan for major incidents and emergencies. As Category 1 responders pursuant to the Civil Contingencies Act 2004 ("the 2004 Act"), they are part of local multi-agency resilience forums ("**LRFs**"). Councils, along with other Category 1 responders, as part of LRFs, are required under the 2004 Act to plan to respond to a range of civil contingencies including those set out in the National Risk Register.

89. Most emergencies to which LRFs have responded prior to 2020, were short-lived and led by the blue-light services. By contrast, the pandemic was unprecedented in its scale, duration and impact, and the leadership of local government was paramount.

90. In its report on Module 1 the Inquiry concluded that the UK was ill-prepared for dealing

with such a catastrophic emergency. This lack of preparedness included lack of proper planning for the impact of a pandemic on those receiving ASC, even though the Association of Directors of Adult Social Services ("**ADASS**") had been commissioned by the DHSC in 2017 to produce reports relating to emergency social care planning in the event of a pandemic. Put simply, the ASC sector struggled because of a lack of preparedness caused, at least in part, by a lack of Government commitment to and reform of the sector.

A summary of what went well, what lessons were learned, and the recommendations that the LGA makes

What local government and the ASC sector was able to achieve

91. I and the LGA know that local government did the best it could in the extremely challenging circumstances of the pandemic. The dedication of council officers and members – at every level of seniority – and their efforts to support ASC as best as possible (both alone and with numerous partners) amazed and inspired at the time and continue to do so.

92. While the Inquiry's questions, and the LGA's response to them, are focussed on the local government dimension to the ASC sector, it would be remiss not to acknowledge and pay tribute to colleagues from other parts of the sector who constituted the wider ASC workforce. Care workers in all settings, registered managers in care homes, and relevant ancillary staff, all demonstrated – with great compassion and dedication – that, at its heart, care is a *relationship*, not merely a task or service to be delivered without compassion and forethought. Of all the times when people drawing on care and support needed that sense of *relationship*, this was it. The care workforce delivered in exemplary fashion, often risking their own lives and wellbeing (and, by association, the wellbeing of their own families) in the process.

93. Reflecting on, and learning lessons from, the pandemic is therefore not a solely negative exercise. To the sector's credit, there are things which stand out as having gone well, despite the inherent intensity and challenge of dealing with the pandemic. Most generally, but no less significantly, the pandemic revealed our instinct to care for one another.

94. During the pandemic, compassion, kindness and humanity from everyone involved ran through so much of the response to the emergency, including from care workers, the wider care workforce, people drawing on social care and their families and other loved ones and volunteers. The community of people involved in work relevant to the entirety of this Module, showed that they are the very best of us.

95. I and the LGA have been able to reflect, after the end of the pandemic, on what went well; the following points should be emphasised:

- ***Culture and relationships*** – The way in which people worked constructively together is a significant and powerful legacy of the period. This is particularly true where, historically, those relationships may not always have been straightforward. Over time, during the pandemic, there was:
    - A more equal relationship between national and local government with greater recognition from the former of the latter's expertise.
    - A more collaborative approach to identifying and solving problems between local government and care providers.
    - A further strengthening of the way in which councils work alongside people drawing on care and support, captured in the notion of '*doing with people, not doing to people*'.
- ***System resilience and agility*** – Likewise, during what was arguably the ASC sector's most challenging time in history, it is important, and must be recognised, that the sector did not 'fall over'. There were no mass walkouts among staff; there was no general withdrawal of support; the sector was able to generate, from within, remarkable resilience and this was evident in its agility in many ways including flexing resources and capacity. This reflects the dedication of local government colleagues and those in the wider ASC sector.
- ***Workforce*** – While it may have taken time, the value, profile, and recognition, of the care workforce came to the fore. While this is not fully sustained it has not been lost but continues and is to some extent 'banked' in the national consciousness. To the extent that this is so, there is a more solid platform from which to work towards a much-needed better deal for the care workforce.
- ***The ASC sector*** – The same point can be made for ASC. While time will tell whether new developments deliver the needed change (such as a Fair Pay Agreement for care workers, or the independent commission on the future of ASC), the sector does find itself more clearly and regularly on the radar of government and politicians.
- ***Vaccination*** – Some progress on the long path to parity of esteem with the NHS was evident in the treatment of the critical issue of vaccination, where eventually

there was prioritisation of some recipients of social care and the frontline care workforce. There remains though a way to go to achieve an entrenched policy of parity of esteem.

Lessons learned

96. As a sector that strives for continual improvement in the interests of local people, the LGA readily acknowledges some outcomes might have been better if more and better planning had occurred.

97. This might have meant, for instance:

- Having effective plans to support unpaid carers and self-funders;
- having appropriate plans and policies to test people before hospital discharge;
- ensuring everyone had enough PPE;
- ensuring people could visit loved ones safely;

and

- making sure people were not left isolated and lonely.

98. With no knowing when it might be, it is critical that the Government commences immediate work to plan for the next pandemic or similar stress event. This must be driven by the evidence and testimony of lived experienced, about which the Inquiry will learn in this Module, including the testimony of people drawing on care and their family/friends, care workers, volunteers, councils, and wider ASC sector partners.

99. While much of the work to plan for a future event necessarily sits at the national level, Government's many partners also need to reflect on what they could or should do differently to optimise their contribution.

100. The LGA too has begun reflecting on its own processes and procedures during the pandemic and while there is much in our response that we are proud of, it is recognised that there is always room for improvement. Bearing in mind the invaluable findings from councils through the M6 Survey, the LGA is alert to the need to strengthen how it should draw on the experiences of councils in real time to inform both its work and the development of national policies and actions.

Recommendations

101. With all these points in mind, I make full recommendations at the end of this statement on behalf of councils and the LGA. In doing so, I have kept two key things well in mind:

- How ASC can be optimised to make its best contribution in responding to the next pandemic;

  and

- the wider progress that is needed to strengthen ASC for the future more generally.

102. It should be obvious that these two points are closely inter-related. The LGA has identified four key challenges that beset ASC prior to the pandemic, and which shaped or explain the sector's effectiveness during it. Addressing these challenges now and in the future requires wider work on how to secure the best provision of ASC.

103. If progress can be made on this front .through a sufficiently ambitious and deliverable reform plan that is coproduced with people working in and drawing on care and support, then the country will have part of the solution for ensuring that ASC sector plays its best role in a future pandemic.

104. The other part of the solution requires action on important specific matters that came to light during the pandemic. The following table sets out the LGA's recommendations to Government for action and seeks to do so in a way which illustrates the analysis of cause and effect that runs throughout this entire witness statement.

105. A key feature of the response from the sector to the Covid-19 pandemic was how it combined working at a local, regional and national level. Consequently, in considering how to implement any recommendations, the Government – with the sector – will need to give careful thought to these local and regional levels, as well as the national level.

106. The LGA's detailed recommendations are brought together in Appendix 5 – Detailed recommendations

Part 2 - The LGA's role, function and objectives in relation to ASC

The role functions, structure and membership of the LGA

107. The LGA was set up in 1997 as an unincorporated Association. In 2018, the LGA moved to a new structure as an unlimited company. Once all member councils had joined the new company, the former unincorporated Association was dissolved. Membership is voluntary and councils make their own decisions on whether to join.

108. The full membership of the LGA in England and Wales now comprises:

- All but two of the 333 principal councils in England (i.e., all but London Borough of Bromley and Leicestershire County Council),

  and

- All the 22 principal Welsh councils through a corporate membership scheme with the Welsh Local Government Association ("**WLGA**"), an independent organisation with its own business plan, priorities and governance structure.

109. The LGA also has Fire and Rescue Authorities, Fire, Police and Crime Commissioners, and National Parks Authorities, as associate members. Further the National Association of Local Councils ("**NALC**"), which is the membership body for town and parish councils, is a corporate member of the LGA.

110. The LGA is funded through a combination of membership subscriptions, central government grants and contracts, and commercial income including income from a programme of conferences and events.

111. It is a politically-led but cross-party organisation, with the overall purpose to promote, improve and support local government. It provides a strong, credible voice for local government with national government. In respect of ASC, it engages with other bodies such as ADASS, the Care Quality Commission ("**CQC**"), Skills for Care ("**SfC**"), the Social Care Institute for Excellence ("**SCIE**"), Think Local Act Personal ("**TLAP**"), SCF, the Care and Support Alliance ("**CSA**"), the Care Provider Alliance ("**CPA**"), the King's Fund, the Health Foundation, and the Nuffield Trust, as well as central Government departments.

112. Its Board of Directors is elected annually by the General Assembly, comprising representatives of all authorities in full membership of the LGA, and meets every six weeks.

113. The LGA's activities relating to council service areas and their statutory duties and related policy issues, such as ASC, public health or emergency planning, can be broadly stated as follows:

- Acting as the national voice of local government, working with councils to promote and improve their activities.

- Providing the views of the LGA's members to Government on national policies, guidance, legislation, or regulations.

- Acting as an interface between central and local government sharing information where this is necessary (for example, in relation to a specific issue or challenge).

- Developing guidance and other support materials (e.g., training programmes) for the LGA's members, including sharing good practice.

- Issuing media and other communications to provide information about the work of the LGA's members and to defend the reputation of local government.

- Working with numerous public, voluntary and private partners to influence their thinking and deliver shared activity, such as reports, conferences, submissions, media stories, and meetings.

114. A key function of the LGA has always been to act as a conduit between central and local government, providing and distilling information from councils into government and vice versa. This role assumed even greater importance during the Covid-19 pandemic.

Groups, sub-committees and policy boards relevant to ASC

115. The LGA's boards, committees and task and finish groups, lead the organisation's work to promote, improve and support local government. The LGA is an unlimited company and the LGA Board is its Board of Directors. The LGA Board sets the strategic direction of the LGA in consultation with the Executive Advisory Board and agrees the annual budget and business plan. The eight policy boards as well as the Improvement and Innovation Board develop the LGA's policy lines and steer and oversee its activity in their respective areas in line with the LGA priorities.

116. Relevant to this Module is the Community Wellbeing Board (described further below), which has responsibility for work directly related to adult social care and will therefore have been involved in direction setting across the breadth of the LGA's response to the pandemic.

The Community Wellbeing Board

117. The purpose of the Community Wellbeing Board is to work to support local government in delivery of its public health, health protection and mental health responsibilities, as well as issues relating to an ageing society and the reform and funding of adult social care. The board's membership is comprised of a politically-balanced group of councillors from member authorities and meets five times per board cycle (LGA Community Wellbeing Board terms of reference dated 8 October 2024, **Exhibit JK4/017 – INQ000581236**). As the policy board responsible for health and adult social care, during the pandemic members of the board regularly considered and provided views on issues relating to care home resilience, funding, testing and PPE in the context of matters relating to this Module of the Inquiry (Agenda and reports pack for Community Wellbeing Board online meeting on 9 June 2020, **Exhibit JK4/018 – INQ000581323**). The Chair of the Board at the time also fronted much of the LGA's media work.

The LGA's Board

118. The purpose of the LGA Board is primarily to set the strategic direction of the Association in consultation with the Executive Advisory Board; direct the activities and business of the Association and ensures its proper management; the management of internal resources; and agrees the annual budget and business plan among other activities listed in the Terms of Reference. The LGA Board directs the LGA's activities, business and strategic priorities. The Board is politically-balanced and is made up of the chair vice and deputy chairs, who are elected annually by the General Assembly.

The Executive Advisory Board

119. The Executive Advisory Board contributes to the development of LGA policy, representing the views of local government; supports the LGA Board to set the strategic direction of the LGA; and holds the Policy Boards to account. The Executive Advisory Board is politically balanced and is made up of voting members, the Office Holders of the Association, the Chairs of the Policy Boards, one representative of each of the regional groupings and of the Welsh LGA; and additional members to maintain political balance.

The Councillors' Forum

120. The purpose of the LGA Councillors' Forum is to provide an effective means of holding the LGA to account by receiving reports from the LGA Board Chairs, providing views and challenge, and discussing topical cross-cutting issues impacting on local government to ensure effective connections are being made across boards. The Councillors' Forum has a core membership of 100 members and is politically-balanced. The group convenes five times per year.

The Care and Health Improvement Programme (CHIP)

121. As I have already noted in Part 1 the CHIP (later called the Partners in Care and Health programme ("**PCH**")) was a structure of relevance to this Module.

122. This structure is the sector-led improvement programme for ASC and public health mostly funded by the DHSC and the NHS. The Programme is jointly-led and delivered between the LGA and ADASS.

The relationship between the LGA and other national Local Government associations

123. In contrast to WLGA, neither the Convention of Scottish Local Authorities ("**COSLA")**) nor the Northern Ireland Local Government Association ("**NILGA**") are members of the LGA. They are independent membership bodies representing the interest of local government in Scotland and Northern Ireland, respectively.

124. Sometimes the LGA will undertake joint work with WLGA, COSLA and NILGA, particularly looking at issues such as the overall financial needs of local government and workforce planning. There is no joint formal work programme on emergency planning between the LGA and WLGA, COSLA and NILGA. The LGA meet with WLGA, COSLA and NILGA through the UK Forum – which is an informal tradition of meetings including chairs and group leaders from each association.

125. WLGA is a member of the LGA, with all Welsh councils having LGA membership through this single national subscription fee. Our formal relationship with Wales is through the WLGA and not through individual councils. WLGA also pays a separate fee for LGA workforce services to support national pay negotiations. Through WLGA membership of the LGA, Welsh councils are included in the calculations for LGA political balance.

126. Welsh councillors have places on LGA Boards and, through these Boards, participate in the LGA's policy making and lobbying. There is policy support from the LGA for WLGA

lobbying priorities and we provide an annual policy directory to ensure that the WLGA is aware of all the LGA's work and where we can help them influence Whitehall.

127. COSLA shares a positive relationship with the LGA, though unlike the WLGA, are no formal links such as shared membership. The LGA and COSLA have worked together on many joint-lobbying programmes including finance, Brexit and civility in public life.

128. The LGA has had minimal engagement with NILGA relevant to the scope of this module.

129. The LGA is a member of the Council of European Municipalities and Regions ("**CEMR**") which brings together over 60+ local government associations across 45 European countries, representing approximately 200,000 local councils. CEMR provides a wide network for mutual learning and comparative data, partnerships and collaboration, policy exchange and development, and lobbying of European organisations on behalf of the sector. This engagement was not particularly significant during the pandemic.

Overview of changes introduced in response to the pandemic

130. From the middle of March 2020, as the country edged towards full-lockdown, there were significant changes in the work the LGA undertook, with resources redeployed accordingly. There were two major drivers for these changes:

- *Firstly*, as existing services had to adapt to lockdown and social distancing, and new services (for example, protecting those clinically extremely vulnerable) had to be developed, a huge number of policy issues and service challenges emerged for local government, which, in both cases, had to be resolved at considerable pace;

and

- *Secondly*, for a short period, much of the LGA's in-person improvement offer (such as corporate peer reviews) was paused. As councils were unable to dedicate the capacity to it, the LGA's improvement support was refocused, and new virtual offers were developed. It will not be surprising to the Inquiry, that, for a period, virtually all of the LGA's policy work related to the impact of Covid-19on council services and councils. Much concerned the issues to be discussed in this Module, but by no means all. There were extensive discussions between LGA officers and Government leads on other Covid-19 issues outside the concern of this Module, which also took a great deal of time and capacity to manage.

New structures

131. While many of the emerging policy issues were picked up by existing policy leads, the extent of the new work, and the unprecedented level of queries from the LGA's members (and national and trade media), meant that the LGA had to set up new structures for managing these.

132. On 19 March 2020, the LGA's senior management team ("**SMT"**) agreed to establish an LGA Covid-19 programme. The programme reflected a need to ensure that the LGA's usual objectives to promote, support and improve local government had a targeted focus on Covid-19 related activity, and was intended to;

- Provide support to councils both, to meet the challenges of Covid-19 while also maintaining business as usual(to the extent that this was possible and/or appropriate), and to plan for the medium term considering the impacts of Covid-19.
- Lead and coordinate councils' liaison with Government and represent the interests of the sector,

  and

- More generally, support councils to support their communities, businesses and the wider country.

The Programme Management Office

133. A Programme Management Office ("**PMO**") was established to support the achievement of these objectives, comprising administrative support and three senior staff working on a part-time basis, reporting directly into the LGA's SMT. Several workstreams were established and within scope of the PMO, these were resourced by staff either performing in their usual roles or being redeployed from other areas. These included –

- financial costs and income losses for councils,
- public health,
- adult social care, Personal Protective Equipment (PPE) and testing,
- community hubs, shielding, vulnerable people and convening the voluntary sector,
- livelihoods,

- children's services,
- deaths management,
- council governance and decision making,
- councils' and contractors' workforce, and
- councils' supply chain, logistics, digital.

134. Other policy areas, such as regulation and enforcement activity, and domestic abuse, were managed through usual policy leads under a watching brief from the PMO.

The Coronavirus case management system

135. Alongside this, the LGA established a coronavirus enquiries email and case management system. This enabled it to capture and process the large number of enquiries and issues being received by the LGA and ensuring a timely response. It also enabled the LGA to use the information collected in this way to analyse the main issues being raised to aid the development of "frequently asked questions" and thus keep the LGA's members up to date.

136. Some idea of the scale of this work can be understood from the fact that between 17 March and 3 June 2020, the LGA received a total of 2,350 emails from councils, resulting in 1,883 cases. The most significant issues raised were as follows (see LGA/ML/M2, **INQ000215538**, at paragraph [62]):

- Around a third of these emails sought guidance from Government or more information/clarity;
- 15% concerned local government finance/benefits;
- a further 15% concerned adult social care;
- 13% concerned the local economy/businesses;
- 11% were about the council workforce and councillors

and

- 10% raised housing/homelessness/planning.

Other topics raised in emails amounted to less than 10% each.

137. The Covid-19 programme, and associated structures, ran as the LGA's response continued at scale until early June 2020, after which the programme and resourcing began to be scaled back into "business as usual" activity.

138. Although the organisation created new internal officer structures for managing the response to Covid-19, at the political level the LGA continued to operate through the normal governance structures so that its members were able to understand and direct the organisation's work on Covid-19. However, between March-June 2020, in recognition of the unprecedented circumstances and their impact on councils, the frequency of the LGA Board meetings increased from six-weekly to three-weekly. Group Leaders also met informally on a more frequent basis.

Part 3 - Pre-pandemic structure and capacity of the ASC sector

The structure, funding and operation, of Local Government in the ASC sector

Overview of the roles and responsibilities of Local Authorities under the Care Act 2014

139. The 2014 Act identifies a class of councils with adult social services responsibilities ("**CASSRs**"). In England there are 153 CASSRs, made up of county and unitary authorities, metropolitan boroughs, London Borough Councils, the City of London, and the Council of the Isles of Scilly.

140. This is not though a full picture of the role of local government in relation to the ASC sector, because in two tier areas, district councils play a crucial role in delivering services which support people's wellbeing such as housing. That said the vast majority of the LGA's work, relevant to this Module, was concerned with the functions of the upper tier councils.

141. The 2014 Act replaced a patchwork of legislation since the National Assistance Act 1948 and sets out duties, functions, roles and responsibilities pertaining to local government in the ASC sector.

142. Part one of the Act sets out those ASC functions that are fully devolved to councils. Section 1 of the Act defines the primary responsibility of councils as the promotion of individual people's wellbeing. '*Wellbeing'* is drawn in deliberately broad terms, encompassing – personal dignity; physical, mental and emotional wellbeing; protection from abuse and neglect; control by the individual over day-to-day life; participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal relationships; suitability of living accommodation; and the individual's contribution to society.

143. Sections 2-7 of the Act set out other broad duties on councils, including, to:

- Prevent or delay the onset of care and support needs,
- carry out functions with the aim of integrating services with those provided by the NHS (or other health-related services),
- provide information and advice for the public, including how to access independent financial advice,

- promote diversity and quality in the market of care and support providers, and

- cooperate with other organisations which have functions relevant to care and support.

144. Councils are required under the 2014 Act to cooperate and share certain functions with other organisations. The legislation and its accompanying statutory guidance both specify and enable councils to work with, or delegate to, others.

145. Importantly for this Module, section 6 of the 2014 Act requires that councils carry out their responsibilities with the aim of promoting greater integration with the NHS, and that councils and their partners must cooperate in performing their functions related to care and support. The 2014 Act also requires councils to cooperate with partners internally and externally:

- *Internally*, councils must cooperate with officers responsible for council duties on housing, children's services and public health,

  and

- *externally*, the Act lists 'relevant partners' as district councils, local NHS bodies, local offices of the Department of Work and Pensions, and the police, prison and probation services in the local area.

146. The Act at sections 6(2) and (3) also gives examples of

> *"… other persons or bodies with whom a local authority should cooperate if it considers this appropriate when exercising care and support functions."*

147. Section 7 of the 2014 Act builds on section 6, creating a duty that can be used by Local Authorities or partners where cooperation is needed in the case of an individual who has needs for care and support. Such a request can only be refused if cooperation would be incompatible with the organisation's own functions or duties.

148. The 2014 Act is supported by "*Care and support statutory guidance*" published by the DHSC. In its most recent version published on 27 September 2024, this Guidance states the broad principle of integration at [15.3], saying that councils -

> *"…must carry out their care and support responsibilities with the aim of joining-up the services provided or other actions taken with those*

provided by the NHS and other health-related services (for example, housing or leisure services)".

149. This requirement applies to all areas of a council's ASC functions (including prevention, information and advice, shaping and facilitating the provider market, safeguarding, cross-border placements and transitions from children to adult services), where the council believes that doing so promotes the wellbeing of adults with care and support needs, contributes to the prevention or delay of people's needs, or improves the quality of care and support in an area.

150. Cooperation and integration can take many forms. At the strategic level, local joint strategic needs assessments (which consider the needs of the wider local population) will often bring partners together, and councils can share population level data with partners. Similarly, strategic approaches to commissioning are a common focus of health and wellbeing boards, which bring councils and their relevant local partners together to plan activity. More practically, pooled budgets, integrated information and advice, or sharing staff or services with partners are ways in which councils fulfil their integration and cooperation responsibilities.

151. Section 79 of the 2014 Act enables councils to delegate many of their care and support functions under Part 1 of the Act, such as assessments, care planning, and information and advice, so long as those who have been delegated to comply with all requirements and duties under the Act and regulations. Furthermore, councils retain ultimate responsibility for how its functions are carried out.

152. However certain functions are explicitly not allowed to be delegated, such as integration and cooperation, safeguarding and charging (see sections 79(1)(a) and (2) of the 2014 Act).

153. Examples of delegation include, for instance;

- Delegating responsibility for deferred payment agreements to another body, potentially allowing several councils to combine collective resources to offer a regionally-based solution,

  and

- contracting with a user-led organisation to carry out specialist needs assessments and/or care and support planning for people with complex learning disabilities.

154. The LGA plays no formal or codified oversight role in how functions are integrated, cooperated on, shared or delegated, though of course it closely observes councils' approaches to ASC, and acts to support and to help improve such work, including by facilitating the sharing of good practice.

155. Sections 8 to 36 of the 2014 Act are arranged to address the stages of an individual's journey through the care system. They cover everything from the assessment of a person's needs and determining whether those needs are 'eligible', all the way through to developing and reviewing a person's care and support plan.

156. The remaining sections of Part One of the legislation, sections 37-80, cover system issues, such as continuity of care, determining ordinary residence, safeguarding, provider failure and market oversight, and transitions between children's and adult services.

157. The LGA has produced an overview of the 2014 Act (LGA paper, June 2014, "Get in on the Act: The Care Act 2014", **Exhibit JK4/019 - INQ000598604** This provides a summary of all the main features of the legislation. This should be read with the National Audit Office ("**NAO**") report "Adult Social Care at a Glance" (dated July 2018, **Exhibit JK4/020 - INQ000514872**) and the King's Fund report "Adult Social Care: Key facts and figures about adult social care" (dated 1 July 2024, **Exhibit JK4/003 - INQ000581203**).

158. While the legislation was heralded as significant when it was passed, and its ambition and intent were widely supported by people and organisations across the sector, there is a view, which the LGA and others hold, that the ambition and intent has not been fully delivered (LGA report dated 14 May 2024 "The Care Act 2014: Ten years on from Royal Assent", **Exhibit JK4/021 - INQ000581360**). That remains the case today, although as set out in the report cited in the previous paragraph, there are multiple causes of this which can be traced back to the overarching challenges facing the sector, which I have already noted.

159. While the Care Act 2014 is the main legislation governing ASC in England, other legislation has important points of crossover. For instance:

- *The Health and Care Act 2022* provides the legal basis for promoting greater integration between health and ASC services. The Act is also the origin of CQC responsibilities to inspect/assess adult social care (often referred to as 'ASC assurance').

- *The Mental Health Act 1983* is the main legislation covering the assessment,

treatment and rights of people with mental health problems. The Mental Health Bill, which had its first reading in the House of Lords in November 2024, makes provision to amend the 1983 Act.

- *The Mental Capacity Act 2005* is the main law in England and Wales about adults who lack capacity to make some or all their own decisions and how those decisions can be made instead. 'Deprivation of liberty' is an important aspect of the legislation and provides safeguards so that people who lack the capacity to make decisions about their care are not deprived of their liberty without legal authorisation.

- *The Children and Families Act 2014* is also important in respect of the key issue of 'transitions' between children and adult services.

160. It is also worth noting here the important role played by DPHs, both in normal times and during the pandemic. These senior officers played a critical role in responding to the pandemic. Their expertise in population health and knowledge of infectious disease control were vital in addressing the immediate impact of Covid-19 on the health of their local populations as well as ongoing economic impacts.

161. DPHs are important members of LRFs, which are aligned to the boundaries of 42 police areas across England and Wales. These forums are partnerships of representatives from several statutory services, including NHS, local authority and emergency services. Local resilience forums plan and prepare for a range of civil emergency situations, including flooding, terrorism and infectious disease outbreaks.

162. As important members of LRFs, DPHs played a particularly striking role in supporting local communities over the course of the pandemic. Community engagement was a major priority and focal point in directors' work – particularly in how they were able to support local people in managing outbreaks and in taking up the vaccine.

163. As part of their statutory responsibilities, public health teams supported care homes with access to PPE and advice on safety for staff, residents and visitors. DPHs, public health teams and infection control leads provided advice to care homes to help them undertake risk assessments (Association of Directors of Public Health report "Covid-19 Members Survey Report, March 2023", **Exhibit JK4/022 - INQ000180773**).

Funding

164. In general, local government funding is complex, coming from a mix of central Government grants, local taxes, specific grants for services, and charges for certain

services. The funding of ASC is even more complicated, and in the LGA's view this may be at least one reason for a deficit in a full understanding of ASC both by the public and Government. I have discussed funding issues, in the LGA's response to question 24, but will make a few further preliminary comments here.

165. For some time prior to the pandemic, and continuing thereafter, the Government has explained local government spending by referring to what they call 'core spending power'. This is the maximum amount of money that Local Authorities can spend after considering total income, including income from people paying for services. Core spending power therefore includes council tax revenue, business rates revenue, revenue support grant, and other specific grants.

166. In the financial year in which the pandemic commenced (FY 2019/20), total core spending of Local Authorities in England was £45.4 billion (Ministry of Housing, Communities and Local Government ("**MHCLG**") analysis dated 18 December 2024 "Core Spending Power table: provisional local government finance settlement 2025 to 2026", **Exhibit JK4/023 - INQ000581235**). This figure includes not only authorities responsible for social care but also other councils such as district councils, fire authorities, the Greater London Authority, and the Greater Manchester Combined Authority, so the spending of authorities responsible for ASC will be less than that figure.

167. In FY 2019/20, the Government calculated that Local Authorities could raise £27.8 billion from council tax. This meant that it expected that significantly more than half of council funding would be locally-set and collected council taxes (61%). The remaining 39% of funding was to come from business rates (which are pooled and distributed to councils according to a national formula), general grants from central Government and specific grants for individual services. The specific grants included £2.1 billion to be spent specifically for ASC, and a further £0.4 billion for social care which could be spent on either adult, or children's, social care, at the discretion of each relevant council.

168. Within the council tax figure, some of the income would have come from the ASC precept which had to be used to fund ASC. The LGA therefore estimates that the total possible amount raised from the precept in 2019/20 was £1.8 billion.

169. There were then and still are limits on how much councils could increase the council tax including the ASC precept.

170. Of the total maximum spending of £45.4 billion, councils spent £16.7 billion on ASC in 2019/20 (after client contributions and other income including specific grants) (NHS

England Digital publication dated 10 December 2020 "Adult Social Care Activity and Finance Report, England - 2019-20", **Exhibit JK4/024 - INQ000502376**; and **Exhibit JK4/023 - INQ000581235**).

171. Taking all these points together it is important to note that the provision of ASC was funded predominantly by local taxation (the council tax) and not by central Government funding. That remains the position to date.

172. It is also important to note that, when talking about ASC funding, 'self-funders' make up a considerable proportion of people accessing support. This has historically been a very difficult group to quantify, but in 2023 the ONS estimated that 23.5% of people accessing domiciliary care were self-funders in the period March 2022 to February 2023 (ONS statistical bulletin dated 26 July 2023 "Estimating the size of the self-funding population in the community, England: 2022 to 2023", **Exhibit JK4/025 - INQ000581251**). Similar ONS data on care homes shows that 37% of residents (137,480 people) were classified as self-funders in the same period (ONS article dated 6 July 2023 "Care homes and estimating the self-funding population, England: 2022 to 2023", **Exhibit JK4/026 - INQ000581218**).

Changes to the structure and capacity of the ASC Sector in response to the pandemic

173. Legislation introduced during the pandemic changed some aspects of the ASC sector and councils' related roles and responsibilities. The Coronavirus Act 2020 ("**the 2020 Act**") received Royal Assent on 25 March 2020 and had three broad aims, to:

- Give powers to Government to slow the spread of the virus;
- reduce resourcing and administrative burdens on public bodies;

  and

- limit the impact of potential staffing shortages on public services delivery.

174. Section 15 of, and schedule 12 to, the 2020 Act introduced "Care Act easements", aimed at supporting councils in their prioritisation of people with care and support needs while, in parallel, protecting the capacity of care services. For a more detailed explanation of the introduction and operation of Care Act easements see Part 14 - Care Act Easements

A high-level overview of Local Government engagement between local and central Government in the ASC Sector

Introduction

175. Local government officers deal with operational ASC issues on a regular basis at the local level. The LGA emphasises therefore that, while it was of course the role of central Government to consider the overall policy concerning the delivery of ASC, it could not do that properly, without considering the operational experience and understanding to be found within local government.

176. Because of its the national membership, the LGA has long-provided the bridge from local to central Government and played a well-regarded, non-partisan role in:

- advising and influencing Government,
- helping to shape national policy,

and

- at the same time, helping councils to deliver the best services to their local communities.

177. That is not to say that there is no dialogue between councils and central Government. Councils can and do engage with the Government on ASC issues specific to their local authority, such as:

- Formally raising concerns,
- clarifying a particular element of Government policy,
- highlighting best practice,
- requesting meetings,

or

- inviting Government to a council visit to see innovation and best practice in person.

178. Such contact may go through ministers or senior officials and may be in the name of the council leader, chief executive, DASS, or lead/cabinet member for ASC.

179. Senior council officers are also often invited to become part of Whitehall departmental

advisory groups. In 2023 for example, the DHSC convened an 'Adult social care capacity: expert group', with the purpose of bring different parts of the sector together to advise on how best to grow capacity, with a particular focus on winter preparedness. Council chief executives and DASSs were part of this group.

180. At an informal level, councils may join together on an *ad hoc* basis to make representations to Government. This may take the form of neighbouring councils writing to Government on an issue of shared interest, or councils coming together at regional level for the same purpose. Supporting ethical international recruitment is a good example. Each region has established a regional hub and CHIP hosts a monthly network to bring regional international recruitment leads together. They collectively or regionally interact with DHSC to inform international recruitment policy and strategy implementation.

181. At a formal level, there are also several local government-related membership bodies or associations that advance the interests of local government as a whole, or ASC in particular. These include, for instance:

- The County Councils Network,
- The District Councils Network,
- The London Councils,
- The Special Interest Group of Municipal Authorities ("**Sigoma**"),

and

- ADASS, which has a regional as well as national presence.

182. The LGA works closely with all such groups on matters concerning ASC, particularly ADASS.

Engagement between the LGA and UK Government

183. The LGA engages frequently with Government on ASC matters. At the political level, there is a long history of senior LGA members meeting with relevant secretaries of state and ministers and attending sector-wide Government roundtables and other high-level meetings. Senior Government figures also attend LGA meetings (such as the Community Wellbeing Board and Councillors' Forum) and speak at prominent national events, including one-day conferences focused on a particular topic and annual residential

conferences such as the LGA Annual Conference and the annual National Children and Adult Services Conference.

184. The LGA's Political Group Offices also play a key role in developing and maintaining political relationships, acting as a political interface between national parliamentarians and members of the Government and the LGA as a cross-party organisation. LGA officers further the relationship-building through meetings with ministerial special advisers. All such engagement is an opportunity both for the LGA to represent the interests and concerns of councils across the country, and for senior Government figures to understand better the deliverability and impact of national policy. In this way, the LGA seeks to influence the direction of travel of national policy affecting councils, ensuring policy is workable and as achievable as possible with no or minimal negative impacts.

185. At officer level, the LGA's engagement on ASC with DHSC and MHCLG officials is extensive and regular. This can take many forms, for instance:

- Regular one-to-ones between the LGA's Chief Executive and departmental director generals;
- similar meetings at director level and below;
- involvement in various working groups established by civil servants;

and

- representation at wider groups created by officials, such as those related to the NHS where the voice of local government and ASC is critical to progress.

186. While member-ministerial engagement tends to focus on the politics of policy, officer-official engagement gets into the technical detail and mechanics of policy.

187. The LGA also plays a role in enabling Government to hear directly from senior local authority officers. This may be one-off or time-limited discussions, or ongoing meetings. For instance, the LGA co-chairs (alongside DHSC) the Local Government Sounding Board ("**LGSB**").

188. The LGSB is co-sponsored and co-chaired by the LGA and the DHSC and is an informal virtual forum for DHSC, NHSE, and other national agencies to take confidential soundings from 9 regional council chief executives. The board is also attended by other health and care organisations such as ADASS, the NHS Confederation, the CQC and

TLAP an organisation formed in 2011 by the UK Government to bring organisations and people together to make health and social care more personalised. When TLAP was established in March 2011, the initial focus was on the development of the Health and Care Bill which later became the Health and Care Act 2022, and the ASC reform agenda. The Sounding Board, which continues to meet, has a flexible remit, and agendas have covered social care, wellbeing and public health issues that impact on local government.

189. There is always a risk of siloed working within Government departments which can be to the detriment of progressing issues related to ASC given that some such issues require sign off from DHSC, MHCLG and the Treasury (and sometimes other Government departments). So, the work of the LGSB is particularly helpful in bringing officials from Government departments together.

190. A continuing discussion topic for the LGA in these contexts is the equal treatment of ASC compared to the NHS.

Government support and assistance

191. Governmental "support and assistance" includes:

- *Funding*: national Government funding and funding-related decisions are a key source of income for councils with ASC responsibilities. This includes grant funding direct to councils, pooled funding with the NHS through the Better Care Fund, and – since 2016 – the ASC precept, which is an additional local tax on top of council tax.

- *Commissioning and sponsoring*: Governments and their departments can commission or sponsor work that impacts the shape and nature of ASC. For instance, DHSC was the sponsoring department for the Law Commission's 2008 review of ASC, which laid the legal foundations for the Care Bill and then the 2014 Act. In 2010, the then Coalition Government created the Commission on Funding of Care and Support (known colloquially as the Dilnot Commission after its Chair, Sir Andrew Dilnot).

- *Legislating and regulation*: designing and delivering law, along with accompanying regulation and guidance, will by its very nature support and assist local government in respect of ASC by setting clear parameters. The 2014 Act is the obvious example and includes regulations related to eligibility criteria, the market, and charging. The legislation is supported through comprehensive statutory guidance. More recently,

the Health and Care Act 2022 provided the legal basis for CQC assessment of councils' performance against their Care Act duties.

- *Innovation and best practice*: alone, or through work with various national ASC sector partners, DHSC encourages innovation and seeks to scale it. For 2023/24 and 2024/25, for example, the previous Government made £42.6 million available through the 'Accelerating Reform Fund' so that councils could pursue innovative activity that was consistent with the then Government's main priorities for ASC.

192. Of most relevance to the LGA, DHSC provides funding for CHIP which helps councils to improve the way they deliver ASC and public health services, and helps Government understand the challenges faced by the sector. The programme is a trusted network for developing and sharing best practice, developing tools and techniques, providing support and building connections.

193. It is offered to councils without charge and broadly operates at three levels:

- *Universal* - available to all, such as self-assessment tools and learning events;
- *targeted* - working with individual or groups of councils, such as peer reviews and options appraisals;

and

- *intensive* - for councils facing immediate and substantial challenges, such as rapid improvement programming).

194. In 2019/20, the grant for CHIP (as was) was £10.6 million; the grant for PCH in 2024/25 is worth £14.7 million.

The state of the ASC Sector at the outbreak of the pandemic

195. There are various reports which together provide an indication of the state of ASC at the outbreak of the pandemic. The most significant are discussed under this cross-heading.

Skills for Care

196. SfC's 'State of the ASC sector and workforce' report is a trusted and comprehensive annual examination of the sector. Published in the Autumn of each year, it provides

detailed information on the make-up of the previous year's workforce and provider market. Its 2020 report, covering the period 2019/20, provides a wealth of information, including that (Skills for Care report (Leeds, 2020) "The state of the adult social care sector and workforce in England, 2020", **Exhibit JK4/027 - INQ000542979**) -

- An estimated 18,200 organisations, across an estimated 38,000 establishments, were involved in providing or organising ASC;
- fifty one per cent of establishments were providing residential services, with 49% providing non-residential services;
- sixty eight per cent of establishments were regulated by CQC. Over the period 2012/13 to 2019/20, the number of non-residential CQC-regulated establishments increased by 2,850 (or 38%), while the number of residential CQC-regulated establishments decreased by 2,150 (or 12%).

197. Non-regulated services should also be mentioned. These include, for instance, companionship and befriending services, and housekeeping. Such services can enhance a person's quality of life and, while 'non-regulation' does not necessarily equate to lower quality, they do operate without the level of oversight and accountability (and therefore adherence to standards) that underpins regulated activity. Crucially, non-regulated services also include services provided by personal assistants ("**PAs**") who are employed by an individual through a direct payment. Direct payments put people more firmly in control of their care and support by providing cash payments to meet identified and eligible needs, instead of services. SfC estimated that around 230,000 adults, older people and unpaid carers were receiving direct payments in 2019/20 with 31% of these people (70,000) directly employing their own staff.

198. I shall include some more relevant statistics:

- Seventy nine per cent of ASC jobs came under independent employers (1.3 million), 7% were council employed (113,200), 6% were NHS employed (102,000) and 8% were jobs linked to direct payment recipients (135,000).
- The care workforce comprised around 1.65 million jobs, with an estimated 1.52 million people working in ASC (compared to 1.3 million NHS workers).
- 7.3% of ASC roles were vacant, equivalent to 112,000 vacancies at any one time. This compared to an estimated vacancy rate of 2.7% for the wider UK

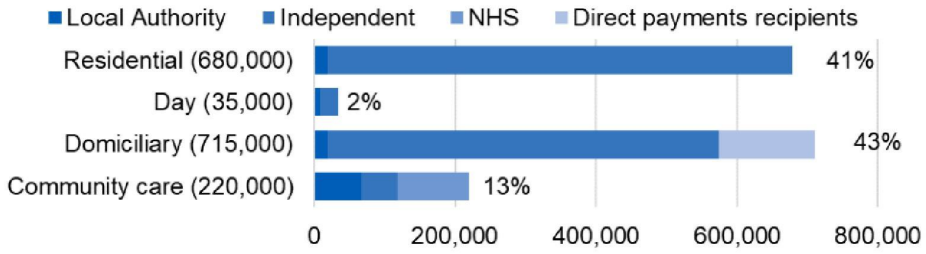
economy. Registered nurse was the role with the highest vacancy rate (12.3%), followed by care worker (8.2%).

- The staff turnover rate of directly employed staff was 30.4%, which equates to 430,000 people leaving their jobs over the 12-month period. This is obviously a concerningly high figure, although it should be noted that many leavers remain within the sector (66% of recruitment comes within ASC), meaning 34% of employees leave the sector. The role with the highest turnover rate was registered nurse (41.3%), followed by care worker (38.1%). Turnover rates by setting were similar between residential (32.1%) and domiciliary care (31%).

- Eighty two per cent of the workforce identified as female (compared to 47% of the economically active whole population) and 27% were aged 55+ (compared to 20% nationally). Twenty one per cent of workers identified as black, Asian, mixed or minority ethnic (compared to 14% nationally). Twelve per cent identified as black (compared to 3% nationally).

199. Chart 6 of the SfC report is particularly useful for illustrating that most of the provision is carried out by the independent sector (**Exhibit JK4/027 - INQ000542979**):

Chart 6. Adult social care workforce estimates by employing care service and type of employer, 2019/20
Source: Skills for Care estimates



The Care Quality Commission

200. The CQC produces an annual report on the state of health and ASC in England. Its 2020 report, covering the period 2019/20, showed that 80% of ASC services were rated as 'Good' and 5% as 'Outstanding' (CQC report dated 15 October 2020 "The state of health care and adult social care in England 2019/20", **Exhibit JK4/028 - INQ000235495** However, the CQC also noted there remained "a small minority of underperforming services that have continually failed to improve". Thus, there were 3% of care homes (512 homes accounting for just under 23,000 beds) that had never been rated better than

'Requires improvement', along with 3% of community social care providers (supporting more than 9,000 people) who had similarly not been rated better than 'Requires improvement'.

The King's Fund

201. The King's Fund's annual report 'Adult social care 360' uses dependable and publicly available data to analyse trends across key areas such as access, expenditure, and workforce and carers. Their 2020 report outlines the state of the sector pre-pandemic (King's Fund (May 2020) "Social care 360", **Exhibit JK4/029 - INQ000581355**).

202. Looking at the period 2015/16 to 2018/19, the report illustrates that while requests for support increased over the period (500,670 to 550,435 for 18-64 year olds; 1.31 million to 1.364 million for people aged 65+) fewer people overall received support (short-term support increased slightly for both 18-64 and 65+ year olds; long-term support increased for 18-64 year olds but decreased for those aged 65+). The reduction in long-term support for older people in this period could be explained by different factors (such as more preventative support, or more use of asset-based approaches to meeting needs), but it is impossible to rule out the idea that some people's needs were not being met, leading to unmet or under-met need.

203. The King's Fund report also usefully highlights how the cost to councils of buying care was increasing at the time (up 1.6% for 18-64 and up 3.4% for 65+ between 2015/16 and 2018/19), but for home care still remained below the recommended minimum price of the UK Homecare Association's ("**UKHCA**").

204. Looking at the period 2012-2019, the report further points out that the number of care home places was continuing to decline. Using the measure of places per 100 people aged 75+, nursing care places fell from 5.2 to 4.8 per 100 people, and residential places fell from 6.1 to 5, over the period.

ADASS

205. The annual budget survey carried out by ADASS provides a comprehensive and invaluable overview of the reality facing councils' ASC services each year. The findings of the June 2020 survey starkly illustrated the issues facing the sector as it entered the pandemic (ADASS report dated 11 June 2020 "Budget Survey 2020", **Exhibit JK4/030 - INQ000103773**). The Inquiry will be interested that it noted that:

- Cumulative savings within ASC since 2010, up to and including planned savings of

£608 million for 2020/21 (i.e. prior to the impact of the pandemic being fully known), totalled £8.3 billion;

and

- Only 4% of directors were 'fully confident' that their budget would be sufficient to meet their statutory duties (down from 35% in 2019/20).

206. In 2021, ADASS began collecting information through its annual survey of the number of people awaiting (i) a needs assessment, (ii) a care package or direct payment to begin, or (iii) a care plan review. This information is outside the scope of the question (the state of the sector at the *start* of the pandemic), but it is shared here to give a general sense of the delays people faced and, consequently, the scale of unmet and under-met need. Respectively, those figures in November 2021 stood at: 204,241 people; 25,468 people; and 166,136 people. For comparative purposes, the latest respective figures (March 2024) are: 227,375 people; 14,832 people; and 175,822 people (ADASS report (July 2024) "2024 Spring Survey", **Exhibit JK4/031 - INQ000581193**).

Laing & Buisson Market Reports

207. Laing & Buisson is an organisation that produces reports across the social care and health sectors and related areas (e.g. housing). The following information has been collated from these reports by the LGA concerning (Laing & Buisson report (34th ed.) "Care homes for older people: UK market report", **Exhibit JK4/032 - INQ000581292**):

- Bed capacity by type of provider / care type, and overall occupancy;
- bed capacity by type of provider / care type;
- bed occupancy in independent homes, split by source of funding;

and

- a comparison of number of older people living in care homes compared to housing with care units as follows:

		LA / NHS registered homes		NHS Long stay homes		Independent nursing care		Independent residential care		Total occupied beds		Total vacant beds	
	Total beds	Number	% of all beds	Number	% of all beds	Number	% of all beds	Number	% of all beds	Number	% of all beds	Number	% of all beds
Mar-20	466,580	18,516	3.97%	8,708	1.87%	246,532	52.84%	192,825	41.33%	396,066	84.89%	70,514	15.11%
Mar-21	465,902	18,188	3.90%	7,626	1.64%	247,744	53.18%	192,344	41.28%	358,333	76.91%	107,570	23.09%
Mar-22	466,705	17,822	3.82%	8,395	1.80%	248,423	53.23%	192,067	41.15%	373,956	80.13%	92,749	19.87%

Bed capacity by type of provider / care type, and overall occupancy.

	Independent nursing care						Independent res care					
	Total		For profit		Not for profit		Total		For profit		Not for profit	
	Number	% split	Number	% split	Number	% of all beds	Number	% of all beds	Number	% of all beds	Number	% of all beds
Mar-20	194,900	N/A	178,800	91.74%	16,100	8.26%	244,500	N/A	201,100	82.25%	43,400	17.75%
Mar-21	195,900	N/A	180,000	91.88%	15,900	8.12%	244,200	N/A	201,800	82.64%	42,400	17.36%
Mar-22	196,500	N/A	180,800	92.01%	15,700	7.99%	244,000	N/A	202,700	83.07%	41,300	16.93%

Bed capacity by type of provider / care type

	Private Pay						LA funded								
	Residential		Nursing		Residential with top-up		Residential no top-up		Nursing with top-up		Nursing no top-up		NHS Funded		
	Number	% split	Number	% split	Number	% of all beds	Number	% of all beds	Number	% of all beds	Number	% of all beds	Number	% of all beds	Total
Mar-20	83,000	24.63%	79,000	23.44%	30,000	8.90%	91000	27.00%	11000	3.26%	45000	13.35%	29000	8.61%	337000
Mar-21	76,000	21.71%	75,000	21.43%	27,000	7.71%	82000	23.43%	10000	2.86%	39000	11.14%	30000	8.57%	350000
Mar-22	80,000	22.04%	78,000	21.49%	28000	7.71%	84000	23.14%	10000	2.75%	40000	11.02%	30000	8.26%	363000

Bed occupancy in independent homes, split by source of funding

	Care Homes		Housing with care		
	Number	% split	Number	% split	Total
Mar-20	396,066	76.12%	124,252	23.88%	520318
Mar-21	358,333	73.61%	128,498	26.39%	486830
Mar-22	373,956	73.85%	132,429	26.15%	506385

Comparison of number of older people living in care homes compared to housing with care units

The LGA

208. In March 2020, the LGA published a short report restating the case for proper action on ASC funding and reform (LGA report (March 2020) "The lives we want to lead: Towards change, towards hope", **Exhibit JK4/033 - INQ000581309**). This followed a major LGA initiative in 2018 of publishing its own green paper on the future of care and support (in the continued absence of one from the then Government) and a follow-up report in 2019. The LGA's 2020 report set out some of the key realities facing the sector at the time, including:

209. Core Government funding to councils overall had fallen by around £15 billion, a near 60% real terms reduction, between 2010 and 2020 (page 6).

210. Adult social care faced an additional funding requirement of £2.6 billion for 2020/21 just to maintain 2019/20 levels of access and quality. This pressure comprised the cost associated with demography, inflation, the National Living Wage (£1.3 billion), and meeting the 'provider market gap' (a further £1.3 billion) – the difference between what providers said was the cost of providing care and what councils were paying (page 7).

211. The difference between the £2.6 billion additional cost pressures and the projected path of income, created a 2020/21 funding gap of £810 million for ASC (page 7).

212. The LGA's 2020 Spending Review submission also provides a clear overview of the pressures facing the sector and the asks we made of Government at the time (LGA submission dated 29 September 2020 on the Comprehensive Spending Review 2020, **Exhibit JK4/034 – INQ000581222**). These include:

- *Pre-pandemic*, the Institute for Fiscal Studies estimated that the aforementioned

'provider market gap' could reach as high as £1.7 billion due to demand and inflation pressures;

Care home provider concerns about their viability, shaped in large part by reductions in occupancy levels (81% in August 2020 compared to 92% in June 2019). Additional quoted research showed that it was smaller independent care homes (the 6,500 homes with 40 or fewer beds) most at risk because they typically do not have scale of larger providers to deal with reduced occupancy levels (Knight Frank research (2020) "Healthcare development opportunities", Exhibit **JK4/035 – INQ000581280**);

and

- Significant levels of unmet need, with Age UK estimating that 1.4 million older people were not receiving the help they needed. The LGA estimated that it would cost approximately £6 billion to address all unmet need across older people and working age adults (**Exhibit JK4/034 – INQ000581222**)

213. The LGA called for (**Exhibit JK4/034 – INQ000581222**) -

- Additional funding (continuing in future years) to shore up the sector ahead of winter 2020 and a likely second wave of Covid-19;
- funding for the medium-term to address long-standing pressures faced by the ASC sector which had been exacerbated by the pandemic;

and

- the use of the called-for funding as a 'down-payment' on reform for the longer-term.

The DHSC

214. The DHSC's 2021 'Evidence review for ASC reform' is another useful source of information on the make-up of the care sector (DHSC report dated 1 December 2021 "Evidence review for Adult Social Care Reform", **Exhibit JK4/036 – INQ000581253**). The review sets out two charts that are of particular interest -

- The first chart below (titled "Figure 2: Total public and private adult social care related spend in England, percentage and £bn, 2020/21") shows total public and private spend on ASC in England, demonstrating that most of the care is funded by

councils, alongside a significant amount of care funded by individual people (self-funders).

- The second chart (titled "Figure 3: People receiving adult social care by age group and setting, 2020/21") illustrates a similar point but looks at the numbers of people supported. This shows that councils fund all support for 18-64 year olds but that support for 65+ is funded by a combination of local government, self-funders, or the NHS.

Figure 2: Total public and private adult social care related spend in England, percentage and £bn, 2020/21[ivv]

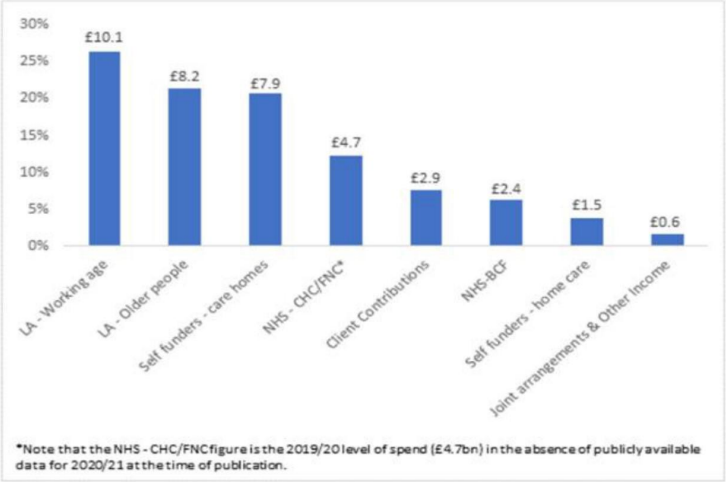
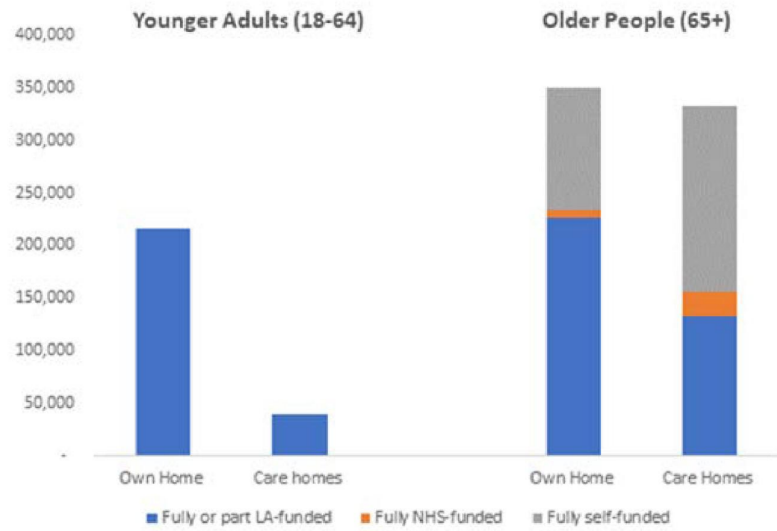


Figure 3: People receiving adult social care by age group and setting, 2020/21[xiii]



The LGA survey of Local Authorities for Module 6

215. Between 1 November and 29 November 2024, the LGA conducted an online survey of all its member authorities in England and Wales (Covid-19 Inquiry Survey for Module 6). The survey was undertaken following a specific Rule 9 request for this Module. A total of 337 authorities responded, giving a response rate of 100%. All the information set out above on the state of the ASC sector pre-pandemic is neatly reflected in the survey sub-section on, 'Findings for single tier and county councils: preparedness and capacity of the sector' (**Exhibit JK4/001- INQ000400522**).

216. There is much of note in this survey for the Inquiry. The LGA wishes to highlight that:

- Zero per cent of councils judged the preparedness of the care sector for a pandemic as 'Very good'. Fifty three per cent judged it 'Not very good' and 20% judged it 'Not good at all' (page 19);
- Only 4% of councils judged the capacity of the care sector as 'Very good'. 24% judged it 'Not very good' and 7% judged it 'Not good at all' (page 19);
- There was a net negative judgement (52%) on the ability of the sector to increase capacity, with 47% of councils judging that to be 'Not very good' and 5% judging it 'Not good at all' (page 19);
- 'Resilience' was perceived more favourably, with 6% of councils judging that to be 'Very good' and 70% judging it to be 'Fairly good' (page 19);
- Workforce recruitment difficulties (selected by 95% of councils), funding pressures (93%), rising demand (93%), workforce retention difficulties (91%), and pressure to take people discharged from hospital (82%) were, by some distance, the highest selected reasons for why capacity and/or resilience was not good leading up to the pandemic (insufficient mix of types of provision was next, selected by 47% of councils) (page 20).

Summary

217. These facts and figures show the extent to which the ASC sector was very challenged before the pandemic started at the beginning of 2020. There can be no doubt that these challenges were even more greater during the abnormal period of the pandemic. The LGA has no doubt that the root cause of many of the difficulties of the ASC sector during the pandemic described in this statement had their origins in the previous inattention to ASC needs over many years. This is discussed further under the next cross-heading.

LGA concerns for ASC sector pre-pandemic and action taken

Introduction

218. For the last 15-20 years, successive Governments of all colours have failed fully to grip the twin issues of ASC funding and reform. The LGA considers that the reasons for this failure can be seen in the four overarching challenges facing the sector that I have discussed in Part 1 - The pre-pandemic challenges to the national provision of Adult Social Care

219. Over many years, successive Governments had mostly offered inadequate and incremental solutions, rather than the sustainable investment that was necessary, pursuant to a workable long-term plan for how care should be organised, delivered and funded. The ASC sector has therefore not been able to look beyond a very short-term future and has often had to pursue a temporary holding approach until the next piecemeal fix. Accordingly, the LGA has been – both on its own and in collaboration with numerous partners – engaged permanently in raising concerns about ASC provision, promoting the true value of care and support, and lobbying for action.

The context over the last decade

220. Over the last decade, for instance:

- The LGA's February 2015 Budget submission led with ASC, calling for funding to better protect services and highlighting the views and concerns of key partners, such as Age UK and the CSA (**Exhibit JK4/037 – INQ000581298**).

- The LGA's 2017 'state of the nation' report on adult social care set out the pressures facing the ASC sector and their consequences, made the case for additional investment, shared personal stories of people accessing care and support, analysed delayed transfers of care, and provided cases studies of council projects aimed at reducing delayed transfers (LGA report (October 2017) "Adult social care funding: state of the nation 2017", **Exhibit JK4/038 – INQ000581167**).

- Between 2017 and 2018, the LGA produced a series of 'think pieces' on the future of adult social care. The publications examined specific questions at the heart of the debate about social care reform, such as 'Why does adult social care matter?', 'Is consensus achievable?' and 'How should we pay for social care in the long-term?' (LGA think pieces (undated), "Why does adult social care matter?" **Exhibit JK4/039**

– **INQ000581372;** "Is consensus achievable?" **Exhibit JK4/040 – INQ000581287;** "How should we pay for social care in the long term?", **Exhibit JK4/041 – INQ000581284**). Each publication provided an LGA perspective on the central question as well as essays from prominent and senior sector figures. Organisations represented included the Health Foundation, the Institute for Government, the Institute for Fiscal Studies, ADASS, Public Health England ("**PHE**"), Ipsos MORI (as it was then called, now IPSOS), NHS Confederation, and the CQC.

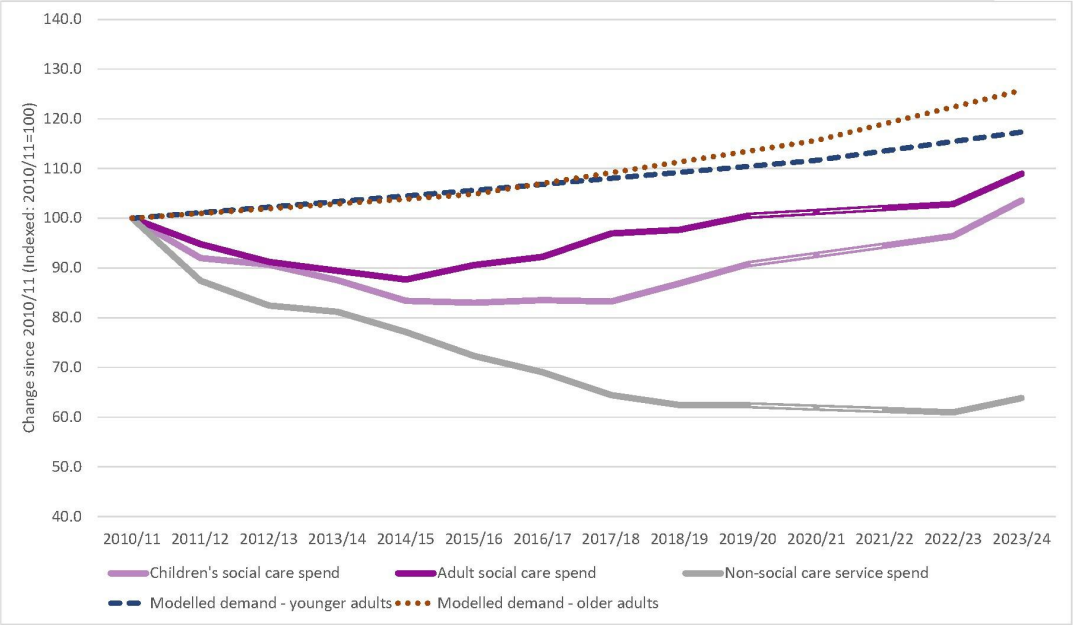
221. It really is correct to say that the historical funding pressures on ASC cannot be overstated. The LGA considers it important to understand what happened to modelled demand and real terms budgeted service spending from 2010/11.

222. In summary, and because of cuts to Government funding, ASC spending reduced by 12.3% during the first half of the 2010s. It was a broadly similar experience in children's social care (16.6% reduction in spending), but clearly different to non-social care services where budgeted spend reduced by 22.9% in real terms throughout the whole of the 2010s. This more severe spending reduction effectively cross-subsidised ASC. It impacted on non-social care services, of course, but also on ASC given those services – such as libraries, leisure, transport and green spaces – all contribute to people's wellbeing in the widest sense.

223. Councils protected social care budgets as best they could, in comparison to other services. However, the spending reduction in ASC in the first half of the decade was significant and not reversed in real terms until 2019/20 when spend broadly returned to 2010/11 levels. Crucially, while ASC spend reduced (2010/11 – 2014/15) and then slowly recovered to 2010/11 levels (2014/15 – 2019/20), there was constant and consistent growth in modelled demand for councils' ASC services (**Exhibit JK4/021 - INQ000581360**).

224. The upturn in ASC spend between 2014/15 and 2018/19 came partly through an increase in NHS transfers following the creation of the Better Care Fund, and the beginnings of a new regime of specific grants through the improved Better Care Fund towards the end of this period. But a crucial driver of the increase in spend was the increased use of locally-raised resources following the introduction of the ASC precept in 2016/17. This upturn in spend stopped further growth in the gap between spend and modelled demand but did little to address the historical gap that had opened in the first half of the decade (**Exhibit JK4/021 - INQ000581360**).

225. The chart set out below brings these points together in graphical form -



226. The historical funding pressures created a legacy of unwanted consequences as the sector headed into the pandemic, and it should be said that these are still playing out today.

The dialogue with Government

227. Prior to the pandemic, and over several years, the LGA had raised these regularly with Government, both publicly and privately, and proactively and reactively in response to others' work. The extent of influencing work, that the LGA undertook, is too long to list here incomplete detail. One way to understand this is to consider the LGA's Green Paper of 2018 written and published because of the continued delays to the then Government's green paper on the future of care and support (LGA report (July 2018) "The lives we want to lead: The LGA green paper for adult social care and wellbeing", **Exhibit JK4/42 – INQ000581209**).

228. This was a significant project which set out in detail the challenges facing the system, the case for change, and options for change. The paper posed 30 consultation questions on the future of care and the LGA received more than 500 responses to them from councils, care partners and members of the public. Alongside this material, the LGA commissioned public polling and public focus groups to build an even stronger evidence base for the case for investment and reform. The LGA's Green Paper received

considerable national media coverage, as did its follow-up report which analysed all consultation responses, drew them together through a set of conclusions, and made a series of recommendations for the future.

229. I can summarise the main problems that the LGA had raised – before the pandemic - as needing to be addressed, as follows:

- The existence of a fragile provider market in which, over time, providers have ceased trading or handed back council contracts to focus just on the self-funder market.
- Significant recruitment and retention challenges with the workforce owing to poor pay, low recognition, inadequate opportunities for progression, insufficient training and development, and the lack of equal or better pay for emotionally and physically demanding work.
- Unmet and under-met need with growing numbers of people unable to access the support needed to live a good life.
- Growing strain and demands on unpaid carers, with consequences for physical and mental health, personal finances, and the ability to maintain paid work.
- Inadequate investment in preventative activity due to limited funding needing to be prioritised on those people with highest levels of immediate need.

230. These issues continue to this day.

231. The LGA raised these concerns both publicly and privately through:

- Correspondence to senior members of the Government,
- submissions to Budgets, Spring/Autumn Statements and Spending Reviews,
- submissions to Parliamentary (and other) Inquiries,

  and

- private meetings with senior members of the Government and public events and conferences.

It continues to do so.

232. For several years, it has been national and local policy and preference to support people receiving care in their own home. It is a fact that only a small proportion, of the total of people receiving some level of support, live in a care home or nursing home, moreover the number of people moving into residential care has either fallen or been static for many years. However, many significant persons concerned with the provision of ASC (including politicians, civil servants and the media, and the public), have had an overly simplistic view of ASC that equates the service to 'older people in care homes'. This was the case both before the pandemic, during that time and now. This incorrect perception was particularly prominent during the pandemic and seen particularly in the significant focus on discharging people from hospital, and there is little doubt among the LGA's officers that this effected policy in this area.

233. This false perception is a barrier to effective policy making and the LGA has long-called on successive Governments to play their part in changing this perception of ASC and being much clearer about the breadth of ASC provision for adults of all ages with a range of different conditions.

Part 4 - Communication with Government and stakeholders

LGA engagement with Government and stakeholders

234. The LGA advised, collaborated and worked extensively with Government departments and partner organisations in various ways and on a range of issues, including ASC, throughout the period from 1 March 2020 to 28 June 2022. The information I set out below provides an overview. Further detail is in Appendix 2 – Timeline of LGA's engagement with organisations. I have also included at Appendix 3 – LGA Webinars and online events a comprehensive list of engagements, such as events and webinars, that the LGA hosted with councils.

235. In normal times, LGA engagement with partners is a key feature of the organisation's work and often leads to or supports sector-wide activity, such as reports or public statements. During the pandemic, and given its impact and emergency status, such engagement became even more important.

236. During the pandemic the LGA was involved in several working groups which engaged with the UK Government on the management of the pandemic. For the purposes of this question, these will be referred to here but see also Part 6 - The LGA's involvement in stakeholder or working groups on the management of the pandemic and Part 6 - Concerning the above groups, dates and summaries of key meetings, Government/relevant body response, adequacy of response. These working groups and stakeholder groups were convened and/or attended by the UK Government, as well as the other partner organisations that the LGA advised, collaborated and worked with during the pandemic.

237. The following table gives an overview of some of the main organisations the LGA worked with on key issues (see Appendix 1 – Acronyms and abbreviations for an explanation of the acronyms used in this table) -

	Govern-ment	Pro-viders	NHSE	PHE	ADASS	CQC	ADPH	Other
Hospital discharge	Yes	Yes	Yes	No	Yes	Limited	No	
IPC	Yes	Yes	Limited	Yes	Yes	Limited	Yes	
Testing	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
PPE	Yes	Yes	Limited	Yes	Yes	Limited	Limit	

	Govern-ment	Pro-viders	NHSE	PHE	ADASS	CQC	ADPH	Other
							ed	
Workforce	Yes	Yes	Limited	No	Yes	Yes	No	SfC
Funding	Yes	Yes	Yes	No	Yes	No	No	
Market resilience	Yes	Yes	Limited	No	Yes	Yes	No	
Vaccination	Yes	Yes	Yes	Yes	Yes	Yes	Yes	TLAP, ACAS
Data	Yes	Yes	Yes	Yes	Yes	Yes	No	
Indemnity	Yes	Yes	No	No	Yes	Yes	No	
Care Act easements	Yes	Limited	No	No	Yes	Yes	No	TLAP, Carers UK
Visiting	Yes	Yes	Limited	Yes	Yes	Yes	Yes	
Action Plan	Yes	No	No	No	Yes	No	No	

Department of Health and Social Care and Department of Housing Levelling – up and Communities

238. As outlined in Part 3 – A high-level overview of Local Government engagement between local and central Government in the ASC Sector the LGA engaged frequently with Government on ASC matters pre-pandemic. This increased further during the pandemic as LGA officers became involved in numerous working groups and recurrent stakeholder meetings. These were attended by civil servants and covered many of the topics in scope of Module 6. Engagement was not limited to meetings alone; LGA officers were in constant touch with civil servants by phone and email in both the DHSC and the Department for Levelling Up, Housing and Communities "**DLUHC**".

Ministerial meetings

239. At a Ministerial level, the Minister for Social Care chaired a regular meeting, around every 6 weeks, with representatives from the ASC sector including, for example, care providers, councils, national voluntary organisations, and the CQC. These meetings were established so that sector representatives could have a direct conversation with the Minister and for the Minister to test views on relevant topics. The Minister for Social Care also at times had informal meetings and phone calls with the LGA Director of Adult Social Care Improvement, ADASS President, ADASS Chief Officer. The LGA's then-Chairman, James Jamieson, would also regularly have meetings with the Minister for Social Care and

the Secretary of State for DLUHC.

240. These meetings were established so that the Minister could gain an evidence-based overview of developments. These occurred between April and June 2020 (for greater detail see Appendix 2 – Timeline of LGA's engagement with organisations).

Working groups/stakeholder groups

241. During the period in question for this Module, the LGA was a member of several task groups organised and/or attended by DHSC and DHLUC.

242. The National Steering Group Coronavirus was convened and attended by DLUHC and DHSC and the LGA. The LGA first attended the National Steering Group Coronavirus on 5 February and the group met 6 times, concluding on 11 March 2020 (see, for example, NSG Coronavirus meeting notes dated 4 March 2020, **Exhibit JK4/043 – INQ000524940**; NSG Coronavirus action log dated 4 March 2020, **Exhibit JK4/044 – INQ000114888**).

243. From early March 2020, the LGA was a core member of the newly created National Coronavirus Advisory Group ("**NCAG**"),[1] which came out of the pre-existing National Steering Group (Internal LGA email dated 4 March 2020 re an update on the ASC Sector and the NSG, **Exhibit JK4/045 – INQ000581232**). Co-chaired by Ros Roughton (Director for Social Care in the DHSC) and James Bullion (Vice-President and incoming President of ADASS), NCAG brought together representatives from the LGA, DHSC, the CPA, the CSA, TLAP, ADASS, the Association of Directors of Public Health ("**ADPH**"), PHE, DLUHC, NHSE, CQC and others (Email from DHSC to NCAG dated 10 March 2020 re newly created NCAG and upcoming meeting, **Exhibit JK4/046 – INQ000582548**; DHSC PowerPoint "Organisation of ASC Covid-19 work", **Exhibit JK4/047 – INQ000581317**; Terms of reference for the NCAG (March 2020), **Exhibit JK4/048 – INQ000114893**).

244. NCAG offered a vital forum to share information, expertise and advice to inform the response to Covid-19 across the twin dimensions of geography (national, regional and local) and stakeholders (national and local government, care providers, people with lived experience, and others). NCAG addressed a range of significant issues facing ASC including PPE, Care Act easements and the accompanying ethical framework for ASC, shielding, key workers, hospital discharge, safeguarding and human rights, and data capture (see, for example, NCAG (social care provider issues) meeting minutes dated 31

[1] Note: the NCAG was interchangeably referred to as the National Advisory Coronavirus Group and the NACG. I use NCAG throughout in this statement, but some documents exhibited may refer to NACG.

March 2020, **Exhibit JK4/049 – INQ000581183**).

245. Four task and finish groups were subsequently established and LGA officers were involved either directly (attending meetings) or indirectly (feeding into the groups outside of the meetings themselves):

- *Task & Finish Group Workforce*: this met twice a week from 19 March 2020 until 29 May 2020.
- *Task & Finish Group Testing*: this met weekly from 23 April 2020 and then fortnightly from 6 July 2020, until the end of September 2020.
- *Task & Finish Group Adult Social Care Personal Protective Equipment*: this met weekly from 7 April 2020 until 1 October 2020.
- *The National Covid-19 Social Care Provider Issues Group*: this met weekly (occasionally twice per week) from 23 March 2020 until the end of February 2022.

Data collection group

246. In March 2020, CHIP convened, and initially chaired, a group that looked at options for data collection from social care providers. The aim of this was to enhance Government's understanding of issues in frontline social care. Membership included representatives from ADASS, the LGA, the CQC, DHSC and providers.

247. By the start of May 2020, the group had recognised it had already moved beyond its original purpose of simply sharing general updates and agreed to embed a greater degree of formality and structure. The group agreed to focus primarily on the implementation of national data collection schemes but also agreed to look at the key issues emerging from the analysis of the data returns and how those could be addressed. At this point, CHIP handed over the chairing and convening of the group to the CQC because of the Commission's independent and neutral position relevant to other attendees, although CHIP continued to play an active role (Email from Isle of Wight Council to LGA dated 30 April 2020 re handover of chairing to CQC, **Exhibit JK4/050 – INQ000581190**).

The Social Care Sector Covid-19 Taskforce

248. As the pandemic progressed, its impact on people drawing on and working in social care became more apparent as the LGA, councils and ASC partners continued to highlight issues (explored in detail throughout this statement). A greater Governmental focus on ASC followed with, for instance, the April publication of the Government's Adult Social

Care Action Plan.

249. Government's ASC focus became sharper with the establishment of the Social Care Sector Covid-19 Support Taskforce, and the appointment of Sir David Pearson (a former President of ADASS and Chair of an Integrated Care Board) as its chair. ADASS were key participants alongside the LGA, CPA, CSA, ADPH, PHE, SAGE, DHSC, DLUHC and others. The Taskforce formally commenced on the 8 June 2020 and completed its work on 18 September 2020 with the publishing of its report on first phase of Covid-19 pandemic (DHSC report dated 18 September 2020 "Social Care Sector: Covid-19 Support Taskforce - Full recommendations", **Exhibit JK4/051 - INQ000472757**).

Advice on key plans

250. The LGA advised and collaborated with DHSC on several key plans. For instance, the LGA commented on drafts of the Social Care Action plan between 11-14 April 2020. On 11 April 2020 the LGA was given 3 hours to comment by DHSC on a full draft of the plan. There was then some follow up correspondence between 12-14 April on the section focused on discharge.

251. For the purposes of this statement, I have addressed the extent to which the LGA advised or collaborated on key plans and guidance under each topic, such as testing, vaccinations, discharge from hospital, funding, etc. This sits within the context in which the LGA raised and/or responded to concerns held by local authorities.

Ad hoc and one-off meetings

252. The LGA had numerous *ad hoc* meetings with the Government and other stakeholders during the pandemic; these occurred outside formal, planned, meetings with the aim of planning for them. There was regular and frequent email exchanges or calls with key civil servants in the DHSC and DHLUC, often out of normal office hours, concerning such matters as drawing up documents or guidance, supporting DHSC with communications with other Government departments, or preparing material for Ministerial sign off.

253. Thus, between 2 March 2020 and 28 June 2020, the LGA's Director of Social Care Improvement and other senior officers, regularly exchanged emails with senior DHSC officials, including Rosamund Roughton (Director of Adult Social Care, DHSC and then Director General for the Department), Richard Cienciala (Deputy Director for Adult Social Care) and Tom Surrey (Co-Deputy Director, Covid-19 Response, Adult Social Care). Likewise, early in the pandemic, for example, emails were sent to flex CHIP resources towards meeting the needs of the national response to the pandemic.

254. There is a further point to be made. While in most cases the meetings I have outlined involved the senior leadership of the LGA, colleagues at a lower level in the LGA's professional hierarchy were also significantly involved. Sometimes they were the sole LGA representative (and sometimes the sole local government representative) in ongoing or *ad hoc* meetings on a wide range of issues, such as testing, PPE, and volunteering. For example, an LGA Adviser (Workforce) had weekly meetings with the DHSC Operations Team from April 2020 onwards to introduce and link up the regional DHSC testing staff with council led regional operations.

NHS England

255. Engagement with NHSE took place broadly in three ways:

- *Firstly*, throughout the period March 2020-June 2022, colleagues from NHSE were regular attendees of several of the working groups and stakeholder meeting outlined above where the LGA was also represented. Examples of this are the groups concerning vaccination, designated settings, and data.

- *Secondly*, the LGA had regular engagement with individuals and teams within NHSE who were responsible for discharge and community services. Specifically, LGA officers attended frequent meetings chaired by senior NHSE colleagues on issues related to discharge and post discharge support.

- *Thirdly*, there was frequent engagement at a regional level between LGA CHIAs, NHSE regionally, and local authorities.

I will give more detail of two examples of the third dimension of engagement.

NHSE East

256. During March 2020, NHSE East set up governance structures to oversee the response to the pandemic. This structure included an Out of Hospital Cell, with a Care Homes Workstream reporting into it. ('Cells' were groups stood up by the NHS to look at various aspects of the pandemic response). The LGA's regional CHIA was involved in these meetings from mid-April 2020, with Sheila Norris, ADASS Associate for ADASS East (and occasionally **NR**, Regional Sector Led Improvement Director for ADASS East), representing the local government/ADASS perspective. The Care Homes Group also included representation from CQC.

257. There were several related meetings in mid-April 2020, including exploring ways to support care homes and importantly, how to extend the workstream to include home care

as well as care homes. NHSE East colleagues had little knowledge about how the care home and home care markets operated, or the most appropriate way to engage with them. The LGA's involvement at that time was crucial in guiding the actions of NHSE East colleagues and ensuring that the primary route for communications to social care providers was through the region's councils, minimising duplication and additional demands on providers who already had regular and well-established lines of communication with councils.

258. On 29 April 2020, an urgent meeting was called by NHSE East in response to the increasing number of deaths in care homes, requesting representatives from all LRFs with responsibilities for care homes (Email from NHSE East dated 28 April 2020 calling for urgent meeting re number of deaths in care homes, **Exhibit JK4/052 – INQ000581365**). NHS and council staff attended, as well as CQC, Sheila Norris and LGA's regional CHIA. This initial meeting led to the establishment of a weekly meeting with the same broad representation and including the Regional Assurance Lead from DHSC, when they came into post. This meeting was used to oversee the ongoing work to support care homes – and home care – and provided two-way communication of information from DHSC and NHSE and feedback from systems, although feedback from DHSC and NHSE on the issues escalated through this meeting where slow to come back to us. Public health colleagues from NHSE East would join for part of each meeting and a care home representative was invited to join the group later in 2020.

259. The key issues covered in these meetings included:

- Rates of infection and outbreaks
- Number of deaths
- Designated premises – or alternative approaches, where used
- Government guidance
- PPE
- Testing
- Workforce
- Capacity Tracker

- Vaccination
- Health inequalities,

and

- Understanding guidance, especially where it was unclear, and systems were interpreting guidance differently.

260. The meetings moved to fortnightly in August 2020, and then weekly again in January 2021 until April 2021 and then fortnightly to July 2021, when they moved to monthly and were stood down in August 2022. At the height of the pandemic, the meetings provided a useful forum for sharing the challenges and frustrations of managing through the pandemic, and the innovative ways that NHS and council colleagues, and social care providers, found to continue to provide support and care to the people in their local areas.

NHS North West

261. In relation to the North West, there were several key areas where the LGA's regional CHIA worked alongside regional council colleagues, ADASS, PHE and NHSE during the pandemic:

262. North West ADASS set up regular meetings with local authorities attended by the CHIA and included PHE, CQC and DHSC and NHSE. It was a forum that responded to and supported local authorities with changing guidance around infection control, visiting in care homes, closure of day centres, respite, setting up designated settings and the vaccination roll out, etc. It also escalated concerns up the chain to regional partners' national/central teams, as well as DHSC.

263. ADASS and LGA's regional CHIA were present at regular meetings with the NHS at the NHS Incident Management Meeting. At these meetings, there were regular discussions on discharge, the epidemiology of the virus, benchmarking the North West with the rest of the country, PPE, care home availability, and pressure on the NHS. The LGA and ADASS regularly worked to explain to regional NHSE colleagues what was happening in care homes and why beds were not available, where they were closed because of Covid-19, and monitoring vaccination take up.

264. The DHSC set up a weekly meeting specifically to look at risk in care homes. There were three sub-regional NHSE nurses on the call with specific responsibility for care homes as well as staff from ADASS and those supporting PHE's Capacity Tracker. The

capacity data was regularly analysed to determine where the hot spots were; this helped enable the best offer of support through the nursing team or by approaching the local authorities. The meetings also supported the development of designated settings and helped with a cohesive response to DHSC questions as well as coordinated actions to support providers (through the nurses) and councils. Later, the vaccination team would occasionally join.

265. The LGA's CHIA for the North West met weekly with the North West NHS Vaccination Lead to set out strategies for vaccination roll out to care staff, working together on devising suitable communications and working through the risk group to support providers and councils.

266. The LGA's CHIA for the region attended the mental health and learning disability NHS North West cells to ensure the LGA was aware of what was happening on the ground. As a result, the LGA's CHIA for the region re-established the Learning Disability Network as there was a lack of focus on people with learning disabilities and a disproportionate number of deaths. This group included all local authorities in the region and the chair of a user group, who was also on a national group where we lobbied for better guidance. The Network shared practice around different ways of providing day services when centres were closed and worked hard on ensuring accessible communications were available (working with NHS colleagues) to support vaccination take up.

Public Health England (latterly the UK Health Security Agency)

267. The LGA's close working relationship with PHE was central to much of the LGA's work during the pandemic and will be reflected in the LGA's submissions to other Inquiry Modules. In relation to the scope of Module 6, the first point to note is that the LGA was in regular contact with PHE, the DHSC, and the Chief Medical Officer ("**CMO**"). There was the regular exchange of emails between the LGA and ADPH and with senior officers within PHE and DHSC, including the then Deputy CMO Jenny Harries.

268. From 31 January 2020, the LGA attended, as an observer, the first of regular (initially fortnightly) situational update meetings with ADPH and the CMO and Deputy CMO. The regular calls provided a space for ADPH, DHSC and PHE to share updates and discuss key issues.

269. The LGA was also a member of existing Government-led working groups on, for example, mental health (Mental Health Prevention and Promotion group - PHE), dementia (Dementia programme Board - DHSC), autistic people (Autism Strategy Executive Group

- DHSC) and the National Suicide Prevention Advisory Group (DHSC). During the pandemic, these groups were used to help identify the impact of non-pharmaceutical interventions ("**NPIs**") on distinct groups of people. Similarly, the LGA was a member of existing external groups at which Government was represented and which also focussed, during the pandemic, on NPIs for people with mental health issues (the ADASS Mental Health network meeting - 90-minute call every month) and those facing end of life and palliative care (the Ambitions Partnership group).

270. There were several significant issues about infection control:

- The risk of infection when visiting into care homes;
- the consequences of isolation and grouping of residents deemed an infection risk;
- cross-infection from staff movement between different settings of care;
- the care environment;

and

- the grant aiding providers with funds to implement infection control measures.

271. The LGA was involved in these discussions with central Government, providers, the NHS, and sources of expertise such as PHE. As well as engaging with the development and implementation of central policies, the LGA also sought to support local interpretation, for example the role of the Director of Public Health in advising care homes. This was a difficult balance in that policy needed to allow for local circumstances and yet providers and relatives might sometimes complain that there was unjustified or unexplained local variation.

272. More generally, throughout the pandemic the LGA liaised with Government departments, NHSE, and PHE to help disseminate Covid-19 Government-produced communications materials to council communications teams. The Government was keen for councils to amplify national public health messages at the local level.

ADASS

273. The LGA represents councils in their widest sense: council leaders, cabinet/portfolio holders, other members, CEXs, and other officers. It is a membership organisation of councils and is local government's national representative body. ADASS has a core membership of actively serving DASSs, plus other serving senior managers, ex-DASS

associates, and principal social workers. It is a charity and has its own charitable objects around supporting its membership but also advocating for social care and social justice. As noted throughout my statement the two bodies often work together very closely on ASC issues.

274. DASSs are statutory chief officers within councils, appointed and paid by councils. Therefore, there can be a general assumption that, when ADASS speaks, it speaks for wider local government as well as for its membership. There can be exceptional circumstances when this may not be the case and the LGA has a different view, but the LGA and ADASS take pains to mutually check views and positions being taken, and usually any differences may be about tactics rather than core beliefs.

275. When it comes to more formal and public expression of views, especially if critical of Government or partners, there is sometimes a case for either ADASS or the LGA to lead on such public facing comments, leaving the other to do more behind the scenes work. Doing this can maximise the influence of local government on national Government.

276. ADASS and the LGA have a long and close relationship. The LGA works closely with ADASS on matters of policy, implementation and delivery and nearly always aligns on core positions. The LGA also co-delivers an annual conference on children and adult services with ADASS and the Association of Directors of Children's Services ("**ADCS**").

277. Away from the policy and communications realm and into one more focussed on improvement, the LGA-ADASS relationship has been further strengthened through CHIP (now PCH). This DHSC-commissioned programme was, and is, produced and delivered jointly between the LGA and ADASS, although as LGA employ the staff it is often more widely perceived as led by the LGA.

278. During the pandemic there was a degree of pooling of resources. This included, for example, the weekly – then daily – bulletin for ADASS members and CHIP staff, attendance at and input to meetings and documents, the sharing of notes and records, and the production of joint letters and documents.

279. Throughout the pandemic the LGA was in frequent contact with ADASS – particularly the President, CEX and the ADASS central team. Early in the pandemic there were weekly discussions between the LGA's Director of ASC Improvement and the ADASS President, James Bullion. These continued throughout 2020 and 2021.

280. At the end of March 2020, the LGA set up a Coronavirus enquiries service. This later

became a national 'Adult Social Care Hub', which helped maximise capacity to respond to Covid.

281. The Adult Social Care Hub was jointly managed by the LGA and ADASS and coordinated the response across ASC and health partners, particularly with regards to hospital discharge, Care Act easements and the additional funding provided to social care. Information was also uploaded onto a Knowledge Hub ("**KHub**") site which councils, LGA and ADASS colleagues could join. In 2021 there were 250 members registered to receive updates from the KHub site.

282. KHub circulated a regular e-bulletin aimed at collating and disseminating communications being issued by central Government during this period (see, for example, a sample of ASC Hub bulletins, 1 March 2022, **Exhibit JK4/053 – INQ000581164**; 4 May 2020, **Exhibit JK4/054 – INQ000581195**; 16 April 2020, **Exhibit JK4/055 – INQ000581170**; 30 April 2020, **Exhibit JK4/056 – INQ000581194**).

283. The ASC KHub update ran for two years from April 2020 – May 2022. Tracking and reflecting the urgency and immediacy of issues, the update was initially circulated daily from 6 April 2020- 14 August 2020, then twice a week until 3 December 2021 and finally from December 2021 to May 2022 it was disseminated once a week.

284. The LGA collated the information and then sent it onto ADASS who included the information in an email bulletin that goes to their membership (see above). The update was also sent as a regular email bulletin to LGA staff and partner organisation contacts including colleagues from SfC and the NHS Confederation. This would have been to somewhere in in the region of 80-100 people.

285. Other relevant activity included:

- A specific lead for workforce/testing was appointed from March to September 2020. Their work involved responding to internal and external queries on these matters and doing relevant updates on testing and workforce issues;

  and

- in response to the pandemic, the LGA worked with ADASS to establish a national resources group and made use of an existing commissioning group to ensure that there was direct and prompt communication to adult social care finance leads and commissioners. The current incarnation of the ADASS Resources Network, run by

the senior PCH CHIA Lead on Resources, emerged during the early days of the pandemic. It was, and remains, the main method of communicating detailed ASC financial issues to councils.

The CQC

286. The CQC is another close and trusted partner of the LGA, and the two organisations have engaged at numerous points and on numerous issues since the regulator was created in 2009.

287. Throughout the period March 2020 – June 2020, the LGA was in regular contact with the CQC, including its then Chief Inspector for Adult Social Care, Kate Terroni. The LGA and CQC both attended the same working groups and stakeholder meetings, as referred to above. In particular, the LGA helped to establish the data group that CQC subsequently then chaired.

288. The LGA was also in regular contact by email and phone with the CQC, for example responding on an *ad hoc* basis or having conversations on the various topics outlined in the table, for example, the LGA commented supportively on a letter CQC thought of sending to providers, making it clear that notifications should still happen including when affected by Covid.

Representative bodies of care providers and individual care providers

289. Throughout the period in question, the LGA was in regular contact with different representative bodies of care providers (such as Care England ("**CareEng**"), National Care Association ("**NCA**"), the UKHCA, the National Care Forum ("**NCF**"), the CSA, and the Association for Real Change ("**ARC**"). There was a regular exchange of emails between the LGA/CHIP and different provider representative organisations.

290. It is worth noting that in the same way that individual care providers are represented nationally by a relevant association (e.g. the NCF), those national associations are also convened to form the CPA. Thus, if the LGA issued joint correspondence with the CPA, this was correspondence representing the voice of nearly all councils and nearly all types of care provider. This context is provided because, by the end of March 2020, CHIP had set up, began providing support to, and co-chaired (alongside the CPA) a commissioner-provider forum, the 'National Covid-19 social care provider issues group' (commonly referred to as the Provider Issues Group). As above, this was a sub-group of the NCAG. From April 2020, this group met twice a week, but from September 2020 meetings were held weekly, and these now continue meeting monthly. Minutes from the eight meetings

that occurred in April are exhibited and aptly illustrate the nature and content of the discussions (NCAG (social care provider issues) meeting minutes dated 31 March 2020, **Exhibit JK4/049 – INQ000581183**; 2 April 2020, **Exhibit JK4/057 – INQ000472630**; 7 April 2020, **Exhibit JK4/058 – INQ000581257**; 9 April 2020, **Exhibit JK4/059 – INQ000581258**; 14 April 2020, **Exhibit JK4/060 – INQ000528675**; 16 April 2020, **Exhibit JK4/061 – INQ000524962**; 21 April 2020, **Exhibit JK4/062 – INQ000524964**; 23 April 2020, **Exhibit JK4/063 – INQ000581262**; 30 April 2020 **Exhibit JK4/064 – INQ000581263**). The notes show that during this period the most common and significant item was "funding". The discussions covered a range of topics including; attendees setting out the cost pressures of their members, requests for additional funding from national and local government and dealing with any funding related matters that could affect provider viability (e.g. speed of payment from local authorities).

291. The next most common and significant item was PPE. The primary aim of this item was the safety of care provider staff and the people they support, but the meeting dealt with issues related to distribution that were vital to the safe and effective operation of care providers. This is a good example of an item that was vital in the wider context of ongoing provider viability.

292. Organisations that represent people drawing on care and support (e.g. TLAP) were also standing members of this group and regularly attended to ensure this voice was front and centre of the group's work.

293. Such was the centrality of funding to the pandemic response, the Provider Issues Group created a sub-group in June 2020, Provider Funding Discussions, to provide a dedicated forum to discuss funding matters. This not only gave an additional space to have broader discussions on finance matters, but it also ensured regular meetings of the group could give sufficient time and space to the variety of existing and emerging issues facing the sector.

294. Due to its broad representation of relevant organisations, individual provider matters were dealt with through the Provider Issues Group (and its sub-group on funding). Of course, this is not to say that the Provider Issues Group was the only forum where the LGA/CHIP interacted with provider partners. There were many *ad hoc* meetings with provider colleagues, as well as a considerable body of email correspondence. There were also various meetings which the LGA/CHIP and provider partners both attended. See **Appendix 2** for examples.

Other key stakeholders

295. Other key stakeholders included:

- **SfC**: LGA and PCH have a long history of collaboration with SfC in supporting the adult social care workforce. On 24 June 2020, at a regular bi-annual information sharing event, LGA, ADASS and SfC discussed ways to prioritise and better align their support to the workforce during the pandemic. In July a working group sought agreement from senior leaders in the three organisations that there would be a focus on five shared workforce priorities (Exhibit M6 18 07 20 ADASS, LGA, SfC, workforce statement). The priorities included focusing on recruitment and retention and supporting the wellbeing of the workforce. A joint implementation group was set up with representatives from the central policy teams in the three organisations as well as regional representatives. The group met fortnightly, then later monthly, from the 18 September 2020 until 2022.

- **TLAP**: The LGA, along with ADASS, ARC, UKHCA, National Care Group, Mencap, Carers UK, CQC and TLAP, were core members of a Care Act Easement Guidance Task & Finish Group convened by DHSC to develop Care Act Easements Guidance. Collectively, partners played a significant role in informing and shaping the easements guidance. The LGA also joined a TLAP Insight Group (June-July 2020) convened during the period to develop a set of FAQs about Care Act easements and to undertake a rapid review of the impacts of easements on people who access care and support (TLAP report dated 14 October 2020 "A Telling Experience: Understanding the impact of Covid-19 on people who access care and support – a rapid evidence review with recommendations", **Exhibit JK4/065 – INQ000509867**). The LGA also worked closely with TLAP to develop a LGA briefing on PAs eligible for vaccination as part of National Priority Group Two: frontline social care workers, alongside accompanying key messages and FAQs (Key messages and FAQs document dated 12 February 2021 re "Personal assistants eligible for vaccination as part of national priority group two - frontline adult social care workers", **Exhibit JK4/066 – INQ000417427**).

Summary of matters worked on with Government and stakeholders

296. The topics covered in the meetings and emails outlined above can broadly be summarised as concerning:

- Discharge from hospital
- Infection, prevention and control
- Workforce
- Testing
- PPE
- Funding
- Provider and market viability
- Vaccination
- Data collection
- Shielding
- Volunteering
- Indemnity cover

  and

- Care Act easements.

297. The Inquiry has asked for information on the LGA's concerns in relation to several significant matters including discharge to assess policies, infection prevention and control ("**IPC**"), testing, PPE, funding, vaccines, data collection and Care Act easements in specific questions. Subject to one point I have sought to provide a comprehensive response to these questions elsewhere in this statement, what follows under this cross-heading is therefore more limited. It seems convenient here to discuss the LGA's approach to hospital discharge policy and guidance.

The LGA's approach to hospital discharge policy and guidance

298. The topic of hospital discharge policy and guidance was a key concern for the LGA during the pandemic. In its Rule 9 request, the Inquiry asked several questions on the issue of hospital discharge, with several more questions indirectly touching on this subject.

299. In the Module 6 Survey, participants were asked to identify "the single issue that most concerned the local authority" during three distinct phases of the pandemic (**Exhibit JK4/001 - INQ000400522**). The results show that 'Spread of Covid-19 in care settings' was the most selected response for the period covering the first lockdown (chosen by 47% of respondents), but was then the fourth most selected response for the period between the first lockdown and the first vaccination (15%), and the second most selected response for the period from the first vaccination onward (16%). In other words, at no point during the pandemic was 'Spread of Covid-19 in care settings' considered to be the single biggest issue of concern for more than half of councils.

300. The LGA fully recognises and respects that others – particularly those left bereaved by decisions on, and approaches to, discharge – will feel this is/was the most significant issue across the whole pandemic period, by some clear distance. For people who feel this way, I wish to reassure them that our own position does not reduce by one iota the enormous degree of sympathy we feel for, and extend to, bereaved families.

301. For ease of reference, and given the importance of the subject matter, I address this topic in full here under four cross-headings:

- 1 - The pre-pandemic background and context for Discharge to Assess
- 2 - Entering the pandemic period and its early days
- 3 - Developments and activity leading up to the publication of guidance
- 4 - Developments and activity following the publication of guidance

1 – The pre-pandemic background and context for Discharge to Assess

302. For many years prior to the pandemic (and since), there has been a crude narrative on hospital discharge that speeding up transfer to care was the prime means of reducing length of stay and bed occupancy in acute hospitals.

303. Though it has often seemed to be predominant it has always been challenged by the LGA. It has called out the use of dehumanising terms such as '*bed blockers*', and has pressed for a balancing emphasis on managing, and if possible, reducing admissions in the first place. It has also pointed out that as many, delayed transfers of care have been attributable to the NHS, rather than the availability of social care.

304. Examples of this work include:

- A public media response to published data in 2017 and 2018 (LGA media release dated 10 January 2019 "Response to latest delayed transfers of care figures", **Exhibit JK4/067 – INQ000581348**);

- A letter (written jointly with ADASS and the Society of Local Authority Chief Executives and Senior Managers ("**Solace**") to the former Secretary of State for Health and Social Care, Rt Hon Steve Barclay MP, in January 2023 (**Exhibit JK4/068 – INQ000581290**);

  and

- The LGA's current lobbying and influencing work, as in for instance its submission to the 2024 Budget (LGA's Autumn Budget and Spending Review Submission 2024, dated 13 September 2024, **Exhibit JK4/069 – INQ000581210**).

305. That is not to say that hospital discharge is not a key operational process of concern to the LGA. Quite the opposite is true: about a decade ago, the LGA commissioned work to look at how the process of discharge from hospital worked and could be improved. This was done with a group of councils and is the origins of what subsequently has become known as '*Discharge to assess*' ("**D2A**"). Indeed from 2016, CHIP, being funded by the DHSC, which was keen, working closely with NHSE, to develop discharge policy and guidance, included this as part of its (CHIP's) workplan (see, for example, Newton report (2017) "Why not home? Why not today?", **Exhibit JK4/070 – INQ000581314**; and LGA report (June 2016) "Efficiency opportunities through health and social care integration", **Exhibit JK4/071 – INQ000581297**).

306. By 2019, NHSE had adopted and approved the D2A Model sometimes referred to as 'Home First' and was preparing to roll it out. At the heart of this Model was a focus on making 'home' both the default pathway for people leaving hospital, and the default setting for assessing a person's possible longer-term support needs. There was indeed an understandable rationale for this approach:

- *Firstly* it has long been recognised that acute hospitals may often provide a poor environment in which to assess a person's future support needs including their potential for independence. It is well known that the hospital environment can itself increase dependency levels, irrespective of the condition or issue for which a person is receiving treatment. If this occurs, then people may leave hospital with an inaccurate and inflated assessment of their ongoing support requirements, including sometimes a belief that they need to be admitted to a care home.

- *Secondly,* for many, in ordinary circumstances, an assessment at home may show that they can continue living at home without the kind of support that would be provided in another residential environment. So, a policy of safe and timely discharge to a person's home (or an environment which replicates home conditions) that would allow that person's potential future needs to be assessed more accurately was plainly a good idea in principle.

- *Thirdly*, such a policy would allow that, where further support is needed, services such as intermediate care and reablement can be geared towards enabling the person to recover as much independence and function as possible. Thereafter, when this period of support concludes, an assessment of the need for ongoing support can then be made with the person in their home and taking account of their short-term support, thus enabling a better prediction of what will be needed in the future.

307. These were the basic purposes of this 'discharge to assess' policy. In summary the discharge happens prior to a full assessment of ongoing needs, to ensure that the assessment considers what is possible in the fullest sense. This is why it is also called 'Home First'.

308. In ordinary circumstances such an approach is plainly right since the expectation, based on extensive research of patient records and discussions with practitioners, is that, on average:

- Ninety five per cent of people discharged from hospital return home,

- four per cent go into a community bed-based environment for rehabilitation,

  and

- just 1% need a long-term admission into a care home.

309. Of course, such a discharge policy requires a preliminary assessment prior to leaving hospital. At this point there should be an initial assessment of the person's situation to ensure they can do so safely. Where a social worker does not conduct this, this kind of assessment is referred to as a *'trusted assessment'*, reflecting that the review/initial assessment can be done by another member of the clinical team working with the person, such as therapists.

2 - Entering the pandemic period and its early days

310. Early in the pandemic, the LGA recognised that Government was in the unenviable position of having to make a series of challenging policy decisions at pace. As the Inquiry has already identified this was due to the lack of proper national planning for dealing with a pandemic like Covid, and a resulting lack of prior preparation for discharging existing patients from hospital to make space for those who were seriously ill from Covid.

311. Sometimes these decisions were made with insufficient information, often they required difficult judgements on how best to balance different risks, and certainly they were made without adequate internal (DHSC) capacity and infrastructure. The LGA was experiencing broadly similar issues internally as it established its pandemic response programme on behalf of councils. So, the approach that the LGA took was not simply to be critical but to offer constructive criticism, based on its knowledge. This was done via email and in relevant meetings that LGA officers either attended or convened. In the latter case, Government heard a range of relevant and informed views on several issues.

312. As D2A had yet to be fully rolled out across the NHS and social care (but was supported by NHSE for potentially providing better outcomes for people and better use of resources) the LGA entered these discussions with a range of starting observations and points in mind concerning:

- The need to free up acute capacity,
- the role of D2A in that process,

  and

- the wider impact on the social care sector.

313. The LGA had in mind the many issues that could potentially impact D2A's value, including -

- The Government's decision, shaped in part by what was being seen in Italy at the time (including an influx of very ill people to the acute sector), to reduce hospital bed occupancy to help enable adequate acute capacity for treating people who were seriously ill from Covid-19 (and, of course, other conditions and illnesses);

  and

- recognition that not taking such measures meant running the risk that people with heightened levels of risk (such as was known at the time), such as older people and people with specific conditions which made them more clinically vulnerable, would not get the acute support they needed, including, of course, people drawing on social care and support.

314. NHSE supported the D2A approach and so there was a readiness to roll it out more fully but the LGA retained concerns that the potential benefit of the approach was susceptible to any development which would change the starting expectation that only 1% of people leaving hospital under the D2A model would require long-term admission to a care home, and 95% of people would return home (with or without support).

315. It is important though to note that the D2A approach was neither tested for, nor based on the expectation of, a high proportion of people leaving hospital being admitted to care homes. This was significant at the time because of:

- A perceived risk, which at the time could not be mitigated, that practitioners, with lower levels of experience, would assume the role of 'trusted assessor' and over-prescribe support, including care home admission.

- Care homes appeared to be a more available discharge destination because Capacity Tracker (discussed elsewhere in my statement at, for instance, paragraph 482 onwards) initially only provided data on care homes and not home care.

316. In summary, and in the very early days of the pandemic, the LGA therefore held a pragmatic but cautious and conditional view at a national level that the Government's drive to free up hospital capacity was necessary, and that D2A was a potential means of supporting and delivering that priority. The two main conditions at this stage were that D2A would not be stretched too far beyond its starting presumption of only 1% of people discharged from hospital being admitted to a care home, and that all discharges from hospital should be safe even where a full assessment is yet to take place.

317. While it is impossible to know the instincts of every single council in these very early days of the pandemic, the LGA is of the view that some councils (particularly as they were one step removed from fast-paced national discussions with, for instance, DHSC and NHSE) wanted to approach the situation differently, including taking a view that people who *might* not have Covid-19 should not be discharged into a care setting until it was *clear* that was the case and therefore the risks to those in that setting were not from this new virus.

318. At this stage, the LGA considered the risk between not accelerating rollout of D2A (e.g. not freeing up sufficient acute capacity) on the one hand, and the risk of doing so and seeing more people being admitted to care homes unnecessarily on the other hand. The LGA did not at this point take a firm and definitive position on the balance of risk. On the latter of the two risks, the LGA emailed DHSC on 18 February 2022 outlining (along with ADASS) key issues and scenarios likely to arise for the ASC sector, including the potential issue for councils of having to find "new temporary forms of congregated care".

319. On this, the LGA noted that care homes will be full and "in any case are full of people most vulnerable to the virus so it would not seem sensible to cram them fuller with people being quickly discharged from hospitals" (LGA email to DHSC and ADASS dated 18 February 2020 re supporting the sector, **Exhibit JK4/072 – INQ000581342**). The LGA also advised Government about the risks of congregating people who were Covid-19 positive in care settings in an email two days later (Email from LGA to DHSC and partners commenting on draft advice to the ASC sector re Covid, **Exhibit JK4/073 – INQ000581345**.

320. What followed was further intensive work with NHSE and DHSC, which culminated in the publication of Government guidance on discharge.

3 - Developments and activity leading up to the publication of guidance

321. In many ways, this is the most important period for understanding some of the biggest issues to do with discharge during the pandemic. The Inquiry must understand that are two periods of particular significance:

- 20 February 2020 to 19 March 2020: First, the period starting around the time of the emails referred to above and ending with publication of the Government's first set of guidance on discharge; and

- 19 March 2020 to 15 April 2020: Second, the period between the first guidance being published, and updated guidance being published in the Government's 'Covid-19: Adult Social Care Action Plan'.

322. To provide the clearest evidence possible, I take each of the periods in turn and detail key developments. The focus of my commentary during both periods is on what the LGA did to try and influence government guidance.

18 February 2020 to 19 March 2020

323. On 16 March Government emailed Sarah Pickup, the LGA's former Deputy Chief Executive (and a former Director of Adult Social Services for Hertfordshire County Council) with a draft of the discharge guidance (Email from DHSC to LGA requesting comments on draft discharge guidance by 6:00pm, **Exhibit JK4/074 – INQ000581366**). The email was sent at 4.17pm with a deadline for comments of 6.00pm. This email was shared with LGA officers later that evening. It is to their credit that a response was sent to NHSE at 12.30am the next day and with Government at 11.20am the same morning. Nonetheless there can be no doubt that a longer period for comments would have been beneficial while acknowledging that this may have been difficult for the Government to achieve in the circumstances.

324. The LGA's officers' comments on this draft document:

- Emphasised that the lack of PPE for social care providers was a major issue and could invalidate the guidance; asked that there be some assurance to social care providers about 24/7 access to NHS community support; and said that under D2A, therapist assessments should not be universally accepted if they were over prescribing care (including over use of care homes).

- Flagged the potential for the use of rehabilitation beds to lead to unnecessary clustering of clinically vulnerable people, advocating rehabilitation at home being the default.

- Outside specific comments on the draft, the LGA expressed concern about the propensity for acute trusts to discharge people to care homes rather than their own homes (Email chain dated 16 March 2020 between NHS and LGA re proposed discharge to assess pathways, **Exhibit JK4/075 – INQ000581343**).

325. On 17 March, the LGA made further comments to NHSE on early drafting of the guidance (Email from LGA to NHS dated 17 March 2020, **Exhibit JK4/076 – INQ000581248**; NHS draft (v 2.0) Covid-19 hospital discharge guidance dated 16 March 2020, **Exhibit JK4/077 –** **INQ000103764** Some of the LGA's feedback, reflecting conversations with providers about them supporting people who had not received a full assessment, included being clear about how providers could access community healthcare support. The LGA also noted sector concerns about, for example, access to PPE, which was so central to the deliverability of the D2A model and therefore its potential value in the expanded context of the pandemic (**Exhibit JK4/077 –** **INQ000103764**).

326. On 18 March, a further draft of the guidance was sent by DHSC at 4.30pm with comments requested by 6.00pm. The LGA was unable to meet this deadline but commented early the next day and then made minor comments on a final draft.

327. On 19 March there was further correspondence with DHSC on further final versions of the guidance, again with extremely short turnaround times (Email from LGA to DHSC and ADASS re final version of discharge guidance, **Exhibit JK4/078 – INQ000581268)**. LGA officers responded, noting that some of their points had been incorporated, and indicated that, overall, the guidance was acceptable.

328. The guidance was published on 19 March (NHS guidance dated 19 March 2020 "Covid-19 Hospital Discharge Service Requirements", **Exhibit JK4/079 – INQ000049702**). It is important to be clear about the reasons why the LGA thought – at that time – that the guidance was acceptable. I summarise the thinking at the time as follows:

- The LGA recognised, understood and supported the need to clear acute hospital beds, which the guidance articulated clearly.
- The main approach for doing this was D2A, which (as above) the LGA cautiously and conditionally supported.
- If followed faithfully, it was considered that the guidance would minimise new admissions to care homes.
- It did not override the right of a care home manager to decide whether admitting a person was appropriate, and if necessary to refuse an admission if the manager believed that an admission would be wrong for the person concerned and/or other residents of the care home.
- The guidance emphasised the need for the NHS to work in partnership with the social care sector: "arrangements will only be successful if NHS organisations work hand in glove with ASC colleagues, the care sector and the voluntary sector". This meant that (or at least felt like) the views and needs of the care sector were to be fully respected and considered.
- It made a presumption that testing for Covid-19 would be in place and shared with providers: "*where applicable to the patient, Covid-19 test results are included in documentation that accompanies the person on discharge*".

- The CQC guidance towards the end of the document stipulated that the NHS and local authorities must listen to any concerns expressed by providers:

  "...providers accepting trusted assessments must have access to a process through which they can escalate concerns when a person has been discharged to their service with needs they are unable to meet. When a concern is raised about the appropriateness of a placement, CQC will expect this to be considered promptly..."

  "...registered providers need to have confidence that legal requirements for assessments are met, and that particular consideration will be given to safety and infection control related needs..."

- To support this happening at scale and pace, Government also made available some funding which meant that any initial (6 weeks) package of support would be free to the end user and would be funded from central government.

329. The guidance was silent on whether *all* people should be tested for Covid-19 as a precautionary measure before leaving hospital, beyond the reference cited above to Covid-19 test results accompanying people on discharge. The LGA has reflected at length on whether it should have argued for such precautionary testing, given the subsequent impact on care homes residents and staff. The LGA of course deeply regrets this impact but would also point to some key factors at the time for considering the extent of difference that testing would have achieved.

330. There was no testing methodology in place at the time which would have enabled the rapid testing on a precautionary basis of many thousands of people. Therefore, mandating such testing could have significantly delayed the freeing up of hospital beds, and could have even led to increased length of stay in hospital.

331. The advice on infection prevention and control from those qualified to give it (PHE) was that Covid-19positive or unknown status people could be safely cared for using PPE, managing the physical environment, and isolation of Covid-19-positive people.

332. Those involved in commenting on the guidance were given very little time to do so, and were asked to treat the drafts in confidence, so were not able to draw in views from other LGA colleagues or from providers. Being unaware of provider views was of particular significance when trying to comment, and the LGA sought to remedy this very soon afterwards as shown below.

333. While the guidance was silent on the issue of testing, this did not mean that precautionary testing was forbidden. In fact, at a local level, the LGA is aware that agreements were reached between some local authorities, local NHS and providers so that, in some cases, people would be kept in hospital and tested before being discharged. The LGA cannot comment as to how common, or widespread, such arrangements were.

19 March 2020 to 15 April 2020

334. It very quickly became apparent that the 19 March guidance was problematic at best and unworkable at worst. Safe application of the guidance was compromised by:

- A notable lack of PPE for staff as advised by ICP guidance,
- the practical difficulty of isolating people in some (smaller) care homes,
- problems with staff accessing tests,

and

- inadequate clarity on the idea of 'cohorted congregate settings' (i.e. moving all Covid-positive care home residents into one section of a care home).

335. As the Inquiry would expect, the speed and degree of concern from councils and providers, about implementing the 19 March guidance, was then mirrored by the speed and degree of action from the LGA and its relevant national partners to address identified problems.

336. On 19 March, alert to the many concerns being raised by providers, and that this was often happening at the end of meetings with insufficient time to get into detail, CHIP's Director of Social Care Improvement had a conversation with the DHSC Director General, followed by an email to provider sector representatives the next day, suggesting the setting up of a forum where providers could be consulted and raise issues in a more methodical way, and offering to support such a forum (see email dated 20 March 2020 from LGA to DHSC and provider representatives, **Exhibit JK4/079a – INQ000545625)**. Provider sector representatives supported the proposal.

337. On 23 March, following the above developments, the LGA and ADASS convened the first meeting of local government, providers, CQC and DHSC so that the Department and Regulator could hear councils' and providers' concerns and questions directly. The meeting established terms of reference, chairing and support arrangements, and identified

a list of 15 priority issues from providers of which discharge guidance was one such issue (see meeting minutes, **Exhibit JK4/079b – INQ000581311;** and terms of reference, **Exhibit JK4/048 –** INQ000114893.

338. From this point on it became easier to have a joined-up conversation, with sufficient time and the right people in attendance, between national government, providers, local government and the Regulator. In parallel to this national-level discussion, regional-level CHIAs were working closely with local NHS and provider colleagues to find solutions to safe implementation of the guidance. For instance, in the West Midlands, CHIAs worked with local partners on contingency planning, communications, and supporting systems to commission additional beds in hotels (see, for example, email from LGA to NHS dated 10 March 2020 re West Midlands care home issues, **Exhibit JK4/079c – INQ000545617**; and email from Warwickshire County Council to ADASS dated 2 April 2020 re using hotels for care homes, **Exhibit JK4/079d – INQ000545634)**.

339. By 25 March, DHSC, NHSE and PHE were requesting comments on revised guidance on infection prevention and control, particularly in care homes (NHS guidance dated 19 March 2020 "Covid-19 Hospital Discharge Service Requirements", **Exhibit JK4/080 – INQ000581349**; Draft guidance "Caring during Covid-19 - Advice for Care Homes", **Exhibit JK4/081 – INQ000581179**). An early draft of that guidance took a more explicit line that care homes should accept people without being tested first. LGA and ADASS officers asked for this to be discussed at the next meeting of LGA, ADASS, providers, DHSC and CQC (see NCAG meeting minutes dated 26 March 2020, **Exhibit JK4/081a – INQ000545619**).

340. On this day, DHSC emailed the LGA and ADASS to see if these organisations would consider co-branding or endorsing draft interim guidance on managing Covid-19 cases and outbreaks in care homes (see email chain, **Exhibit JK4/081b – INQ000545620**). In the same email thread, both the LGA and ADASS declined to do so. The LGA declined the request for two main reasons: first, the timescales set by DHSC were prohibitive in terms of securing internal LGA approval; and second, doubts remained about some elements of the guidance (as described below). ADASS offered to quickly (within a day) produce a short guidance note to be endorsed by ADASS, LGA, CQC, PHE and the CPA where all organisations were unified on some high level 'sector messages' (ie separate to the more detailed government guidance). The guidance note was not ultimately produced.

341. On 26 March, ADASS, LGA and DHSC arranged to discuss the draft guidance at the social care provider issues group meeting scheduled that day (Email chain dated 26 March

2020 between DHSC, LGA, NHS re IPC guidance and arranging to discuss at social care provider issues group, **Exhibit JK4/082 – INQ000581176**).

342. At 8.15pm, DHSC sent LGA and ADASS an updated draft of the guidance for IPC in care homes, suggesting that they had taken on previous feedback (Email chain dated 27 March 2020 between DHSC, LGA, ADASS, NHS re draft IPC guidance, **Exhibit JK4/083 – INQ000581180**). DHSC asked for comments to be returned by 10.30am the next day.

343. On 27 March the LGA raised concerns with DHSC by email about the expectation of social distancing, which is clearly impossible when providing personal care. On this day, the LGA also provided comments at 8.39am, as requested the day before, including the following (**Exhibit JK4/083 – INQ000581180**):

> *"Says nothing about how discharge to assess actually works: care homes expected to take admissions with minimal or no assessment, how does this then get done? Am I missing something?"*

344. The IPC guidance was published on *2 April*, just a week (including a weekend) after interim draft guidance was shared. By *2 April* there was no requirement under the discharge guidance to test asymptomatic patients for Covid–19 prior to discharge, whether to a care home or into the community. Only those in hospital with pneumonia, acute respiratory distress syndrome ("**ARDS**") or flu-like illness were to be tested. The 19 March 2020 letter from the Government and NHS to local authorities said (**Exhibit JK4/084 – INQ000103858**):

> *"One of the most important tasks will be to ensure we have the capacity to support people who have acute healthcare needs in our hospitals. To do this we need to organise the safe and rapid discharge of those people who no longer need to be in a hospital bed. The new default will be discharge home today."*

345. On 11 April, with concerns regarding the 19 March guidance now abundantly clear, and with hospital bed occupancy reductions largely achieved, DHSC sought to revise its March guidance as part of work preparing its ASC Action Plan. The draft shared with the LGA on this day (a Saturday at 2.01 pm with a request for comments by 5.00 pm the same day) stated that: anyone who was Covid-positive should be cared for in "community settings" for 7 or 14 days before going home or being admitted to a care home; anyone in hospital who was Covid-positive must be tested before discharge; and that care homes would have to isolate asymptomatic patients for 14 days since this group was still not being tested (Email from DHSC to LGA and partners dated 11 April 2020 re request for comment

on draft ASC Strategy, **Exhibit JK4/085 – INQ000581326**).

346. This meant that there was insufficient opportunity to consult with LGA and local government colleagues, or with social care providers. In its email, DHSC specifically asked for (**Exhibit JK4/085 – INQ000581326**):

> *"... views on the feasibility of is the suggested change to discharge and isolation (see chapter 1). We are still in discussions with PHE, NHS and Clinical colleagues on this but wanted to get your reflections".*

347. Again, LGA officers did respond with some key comments by 5.09pm (LGA feedback on DHSC draft ASC Strategy dated 11 April 2020, **Exhibit JK4/086 – INQ000581171**).

348. In particular, the LGA asked for clarity on the following issues but received no specific response from DHSC:

- When it would be assumed that someone was Covid-positive (including in the absence of testing), so that the right decisions could be made about social care support, infection control and PPE.
- What was meant by an "outbreak" in a congregate setting such as a care home.
- Whether "community settings" meant NHS community and Nightingale hospitals, since these community settings were to be used to care for and quarantine Covid-positive discharged patients before they returned home or to a care home.

349. The LGA asked also for some clarity about the idea that long term care home residents could be moved around to create "cohorted" congregate settings for the purpose of IPC. The idea behind this idea in the strategy was that all Covid-positive residents would be cared for in one building or part of a building, to reduce the risk of their infecting others: clarity asked for was for example whether this might mean moving people between care homes.

350. LGA officers compared notes on this new draft guidance with ADASS (Email dated 13 April 2020 from LGA to ADASS feedback on new draft guidance, **Exhibit JK4/087 – INQ000581339**; and LGA feedback on new draft guidance, **Exhibit JK4/088 – INQ000581241**) and asked Government to include the LGA on the core list of organisations for comment.

351. Then on 15 April the Government published the "Covid-19: Adult Social Care Action Plan", announcing a move to institute a policy of testing all residents prior to admission to care homes, beginning with those being discharged from hospital (**Exhibit JK4/089 – INQ000233794**). The NHS held responsibility for testing patients prior to discharge.

4 - Developments and activity following the publication of guidance

352. Following the publication of the ASC Action Plan, the level of challenge and urgency lessened somewhat for three broad reasons:

- attention turned to implementing the Plan,
- testing became more widely available,

and

- pressure on NHS beds was less than initially forecast.

353. Of course, this is not to say that the LGA was inactive on the discharge agenda. On 1 October, for instance, LGA officers commented on further iterations of policy and guidance on discharge from hospital, confirming its view that no one should be discharged from hospital without testing (see email from LGA to DHSC, **Exhibit JK4/089a – INQ000545641**).

354. In Autumn 2020, and looking ahead to Winter, Government was considering "designated premises" as part of the solution to enabling safe discharge from hospital (such premises being care homes or other non-NHS settings which were equipped to care for Covid-positive patients safely with facilities and staffing to isolate where needed). This idea featured in the Government's Adult Social Care Winter Plan (18 September) and on 14 October DHSC wrote to council, acute trust and Clinical Commissioning Group ("**CCG**") CEXs as well as DPHs, setting out a requirement for designated care settings for people discharged from hospital who were Covid-19 positive, alongside an instruction to councils to identify and notify CQC of those settings by 16 November.

355. The LGA requested more time for DASSs to get back to Government about whether they had identified such premises, and offered to help with predictive modelling for demand, communicating any guidance, and facilitating discussions with providers. The LGA continued to check how the policy was working through feedback from CHIAs (see, for example, Email dated 21 October 2020 from DHSC to LGA and ADASS re update on discharge to designated premises, **Exhibit JK4/090 – INQ000581330**; Email from DHSC

to LGA and ADASS re designated premises, **Exhibit JK4/091 – INQ000581329**).

356. As detailed at various points in this statement, this kind of regional LGA working through CHIAs was critical for the LGA's work and its relationship with DASSs, social care providers and NHSE to identify issues and find effective solutions. On the specific issue of discharge, this led in some places to acute hospitals agreeing to keep patients until their Covid-19 status was clearly negative.

Conclusions

357. My treatment of the issue of hospital discharge in this standalone section is necessarily detailed and hopefully helpful. There can be no doubt that this was one of the most challenging aspects of the pandemic for ASC and, consequently, one of the most upsetting for those drawing on and working in ASC. In one sense, the entire experience is a case study in illustrating that the best plans mean nothing without the necessary delivery structures around them for implementation. These structures, in the context of discharge, include obvious considerations such as PPE and testing, but also include organisational knowledge and expertise, and pan-government prioritisation. It is difficult not to conclude that the Government's approach to discharge, however well-intentioned, was flawed from the outset and led to avoidable pain and suffering. Councils, providers and their partners, did an incredible job in the face of an initially unworkable plan and confusing and changing guidance. In short, the initial plan generated even more work for the ASC sector before it even got proper delivery.

358. It is easy to find fault in hindsight and the LGA apportions no blame on civil servants who were no doubt doing the best they could with the knowledge they had and within the wider parameters set by Government (such as issue prioritisation). To their credit, officials pivoted quickly to listen to, and act, on local government's experience. This ensured that the period between having an inadequate and unworkable plan for discharge and having a plan that better reflected councils' and providers' experience and was implementable, was shorter than it could have otherwise been. However, there is no escaping the fact that such a gap existed with serious consequences for people. Taking the learning from this specific issue and building recommendations from it to ensure such a situation never again occurs must be on the strongest legacies of the pandemic and the Inquiry's work.

Infection prevention and control (IPC)

359. As the LGA has set out in other Modules and elsewhere in this statement, council DPHs, and their representative body the ADPH, have long played a critical role in local

health improvement, health protection and public health. DPHs have a close relationship with DASSs and ADPH works closely with ADASS and the LGA. Public health is also a key area of work for PCH.

360. There were several significant issues about infection control. These included:

- The risk of infection when visiting into care homes;
- the consequences of isolation and grouping of residents deemed an infection risk;
- cross-infection from staff movement between different settings of care;
- the care environment;
- grant aiding providers with funds to implement infection control measures;

  and
- the guidance given in relation to IPC.

Outline of discussions

361. The LGA was involved in various discussions on these issues with Government, providers, the NHS, and sources of expertise such as PHE.

362. ADPH, alongside the LGA, was a key attendee at various DHSC task and finish groups which brought sector stakeholders together to consider relevant issues, including:

- Testing Task & Finish Group
- Care Home Visiting Guidance Task & Finish Group
- NCAG
- DHSC Social Care Stakeholder Group
- Covid ASC Working Group for Stakeholders

  and
- DPHs worked with PHE advising on the development of guidance, particularly around the role of DPHs in local government.

363. The LGA were asked to comment on the first iteration of PHE guidance for care homes,

published 13 March 2020 and then withdrawn.

364. LGA were then asked on 25 March 2020 to comment on some revised IPC guidance, for which James Bullion (ADASS) and Simon Williams (LGA/CHIP) convened a meeting on 26 March. The detailed correspondence about this revised guidance is summarised in our consolidated evidence on discharge from hospital in the previous section.

Workforce

365. Workforce capacity was a significant challenge during the pandemic as more staff became sick or were self-isolating. The lack of local authority wide data on the workforce made it difficult for councils to have oversight of the evolving challenges and to manage risk accordingly. In addition to the challenge of reduced numbers in the workforce, many individuals had to adapt rapidly to new roles or tasks, often with little training or supervision. These issues, alongside those around pay, rapid onboarding, training and development were regularly discussed at various working groups and stakeholder meetings. As a result, CHIP undertook a workforce stocktake in late March 2020 to understand which roles were under pressure in the short- and medium-term. Lack of social work capacity was identified as a challenge. The LGA upscaled the Return to Social Work programme. The programme offered free training to social workers looking to return to practice after a career break. By March 2021, 133 practitioners had been restored to the register and 72 returned to employment.

366. Staff across the ASC workforce experienced significant trauma as people they cared for through their work, and/or their colleagues, became ill and in some instances, sadly died. The LGA, with partners such as SfC and NHSE, developed and promoted resources to support the wellbeing of the workforce (although take up of these resources at the time was low). Anecdotal feedback from online events and meetings suggested that frontline staff most valued peer support from their manager or those going through similar experiences. The lack of recognition of the sacrifice of the care sector became a growing frustration as the pandemic progressed. While NHS staff were thanked with weekly clapping and provided additional benefits such as store discounts and parking permits, the same parity of esteem was not extended to the social care workforce. These issues were also raised in various groups and meetings.

Testing

367. Testing was of course a major issue for the ASC sector throughout the pandemic. As such, it is afforded full consideration later in this statement in Part 8 - Testing . Here, I

simply set out some of the key matters that the LGA engaged relevant partners on.

368. Testing task and finish groups included discussions on:

- Prioritisation of tests and testing capacity and availability. In the early stages of the pandemic, the workforce was unable to access tests, even when symptomatic.
- Lack of prioritisation of those delivering home care, working in supported living or PAs, and people with learning disabilities and people with autism.
- Distribution of tests. At a time when much of the distribution was organised nationally, CHIP and partners wanted greater autonomy for local areas to determine how to manage testing.
- Accessibility of testing sites for the workforce.
- Take up of testing in the workforce, which became a concern from Autumn 2020.
- Delays in receiving test results and the reliability of results.
- Procedures in testing those who lacked mental capacity;

  and

- communication around testing. It was felt that poor communications lead to unnecessary confusion with partners and in the sector.

PPE

369. As with testing, PPE – demand, supply, challenges, solutions – was a critical matter for the duration of the period in question. I have provided a more detailed commentary in response to the Inquiry's dedicated question on the matter in Part 9 - PPE Here, I simply give a flavour of some of the key matters that the LGA engaged relevant partners on, these included:

- Sustainable supply and issues to do with prioritising limited resources to primary care;
- a lack of a coordinated strategy on distribution;
- inadequate engagement with councils on relevant decisions;

- inconsistency in guidance;
- CHIP input to PPE guidance, tailored for a specific social care audience;

  and
- the LGA's involvement in developing case studies and input to videos and other resources supporting the care workforce in the effective use of PPE.

Funding including Provider and market viability

370. The financial pressure on ASC exerted by the pandemic (coming on top of an already financially stressed system) was significant. The case for, and subsequent distribution and use of, emergency funding was central to the ASC sector's handling of the pandemic. A full exploration of the issue is provided later in this statement; here I list just some of the key matters that were at play:

371. LGA, ADASS and CPA guidance to councils to help steady providers' financial position, particularly measures to support providers' cashflow.

372. Work to understand and estimate the additional costs providers were likely to face and the adequacy of Government funding.

373. Raising and escalating concerns about grant arrangements, including conditions attached to different funding streams.

374. It was critical that the financial viability of providers and sustainability of the social care market was kept under review during the pandemic. CHIP supported this process through regular meetings with care provider associations on a wide range of issues. CHIP also worked with councils and Government to deliver a major review of market sustainability in the autumn of 2020, including the range of measures that councils would typically take to maintain continuity of support in the event of a provider leaving the market.

Vaccination

375. I have addressed the issues around vaccination in my statement concerning Part 12 - Vaccines & Vaccination as a Condition of Deployment .

Data

376. I have also addressed the issues around data in greater detail at Key or significant concerns with data. I shall say only a little more here in relation to this subject.

377. The LGA set up and initially chaired a Task & Finish group concerning data which ran through March and April 2020 before it was handed to CQC to chair.

378. The LGA had to broker an agreement for one system to be used to get data from providers, despite the LGA's reservations and with promises that this would be reviewed in a small number of months. The system finally used was Capacity Tracker a cloud-based digital insight tool built by the North of England Care System Support in partnership with NHS England that enables care home, home care, in-patient community rehabilitation, substance misuse and hospice providers to share vacancy and other critical information easily and quickly in real time.

379. The LGA was concerned that a) ADASS regions were not happy that providers would not use the systems they had set up, b) that the data from capacity Tracker was initially not being available to local authorities, c) there was a failure to give feedback to providers, and 3) Capacity Tracker being used as a vehicle to do D2A from acute hospitals in the wrong way.

Volunteering

380. The LGA worked with the NHS and central Government in response to issues concerning the Government's centralised NHS-based volunteering scheme. This scheme had been criticised for potentially diverting volunteering capacity away from existing local platforms. In June 2020, the LGA published a briefing paper explaining the role of the voluntary and community sector during the pandemic, stating (LGA report dated 2 June 2020 "Accessing support: The role of the voluntary and community sector during COVID-19", **Exhibit JK4/092 – INQ000581192**):

> *"…Since its introduction, we have worked closely with the NHS and Government to improve coordination and alignment between national and voluntary volunteering capacity to support vulnerable people. For example, we are working with NHSE to identify a quick and easy way for local partners to share high level data on Clinical Commissioning Groups and local authority level, including the number of NHSVR volunteers available, the level and type of requests made, and who is making requests. In two-tier areas, the data will be available at district level which can be aggregated at county level. This will assist Councils and their partners in the voluntary and community sector gain a more comprehensive idea of voluntary capacity to provide support to*

vulnerable people in the community.

Originally, each request for help had to be referred separately. The system has now been improved so that referrers to NHSVR support are able to make 'bulk' referrals using the GoodSam app. This means that someone from a council, adult social care provider, pharmacy, GP surgery can refer several requests for support at the same time, rather than having to enter them all individually..."

Shielding

381. This is discussed further in my evidence in Part 13 - Funding

Indemnity cover

382. As described elsewhere in this statement, providers faced immediate, ongoing and significant funding pressures because of the pandemic. With the Government providing indemnity cover for the NHS, providers looked for the same as they were concerned that their insurance cover would not cover Covid. A lot of discussions took place on this matter (with both providers and national Government), but Government was unwilling to be 'cover of last resort' due to concerns about the precedent it might set.

Care Act easements

383. These are discussed further in Part 14 - Care Act Easements

Summary of the LGA's concerns regarding Government decision-making in the ASC Sector during the pandemic

Introduction

384. The LGA recognises that Government needed to make numerous decisions quickly, and that in many cases there were no options free of risks or problems. In this part the LGA has focussed on the concerns that it had during the pandemic rather than those further concerns it has had with the benefit of hindsight.

PPE

385. The provision of PPE was a significant area of concern, as is discussed further in Part 9 - PPE

386. In summary the ASC sector lacked suitable PPE at the beginning of the pandemic (despite Government assurances that there was enough) because planning assumptions were based around seasonal flu.

387. There were also problems with its effective and timely distribution, in part due to an early decision to move the responsibility for its distribution from upper tier local authorities to LRFs, which had bigger footprints but were not resourced to deal with an exercise of this nature, which involved dealing with numerous questions and demands from providers. Government decided in early April 2020 to use the Clipper logistics mechanism for this distribution but delayed until late May before it got going. There was confusion among providers on how to access PPE through these mechanisms.

388. Moreover, the NHS was consistently prioritised over social care, as detailed below.

389. Added to these issues the centralised procurement process did not always lead to the supplied PPE of sufficient quality to be fit for purpose.

Data

390. The collection, analysis and sharing of data, relating to the social care sector was a third area of concern. Of course, the LGA recognised the need rapidly to find a means of collecting frequent and timely data from providers on matters such as vacancy levels or staff sickness levels. Likewise local authorities in many regions already had well-tested

and used mechanisms by which to collect data from providers about matters such as available capacity. Unfortunately, these were set aside by Government in favour of a) an expanded use of Capacity Tracker, a system set up by the NHS's North of England Care System Support ("**NECS**"), for the collection in real time of vacancies in social care providers and b) (initially) a separate collection of data by CQC from homecare providers.

391. This was significantly sub-optimal. Local authorities, who had the statutory responsibility for market oversight, could not see the information from homecare providers coming through CQC, and could only see returns in Capacity Tracker for their own local authority.

392. The LGA was, to an extent, able to mitigate this through developing its own Covid-19 Adult Social Care Tracker, by which local authorities were able to see all relevant data for their own area. However, this did not apply to social care providers, who were not able to see their own data in the context of wider benchmarking. For them, this was a missed opportunity to use the analysis for their own business intelligence and planning.

393. Overall, the LGA's sense is that a range of opinion on Capacity Tracker existed (and still exists) among councils. At one end of the spectrum, some councils and care providers had misgivings about the use of Capacity Tracker as a platform for collection from all social care providers and for data wider than simply how many vacant beds they had. Nonetheless, in the short-term, they supported its use as a pragmatic way forward, on the basis that there should be a review in the medium-term (after a year or so) as to how it was working. A particular concern was to see what other and more useful options might exist if such collection was to be a long-term mandated requirement of providers. Although DHSC agreed that such a full-scale review should take place, this has not happened and there continues to be a mandated data collection from providers using Capacity Tracker. At the other end of spectrum, some councils did not, and do not, see Capacity Tracker serving any useful purpose, consider it an unhelpful burden, and are frustrated that DHSC's promised review has not materialised.

Testing

394. Early in the pandemic social care staff did not have the same access to testing and speedy results that was made available to NHS staff. This was an obvious example of the lack of parity of treatment as between health and social care. This had significant effects:

- It compromised the ability of the sector to protect both staff and those they support whether in care homes or in domiciliary care,

and

- it exacerbated the risks associated with using agency staff working between different care settings because of the levels of sickness among directly employed care staff.

395. The LGA also expressed concerns about the reliability of Lateral Flow Tests ("**LFTs**") in comparison with Polymerase Chain Reaction ("**PCR**") tests. The LGA briefing on 27 November 2020 highlighted the pros and cons of LFTs compared to PCRs, linking to the BMJ article about LFTs and use in mass testing (LGA briefing dated 27 November 2020 "Briefing on Lateral Flow Testing", **Exhibit JK4/093 – INQ000581214**). The LGA was also aware of ADPH's concerns in its statement, also published on 27 November 2020 (ADPH and Faculty of Public Health statement dated 27 November 2020 "Joint Statement: Targeted Community Testing", **Exhibit JK4/094 – INQ000581291**).

Vaccination

396. This is discussed further in Part 12 - Vaccines & Vaccination as a Condition of Deployment.

397. When vaccinations were made available, the LGA welcomed the decision to prioritise social care staff for vaccination, and worked with Government and the NHS to find workable solutions for reaching social care staff and ensuring they could take up the vaccine. As part of this, the LGA argued that recording uptake among social care staff should be done at the point of vaccination, since the plurality and diversity of the sector made it difficult to collate information about uptake in any other way. If it had been necessary, individuals could have been traced through their employers National Insurance numbers, though this was never done.

398. The LGA, alongside councils and other ASC partners also worked to address vaccine hesitancy overall and in certain community groups. For instance:

399. In 2021 the LGA published a comprehensive guide for councils on applying behavioural insights to improve vaccination take-up (LGA report dated 22 April 2021 "Applying behavioural insights to improve Covid vaccination uptake: a guide for councils", **Exhibit JK4/095 – INQ000581206**). This included many examples of effective activity undertaken by councils on a range of related matters identified in the LGA guide (such as communications, how to highlight the pro-social benefits of vaccination, positive reinforcement and how to leverage social networks).

400. In March 2021, the third episode of the LGA's 'Forget what you think you know' podcast series explored the issue of vaccination rollout. Contributors included a councillor cabinet member for adult services, a DPH, the lead consultant for screening and immunisation at PHE, and a council CEX. Part of the conversation was about tackling vaccine hesitancy.

401. In January 2022, the LGA published a research report from the Behaviouralist (a behavioural insights consultancy) that looked at understanding vaccination behaviours in the workplace (The Behaviouralist report (LGA commissioned, January 2022) "Understanding Vaccination Behaviours within Workplaces in Sandwell", **Exhibit JK4/096 – INQ000581299**). The workplace in question was Sandwell Metropolitan Borough Council which had commissioned the work as part of the LGA's Behavioural Insights Programme, a fund that supports council innovation.

402. The other key decision about which the LGA expressed concern was vaccination as a condition of deployment ("**VCOD**") for social care staff. In its response to the consultation on this issue, the LGA pointed out the risks of this policy, including:

- The resentment felt by social care staff at the inequity of applying this to social care staff and not to NHS staff.
- The consequence it had in – paradoxically - driving greater vaccine hesitancy.
- The lack of evidence of the necessity to apply VCOD to this group;

  and
- its impact on staff recruitment and retention.

403. This is described in greater detail below in the evidence I shall provide in answer to LGA concerns with the policy of 'vaccination as a condition of deployment' and it has already been addressed in the LGA's evidence to the Inquiry in Module 4.

Care Act easements

404. In general, the LGA supported the Government's policy intentions that gave rise to the Care Act easements. It worked closely with Government to ensure that the detailed policy and guidance was proportionate and fit for purpose. However, the LGA had concerns about councils choosing to use the easements being publicly 'outed' without notifying them first and before the list had been published by CQC (as had been agreed).

Grant conditions

405. Finally, in this section of my statement I should note that the LGA had concerns about the detailed conditions for key grants such as the Infection Control Grant. The LGA welcomed this funding and supported the need to ensure that it was reaching providers and being used for the grant's purpose. However, the level of detailed assurance required of local authorities, including the threat of claw back from those authorities that did not provide all this detail, was an issue. In short Local Authorities could not meet these conditions without in turn requiring detailed assurances from providers. To an extent local authorities did not feel able to take up the grant where there was a concern that providers would not be able to provide the necessary assurances and information.

Part 6 - The Management of the Pandemic

The extent of the understanding and consideration of ASC by core UK Government political and administrative decision-makers

Introduction

406. In LGA/ML/M2 INQ000215538 at paragraphs [28] and [35], the former CEX of the LGA said -

> *"28. Consistent concerns were raised with LGA from an operational perspective about the steps Government took in terms of the timeliness of decision making and communication to Councils, funding and workforce issues. Local Government was rarely a partner in co-designing the response to the pandemic, despite the extent to which it was critical in managing this. Moreover, particularly at the beginning, the disconnect between national policy formation and its local implementation, meant that Councils spent much effort trying to stitch together different elements of the pandemic response on issues such as PPE, volunteering, and test and trace.*
>
> …
>
> *35. A last key point concerns social care. During the period covered by Module 2 many issues arose about the treatment of those in social care. It was soon reported that adult social care settings were suffering severe problems from lack of PPE, cross-infection, and high morbidity. As Councils have statutory responsibility for social care, the LGA was highly aware of these issues. As I describe below, the treatment of the social care sector was at times chaotic, with an overall Governmental failure to recognise that those involved in this sector, whether as staff or care – recipients, were particularly vulnerable. This kind of chaos cannot be repeated. It is imperative in the view of the LGA that the Inquiry highlights the importance of addressing the needs of, and risks in, the social care sector, on a basis of equality with its approach to the NHS, in any future similar crisis."*

407. The LGA does not in any way resile from these comments as will already be clear. It seems, from the focus in the section The extent of the understanding and consideration of ASC by core UK Government political and administrative decision-makers on 'understanding' and 'consideration' by both politicians and officials in the Government, that the Inquiry now seeks to know more about the reasons, facts, and matters, which led up to this lack of adequate prioritisation of good policy making for the ASC sector during the pandemic. As I have already noted, in short, this because historically it has not been a national priority to make good workable policy for the ASC sector. In this part I shall develop this point.

408. This view is not particularly controversial and various organisations have written in similar terms. For instance:

- In its press release accompanying their 2024 'Social Care 360' report, the King's Fund make clear that, "Adult social care support continues to stagnate following a lack of action to reform the sector by successive governments" (Press release dated 13 March 2024, **Exhibit JK4/097 – INQ000545621)**.

- The NAO's 2021 report on the ASC market noted that, "Despite many years of government papers, consultations and reviews, the Department [of Health and Social Care] has not yet brought forward a reform plan" (**Exhibit JK4/097a – INQ000506973**). Linked, one of the NAO's recommendations was that DHSC should, "*as a priority* [emphasis added], set out a cross-government, long-term, funded vision for care".

- Going back in time further to illustrate the point that organisations have long highlighted a lack of priority for adult social care by national governments, a 2018 joint report by the King's Fund, the Nuffield Trust, the Health Foundation, and the Institute for Fiscal Studies, noted that (**Exhibit JK4/097b – INQ000545626**):

> *"Despite 12 green and white papers and five independent commissions over the last 20 years, successive governments have ducked the challenge of social care reform…The [ASC] system is complex and poorly understood. The public do not like many of its fundamental aspects when they understand it and believe it is unfair. [An] underlying lack of knowledge makes it hard for the public to assess any reform proposals when they are put forward, in turn making such proposals easy to attack*

by political opponents…A sustainable solution to social care funding is likely to need an uncomfortable process of public education and of political collaboration."

Adult Social Care's lack of a strong clear public profile

409. It is obvious that the public profile and concern about an issue is likely to be a very significant determinant of the priority given by politicians to it, but regrettably, the ASC sector has had a low public profile. As I have already noted in Part 1 in 2 - Government understanding, and public perception of the ASC sector, many people do not know what ASC is and how it operates and how it is funded, with many thinking that it will be freely provided. Many people do not give much thought to their possible future social care needs, either as a deliberate avoidance of facing up to potentially difficult future circumstances, or a genuine sense that it is not a service they will have cause to access.

410. Much of the national portrayal of social care, and those who access it, is negative, with the service framed as being in 'crisis', or 'broken', or facing a 'tsunami of need' of 'vulnerable' people. The care workforce is often similarly framed in negative terms, for example, 'unskilled', 'poorly paid' and 'suffering from burn out'. Such framing does little to create the conditions in which people can think positively about social care and, for the workforce, consider a career in it.

411. More practically, much of the provision of ASC is behind closed doors – either in people's own homes, or residential care. This contrasts with the far more public GP surgery or hospital, which helps create a stronger emotional connection to the health service and partly explains why – in the realm of the NHS and ASC – the former tends to win hearts and minds, translating into public, and therefore political, prioritisation. This may in turn contribute to the perception that ASC is simply an adjunct of the NHS, existing primarily to mitigate demand pressures facing the health service, rather than a vital service in its own right.

412. While not wanting to overstate the point, it should be born in mind therefore that as the country entered the pandemic, ASC was not a public or political priority (at least not as much as it should have been) and – when it was talked about – it tended to be framed negatively, and because it was not seen, in the same way as the NHS, as a national treasure to be protected and preserved, it just had not received the same priority.

How the politics of ASC provision played out in the pandemic

413. The view of the Health Foundation in a July 2020 briefing assessing the initial policy

response to the pandemic (**Exhibit JK4/098 – INQ000475075**) was that:

> *"Protecting and strengthening social care services appears to have been given far lower priority by national policymakers than protecting the NHS".*

414. The LGA, no doubt in common with many parts of the care sector, shared that view then and continues to hold that view now.

415. The LGA was therefore aware of the need to address the longstanding lack of parity of esteem with Government. On 6 March 2020, a LGA press release on cross-party talks to reform adult social care highlighted the need to "[make] the case for the value of social care in its own right" (LGA press release dated 6 March 2020 "LGA responds to cross-party social care talks", **Exhibit JK4/099 – INQ000581295**). The LGA referred to its report, published that same day, "The lives we want to lead; towards change, towards hope" which called on the Government, NHSE and NHS Improvement to "Consider how the NHS might change to be a more equal, modern and responsive partner" in the context of ASC (**Exhibit JK4/033 – INQ000581309**).

416. More explicitly, on 18 March 2020 in the LGA's briefing in advance of a meeting with the Prime Minister and Secretary of State for Communities and Local Government, the LGA's overarching key message was "Recognising the massive efforts so far and on-going of council teams like public health and social care as well as the NHS", the need to adequately resource the sector, calling for "the Government to be realistic about the enormous strains on social care, which could be seriously exacerbated by the virus" (LGA briefing, dated 18 March 2020, for meeting with Prime Minister and SoS for Communities and Local Government, **Exhibit JK4/100 – INQ000514925**). This sentiment was reflected in the then-Chief Executive's update to member authorities sent after this meeting (Email dated 18 March 2020 from LGA CEX to member councils re Coronavirus update, **Exhibit JK4/101 – INQ000581223**).

417. While somewhat anecdotal, it is also worth noting that it was not until 28 March 2020 that Matt Hancock wrote publicly an open letter to the care workforce thanking them for their work (Letter dated 28 March 2020 from Rt Hon Matt Hancock MP to ASC Sector, **Exhibit JK4/102 – INQ000565704**

418. The letter is important as indicating his approach to ASC. It was addressed "To my brilliant colleagues in social care", and concluded by saying -

> *"…we are committed to doing whatever is needed [to support the sector*

through the pandemic]; that promise applies just as much to social care as it does for the NHS".

419. On the one hand, this was a reassuring message to give and receive, but on the other hand, the fact that he thought it needed to be spelt out reflects the fact that the sector knew that hitherto it had not been the case and sadly this continued. For instance, gold and silver awards for exceptional service were introduced in the NHS in 2019, whereas it took a further two years before a parallel award was introduced in relation to ASC workforce practice.

420. In short ASC, which proved to be one of the most important public services in responding to the pandemic started from a position of inadequate attention, poor recognition and insufficient priority, and a lack of parity of esteem with the NHS.

421. As Prof Jon Glasby and colleagues noted in a retrospective review in 2023, (Jon Glasby et al (BMJ, 4 July 2023) article "Building a better understanding of adult social care", **Exhibit JK4/103 – INQ000581211**):

"…During the pandemic, the immediate focus in many countries was on acute hospital care, with a tendency to overlook ASC. This had tragic consequences for many people's lives and the wellbeing of care workers. Whereas systems were rapidly put in place to supply hospitals with extra funding and as much personal protective equipment (PPE) as was available, social care staff were initially almost entirely neglected…"

422. Of course, councils were all too aware of this. Thus, the LGA's survey of all councils conducted at the request of the Inquiry, noted how (**Exhibit JK4/001 - INQ000400522**):

- 20% of councils said they experienced orders of PPE being diverted to the NHS 'very often' and 24% experienced this happening 'fairly often' in the first six months of the pandemic;
- 15% of councils experienced hand sanitizer being diverted to the NHS 'very often' and 12% of councils experienced this 'fairly often';

  and
- tests being diverted to the NHS was experienced 'very often' by 17% of councils and 'fairly often' by 16% of councils.

Summary

423. As I have set out at various points in this witness statement, there is much evidence showing the extent to which the Government at the time (and Governments in general) lacked an understanding of ASC, both in terms of its value and its operation, and how this has contributed to a lack of prioritisation by successive Governments to fully tackle the fundamental issues of ASC funding and reform.

424. However, at the same time it is impossible to believe that the then Government did not understand the significant pressures facing ASC in the years before the pandemic and during it, because for at least the last 15 years, in increasing unison, the LGA, other local government organisations, individual councils, and many partners across the ASC sector (including the NHS), have been banging the drum for Government to address both the problems and potential of ASC.

The level of UK Government consultation and communication with ASC sector about significant decisions made during the pandemic

425. In this section, I summarise the LGA's views on whether the UK Government had sufficient levels of consultation and communication with the ASC sector about significant decisions made during the pandemic, including the timing and adequacy of the consultation and communications. I then go on to explain how the LGA responded to try to mitigate any inadequacies in this respect.

426. At the beginning of the pandemic, from February to April 2020 in particular, Government made attempts to consult with the sector. However, this was often undermined by several factors. While the LGA appreciates that the nature of the pandemic made consultation and communications extremely difficult, it is important that the ASC sector's perspective, being on the receiving end of this, is made clear, because:

- *Firstly*, there was limited capacity in the social care part of DHSC and in some organisations in the social care sector which had to respond, in particular the ADASS central team. The LGA believes that there were about 50 civil servants working in the social care part of the DHSC at the start of 2020. Certainly, this increased substantially later on as the Nuffield Trust and London School of Economics note in their excellent 2023 report, 'Building a resilient social care system in England: what can be learned from the first wave of Covid-19?' (**Exhibit JK4/103a – INQ000553858**):

  "Recent workforce data indicate that 330 staff work in the DHSC social care team

as of December 2020, which we understand may represent a seven-fold increase on pre-pandemic levels"

The LGA understands that as at 2019, the ADASS team at a senior policy level consisted of the chief executive, deputy chief executive and two senior policy officers.

- *Secondly*, it took a while to organise consultation and dialogue effectively. Whilst Government set up NCAG, co-chaired by Ros Roughton and James Bullion, it was very large and difficult to conduct in depth and meaningful discussions on key topics. Government sought to mitigate this through establishment of task & finish groups, but they were of varying effectiveness. Those on workforce and easements met and ensured that discussions took place, those on finance and communications did not appear to get off the ground.

- *Thirdly*, consultation on key topics tended to be conducted by Government on parallel lines, so that responders would not be aware who else was responding and what they were saying. This was especially true of ADASS, the LGA, and provider organisations like the CPA, NCF, CareEng, and the UKHCA. This hindered a joined-up response from the sector.

- *Fourthly*, turn-around times for responding to consultations were often very constrained. Examples are the first draft of the hospital discharge guidance on 16 March 2020 (1.5 hours), the final draft of the same guidance on 19 March 2020 (3 hours), a draft of the Adult Social Care Strategy on 11 April 2020 (3 hours). While the LGA appreciates that the Government was, like everyone else, operating under extreme conditions, the lack of time was a significant hindrance in being able to adequately consider and feedback on strategies and guidance.

- *Fifthly*, communication to the sector was coming from multiple sources within Government, yet with no attempt being made to provide summaries for managers and staff in the sector who were exceptionally busy operationally.

427. It appeared to the LGA that, going into the pandemic and in its early weeks, Government took what might be seen as a cautious approach to consultation and engagement. What time there was to produce policy and guidance was being spent on internal Government discussion, so that time to engage the sector more broadly was compressed. There was also an understandable emphasis on secrecy, with key respondents being asked not to share policy and guidance drafts any further. This was not

universally true, of course. For example, the work on Care Act easements was an early example of how Government could work with the sector on a more co-produced basis.

428. The LGA sought to mitigate these concerns in the following ways:

- *Firstly*, it organised its own officers, across the then CHIP and policy teams, to lead on key themes such as PPE or testing. This created some internal capacity and meant that officers could engage with thematic groups on a consistent basis. The LGA emailed Ros Roughton on 17 March 2020 to say that this meant that it could engage and give advice without asking for more resources, as long as it was understood that CHIP was being reprioritised as a programme to do this (Email dated 17 March 2020 LGA to DHSC re resourcing and internal capacity, **Exhibit JK4/104 – INQ000581175**). The ASC Hub daily bulletin, mentioned above, operated to ensure consistent messages were given to LGA/ADASS staff and to respond to external queries. To address the issue of so much such policy and guidance coming from multiple sources, the LGA also used the bulletin to give a regular and frequent digest for DASSs in particular.

- *Secondly*, recognising the need for Government to consult with the sector as a whole rather than on parallel lines, the LGA made an offer to Government and the provider sector to convene and support a national social care provider group with a focus on Covid-19 issues. The offer was made on 20 March 2020 and up and running at the end of March. It met initially twice a week due to the volume of work to be handled, before stepping down to weekly later in the year and then fortnightly. It was co-chaired by the chair of the CPA and the LGA Director of Adult Social Care Improvement. At the outset a list of issues of provider concern and interest was compiled, so that issues could be worked through systematically. At the same time, the group was open to and encouraged civil servants and NHS managers to come and engage with the group. The view of the LGA was that this supported a more joined up response from the sector, greater confidence that there was a means of addressing concerns and facilitated earlier testing of policy and guidance by Government.

- *Thirdly*, the LGA encouraged Government to involve the sector earlier in designing policy and guidance, on the grounds that better solutions could be found if all relevant parties started with a shared view of the problem to be addressed and then worked together to find solutions (see, for example, an dated 25 May 2020 from LGA to DHSC re care home support and need for earlier engagement over

guidance, **Exhibit JK4/105 – INQ000581346)**. The LGA recognised that working in this way required mutual trust that confidential ideas or information would indeed be kept confidential, and this is part of the reason why the LGA sought to advise and influence Government through these channels and made sparing use of public criticism of Government.

429. Government, to its credit, adapted its methods of consultation with the sector. It engaged with the provider group described above to test thinking on an informal basis. It also sought to engage with ADASS and to a degree with ADPH in a similar way. This change of methodology was most apparent when it set up the Social Care Task Force under the leadership of Sir David Pearson in June 2020, with task and finish groups led by people from the sector contributing to the overall work. The change was also apparent in the earlier sharing of ideas, policy and guidance, with greater discussion before draft policies were firmed up. Examples were the issues tackled by the social care task force, designated premises, and the roll out of vaccination for social care staff.

The LGA's concerns about guidance to the ASC sector

430. The LGA has held significant concerns over some of the guidance published by the Government that concerned the ASC sector during the pandemic, concerning the connected issues of IPC and hospital discharge to care homes in the early months of the pandemic.

431. I have discussed the factual issues concerning the guidance on IPC already in a number of places in this statement, see in particular the discussion in Part 5 - Key decisions made by the UK Government.

432. In addition to IPC and D2A, the LGA also had concerns over guidance published on:

- *PPE* which I have discussed in Part 9 - PPE .
- *Staff movement* was an area where the LGA had concerns over guidance at the consultation stage but was pleased to see the Government take its feedback onboard. In November 2020, the Government proposed to introduce additional measures to regulate staff movement between care settings. The LGA pushed back on behalf of the sector, advising that this approach was counter-productive and that the Government should instead provide further guidance, rather than regulations (LGA press release dated 4 March 2021 "New guidance on restricting staff movement in care homes", **Exhibit JK4/106 – INQ000581313**). The Government

adopted this approach in its guidance published on 3 March 2021.

- *Indemnity for care providers* was a big issue in early NCAG meetings. The problem was that while Government decided to indemnify the NHS for future claims related to Covid-19, it would not do so in relation to social care. It was another powerful example of lack of parity of esteem for the ASC sector as compared to the NHS. The issue was never resolved so care homes were left on their own with this. I have discussed this issue in a number of other places in this statement, see in particular Part 4 - Indemnity cover and in Part 13 - Financial support to providers

and

- care home visiting which I have discussed in Part 8 - Testing visitors to care homes

The LGA's involvement in stakeholder or working groups on the management of the pandemic

Introduction

433. In the LGA's witness statement for Module 1 (**INQ000177803**), the former-Chief Executive, Mark Lloyd, said [121] –

> *"…Government departments established numerous working groups and other arrangements to which they invited local government representatives and the LGA, and the LGA worked hard to coordinate input from the sector to ensure consistent messages were fed into those discussions as far as possible..."*

434. He provided a table of the groups, dates and engagement in the following paragraphs. In addition to the bodies discussed below, I also refer the Inquiry to the section "LGA engagement with Government and stakeholders" and Appendix 2 – Timeline of LGA's engagement with organisations.

The R9 group of council chief executives

435. The R9 group of council CEXs comprised of a representative group of council CEXs from each of the nine English regions, London Councils, and senior LGA policy officers. This group was convened by DHLUC and met weekly for most of the period. Through cross Government boards and meetings, held on an *ad hoc* basis at different stages of the pandemic, the views of the R9 CEXs were sought, and councils' perspectives of the key risks were identified. The consensus views of the R9 group were presented in summary

form, facilitated by the LGA. For example:

- *09/03/21 Cross Whitehall Delivery Board* – Risks to next stage of the roadmap – risks relating to social care were D2A funding continuation, care home staff sickness / self-isolation at same time as visits.

- *19/08/21 Cross Whitehall Delivery Board* – Test, Test, Trace & Isolate Autumn/Winter risks were the impact of requiring all ASC workers to be vaccinated - loss of expertise and loss of workers. Sector already in a precarious workforce situation.

- *24/08/21 Cabinet Office Test, Trace & Isolate challenge session risk* - impact of requiring all ASC workers to be vaccinated - although vaccination of ASC staff is crucial there are major concerns about loss of expertise, as well as loss of workforce. The disparity with NHS staff impacts on this. ASC sector already in precarious workforce situation.

- *14/01/22 R9 Omicron asks and key issues for the sector* – summary of key issues and what is needed for Local Government at this stage of the pandemic (Omicron crisis) from the R9 to Cabinet office and Cross Whitehall Delivery Board, including:

    - Significant concerns around discharge and implications for social care and other council services with the need to ensure the combination of measures used locally is agreed with councils, and there is a joint approach to finding quickest and best solutions with clear undertakings on resource.

    - Clearer guidance on circumstances in which the closure period for care homes after a Covid-19 outbreak can be reduced from 28 days to 14 days would be broadly welcomed by the care sector.

'Leaders Group' meetings

436. Ministers met with a group, informally known as the 'Leaders Group' consisting of the chairs of the different local government groupings (represented through LGA special interest groups), the London Councils, the LGA's political group leaders and the LGA's Chairman. This was one of the main engagement routes in the earliest days of the pandemic. For example, on 16 March, and on 5 April 2020, the then Secretary of State Robert Jenrick met with the group to discuss developments in the early stages of the pandemic.

Local Outbreak Advisory Board

437. At the end of May 2020, the Local Outbreak Plan Advisory Board was established. This was chaired by the LGA Chairman, and from the local government side, it comprised council leaders, CEXs, DPHs and a Director of Adult Social Services. Meetings of the Board were attended initially by the Public Health Minister, as well as officials from the DHSC, PHE, NHSE and the MHCLG. The Board originally met weekly, then fortnightly during summer 2020 and meetings became monthly in 2021.

438. Its remit was to ensure that:

- National policies for testing and contact tracing arrangements took full account of local government and wider local capability,

  and

- there were effective local plans and coherent local arrangements for testing, contract tracing and tracking to manage local outbreaks, and providing support for those who needed it.

Ad hoc discussions

439. An example of an *ad hoc* discussion with LGA political leaders and Government ministers is the roundtable for LGA lead members and Kemi Badenoch Minister of State for Levelling Up Communities held on the 17 December 2021. The issues raised at this meeting included:

- *Discharge* - There was once again a need to discharge patients into the community. This posed a significant challenge for the ASC sector because it was so under-resourced;

- *Booster uptake by social care staff* - This was running at only 32.1% and in care homes for younger people and in domiciliary care it was even lower than for care homes at 20.2%;

- *Staffing levels* - Councils were continuing to have concerns about staffing levels within care services as compulsory vaccination continued to present a challenge for the sector.

440. The LGA had, or facilitated, a range of *ad hoc* engagements with ministers, such as informal/private feedback and exchanges on a range of different issues between the LGA's Chairman and Government Ministers. The Ministers concerned included Matt Hancock

(Secretary of State for Health and Social Care), Helen Whately (then Minister of State at DHSC), Jo Churchill (Parliamentary Under Secretary of State at DHSC), Robert Jenrick (then Secretary of State for Housing, Communities and Local Government), and Luke Hall (then Parliamentary Under Secretary of State at the MHCLG).

441. A sample of key meetings relevant to the scope of this Module follows -

Helen Whatley then Minister of State at the Department of Health and Social Care

- March 2020 – The LGA raised issues on decant from hospitals, the need for health support, clinical supplies, the handling equipment and forewarning, testing and concerns regarding getting PPE for social care settings.

- March 2020 – The LGA raised issues concerning the difficulties with PPE and patients leaving hospital to care homes without test results.

Jo Churchill then Parliamentary Under-Secretary at the Department of Health and Social Care

- March 2020 – There were numerous discussions regarding PPE and difficulties of extracting from NHS central depot to LRFs.

- Regularly raised issue of lack of PPE in care settings.

Robert Jenrick - then Secretary of State for Housing, Communities and Local Government

- The LGA raised issues on local lockdowns in 2020/21, also remote meetings for councillors.

- March 2020 – The LGA raised issues on hospital decant, shielding of vulnerable and poor quality of data being provided to councils.

- March 2020 – The LGA raised issues on lack of PPE for social care and other areas including the police.

- April 2020 – The LGA raised issues on household waste and recycling centres, also issues around business grant distribution and additional bureaucracy being requested by Civil Service, and concerns regarding the Clipper Service for PPE and potential delays.

Matt Hancock then Secretary of State for Health and Social Care

- There were informal political meetings between the Conservative Councillors Association, the LGA and DLUHC politicians (involving the LGA Chairman and Conservative Group Leader, Chairs of the District and County Councils Networks, and Conservative Lead at London Councils); these also took place sporadically with Minister Luke Hall between January-November 2021 and irregularly with the Secretary of State after November 2021.

Webinars

442. The LGA regularly provided a platform and opportunity for Government officials or Ministers to engage with all council CEXs or leaders through a series of webinars on key issues. Specific examples of these webinars have been mentioned as relevant in my statement, see also Appendix 3.

National Steering Group Coronavirus (later the National Coronavirus Advisory Group)

443. The National Steering Group: Coronavirus was a repurposed structure, previously used to discuss Brexit implications, and convened by DHSC. The group held multiple meetings in the early days of the pandemic, from early February through to mid-March 2020. This group was attended by officers from DHSC, MHCLG, ADASS, CQC, and the LGA, as well as representatives from Scotland and Wales.

444. In March 2020, the group was stood down and replaced by the NCAG. This group was co-chaired by the DHSC Director General for Social Care and by the ADASS President-elect. It was a large group which included stakeholders from local government, government agencies such as PHE, the social care provider sector, voluntary organisations, and organisations representing those who draw on social care. I have discussed this body above in Part 4 - Working groups/stakeholder groups

Local Resilience Forum: Chairs' Call

445. As detailed in Mark Lloyd's statement on behalf of the LGA for Module 1 (**INQ000177803**), the Government has several mechanisms for engaging with LRFs. These include calls with LRF chairs where appropriate. The focus of these calls started to shift in early 2020 on to Covid, and from April 2020 they became more frequent with weekly calls taking place until the summer of 2020. The LGA participated in these meetings in an observer role to help inform its work in response to Covid, and to better understand the issues councils were dealing with.

446. The calls provided an opportunity for Government to update LRFs on the latest information on epidemiology of the Covid, recent initiatives and developments in policy. They also provided and opportunity for LRF chairs to ask questions and raise issues, including in relation to social care, and issues that had a direct impact on it. A non-exhaustive review of notes taken by LGA officers during the calls show matters relating to social care were raised by LRF chairs early in the pandemic at the following meetings:

- 13 February 2020: Advice on what to do in specific settings was discussed, including in care homes, and what guidance PHE would provide for social care settings.
- 25 March 2020: The provision of food parcels to clinically extremely vulnerable ("**CEV**") who were shielding, and the flow of data from the NHS to local authorities.
- 8 and 15 April 2020: The provision and distribution of PPE, with chairs explaining that the social care sector was in crisis as not enough PPE was being delivered.

Task & Finish Group - Adult Social Care Workforce and Covid-19

447. The Task & Finish Group – Adult Social Care Workforce and Covid-19 was convened by DHSC and met several times between 19 March – 29 May 2020. Attendees included CQC, ADPH, ADASS, NHSE, then PHE, and the LGA among others. The group raised concerns on behalf of the care sector in response to Covid-19 and discussed maximising supply and capacity of the social care workforce. I have included an example of the ASC Workforce Task & Finish work plan, agenda and group slides from 22 May 2020 (Email dated 22 May 2020 re ASC Workforce T&F group agenda, **Exhibit JK4/107 - INQ000581270**; ASC Workforce work plan, **Exhibit JK4/108 - INQ000581207**; PowerPoint ASC Workforce group slides, **Exhibit JK4/109 - INQ000581188**).

448. The scope of the group during the early days included the following, and grew as the pandemic developed:

- workforce assumptions and impact on the social care sector,
- pay,
- measures to enable flow into the workforce and enable more flexibility and resilience,
- volunteering,
- reviewing and developing sector support,

- workforce wellbeing,

  and

- personal assistants.

Task & Finish Group - Adult Social Care Personal Protective Equipment

449. The Task & Finish Group for Adult Social Care and PPE met between April – October 2020. Alongside the LGA, members included CQC, then PHE, NCF, CareEng, and Social Work England. DHSC Adult Social Care PPE officers provided the secretariat for the group, with outputs of the meeting feeding directly into guidance and approach to provision of PPE in the care sector. The group was established to work through all the issues raised by care providers, users and staff and ensure that feedback is rapidly acted on.

450. The issues included:

- *Guidance on the use of PPE* - To ensure PPE was used correctly, both to protect staff, and residents/individuals receiving care and support, from Covid-19 and to regulate stock by preventing overuse, there needed to be clear guidance. This platform was aimed to communicate effectively to the sector and provided an opportunity to feedback and highlight any additional areas requiring guidance.

- *Logistics, including supply and distribution of PPE* - DHSC needed to be clear and transparent on how each group in the sector could acquire PPE. The meeting provided an opportunity for a first-hand update from the LGA's supplies team, DHSC central PPE team and a representative from the National Supply Disruption Response team ("**NSDR**").

- *Funding impacts* - The group considered the issues of rising costs for PPE.

National Covid-19 Social Care Provider Issues Group

451. I have discussed this in Part 4 - Working groups/stakeholder groups and Appendix 2 - Working groups

Social Care Sector Covid-19 Taskforce

452. I have discussed this also in Part 4 - The Social Care Sector Covid-19 Taskforce and Appendix 2 - Working groups

LGA engagement with WLGA, NILGA, COSLA

453. The LGA has worked alongside and communicated on an *ad hoc* basis with the WLGA, COSLA and NILGA before, during and after the Covid-19 pandemic.

454. While the LGA's core members are English councils, Welsh councils are also in corporate membership through the Welsh LGA. In contrast to WLGA, neither COSLA nor NILGA are members of the LGA. They are independent membership bodies representing the interest of local government in Scotland and Northern Ireland, respectively.

455. Sometimes the LGA will undertake joint work with the WLGA, COSLA and NILGA, particularly looking at issues such as the overall financial needs of local government and workforce planning, but there is no formal relationship between the LGA and these bodies.

456. The LGA's previous CEX said in his evidence for Module 2 (LGA/ML/M2, **INQ000215538**):

> *"…The LGA's primary focus during the pandemic was supporting English Local Authorities' emergency response and engaging with the UK Government and public service partners in that content. The Welsh Local Government Association (WLGA), Convention of Scottish Local Authorities and Northern Ireland Local Government Association were similarly focused on supporting their respective members' response to the pandemic.*
>
> *The WLGA was represented on the LGA's Executive Advisory Board (through the WLGA's Deputy Leader) which met on a six-weekly cycle through the pandemic.*
>
> *The Local Government response to the pandemic and relationship with the UK Government was a key topic of discussion, and the forum provided an opportunity to compare respective approaches and issues between England and Wales.*
>
> *The four UK Local Government associations met twice during the pandemic through the UK Forum, on 7th August 2020 and 3rd June 2021, and the comparative approaches to the pandemic was a topic of discussion. The respective finance teams met regularly from May 2020, exchanging information on Covid income losses and their recovery, Local Government fiscal deficit forecasting and analysis, and sharing*

approaches to engagement with UK and Devolved Governments. Officials from the four associations also met regularly throughout the pandemic through the National Association for Regional Employers, to discuss common matters of interest relating to workforce matters.

These forums provided opportunities to exchange information and compare approaches but did not agree common lines or joint documents for consideration by devolved or UK Governments. Governmental colleagues were not involved in these meetings..."

457. The LGA does not hold a central register of meetings or communications with these organisations during the pandemic beyond what is outlined in LGA/ML/M2 (**INQ000215538**) above. The LGA does not consider that its engagement with these organisations had a significant impact on the LGA's approach to the ASC sector during the pandemic. The relevant officer who engaged with COSLA, NILGA and WLGA has since left the LGA and had not been contacted to comment on this.

Key or significant concerns with data

458. At the beginning of the pandemic, the Government faced challenges in the lack of real time data at a national and local level on issues such as bed availability, demand, workforce and infection control. This was made more difficult due to the complexity of provision. SfC estimated that, in 2019/20, 38,000 establishments across 18,200 organisations provided or organised ASC (**Exhibit JK4/027 – INQ000542979**).

459. '*Organisation*' is defined by SfC as large national employers, large charities, local authority adult social services departments, and small independent care services (**Exhibit JK4/027 – INQ000542979**). These figures do not include people employing their own care and support; SfC estimates that around 230,000 adults, older people and unpaid carers, were receiving direct payments in 2019/20, with 70,000 of those directly employing their own staff. These figures do not include those people who employ their own staff via other funding, including their own.

460. In early June 2020, the LGA raised concerns at a senior level within MHCLG about the burden placed on councils by multiple onerous data requests (Letter dated 3 June 2020 from LGA to Director General for Local Government and Public Services regarding supporting vulnerable people and businesses during the Covid-19 crisis, **Exhibit JK4/110 - INQ000103837**). Prior to the pandemic, the Government did not have a detailed and direct understanding of what was happening in the ASC sector, because of several factors,

including:

- The dispersed nature of delivery through thousands of providers,
- the infrequency of standard data collections from councils,

  and

- the fact that the regulation of councils' ASC functions had ended since 2010. Government, and particularly Helen Whateley MP, the Minister for Social Care, wished to change this early on during the pandemic.

461. CHIP sought to support this proposed change, provided it did not cut across councils' statutory responsibilities and did not impose undue new administrative burdens.

462. The LGA worked closely with DHSC and other national organisations to ensure a co-ordinated effort in collating and utilising data for ASC to inform the Covid=19 response. Key areas of support in relation to data and intelligence included –

- Supporting councils to help providers through access to the latest daily care provider data via the secure online Covid-19 Adult Social Care Tracker;
- Support for the Infection Control Fund process, including regular summary analysis of the provider data by council area (weekly until August 22, monthly since);
- Voluntary benchmarking for monitoring monthly safeguarding activity during the Covid-19 pandemic;
- Working with councils to develop and analyse the responses to an effective and constructive Self-Assessment Questionnaire and regional approach to inform the Service Continuity and Care Market Review ("**SCCMR**");

  and

- support to DHSC in the development and governance of the Provider Data Collection and the Covid Dashboard.

Data collection by the LGA

463. I have already stated that one of the most important roles the LGA played during Covid-19 was to act as a conduit, and filter for information between councils and the Government. The LGA regularly fed soft intelligence and case studies into Government about the issues

that councils were experiencing in their communities and then provided information and advice back to councils. However, due to the pressures on councils, formal data collection and detailed research was limited.

464. There was, however, one set of local data that the LGA consistently provided to the Government to help inform the response to Covid-19. From early May 2020, the LGA's research team surveyed councils to collect data on their workforce capacity to deliver required services. In 2020, surveys were conducted fortnightly; this changed to monthly between January and August 2021, with two final quarterly surveys in October 2021 and January 2022.

465. The surveys covered some especially important issues for the management of local government during the pandemic and the capacity of the sector to support the overall response to the pandemic. The surveys covered:

- headcount,
- death in service,
- numbers of staff furloughed, redeployed or unavailable for work,
- service disruption linked to staff availability,

and

- access to PPE and Covid-19 tests.

466. For clarity, I must add that the work that CHIP supported, through the Capacity Tracker and the SCCMR, was to ensure oversight of issues in the registered care market; the safeguarding exercise was to support councils in ensuring the safety of people under their responsibility. The LGA workforce survey was separate from this – it focused on council staff.

Role of the LGA in the creation and use of the Capacity Tracker

467. Early into the pandemic a meeting was convened including the CQC, DHSC, LGA, ADSS, and the CPA, to determine the most appropriate way to ensure data and intelligence from social care providers could be captured and collated. It was important that,

- such data should be effective to support the people they care for safely;

- resources should be targeted most effectively where they were needed;
- the impact of Covid-19 on the people cared for, the ASC workforce, and providers' ability to deliver services collectively (nationally, regionally and locally), was understood;

  and

- this collection should be in such a way that did not impose such a burden on providers as to impinge on the delivery of safe care.

468. In March 2020, CHIP convened and initially chaired a group with membership of ADASS, LGA, CQC, the DHSC and provider representatives. This group looked at options for data collection from social care providers, with the aim being to enhance Government's understanding of issues in frontline social care. After some discussion, it was agreed that an NHS tool Capacity Tracker (which I have already mentioned) offered the most immediate and pragmatic means in the short term of getting a frequent data collection from providers up and running. This was agreed on the basis that it was expected that during 2020 there would be a proper review of how such data collection could be best continued.

469. The CQC set up an alternative mechanism for daily reporting by homecare providers and CHIP rapidly set up a secure system using LG Inform for councils to access in one output all data reported by homecare and residential care providers. The Government's approach demonstrated a tendency to fail to understand the diversity and complexity of the care market and that many providers have little or no "back office" support for non-care tasks as they do in the NHS. LG Inform enabled councils to access the current information about their providers regularly and easily, which was lacking in the Capacity Tracker.

470. On 17 April 2020, a letter was sent to all registered social care providers requesting that they submit a daily data return (Joint letter dated 17 April 2020 from CPA, CQC, DHSC and NHS to ASC providers, **Exhibit JK4/111 - INQ000532379**). The letter was signed collectively by the CPA, CQC, DHSC, NHSE and NHS Improvement. All residential and nursing homes were asked to complete a return using the NHS Capacity Tracker; homecare providers were asked to complete CQC's 'Update CQC on the impact of Covid' online form. Providers were assured that if they provided the information daily, councils and other local bodies would receive that data, thus minimising the possibility of any duplication of data requests from care providers.

471. Detailed outputs from care home location level were provided for registered council users to view through Capacity Tracker. However, user restrictions in Capacity Tracker determined that councils could only see care providers in their own area, and accessing the detailed returns required the extract of several disjointed reports. At the start of the pandemic, there was no output for councils to access the outputs from the CQC online returns from homecare providers – so they would not be sighted when concerns were flagged.

472. The LGA developed an online Covid-19 Adult Social Care Tracker on LG Inform to provide councils with secure access to daily care provider updates for both care homes (collected through Capacity Tracker) and for domiciliary care collected (through the CQC survey form). Both systems have been maintained since April and continue to provide daily outputs.

473. Through the LG Inform view, registered users, nominated by their DASS, had the ability to access the full dataset for all registered care providers across England, including those not submitting a return. The information was extractable as a CSV file and included contact details for the provider to facilitate rapid action where support, e.g. low stocks of PPE, was urgently needed.

474. The LGA provided Capacity Tracker with the latest new registration details so that council users could be quickly onboarded to access the Capacity Tracker system.

475. With the introduction of the Infection Control Fund, managed by the Better Care Fund Support Team, the LGA provided (at the request of the BCF team) a concise weekly summary analysis at local authority, regional and national level to monitor progress and areas of concern.

476. Provided they were nominated by the DASSs there was no limited on the number of users per council. Over 1,000 users across all CASSRs were registered.

477. While the Capacity Tracker collection was eventually used to record many aspects of both home care and care home provision, and whilst it was incentivised in that much funding was conditional upon its completion, scrutiny of the data in relation to care homes received much more attention than data relating to community provision.

478. CHIP handed over the chairing and convening of the group to the CQC but has continued to play an active role. The LGA and providers have been frustrated that two years later the agreed review of data reporting by social care providers had not yet been

delivered by Government. The absence of this review and continued reliance on what was expected to be a short term fix via Capacity Tracker, has meant that in some instances councils, both individually and on a regional basis, have either needed to continue their own data collections, which is an unwelcome extra burden for providers, or do not receive the market oversight information that they need to ensure that their functions in this area are properly discharged.

479. CHIP, has, however, sought to ensure that councils continue to have prompt and usable access to this data and has done this through the LG Inform secure summary and regular summary reporting of the data it contains. CHIP has also supported efforts to address information collection from councils, for example in reviews of the NHS Adult Social Care Outcomes Framework and the replacement of Short- and Long-Term Support annual statutory return to the DHSC with a system which uses information about social care customers at an aggregated level.

Safeguarding Adults Insights Project

480. The Safeguarding Adults Insights Project was a voluntary benchmarking exercise mapping safeguarding activity during the pandemic. It was developed to create a national picture regarding safeguarding adults' activity during the Covid-19 pandemic. It was felt that a data collection was needed to prompt further questions and provide data rather than anecdote to support understanding about the impact of Covid-19 on safeguarding activity in England. The data provided a picture of how safeguarding adults activity in England was affected by the initial stage of the pandemic and first lockdown, up until June 2021. Around two thirds of councils submitted data as part of the exercise. The Safeguarding Adults Insights Project produced three reports:

- Covid-19 Adult safeguarding insight project: findings and discussion (December 2020) (**Exhibit JK4/112 - INQ000581226**);
- Covid-19 adult safeguarding insight project - second report (July 2021) (**Exhibit JK4/113 - INQ000581224**);
- Covid-19 adult safeguarding insight project - third report (December 2021) (**Exhibit JK4/114 - INQ000509872**)

481. Concerns about quality and safeguarding were critical as an absence of relatives, inspectors, health staff and social workers going into care homes meant that, in effect, the number of closed institutions increased. This, together with existing concerns about too

many providers being judged as inadequate or requiring improvement and staff shortages due to existing high vacancy rates but exacerbated by sickness or isolation raised concerns further).

482. In December 2020 the Safeguarding Adults Insights Project reported that (**Exhibit JK4/112 - INQ000581226**) –

> *"The percentage of Section 42 enquiries where the risk is located in the individual's own home increased markedly since the start of the COVID-19 lockdown period, with evidence from participants that this is a direct result of the confinement of people in their homes. Enquiries with risk located in care homes decreased as a percentage in the same period, possibly because of the relative lack of outside scrutiny in those environments during the lockdown period"*

Market sustainability and continuity of support

483. It was critical that the financial viability of providers and the sustainability of the social care market was kept under review during the pandemic. CHIP supported this process through working with councils and Government to deliver a major review of market sustainability in the autumn of 2020, including the range of measures that councils would typically take to maintain continuity of support in the event of a provider leaving the market.

484. The importance of the financial viability of providers and the sustainability of the social care market meant it was critical that this was kept under review during the pandemic. CHIP provided significant input into the planning, design and delivery of a Government-led review, being the SCCMR. CHIP worked with DHSC and in close consultation with ADASS throughout 2020 to develop a detailed and complex set of questions and response options that sought the views of DASS on the stability and key challenges of all areas of their provider market. This questionnaire was created and hosted online by CHIP. On 30th September 2020, a link was sent to the DASS in each local authority so they could access their unique version of this questionnaire (see the self-assessment questionnaire, **Exhibit JK4/114a - INQ000545636**; and supporting letter from DHSC, **Exhibit JK4/114b - INQ000487984** CHIP analysed the results of this questionnaire and shared this analysis with local authorities shortly after the survey closed (**Exhibit JK4/114c - INQ000545603**). DHSC also produced its own final report on this survey (**Exhibit JK4/114d - INQ000545637**). DHSC sent the report and an accompanying letter (**Exhibit JK4/114e - INQ000059457**) to the DASS in each local authority in January 2020.

485. Further analysis was carried out by the team at DHSC, but no final report of the findings was ever published or shared with the sector by DHSC.

Issues

486. The Government's response to challenges imposed by Covid-19, both for data and more broadly, was, among other things, to expand capacity in the social care directorate of the DHSC significantly, setting up meetings to discuss immediate issues with the sector, and involving the sector in relevant workstreams.

487. Whilst welcome in principle, additional capacity was not however on offer to the care sector, including provider representative organisations, ADASS and the LGA. They and the LGA had to juggle demands to join frequent meetings by DHSC, usually at short notice, with supporting a sector under enormous pressure especially in the early months of the pandemic including managing PPE shortages, infection control, high mortality rates and staff sickness.

488. This included frequent meetings to support:

- Development and oversight of the Provider Data Collection (hosted in Capacity Tracker),
- Adult Social Care Task Force Dashboard Steering Group,
- Adult Social Care Covid Dashboard Governance Group,

and

- development, implementation and analysis of the SCCMR survey of councils.

489. Whilst frequency has diminished over time, over four years later there is still a disproportionate ask of the sector to oversee the ongoing development of the Provider Data Collection.

490. During the pandemic, and unfortunately since, consultations and discussions often happen too quickly / at unreasonably short notice, to enable capability of the sector to inform policy development. The LGA, ADASS and care provider organisations can represent the needs of the sector but need sufficient and timely opportunity to seek input from councils and care providers.

491. There were consistent concerns about the accuracy of the care provider data

collection. One of its tasks, for example, was to record uptake of vaccines within the sector. This recording was onerous and frequently impractical for very many social care providers, resulting in under-reporting of vaccination among social care staff. During the pandemic providers were struggling hugely to meet people's basic needs. Many staff were off sick or isolating and managing risks and following changing guidance. It was therefore a struggle to make frequent Capacity Tracker returns and keep it up to date.

492. Capacity Tracker was also not suitable to identify PAs and to capture their vaccination rates (Email chain between ADASS officials, regarding Social Care Vaccines Stakeholder Group, dated 1 February 2021, **Exhibit JK4/115 - INQ000397403**). PAs are employed directly by a disabled person either privately or via direct payments from the council and there is no central register. This created complex data capture issues for local authorities, where the expectation was that they would provide the data for Capacity Tracker and determine the cohort numbers of each local authority. Councils were unable to capture and report data for some parts of the ASC workforce, such as PAs and those working in unregulated settings such as day care, and those employed privately by people who self-fund their own care.

493. Despite repeated requests from care providers, benchmarking and insight reports using the provider level data in Capacity Tracker designed for care providers' business improvement use were still very limited. This would have taken limited expertise and capability to build in, or extract from Capacity Tracker. However, it has clearly not been a priority for DHSC to ensure this is actioned.

494. The rapid development and use of the Capacity Tracker during the Covid-19 response was intended as temporary and finite. Whilst there may be mutual benefits in securing a national overview that cascades through different aggregated views through to location level, the promised review of the collection is still yet to be realised over four years on.

495. The mandated and additional voluntary collection hosted by Capacity Tracker has developed into an approach that lacks clear purpose and governance, and an approach which is not sector led. There continues to be issues with data quality and overlap with trusted data collections such as the workforce intelligence collated by SfC. The collection cannot be relied on as an accurate view of the sector overall or provide the information that councils need to oversee their local care market. There continues to be a bias on care homes and not giving equal focus to community care settings.

496. Whilst fully appreciating that data was needed to inform national, regional and local

decision making, during the pandemic councils had numerous concerns about what felt like the imposition of a national system originating in the needs of acute hospitals. This was exacerbated by messages from DHSC that this was to replace local and regional systems, which had been developed in the absence of the establishment of sound national mechanisms, and which were felt to be more sophisticated in supporting DASSs in their market shaping responsibilities.

497. The LGA considers that a focus on medium- to long-term needs must be commissioner-led, evidence informed and co-produced with care providers and councils. Individual councils need to continue to manage relationships with their market and providers. A successful provider data collection approach should be coproduced by councils and care providers, and provide a locally driven evidence and intelligence base that:

- Supports councils in delivering their market shaping duties;
- supports and informs commissioning decisions at a local level;
- provides an understanding of capacity in the market, including specialist provision;
- supports councils in managing their relationships with care providers,;
- provides a national provider voice - unmediated by the large representative bodies;
- supports working with the NHS, but is not led by NHS requirements and priorities;
- provides assurance to Government about the state of the care market;
- rationalises the overall data collection burden on care providers (and councils) – minimising new requests and rationalising or making better use of existing requests, including better use of technology;

  and

- maximises the benefits for providers and councils.

498. The absence of this review and continued reliance on what was expected to be a short term fix via Capacity Tracker, has meant that in some instances councils, both individually and on a regional basis, have either needed to continue their own data collections, which is an unwelcome extra burden for providers, or do not receive the market oversight information that they need to ensure that their functions in this area are properly

discharged.

499. In October 2020 following the recommendations of the ASC Taskforce, a new Adult Social Care Dashboard for monitoring, managing and reporting on the pandemic was created and launched by DHSC. This aim of the dashboard was to bring together in one place data on deaths, outbreaks, testing data, and infection prevention control measures - presented geographically from national to individual care home level. It was proposed that this would help councils to identify outbreaks and other emerging issues so that they could update advice and consider how to best help social care providers.

500. However, the design of the dashboard was not practical for councils to use because:

- access for councils was initially given to DASSs, with one registration available to each DASS (or nominated equivalent). Further limited registrations were available later;
- it did not initially include any data from community care providers;
- registration was complex and unwieldy, and use was not intuitive;
- there was no capability to extract information from the dashboard for further local use; and
- councils could only see their own areas – often councils commission in wider areas beyond their geographical boundaries, and neighbouring areas' market has an impact: the many DHSC and NHSE users of the dashboard could see more than one council area.

501. Councils have statutory responsibilities to protect and improve the health of their local population and ensure the provision of appropriate care. To be able to fulfil these responsibilities, social care and public health teams require access to the relevant data on local population and individual health and care needs, and how well local health and care services are addressing these needs.

502. Before, during and after the pandemic, councils have not had the access to such information that is key to informing their service planning. With the development of Federated Data Platforms and other health driven data initiatives across health and care, there is a risk that council offices continue to be compromised with their access to key data, whilst it is easily available to NHSE and DHSC across the country.

Key or significant concerns regarding the impact of IPC measures on recipients of care and those providing care

503. There were several significant issues about infection control during the pandemic. There was a risk of infection when visiting into care homes, including from

- visiting friends and family;
- professional visitors such as GPs, CQC Inspectors, social workers, nurses; and
- tradespeople.

504. The willingness of visitors to wear PPE and abide by IPC protocols around handwashing, sneezing/coughing, social distancing, and observing limits on numbers visiting friends/family also raised issues for care homes, along with how to manage visitors who refused a test or to share test results (once testing was available for visitors.)

505. There were also consequences of isolation and grouping of residents deemed an infection risk.

506. *For providers*, the design and layout of care homes was a challenge (e.g. shared bathrooms) because:

- there was insufficient space for safe zoning/cohorting;
- there were no separate staff rooms to reduce risk of cross-infection;
- smaller homes or those in older buildings found it impossible to create physical separation;

  there were risks to staff from working in zoned/cohorted areas; and
- there were issues with managing visits to those in zoned/cohorted areas.

507. *For residents*, there were adverse impacts from:

- moving to different/unfamiliar settings within a care home;
- being corralled with others deemed an infection risk;

- issues as to whether family/friends could visit;
- issues arising from the increase in deconditioning (physical, cognitive, psychological or spiritual) especially on leaving hospital;
- cross-infection from staff movement between different settings of care. This was an issue for residential and domiciliary care providers, also for those PAs working with several clients;
- concerns over sufficient supply of PPE when staff moved between multiple settings; and
- concerns over the increased use of agency staff working across multiple setting to cover for sickness absence.

508. The LGA was involved in these discussions with central Government, providers, the NHS, and sources of expertise such as PHE. DPHs via the ADPH, provided technical advice. As well as engaging with central Government, the LGA also sought to support local interpretation. This was a difficult balance in that policy needed to allow for local circumstances and yet providers and relatives might sometimes complain that there was unjustified or unexplained local variation.

509. For providers specifically, the key concerns over IPC were:

- being asked to take patients that they could not effectively and safely manage;
- balancing understanding of the need for prompt hospital discharge with what homes could safely do; and
- whether care homes would be supported to say to say 'no' when they were unable to accept a Covid-19 positive person,

510. For care commissioners the issues were:

- not fully understanding the risks that providers and residents were exposed to;
- lacking necessary training, equipment, specialist advice or support to deal with risks associated with e.g. shared bathroom facilities; and
- whether they would be financially supported while placements into a home were suspended due to IPC concerns.

Part 8 - Testing

Summary of LGA concerns regarding testing for Covid-19

511. Testing was obviously a key issue for the ASC sector as I have already mentioned in several places in this statement, in particular in Part 4 -Testing In this part I shall try to bring these issues together.

512. The LGA received and heard concerns both from councils and care providers, frequently – although not exclusively – through the National Covid-19 social care provider issues group co-chaired by the LGA and national provider organisations.

513. Those concerns, which the LGA shared, can be summarised as follows:

- Lack of early prioritisation of the social care workforce and poor access to testing.
- The different testing regime and testing frequency for care homes compared to the NHS.
- Availability of PCR tests and turn-around times in care homes.
- The Government's reliance on PHE advice and a PHE prevalence study in July 2020, resulting in a Government policy that delayed testing staff working in domiciliary care for several months.
- The Government's approach to using different tests given reliability differences between LFT and PCR tests.
- Testing visitors to care homes, including both family/friends and professional visitors.

514. While the LGA was aware of some concerns around the availability of testing for unpaid carers compared to paid carers, this was not a key or significant concern for the LGA during the relevant period.

515. The delay in testing of people with learning disabilities, people with autism and those who lacked mental capacity was an ongoing concern of the LGA, councils and providers. All had persistently lobbied the Government for whole home testing, guidance and support. For example, on 19 May 2020, ADASS asked DHSC whether DsPH could prioritise testing for care homes which look after people with learning disabilities and raised concerns about guidance for testing people who might lack mental capacity to consent (Minutes of the

Testing Task and Finish Group dated 19 May 2020, **Exhibit JK4/115a – INQ000545610**). The next day, DHSC confirmed via email that this would not be possible until DHSC had "the right clinical guidance in place for the specialist care market" (email chain dated 22 May 2020 between DHSC and Testing Task and Finish Group, **Exhibit JK4/115b – INQ000545604**).

516. An ADASS member responded on 22 May 2020 escalating learning disability provider concerns and calling for the issue to be addressed at the next meeting (**Exhibit JK4/115b – INQ000545604**). The ADASS member also brought to DHSC's attention a Mencap press release noting that the death rates for people with learning disabilities had doubled on the previous year, with 45% of those deaths notified as Covid-related (Mencap press release dated 19 May 2020 "Mencap sounds the alarm as higher proportion of people with a learning disability dying with Covid-19 than people in care homes", **Exhibit JK4/115c – INQ000545623**). Mencap called for urgent action to address "any potentially discriminatory". On 3 June 2020, ADASS again asked for this issue to be discussed at the next Task and Finish Group meeting, noting the high death rates for people with learning disabilities and requesting that it be first on the agenda as there had not been time to discuss it at the last two meetings (Email chain dated 3 June 2020 between ADASS, DHSC and Task and Finish Group, **Exhibit JK4/115d – INQ000545593**). The Government finally published guidance on testing people with learning disabilities and/or autism on 17 June 2020 (see, for example, article dated 17 June 2020 from the Nursing Times "Tailored Covid-19 guidance finally published for learning disabilities", **Exhibit JK4/115e – INQ000545639)**.

LFT and PCR testing

517. In the first week of November 2020, the Government announced the roll out of a new rapid test, the LFT. The reliability of LFTs compared to PCR tests was one of the major issues in the early days of testing. The LGA was aware of widespread concerns, including from DPHs, about their reliability and deployment compared to PCR testing, although there were advantages such as instant results.

518. On 27 November 2020, the LGA published a briefing in relation to the roll out (**Exhibit JK4/093 – INQ000581214**). The briefing included the Government's advice that LFTs were accurate enough for community testing (based on a large-scale pilot in Liverpool). However, the briefing also passed on the LGA's concerns about the reliability of LFTs, linking to an article from the British Medical Journal (Gill & Gray (BMJ, 16 November 2020) article "Mass testing for Covid-19 in the UK", **Exhibit JK4/116 – INQ000499017**). The LGA

was aware of concerns in the academic and public health world about the reliability of the test and impacts of false positives, or false negatives, from LFTs (for example, the ADPH raised its concerns about LFTs on the same day as LGA's briefing, 27 November 2020, **Exhibit JK4/094 – INQ000581291**).

519. In December 2020, the LGA was approached by media outlets for a statement about the use of LFTs to enable families to visit loved ones in care homes at Christmas. The LGA provided the statement, made by Cllr Ian Hudspeth, Chairman of the LGA's Community Wellbeing Board (The Guardian article dated 12 December 2020 "Promise of UK care home visits is not being kept to, warns charity", **Exhibit JK4/117 – INQ000581322)**:

> *"…Councils and care providers want to do all they can to ensure people can visit their loved ones in care homes and other care settings, safely and securely, without risk of passing on the virus. "Families, residents and care staff all need to have full confidence in arrangements for testing, knowing that the risks and benefits are fully understood, alongside continued safety measures including use of PPE, social distancing and hand hygiene. "It is important for Government to be open and transparent about the reliability and limitations of lateral flow tests, and the ability of care homes to implement these fully and safely as part of opening up visiting, in time for Christmas. "We want to work with Government and providers to plan and resource these changes in a fair and reasoned way, so that families have the best possible chance to see their relatives over Christmas, but within realistic expectations of what is possible…"*

520. On 10 December 2020, the LGA and ADPH ran a webinar on mass testing using LFTs with a presentation from NHS Test & Trace and a DPH. There was a panel Q&A session as part of the webinar which included an academic and former DPH who cautioned against an over-reliance on LFTs for mass community testing in the way proposed by Government. After the webinar the LGA collated a list of unanswered questions from the floor which demonstrated sector concerns and the LGA's efforts to address these via the webinar during the relevant period (dated 14 December 2020, **Exhibit JK4/118 – INQ000581320**).

521. On 3 December 2020, the LGA provided members of the LGA's Executive Advisory Board with a "Covid-19 Work Programme" report (**Exhibit JK4/119 – INQ000581254)**. The report summarised the LGA's position on, and work to address, the need for greater localisation of testing and tracing, including:

- Following publication of the ASC Winter Plan, the LGA made the case for greater localisation of testing and tracing because the more than 163 local contact tracing partnerships had greater success than the national NHS Test and Trace system at reaching cases and contacts.

- The LGA urged that "making greater testing capacity available to councils would help to address the spread of the virus in areas of high deprivation, crowded and multi-generational households, concentrations of vulnerable communities and younger age groups".

- However, we also argued that localisation should be voluntary, accommodate different speeds of localisation, and must be adequately resourced both financially and with programme managers (e.g., from the Ministry of Defence).

522. The Government's response was to make LFTs available to DPHs. At the time of the report, over 90 councils were receiving the tests but with reported delays or partial receipt.

523. Considering the mass population screening pilot in Liverpool, the LGA suggested that:

> *"…greater consideration is given to whether mass population screening is the most effective use of the increased testing capacity available, and consideration instead is given to targeted testing at scale led by local Directors of Public Health as a better means of breaking the chain of transmission in the population".*

524. Finally, the report called for greater clarity from Government on the details of how mass testing would work, the availability of additional funding, capacity and capability to conduct tests, how local data would be integrated into the national system, and how people would be incentivised to take tests. There was no Government response to the report, although the Government did tackle the issues over time, albeit in piecemeal fashion.

Testing of staff working in domiciliary care

525. Another of the LGA's key concerns was the significant delay in Government testing of home care workers. In July 2020, the Government advised DASSs and DPHs that it would rely on PHE advice from a prevalence study published that month (Letter dated 3 July 2020 from DHSC to DASSs and DPHs re outbreak testing and regular testing, **Exhibit JK4/120 – INQ000051152**). PHE used the July 2020 prevalence study to advise the Government against regular testing of home care workers.

526. It wasn't until 20 November 2020 that testing was made available to home care workers with PHE advising "regular asymptomatic rapid lateral flow testing for staff in CQC registered homecare services in England" (UKHSA guidance withdrawn 4 April 2022 "Coronavirus (Covid-19) testing for homecare workers", **Exhibit JK4/121 – INQ000581374;** LGA press release dated 20 November 2020 "LGA responds to weekly testing of homecare workers", **Exhibit JK4/122 – INQ000581296**). Until that time, although deemed "essential workers," home care staff had to source their own tests alongside member of the public. At this time, accessibility to testing was unclear and difficult. As early as 20th April 2020, LGA, with other members of the national Testing Task & Finish Group, requested that DHSC provided clearer communications on the prioritisation and access to testing via the various routes emerging.

527. On the same day, the LGA issued a press release emphasising that this was something that (**Exhibit JK4/122 – INQ000581296**):

> *"…Councils and care providers have long been calling for" and reiterating that "Homecare workers have not been able to access the same level of testing as their colleagues working in care homes, so this announcement should redress this balance. The further rollout of these tests to live-in carers and PAs also needs to happen as quickly as possible…"*

Lack of prioritisation of the social care workforce and poor access to testing

528. Early in the pandemic, the prioritisation of the social care workforce and guidance around testing was disjointed and unclear to those in the sector. Several online referral portals were launched (employer, self-referral, care home portals) as well as local testing and mobile testing units. The LGA, with providers, repeatedly asked for greater clarify on referral routes, clearer guidance on testing and better communication on the prioritisation of those in the social care workforce to access testing. The confusion remained for several months and issues around testing continued to be discussed with ongoing confusion and lack of action in some areas.

Different testing regime and testing frequency for care homes compared to the NHS

529. The LGA and local authorities had concerns that care home staff were being treated differently to their NHS counterparts with daily LFTs for care homes compared with twice weekly for patient-facing NHS staff. This added to the perception that care home staff did not have parity with their NHS counterparts. The LGA and ADASS were copied into a letter

from the Home Care Association's Dr Jane Townson on 10 March 2022 to Minister Gillian Keegan MP asking for testing requirements to be brought in line with the NHS (twice weekly) (Letter from Home Care Association to Minister Keegan re testing, **Exhibit JK4/123 – INQ000571073**).

530. On 18 September 2020, DHSC published its 2020-2021 Adult Social Care Winter Plan. The LGA was not consulted on this document and was concerned over the lack of discussion of testing in the ASC Sector. The plan merely mentioned the "social care testing strategy", but it was not clear what this entailed.

531. On 1 October 2020, the LGA published a briefing for councils summarising the key points in the ASC Winter Plan and providing councils with a Winter Plan checklist to enable them to verify that actions were in place, ready for the assurance to be submitted to DHSC on 31 October 2020 (LGA Adult Social Care winter plan 2020-2021, **Exhibit JK4/124 – INQ000581200**).

532. For the following 2021-2022 ASC Winter Plan, the LGA were invited by DHSC in September 2021 to comment (Draft DHSC winter plan for social care 2021-2022, **Exhibit JK4/125 – INQ000581244**).

533. On 4 June 2021, LGA, ADASS, ADPH and PHE participated in a discussion convened by DHSC on "proportionate testing strategy". The key issues discussed at the meeting were:

- the significant, unfunded, extra burden on care settings to test and report via Capacity Tracker, even when Covid-19 prevalence was low;

  and

- reports of '*testing fatigue*' setting in, again, where prevalence was low.

534. The LGA suggested that the local DASSs and DPHs should advise on appropriate levels of testing depending on local prevalence. The LGA does not know whether the DHSC progressed this strategy following the meeting.

535. On 6 April 2022 the LGA raised a concern with DHSC about why some professionals and not others in councils were being offered free tests (Email chain dated 8 April 2022 between LGA, DHSC and ADASS re testing guidance, **Exhibit JK4/126 – INQ000581328**). Social workers were afforded free testing whereas fellow professionals such as occupational therapists and physiotherapists were not. DHSC responded on 7

April 2022 that (**Exhibit JK4/126 – INQ000581328**):

> *"… [the issue was a] tricky one… [but that] …ultimately we have to draw a distinction somewhere due to constraints on testing volumes…" [and that the rationale for giving separate access to social workers was due to social workers'] … "safeguarding and statutory responsibilities…"*

536. The LGA responded that it did not agree with this rationale. The Department's explanation was that occupational therapists would be eligible if visiting a care home as part of the care home testing, yet this completely missed the point that occupational therapists are much more likely to be going into people's own homes, not a care home. This characterised the DHSC's misunderstandings about how the care sector operates.

Availability of PCR tests and turnaround times in care homes

537. The LGA was aware of issues surrounding the supply, delivery, collection and reporting of PCR tests for care homes with turnround times not being met. Care homes were concerned over delays in getting responses back.

538. On 3 September 2020, the LGA and the CPA chaired the "National Covid-19 social care provider issues group" (Meeting minutes, **Exhibit JK4/127 – INQ000581356**). The meeting was attended by representatives from CPA, Care Association Alliance, LGA/CHIP, CQC, ADASS and DHSC.

539. At this meeting, DHSC acknowledged that there was a:

> *"…recent issue for test results in care homes which began last week, and that this has been the focus of his work in the last few days…"*

540. DHSC acknowledged that there were delays in lab processing. Part of this delay was caused by labs stopping sampling tests that were older than 12 hours. Tests for the ASC Sector were at times being reassigned to increase testing capacity in remote and local community outbreak situations. However, DHSC had sent out 115,000 tests the day prior, 100,000 of which went to care homes.

541. In the notes from the national Testing Task & Finish Group on 4 September 2020 DHSC indicated that turnaround times in labs were still around 4 days, which DHSC said "*needs to be reduced*" (**Exhibit JK4/127a – INQ000545622**).

Testing visitors to care homes

542. The LGA was aware of significant concerns in the sector regarding testing visitors to care homes. For example, the LGA was provided with copies of correspondence between CPA and ADASS/Healthwatch and DHSC in October 2020, discussing the human rights implications over visitor restrictions in care homes. On 9 October 2020, the CPA and ADASS/Healthwatch sent Matthew Hancock MP, the Secretary of State for Health and Social Care, a letter emphasising the human rights implications of blanket bans on visitors to care homes (**Exhibit JK4/128 – INQ000581289**):

> *"…For most, there is probably a decision to be made about a balance of risks to themselves and to others. Those who are able to do so have a right to choose what risks they are willing to take for the benefit of seeing their family. Obviously, the accommodation of such choices has to have regard to the protection of others from harm. Those unable to make decisions for themselves are entitled to have choices made which are in their best interests and looked at holistically, not just with regard to protection from infection. However, a lack of clarity in the current guidance regarding involving residents and their families in decision-making around visits has led to many visiting policies which remove the rights of people to make decisions on their own lives. Taking away the rights of people to make their own choices or take part in conversations around joint decision-making runs contrary to Article 8 of the Human Rights Act 1998 and Section 4 of the Mental Capacity Act 2005. There may also be a further breach to Article 8 and an unlawful deprivation of liberties if all visits moving forward are to be supervised, as stated in the Adult Social Care Winter Plan..."*

543. DHSC responded on 20 October 2020, requesting CPA and ADASS and Healthwatch's support as it continued to develop visiting policy (**Exhibit JK4/129 – INQ000514974**). In relation to blanket bans, DHSC stated:

> *"…You highlight that blanket bans are something that we should seek to avoid; and you describe some providers taking an unduly risk-averse approach to implementing national and local guidance, which may have had this effect. As our updated care homes visiting guidance (15th October) points out, the impact of visiting on the health & wellbeing of residents, and the needs of individual residents should be considered when providers are developing their visiting policies. The guidance*

makes clear that even in Very High-risk areas, visits should be facilitated in exceptional circumstances, such as end of life…"

544. Upon receipt of this correspondence, the LGA undertook internal discussions regarding the human rights balance to be struck and produced an internal summary in October 2020 that compared what the CPA was asking for with what was in the DHSC guidance at the time (**Exhibit JK4/130 – INQ000581234**).

545. The LGA also produced a briefing note on 16 August 2021 regarding the updated visiting care homes guidance (**Exhibit JK4/131 – INQ000581215**).

Part 9 - PPE

Summary of LGA concerns regarding PPE

Introduction

546. The Inquiry will already know that the LGA fielded significant concerns around PPE during the pandemic about the timely and appropriate provision of adequate PPE from my evidence in Module 5. In answering this question, I shall repeat that evidence with some additions to reflect the ASC context. For a helpful overview of PPE issues at the time, see the LGA's PPE issues log (**Exhibit JK4/132 - INQ000472399**).

547. Specifically, there were significant concerns around:

- access to suitable PPE which included matching demand to supply;
- distribution channels once Government had accepted responsibility for this;
- advice on PPE use;

and

- how to pay for it.

548. The concerns of the LGA were formed following the live feedback from councils during the pandemic, specifically between 1 March 2020 and 28 June 2022. Prior to the pandemic the LGA did not provide any policy or improvement support on the topic of PPE, so this topic was fast emerging and one that the LGA did not have prior experience of. A key function of the LGA in this topic area was about understanding the issues and assisting Government to understand how the situation was unfolding and being experienced on the ground, and as such the below answer reflects that. The LGA's role was not to say exactly how much PPE or of what kind was needed but to collate and pass on the concerns that its members had, and to feed back the responses from Government.

Concerns around general access to PPE

549. The greatest challenges with PPE concerned the shortage of suitable PPE for those that needed it, and the difficulty in procuring it given the surge in global demand.

550. As identified in the NAO report, the volume of PPE required to respond to the Covid-19 pandemic far exceeded that of an expected influenza pandemic. The NAO report found that that existing PPE stock would not meet demand for certain items beyond a matter of

days for the NHS and social care sector, and some equipment had expired or did not meet current standards for safety. When the Covid-19 pandemic hit, the UK began with insufficient PPE resources to supply the NHS, social care sector, and frontline workers, and inadequate mechanisms to rectify this.

551. Government decided in early April 2020 that PPE would be supplied directly to LRFs who would then be responsible for managing distribution locally. This was only intended to be a temporary two-week solution but ended up operating until September 2020.

552. Previous emergency planning took place through Exercise Cygnus which took place over three days between 18-20 October 2016. It was a cross-Government exercise to test the UK's response to a serious influenza pandemic. The LGA was not involved in the actual exercise, but a report published by the Government in October 2020 outlined how further work was required to prepare secondary care and community care services in the event of a pandemic. The report also recommended that PHE should "communicate who will receive PPE from national stockpiles and which parts of the private and voluntary sectors are expected to make their own arrangements to safeguard their workers" (**Exhibit JK4/133 - INQ000492917**).

553. This emergency planning had set out the expectation that upper tier authorities would play a role in the distribution to social care staff of facemasks from the national stockpile; this persisted in the early days of the pandemic. However, at short notice the LRF route was introduced, covering a wider range of PPE (such as different types of masks for different settings and protective gowns and aprons). This had not been included within pandemic plans and had not previously been suggested as the route through which PPE would be distributed.

554. While the change may have had limited impact where the LRF contained a single upper tier authority, for other LRFs, with multiple upper tier authorities, this change meant a markedly larger distribution footprint to what had previously been proposed and expected. Further information on LRF footprints and how those compare with local authority boundaries can be found in paragraphs 59-63 of the LGA's witness statement for Module 1 of the Covid-19 Inquiry (**INQ000177803**). As mentioned, these arrangements were subsequently in place much longer than intended, as this initially temporary arrangement extended for five months.

555. There were issues with stock levels in the early days of the LRF provision, with ongoing local concerns about running out of PPE. Although the drops helped, demand outweighed

supply. Drops of PPE were perceived to be erratic and often short notice, with uncertainty about the timing and quantity of individual drops to LRFs (**Exhibit JK4/134 - INQ000504853; Exhibit JK4/135 - INQ000504846**). One example of this was from the Chief Executive from Solihull Council who emailed on 6 April 2020 to report that the LRF drop for West Midlands was short on masks. This was also confirmed by the Chief Executive of Nottingham County Council on 7 April. The LGA does not however have a detailed overview of how the distribution system of drops of PPE to LRFs worked in practice.

556. As a result, LRFs were left with the difficult decision about how to prioritise the distribution of scarce PPE. Often the final decision would fall on the relevant director of public health. This often placed significant strain on them, particularly as they were having to make decisions without adequate guidance on PPE or infection control for social care and wider council services, such as housing officers or children's social workers (**Exhibit JK4/136 - INQ000504855; Exhibit JK4/137 - INQ000504856; Exhibit JK4/138 - INQ000504857; Exhibit JK4/139 - INQ000504858**).

Concerns of PPE access and use in ASC

557. In late March/early April 2020, the Government announced that supplies of PPE would be managed through the Clipper logistics PPE portal system (**Exhibit JK4/140 - INQ000114942**). As far as the LGA is aware, this was communicated to councils through the PPE Task & Finish Group by DHSC, although the LGA does not know if the Department communicated this to the sector via other routes. The initial timeline given was that Clipper logistics would be available from 6 April 2020. However, the launch of this was frequently delayed and it did not go live until May 2020 and then only with a phased approach to new users with very limited quantities of stock (**Exhibit JK4/141 - INQ000191912**).

558. In June 2020, the position gradually improved as more PPE came on the market. Although the Clipper logistics system went live in May it only took on a small number of providers within geographically targeted areas. For instance, as of 8 May 2020, 1,371 care homes were invited to the portal; this is only a tiny proportion of the approximately 18,000 providers in the social care sector (**Exhibit JK4/142 - INQ000472427**). DHSC was responsible for the portal and invited care providers in cohorts, starting with smaller providers. Large providers were only invited later in 2020. There were set limits and frequency that care providers could order, although we do not have the exact details of this. Until all care providers were invited onto the system, DHSC continued to ask them to

use the existing PPE routes which are set out in several communications, including the communication on 15 April 2020 from DHSC. A communication sent by NR (Covid-19 Adult Social Care Cell, DHSC) on 28 May 2020 illustrates the limited quantities available to order when the portal was launched (see email, **Exhibit JK4/142a – INQ000545628;** and attachment to email "PPE Portal Update", **Exhibit JK4/142b – INQ000545627)**. This was not available to councils at this time in June. It took several months after June 2020 for councils and care providers to access and supply adequate stock quantities to meet the needs of organisations in line with PPE guidance set out by DHSC and PHE. Government is best placed to explain why it took so long for councils and care providers to access adequate supplies. An email from NR (Covid-19 Adult Social Care Cell, DHSC) on 29 July 2020 notes that large providers were being invited and that (**Exhibit JK4/142c – INQ000545630**):

> *"…current order limited offered on the portal will remain the same and we recognise that they will only meet a small proportion of PPE requirements".*

559. It is the LGA's understanding that the overall quantity provided was initially based on ability and logistics rather than demand modelling or estimated need (see, for example, **Exhibit JK4/142b – INQ000545627)**. The communication around this portal system was inconsistent, with regular updates being vague on realistic timescales and intermediate processes. The LGA is aware that from May 2020 the PPE portal became a standing item on the PPE Task & Finish Group; prior to this there was limited communication on the portal. This delay meant that councils and care providers had to source their own PPE and find local routes for procurement.

560. The exact date for Government taking responsibility for distribution is hard to define. However, we would point to a letter from DHSC dated 4 September 2020 which sets out the new distribution arrangements going forward (**Exhibit JK4/143 - INQ000058237**).

561. By November 2020 there were still concerns from the sector about the ability of the portal to supply the sector's Covid-19 PPE needs, with ongoing limitations on the quantity of PPE that providers could order. The LGA did not receive details about how the portal operated or the specifics about the roll out. Nor did we seek out the detail as this was relevant to care providers and not councils who we represent. To the LGA's understanding, care providers had to register directly with the portal and then order directly.

Concerns around prioritisation of PPE use

562. At the time, the LGA was particularly concerned that the NHS was being prioritised over social care in terms of access to PPE and that there was a lack of understanding in Government about the range of both adult and children's social care workers who would need access to PPE. Specifically, there was a lack of understanding of ASC's diverse delivery model. For example, the total number of organisations involved in providing or organising ASC in England has been estimated at around 18,000. This includes councils, large national providers, small and independent providers, and charities. Two in five organisations were providing residential services and three in five were providing non-residential services. An estimated 39,000 establishments were involved in providing or organising ASC in England (reflecting the fact that one 'organisation' such as a large care home provider could have multiple care homes, or 'establishments'). The residential / non-residential split for these 39,000 establishments was 50:50. In addition there were 69 residential special schools registered as children's homes (with 1,911 places), and 167 short breaks only children's homes (offering 1,037 places).

563. The LGA received reports from councils and care providers regarding NHS prioritisation for PPE (**Exhibit JK4/132 - INQ000472399**). Examples include feedback from East Sussex County Council, Rutland Council, Leicestershire County Council and Nottingham County Council, who informed the LGA on 27 March 2020 that the PPE supplier had in one instance cancelled their order as they only provided to health, or had informed the council that due to new guidance from DHSC they did not provide PPE to councils (**Exhibit JK4/144a – INQ000472401; Exhibit JK4/144b – INQ000545595**). On the 30 March 2020 the LGA received further information that Blueleaf, one of the designated PPE suppliers recommended by Government on the national helpline, was not supplying councils with PPE on the request of DHSC (**Exhibit JK4/144c – INQ000472862**). On 2 April 2020, the LGA heard from Essex County Council that PPE did not appear to be reaching social care locally and that LRF drops of PPE were being diverted to NHS (**Exhibit JK4/144d – INQ000504812**). Further concerns were raised on 6 April by Leeds City Council (**Exhibit JK4/144e – INQ000545599; Exhibit JK4/144f – INQ000504844**), and on 8 and 9 April there were three concerns raised by wider LGA staff from their discussions with councils, one of which included a report that PPE was being seized at customs and diverted to the NHS (**Exhibit JK4/144g – INQ000545601**).

564. Although this occurred in the first month of the pandemic, it created a lasting effect across the ASC sector which felt like it was not considered with the same standing or prioritisation as wider health colleagues. This issue was raised to the LGA on more than

10 occasions between 24 March and 26 May 2020. Furthermore, this issue can also be seen in the concern raised by the Chief Executive of Cheshire West and Chester Council on 2 April 2020 who fed back that the new PPE channel was set so that councils had no status in the list of eligible organisations, other than "wider community requirements". This clearly demonstrated a lack of awareness of the legal duties of Councils (**Exhibit JK4/144h – INQ000504804**).

565. In the first few weeks of the pandemic, there was confusion over how to access PPE, the official route for providers to request it, the role of DHSC's NSDR, and what should be done when it could not deliver PPE. There were several reports of councils or providers being told by the NSDR and its recommended providers that the PPE was for NHS only, as set out above. This advice was corrected by DHSC, and call operators were provided with training. However, councils and providers signalled a loss of trust in the NSDR – reported primarily anecdotally through verbal conversations with councils and within meetings held with DHSC as part of the Task and Finish Group.

566. In late March 2020, the LGA and the ADASS wrote to the Secretary of State calling for the Government to urgently make PPE available to the ASC sector, highlighting that "...we continue to receive daily reports from colleagues that essential supplies are not getting through to the social care front-line. Furthermore, national reporting that equipment has been delivered to providers on the CQC registered list does not tally with colleagues' experience on the ground" (**Exhibit JK4/145 - INQ000103867**).

Concerns around advice on PPE use

567. An ongoing issue throughout was the application and understanding of guidance for the social care sector. Initial guidance in the early stage of the pandemic was focused on clinical settings and procedures within the NHS, which left the ASC sector unclear about how to apply these to non-clinical settings. Several queries came to the LGA from councils and providers about how to interpret guidance, however the LGA was clear that it was unable to provide advice on the appropriate use of PPE. Even once guidance came out there was continued frustration, particularly from providers, where the guidance did not clearly understand the role of social care. This did improve gradually but ongoing comments within the DHSC PPE Task & Finish Group made it clear that the sector found the guidance slow to be released and did not always help the sector to understand infection control and PPE requirements.

Concerns of suitability of PPE

568. There were also sometimes issues with the quality of the stock issued by central Government; sometimes this was out of date although assurances were given about its use, at other points it was dusty and dirty from storage. The LGA received two reports of mouldy masks being received by one council and a care provider, these both occurred on 27 March 2020 and appear to be in relation to an initial emergency drop from Government. Occasionally, supplies included kit that simply was not fit for purpose, such as builders' dust masks. All issues regarding PPE quality raised to the LGA were escalated to DHSC officers via email (**Exhibit JK4/146 - INQ000472400; Exhibit JK4/147 - INQ000504860**).

Summary of actions the LGA took

569. The LGA acted on this through the following:

- Attending a DHSC PPE Task and Finish Group which operated during the main stages of the pandemic.

- Working at the request of the Minister for Social Care, over a 48-hour period in April 2020, with social care providers, to cost the impact of the Government's policies and guidance on PPE; the costs involved surprised some, and caused Government to decide to absorb the unpredictable costs and provide PPE free to social care providers.

- Responding to issues and queries reported by councils, businesses, and care providers and providing frequently asked questions on the LGA website.

- When invited to do so, commenting on and shaping, DHSC guidance and communications, to ensure they reflected the reality for councils and care providers; early on, this Guidance lacked provider input and as a result suffered from a lack of understanding of the practicalities of implementation in social care settings; as time went on, this improved, with greater openness to an exchange of views about guidance and policy formulation; this is therefore a good example of how the provider forum supported by LGA/CHIP helped such dialogue.

- Communicating key messages regarding PPE to local authorities in a timely manner.

- From April to mid-May 2020, providing daily (and subsequently weekly) summaries to DHSC of issues reported to the LGA.

- Providing feedback to Government when appropriate on the experience of local government in PPE response.

570. As well as the above the LGA specifically provided raised issues to the Government on the following occasions:

571. In April 2020, the LGA summarised the position in terms of social care access to PPE as follows (**Exhibit JK4/148 - INQ000103868**):

> *'…For Councils and care providers, the current arrangements for accessing PPE are not fit for purpose and are failing to provide what is needed on the frontline. It is vital that the arrangements set out in the ASC plan [the DHSC's action plan for the pandemic] and associated guidance are urgently translated to the reality on the ground. We have heard numerous reports from Councils about how this is affecting their ability to care for their communities. One council reported their delivery of PPE was delayed by over a day last weekend, and when they received it, it was only 40 per cent of what they were promised. Another council area reported how its discharge system fell over one day because of a lack of PPE supplies in local care homes. Another council noted how, given the change in guidance meaning we are in a 'period of sustained transmission', care staff should wear eye protection, a fluid repellent mask, gloves and an apron - and this must be changed between contacts. This council has done some scenario planning and found that in a medium sized care home, this would use 10,000 pairs of gloves in a day. This has huge implications for PPE stocks…'*

572. In late March 2020, the LGA and the ADASS wrote to the Secretary of State calling for the Government to urgently make PPE available to the ASC sector, highlighting that (**Exhibit JK4/145 - INQ000103867)**:

> *"...we continue to receive daily reports from colleagues that essential supplies are not getting through to the social care front-line. Furthermore, national reporting that equipment has been delivered to providers on the CQC registered list does not tally with colleagues' experience on the ground…"*

Part 10 - Visiting Restrictions

Concerns regarding visiting restrictions on people visiting loved ones and LGA actions taken to address/escalate those concerns

The impact of the restrictions on visits by loved ones on recipients of care

573. The LGA held significant concerns over the impact of visiting restrictions on recipients of care. The restrictions separated clinically vulnerable people from their loved ones, leading to incredible trauma and grief as people died alone or suffered from loneliness or sadness at the absence of a loved one's touch. There was increased pressure on families to try to care for loved ones in care without being able to visit face-to-face, and relatedly significant pressures on care providers trying to manage and mitigate this. For the care workforce, particularly those who had been in post long enough to develop meaningful connections with those they supported, it was also a stressful and upsetting experience. The key impact that the LGA focused on was the impact of the restrictions on safeguarding, which I describe in more detail in this section.

574. All three Insight Covid-19 and Safeguarding Adults Insight projects reported that, throughout the pandemic, there were concerns that safeguarding issues were not being identified and reported, due to reduced 'face-to-face' contact between adults with care and support needs and professionals, families and friends, especially, but not only, regarding people living in care homes (92-104 councils participated in the voluntary data returns for these projects) (**Exhibit JK4/112 - INQ000581226; Exhibit JK4/113 - INQ000581224; Exhibit JK4/114** **INQ000509872**.

575. The impact of restrictions was identified as an issue when care homes were closed to visitors to assist in the prevention of Covid-19 transmission.

576. The data reinforces these concerns as councils reported reduced number of safeguarding concerns and consequently safeguarding enquiries from residential care settings during the lockdown periods. Some councils reflected on the absence of referrals (concerns) from residential and nursing care settings during lockdown because of reduced or an absence of visits from professionals, family members and friends to the person in residential settings; they were effectively 'hidden from view'.

577. Alongside reduced reporting of safeguarding concerns during lockdown periods, there was also a reported decrease in safeguarding enquiries in both nursing and residential home settings during the lockdowns in the early pandemic period. Councils commented

on reduced access by professionals, families, and friends to care homes being relevant to this decrease.

578. Most councils reported 'surges' in safeguarding demand and activity when lockdown restrictions were eased and face-to-face social (and professional) contact restarted and intensified.

579. The quantitative data suggested that abuse and neglect in residential and nursing settings were either unidentified or were identified later due to Covid-19 restrictions, especially regarding adults who were known to ASC. One council drew a link between late identification of safeguarding concerns and an escalation in organisational abuse.

580. For those councils who experienced decreased rates of safeguarding concerns, the majority said that they saw a correlation with the reduction in ASC, health and other professionals making regular visits into care home. This meant that visual observations of care home environments and staff practices within the homes were not noted resulting in less reporting of safeguarding concerns (**Exhibit JK4/113 - INQ000581224)**.

581. There were many local variations in experiences of the impact of Covid-19 restrictions throughout the period. The NHS Digital mid-year data collection April-September 2020, cited in the second Insight report, showed that neglect and acts of omission within residential care homes became more prevalent, rising from 11.4 to 13.5% during this period (although neglect and acts of omission within nursing care homes remained virtually unchanged).

582. In the third Insight report four of the 50 councils providing qualitative insight described increases in organisational abuse that were linked to closed environments (e.g. residential and nursing care homes) (**Exhibit JK4/114 - INQ000509872**).

583. The first Insight report identified increased isolation and adults at risk of increased levels of abuse and anticipation of increased levels of safeguarding concerns at the end of lockdown. The later third Insight report cited the LGA's publication, Age and gender – The Impact of Covid-19, which draws attention to the experience of older people in care homes, and the sharp increase in deaths. Enforcement of strict rules restricting visits from family and friends to protect against the disease often extended older people's isolation and loneliness.

584. The second national analysis of 652 Safeguarding Adults Reviews ("**SAR**") undertaken between April 2019 – March 2023 notes that SAR authors commented on the negative

impact of Covid-19 restrictions limiting contact with, support for and the monitoring of, adults at risk by their relatives (as well as practitioners) in 22% of the SARs, which commented on shortcomings arising from the Covid-19 pandemic. SARs provided evidence of the profound effects of Covid-19 on individuals in care settings, and of the challenges experienced by health and social care staff in undertaking their duties in respect of safeguarding adults with care and support needs (LGA and ADASS commissioned report "Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 (executive summary)", **Exhibit JK4/149 - INQ000581353)**.

585. As the restrictions continued, it is noteworthy how councils adapted their approaches and methods (including digital means) to work proactively with nursing and care homes.

Actions taken by the LGA to address or escalate those concerns

586. The safeguarding adults workstream was an element of the joint LGA and ADASS Adult Social Care Hub, Covid-19. The CHIA Safeguarding Lead set up regular meetings with key partners from relevant networks to be able to share insight and intelligence about the impact of the pandemic on safeguarding activity and practice, discuss what might be required to assist colleagues in these circumstances and develop advice or promote resources.

587. Information was compiled through a 'safeguarding issues grid', with issues raised by Safeguarding Adults Board ("**SAB**") chairs, SAB managers, principal social workers and others in response to the Covid-19 crisis. This aimed to help SABs and partners to identify key areas for consideration in relation to safeguarding adults, actions that had been taken to mitigate risks for others to learn from, and any further actions that SABs and partners may want to consider. It was a 'live' document, and a resource pack was subsequently published with resources collected between March and October 2020 to support ongoing safeguarding work during the Covid-19 pandemic. The resource pack included: signposting to relevant resources; good practice examples of changes in practice and service delivery in response to the Covid-19 pandemic; and top tips for SAB managers.

588. The potential negative impact of vising restrictions in care homes was raised as an issue by the sector (including SABs). This was an area included in the safeguarding resources pack, which provided resources to help practitioners address specific concerns about safeguarding risks in institutional care environments and care homes.

589. Additionally, the Insight Project reports were cascaded as papers and presented to the sector through webinars, organised by CHIP, to share examples of how councils nationally

had adapted ways of working to positively improve safeguarding practice despite the considerable challenges of the pandemic (see, for example, LGA and ADASS "Covid-19 and safeguarding adults: FAQs", **Exhibit JK4/150 - INQ000581228;** and Cooper A., article, (2020) “Safeguarding Adults and COVID-19: a sector-led improvement response”, **Exhibit JK4/150a - INQ000545635).**

Concerns regarding access to healthcare professionals, services, medication and other support for recipients of care and actions taken

590. I can only give limited evidence on this topic. The LGA was aware, from its interactions with social care providers, that there were some difficulties in accessing healthcare support. This was listed as one of 15 issues in the first meeting of the provider forum on 23 March 2020, and the LGA sought to ensure that any examples or overall concerns were brought to the attention of the NHS.

591. At a regional level, this is another example of a matter where CHIAs were involved in working between local authorities, providers and the local NHS.

Part 12 - Vaccines & Vaccination as a Condition of Deployment

LGA concerns regarding access to, and distribution of vaccines and action taken

592. The LGA's concerns over, and involvement in access to and distribution of, vaccines to the ASC Sector are summarised in my witness statement for Module 4 (**INQ000474430**) in which I said, at paragraphs [106]–[118][2]:

> *"…Councils played an important role identifying eligible frontline care staff to be offered a vaccination. There was a need in the early days of the vaccine rollout for central Government to clarify the role of Local Government, alongside identifying adequate funding and resources, to support vaccination of the clinically extremely vulnerable and unpaid carers.*
>
> *The LGA and its member Councils were actively and heavily engaged in supporting vaccination uptake by frontline social care workers, unpaid carers and PAs both within their own services and alongside their commissioned care providers.*
>
> *Each council had a designated vaccination lead; the LGA hosted the list of designated leads and kept it updated. At a local level Councils developed their own comprehensive vaccine uptake action plans.*
>
> *DPHs were an essential conduit for advice, information and education for local services seeking to maximise vaccination uptake and tackling vaccine hesitancy, but civil servants were often slow to recognise and value this local knowledge and expertise about the local population, relying instead on centralised, top-down approach.*
>
> *Once a decision had been taken to prioritise frontline social care workers, the issue was how to identify them for communication. Civil servants within DHSC and NHSE did not initially always understand that Councils do not hold information about every frontline social care worker in their patch, and that the vast majority were employed in the private/not for profit sector, some of whom would have no relationship with the council;*

[2] Note: the exhibit references in this quote have been updated to reflect the order in which they appear in this statement.

they also did not understand the difference between care workers operating in Care Quality Commission (CQC) regulated settings, and unregulated settings or that Councils could not collect or report vaccination uptake data on staff not employed by them. Once this had been pointed this out, officials did work with the LGA and others to find work around solutions.

Emails between the LGA and DHSC (Exhibit JK4/151 - INQ000503958) reinforce why it was/is important to collect data about all care workers regardless of sector or role at the point of vaccination as there is no central registry of all those working in the care sector (regulated and unregulated). There were low levels of confidence in the data being reported on Capacity Tracker for those working in unregulated settings. Also worth being mindful that it is the setting, which is regulated, not the care worker. The care workforce is unregulated. In the end NHS and DHSC accepted our pragmatic suggestion that, in the absence of having a registered workforce and in the absence of any data being collected at the point of vaccination, vaccination points would simply have to accept at face value any declaration from someone claiming to be a front-line social care worker.

During the roll out of the vaccine, at strategic level, the LGA were full partners in the design, development and operationalisation of the Standard Operating Procedure (SOP) for frontline care worker vaccination (priority group 2) - this was an excellent example of co-production and civil servants made an effort to listen to the advice and experience of the sector. The LGA also contributed to the SOP for unpaid carer vaccination (priority group 6).

The LGA published an extensive list of resources for Councils and partners to tackle vaccine hesitancy taking a behavioural insights approach as well as case studies a three-stage guide to encourage vaccine uptake a report on countering vaccine misinformation, a review of research on vaccine uptake, encouraging uptake among younger people.

The LGA ran a series of webinars, disseminated all communications it received from DHSC and NHS England which encouraged uptake and

tackled vaccine hesitancy in social care through multiple channels including e-bulletins to chief executives in member Councils, e-bulletins to directors of adult social care, e-bulletins to vaccination and operation leads in ASC in Councils, webinars, and through our LGA networks of principal advisers, care and health improvement and advisers, and our ADASS networks in the English regions. The LGA also worked with provider representative organisations such as the Care Provider Alliance, using the forum which the LGA convened in March 2020, to promote mutual communication and understanding between providers and central Government/the NHS.

The process used to improve uptake and to measure the degree of success achieved was via the Capacity Tracker - a spreadsheet set up originally to monitor bed capacity in care homes (hence the name) and was hastily repurposed as a tool for monitoring a range of Covid-related issues in care settings, including reporting vaccination take up by frontline social care workers.

Levels of confidence in the Capacity Tracker in terms of the reliability and validity of the data remained low. Problems included not being able to see aggregated vaccination uptake data at local level, even though this would give a local snapshot or support benchmarking; it was a significant extra reporting burden on care providers already stretched to the limit which was completely unfunded; providers often found discrepancies in the reported data; it was frequently out of date; and crucially, it was impossible to disaggregate the numbers unvaccinated by choice, and those claiming an exemption from vaccination.

The LGA and ADASS, as well as care providers, repeatedly asked Government, civil servants and NHS England for a central mechanism to collect information about vaccination status and who was a care worker at the point of vaccination delivery, i.e. by the NHS when people turned up to get their injection. The sector received "Confirmation that plans are in place to develop a national vaccination register to collect information on vaccination status, this will be linked to the GP record." (Exhibit JK4/152 - INQ000503970) (Exhibit JK4/153 - INQ000503971) Scotland for example holds a central register of all care workers so tracking vaccination was much easier. Use of NHS numbers to link to care worker

status was also suggested. None of the promised central processes materialised. In emails between the LGA and DHSC we raised our concerns (Exhibit JK4/151 - INQ000503958) This is one of the great failures of frontline care worker vaccination and VCOD: that a central system was never set up and should a pandemic or similar reoccur, we will have nothing better in place than individual settings reporting individual vaccinations.

There were also discussions about how to verify at the point of delivery, whether those attending were indeed social care workers. In the absence of any central registration process, some workarounds were suggested, all of which had problems. In the end, it was decided, correctly in the LGA's view, that on a balance of risk it was best to accept that those attending were indeed social care workers without demanding proof. This does flag up the ongoing need to address the issue of registration of this workforce…"

593. Accessing vaccinations could be difficult for those care workers who were unable to "prove" they worked in social care such as PAs who did not have any kind of official/employer ID badge. The LGA developed and published a Q&A for councils and PA employers responding to their queries about how PAs could access vaccinations as part of priority group 2 (LGA published Q&A "Personal assistants eligible for vaccination as part of National Priority Group Two: frontline social care workers", **Exhibit JK4/154 - INQ000581321**).

LGA concerns with the policy of 'vaccination as a condition of deployment'

594. In my witness statement for Module 4, I addressed the LGA's involvement in, and concerns regarding, the introduction of the policy requiring vaccination as a condition of deployment (**INQ000474430**). At paragraphs [119] - [129],[3] I said:

"…There was little support for 'Vaccination as a condition of deployment' (VCOD) from the care sector, with a consistent message from stakeholders that encouragement and support were better than threats

[3] Note: the exhibit references in this quote have been updated to reflect the order in which they appear in this statement.

of being sacked ("no jab, no job") in increasing take up.

Care providers developed strategies likely to support uptake, including information campaigns and facilitating communication between staff and managers to openly discuss concerns regarding possible vaccination side effects.

*Overall, most respondents (57%) to the Government's consultation (**Exhibit JK4/155 - INQ000468754**) did not support the proposals, but Government pressed on. On the 21 March 2021, the LGA published our public response to the first VCOD consultation (**Exhibit JK4/156 - INQ000485183**).*

The LGA cautioned that the approach proposed could entrench vaccine hesitancy (subsequent evidence suggests that this indeed happened) and exacerbate health inequalities (also evidence this happened). It urged Government to concentrate on maximising voluntary take-up and tackling vaccine hesitancy.

National data told us that the target of 80 per cent take-up had already been reached, but with significantly lower take-up in some places; the LGA therefore suggested a targeted approach to voluntary take up with outliers could be more appropriate than making this mandatory across the board.

The LGA warned about the sense of grievance, unfairness and injustice which could result from this policy being applied only to those working in older age care homes, and not the NHS, saying –

"Care workers across all settings understandably feel undervalued, underpaid and marginalised compared to their NHS counterparts, and may feel particularly aggrieved that the outstanding commitment and care they have shown in performing their caring duties, often sacrificing time with their own families in the process, is to be rewarded with a mandatory vaccination requirement which will not apply to those in similar frontline care roles in the NHS or in other parts of the care sector."

The LGA cautioned about the impacts this policy could have on recruitment and retention –

"This proposal, as it stands, does not offer a convincing clinical and scientific argument for limiting this intervention to a single segment of the health and care workforce, or set out how the risks in terms of impacts on morale, motivation, recruitment and retention will be mitigated e.g. through increased pay or improved terms and conditions."

The LGA highlighted the additional unfunded extra burden for employers including.

"… the feasibility for many care providers of redeploying unvaccinated staff; the time, cost and resources involved in making changes to existing contracts and terms and conditions; the cost of defending potential legal challenges; and the administrative burden on providers of verifying vaccination or exemption from vaccination…"

595. The LGA made the following requests in its response:

- A fuller understanding of why a minority of older adult care home workers were still choosing not to be vaccinated and what progress has been made in achieving vaccination targets voluntarily since the consultation was launched.
- The estimate of the anticipated impacts of the proposal on existing recruitment and retention, and projected numbers of leavers from the sector following implementation of the policy, as well as the assumptions underpinning the estimate.
- Factual and demonstrable evidence that this policy would have a net benefit, and that the benefits of implementing this policy would not outweigh the negative consequences for the sector, and quality and sustainability of care overall.
- What additional and more focussed work the Government intended to undertake to increase voluntary vaccine take-up.
- How the Government would engage with all relevant stakeholders, including: councils, care providers, care workers, unions, organisations representing people who draw on social care and support, and individuals in receipt of care and support, and their families, friends and advocates.

596. Regrettably these never materialised.

597. Despite being pressed by the LGA, CareEng and NCF, the Equality Impact Assessment was only published two days before legislation was enacted. It acknowledged the potential for a disproportionate adverse effect of VCOD saying that:

> *"… a higher proportion of staff from ethnic minority groups could therefore face action from their employers or lose their jobs for refusing to take the vaccine…"*

598. The LGA convened weekly national Covid-19 Social Care Provider meetings convened by the LGA with DHSC and others by invitation for specific items; VCOD was a standing agenda item and issues, concerns and challenges of implementing the policy were regularly flagged with DHSC civil servants joining the meetings.

Part 13 - Funding

LGA concerns with funding and action taken

599. To fully understand our concerns with ASC funding during the period in question, it is first necessary to understand the position in the period before the pandemic. Below, I expand on points made earlier in this statement.

600. In LGA/ML/M2 (**INQ000215538**), it was stated at [302]-[304]:

> *"It was critical that the financial viability of providers and sustainability of the social care market was kept under review during the pandemic. Central govt accepted this.*
>
> *CHIP supported this process through -*
>
> - *Establishing and supporting a provider forum which met frequently and where central government could engage with providers on a range of topics;*
> - *Advising on what reasonable measures councils could take to address early threats to viability, such as cash flow;*
> - *Working with Government and providers to find mechanisms for central government funding to reach providers via councils, for example through the Infection Control Funds;*
> - *Working with providers and Government to seek solutions to other issues such as access to affordable insurance for providers;*
> - *Working with councils and Government to deliver a major review of market sustainability in the autumn of 2020, including the range of measures that councils would typically take to maintain continuity of support in the event of a provider leaving the market. Alongside this review the LGA / CHIP also inputted to other Government-commissioned exercises such as Exercise SWIFT (September 2020) and a review by Mckinsey of care home viability; and*
> - *Advising Government on the financial position of councils and the potential impact on them of any policies designed to address market sustainability.*
>
> *In general, there was a balanced and reasonable dialogue between Local Government, providers, and central government on these issues.*

However, the LGA's efforts to find reasonable solutions were hampered by a degree of Government mistrust of the extent to which councils knew how their local markets operated and passing on any central funding to providers, in part due to providers finding and presenting alleged examples of this not working. This level of mistrust in turn sometimes led to over engineered grant conditions which placed an onerous financial risk on councils if every pound could not be accounted for in the detail."

601. On 1 June 2020 the LGA published "LGA Headlines" (**Exhibit JK4/157 - INQ000103780**), a high-level summary of "current and anticipated headline issues". The first issue listed was the need for certainty over ongoing Covid-19 funding for councils.

602. I reproduce the "summary asks" on finance in full as they capture the key issues:

"• *Certainty needed over ongoing COVID-19 funding for councils*

Grant funding worth £3.2 billion and cash flow measures have been welcome and provide additional certainty over the short term. However, analysis of the May round of the MHCLG financial information survey returns suggests that £3.2 billion of cost pressures and income losses has already been incurred by councils between the months of March and May. Overall, at least another £6 billion might be required to cover the rest of the financial year. We want to work with Government to ensure a package of measures are put in place to address funding pressures and provide the certainty councils need to keep responding fully to the COVID-19 emergency and help prepare for the recovery.

• *Certainty needed over 2021/22 budgets funding for councils*

The financial impact of the crisis, including the economic fallout, will continue to be felt into next year and beyond, both in terms of councils' own income and grant funding available (such as through the Spending Review and 2021/22 Local Government finance settlement). Certainty around this is desperately needed so councils can balance their budgets this year and take vital decisions about how to pay for vital local services next year.

• *The Government needs to work with the sector to look ahead to the long-term impact of the crisis, beyond next year*

The Government has announced that implementation of both its review of relative needs and resources ('Fair Funding Review') and the move to 75 per cent business rates retention will now be postponed and not go ahead from April 2021. This will provide councils with more certainty over their 2021/22 budgets. However, both reforms have been delayed on three separate occasions. The Government must provide clarity over the future of these reforms, including whether and when they will now be implemented, as soon as possible to help councils plan their medium-term financial strategies which will already be challenged by the impact of COVID-19."

Financial position before Covid

603. As described earlier in this statement, local government experienced a significant reduction in funding from 2010 onwards. In March 2018, the NAO reported that there had been a 49.1% reduction in real terms of government funding for local authorities between 2010/11 and 2017/18 (page 4, NAO report dated 8 March 2018 "Financial sustainability of local authorities 2018", **Exhibit JK4/158 – INQ000581266**).

604. Spending on ASC services had fallen by 3.3% in real terms between 2010/11 and 2016/17 (paragraph 12, page 7). This was significantly less than the reduction in spending in real terms on non-social care services (32.6%) over the same period (page 4). This shows that councils did what they could to protect adult social care, albeit at the expense of other services, many of which contribute to people's wellbeing in the widest sense (such as leisure, libraries, parks and green spaces).

605. However, while councils managed to limit the extent of their reduction in ASC spending, demand increased over that period (paragraph 10, page 7). This meant that councils were therefore spending less in real terms on ASC at the same time as needing to spend more in response to rising demand.

606. This situation was reflected each year in the annual (summer) ADASS Budget report. That recorded the impact of demographic pressures on each council – around £400 million in each year – as well as the scale of the planned savings in ASC that local authorities had to make each year (on top of savings made in previous years). The annual planned savings varied each year between £699 million in 2019/20 and £1,065 million in 2015/16.

607. The Inquiry will note that savings were significantly higher than the cost of meeting the changes in demography. This partly reflects the fact that, since April 2017, inflation in ASC

has been significantly higher than the Government's GDP deflator (which is used by organisations to calculate real changes).

608. The key inflationary pressure in ASC is the labour cost of providing ASC. The LGA estimates that labour costs account for about 70% of the total costs of providing ASC. Provider organisations agree with that assumption.

609. Any policy that impacts labour costs, even those which are universally welcomed, will therefore have serious implications for the cost of, and spending on, ASC. The most significant such policy in recent years was the introduction of the National Living Wage ("**NLW**") in April 2016, given that almost all employees working for ASC providers are paid the NLW or just above. We therefore see that annual increases in the NLW were significantly higher than the GDP deflator in the three years prior to the pandemic.

National Living Wage Increase April /%	GDP deflator for the financial year /%
April 2017: 4.2	17/18: 1.57
April 2018: 4.4	18/19: 2.11
April 2019: 4.9	19/20: 2.37

610. While of course welcoming an increase in pay for care workers, both the LGA and ADASS have made public their concerns about the financial pressures on ASC, including the need for adequate funding to cover the cost of inflation, demography and the NLW.

611. For instance, in July 2019, ADASS commented (page 5, **Exhibit JK4/158a – INQ000574133)**:

> *"Local Government is struggling to balance the books and directors know that adults of all ages with disabilities are not getting all the care they need. Directors are increasingly saying they cannot meet their legal responsibilities to the public. The NHS is under pressure; after prolonged reductions social care is struggling to cope with increased need."*

612. The report also acknowledged, at page 8, that "Despite raising fees to providers, fees do not match what providers say they need to be sustainable."

613. In 2020, the LGA co-commissioned the Institute for Fiscal Studies to look at the impact of the pandemic on English council funding through a series of reports. Its second report, examining the medium-term outlook, said the following (IFS Report on Covid-19 and English Council funding, **Exhibit JK4/159 – INQ000581324**):

"Based on the prices councils pay for adult social care services and benchmark prices needed to meet costs and provide a suitable return on capital for suppliers, councils underpaid by £1.2–£1.4 billion in 2018–19. This could increase to £1.4–£1.7 billion in real terms by 2024–25."

614. The LGA recognises that there can be a gap between the cost to providers of providing care, and what councils pay. It also recognises that any such a gap may have consequences for provider viability and/or focus and, ultimately, people with cause to draw on social care and the workforce. As the Inquiry might expect, providers and their representative associations report differing levels of underpayment because of differing fee levels. Therefore, in some council areas, pressure on the provider market may be more marked than in others.

615. In summary, from both the council and ASC provider perspective, the financial situation at the start of the pandemic was precarious.

ADASS Budget Survey 2020

616. Early in the pandemic, the 2020 ADASS survey offered a valuable opportunity to start understanding the financial consequences of the pandemic for ASC. ADASS and LGA therefore jointly agreed to orientate the survey toward the impact of Covid-19 on ASC finances. This was communicated to DHSC and MHCLG on 20 April 2020 by email and draft questions were shared with government departments on 22 April 2020 by email (see email chain dated 22 April 2020, **Exhibit JK4/159a – INQ000545605**; and attachment with draft questions, **Exhibit JK4/159b – INQ000545606**. In response on 23 April, DHSC highlighted the importance of understanding the impact on "frontline service provision" (**Exhibit JK4/159c – INQ000545608**).

617. The survey was published in June 2020, noting the additional financial pressures on ASC posed by the pandemic (**Exhibit JK4/030 – INQ000103773)**:

"There are huge additional financial pressures being faced by councils because of the COVID-19 pandemic. Planned savings of £608 million to balance budgets and the loss of a minimum of £190 million of planned income means that only 4% of directors are confident that their budgets are sufficient to meet their statutory duties…" (page 6).

618. ADASS carried out a rapid review of how councils were responding to the pandemic in early May 2020. This showed that over 90% of councils had taken action to support

providers. The next section explores this in further detail.

Financial support to providers

619. Early in March, the LGA and ADASS came together with the CPA to draft joint guidance for council commissioners on how to support local care providers. This was issued on 13 March 2020 (the final draft of the guidance, pre-publication, is exhibited as **Exhibit JK4/159d – INQ000545638**). The key financial aspects covered in the guidance were the importance of helping providers to manage their cashflow, and for councils to consider temporary extra funding to providers to reflect their sudden increased costs. There was also consideration of how providers could be helped with PPE.

620. In a meeting with the CPA on 27 March 2020, providers continued to raise their concerns about the financial position they faced, including that some council fee increases were insufficient to cover the 5% increase in the NLW, let alone the emerging pandemic-related pressures. Surprisingly, the CPA called for a further increase in council fees to reflect the additional costs arising from Covid. CPA suggested that:

> *"The real operating cost increases for care are around 35%",*

taking into account costs associated with PPE, covering sickness and social isolation, pay incentives to retain staff in their current posts, and changes to the configuration of staff to maintain safe care in residential settings.

621. On 2 April, and following the above discussion, the LGA emailed DHSC (through David Pearson) with our estimates of the possible extra temporary costs faced by providers. That note concluded that provider costs would go up by at least 12–14% based on wage cost increases (of around 20%), with the costs of PPE and other factors increasing costs still further.

622. The LGA and ADASS issued advice to councils on 8 April 2020, entitled "Temporary Funding for Adult Social Care providers during the Covid-19 Crisis" (**Exhibit JK4/160 – INQ000581358**). That note highlighted the impact of the 5% increase in the NLW increase and raised the idea of councils offering temporary fee cost increases. The note was clear that, following an initial review of the information provided by providers, it appeared that providers could be facing a cost increase in the region of 10% that month. The note was also clear that the LGA and ADASS wanted to "understand this issue better". In recognition of the challenges providers faced, the LGA and ADASS also encouraged councils to pay in advance to help providers with cash flow pressures.

623. However, the note was also clear that:

> *"There are many calls on the Government grant of £1.6 billion and whilst it was expected that a substantial part of would be needed for ASC, it would not be possible to sustain substantial temporary increases in funding to providers over a number of months without additional Government resources."*

624. The LGA had hoped that the NHS would also sign this note, but the need to issue it promptly precluded NHS involvement. However, there were significant discussions with the NHS and Government (primarily DHSC but also MHCLG) on the multiple drafts of the document that were produced (**Exhibit JK4/161 – INQ000581246**).

625. During further discussions in April between the LGA, ADASS and providers, providers highlighted that their cost increases were turning out to be higher than first thought. Local authorities, on the other hand, were concerned that the extra funding already announced by the Government (£1.6 billion) would not be sufficient to meet all the possible extra financial pressures facing councils. These tensions played out further when a CPA survey indicated that many councils were not paying providers anything extra in response to the pandemic. This was not consistent with ADASS survey findings.

626. It is worth noting that there were other uncertainties at play at this time, such as whether there would be government compensation for Statutory Sick Pay payments and the impact of support for businesses already announced by the Government (see for example, internal LGA email dated 22 April 2020, **Exhibit JK4/162 – INQ000581238**; **Exhibit JK4/163 – INQ000581237**). The LGA responded promptly to issues raised with us by providers where possible. One example related to providers complaining that they were only being refunded for 1% of the 20% VAT they were paying. This was raised with us on 22 April 2020 and the LGA raised it with DHSC the same day.

PPE

627. Over the course of April, it quickly became apparent that PPE would become a significant cost pressure facing ASC providers following changes to PPE requirements and PPE use. UKHCA raised this with us on 26 April and, the following day, alerted us to new PPE guidance published by PHE.

628. Local government did not have significant expertise regarding PPE. Necessarily, the LGA therefore had to pay close attention to the views of providers given it was their

employees who were using PPE (if they could get it). At this point in time, providers had to pay for PPE, although some local authorities were providing it free from their own supplies.

629. UKHCA worked with Accenture to identify additional provider costs arising from the pandemic. These suggested that the extra costs of PPE were significantly higher than the additional labour costs. Feedback from councils was consistently of the view that the total costs quoted by UKHCA were unsustainable. The LGA liaised with CQC on the matter; their view was that the UKHCA assumptions looked reasonable.

630. Government responded to the PPE cost issue by saying that it would be free from VAT for 3 months from 1 May 2020.

The pandemic and provider costs

631. In the face of clear and growing pressures on providers, and new funding from Government to help address those pressures, DHSC asked councils to (see Government letter dated 14 May 2020 re care home support package, **Exhibit JK4/164 – INQ000050497**):

> *"…review or put in place a care home support plan drawing on local resilience and business continuity plans" [by 29 May and to make this public].*

632. The LGA advised DHSC that expecting councils to publish this material on their websites was workable (Email from LGA to DHSC on 5 May 2020, **Exhibit JK4/165 – INQ000581250**). In June, CHIP followed up with those councils who had not responded by the 29 May deadline.

Government engagement

633. On 6 May, the LGA met with the Minister for Social Care. In that meeting, the LGA agreed to work with providers to produce a shared view of the cost of the pandemic on providers. Laing Buisson were commissioned to provide technical support. This analysis was completed and sent to the Minister on 9 May. It concluded that "the cost pressures and lost revenue facing the ASC provider sector" was £6.567 billion for the 6 months April-September 2020. By far the biggest cost was PPE, at over £4 billion. This information was also shared with MHCLG.

634. There was no reply from the Minister for three weeks (**Exhibit JK4/166 –**

INQ000581264). In that time, on 13 May, £600 million additional resources were made available through the Infection Control Fund.

635. On 27 May 2020, the LGA and ADASS therefore wrote to the Minister asking for her "thoughts on what you plan to do with this information" (**Exhibit JK4/167 – INQ000581172**). At this stage, the information had not yet been shared with councils because, as we wrote to the Minister, "We have wanted to give you and your officials time to digest the analysis and have not wanted you to be wrong footed."

636. The work was shared with councils on 3 June 2020.

637. On 25 August, ADASS, the CPA and the LGA wrote to DHSC civil servants asking once again "for some indication of your collective thinking and intentions" regarding the analysis that the Minister and officials had been in possession for approaching four months. The letter added:

> *"…While we have welcomed the further injection of funding through the Infection Control Fund, this has not been for the whole sector, its uses have been restricted, and providers are now worried by what they see as a cliff edge approaching on 30 September as the current ICF [Infection control fund] ends..."*

638. On 7 September, DHSC finally offered to meet to discuss the joint analysis.

639. The Government's Winter Plan, published in September 2020, offered to make PPE free to all care homes and home care providers. While a positive (albeit late) development, there were issues. In the weeks following publication of the Winter Plan, there were comments from some councils that there were practical difficulties accessing the PPE. For an example see the email from the London Borough of Hammersmith & Fulham 8th October 2020 (**Exhibit JK4/168 – INQ000581245**). Furthermore, there were restrictions on the use of the Infection Control Fund to purchase PPE. This was an issue we discussed with the NAO to inform its work on the on the pandemic (**Exhibit JK4/169 – INQ000581334**).

Summary of additional funding provided by the Government

640. The following table provides an overview of funding that Government made available to support adult social care directly or indirectly:

Fund name/area and date announced	Amount	Purpose/detail
Covid-19 Response Fund 19 March 2020 (Spring Budget)	£5bn overall funding, of which: £1.6bn to councils £1.3bn to support hospital discharge	£1.6bn funding to help councils respond to pandemic pressures across all council services, including "increasing support for the ASC workforce and for services helping the most vulnerable, including homeless people".
Local government 15 April 2020	£1.6bn to councils	A further £1.6bn to support councils across all service areas. Announced alongside publication of the Covid-10 ASC Action Plan.
Infection Control Fund (1) 13 May 2020	£600m	To support providers to implement IPC measures, including PPE, testing, cleaning and sanitation, staff recruitment. Released in two tranches: 22 May 2020 and early July 2020. 75% of fund required to be spent on IPC measures in care homes. Second tranche contingent on the council publishing a care home support plan by 29 May (actual grant conditions were not published until 22 May 2020).
Infection Control Fund (2) 17 September 2020	£546m	To support providers to implement IPC measures. An extension of funding for the period September 2020 to March 2021. Released in two tranches: October 2020 and December 2020. A new grant with revised conditions. 80% of fund required to be passed to care homes on a per beds basis, and CQC-regulated community care providers on a per user basis. 20% of fund required to be spent on IPC measures but at councils' discretion. Consolidated with Rapid Testing Fund.
Infection Control Fund (3) November 2020	£388m	To support providers to implement IPC measures. An extension of funding to March 2022. Released in two tranches: 60% in October 2021 and 40% in January 2022. 70% direct funding to providers. 30% of fund required to be spent on IPC measures but at councils' discretion.
Rapid Testing Fund 15 January 2021	£149m	To support the rollout of testing care homes. Paid in January 2021 to cover the period 2 December 2020 to 31 March 2021. 80% of funding to be passed directly to care homes on a 'per bed' basis. 20% of funding to be spent at councils' discretion on measures to support increased

		testing in care homes.
Workforce Capacity Fund 19 January 2021	£120m	Funding to enable councils to deliver measures to supplement and strengthen ASC staff capacity. Separate to ICF (2). 70% paid to councils by early February 2020. 30% paid to councils in March 2020, subject to councils completing a return to DHSC by 12 February.
Infection Control Fund (4) July 2021	£251m	To support providers to implement IPC measures. An extension of funding to September 2021.

Issues and challenges

641. While all funding was of course welcome in the face of significant pressures and the strongest desire to support people drawing on social care and its workforce, there were concerns and frustrations with aspects of its design and allocation. For instance:

- The ICF (1) was felt to be too restrictive, particularly in its prohibition of using the fund to purchase PPE or deep cleans (a more enhanced programme of cleaning to complement more routine cleaning including, for instance, thorough cleaning of surfaces, floors, soft furnishings and reusable equipment). Councils and providers believed such activity should have been permitted under a broad banner of 'infection control'.

- Councils (and, by association, providers) were frustrated by the level of assurance required of councils in respect of the ICF (1) and, where Government was not assured, the threat of funding being clawed back. Assurance therefore became unnecessarily capacity-intensive for providers as well as councils because the latter would need the input of the former to gather and provide the required information which the latter often would not have. The overly-bureaucratic nature of funding reporting – at a time when the absolute priority should have been keeping people drawing on and working in ASC safe – meant some councils felt unable to take up the funding.

- State aid was another source of frustration during ICF (1) and was the backdrop to the issues set out above. State aid is financial support provided by government to businesses and might be given to support policies/business that are in the public interest and/or to address a market failure, for example. In offering state aid, government must ensure fairness by not distorting market competition. In ASC during the pandemic, local government pushed the Government to define national government financial support to providers as state aid. This was because state aid

would have allowed for greater flexibility in how such funds were allocated and on what basis. Without a classification of state aid, it was easier for the Government to impose restrictions which, as detailed above, is exactly what happened.

- The ICF (2) also posed challenges, with many councils feeding back that one reporting requirement did not work. The LGA's data team produced a solution and DHSC took council and LGA feedback on board, amending guidance as a result.

- More generally, council chief financial officers questioned the level of monthly reporting requirements for some funding streams which constituted a relatively small amount of public spending.

- Councils also raised general objections to the late publication of grant conditions, sometimes weeks or even months after funding was announced and sometimes with only weeks to go before funding was due to be fully spent.

Impact of working conditions on care workers' ability to self-isolate and/or shield

642. The LGA lobbied Government from the start of the Covid-19 pandemic in 2020 to provide adequate funding for councils and providers to support the workforce both during the pandemic and to aid recover. The funding was essential to bring the additional capacity that was required to support the health and care system and to enable the workforce to be more flexible in undertaking different functions to support those who were ill and/or vulnerable. Later in the pandemic there was dedicated workforce funding identified, and local authorities welcomed this, however it was challenging to determine how it should be allocated locally.

643. LGA worked with Government and partners to bring new people and 'returners' into the sector and to onboard them quickly. They did this through the national recruitment campaign for ASC (launched 23 April 2020, **Exhibit JK4/170 – INQ000581201**) and the Social Work Together campaign. A process was developed to redeploy nurses to health and care following the NHS 'return to practice' call. The Social Work Together campaign, which the LGA led, saw over 1,000 social workers return to ASC in 2020.

644. Returners to local government expressed concerns about pension rights which potentially impacted on returning or any subsequent absences. The LGA, working with the Local Government Pension Scheme administrators waived any pension abatement rules

for returning local government staff to support the return to the sector. There was an expectation that other workplace schemes would do the same at this exceptional time.

645. Rapid onboarding of staff joining the sector was achieved via online induction and more rapid Disclosure and Barring Service checks (Guidance announced 27 March 2020, **Exhibit JK4/171 – INQ000581375;** see also ASC Workforce Task & Finish spreadsheet, **Exhibit JK4/172 – INQ000581304)**. While this helped to get people in to posts quickly there were questions about both the quality of care provided by new recruits but also the experience to mitigate infection risk.

646. One of the issues that was raised at meetings was around insurance and indemnity cover for those undertaking new roles or new tasks (ASC Hub weekly updated, 29 April 2020, **Exhibit JK4/173 - INQ000581189**. Providers reported potential issues with insurance, litigation, inability to deliver to usual standards meaning they might need indemnity. LGA collected examples of indemnity and insurance issues to share with DHSC to help it to inform a position. The 2020 Act contained emergency powers for pandemic related claims that were not addressed via other insurance schemes.

647. Working terms and conditions for many in social care impacted on the ability of the workforce to self-isolate or shield. Minimum pay levels, zero-hours contracts or temporary contracts that did not include sick pay acted as a disincentive to self-isolating. Many care workers, already on minimum wages could not afford to take periods of non-paid leave. Payment of sick pay was often dependent on how it was defined in the contract of employment. For others sick pay was only determined to be paid if a worker was incapable of working. For many asymptomatic workers wishing to self-isolate that was not the case.

648. In August 2020 at the national Testing Task & Finish Group chaired by the DHSC, Unison reiterated the financial impact of needing to self-isolate on care workers and said only 25% of staff received full pay when self-isolating and a similar percentage got no pay at all. Concerns around the need to self-isolate may have contributed to low take up of testing among some care workers. Unison shared findings that revealed that 18% of care workers had not been tested at all, 46% had been tested once and 23% had been tested twice. Providers reported that funding from the Infection Control Fund, intended to cover the cost of people self-isolating, was not always passed on to employees. DHSC agreed to investigate at that time. The LGA is not aware of the outcome of that investigation.

649. Parity of working conditions and benefits with the NHS was a recurring theme that impacted on the resilience of the social care workforce throughout the pandemic. While

the efforts of the NHS were recognised through several approaches, social care staff were often overlooked, or recognition came secondary to other blue light services.

650. Access to testing facilities was difficult for many social care staff. In April 2020, the LGA tried to influence Government to ensure that the social care workforce could test easily for Covid-19, but they frequently had to travel by car to a regional test centre, often long distances (**Exhibit JK4/174 – INQ000581303**). This distance may have been a deterrent to testing at this time, particularly coupled to the reservations around sick pay. LGA regularly requested that the plans and process for the roll-out of testing would address the accessibility of testing centres. On 5 May 2020, the NCF circulated survey results following research with its members into the experience of staff testing under the Get Tested portal. On 5 May 2020, the NCF raised concerns over a lack of social care staff prioritisation, including that fewer than a quarter of symptomatic staff who required testing were able to access it through any of the various systems at the time (**Exhibit JK4/175 – INQ000581302; Exhibit JK4/176 – INQ000581301**).

651. Testing for people with learning disabilities, autistic people and people lacking mental capacity came sometime after testing in care homes for older people. The LGA, along with councils, lobbied for this to be prioritised, but it took some months for it to happen and for guidance to be produced for staff in undertaking tests. This delay left these people more vulnerable and possibly exposed to unnecessary risk.

652. At a time when many social care staff were off work with Covid-19 or self-isolating, the use of agency or bank staff increased to meet demand. As testing was developed over time it became apparent that the spread of Covid-19 by agency or bank staff moving between care homes was likely greater than those working in one setting (**Exhibit JK4/177 – INQ000472799**). This may also be true of registered professionals, i.e. social workers, occupational therapists, and nurses, working between different settings.

653. Early in the pandemic, the LGA became aware that there may be an association between ethnicity and adverse outcomes from Covid-19, and that this was impacting BAME members of the ASC workforce. In advance of a meeting of the Community Wellbeing Board on 9 June 2020, the LGA circulated a report updating members on the LGA's activities (**Exhibit JK4/018 – INQ000581323**). Following the publication of the PHE review of disparities and risks in outcomes on 2 June 2020 (**Exhibit JK4/178 – INQ000581230**), the LGA advised that it would be working to support local authorities to tackle the disproportionate impact of Covid-19 on BAME communities, noting that PHE found there was a particularly high increase in all cause deaths among those working in

social care and care homes. Having already held a successful webinar on “Covid-19 and ethnicity” on 2 June 2020, the LGA advised it would look to engage more on this topic in the coming months to ensure members were supported to take action to limit the disproportionate impact of Covid-19 on these communities (**Exhibit JK4/018 – INQ000581323**).

Part 14 - Care Act Easements

LGA involvement in the introduction of Care Act easements

654. In this part, I shall outline the LGA's involvement with the introduction, monitoring, oversight, and ultimate withdrawal of Care Act easements. These easements referred to temporary changes made to the 2014 Act to make it possible for councils to reduce their usual duties.

655. In LGA/ML/M2 (**INQ000215538**), it was noted that:

> *"The LGA/CHIP gave advice to Government in this area, especially regarding the need for any easements for the Care Act, and how best to enable this to happen."*

656. In March 2020, the LGA was approached by the DHSC to provide input into the drafting of guidance on '*Care Act easements*' as well as a '*core script*' that summarised the main features of the guidance.

657. The LGA recognised there were difficulties in carrying out Care Act assessments and in then sourcing sufficient capacity in the social care sector to provide support in accordance with assessed needs. There was thus a gap between the need for social care (which continued and if anything increased) and the capacity to assess for and meet these needs. For this reason, along with other partners such as ADASS, the LGA initially supported the notion of easements being needed, and Government listened to this advice from the LGA and others.

658. The easements were created under section 15 of, and schedule 12 to, the 2020 Act to ensure that during the pandemic the best possible care and support could be provided. They enabled councils to streamline certain processes (e.g., assessments, care reviews, and care planning) and prioritise care and support so that the most urgent needs were met.

659. The LGA was not the only stakeholder engaged in this work. Other organisations included: the Association of Retirement Community Operators, UKHCA, the NCF, TLAP, Carers UK, Mencap and the CQC.

660. A task and finish group, chaired by DHSC, was created to oversee the development of the guidance, and accompanying products. An invitation to the group's first meeting on 23 March was sent on 20 March 2020. This followed an email from DHSC alerting partners

to the necessary work and a request for support and input.

661. Following the first meeting of the group, the LGA and ADASS had concerns that the draft developed by DHSC officials reflected their lack of experience and expertise in social care, particularly in relation to the 2014 Act, and did not reflect the full range of queries on easements that the LGA was receiving from councils and other sector partners.

662. The LGA and ADASS subsequently offered to take responsibility for drafting several sections of the guidance. DHSC quickly took up the offer and the LGA and ADASS therefore worked at pace on the relevant sections of the guidance, plus the accompanying core script, thus helping to enable publication of the material by 31 March.

663. While the draft was based on the brief from Government and signed off by them, the input from the LGA and ADASS ensured that it was understandable and implementable by councils.

LGA involvement in monitoring and oversight of use of Care Act easements

664. The role of monitoring and overseeing the enactment of easements by councils, and the protection of individuals potentially impacted, sat with the DHSC and CQC, not the LGA.

665. Councils enacting easements were tasked with informing DHSC directly about their intention to enact easements, using a standardised form completed by the DASS. The CQC was tasked with making public and keeping updated the list of councils operating under easements. DHSC said that the information provided by councils about triggering easements would be held by the Department and shared with CQC, ADASS, LGA and other relevant parties (DHSC guidance, **Exhibit JK4/179 – INQ000581373**). I am not aware of any information shared with the LGA by DHSC beyond those councils who had notified DHSC that they were enacting easements.

666. However, the LGA and ADASS did produce summary notes on the Care Act easements setting out what governance and oversight arrangements should be when councils enacted easements (**Exhibit JK4/180 – INQ000103873**; **Exhibit JK4/181 – INQ000115333**), this discussed:

> *"…Governance and oversight when triggering easements*
>
> *1. An individual council decision to trigger the Care Act easements should be made by the DASS with, or on the recommendation of, the PSW. The*

Lead Member, HWBB and local NHS CCG leadership should also be aware of, and involved in, this decision-making process.

2. *Councils should evidence the basis for their decision to trigger easements, using the decision-making table below, and ideally capturing the following information (section 6. in the Guidance):*

    - *The nature of the changes to demand or the workforce.*
    - *The steps that have been taken to mitigate against the need for this to happen.*
    - *The expected impact of the measures taken.*
    - *How the changes will help to avoid breaches of people's human rights at a population level.*
    - *The individuals involved in the decision-making process.*
    - *The points at which this decision will be reviewed again.*

3. *Any changes to practice arising from the decision to trigger easements must be underpinned by the Ethical Framework and be proportionate to local circumstances.*

4. *DHSC should be notified at CareActEasements@dhsc.gov.uk that easements have been triggered (at both stage three and stage four) and the reasons for this decision.*

5. *The Coronavirus Act 2020 says that Councils must have regard to the Care Act easements Guidance and comply with it as directed by the Secretary of State along with the Ethical Framework.*

6. *The decision to trigger easements should be communicated to all staff, providers, service users and carers, taking account of the communication needs of service users and carers in particular.*

7. *Councils need a clear pathway in place for people with care and support needs, carers, and providers to quickly raise concerns if they believe either a decision or a care package is in breach of the European Convention on Human Rights…"*

667. On 23 April 2020, the LGA published a briefing stating (**Exhibit JK4/148 – INQ000103868**):

> *"…Councils, operating under the Coronavirus Act and guidance on Care Act 'easements', may face difficult decisions on prioritising their resources and capacity. It is not inconceivable that some decisions may be questioned or challenged. The easements guidance must therefore also be kept under close and regular review and revised as necessary based on implementation experience of the easement measures. Any measures for oversight and monitoring of the easements must be sensible, proportionate and not burden Councils with unnecessary reporting requirements.*
>
> *[…]*
>
> *The Coronavirus Act and accompanying guidance put Councils in uncharted territory, and it is possible that decisions Councils may make may be challenged. The LGA will work closely with Councils and relevant partners to collect information on issues Councils encounter in operating under the easement measures. We will share this insight with DHSC to ensure that possible future iterations of the guidance reflect the real experience of implementation…"*

668. The LGA was aware of concerns from councils that the effect of publishing a list of those making use of such easements – especially as this was by the regulator, CQC – would have the effect of seeming to involve "naming and shaming". This concern proved to be correct with those giving effect to easements experiencing significant criticism on social media for their decision, not helped by this information becoming public before it had been published by CQC.

669. Most councils did not in fact make use of these easements; where they did, councils faced criticisms around due process such as consultation with people likely to be affected by the decision. It was unfortunate that there was an under-managed process whereby Government put into the public domain the names of those councils which first used the easements, without telling them, leading to a level of concern from service users and very public criticism, which could have been at least mitigated. In the end only eight councils made use of the easements; despite the challenges, most councils were able to find sufficient flexibilities within the existing Care Act framework to avoid the need to do so.

LGA involvement in withdrawal of Care Act easements

670. On 12 February 2021, one-year after the 2020 Act came into effect, DHSC wrote to the LGA seeking its views on (**Exhibit JK4/182 – INQ000581187)**:

> *"…whether the easements provisions should be retained, suspended, sunset/withdrawn from March 2021…"*

671. On 16 February 2021, the LGA's Director of Social Care Improvement responded in support of either suspending or revoking the easement provisions on the basis that (**Exhibit JK4/183 – INQ000581267**):

> *"…My [Director of Social Care Improvement] view, and from the soundings from others that I have taken, is that it is now difficult to make any case for the continuation of this policy. It has not been used since last summer, and we have now come through (arguably and hopefully) the worst of the pandemic in terms of impact on capacity in social care, without any local authority resorting to this provision. It would seem that the Care Act has allowed sufficient flexibility for Local Authorities to adjust their service offer to meet the demands of this pandemic. Furthermore, it would seem that the provision is creating anxiety for some of our service users, if we listen to the groups representing them, and this would now be a further reason for not continuing unless there is a demonstrable need…"*

672. Considering the issues outlined in this section, the LGA therefore supported the review of the ongoing need for these easements and the eventual decision that they be discontinued: this review was helpfully supported by a piece of work from ADASS.

Part 15 - Do Not Attempt Cardiopulmonary Resuscitation

LGA concerns with DNACPRs and LGA views on survey returns on DNACPRs

673. Do Not Attempt Cardiopulmonary Resuscitation ("**DNACPR**") notices are a clinical matter that generally lies outside the remit of councils and the LGA, however as the responses to the Module 6 Survey set out councils found the guidance on their use difficult to use (**Exhibit JK4/001 - INQ000400522**).

674. Almost half of authorities in England (45%) were unable to rate Government guidance on DNACPRs; in Wales, the proportion was 41%. In England, around a quarter (27%) rated it as 'not very good' (14% in Wales), 14% as fairly good (18% in Wales), 13% as not good at all (27% in Wales), and 1% as very good (0% in Wales)

675. Those authorities able to rate the guidance were asked how easy or difficult it was to apply it. In England, just over a half (52%) thought that it was either fairly difficult (28%) or very difficult (24%) while only 10% thought it very or fairly easy. In Wales, 61% thought it very or fairly difficult and 23% considered it very or fairly easy.

Part 16 - Changes to Regulatory Inspection Regimes

LGA concerns with changes to the regulatory inspection regime

676. The CQC's proposal was to move away from regular inspections and ratings of provider services, on the grounds that such inspections had potential to divert the capacity of providers away from managing the safe delivery of care and support and towards the precise requirements of regulation, many of them being about process.

677. The CQC instead established an Emergency Support Framework which was described as providing:

> *"…a structured framework for the regular conversations that inspectors are having with providers and provides CQC with an additional source of intelligence to help monitor risk, identify where providers may need extra support to respond to emerging issues, and ensure they are delivering safe care which protects people's human rights…"*

678. The LGA understood that this change was not to cease regulation or oversight, but rather to continue it on a more risk-based basis, and with greater flexibility to listen to, respond to and escalate issues from providers and recipients of care. As such the LGA did not raise any objections to this change.

679. The LGA was aware of the need to maintain good evidence-based oversight of what was going on in settings of care. As such, it supported the rapid setting up of a consistent data collection through Capacity Tracker and initially through CQC, whilst recognising some concerns about this precise means of doing so which are rehearsed in the LGA's more detailed response concerning data. It believed that there was a system in place to monitor infections and outbreaks of Covid-19 in care homes, which was separate from regulation.

680. In late 2020, Government began to signal its intention to strengthen oversight of local authorities' ASC functions, and during early 2021 this became a more specific proposal to do this by extending CQC regulatory oversight to local authorities. The LGA sought to engage with this collaboratively with both CQC and Government, and understood the desire for transparency, but signalled that the timing of this was poor, as local government was still intensively occupied in addressing issues from the Covid-19 pandemic and was struggling with resources, in terms of capacity and funding.

Part 17 - Deaths Relating to the Infection of Covid-19

LGA concerns with deaths related to Covid-19

681. I express my sadness about the number of people who lost their lives to Covid-19, including those who were receiving and giving social care. I know that dedicated carers and workers also succumbed to the disease. We will always remember them. This impact is evidenced in reports such as CQC's 2021 report, "The state of health care and adult social care in England 2020/21" (**Exhibit JK4/184 – INQ000235497**).

682. During the pandemic the LGA highlighted the need for accurate data in relation to deaths from Covid-19 as councils wanted accurate and timely data identifiable by local authority area to help to manage risk, including to those working in adult social care and specific groups who were at higher risk such as people with learning difficulties (LGA press release dated 21 April 2020 "LGA responds to latest ONS figures on coronavirus community deaths", **Exhibit JK4/185 – INQ000581181**):

> *"…Every death from this virus is a tragedy. We must take every possible step to protect our elderly and most vulnerable and those who work with them from this disease.*
>
> *"Today's sad and shocking figures highlight just what a severe challenge we face in care homes and other community settings. Council social care staff and care homes need urgent access to reliable and ongoing supplies of quality PPE, increased rapid and comprehensive testing and greater support with staffing and other equipment, on an equal footing with the NHS.*
>
> *"Data on all deaths from COVID-19 needs to be published promptly and accurately, so we can have full confidence and transparency in these figures as part of our plan to defeat this deadly virus..."*

LGA concerns regarding the impact of the pandemic on recipients of care

683. The safeguarding adults workstream was an element of the joint LGA and ADASS Adult Social Care Hub, Covid-19. From April 2020, the CHIA Safeguarding Lead set up a reference group and regular virtual meetings with key partners from relevant networks (as well as the DHSC's Interim Chief Social Worker for Adults) to be able to share insight and intelligence about the impact of the pandemic on safeguarding activity and practice, discuss what might be required to assist colleagues in these circumstances and develop advice or promote relevant resources (**Exhibit JK4/150a - INQ000545635**). Safeguarding activity, by definition, refers to prevention and protection of people with care and support needs at risk of abuse or neglect and so this work captured how the pandemic affected recipients of care, and the changing risks that they experienced.

684. Issues that were raised by SAB chairs, SAB managers, principal social workers and others in response to the Covid-19 crisis were collated, and responses and information were presented, in a 'safeguarding issues grid'. This aimed to help networks to identify key areas for consideration in relation to safeguarding adults, actions that had been taken to mitigate risks for others to learn from, and any further actions required. It was a 'live' document. A pro forma was circulated through networks and bulletins to capture examples both of issues and responses. A pack was subsequently published, promoting the resources that had been collected, to support ongoing safeguarding work during the pandemic. The resource pack included: signposting information; examples of changed practice and service delivery in response to the Covid-19 pandemic; and top tips for Safeguarding Adults Board managers.

685. Issues regarding changing expectations about SAB functions during the pandemic were escalated by CHIP to DHSC policy officers to address.

686. The three Insight Project reports were published by CHIP's safeguarding workstream, which aimed to identify and describe the impact of Covid-19 and the lockdowns on safeguarding activity and practice (**Exhibit JK4/112 - INQ000581226; Exhibit JK4/113 - INQ000581224; Exhibit JK4/114 - INQ000509872**. The Insight reports are also discussed at paragraphs 480 to 502.

687. Responding to a proposal from the executive group of the National Network of Chairs of SABs, the safeguarding adults workstream of CHIP invited councils to participate in a

voluntary data collection exercise to help the sector promptly understand the nature of the impact of Covid-19 and the lockdown on safeguarding people with care and support needs, and how services were responding to these new challenges. Quantitative (according to a sub-set of NHS Digital categories) and qualitative data were collated.

688. The reports were cascaded and presented to the sector through webinars to share examples of how councils nationally had adapted ways of working to positively improve safeguarding practice and face the challenges of protection people with care and support needs during the pandemic. The three Insight Reports are rich with data and are exhibited to my statement; they are discussed further in The Insight Reports.

689. In this section, I summarise the key data and findings from these reports, noting that a significant amount of the valuable data coming from these reports is based on qualitative, rather than quantitative data. The difficulties with drawing conclusions from the quantitative data is explained in the reports.

690. The second national analysis of SAR (**Exhibit JK4/149 - INQ000581353,** referred to above see Part 10 - The impact of the restrictions on visits by loved ones on recipients of care) was commissioned by the safeguarding workstream of Partners in Care and Health. This found that 22% of the SARs commented on shortcomings arising from the Covid-19 pandemic. Several reviews demonstrated the impact of interconnected features: responses to the pandemic alongside the impact of austerity and available legal powers; NHS or social care policy in the context of austerity. These shortcomings contributed to the poor care and support of the people who were the focus to the SARs.

The Insight Reports

The First Insight Report

691. *The First Insight report* (data from January 2019-June 2020 from 92 councils) reported that the volume of safeguarding concerns dropped markedly during the initial weeks of the first Covid-19 lockdown in March 2020, only to return to and then exceed normal levels in June 2020 (**Exhibit JK4/112 - INQ000581226**). Sixty per cent of councils in the qualitative data described a decrease in the level of safeguarding concerns at the start of the Covid-19 lockdown, compared to the previous year.

692. Some councils who experienced significant increases in reporting of safeguarding concerns during the lockdown period, described a different picture; there were high levels of anxiety and distress being reported, and this was expressed by the referrers of those

safeguarding concerns, mainly from blue light services, who were coming face-to-face with people in the community who were shielded and vulnerable residents, particularly reporting concerns about self-neglect, although these mostly did not meet the criteria for section 42 safeguarding enquiries. In community settings, there were increased concerns about people with care and support needs who were socially isolated and at risk of abuse.

693. Some councils mentioned that the complexity and/or severity of safeguarding concerns reported were greater than usual, which were due to delays in making referrals or because people were approaching services later than usual because of fears of contracting Covid-19.

694. The trend of section 42 safeguarding enquiries showed a similar pattern as safeguarding concerns however, the averages disguise a considerable amount of variation between individual councils: many of the effects of Covid-19 and lockdown on safeguarding activity were localised and varied across England as the pandemic impacted the country unevenly. The types of abuse identified in section 42 enquiries indicated that domestic abuse of people with care and support needs increased overall (there was a particularly sharp increase in May 2020) and significantly within some council areas, as well as increases in psychological abuse and self-neglect. The percentage of section 42 enquiries where the risk is located in the individual's own home increased markedly from the start of the Covid-19 lockdown period, with evidence from the Insight project participants that this was a direct result of the confinement of people in their homes. Enquiries where risk was located in care homes decreased as a percentage, probably because of the relative lack of outside scrutiny in those environments during the lockdown period.

695. New types of concerns were reported including Covid-19 related financial scams regarding cleaning, charging for testing or other testing scams; inability to social distance or adhere to lockdown measures; misuse, lack of and non-adherence to PPE guidance and lack of PPE. There were reports of increases in family disputes and family members being suspected of abuse, including financial abuse; and increased concerns regarding mental health ('isolation', 'anxiety', and 'suicide risk').

The Second Insight Report

696. *The Second Insight Report* (July-December 2020 data from 101 councils) reiterated the above findings and added that the steep increases in safeguarding concerns immediately as lockdowns ended were often sustained until the following lockdown period (**Exhibit JK4/113 - INQ000581224**). However, not all councils followed the national trends.

Data continued to show moderate increases in the rates of domestic abuse, self-neglect and psychological abuse in 2020, compared to 2019 and increased safeguarding risks in a person's home during the lockdown periods.

697. Increased levels of complexity in safeguarding activity, challenges that social distancing brought to the safeguarding enquiry process regarding adults with care and support needs, including being unable to undertake essential face-to-face visits were reported. The Covid-19 pandemic and lockdowns were considered to create barriers in how people could report abuse and neglect.

698. There was considerable variation between councils' experiences regarding safeguarding activity and variables included: the number of 'anxiety referrals' received; proactive/preventative approaches taken; local demographics; the local provider profile; how safeguarding concerns and section 42 enquiries were recorded; the partnerships dynamics that could enable effective multi-agency working; localised lockdowns coming into force; the complexity of safeguarding concerns and enquiries themselves and Covid-19 related safeguarding issues emerging and manifesting across various abuse and neglect categories.

699. Councils reported on how they adapted to maintain safeguarding roles and responsibilities during the Covid-19 pandemic in the face of challenges of reduced face-to-face contact and significantly increased workloads. They innovated and adapted their communication methods, developed new approaches to the section 42 enquiry process; improved how they worked with other agencies; increased the frequency of meetings using technology; created new partnerships; extended professional curiosity; and worked flexibly; and proactively to create bespoke solutions to emerging issues. Councils developed new strategies, anticipated change, were proactive and adaptive, based on local circumstances and learning from experiences during the first lockdown.

700. The second National SAR analysis concluded that:

> *"…the biggest challenges arising from the COVID pandemic for professionals was that it hindered the ability to undertake home visits… [for example] …In the absence of face-to-face contact with X, professionals found it harder to monitor his care needs and support. As other services were not undertaking home visits there was an unavoidable reliance on the Day Centre to communicate any change in need and it is good practice that when staff became concerned for him,*

they referred immediately for support. However, there was an unavoidable closure of the day service in January 2021 due to a COVID outbreak, and hence a period when no professional saw him."

701. In another SAR, it was said

"…X was supported via telephone only services during the lockdown just prior to her death. She felt isolated and requested face to face but was thought to not have a high enough risk to warrant the COVID infection risk. The coroner's verdict specifically identified that her suicidal intent was aggravated by the restrictions imposed in response to the COVID-19 pandemic…"

The Third Insight Report

702. *The Third Insight report* concerned the period January-June 2021 with data from 106 councils Safeguarding Insight Project (**Exhibit JK4/114** - **INQ000509872**). This third report further evidenced that safeguarding concerns continue to show a long-term upward trend, tending to decrease during periods of lockdown and other Covid-19 restrictions, followed by a sharp increase once those restrictions are lifted. Section 42 safeguarding enquiries did not show the same upward trend, although they did fall and rise in line with changes in the volume of concerns. There was variation between local authorities as they responded to differing circumstances in their local areas.

703. There was ongoing evidence that psychological abuse, domestic abuse and self-neglect had risen. Councils specifically mentioned increasing complexity in safeguarding activity, in terms of multiple abuse and neglect categories identified regarding individuals, alongside mental health problems, social isolation, health inequalities, deprivation and poverty, homelessness, substance misuse and/or exploitation, as well as reduced/no access to care and support services during the lockdowns which provided additional challenges.

704. Due to lockdown regulations, many safeguarding concerns were reported to ASC services later than prior to the pandemic, particularly regarding domestic abuse and self-neglect where lockdowns increased the isolation of those experiencing abuse. Delays in reporting affected how they were dealt with, there were also more acute or severe consequences, making preventative measures more difficult to implement or situations were more likely to require crisis management.

705. Offending family members working from home further increased the vulnerability of those experiencing, or at risk of experiencing, domestic abuse. Domestic abuse during the pandemic was exacerbated by social isolation and loss of support networks. The nature of abuse being presented was at a more severe stage, resulting in the safeguarding process taking longer to resolve and increased levels of risk and harm for victims. There were reports of an increase in domestic homicide reviews. The pandemic and lockdowns further hindered availability and ability of professionals to respond as they might have done in pre-lockdown/pandemic times. Councils described an increase in the reporting of carer breakdown in domestic abuse situations, which put a strain on the family dynamics and the safety of the adult with care and support needs.

706. The following case study illustrates councils concerns over increasing rates of domestic abuse during this time (**Exhibit JK4/114** **INQ000509872** Part 7):

> *"**Case Study council 1**: Council 1's Domestic Abuse Partnership Board, was established to drive a co-ordinated multi-agency approach to domestic abuse and has highlighted the significant impact that the COVID-19 pandemic has had on reports of domestic abuse. The Board reported a 27 per cent increase in incidents of domestic abuse during the 2019/20 period. An increase in people accessing specialist domestic abuse support also rose during this time, with 1,727 accessing helpline support. Although these figures indicate a recent increase of incidents of domestic abuse, the Board have highlighted that the real impact of COVID-19 will not be fully understood until there are increased opportunities to engage and access to face-to-face universal provision…"*

707. Councils reported an increased number of self-neglect safeguarding concerns and enquiries, over the course of the pandemic. Referrals received during the pandemic tended to come from friends, neighbours, volunteers, and included people who were previously not known to ASC. As lockdown restrictions were relaxed, self-neglect referrals increased, often of greater complexity, alongside multiple abuse types and associated issues, which manifested in specific ways in for example older and younger age groups. Complicating factors accompanying self-neglect included mental health issues, isolation from lockdown restrictions, substance misuse, domestic abuse, obesity and homelessness. There were also challenges with engaging with services and there were attempts to counter this by creating multi-agency safeguarding cells/forums or subgroups. Vulnerabilities were exacerbated during the pandemic in a similar way to health

inequalities.[4]

708. The Third Insight Report includes the following case study demonstrating how one council, with the benefit of preparedness, was able to better respond to self-neglect concerns (**Exhibit JK4/114 -** **INQ000509872** Part 7):

> *"**Case Study Council 3**: Prior to the pandemic, Council 3 were in the process of developing a self-neglect toolkit and pathway. This work was halted due to the pandemic. However, a few weeks after the start of the pandemic the working group got together virtually to finalise the development of the toolkit, which was co-produced with a number of agencies. It was fully implemented, worked well and provided a consistent approach, as well as identifying specific legal duties to support people who self-neglect or hoard during the pandemic period.*
>
> *Council 3 also implemented an 'Every COVID Visit Matters' (ECVM) process, which allowed people to feedback directly to the local authority. During the pandemic, audits were developed that included the guiding principles of safeguarding, and adherence to Making Safeguarding Personal. Looking at the preventative approaches needed and the challenge to prevent safeguarding concerns being raised. Council 3 changed their care management aiming to reduce safeguarding activity. This involved reducing incomplete care reviews and requests for assessment (which were late) and resulted in reducing the number of safeguarding referrals. Council 3 staff also utilised non-statutory enquiries (section 42 (i)), especially with people who self-neglect, applying Section 11 of the Care Act duties. This ensured that relationships were developed and people got the best quality service, given the resources constraints, throughout a pandemic. Consequently, they were able to mitigate risks and identify areas of good practice. Additionally, they valued maintaining relationships with provider services, to ensure an open, honest and transparent dialogues. As visits to care*

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[4] These findings, and other are supported by research evidence see Manthorpe, J., Woolham, J., Steils, N., Stevens, M., Martineau, S., Owen, J., & Tinelli, M. (2022) Experiences of adult social work addressing self-neglect during the Covid-19 pandemic. *Journal of Social Work*. https://doi.org/10.1177/14680173221083446

homes were limited to health professionals, including district nurses, GPs, ambulance staff and funeral directors, and neither CQC nor the in-house Quality Assurance Team were able to access care home in lockdown conditions, professional feedback from to staff was encouraged and, as a result Council 3's feedback both was both positive and identified areas for improvement."

709. Councils mentioned an increase of financial abuse referrals regarding people with care and support needs by family members, fraudulent applications for credit cards, stealing of pensions, friends and neighbours being paid disproportionately for support, financial abuse from paid carers and financial scams. This continued into the third wave of the pandemic, including issues of financial abuse by paid carers. Financial abuse of people with learning disabilities from their friends and families was reported as well as being targeted for Covid-based scams, which could come in the form of telephone calls, texts, phishing (scam emails), social media, fake websites and on the doorstep scams.

710. Councils used technology to increase opportunities for multi-agency engagement with professionals and this had a positive impact on the safeguarding work with adults with care and support needs. New and stronger partnerships and multi-agency working were prominent during the pandemic. Innovative and responsive services were developed in response to the challenges presented by the pandemic and lockdowns. Case studies of innovative practice were included in the Insight reports and webinars publicising the reports, to share learning and promote improvements in practice.

711. The second SAR analysis reported references to the impact of the pandemic on adults at risk from domestic abuse or substance misuse, and on those living in supported settings, on learning disabled people and those living with other forms of neurodiversity. It noted, for example the effects on an individual saying that:

"…[t]he COVID pandemic caused a traumatic loss of routine. It was hard for [him] to understand the loss of activities such as holidays and trips out. It must be acknowledged how his stress and anxiety would have intensified the demands of his care and although this review is unable to ask his parents for clarification, it undoubtedly must have had an effect on them as his carers..."

Quality of care provided to recipients of care

712. Poor quality of care becomes a safeguarding issue when neglect, acts of omission or

organisational abuse occurs. In the second half of 2020 there were a range of reasons reported (in the Insight projects) regarding increases in safeguarding concerns about residents of care homes. This was attributed to different factors including (**Exhibit JK4/113 - INQ000581224)**:

- closer monitoring and engagement with providers by councils;
- anxiety expressed by care homes around transmission of Covid-19;
- low numbers of staff working in care home, which caused acts of omission;
- increased medical errors;
- agency staff unfamiliar with adults they were supporting resulting in increased referrals;
- confusion over Government advice causing providers to "appear to be acting in a neglectful manner";
- increase in incidents between people with learning disabilities;
- increased referrals relating to pressure area care and pressure injuries;
- increased referrals where deteriorating health conditions had not been recognised or escalated appropriately;

  and

- staff not wearing or inappropriate use of PPE.

713. Councils commented on safeguarding risks connected to the Covid-19 pandemic; they described challenges regarding supporting people living in care homes and the multi-disciplinary work undertaken to reduce the risks (including safeguarding risks) for residents. Councils also commented on the impact of the pandemic and lockdowns on ways of working, particularly the reduction in face-to-face contact and the consequences for safeguarding activity. They described the pros and cons of using IT and video conferencing, and the learning from their experiences.

714. Councils reported that ASC services experienced significant increases in contact from care home providers seeking information and advice. Services were put under increased pressure to provide preventative and reassurance work from social work teams, quality

assurance teams, commissioning teams, public health teams and other joint initiatives with health services. They provided a range of support and interventions to care homes and support to protect their residents. There was an increase of multi-agency meetings to support providers to face the challenges of the pandemic (with CCGs, quality assurance, ASC, safeguarding teams, general practitioners, public health, and commissioning) to compile intelligence, which was analysed to ensure a responsive approach to any emerging areas of concern, including safeguarding risks.

715. These approaches were able to monitor emerging themes such as supply and use of PPE, reporting and management of Covid-19 outbreaks, deaths in care home, staffing capacity and capability, agency staff use and incident/safeguarding reporting. This enabled councils and their partners to make timely interventions to support care homes or escalate any concerns. Councils described commissioning teams holding weekly group calls with care homes and creating peer support for providers with the aim of resolving common issues.

716. Councils highlighted safeguarding referrals that were Covid-19 specific, which included:

- the risk and spread of the virus in care homes, particularly if residents or staff were Covid-19-positive and continued to mix with others;
- support being declined by people concerned about possible transmission of Covid-19;
- self-neglect due to concerns about Covid-19;
- increased referrals about People in Positions of Trust not following Covid-19 guidance;

and

- local approaches to being able or unable to enter residential settings.

717. Concerns were received about care home residents not going to hospital to receive treatment because of the fear of catching Covid-19, tenants of supported living schemes reported people not abiding by social isolation rules, issues were reported about care home staff being expected to carry out nursing tasks, unsafe hospital discharges back into care homes and community with lack of inaccurate or poor communication about the Covid-19 status of the individual were reported as safeguarding concerns. This led to great

pressures within residential care settings.

718. Safeguarding concerns were received about lack of PPE equipment or staff not using PPE equipment appropriately. However, subsequent waves of the pandemic saw councils and partners adapt to the changing landscape of Covid-19, developing strategies to support care providers, using relationships, networks and forums to share up-to-date guidance, clear up misunderstandings or confusions, identify issues as they arise, to use technology where appropriate and work in partnership with care providers and others to respond to the huge challenges created by to the pandemic. Learning how to "work within the new normal" was a key modus operandi that councils adopted.

719. Councils responded to the range of pressures, developing closer relationships with providers and often providing intensive support to them including independent hospitals, domiciliary care services and care homes. Staffing issues – recruiting and retaining staff of a sufficient quality – were cited as ongoing challenges.

720. The Insight Project was interested in exploring the impact of Covid-19 and lockdown on the experience of unpaid during the pandemic[5]. Councils described unpaid friend and family carers as experiencing increased "pressure", "stress", "isolation", "frustration", "exhaustion", "impact on their mental health" and "burnout" due to the closure of day services, reduced care and support services, which meant increased number of hours caring.

721. There was also some mention of increased behavioural issues and mental health issues for the adult with care and support needs, due to the impact of the pandemic. This was further exacerbated during the winter when the ability to meet safely outside or meet people outside of the household or 'support bubble' reduced social contact. One council described the impact on unpaid carers as "intolerable" where carers were caring without a break, in addition to working from home and providing childcare; such conditions had negative impacts on the mental health of both the carer and the person being cared for. Increased stress levels and isolation, without formal or informal networks of support were reported, and for some this meant increased levels of domestic abuse. Reporting included risks of carer breakdown, due to feelings of 'being unable to continue in the caring role'. Councils reported breakdowns in care packages due to carer stress resulting from limited access to community services, care support reduced or withdrawn, and the fear and

[5] Carers UK and Age UK reported on the impact of the pandemic on carers – there was an estimated increase on 4.5 million carers who began to provide unpaid care during the pandemic

anxiety about the transmission of Covid-19.

Unequal impacts experienced by recipients of care

722. Age specific issues were reported in the Third Insight report regarding safeguarding adults.

723. Thus, in the Third Insight report, some councils reported specifically on the safeguarding needs of young people in transition into adulthood and difficulties with the application of care and support needs criteria under the Care Act under pandemic conditions, resulting in not being able to access services, where previously they were supported by children's services. There were concerns about access to mental health services. A higher number of situations involving young adults engaged in risky behaviour were reported, which was exacerbated by lack of community resources and support, due to the lockdowns. Concerns regarding gang related activity for young people increased as lockdown restrictions were eased. Councils identified increases of domestic abuse, neglect and acts of omission amongst younger adults.

724. The second National SAR analysis also identified Covid-19 related challenges contributing to the death of young adults who were affected by difficulties of finding appropriate placements, such as mental health beds, commissioning services within the available funding envelope as well as limited access to mental health services and increased emotional and mental distress.

725. SARs provide evidence of the profound effects on individuals and on care settings, and of the challenges experienced by health and social care staff. For instance:

> *"…Whilst [two named young women] continued to receive services during the COVID pandemic the lockdown may have impacted negatively on their mental health, increasing risks to them. The research evidence supports this and identified that the negative impact had been greater for younger people. This appears to have been the case for [one of the young women], who was reported by her PA to have found isolation very difficult emotionally. She had said in June 2020 that she was part of a suicide pact and took her own life in July 2020, after the first national lockdown had ended. Similarly, [the second young woman] appears to have been grieving the loss of her partner to suicide. These are factors that can increase the risk of suicide. She was living with a friend when she took her own life in May 2020, whilst the first lockdown was still in force…"*

726. National data for the pandemic period shows that there was a distinct decline in the rate of individuals aged 85 and over involved in section 42 safeguarding enquiries, with other older age groups experiencing lesser declines and the rate of individuals aged 18 to 64 experiencing a slight increase.

727. However, in the Third Insight report some councils documented increased reporting of longstanding domestic abuse in the over 60s age group. One council noted increases in the number of deaths of older people that met the requirement for domestic homicide reviews. Another council reported that the largest increase of safeguarding concerns was regarding older people. This information should bear in mind that, as we have documented in Part 3 (The state of the ASC Sector at the outbreak of the pandemic"), self-funders make up a considerable proportion of those accessing ASC.

728. Whilst not exclusively impacting older people, pressure sores issues greatly affected older people. In the Third Insight report three councils reported a sharp increase in referrals related to pressure ulcers (associated with neglect), most notably in care homes and hospitals connected with delays in seeking help during the pandemic, as well as with increases in pressure ulcers around the face associated with oxygen masks. There were increased referrals regarding older people not previously known to services, particularly referred by hospitals. There were also reports of older people delaying seeking medical support.

729. Due to data gaps and inconsistent collection of equality data in ASC, it would be difficult to give definitive view on the unequal impact experienced by recipients of care. The Third Insight Report notes that 32% (16/50) of councils sending in qualitative data, specifically mentioned increasing complexity of safeguarding concerns and enquiries during the pandemic, with reports of multiple abuse and neglect categories alongside mental health problems, social isolation, health inequalities, deprivation and poverty, homelessness, substance misuse and/or exploitation. Some concerns were raised regarding the differential impact of Covid-19 on Black and ethnic minority communities during the work on the FAQ.[6]

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[6] See Cooper, A (2020) ' Safeguarding Adults and COVID-19: a sector-led improvement response' *Journal of Adult Protection.*

LGA concerns regarding the impact of the pandemic on the workforce

Physical health, mental health and/or wellbeing of the ASC workforce, including unpaid carers

730. In May 2020 the Health Foundation reported that (**Exhibit JK4/186 – INQ000581371**):

> *"…when adjusted for age and sex, social care workers are more than twice as likely to die from COVID-19 compared to the general population. In contrast, staff working in the health care sector do not appear to have a statistically significant raised risk of death compared to the general population"*

731. It was recognised that there would have been several reasons for this, including data reporting considerations, however the management of risk social care, including access to information, PPE, testing and vaccinations, is likely to have been a factor.

732. Burnout among those working in a range of social care settings during the pandemic was prevalent. Lack of capacity in the sector prior to as well as during the pandemic meant that the pressure on those able to work was great and relentless, with little respite. Working terms and conditions, such as minimum wages and zero-hours contracts, made it hard for some parts of the workforce to follow rules around self-isolation, without being financially disadvantaged. The LGA has long lobbied Government for sustainable pay, terms and conditions for social care and the social care workforce and more so during the pandemic (**Exhibit JK4/187 – INQ000581166**).

733. There was also significant pressure felt by unpaid carers. The respite care and day services that were normally available to support unpaid carers were frequently closed or unavailable, therefore local authorities had to make other arrangements to ensure that unpaid carers were still supported. Guidance was published by Government on 8 April 2020 to support unpaid carers.

734. The wellbeing of the workforce was impacted by a lack of recognition and parity of esteem when put alongside the NHS. This was a recurring theme that was raised in discussions throughout the pandemic, whether relating to the provision of PPE, recognition of the sustained efforts of the workforce, requests for volunteers, wellbeing support and benefits to those working during the pandemic. In June 2020, an LGA briefing said, *"Government is still too fixated on a misguided view of social care solely as a dependency of the NHS"* (**Exhibit JK4/187 – INQ000581166**). The obvious disparity of provision, support and recognition had a negative impact on the wellbeing of the workforce, which

was demonstrated through retention in the sector.

735. In April 2020 the LGA and CHIP developed and signposted to resources to support the wellbeing of the social care workforce, particularly frontline workers in contact with vulnerable people with symptoms of Covid-19 or who were self-isolating (**Exhibit JK4/188 – INQ000115357**). All resources were shared with LGA regional staff and the wider sector. Later LGA/CHIP organised wellbeing webinars led by Our Frontline, which were attended by several hundred social care staff.

736. In mid-April 2020 the LGA commented on Government guidance on workforce wellbeing requesting that support roles (cleaning staff and caterers) also be in scope, allowing access to measures such as bereavement support following the loss of a work colleague. The guidance also signposted to LGA resources (**Exhibit JK4/189 – INQ000581341).**

Unequal impacts experienced by the workforce

737. Local authorities were keen to give attention to those groups at risk of marginalisation and exclusion, including people with learning disabilities, autism, mental illness, substance misuse, or those at risk of domestic violence. Policies were often largely designed with older people in mind so were not sensitive to these groups' needs. For example, people with learning disabilities and/or autism were required not to leave their homes, when being in contact with their local communities played a vital role in their wellbeing.

738. By early May 2020 the impact of Covid-19 on the BAME workforce was identified as a concern (**Exhibit JK4/173 –** **INQ000581189** . In April 2020 it was noted that information and advice needed to be available in multiple languages to reflect the BAME profile of the care workforce (**Exhibit JK4/177 – INQ000472799**). An article in the Guardian newspaper reinforced this need (The Guardian article dated 1 May 2020 "'Every day I hear about a Covid-19 death': life in the UK's worst-affected area", **Exhibit JK4/190 – INQ000581252**). On 13 May 2020 the NHS published an ASC Workforce Risk Assessment Framework which considered ethnicity alongside other risk factors (**Exhibit JK4/191 – INQ000553302**).[7] It aimed to help employers to risk assess staff and ensure staff wellbeing.

739. The ASC Workforce Task & Finish Group agreed that DHSC would work with SfC, CHIP and other partners to produce tools for social care to support employers to discuss

[7] Note: the version exhibited was updated November 2020 and withdrawn April 2022.

and manage risks to their staff – this included risk by ethnicity, but also age, gender and underlying health conditions (see, for example, the ASC Workforce Task & Finish Group email chain dated 28 May 2020 discussing feedback on the draft risk reduction framework, **Exhibit JK4/192 – INQ000581273**; and the attached draft risk reduction framework, **Exhibit JK4/193 – INQ000581243**). On 20 May 2020, the LGA, as part of the ASC Workforce Task & Finish Group, provided feedback to DHSC on its draft risk reduction guide focusing on BAME and disability issues in the context of suitable alternative work (**Exhibit JK4/194 – INQ000581269**).

740. With emerging evidence suggesting that some of the social determinants of health – including ethnicity, but also obesity, deprivation, poor mental health, and socio-economic status – were contributing to higher levels of Covid-19 related deaths, the LGA on 23 June 2020 organised a webinar presented by Professor Sir Michael Marmot, Director of the UCL Institute of Health Equity, to support councils in tackling health inequalities (**Exhibit JK4/195 – INQ000581310**). Professor Marmot shared research findings and councils shared their approaches to leading on tackling health inequalities.

The impact of the pandemic on workforce capacity, including recruitment and retention of the workforce

741. In October 2020, SfC reported that staff sickness levels had nearly doubled over the course of the pandemic (an average of 9.5 days lost to sickness in 2020/21 compared to 5.1 days before the pandemic) (**Exhibit JK4/027 – INQ000542979**). Staff turnover rates decreased during the pandemic in 2020/21, however, since March 2021, the opening up of the wider economy has been reported by employers to be adversely affecting retention, with many reporting that recruitment and retention is now more difficult than before the pandemic.

742. In early April 2020, capacity issues were being reported in the sector over and above the usual pressures. CHIP undertook a stocktake survey of each of the ADASS regions to determine what the immediate workforce pressures were. The survey identified a shortage of care workers, social workers, particularly with specialist expertise in mental health and learning difficulty and to a slightly lesser degree in respect of Occupational Therapists ("**OT**") and PAs. Findings were discussed at a cross-partner round table on 1 April 2020 (**Exhibit JK4/196 – INQ000581165**).

743. Although several recruitment campaigns were being launched there was confusion in the sector over the various initiatives being developed to bring people into ASC. Some were led nationally but many regionally or locally and there was feedback that they needed

to be better communicated and aligned to have impact (**Exhibit JK4/197 – INQ000581221**).

744. In May 2020, councils and partners developed creative approaches to addressing workforce shortages, particularly, of nursing staff in care homes, but they fed back that all approaches were met with barriers. Councils looked to LGA / CHIP for support to lobby Government to remove the barriers or resolve the issues holding them back. Social care sought to tap into the NHS nurse returners, funded through Health Education England ("**HEE**"), but were coming up against issues around indemnity, clinical responsibility/support and/or terms and conditions. They tried to access the acute hospital staff bank however local legal advice suggested that this was not viable. There was success in utilising an external staffing agency that supplied nurses to all the local NHS providers at reasonable rates, however exploration of these potential approaches took time when capacity was already very stretched (**Exhibit JK4/198 – INQ000581216; Exhibit JK4/199 – INQ000581213).**

745. LGA, ADASS, SfC and CPA developed a resource to share good practice examples to reduce staff turnover and retain staff post pandemic. The Top Tips for Retention – a briefing for ASC providers was launched online in May 2020 (**Exhibit JK4/200 – INQ000581364**).

LGA concerns about pandemic impact on providers

746. There are two key points to keep in mind when viewing the relationship between local authorities, the LGA and care providers in the ASC Sector. As previously stated, local authorities' primary duty under the 2014 Act is to ensure that the social care and support needs of local people are met. The second vital point is that almost all the care and support delivered in each local authority area is provided by the independent sector, with little delivered directly by local uthorities. For example, the Laing & Buisson "Care Homes for Older People – UK Market Report" provides data that shows in March 2020, under 4% of all care homes beds in England were in homes operated by a local authority (**Exhibit JK4/032 – INQ000581292**). This average national figure varies little at a local authority area level or across different adult social care services.

747. Every local authority can only fulfil their primary 2014 Act duties if there is a well-functioning, viable and sufficient group of local independent sector providers. This explains why the LGA placed so much emphasis on developing relationships and effective working

arrangements with national care provider representatives at the early stages of, and throughout, the Covid-19 period. This also explains the focus of the LGA's work on identifying, understanding and where possible helping address, the things that posed the greatest threat to the ongoing stability of the independent care and support sector, which is evidenced extensively by the minutes of the twice weekly "National Covid-19 social care provider issues group" (**Exhibit JK4/201 – INQ000581311**). This goes a long way to explaining the actions or approaches the LGA advised or supported local authorities to take, which would focus on addressing what was felt at that time to be one of the greatest risks to the 2014 Act duties set out above, see Overview of the roles and responsibilities of Local Authorities under the Care Act 2014 .

Financial and commercial impacts

748. Whilst the care sector ran on tight margins and faced financial challenges, cases of individual care providers closing due to financial issues were rare and infrequent, before the pandemic. However, in the very earliest conversations with care providers it became apparent to the LGA that the financial challenges were perhaps the most significant issue facing providers. To illustrate this, at the very first meeting of the "National Covid-19 social care provider issues group", after matters relating to how the group would function were covered, the group then discussed the main issues facing providers.

749. The minutes record the first of the issues to be discussed as follows:

> *"Funding (rates, cashflow, FNC, how new money will flow via CCGs, allowance for extra costs)".*

750. This both shows how this issue was at the forefront of provider concerns but also points to some of the various financial issues providers were concerned about. I will illustrate these concerns with a description of four topics –

- *Rates* – Many care providers support people whose care is funded by a local authority, at rates set by the authority. It is recognised that these rates leave little room for surplus and so care providers operate on tight margins and do not typically have large cash reserves, or a means of increasing income significantly at short notice, unless local authorities agree to increase their rates.

- *Cashflow* – There are two elements to this. The first is that local authorities, and people who fund their own care, will typically pay for the care service after it has been delivered. These are contractual arrangements that cannot easily be changed

by the care provider. The other issue is that sadly, when a person dies in the care of a provider, aside from the tragic human loss, this also represents an immediate loss of income for that organisation.

  - There was a real concern early in the Covid-19 period that due to the nature of the infectious disease a care provider could see many of the people they support pass away in a short space of time. Sadly, we saw the reality of this early in the Covid-19 period and the impact this had on providers, especially care homes, who may have lost half of their income in a matter of days. Both these situations create a challenging cashflow position.

- *How new money would flow from CCGs* – Mechanisms do not exist within the adult social care sector that allow money to easily be shared by national government directly with independent care providers. Money is typically given either to the NHS, or to local authorities, with the requirement that it is 'passported' to care providers. However, the exact process by which this is done can affect the speed of it and the extent to which it benefits individual care providers. For instance, if the money is passed through local authorities this additional funding may only go to care providers they work directly with and commission from.

- *Extra costs* – This is linked to the cashflow issue and by the time of this first meeting care providers were already experiencing or expecting increased costs. These related to:

  - items they had not previously purchased (such as PPE),

  - physical changes to buildings (e.g. to provide IPC), or

  - increases in operating costs (e.g. for food).

- Almost all of these costs would have to be incurred immediately that the good or service was provided, yet as explored above, payment for the service provided was only received at a point a few weeks later. This exacerbated the cashflow challenge facing care providers.

Workforce

751. The nature of social care and support is that it relies on people to provide the service. If a care provider cannot recruit, retain, and have on shift enough well-trained staff, they simply cannot properly care for people. This creates legal, financial, and human impacts.

In the minutes of the first "National Covid-19 social care provider issues group", "Workforce" was listed as a significant concern; the minutes noted:

> *"…threat of resignations, making key worker status real, being able to hire quickly..."*

752. With hindsight, the most immediate issue care providers faced was the number of staff who became ill at a greater rate than previously seen or were isolating or shielding. This meant care providers typically had a lower proportion of their staff able to work at any point in time, at a time when more staff were needed on shift due to IPC issues. This created a vicious cycle as those staff who were on shift faced increasing mental and physical challenges, which fed the risk raised at the meeting around "threat of resignations".

753. The only way care providers could realistically address this was to be able to hire people quickly. This has never been simple in the care sector and at the initial stages of Covid-19 this was exactly what providers reported.

754. The final part of this vicious cycle was that many care providers could not support new people as they often did not have sufficient staff to care for people they currently supported. This is a simple description of the most obvious part of the workforce challenge and does not get into the myriad of complex scenarios that care providers shared, all of which affected their workforce and ultimately that care providers ability to operate effectively.

Visiting and other issues providers faced as they sought to keep people safe

755. Turning again to the minutes of the first meeting of the "National Covid-19 social care provider issues group", I note also that it is said:

> *"…Hospital discharge processes (implications of Discharge to Assess and how providers can be supported/protected, testing patients before discharge, care homes rights to refuse admission).....How prioritisation within the ethical framework will actually work, in order to avoid those most vulnerable being left without support.....Preventing transmission (advice to social care workers, effective and consistent advice).... NHS support for providers once people are discharged/living in care homes and community, including access to NHS111, medication advice, specialist areas like pressure care) ... Sharing patient/individual information safely (NHS Mail) ... Supporting people who lack mental*

capacity and/or with dementia, learning disabilities and mental health issues."

756. This illustrates the variety of complex, ethical and human issues facing care providers at a time when they faced serious threats their financial viability and challenges ensuring sufficient staff were working to ensure they operated in accordance with the legal and regulatory framework.

757. It should be recognised that most care providers are small or medium-sized enterprises and not large national operations with large networks of support staff. They will usually have perhaps 2 or 3 sites (e.g., care homes, offices) and minimal back-office staff having to deal with complex financial, workforce and human challenges.

758. A selection of agendas and minutes from the early meetings of the "National Covid-19 social care provider issues group" show how the issues set out above were raised and discussed consistently and in various ways.

Steps taken by the LGA to monitor the wellbeing of recipients of care and care workers

Monitoring the health and wellbeing of recipients of care

759. The LGA had a role in supporting councils to understand the risks to those in receipt of care through sharing national data in a way that best supported local areas, over and above the 1.5 million people identified by the NHS as being vulnerable due to medical conditions.

760. The quality of national data on those considered to be vulnerable and/or needing to shield was poor. While the NHS were able to quickly identify 1.5 million people identified as being vulnerable due to medical conditions, it was less easy for councils to identify people using social care services, who were not previously known to local authorities but who now needed support. This impacted on the early assistance that could be provided to those people.

761. Data provided via Capacity Tracker at the start of the pandemic was felt to be partial and later efforts to identify vulnerable people were disjointed and unhelpful. Council CEXs expressed concerns about data protection issues with DHSC sharing names and postcodes of vulnerable people but with no clear expectation of what the next steps would be to provide funded support.

762. In response to this, the LGA took steps to monitor Covid-19 cases in ASC better. In late March 2020, the LGA Research and Information team started to publish PHE daily data of Covid-19 cases in LG Inform. LG Inform contained more detail than was on the PHE website at that time, including showing trend data over time and data from domiciliary care providers as well as just care home data. The LGA combined it with population data to create a Covid-19 rate per 100,000 population per council, which was shared in table form and graphically. In addition, the LGA showed the top 10 councils each day, which helped to show those councils that had a sudden increase in cases. This data was shared with CHIAs on a daily or weekly basis. CHIAs at this time asked if it was possible to share death rates as well as cases. The data was well received by councils. However, despite repeated requests of Government there was no additional funding provided for the significant data collection and reporting function.

763. In early April 2020, the NHS was using Capacity Tracker to monitor Covid-19 issues, but this only included care home data for social care. LGA worked with DHSC, CQC and others to pilot a tool that collected data on the wider social care workforce, identifying issues around capacity, staffing and supply.

764. In early April 2020, the LGA produced a briefing on the council role in protecting clinically vulnerable people during the Covid-19 outbreak, which was produced in response to the Government guidance at the time. Vulnerable groups were defined as including those receiving care and support as well as those providing unpaid care. The LGA worked with the 132 local authority-led hubs that were set up within the LRF framework to identify vulnerable people and develop the support mechanisms and infrastructure to implement the guidance. Councils' role in supporting CEV persons to shield is covered in depth in LGA/ML/M2 (**INQ000215538**) at paragraphs 203-223. I summarise the key points relevant to this topic here:

765. On 22 March 2020, the Government advised that people defined as CEV to Covid-19 should immediately shield themselves at home and were not permitted to leave the house for shopping or exercise.

766. While DLUHC assumed overall policy lead for ensuring the shielded group were supported to isolate at home, councils stepped in to provide assistance at the local level, by distributing emergency food supplies in the early stages of shielding, contacting CEV people who had not been reached by the national contact centre, and providing basic care and assistance for people who needed it.

767. The LGA and councils were not involved in discussions about the design of the overall support scheme, only being brought in to discuss once the national food parcel concept has been developed. The Government chose a centrally-directed model but engaged with councils when it wanted to establish local support hubs to coordinate emergency food drops.

768. During the emergency food drops from the end of March to early April 2020, councils raised concerns with the LGA, which were passed onto Government, over the food distribution model. Criticisms included that the food was of poor nutritional value, randomly selected, poorly apportioned, not fit for purpose for dietary, cultural and religious needs, and at times rotten. Residents complained to councils about missing deliveries or finding it difficult to cancel deliveries when no longer required. There were also significant issues with data which councils needed to rely on to ensure they were aware of the CEV cohort in their area.

769. Councils found they were significantly more successful at contacting the CEV group than the national call centre, but the model remained centrally-led. For example, councils would move to initiate door knocking when phone contact was ineffective.

770. DLUHC significantly increased its engagement with councils from early April, including through the R9 chief executives meeting and, later, through the Shielding Stakeholder Engagement Forum ("**SEF**"). The SEF met at least fortnightly, and often on a weekly basis, outside the scheduled fortnightly slots, between April and June, LGA officers held additional regular bilateral discussions with the Government officials leading on shielding support, funding, and linked data issues, as well as on access to food.

771. During June and July 2020, the LGA and councils worked extensively with Government to develop a better model of future support to the CEV group. The LGA developed a paper on "The future of the programme" for discussion at the SEF on 7 July 2020. The LGA and councils on the SEF consistently argued that any future support to be provided to the shielded group should be delivered locally by councils, rather than through a return to the national programme of food deliveries, with a sector-led support model in place to assist any councils struggling to deliver support to the shielded group.

772. The LGA and councils welcomed the Government's decision to adopt a more localised model of support for the CEV group for future lockdowns. Although the original advice for the CEV group to shield was never fully reinstated, in November 2020 and from January 2021, the CEV group were advised to work from home and stay at home as much as

possible, other than exercising and attending essential health appointments. During this period, councils were provided with funding per head of the CEV population to enable them to provide localised support for those who needed it.

773. In practice, significantly fewer numbers of the CEV group sought support from councils in the later lockdowns than during the first lockdown, reflecting the extensive work councils had done with local CEV residents as the shielding programme ended in summer 2020, to develop sustainable access routes to food, including routes which could endure in the event of future lockdowns or changes in guidance. Over time, and particularly by the end of 2020 and early 2021, the Government increasingly used the SEF group to consider the support that could be provided to people self-isolating as well as to the CEV cohort. There were challenges in coordinating the different Government teams looking at this issue across DLUHC, DHSC and the Department of Work and Pensions to ensure a joined-up discussion and coherent approach.

774. The LGA also worked with councils to support those facing immediate financial hardship because of Covid-19. This included welfare support for homeless people and those with no recourse to public funds. The LGA helped to develop processes to administer the £500 million Hardship Fund (MHCLG guidance (March 2020) "Covid-19 hardship fund 2020-21 – Local Authority Guidance", **Exhibit JK4/202 – INQ000581231**), which included council tax reductions as well as a discretionary element to the support. The LGA promoted Covid Mutual Aid UK and the Emergency Volunteer Scheme to provide additional support to those needing help, and worked with the Government to develop a certification process for volunteers.

775. Importantly the briefing produced by the LGA encouraged councils to identify other 'hidden' vulnerable people who were not on the radar of statutory organisations. This included self-funders, those who lack mental capacity and kinship carers among others. The LGA promoted ways that councils could work with partners to identify those needing support. It suggested four data sources – council data, housing data, voluntary and community sector networks and other sources. Councils were encouraged to continually map need, triage assessments and ensure that support was communicated locally. Councils were encouraged to use the data available to monitor that they were reaching those that needed support and assess that their system is working. The LGA sought clarification from the Government regarding GDPR, which councils were concerned about.

776. The LGA Supporting Vulnerable People Programme identified and supported those

most vulnerable in the pandemic. DPHs felt that there was a lack of national focus on whole population and preventative approaches, which they felt could result in later problems.

777. The LGA and councils had been increasingly vocal from April/May 2020 in their requests to prioritize testing of people with learning disabilities and autistic people. This did not start to happen until Autumn, several months after testing for older people was implemented. Council representatives on the Testing Task & Finish Group, in frustration, shared data from the Learning Disability Mortality Review programme that revealed that 1,210 people with a learning disability had died between 16th March and 22nd May 2020 from Covid-19.

778. The LGA submitted evidence to the Women and Equalities All Party Parliamentary Group on the impact of the virus and measures on people with protected characteristics (including children, older people, disabilities, religion, race, sex, etc.). The group identified a need to support the mental wellbeing of carers, particularly in providing end of life care and bereavement.

779. A mental health and wellbeing update was presented to LGA Group Leaders reflecting all activity across the programme and with the Centre for Mental Health, developed joint resources for councils about public mental health recovery and re-building community resilience.

780. In May, the LGA requested that further guidance be developed to ensure councils could continue to support non-shielded vulnerable residents, individuals who had "fallen through the gaps," vulnerable children, and victims at risk of domestic abuse and consequential homelessness.

781. By May 2020 the LGA was asking for clarity on the role of local government in testing and tracing, including tracing the contacts of those infected with coronavirus, those self-isolating and monitoring them over time. The LGA sought a system-wide approach to build on local government tracing capabilities.

782. In June 2020 it was noted that councils were supporting those in food poverty even though they had no funding or statutory role to do so.

Monitoring the health and wellbeing of the care workforce

783. The LGA and councils also played a role in tracking the impact of the pandemic on care workers.

784. In April 2020, the LGA with SfC, CQC, National Institute for Health and Care Excellence ("**NICE**"), providers, ADASS and with DHSC convened a national group to support the wellbeing of the ASC workforce. The National Wellbeing Steering Group saw wide representation across the sector and continued to meet regularly throughout 2020-2021. The group helped to influence guidance and funding available through DHSC to support the workforce. The members collaborated to develop and promote resources, mapping resources to identify gaps and promoting support available through websites, events, webinars, networks, social media etc.

785. The National Wellbeing Steering Group sought intelligence and insight to monitor the wellbeing of the workforce and the take-up of support. The LGA developed resources to support financial wellbeing and put on webinars, including some developed with Our Frontline, a partnership between Shout, Samaritans, Mind, Hospice UK and The Royal Foundation. While the webinars were well-attended, anecdotal evidence suggested that the take up of online resources was low; in particular, front-line workers preferred in person peer support.

786. In May 2020 the LGA flagged that it was deeply concerned about staff wellbeing due to taking on new roles at speed, lack of training and potential PTSD of care home staff.

787. The LGA / ADASS ASC Bulletin on 12 May 2020 shared that people working in social care in England and Wales had been twice as likely to die with coronavirus as the general working-age population, Office for National Statistics figures showed. Collating data on the number of deaths in the ASC workforce was not straight forward with such a devolved sector. DHSC responded by setting up a manual process for local authorities and care providers to notify them of if a care worker has died, to ensure that employers, families, and the people who they cared for are given the support they need,this included volunteers. Employers were requested to send brief details (name, job role, employer, local authority worked in, date of death, Covid-19 confirmed/suspected) to a central email (ASCcovidinform@dhsc.gov.uk). The process felt unsatisfactory and there was a lack of confidence that it would yield timely or accurate information.

Part 19 - Lessons Learned and Recommendations

Introduction

788. As I have made clear at the beginning of this statement the LGA is local government's national representative body in England, see Part 2 - The LGA's role, function and objectives in relation to ASC

789. In all that the LGA does, it is the experience of the LGA's member councils that informs its positions and its subsequent lobbying and influencing work. It is, of course, a cross-party organisation with a very wide range of members. During the pandemic, it is remarkable that, despite the many differences in type, geography, political control, priorities, and strengths of the LGA's members, local government was broadly in agreement on the big issues.

790. Agreement in this way is common; there is, for instance, much agreement on issues such as the need for an increase in funding, on affordable housing, or devolution of powers, yet in the pandemic the sense of unity of views was significantly different. The Inquiry will see this in the is in the response to the Module 6 survey it requested (**Exhibit JK4/001 - INQ000400522**).

791. It is because of these two points that I think it makes more sense for me to answer Questions 37 which focuses on the survey of councils and question 41 which is seemingly wider in scope together in a general review of the lessons learned and recommendations that the LGA wishes to put before the Inquiry.

792. I have set out the LGA's response to these two questions at the conclusion of this part, after I have addressed the other questions that are more limited in scope, where I believe they will provide a clear overall conclusion to the issues which the Inquiry has raised in these 41 different questions.

List of any 'lessons learned' reviews produced or commissioned by the LGA

793. Although the LGA has not formally led or commissioned specific work relating to lessons learned from the pandemic across the entirety of adult social care, it has extensively written about and discussed the experience of the pandemic for councils and how that experience should inform the future of the local government sector. This work has included making submissions to Parliamentary Select Committees, discussed under the next cross-heading.

794. The LGA also produced a specific report on learning disability in the context of Covid-related health inequalities (**Exhibit JK4/203 – INQ000581279**) and developed a range of case studies in tandem with councils on specific issues to tackling the pandemic at the local level.

795. In August 2020, the LGA hosted five separate but linked roundtables with a range of colleagues from different parts of the ASC sector to explore emerging learning from the pandemic. The roundtables included representatives from local government, care providers, the NHS, the voluntary, community and charity sector, and people with lived experience.

796. The discussions in these roundtables culminated in a report entitled "The lives we want to lead: where next for the debate about care and support reform?" published online in Spring 2021 (**Exhibit JK4/204 – INQ000581361**). This report looked beyond the pandemic but also contained reflections from people working in and with the ASC sector during it.

Any LGA analysis on how the sector coped during the pandemic

797. While the LGA neither produced, nor commissioned, a specific 'lessons learned' review of ASC during the pandemic, it has shared its thinking on this question – directly and indirectly – through various reports and submissions.

798. Most notably, the LGA has responded to numerous parliamentary select committee inquiries, providing both written and oral evidence. This was again the case on key inquiries related to the pandemic (or had indirect links to thinking about lessons learned through, for instance, a submission on the integration landscape) held by the Health and Social Care Select Committee and the Public Accounts Committee.

799. The LGA submitted written evidence to the following select committees:

Health and Social Care Committee

- Social care: funding and workforce
- Delivering Core NHS and Care Services during the Pandemic and Beyond
- Workforce burnout and resilience in the NHS and social care
- Coronavirus: lessons learnt

- Department's White Paper on health and social care
- Workforce: recruitment, training and retention in health and social care
- Integrated Care Systems: autonomy and accountability
- Prevention in health and social care

Public Accounts Committee

- Whole of Government Response to Covid-19
- Readying the NHS and social care for the Covid-19 peak
- Covid-19: Government procurement and supply of personal protective equipment
- Covid-19: Test, track and trace (part 1)
- Covid-19: Supporting the vulnerable during lockdown
- Covid-19: Local Government finance
- Adult social care markets
- Introducing Integrated Care Systems
- Local authority administered Covid-19 grant schemes

What went well?

800. Amidst the extremely difficult and upsetting experience of responding to a global pandemic at the local level, there was a lot that went well. This was, of course, harder to discern during the period in question, but the passage of time has allowed for greater perspective and reflection. Some of these have endured, shaping today's reality in a helpful way; others have not, to the continued detriment of the sector. I discuss the areas of success in the following paragraphs.

Culture (national-local relationship)

801. As evidenced in many places throughout this statement, and specifically about the early months of the period in question, the national government - local government relationship can be characterised as one in which the former failed to capitalise on the

experience and expertise of the latter.

802. The LGA does not offer a single reason for this and instead suggests that different factors were likely to have been at play. At one end of the spectrum, inadequate central capacity and central knowledge, combined with serious time pressures and overwhelming workloads on officials, at times led to a blinkered and short-sighted approach. This may have created (or contributed to) the over-focus on older people and care homes, for instance. At the other end of the spectrum, an underpinning notion that 'the centre knows best' – forged over many decades and certainly not unique to the pandemic – minimised both genuine engagement and, when engagement did happen, the application of views and opinion gathered from partners.

803. Admirably, the centre did adapt. The LGA would suggest that this occurred both of its own volition and in response to local government calling for more and better engagement.

804. DHSC officials and senior officials began attending local government-convened groups and, from mid-March 2020, the Department's newly-appointed Director General for Adult Social Care co-chaired (alongside ADASS) NCAG and oversaw the creation of its four sub-groups.

805. The publication in mid-April 2020 of the Government's 'Covid-19: our action plan for adult social care' report (**Exhibit JK4/089 – INQ000233794**), which reflected local government's views in places, helped cement the national-local relationship further.

806. So too did the creation of the Social Care Sector Covid-19 Support Taskforce, chaired by a prominent local government figure, Sir David Pearson. The Taskforce, with its membership comprising, among others, senior figures from the LGA, ADASS and ADPH, oversaw delivery of the action plan, and established eight advisory groups which helpfully took a far broader view of the sector (for example, BAME communities, mental health and wellbeing, people with learning disabilities and autistic people).

807. While the LGA does not suggest that, from mid-March 2020 onwards, the national-local relationship was perfect, there was a marked contrast to the engagement in the period from December 2019 – mid-March 2020. Engagement improved and evolved to coproduction on some matters, and officials listened to and acted on the views of the LGA and more widely local government, on matters of significance such as vaccine rollout. This more equal and balanced relationship helped policy pitfalls be avoided, such as on vaccination as a condition of deployment, and designated settings.

808. While the LGA does not consider that the current national - local relationship is ideal, it is acknowledged that post-pandemic Government's working approach to local government is better than before. For instance, local government co-chairs or is represented at different working groups attached to the Government's Health Mission work.

Culture (commissioner-provider relationship)

809. A strong and effective relationship between commissioners (councils) and providers is key to the provision of high quality and personalised care. It is why, at a national level, care provider representative organisations are such important partners of the LGA. The hollowing out of resources over many years prior to the pandemic inevitably put the commissioner-provider relationship under strain as the latter sought fee increases that the former could not always deliver. Certainly, for a period during the 2010s, including leading into the pandemic, the relationship between the two sides was at times challenging both locally and nationally.

810. During the pandemic, the close local working between commissioners and providers, mirrored at the national level between the LGA and care provider representative bodies, was both notable in itself, and because it was effective. At the national level, the creation of working groups that met regularly to share intelligence and issues, joint guidance notes, and shared influencing of Government plans, brought commissioners and providers together as one. This enabled – both locally and nationally – each side to understand the other's particular pressure points better and so to work more harmoniously to find solutions. For instance, the LGA's work with national provider representative bodies over one period of 48 hours, led to a shared position on the levels of funding required nationally to keep care providers functioning well locally.

811. This closer and more coproduced approach has continued post-pandemic. In November 2024, for instance, the LGA led on a national statement to Government seeking additional funding to meet the cost pressures associated with changes to employer National Insurance contributions. The statement was co-signed by senior figures from more than 100 different organisations, the majority of which were local care providers or care associations, or their national representative bodies.

Culture (commissioner-care recipient relationship)

812. In the late summer of 2020, the LGA held a series of roundtable meetings with different parts of the ASC sector to reflect on the pandemic and the lessons it taught for the future

of care and support. As mentioned above, the discussions in these roundtables culminated in a report entitled "The lives we want to lead: where next for the debate about care and support reform?" (**Exhibit JK4/204 – INQ000581361).** Participants acknowledged that adult social care is complex and involves a range of different partners each with their own priorities and pressures. They also highlighted that the pandemic was notable for helping to reinforce the common purpose and shared endeavour that unites everyone connected to social care. This was defined in different ways, but the core reflection was that the pandemic had helped demonstrate that social care is, first and foremost, about human relationships; that it is impossible to support someone to live the life they want to lead if you do not understand what gives that person's life meaning.

813. In much the same way, participants observed that the pandemic showed that we should not expect people's lives to be lived according to a set offer of services, nor that a particular condition or conditions equates to a particular service or services. 'Doing with' people, rather than 'doing to' people was a common reflection from participants of where social care worked well in the pandemic.

814. On a linked point, the notion of 'trust' came to the fore in many of the roundtables. This took different forms depending on which part of the sector was being considered, but when the discussion turned to councils' relationships with people who draw on care and support there was a helpful reflection that the pandemic demonstrated the benefits of people being trusted to direct their own support.

815. Overall post-pandemic, the LGA considers that some areas have sustained those greater levels of trust, and other areas have more to do. Promisingly, much of the Government's language on ASC – whether that's been in, for example, fiscal events, announcements or publications – has talked in broadly similar terms, with an onus on personalisation and people being more in control of their care to better enable them to be more in control of their lives and the things that give those lives meaning and purpose.

System (resilience and agility)

816. It must be noted also that, as discussed throughout this statement, ASC continued to be delivered throughout the pandemic. It came under tremendous pressure, but, thanks to tireless and dedicated work from all corners of the sector and at every level of seniority, plus great agility to flex capacity and resources, the system continued to meet needs. There were no mass walkouts, and there was no general withdrawal of support to any groups. Indeed, participants in the LGA's roundtables highlighted the speed at which systems were able to change, challenging the validity of the historical 'we've always done

it this way' explanation for why change is neither possible nor desirable. Care workers should be praised for the role they played, often at great personal risk to themselves and their loved ones.

817. In one sense, it might be said that the ASC sector and those working in it did well despite national Government, not just because of it. The sector had its resilience tested pre-Covid: operating under pressure, having to be creative and innovative, battling for focus and attention, and only having a short horizon of certainty. This was some preparation for the greater stresses during the pandemic.

Workforce (value, profile and recognition)

818. It may also be fairly said that the pandemic brought to the fore the human instinct to care about each other, and the sector's core values of compassion, kindness and humanity. There was some evidence that this had begun to resonate with the people at a deeper level than before, when by its end, the 'clap for carers' had become a 'thank you' not just to the NHS but to all those people involved in supporting other people's wellbeing.

819. However the journey to that point was not plain-sailing. For many months the care workforce felt forgotten, overlooked, deprioritised and not on a level playing field with peers in the NHS. The LGA regrets that the value, profile and recognition of the care workforce which existed by the end of the pandemic has subsequently reduced. Previous Governments reduced certain funding streams linked to the workforce; it remains a sector that is underpaid and facing ongoing recruitment and retention challenges.

820. Rachel Kelso, a care worker who provided an article for the LGA's 2024 publication marking a decade since the Care Act received Royal Assent, has summed up many of these points about the ups and downs of workforce recognition (**Exhibit JK4/205 – INQ000581325**) -

> *"…When, in 2020, COVID-19 threw the world into disarray and domiciliary care workers carried on visiting clients as usual, my colleagues and I experienced an exceptional moment of public recognition for our work. The claps grew uncomfortable in the end as people came to realise how materially undervalued our efforts are. Forgive the digression here, but when I watched the BBC Panorama programme about the Post Office scandal in 2020, I somewhat naively assumed that meant the issue was being resolved. It was not until a fictional drama was released about the same scandal four years later that I realised no meaningful action had yet*

been taken to rectify that huge miscarriage of justice. I mention it because the same can surely be said of employment conditions for care workers.

The people who stopped clapping in solidarity with care workers during the pandemic would be rightly outraged if they knew that no action had been taken to improve matters in the four years since. They would be stunned to learn that the only solution our purportedly 'tough on immigration' Government had implemented in that time involved charging people from overseas to work in social care under the same conditions which make it so hard to recruit and retain domestically. The Health and Care Worker Visa is a woeful alternative to the sustained increase in central Government funding that social care so urgently needs, alongside wholesale reform of how social care is organised and commissioned in the first instance. If COVID-19 did not provide enough of a flashpoint for change for care workers, I'm not sure what will.

I consider it an unwise decision to commit to full-time care work under current working conditions - financially, emotionally and physically. If every care worker took the same position as mine, where would this leave us?"

Adult social care (value, profile and recognition)

821. At the outset of my statement I noted how, over a long period, governments have tended to prioritise the NHS over social care and how they too often view social care through an NHS lens and prioritise those elements of social care that have the biggest impact on the health service. This may be inadvertent or deliberate, but it was certainly the case in the early stages of the pandemic.

822. However, recognition of ASC, its profile and value did eventually increase during the period in question. This was aided by increased adult social care capacity within DHSC and officials' and ministers' increased knowledge of the sector. The Government's language shifted and that has been maintained since the pandemic.

823. The way ASC is presented and framed by the current Government, for instance, is about its value, and with a clear connection to people drawing on care and those delivering it. Similarly, during the pandemic and since, national language on social care moved away from being about tasks being administered (characterised as 'maintaining a life' e.g. washing and dressing) and toward social care's wider role in supporting people's

relationships with friends, family and their local community (characterised as 'living a life'). Increasingly, we see helpful examples from Government and officials of putting an accent on 'What do you want to achieve?' and not on 'are you eligible?' Of course, only time will tell if improved rhetoric yields an improved reality.

824. The unhelpful predominant focus on older people and care homes in the early months of the pandemic created the wrong impression of the fullness of care and support, but that did change. ASC began to get more airtime from the media and politicians, and so its challenges and its value and potential value, were revealed to society at large in a way not seen pre-pandemic.

825. During the pandemic we all witnessed the impossible circumstances facing people with lived experience of care, care providers, their workforce, councils and the many others involved in supporting people to live their best life.

Vaccination

826. The LGA has commented on the detailed dilemmas and issues in delivering vaccination to the sector. It should however be noted that the prioritisation of some recipients of social care, and of front-line social care staff, was a significant step forwards and went some way towards the equality of esteem with the NHS which was lacking earlier in the pandemic. The tireless efforts of many local authorities to support the take up of vaccination in key communities is also an important point.

Data

827. Again, we have rehearsed in some detail some problems in efforts to create better data about the social care sector. However, we should note that establishing consistent data collection from social care providers was a major step forward in having an up-to-date view of key issues such as workforce vacancy rates, and that having this overview has continued. We also note that the Government has embarked on the strategy "Care Data Matters", which is the first attempt to have a truly comprehensive overview of data for many years.

Module 6 LGA survey - key lessons learned, observations and recommendations

828. I shall first set out the factual key findings of the survey, interspersing them where relevant with (i) further specific facts gleaned from the survey, and/or (ii) views from councils that were shared in 'free text'.

829. Thereafter, with this information firmly in mind, I put forward the LGA's views on recommendations for the future. I have two issues particularly in mind.

830. *First*, and as requested by the Inquiry, I focus on what is needed to improve the ASC sector's response to a future pandemic.

831. *Secondly*, and given the sector's future response depends closely on tackling wider and deep-seated issues, I offer some reflections on what is needed for the ASC sector overall (i.e. irrespective of if, or when, we are again thrown into the midst of a global pandemic or similar stress event).

832. I do not think that the Inquiry could properly conclude this Module ignoring these larger issues. Unless the ASC sector is reformed it will remain weak and susceptible to the stresses that another pandemic would inevitably subject it to.

833. So, thinking how to improve ASC in the future, is precondition to thinking appropriately to the more specific issue for this Module as to what is necessary to prepare for another pandemic event.

834. The Inquiry knows that a new Commission (chaired by Baroness Louise Casey) on the future of the sector is set to commence work in April 2025. Its remit is of course wider than that of this Module, but I am sure that the report of this Module can be valuable to that Commission.

Module 6 survey: key findings and individual reflections from councils

835. Key findings, reproduced directly from the survey report, are as follows (England only) (**Exhibit JK4/001 - INQ000400522**):

- Councils reported considerable difficulties in the adult social care sector prior to the pandemic. Over a fifth of respondents said that the capacity and/or resilience of the adult social care sector in their area were not very good or not good at all, whilst 95% of these cited workforce recruitment difficulties, 93% cited funding pressures, and 93% cited a rising demand for adult social care services.

- Seventy three per cent of councils rated the ASC sector's preparedness for a pandemic as either 'Not very good' (53%) or 'Not good at all' (20%). Not a single response judged the state of preparedness as 'Very good'.

- The top five reasons given for why capacity and/or resilience was not good leading

up to the pandemic were: workforce recruitment (identified by 95% of councils); funding pressures (93%); rising demand (93%); workforce retention difficulties (91%); and pressure to take people discharged from hospital (82%)

- "Preparedness [was] minimal because [our] only scenario planning related to influenza" (English unitary council).

836. Following the onset of the pandemic, councils adapted rapidly to the new situation and changed at pace to protect their local communities. A large majority (80%) reported changing the structure or mechanisms of decision-making in relation to the adult social care sector, and councils reported undertaking a wide range of activities to support care providers during the pandemic, with nine out of 10 purchasing and distributing PPE, and similar proportions mentioned providing advice and support on recruitment, retention and outbreak management. In addition, over three quarters of councils reported supporting social care users who had unpaid carers unable to visit them through welfare checks, prescription or medicine collections, and temporary alternative domiciliary care.

- *"Gold, silver, and bronze escalation meetings were in place during the pandemic, to escalate any arising concerns, share information and make effective decision making"* (Metropolitan borough).

- *"The council implemented a gold and silver command structure across the whole council including ASC with delegation given to directors to make decisions. We also invoked the emergency decision procedures within the constitution enabling key decisions to be taken by the leader and chief executive"* (English unitary council).

837. Councils demonstrated a strong understanding of the local issues affecting their area before, during and after the pandemic. Respondents mentioned a wide variety of local issues and shared detailed insight about issues affecting the social care workforce. Councils were engaged in a range of activity to help counteract these difficulties with, for example:

- 94% helping care workers and auxiliary workers access vaccinations.

- 85% of councils helped with limiting staff movement between care settings.

- 61% of councils campaigned to encourage people who had retired or left the sector to 'return to work'.

838. Councils drew on their own local networks to support their area during the pandemic. Respondents noted a wide variety of ways in which they helped care providers, and significant numbers mentioned sourcing or establishing pipelines for PPE supplies:

- 93% of councils used data they regularly collected from providers to assess the situation facing providers (e.g. available beds, vaccination rates, test results, etc). Eighty-nine per cent of councils used data from Capacity Tracker for the same purpose, and 75% used data from PHE, NHSE and NHS Digital.

- One hundred per cent of councils helped care providers access PPE, 94% helped with access to hand sanitizer/gel, and 87% helped with access to tests.

- "We proactively contacted providers on a daily basis throughout the pandemic to ensure up to date information was available on the position within each service including staffing, sickness, vacancies and capacity" (English unitary council).

839. Local authority communications relating to Covid-19 were widespread, with 93% communicating to the public and people using social care services about adult social care both during lockdowns and in the periods in between.

- More than three quarters of councils (76%) undertook joint communications with local care providers.

- *"Using influencers and well-known local people via social media got the public more engaged and got them talking. This was beneficial overall and helped push the message"* (County council).

- *"[We] introduced provider webinars which at the time were extremely innovative (April 2020) in communicating with providers, who were in the main isolated"* (Metropolitan borough).

- *"Working jointly with partners including a care association, the NHS, and other councils in the area, we gave a consistent voice about the situation, rather than the more traditional discreet messages from the individual organisations"* (English unitary council).

840. Local government felt that social care was sometimes treated as an afterthought compared to the NHS. Over two-fifths of English councils reported their orders of PPE being diverted to the NHS very or fairly often during the first six months of the pandemic, and respondents noted differences in staff capacity and vaccination and testing guidelines

between the NHS and the social care sector, putting the latter at a perceived disadvantage:

- One in five councils (19%) reported that national IPC policies focused on and prioritised the NHS, which impacted on their relevance to and effectiveness in a social care setting.

- Visits by healthcare professionals were frequently limited by the restrictions imposed during the pandemic, with 86% citing limitations in care homes and 75% citing limitations among people using domiciliary care. These limitations were reported to result in longer waits for treatment, inadequate treatment, necessary transfers to hospital not undertaken and unnecessary transfers to hospital undertaken.

841. Care home residents were discharged from hospital without being tested. Almost eight in 10 English councils reported that the NHS discharged people from acute hospitals into care homes without routinely testing them first, and almost nine in 10 said that care homes in their area were sometimes unaware of patients' Covid-19 status on receiving them from hospital. Similarly, around nine out of 10 English councils reported that their local care homes were pressured to take people discharged from hospital, and nearly four-fifths said that guidance on hospital discharge was poor:

- 89% of councils reported that pressure to take people discharged from hospital was one of the reasons for the sector's difficulty with capacity and resilience during the pandemic.

- 25% of councils were unaware of any consultation between their council and the NHS on the discharge policy for moving people between hospitals and care homes.

842. Delays in receiving test results made it harder to control outbreaks of Covid-19. Around nine out of 10 councils reported that test result delays made it difficult to control outbreaks, compounding the difficulties caused by the difficulty in obtaining tests.

843. Respondents consistently emphasised the confusing nature of key guidance distributed by central government and some national agencies. In particular, three-fifths of respondents in England reported that the national infection prevention and control policies worked not very well or not at all well. Nevertheless, 95% of respondents said that care homes in their area were able to isolate residents who potentially had Covid-19 at least to some extent.

844. Fifty-seven per cent of councils described Government guidance on how to deal with

people who use adult social care returning from hospital as 'Not very good'. 22% described the guidance as 'Not good at all'.

845. The Covid-19 pandemic had a highly negative impact on unpaid carers, and councils stepped up to help provide them and those they cared for with support. Over nine out of 10 respondents reported that unpaid carers in their area suffered from mental stress, increased physical demands and/or a lessening of available respite. Councils responded in numerous ways. Fifty three per cent offered emotional wellbeing support in the form of telephone welfare checks, befriending calls and counselling services. Over half of councils also offered information and advice and 39% provided, or helped unpaid carers access, PPE, tests and the vaccine. Finally, a third of councils offered practical support such as food deliveries, prescription and medicine collection, and technology and equipment.

- Forty per cent of councils thought unpaid carers had "not very adequate" PPE to deal with isolating people who had returned from hospital. Twenty one per cent of councils thought provision was "Not adequate at all". On testing, the figures were 36% and 26% respectively.

- Of the 82% of respondents who answered a survey question about "other effects of the pandemic on unpaid carers" (i.e. separate to effects listed by the survey), 46% reported unpaid carers experiencing feelings of isolation or loneliness.

- *"Many carers found it hard to be sure what they were allowed to do under lockdown regulations, which were clear about exemptions for paid care workers, but less so about unpaid carers"* (County council).

846. District councils, despite not being directly responsible for adults' social care, worked effectively with their respective county councils to provide support for individuals using social care services. Eighty five% of county councils reported that their district councils helped combat the spread of Covid-19 through finding solutions for street homelessness, and 75% mentioned the support of district councils in the 'no evictions' policy and 70% supported welfare checks. Similar proportions were reported for these activities by district council respondents themselves, 70% of whom also mentioned organising and co-ordinating volunteers and community champions.

Recommendations: ASC and a future pandemic

847. It is clear throughout this statement that the ASC response to the pandemic was not as strong as it could have been. Further, it is clear that – at times – the sector succeeded

despite national government action, rather than because of it. It is of critical importance that the ASC sector is enabled to play a full and immediate role in the next pandemic or equivalent stress event. With this in mind, we therefore recommend the following:

848. All future government work on pandemic-preparedness, including planning exercises, must involve local government as an equal partner. Plans should be kept under review and should empower councils to lead and act.

849. Following on from this, and from the outset of the next pandemic, local government expertise must be drawn into all relevant processes to do with national governance, thinking and decision-making.

850. The ASC sector should be treated as an equal to the NHS. The Government must have robust plans in place to ensure that (i) ASC has access to PPE, testing, vaccination and other IPC measures in the event of another pandemic; and (ii) the importance of ASC alongside the NHS in keeping the nation safe is included in all Government plans for messaging and communication in a pandemic in terms of both (i) access to free PPE, testing, vaccination and other IPC measures, and (ii) priority status in government messaging and public communications.

851. The Government must have plans in place (developed in partnership with the ASC sector) to ensure there can be the safe discharge of people from hospital into ASC during a pandemic or similar crisis, and that ASC has the guidance and support it needs to manage infection control, as well as comprehensive wellbeing support to the care workforce, alongside better legal protections for staff (for example, in relation to sick pay).Government should provide clearer and more timely guidance, including concerning (but not limited to) hospital discharge and infection control, as well as comprehensive wellbeing support to the care workforce, alongside better legal protections for staff (e.g. sick pay).

852. At the onset of another pandemic, specific working groups should be stood up immediately to monitor any unequal impacts of the next pandemic.

Recommendations: the future of ASC

853. One the LGA's central arguments throughout this statement is that many of the challenges faced by the ASC sector during the pandemic can be traced back to a historical lack of political and public focus on, and understanding of, the true value of great adult social care to people and communities.

854. National political leadership of ASC has been found wanting for several years. In January 2020, former Secretary of State Jeremy Hunt MP said on Twitter, now X,

> *"For my last six months as Health Secretary, social care was formally added to my responsibilities but it was not long enough to bring forward reforms or – more crucially – a funding settlement for social care".*

855. The words "and Social Care" may not have been formally added to the Secretary of State's title and department until 2018, but responsibility for the service had always rested with the Secretary of State. Mr Hunt was, for instance, the sponsoring Secretary of State for the Care Bill, and was responsible for social care from the moment he took office in 2012. To imply otherwise raises troubling questions about understanding, prioritisation and accountability.

856. At ministerial level, there has been a notable lack of permanency, with more than 10 different ministers (or parliamentary under secretaries of state) over the last decade. This does little for continuity, relationship-building, and developing a meaningful understanding of the value of ASC and its challenges at senior political level.

857. The LGA therefore takes a firm view that delivering a brighter future for the ASC sector must involve concerted effort from the top of government. With that in mind, and with Baroness Casey commencing her Commission on the future of ASC in April, we recommend the following:

858. Government must prioritise the ASC sector. It must work with the sector to come to a shared understanding of immediate pressures (and their consequences) as well as the level of funding needed to meaningfully tackle them and provide stabilisation for the short- to medium-term. Such funding is needed to address unmet and under-met need, provider instability, a lack of investment in ASC prevention, growing strain on the care workforce and unpaid carers, and support for innovation (including through digital and new technology) and new models of care.

859. That understanding must be built from engagement with the ASC sector in its entirety, including people who draw on care, unpaid carers, and the care workforce.

860. Funding should be transparent, come with as few conditions as possible, and provide certainty for future years, ending the unhelpful approach of piecemeal and incremental hand-outs.

861. Government should embark on a major awareness raising campaign to help the public

understand what great ASC looks like, how it works, and the role it plays in people's lives and the communities in which they live. We must end simplistic stereotypes and negative connotations, such as ASC only/primarily being about older people in care homes, or a problem to be fixed. Great ASC is, for many thousands of adults of all ages, the glue that binds our communities together and supports their relationships, work, activities and ambitions.

862. As part of this work, Government should play its part in countering the presentation of ASC as a service which exists simply to mitigate demand pressures facing the NHS (and to blame when such pressures are not dealt with). True parity of esteem between the NHS and ASC is needed if both sides are to flourish and thrive.

863. In particular, the ASC workforce should be better paid (we recognise the current Government's work to address this through a Fair Pay Agreement), better valued and appreciated, better trained and developed, and provided with better opportunities for career progression. Government should look in detail at the recommendations in SfC's long-term strategy for the care workforce and take forward those that can be done at pace.

864. For the longer-term, and a properly reformed system (potentially a 'National Care Service'), the question of who pays for ASC, on what basis, and how the system is funded must be tackled head-on. All options should be on the table and Government should end the reliance on council tax and the social care precept to raise revenue for ASC; national rights and entitlements under the 2014 Act (and potentially under a National Care Service) should not be funded in the main through local taxation.

865. The LGA believes that action on the above would help deliver the brighter future for ASC which the sector has long called for, based on the following principles.

- ***People first and the value of social care.*** Whatever emerges for social care in the future should be rooted in, and guided by, what works best for people. It must support the realisation of TLAP's 'Making It Real' framework for quality, personalised and community-based support. It must also properly reflect the value of social care in its own right; as a way in which we help improve social justice and inclusion, and support people's freedoms and human rights. The narrative we all (government, media, public, etc.) use when talking about care and support should reflect the role great social care plays in all our lives.

- ***The importance of 'local'.*** Social care plays a key role in making connections in our local communities between a wide range of public, private, voluntary and

community organisations that all work together in supporting people to be well, safe and independent. Links with housing are particularly important and support people to remain independent at home and in their community. Councils' democratic accountability and leadership supports effective partnership working at the local level and the Government should follow this lead by working with local government and its many partners as equals in helping to build resilient communities that are geared towards prevention, wellbeing and public health.

- ***Funding and workforce.*** Any additional funding that is made available to ASC, whether in the short- or medium-term, should not simply be used for 'more of the same'. Rather, it should be used to help us move to a more person-centred and preventative model of social care that is rooted in supporting people's wellbeing in line with the Care Act 2014 ("**the 2014 Act**"). The future requirements of and for the social care workforce should be a far more prominent consideration for Government, both as a standalone priority and in respect of its links with NHS workforce planning. Action on pay, training and development, career progression and recognition, are all necessary.

- ***Provision and commissioning.*** Traditional services (such as residential care, domiciliary care and day centres) will continue to have a role to play in the future. But they need to be part of a much broader local offer including smaller, more bespoke providers, micro-enterprises, a vibrant voluntary sector and wider community assets, such as community-owned care, mutual aid and shared lives, that all played a part in responding to the pandemic. These would help bolster community resilience and their potential to help secure a more preventative approach to wellbeing that supports people to live safely and well at home must be harnessed.

- ***Health and integration.*** NHS services and social care are equally important and decisions and prioritisations about the future of each should reflect that. The needs of one should not be addressed to the detriment of the other and both should unite around embedding a far more preventative approach to wellbeing that works closely with public health and housing. The Government's Health Mission and its work on a 10 Year Plan For Health are valuable opportunities in this regard.

- ***The scope of 'reform'.*** Protecting a person from having to sell their home to pay for care is certainly one element of the 'fairness debate' at the heart of the question about long-term reform. But it is not the only one. The scope of and ambition for

social care reform must be far greater, support adults of all ages including unpaid carers, and have at its heart a commitment to the 2014 Act's wellbeing principle and improving people's choice and control of the care and support they use to live their best life. Progress must be made quickly.

866. Thes points have been brought together in Appendix 5 – Detailed recommendations

Statement of Truth

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

Signed: **Personal Data**

Dated: 17 April 2025

Appendix 1 – Acronyms and abbreviations

Acronym	Meaning
ADASS	Association of Directors of Adult Social Services
ADCS	Association of Directors of Children's Services
ADPH	Association of Directors of Public Health
AMHP	Approved Mental Health Professional
APPG	All-Party Parliamentary Group
ARC	Association for Real Change UK
ARDS	Acute respiratory distress syndrome
ASC	Adult Social Care
BASW	British Association of Social Workers
BEIS	Department for Business, Energy & Industrial Strategy
BAME	Black, Asian, and Minority Ethnic
CareEng	Care England
CASSRs	Councils with Adult Social Services Responsibilities
CCG	Clinical Commissioning Group
CEMR	the Council of European Municipalities and Regions
CEV	Clinically extremely vulnerable
CEX	Chief Executive
CHIA	Care and Health Improvement Adviser
CHIP	Care and Health Improvement Programme
CMO	Chief Medical Officer
COSLA	Convention of Scottish Local Authorities
CPA	Care Provider Alliance
CQC	Care Quality Commission
CSA	Care and Support Alliance
D2A	Discharge to assess
DASS	Director of Adult Social Services
DHSC	The Department for Health and Social Care
DLUHC	The Department for Levelling Up, Housing and Communities
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DPH	Director of Public Health
FY	Financial Year
GCPA	Gloucestershire Care Providers Association
HASTEC	Health and Social Care Technology
HEE	Health Education England
HWBB	Health and Wellbeing Board
ICF	Infection Control Fund

Acronym	Meaning
IPC	Infection Prevention and Control
KHub	Knowledge Hub
LA	Local Authority
LFTs	Lateral Flow Tests
LGA	Local Government Association
LGSB	Local Government Sounding Board
LGA/ML/M2	Statement of Mark Lloyd, the LGA's former CEX for Module 2 (INQ000215538)
LRF	Local Resilience Forum
MHCLG	Ministry of Housing, Communities and Local Government
NCAG	National Coronavirus Advisory Group
NALC	National Association of Local Councils
NAO	National Audit Office
NCA	National Care Association
NCF	National Care Forum
NECS	North of England Care System Support
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NILGA	Northern Ireland Local Government Association
NLW	National Living Wage
NPIs	Non-pharmaceutical interventions
NSDR	National Supply Disruption Response
ONS	Office for National Statistics
OT	Occupational Therapist
PAs	PAs
PCH	Partners in Care and Health
PCR	Polymerase Chain Reaction
PHE	Public Health England
PMO	Programme Management Office
PPE	Personal Protective Equipment
PSW	Principal Social Worker
R9	The R9 group of CEX
RCOT	Royal College of Occupational Therapists
Rule 9	Rule 9 of the Inquiry Rules 2006
SAB	Safeguarding Adults Board
SAGE	The Scientific Advisory Group for Emergencies
SAR	Safeguarding Adults Review
SCCMR	Service Continuity and Care Market Review
SCF	Social Care Future

Acronym	Meaning
SCIE	Social Care Institute for Excellence
SCW	Social Care Worker
SEF	Stakeholder Engagement Forum
SfC	Skills for Care
Sigoma	Special Interest Group of Municipal Authorities
SMT	Senior Management Team
Solace	The Society of Local Authority Chief Executives and Senior Managers
The 2004 Act	The Civil Contingencies Act 2004
The 2014 Act	The Care Act 2014
The 2020 Act	The Coronavirus Act 2020
TLAP	Think Local Act Personal
UKHCA	United Kingdom Homecare Association
UKHSA	UK Health Security Agency
VCOD	Vaccination as a Condition of Deployment
VODG	Voluntary Organisations Disability Group
WLGA	Welsh Local Government Association

Appendix 2 – Timeline of LGA's engagement with organisations

Note: The LGA has endeavoured to capture its engagement with relevant organisations in relation to the ASC Sector to the best of our ability. However, the nature of the pandemic, the number of staff and resources involved (and the related strain on those staff and resources), combined with the amount of time that has now passed means that there may be some gaps in this timeline.

Ministerial meetings

Date	Title of meeting	Attendees/Attending agencies
27/04/2020 – 22/06/2020	NR (LGA) and MSC, 1:1 (recurring every 4 weeks, 11.30-11.45am)	LGA (Director of Adult Social Care improvement) and MSC (Minister for Social Care)
30/04/2020 – 03/06/2020	Weekly meeting between LGA, ADASS and MSC (recurring weekly, 2.30-3.15pm)	LGA, ADASS, MSC

Working groups

First/Last Meeting Date	Meeting Title	Convening Department	Attending agencies
05/02/2020 - 11/03/2020	National Steering Group: Coronavirus - with Local Government Association CHIP	Department of Health and Social Care	DHSC, DLUHC) LGA
13/02/2020 - 09/02/2022	Local Resilience Forum: Chairs Call	Department for Levelling Up, Housing and Communities Resilience and Emergencies Division (DLUHC RED)	DLUHC, Councils?
06/03/2020	National Social Care Coronavirus Planning Group	DHSC	CQC, ARCUK, NCF, NHSE, UKHCA, PHE, DLUHC
10/03/2020 – end date	Task & Finish Group: COVID - 19 Operational Guidance	DHSC	LGA, BASW, RCOT, CQC, ADASS
11/03/2020 - 24/04/2020	NACG Call	Department of Health and Social Care/Local Government Association	CQC, ARC, UKHCA, ADASS, PHE, NHSE, BEIS, Carers UK, AMHP, ADPH, TLAP
19/03/2020 -	Task & Finish Group - Adult Social Care	Department of Health	DHSC, ADASS, SfC, CQC, UKHCA, LGA,

29/05/2020	Workforce and COVID - 19	and Social Care	NCF, CareEng, ARC, Unison,
05/02/2020 - 24/02/2022 [amended date]	Regional Leads Call	Ministry of Housing, Communities and Local Government	
27/03/2020 - 01/10/2020	ASC Task & Finish Group - PPE	Department of Health and Social Care	DHSC, PHE, NATIONAL CARE FORUM, CQC, UKHCA, CareEng, SOCIAL WORK ENGLAND
29/04/2020 - 20/05/2021	National COVID - 19 Social Care Provider Issues Group	Local Government Association	DHSC, NATIONAL CARE FORUM, NCA, VODG ARCUK, CAREENGLAND NHS CQC
19/06/2020 - 26/08/2020	Social Care Sector COVID - 19 Taskforce	Department of Health and Social Care	
06-01-2021 - end date	Social Care Stakeholder Group Meeting (recurrent)	DHSC	LGA, ADASS, NHSE, Carers UK, PHE, Unison, Health Watch, TLAP, CQC
08/01/2021 - 10/12/2021	Department of Health and Social Care/ Local Government Association/Association of Directors of Public Health fortnightly catch up	Department of Health and Social Care	DHSC LGA ADPH

Additional ad hoc meetings

Date (one-off/recurring)	Title of meeting	Attendees
19/03/2020	Teleconference with representatives of ASC users and carers	DHSC – Helen Whately, Minister of State for Care (recurring)
20/03/2020	Monitoring home care provision in the current crisis	DHSC, HASTEC, LGA
20/03/2020	Information from home care providers	DHSC, UKHCA, LGA, ADASS
23/03/2020	Data on home care capacity and resilience	DHSC, UKHCA, LGA, CQC, ADASS
23/03/2020	Capacity Tracker	DHSC, UKHCA, LGA, CQC,

		ADASS
25/03/2020	Modelling for Covid social care payment proposals	DHSC
25/03/2020	Pricing Model for Care Homes and Domiciliary Care under Covid	*(included in Module 2 statement – but not clear which department convened- assume DHSC)*
25/03/2020	Data and home care providers	*(included in Module 2 statement – but not clear which department convened- assume DHSC)*
31/03/2020	Catch up on provider fee levels and discharge	NHS, DHSC, ADASS
01/04/2020	Funding to providers	LGA, NHS, DHSC, ADASS
02/04/2020	Update on provider funding	NHS, DHSC, ADASS
02/04/2020	Q&A Forum: Discharges into Care Homes with Matthew Winn	DHSC, LGA, ADASS, NCF, ARC, UKHCA, CQC, Carers UK, BASW, RCOT, NHS, TLAP, CareEng
02/04/2020	Developing further discharge guidance	NHS, LGA, DHSC, ADASS
07/04/2020	NR Zoom Meeting - Data Collection	CareEng, DHSC, ARC, LGA
14/04/2020	URGENT: Discussion on Discharge Text for SC action Plan	DHSC, NHS ENGLAND & IMPROVEMENT
15/04/2020	MSC and DASS	ADASS, OFSTED
16/04/2020	Invitation: LGA - PPE discussion @ Thu 16 Apr 2020 12:15pm - 1pm (BST) (simon.williams@local.gov.uk)	CABINET OFFICE, NO10
17/04/2020	FW: Community and Care Home Sector - COVID - 19 Education and Training	NHS, SKILLS FOR CARE
20/04/2020	DHSC/LGA call - provider indemnity issue	DHSC, HM TREASURY
21/04/2020	Data collection from care providers - minimising burden and focus for use of data	DHSC, CareEng, CQC. NHS, NATIONAL CARE FORUM, COMMUNITES UK, ARC
22/04/2020	MSC, LGA, ADASS - Overseeing the system and responding to it	DHSC, CQC, COMMUNITIES,
23/04/2020 – 24/04/2020	Next Steps on Support to Care Homes	National care forum, CareEng, DHSC, NHS, PHE, SKILLS FOR CARE, CQC NATIONAL CARE ASSOC
24/04/2020	Call ahead of NACG	CQC, DHSC
28/04/2020	Data collection from care	DHSC, PHE, NATIONAL CARE

	providers - minimising burden and focus for use of data	FORUM, CQC, UKHCA, CareEng, SOCIAL WORK ENGLAND
29/04/2020	FW: Support to Care Homes: Next steps	DHSC, COMMUNITIES UK
28/05/2020	Regional oversight of care home support plans	NHSE, ADASS, LGA
04/06/2020	Infection Control Grants and Deep Cleans	DHSC, LGA
04/06/2020	Meeting: Richard/James/Simon	DHSC, LGA, ADASS
05/06/2020	Medium Term Planning on ASC	DHSC, LGA, regional CEXs
11/06/2020	Discharge & Domiciliary Care Support	DLUHC
12/06/2020	Call: NR Simon Williams	DHSC
17/06/2020	Discussion about state aid	DHSC, LGA
24-06-2020	Workshop – LGA/ADASS workshop with DHSC	LGA, ADASS, DHSC
25-06-2020	Staff Movement Workshop with David Pearson	DHSC, Care UK< Nadra Ahmed, Achieve Together To ensure that this is focussed the group consists of some large providers; some providers from the not for profits and some SME providers (courtesy of Nadra) with a colleague from the LGA and ADAS
01-07-2020	Day Services	DHSC, LGA
03-07-2020	ADASS/LGA workshop	ADASS, LGA, DHSC
07-07-2020	PPE Update - Local Government Association	LGA, DHSC
27-07-2020	Urgent Meeting to Discharge Draft COVID - 19 Discharge Guidance	DHSC, LGA, ADASS, S&CS, NCA, NHSE, ADPH
04-08-2020	Homecare & Next phase	DHSC ADASS Newton Europe NHSEI UKHCA
07-08-2020	Meeting to discuss ICF - Simon Williams	DHSC
12-11-2020	Assurance Meeting VI (with paper and agenda) ('This week's recurring meeting?)	DHSC, COMMUNITIES UK, PHE, NHS
17-11-2020	Collaborative workforce	DHSC, SKILLS FOR CARE,

	priorities	CHESHIRE WEST
17-11-2020 – end date	Data Collection meeting (recurrent)	DHSC, NATIONAL CARE FORUM, NHS, CQC, NATIONAL CARE ASSOC, COMMUNITIES UK
25-11-2020 – end date	MS(C) COVID-19 telecon (recurring)	DHSC, LGA
26-11-2020	Care Home Visiting - Update on new guidance	*included in Module 2 statement – but not clear which department convened- assume DHSC)*
03-12-2020	Extraordinary meeting of the National Vaccine Deployment Steering Group	DHSC, NHSE, DHLUC, LGA, various local authorities (LRF chairs?)
03-12-2020	Adult social care stakeholder briefing - Pfizer /BioNTech COVID-19 vaccine	NHSE, LGA, ADPH, Cabinet Office,
03-12-2020	LGA / DHSC - views on new guidance	LGA, DHSC
09-12-2020	URGENT: Vaccination Update Meeting	DHSC, Care UK, ADASS, Achieve together, Irrelevant & Sensitive Worcester Garden, NCF, LGA. Providers.
10-12-2020	NHS COVID - 19 App: Important Updates and T&T Support Payment Scheme Deep Dive Session	SfC, SCIE, Care Provider Alliance, Carers, Carers UK, Mencap, LGA, ADASS, Arul, Shared Lives Plus, MSC, National Carers Forum Solace, Sense
11-12-2020	National Social Care Leads with DHSC colleagues (recurrent – end date?)	DHSC, LGA
22-12-2020	Community-based social care workers and vaccination - workshop	NHSE, DHSC, UKHCA, Carers UK, ADASS, NCF, CPA
04-01-2021	CSWs/Simon Williams Catch up	LGA, DHSC
04-01-2021	Catch up	LGA, DHSC
06-01-2021	SCCMR – Advisory Group (Service Continuity and Care Market Review)	DHSC, LGA, ADASS, Local authority chief executives
13-01-2021	Provider Group Strategic Discussion	DHSC, LGA, ADASS, Providers and representative organisations – AMHP, national Care Forum, UKHCA, CareEng, GCPA, NCA, VODG, Irrelevant & Sensitive, Arc UK
13-01-2021	Discussion - CHC Suspension	LGA, DHSC,
14-01-2021	Fortnightly Contingency Planning	DHSC LGA, ADASS, CQC, NCF,

	for Major Provider Failure Group	UKGI
14-01-2021	Discharge legislation meeting	NHSEI, DHSC, Browne Jacobson, LGA
18-01-2021	WRES final Task & Finish Group	LGA, SfC, BASW
06-01-2021	A strategy for vaccine hesitancy in the social care sector	DHSC, LGA, NHSE, ADASS, NCF, NCA
06-01-2021	Vaccines planning meeting (recurrent)	
Jan 21	Vaccine deployment	
	Data SCW SOP Discussion	
Feb	vaccinating social care workers	
	Designated settings working group meeting (recurrent)	
March 21 (confirm if correct start date)	Informal Fortnightly Meeting with LGA/ADASS (recurrent)	
	Simon Williams, LGA - BCN Learning links into Local Government/Social care	
	Capacity Tracker: Data Advisory Group meeting	
18.03.2021 – end date	CQC/ DHSC/ LGA/ ADASS (recurrent)	CQC/ DHSC/ LGA/ ADASS
23-03-2021	LGA/ADASS with DHSC	LGA/ADASS with DHSC
	FW: Cohort 1 Staff Vaccination Drive Workshop	
	FW: Unpaid Carers - stakeholder briefing on changes to NBS	
April 2021	Unpaid Carers & Vaccination	
May 2021	Vaccination as a condition of deployment in older adult care homes - stakeholder working group (session 2)	LGA DHSC
June 2021	Vaccination as a condition of deployment	
July 21	Invitation-stakeholder working group: vaccination as a condition of deployment in care homes (new – recurring)	

July 21	Vaccine Data Collection for Unregulated Care Workers	
August 21	Update on self-isolation arrangements	
04-01-22 (NB – not clear that this is when it started – replaces a previous invite) (recurrent)	National Discharge Task Force - weekly meeting	
06-01-22	Catch up and introduction	DHSC, LGA
11-01-22	Discharge Data and Trigger Points Discussion	
12-01-22	Catch up on omicron funding	
17-01-22	FFP3s	
	Regular catch up LGA/ADASS/DHSC Reg Team	LGA/ADASS/DHSC
	Fit testing ASC	
	Visiting restrictions: local advice vs guidance	
	Vaccine Boosters Taskforce Meeting	
	Discussion on fit testing	
	Discharge Taskforce - Draft Workstream 4 Proposal	
	National discharge taskforce (meeting postponed from 24/01)	
	Claire/Simon - Catch Up	
01.02.22	DHSC / ASC system leaders meeting on VCOD	
14.02.22	VCOD consultation group discussion	
	Discharge Meeting - WS1 / MS(H) (TR)	

NHSE (where not within a wider working group/NHSE/ADASS and LGA specific)

Date	Title of meeting	Attendees/Attending agencies
03-06-2020	BCA/MDC – Senior level catch-up – Rosie/Simon	LGA, NHSE
04-06-2020	NHSE-I COVID-19 Discharge and Social Care Cell: Update for NHSE-I Regional Programme Leads (whole series- recurrent meeting)	NHSE, LGA/ADASS (CHIP)
05-06-2020	Local Government Briefing on COVID-19	NHSE, LGA
18-11-2020	Beneficial Changes' during Covid	NHSE
05-01-2020 (end-date) NB – not clear – these were postponed.	LGA/ADASS Weekly Catch up (With NHSE?)	ADASS, LGA, NHSE
28.01.2021	Care Homes vaccination letter DPHs action (NHSE – not DHSC)	LGA, NHSE
30-03-2021	LGA / ADASS to Discuss vaccinating social care staff	NHSE, LGA, ADASS

CQC (where not a wider working group)

Date	Title of meeting	Attendees/Attending agencies
30-03-2020	Simon Williams/ Kate Terroni	CQC, LGA
02-06-2020 – end date 16-06-2020 23-06-2020 30-06-2020	Data Collection from Care Providers	CQC, LGA – sent over 'next few weeks' weekly series. Recurring till?
17-06-2020	Regular policy and strategy catch-ups with the LGA	CQC
18-03-2021	CQC/ DHSC/ LGA/ ADASS	CQC/ DHSC/ LGA/ ADASS

Providers

Date	Title of meeting	Attendees/Attending agencies
05/06/2020 17/06/2020 24/06/2020	Provider Funding Discussion	LGA, UKHCA, Irrelevant & Sensitive CareEng, ADASS, ARCUK, NCF, AMHP, VODG, GCPA

Appendix 3 – LGA Webinars and online events

Date	Title	LGA/CHIP	Attendance (if known)	Event description / summary / background
2020				
14/04/2020	Temporary Funding for Adult Social Care providers during the Covid-19 Crisis	CHIP	116	Context to, and detail of, the joint LGA and ADASS statement on temporary funding for adult social care providers. This statement is attached and we ask that if possible, you read this before the webinar.
15/04/2020	Temporary Funding for Adult Social Care providers during the Covid-19 Crisis	CHIP		Context to, and detail of, the joint LGA and ADASS statement on temporary funding for adult social care providers. This statement is attached and we ask that if possible, you read this before the webinar.
21/05/2020	Supporting the Mental Health of our communities during COVID-19	LGA	396	As our residents continue to experience self-isolation and social distancing measures, the impact on mental health and wellbeing is becoming increasingly apparent, including for children and young people. To help councils think through their local responses, this webinar will explore the public mental health and wellbeing impacts of Covid-19 across the life course and share how councils are working with partners to support people's mental health and wellbeing both in this immediate phase and looking ahead to recovery.
22/05/200	Local Outbreak Plans – Council Chief Executives & Directors of Public Health	LGA	329	Content not available / closed or invitation-only session
27/05/2020	Confidential briefing ahead of announcement on testing and tracing	LGA	430	Content not available / closed or invitation-only session
02/06/2020	COVID-19 and ethnicity	LGA	758	Some groups within our communities are being disproportionately affected by Covid-19. Increasing evidence and concern regarding the impact of Covid-19 on Black, Asian and Minority Ethnic groups (BAME) led to the announcement, early this month of the Public

				Health England (PHE) Review on Covid-19 and BAME.
10/06/2020	Local Outbreak Plans – Council Chief Executives & Directors of Public Health	LGA	283	Content not available/ closed or invitation-only session
16/06/2020	SCDIP Accessibility workshop (part 1)	CHIP	48	As a whole day's webinar can be a challenge we are proposing to split this planned workshop across two days: • Part 1: 16th June, 10:00 - 12:30 • Part 2: 18th June, 10:00 - 12:30 Please let me know if there are issues with the date and time suggested for the second half. In addition to exploring accessibility issues and requirements, this will be a chance for councils to come together, share project learning and reflect on Covid-19 challenges and opportunities.
17/06/2020	Tackling COVID-19: An International Perspective	LGA	276	The Covid-19 pandemic has been a global event, touching every country. Local councils across the world have responded to the challenge in different ways, along different timelines, and with varying success. The UK has followed a similar curve to other countries, but slightly later, meaning that the strategies being followed today elsewhere can help inform our own preparations for further relaxation of the lockdown and planning for recovery.

18/06/2020	SCDIP Accessibility workshop (part 2)	CHIP	48	As a whole day's webinar can be a challenge we are proposing to split this planned workshop across two days: • Part 1: 16th June, 10:00 - 12:30 • Part 2: 18th June, 10:00 - 12:30 Please let me know if there are issues with the date and time suggested for the second half. In addition to exploring accessibility issues and requirements, this will be a chance for councils to come together, share project learning and reflect on Covid-19 challenges and opportunities.
23/06/2020	Using Marmot principles to tackle health inequalities and COVID-19	LGA	822	A decade after Sir Michael Marmot's landmark research "Fair Society, Healthy Lives", a review was published in February, "Health Equity in England: Marmot Review,10 years on" at the outset of the coronavirus (Covid-19) pandemic. It revealed that the health gap has widened between poor and wealthy areas, improvements to life expectancy have stalled and in fact declined for the poorest, particularly women, and the importance of place on health. The pandemic, and the wider governmental and societal response, have brought these health inequalities into sharp focus. There is early evidence which suggests that some of the social determinants of health, including obesity, ethnicity, deprivation, poor mental health, and socio-economic status are contributing to higher levels of Covid-19 related deaths. Measures to control the spread of the virus are likely to have significant longer term implications on health inequalities, related morbidity and mortality of certain groups of people, for example those experiencing social isolation, financial insecurity and domestic abuse. How do we mitigate the impact of Covid19 to more deprived and excluded groups? This webinar will explore the health inequalities exposed by Covid-19 and look at how they can be addressed. Professor Sir Michael Marmot, Director, UCL Institute of Health Equity is the keynote speaker and we will also hear from local case study areas on how they and their Health and Wellbeing Boards are

				leading on the wider determinants of health and tackling health inequalities.
24/06/2020	Creating inclusive economies post COVID-19	LGA	180	Content not available/ closed or invitation-only session
29/06/2020	Webinar on Test and Trace & Local Outbreak Plans	LGA	295	Content not available/ closed or invitation-only session
15/07/2020	Working with the voluntary and community sector to support communities	LGA	256	One of the most striking positive impacts of Covid-19 has been the huge surge in volunteering. Whether it is local recruitment campaigns by councils and in partnership with their voluntary and community sector, spontaneous, self-organising mutual aid and neighbourhood Whatsapp groups or national initiatives such as the NHS Volunteer

				Responders schemes, many hundreds of thousands of people from all parts of the country have come forward to offer help to others in their communities.
16/07/2020	Financial hardship and economical vulnerability - the role of councils and their partners in delivering protective and preventative support	LGA	148	Local government has a key role to play in supporting low income and economically vulnerable households. Coronavirus has placed some households at immediate risk of financial hardship, and exacerbated vulnerability for many more. Councils and their partners had to respond swiftly and effectively to increased demand for support. The economic impacts of the pandemic are likely to be felt for some time to come, so councils are also considering how best to ensure that they are able to identify those who need help, and put in place an effective local safety net in the longer term. The programme will cover both direct support and integration with wider support including health, housing and social care. We will also consider approaches to liability and debt recovery; interaction with the national benefits system and access to affordable credit and financial services.
20/07/2020	Covid-19 & Day Service Re-opening Webinar	CHIP	90	Content not available/ closed or invitation-only session
21/07/2020	Shaping Places for Healthier Lives re-connection workshop	CHIP	53	Session overview: • Reflect individually and as a group on the last few months – highs & lows • Share what new things have become possible • Think practically about moving forward
27/07/2020	Reset, not restart: shaping the future of social care in light of COVID-19	LGA	270	Content not available/ closed or invitation-only session
13/08/2020	Local Outbreaks and Living with COVID-19	LGA	325	We are hosting a webinar in collaboration with the Department for Health and Social Care (DHSC) on communicating local outbreaks and living with Covid-19. We'll discuss local outbreak planning, lessons learned from areas that have seen outbreaks in recent weeks and how effective local communications can support our national

				recovery.
08/09/2020	Local testing and contact tracing	LGA	292	Content not available/ closed or invitation-only session
14/09/2020	High Impact Change Model (HICM) Webinar - East Midlands	CHIP	76	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.
17/09/2020	HICM Webinar - West Midlands	CHIP	37	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.
21/09/2020	HICM Webinar - North East	CHIP	19	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.

22/09/2020	HICM Webinar - Yorkshire and Humber	CHIP	41	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.
22/09/2020	HICM Webinar - North West	CHIP	19	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.
23/09/2020	HICM Webinar - South West	CHIP	12	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.
23/09/2020	HICM Webinar - London	CHIP	38	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.

25/09/2020	HICM Webinar - South East	CHIP	26	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.
28/09/2020	Local Outbreaks and Living with COVID-19	LGA	182	Content not available/ closed or invitation-only session
30/09/2020	HICM Webinar - East of England	CHIP	33	The Local Government Association updated attendees on the latest changes to the High Impact Change Model (HICM). These changes were made to reflect the new discharge policy and local experiences of Covid-19. Attendees on the webinars and those who completed the online questionnaire largely agreed with the changes that had been made and noted the continued value of the HICM to support timely hospital discharge and improve outcomes for people.
28/10/2020	Discharge to Assess (D2A) webinar series: 1 - Policy, model and pathways	CHIP	570	The Hospital Discharge Service: Policy and Operating Model (August 2020) has formalised the Home First approach using discharge to assess to allow people to return home to recover and be assessed for any ongoing care and support needs in their own home environment. The Emergency Care Improvement Support Team (ECIST) at NHS England and Improvement in partnership with the Better Care Fund team and the Care and Health Improvement Team at the Local Government Association, are hosting seven webinars, running until mid-November, when you will be able to hear from experts about key aspects of the Policy and those with first-hand experience of making it work. The policy, the model and pathways Will include: Key aspects of the policy from Liz Sargeant, Professor John Bolton talking about the model and Oxfordshire sharing their experience.

02/11/2020	Social Care Digital Innovation - sharing the learning	LGA	118	These webinars, presented by council teams, provide an opportunity for adult social care councils to understand the learning from these projects and opportunities for adoption in their own areas - from remote video assessments in Derbyshire, to hydration in care homes in North Somerset; from connecting communities and supporting independent travel in Camden to falls prevention in Southwark; from online care accounts in Kirklees to care technology guidance in Cambridgeshire.
02/11/2020	Social Care Digital Innovation - sharing the learning	LGA	89	These webinars, presented by council teams, provide an opportunity for adult social care councils to understand the learning from these projects and opportunities for adoption in their own areas - from remote video assessments in Derbyshire, to hydration in care homes in North Somerset; from connecting communities and supporting independent travel in Camden to falls prevention in Southwark; from online care accounts in Kirklees to care technology guidance in Cambridgeshire.
03/11/2020	Discharge to Assess (D2A) webinar 2 - Personalisation	CHIP	232	What the policy means for people being discharged from hospital and their families and carers. Healthwatch England will share the headlines from their recent work with the British Red Cross into people's experiences of being discharged from hospital. The Isle of Wight will share how they implemented a specific personal assistant scheme to support hospital discharge to home.
03/11/2020	Social Care Digital Innovation - sharing the learning	LGA	105	These webinars, presented by council teams, provide an opportunity for adult social care councils to understand the learning from these projects and opportunities for adoption in their own areas - from remote video assessments in Derbyshire, to hydration in care homes in North Somerset; from connecting communities and supporting independent travel in Camden to falls prevention in Southwark; from online care accounts in Kirklees to care technology guidance in Cambridgeshire.

03/11/2020	Social Care Digital Innovation - sharing the learning	LGA	80	These webinars, presented by council teams, provide an opportunity for adult social care councils to understand the learning from these projects and opportunities for adoption in their own areas - from remote video assessments in Derbyshire, to hydration in care homes in North Somerset; from connecting communities and supporting independent travel in Camden to falls prevention in Southwark; from online care accounts in Kirklees to care technology guidance in Cambridgeshire. Additionally, multiple councils have come together to co-fund and co-develop digital innovations through the Social Care Digital Innovation Accelerator (SCDIA). Projects include discharge to assess (D2A), employability virtual support for people with learning disabilities, and multi-agency safeguarding active intervention management (AIM).
05/11/2020	Discharge to Assess (D2A) webinar 3 - Data	CHIP	215	The details of the data collection and reporting requirements as well as how this data can be used to inform planning and commissioning. There will be an opportunity to ask questions of the experts behind the data.
10/11/2020	Discharge to Assess (D2A) webinar 4 - Joint Commissioning	CHIP	234	How to commission for discharge to recover and assess; the policy requires commissioners to plan and commission care that meets the needs of local populations and based on a Home First ethos. Hear about Devon's experience of joint commissioning.
12/11/2020	Discharge to Assess (D2A) webinar 5 - Workforce	CHIP	181	The key roles needed to deliver the policy and the Covid-19: ethical framework for adult social care which supports the planning and organisation of adult social care currently. Hear about how the Swindon system managed their workforce to meet the demand.
17/11/2020	Discharge to Assess (D2A) webinar 6 - Funding and Finance	CHIP	240	What the funding can be used for, how to claim it, what does it mean for self-funders, and future arrangements. Hear from Alan Lotinga (ADASS) on how the money has been spent so far and Hampshire's experience.
19/11/2020	Discharge to Assess (D2A) webinar 7 -	CHIP	218	What does the policy mean for domiciliary care providers and care homes? Hear from two areas about their experience of implementing

	Providers			the policy in domiciliary care and care homes.
26/11/2020	Launch webinar: Care Technology Offer	CHIP	70	Thank you for your interest in joining this webinar to launch our Care Technology Diagnostic and Planning Tool and wider care technology offer.
16/12/2020	Launch webinar: Care Technology Offer	CHIP	103	Thank you for your interest in joining this webinar to launch our Care Technology Diagnostic and Planning Tool and wider care technology offer.
September 2020 - March 2021				Not known / closed or invitation-only session
Exact dates in this period not known	Event Series: Making Safeguarding Personal (MSP)	CHIP	244	Open access webinars in partnership with Research in Practice to support implementation of Making Safeguarding Personal. Target audience: Aimed at practitioners and people responsible for the learning and development of other professionals. Following up on a set of resources on Making Safeguarding Personal developed and updated in 2018/19, in response to sector demands. The events aimed to publicise and disseminate these resources. They provided an overview of resources available to support MSP and how to use them. The next stage of work will be shaped by the feedback from participants at the events and any further demand from the sector.

Exact dates in this period not known	Event Series: Adult Safeguarding and Homelessness	CHIP	421	A series of 8 themed workshops with themes including: Foundations for Positive Practice in safeguarding people who are homeless; Commissioning and Provider Services; Psychologically-informed and Reflective Practice; Learning Lessons from the Response to Covid-19; Legal Literacy; Governance of Adult Safeguarding and Homelessness; Tackling Specific Issues (alcohol abuse, mental capacity, multi-agency collaboration), Making Every Adult Matter and Every Contact Count – Reviewing Learning about Positive Practice. Target Audience: The audience for these events is very broad – any organisation or service working to safeguard adults or with people experiencing homelessness. Event series was developed because we were unable to hold regional or local workshops to disseminate and discuss the messages from the first briefing on safeguarding adults and homelessness which was published in 2020 due to the Covid-19 pandemic. (This first briefing was the product from 4 CHIP national workshops held 2019 on safeguarding adults and homelessness). The expert reference group that has supported this workstream since 2018 had suggested key topics for the individual workshops to focus on, to explore this area of work. A briefing on adult safeguarding and homelessness, published by the Local Government Association and the Association of Directors of Social Services: https://www.local.gov.uk/adult-safeguarding-and-homelessness-briefing-positive-practice was published in early 2020. This series of workshops were developed to disseminate and take this work forward. and to inform a further briefing. The outcome of the 8 Webinars will be a follow up 2nd briefing to be published mid-2021.

Exact dates in this period not known	Event Series: Understanding what constitutes a safeguarding concern and how to support effective outcomes	CHIP	1012	A series of 10 virtual workshops. Target Audience: Any organisation or service working to safeguard adults. These events complimented a previous series of events in focused on interpreting section 42 of the Care and Support statutory guidance, which determines safeguarding adult pathways. Regional work in 2018 & 2019 evidenced a spectrum of difference in application of the statutory guidance and the first phase of the work focused on achieving better consistency in decision making regarding section 42 safeguarding enquiries. The second phase of the work focused on understanding what constitutes a safeguarding concern. The events were commissioned as face to face workshops were unable to be held due to the Covid-19 pandemic. The event series supports the use of the multi-agency concerns framework to helped safeguarding practitioners use it in their daily lives. An updated briefing will follow, informed by the feedback from the workshops.
2021				
08/01/2021	Launch: Supporting People with Learning Disabilities to Have Better Lives Outcomes Framework	CHIP	300	Preparation & delivery of webinar to launch Supporting People with Learning Disabilities to Have Better Lives Outcomes Framework & follow up responses to questions posted during the webinar.
02/02/2021	Local recruitment initiative - webinar 1	CHIP		Joint piece of work between ADASS, Skills for Care, LGA and CPA who have been working together to showcase local recruitment initiatives.
04/02/2021	Local recruitment initiative - webinar 2	CHIP		Joint piece of work between ADASS, Skills for Care, LGA and CPA who have been working together to showcase local recruitment initiatives.
05/02/2021	Local recruitment initiative - webinar 3	CHIP		Joint piece of work between ADASS, Skills for Care, LGA and CPA who have been working together to showcase local recruitment

				initiatives.
09/02/2021	How can the voluntary care sector support hospitals to discharge patients?	CHIP	194	How can the voluntary care sector support hospitals to discharge patients quickly and safely during Covid-19? The Care and Health Improvement Programme at the Local Government Association and the British Red Cross, in partnership with the Better Care Fund Team, ECIST and Healthwatch England are hosting a webinar to bring together health and social care commissioners and voluntary care sector organisations to consider how they can collaborate to support effective hospital discharge and enable more people to recover safely at home.
11/02/2021	How can the voluntary care sector support hospitals to discharge patients?	CHIP	242	How can the voluntary care sector support hospitals to discharge patients quickly and safely during Covid-19? The Care and Health Improvement Programme at the Local Government Association and the British Red Cross, in partnership with the Better Care Fund Team, ECIST and Healthwatch England are hosting a webinar to bring together health and social care commissioners and voluntary care sector organisations to consider how they can collaborate to support effective hospital discharge and enable more people to recover safely at home.
24/02/2021	Designated Settings: Sharing Experiences and Learning Event	CHIP		This event – hosted jointly by the Care Provider Alliance, Local Government Association, Care Quality Commission, NHS England and Improvement, and Association of Directors of Adult Social Services – brought together people who are already running a designated setting and those who are thinking about it to share experiences and learning from setting up and running designated settings, and what we may do going forward.
18/03/2021	RPA Consultative Workshop	CHIP	60	We are planning to hold a consultative session to get feedback on the HICM on Reducing Preventable Admissions
22/03/2021	Young People's Mental Health	LGA	335	In this webinar, Centre for Mental Health will present findings from their recent project on how councils support young people aged 14-25 with their mental health. The project focused on councils working with families and community partners to promote good mental health

				and wellbeing as children transition from teenage years to adulthood.
23/03/2021 - 24/03/2021	Annual Public Health 2021	LGA	1142	Directors of public health and lead members for health, care and wellbeing have been at the centre of the effort to limit the spread and impact of Covid-19. It is more important now than ever to take time to reflect on how local and national systems have risen to the challenges brought about by the pandemic and explore how we can support our communities to emerge and recover from its impact. This annual conference, organised by the LGA and the Association of Directors of Public Health (ADPH), will include sessions on the future of the public health system, the new National Institute for Health Protection, public opinion on public health, and how we redouble our efforts on tackling health inequalities.
01/04/2021	Transitional Safeguarding	CHIP	620	Hosted webinar on Transitional Safeguarding for the Chief Social Worker (Adults) developed with ADASS,Research in Practice, BASW, NWG, CHIP, published July 2021. c.620 people attended (full feedback report available)
05/04/2021	LOMP Review and VOC	CHIP	200	Webinar for Chief Executives. Topic, LOMP Review and VOC
08/04/2021	Universal Testing	CHIP	200	Webinar for Chief Executives. Topic, Universal Testing
29/04/2021	A New way Home - moving people home using personalised funding	CHIP		Part of better outcomes work
04/05/2021	Fee setting and commissioning practise	CHIP	80	Webinar hosted by CHIP and Care Provider Aliance on fee setting and commissioning practise

06/05/2021	Peer Support Improvement work in Cumbria Webinar	CHIP	382	The Better Care Support Team, in collaboration with the LGA and NHSEI would like to invite you to join a webinar to hear about the peer support system improvement work in Cumbria. As well as hearing about the improvement work methodology from Sarah Mitchell and Liz Sargeant, you will hear from colleagues in Cumbria, from across the system, talk about their experience of the peer review and how they have achieved their current culture of collaboration between system leaders. We urge you to join us for this discussion, to learn more about the support available to all systems and to hear the powerful story of the Cumbria journey over the last year.
07/05/2021	Home Not Hositals	CHIP		Part of better outcomes work
18/05/201	Inclusive economies and fairer futures: How to build back better	LGA	311	In support of the wider Levelling Up agenda, this webinar brings together cross-sector stakeholders with an interest in building inclusive economies and reducing health inequalities. The webinar will take stock of existing work on the inclusive economies agenda, leading to an open discussion on what to do next at this important time as we plan to 'build back better' from Covid-19.
18/05/2021	Support to contain outbreaks of Variants of Concerns - Leaders, Chief Executives, DsPH	LGA	188	Content not available / closed or invitation-only session
20/05/2021	COVID-19 vaccine communications: engaging with young people	LGA	402	Insight has shown that those in the youngest age cohort, from 18 to 29, are more likely than other ages to be hesitant about choosing to receive the Covid-19 vaccine. In this webinar, we will explore how council communications teams can work to increase vaccine uptake amongst our younger residents.
24/05/2021	Grief not Grievance	CHIP	238	Joint webinar ADPH/Centre for Mental Health/LGA

26/05/2021	Care and Health Improvement Programme: Learning Lunch	CHIP	69	Join us for our inaugural Learning Lunch. This new monthly webinar will keep you up to day with national policy developments relating to health and care integration and showcase new ideas and good practice from around the country. The first webinar will be on 26 May 1-2pm. We will hear updates on the new Health and Care Bill and developments around ICSs, and Discharge to Assess including using the additional funding. We will hear also from Mel Lock, Director for Adult Social Care at Somerset County Council, about how they have developed a model of intermediate care to support D2A.
27/05/2021	Preparation for adulthood	CHIP	100	Hosted for yorkshire and humber region
28/05/2021	MHA reforms workshop	CHIP	35	High level scoping workshop, CYP complex needs.
04/06/2021	Learning and insights from the mass events pilots	CHIP	650	Content not available/ closed or invitation-only session
14/06/2021	Collaborative Commissioning Webinar	CHIP	122	Collabrative Commissioning Webinar with Portsmouth Presenting good practice
18/06/2021	Fee Setting and Commissioning Practice Webinar	CHIP	64	Held in conjunction with care providers
30/06/2021	Learning Lunch: How should ICSs develop to have the biggest impact?	CHIP	116	How should ICSs develop to have biggest impact? Our regular learning lunch will this month hear from Cllr Izzi Seccombe, leader of Warwickshire County Council, and Dame Stella Manzie DBE, Chair of University Hospitals Coventry & Warwickshire NHS Trust, reflecting on how they have developed their partnership as the Coventry and Warwickshire ICS, and considering what the next steps are for their system. They will explore the opportunities and tensions inherent in the ongoing transformation – how to balance whole-scale change at pace with a continued focus on improving outcomes for their communities. We will hear too from Alyson Morley, the LGA's policy lead for system transformation, on what to expect in the upcoming Health and Care Bill and national guidance.

08/07/2021	Using data to deliver best outcomes in discharge - Presentation from the Somerset system.	CHIP	198	Please join us for a national webinar on Thursday 8th July at 11am to look at how a system is working with the new Discharge Policy and data to implement a Home First approach. Working collaboratively to embed a person centred strength based approach the Somerset system has used their data to inform and drive their approach. We seek to share examples of best practice in implementing the Discharge Policy to enable us all to deliver the best outcomes for patients and people.
08/07/2021	Covid-19 Second Safeguarding Adults Insight Project (until December 2020)	CHIP	90	The Covid-19 pandemic and accompanying lockdowns have had an unprecedented and extraordinary impact on all aspects of day-to-day life and behaviours. There are ongoing concerns about how people with care and support needs may experience different or more abuse or neglect due to these changes. Insight into the impact of the pandemic on safeguarding activity can firstly, describe what is happening, secondly, inform future activity to mitigate increased or different risks of abuse and thirdly, offer a national picture for the varied and shared local experiences. Data and intelligence provide evidence, both to emphasise the importance of safeguarding adults and influence policy and decision makers. The Care and Health Improvement Programme (jointly funded by the LGA and ADASS) has produced the 2nd Adult Safeguarding Insight report, which is pending publication on the LGA website (expected in early July). We are planning a Webinar on Thursday July 8, 10am-12pm to present the 2nd report. The Insight Project was developed to create a national picture regarding safeguarding adults' activity during the Covid-19 pandemic. The first report provided a picture of how safeguarding adults activity in England was affected by the initial stage of the pandemic and first lockdown, up until June 2020. This second report provides information on safeguarding adults activity up to December 2020.

12/07/2021	Grief not Grievance: supporting community recovery from the mental health impacts of COVID-19	LGA	229	This webinar is for public health professionals exploring learning from incidents of mass collective trauma. It will look at the public health responses needed to ensure that grief doesn't turn into a sense of grievance from not having had the space and opportunity to grieve fully for those lost during the pandemic.
27/07/2021	Joint ICS Webinar Series - Making sense of ICSs	CHIP	133	Welcome to the first in a series of lunchtime webinars to help us all make sense of Integrated Care Systems. In the spirit and practice of collaboration, these webinars are delivered jointly between the LGA, NHS Providers and NHS Confederation as part of the joint peer support offer for local systems.
28/07/2021	Learning Lunch: Delivering better outcomes for Local communities with the VCS	CHIP	48	Delivering better outcomes for local communities with the VCS At our next Learning Lunch we will be exploring the role of the VCS and how it is working with system partners to develop place-based arrangements that best meet the needs of local communities. We will hear from Jemma Mindham, Chief Executive Officer for Rainbow Services in Harlow on their 'Let's Get Connected' project and working with partners to effectively engage with people to co-design and co-produce services to achieve better outcomes.
29/07/2021	Induction event for new HWB Chairs	CHIP	22	Induction event for new HWB Chairs, Vice-Chairs and ASC portfolio holders, or ones wishing to attend a refresh
18/08/2021	Discharge to Access webinar	CHIP	100	D2A webinar for the North East and Yorkshire and Humber
19/08/2021	Autistic people and housing	CHIP	291	Content not available/ closed or invitation-only session
27/08/2021	JCVI webinar in collaboration with ADPH	CHIP	200	Invite to Chief Executives

21/09/2021	ICS Webinar Series - What Good Looks Like - Engaging Councillors and NEDs	CHIP	86	Welcome to the second in a series of lunchtime webinars to help us all make sense of Integrated Care Systems. In the spirit and practice of collaboration, these webinars are delivered jointly between the LGA, NHS Providers and NHS Confederation as part of the joint peer support offer for local systems.
28/09/2021	TLAP led ICS Webinar Series - What Good Looks Like - Co-production	CHIP	70	Welcome to the second in a series of lunchtime webinars to help us all make sense of Integrated Care Systems. In the spirit and practice of collaboration, these webinars are delivered jointly between the LGA, NHS Providers and NHS Confederation as part of the joint peer support offer for local systems.
29/09/2021	Learning Lunch: The importance of building strong partnerships and collaboration across the system	CHIP	41	The importance of building strong partnerships and collaboration across the system Our next learning lunch will be on Wednesday the 29th of September 2021 from 1pm to 2pm. We will be discussing joint working and how this will continue to develop going forward. We will be joined by Bernadette Enright, Executive Director of Adult Social Services, who will discuss how the local authorities across Manchester collaborate. We will also hear from Mark Edwards, Chief Operating Officer at Manchester Local Care Organisation, on how the joint integrated ToC hub was developed.
30/09/2021	Embedding a wellbeing culture	CHIP	160	Workforce focused
05/10/2021	ICS Webinar Series - ICP Guidance	CHIP	35	This webinar will focus on webinar will focus on making sense of tackling health inequalities and understand what questions that senior leaders should be asking of your own systems. It provides the opportunity to ask the expert panel questions, raise comments and concerns and highlight any l good practice.
08/10/2021	Putting Health and Care at the heart of economic renewal: Launching the Inclusive and Sustainable Economies Network	LGA	205	The pandemic has highlighted just how interconnected health and the economy are. As local leaders reflect on the broad impact of the pandemic and look to develop their longer-term strategic response, how can we ensure that health, and the health sector, is an understood, important and active participant?

	series			
19/10/2021	COVID-19 Comms - Living with COVID 19 and preparing for the challenges of winter	LGA	262	As the vaccination programme is rolled out to cover 12 to 15-year-olds and booster jabs, this webinar will include presentations from central government and local authorities on their plans to protect communities over the winter months.
21/10/2021	Showcasing the work of the North East Safeguarding Adult Review Champions	CHIP	75	Responding to the National SAR Analysis Showcasing the work of the North East Safeguarding Adult Review Champions This is the first in a series of webinars that aim to demonstrate how progress is being made in responding to the recommendations set out in the National Safeguarding Adult Review Analysis. The North East Safeguarding Adult Review Champions are a strong and effective regional network that have produced some demonstrable practical solutions to facilitate sharing knowledge, experience and learning to drive forward improvements with respect to Safeguarding Adult Reviews. The Champions will provide an overview of their progress to date and share their future plans

21/10/2021	Considering and meeting the sensory needs of autistic people in housing	CHIP	293	This webinar will give you an overview of the findings from a new report commissioned by CHIP from NDTI 'Supporting Autistic people to flourish at home and beyond'. In recent years, a greater understanding of autistic people has emerged. New research and years of collaboration with autistic people has changed almost everything society thought it knew about autism. One of the most important findings is that most autistic people have significant sensory differences, compared to most non-autistic people. Enabling autistic lives does not just mean improving social care or hospital settings, but also considering a wide range of environments and everyday places. The webinar will cover the findings and recommendations in the report, and help participants to consider sight, sound, smell, and touch when designing or commissioning spaces, focusing on how these differences might be considered within a housing environment, and also covering the challenges of shared spaces and other issues. The event will be helpful for council staff including commissioners of housing and care and support, as well as social work operational and NHS housing leads. This report was commissioned in 2020 from NDTI by the Care and Health Improvement programme and co-produced with a group of people with lived experience.

26/10/2021	Hearing the Young Person's Voice - Childhood Obesity Trailblazer workshop	CHIP	67	Much progress has been made within the five Trailblazer areas and more widely towards tackling childhood obesity at a local level. As part of the Trailblazer programme, action has targeted different parts of the system that play an influential role in the lives of children, young people and families: planning and development of cities, the nature of advertising and promotion of health messaging, and the influence of religious settings to name but a few. But how can we give children a real voice in work on childhood obesity? Through the Childhood Obesity Trailblazer Programme Learning Network, we have learned how valuable community engagement and co-production techniques have been in the development and delivery of interventions, both within the Trailblazer areas and more widely. This online workshop builds on work of some of the Trailblazers and brings children and young people into the conversation. The workshop will give attendees the opportunity to hear the voices of children and young people, to hear their views on the challenges they face with living healthily, what they feel can be done to help them live healthier lives and how they can best be involved in work such as this. This will be an interactive workshop where you will be able to ask the young people questions and discuss what the views you have heard mean for those undertaking action to tackle childhood obesity
24/11/2021 to 26/11/2021 Annual National Children and Adult Services Conference	NCASC WW2 Community mental health Framework	LGA	669	This year's virtual conference will offer the opportunity to hear from high profile ministerial and keynote speakers and to engage in interactive workshops on the current and future challenges. Sessions will include issues and priorities within children's and adult services at a strategic level, share innovation, and have participation from senior representatives in councils, partners and the crucial voice and perspective of those with lived experience wherever appropriate.
	NCASC WW4 Adult social care funding and reform: How can we turn aspiration into reality?	LGA		
	NCASC TW6 The 3Rs of social care reform	LGA		

(NCASC)	NCASC FW10 The national strategy for autistic children, young people and adults – what does it mean for local government?	LGA		
	NCASC FW12 Workforce capacity: embracing local solutions to a national challenge	LGA		
	NCASC Plenary 6: Living with COVID-19: working with partners – panel session	LGA		
27/10/2021	Learning Lunch: Reducing Preventable Admissions	CHIP	103	Our next Learning Lunch will be on Wednesday 27 October 2021 from 1pm to 2pm. Come and join us at our next Learning Lunch to hear from a system on their approach to keeping people well in the community, and to learn about the new High Impact Change Model the LGA have developed to support systems to reduce avoidable admissions.
01/11/2021 to 03/11/2021	Leadership Essentials	CHIP	18	Leadership essentials with a focus on public health
02/11/2021	ICS Webinar Series - ICP Guidance. Making sense of tackling health inequalities	CHIP	100	This webinar will focus on webinar will focus on making sense of tackling health inequalities and understand what questions that senior leaders should be asking of your own systems. It provides the opportunity to ask the expert panel questions, raise comments and concerns and highlight any l good practice.
16/11/2021	Webinar - Engagement through and with Emergency Department	CHIP	79	Following on from previous correspondence, here is your invitation to our webinar 'Engagement through and with Emergency Department teams: what works well?' as part of the webinar series for the Out of

	teams: what works well?			Hospital Care Models Programme.
25/11/2021	What makes a good SAR author and report?	CHIP	144	Drawing on the national SAR analysis, the quality markers, the experience of SAR authors, SAR sub-group and panel members, and SAB chairs, this webinar will begin to explore the components that comprise a good review process and outcome. It will include observations on what SAR authors can helpfully bring to the review process, and on report structures that enable lessons to be clearly identified and acted upon
30/11/2021	Implementing D2A - What you can do now to help you through winter	CHIP		Content not available/ closed or invitation-only session
30/11/2021	Webinar - Housing and Accommodation: maximising local opportunities and resources	CHIP		Accommodation issues and approaches to support hospital discharge
30/11/2021	Health inequalities and the impact of COVID-19 – Learning Disabilities	LGA	245	The Local Government Association has arranged this webinar to discuss Covid-19 risk factors and the evidence to date on inequalities impacting people with a learning disability. It will examine this as well as what steps councils can and are taking to reduce those inequalities.
07/12/2021	The role of Housing and the Disabled Facilities Grant in Hospital Discharge	CHIP	260	This webinar will explore the important role that housing partners play in hospital discharge and how Disabled Facilities Grants (part of the Better Care Fund) can be utilised to support hospital discharge pathways. Our speakers, including representatives from Foundations and the Better Care Fund Team, will discuss the latest data around discharge delays due to home adaptations and we'll hear good practice examples from around the country, demonstrating how Housing partners can collaborate with health and social care partners to support the discharge process.

08/12/2021	LGA Digital Support Programme Masterclass 1: Digital Benefits Realisation	CHIP	123	The LGA Care and Health Improvement Team are pleased to have launched a new Digital Support Offer for Councils. The programme will be delivered by Rethink Partners and co-produced with the sector. To support programme delivery, we have launched a digital resource centre to capture and share content, tools and other resources in one place. This is the first Masterclass session of a five-part series exploring the liberation of value from digital in adult social care. This session will take a deep dive into the complexity and variety of approaches to evaluating the impact of care technology - both in terms of financial benefits to councils and the positive impact on people's lives. We will share experiences of councils who are leading this agenda and seek to demystify how to compare "apples and pears" and how to develop your own approach locally.
08/12/2021	Learning Lunch: Working better together with the people we serve in health and social care systems	CHIP	97	Our next Learning Lunch will be on Wednesday 8 December 2021 from 1pm to 2pm. Please join us for a timely and challenging learning lunch at which we will have a presentation from communications agency, Claremont on the work they have done for Hackney Council on effective communication with people, patients and their families during the discharge process. We will also present some top tips on the Choice elements of the Discharge Policy which we have developed in partnership across the LGA, ADASS and NHSEI. This learning lunch is a timely and practical session with ideas and practical suggestions which you can implement now and which will help you to work better together with the people we serve in health and social care systems.

09/12/2021	The 3rd Covid-19 Adult Safeguarding Insight Project – Webinar	CHIP	123	This Webinar will present the findings and discussion from the 3rd round of information provided by local authorities on the impact of Covid-19 pandemic on safeguarding activity in England (up to June 2021). The Insight Project was developed to create a national picture regarding safeguarding adults' activity during the pandemic. The first report (Covid-19 Adult Safeguarding Insight Project: Findings and Discussion) provided a picture up until June 2020. The second report provided information up to December 2020. This third report covers the period up to June 2021. The Webinar will feature contributions from participants, sharing their experiences and insights regarding responding to the challenges presented by the pandemic, and how people have continued to be safeguarded.
14/12/2021	Webinar - Step-Down and Onwards Accommodation: good practice models and resources	CHIP	155	Following on from previous correspondence, here is your invitation to our webinar 'Step-Down and Onwards Accommodation: good practice models and resources' as part of the webinar series for the Out of Hospital Care Models Programme.
2022				
11/01/2022	Long COVID: emerging data and implications for health and care	LGA	428	Joined by a range of experts from across local and national government, including the Deputy Chief Medical Officer Dr Aidan Fowler, this webinar will explore what we know about Long Covid or Post Covid Syndrome. It will look at what the data is telling us, drawing from the latest ONS data on the prevalence of ongoing symptoms following Covid-19 infection in the UK. Panelists will also discuss the implications this has for a health and care sector that is already under a great deal of pressure.
11/01/2022	Webinar - Developing the evidence base	CHIP	139	Webinar 'Developing the evidence base' as part of the webinar series for the Out of Hospital Care Models Programme.

18/01/2022	Health inequalities: the impact of the pandemic on younger and older people	LGA	344	Age is a significant risk factor for Covid-19 mortality. The virus is having dramatically different effects on different generations. While older people are much more likely to get severely ill, younger people are taking a much worse economic hit. Their education and employment opportunities have been severely altered and curtailed.This webinar, the third in a series of webinars focused on health inequalities following the publication of the LGA's A Perfect Storm report, will explore the real impact of Covid-19 on both younger and older people.
18/01/2022	Webinar- Collaboration between Health, Housing and Social Care on complex cases	CHIP	160	This webinar explores the importance and opportunities for collaboration between housing, health and social care (in line with Better Care Fund objectives) that aim to improve outcomes for people with complex needs. Our speakers will include Dr Rachel Russell, Occupational Therapist and Senior Regional Adviser at Foundations, Susie Rabin, Head of Policy and Campaigns at MND Association and Stephen Archer, Principal Surveyor from Stevenage Borough Council. They will share how housing, health and social care have worked successfully together on complex cases to achieve the best solution for the service user and discuss opportunities for more collaborative working.
20/01/2022	LGA, ADASS, Skills for Care workforce bi-annual event	CHIP	35	discussion on workforce planning
24/01/2022	Safeguarding Adult Reviews - Assessing the Impact and Managing the Challenges of Embedding Learning	CHIP	189	A series of webinars will be offered to address the challenges expressed by Safeguarding Adult Boards regarding how to embed the learning from SARs, how to choose the right methodology from a range of possible options, and how to determine that findings and recommendations have led to policy changes. In this first webinar we will assess the impact of SARs and embedding learning in practice and managing the challenge of transformational change.

25/01/2022	Webinar - Discharge from acute mental health settings	CHIP	155	webinar 'Discharge from acute mental health settings' as part of the webinar series for the Out of Hospital Care Models Programme
26/01/2022	LGA Digital Support Programme Masterclass 2: Digital Culture Change	CHIP	171	The LGA Care and Health Improvement Team are pleased to have launched a new Digital Support Offer for Councils. The programme will be delivered by Rethink Partners and co-produced with the sector. To support programme delivery, we have launched a digital resource centre to capture and share content, tools and other resources in one place. This is the second masterclass session of a five-part series exploring the liberation of value from digital in adult social care. Too often when organisations think about technology they forget the people – staff, leaders, partners, residents, families. If they don't learn to use, trust and love the technology in their lives then no one will feel the benefit. Join us to hear about how to get hold of changing culture – in adult social care and beyond – so that technology can be used to the full to improve lives. To learn more, join us on 26 January at 10-11.30am

26/01/2022	Better Lives Framework Webinar	CHIP	369	Supporting adults with a learning disability to have better lives framework webinar - launch and introductory session. This webinar will tell you more about the Supporting adults with a learning disability to have better lives framework. This free webinar is designed for Directors of Adult Social Services, council staff working with people with a learning disability, health staff and others with an interest in services for people with a learning disability. This outcomes and improvement framework was commissioned by the Local Government Association (LGA) and the Association of Directors of Adult Services (ADASS) from Alder Advice working with a steering group including sector led improvement staff, a Director of Adult Social Services (DASS), experienced staff from the learning disability sector and a representative of family carers of people with a learning disability. The aim of the Supporting adults with a learning disability to have better lives framework is to help DASS work with their colleagues and partners to identify how they can improve their support to adults with a learning disability and how they can be assured that the care and support in their area is delivering positive outcomes and is good value for money. Councils or regions can independently self-evaluate their support for adults with a learning disability against the framework. CHIP has developed survey tools and a data template to assist councils in carrying out a self-assessment. This approach helps councils to reflect on current system service delivery before developing a transformation action plan. The framework is aimed at addressing services for adults with a learning disability and young people preparing for adulthood. This includes autistic people who also have a learning disability. It does not include autistic people without a learning disability, as they are

				likely to have different needs.

26/01/2022	Learning Lunch 26th January	CHIP	113	We are delighted to have the team from Wakefield and North Yorkshire NHS Trust and the Local Care Providers talking to us about how they are working together to deliver the new Discharge Policy – in particular how they progress projects and troubleshoot together on a weekly basis creating a true health and care partnership approach. We are also pleased to be joined by colleagues from Devon, Torbay and Cornwall talking about how they are integrating Personal Health and Social care budgets and a strength based approach into their Home First /D2A work. These sessions are all about learning together and sharing best practice, whilst hopefully you get an opportunity to grab some lunch and listen.
31/01/2022	Making sense of the value of using the Relational Audit Survey	CHIP	14	The LGA, NHSEI and NHSX are collaborating on webinars to support ICSs and Places participating in the ICS Population Health and Place Development Programme. For Place leaders across the local partner organisations, the first webinar will focus on making sense of the quick and easy Relational Audit Survey. Creators of the Survey, Whole Systems Partnership, will discuss how it works and the valuable insight it provides on the quality of relationships and the culture at Place and answer your questions. We look forward to you joining us.

08/02/2022	Health and Care Partnership Working	CHIP	105	This Health and Care Partnership Working: Joint Commissioning and System Working in Crisis and Going Forward webinar will examine the common success factors behind, and share examples of, effective whole system partnership working and joint commissioning between health and social care. It will view this topic through the lens of: the current staffing and Covid-19 related challenges and the future vision for joint commissioning. Speakers from a range of councils and ICS's will cover the following: Key principals of partnership working between health and LA commissioning teams How a system can work together in crisis – what did you put in place + what have you learnt. The vision and landscape for health and social care joint commissioning and integration. This webinar will feature Q+As and a panel discussion with each presenter. It will be chaired by Hazel Summers, Care and Health Improvement Adviser for the North West Region.
09/02/2022	COVID-19 vaccination and your community webinar	CHIP		Content not available / closed or invitation-only session
10/02/2022	Climate crisis, health and prosperity: Aligning policy and action for an inclusive and sustainable economy	LGA	361	In this session we will explore how in England we can address the climate crisis in a way which facilitates an inclusive and sustainable economy as well as health and wellbeing for all. With a panel of experts we will explore key actions that local government, the NHS, industry and communities can take to achieve this including opportunities for partnership and alignment.
11/02/2022	Health Inequalities report – The Unequal Pandemic	LGA	420	In this webinar Professor Clare Bambra will share the findings of her recent co-authored book ''The Unequal Pandemic: Covid-19 and Health Inequalities'. In her talk, she will outline how the pandemic is unequal in three ways: it has killed unequally, been experienced unequally and will impoverish unequally. Professor Bambra will be

				joined by a range of speakers from across the sector.
15/02/2022	Health inequalities: the impact of the pandemic on mental health	LGA	459	Working across local government and with partners in the voluntary sector there is a great deal that can be done to meet these challenges head on. Up and down the country councils have recognised the potential of a mental health crisis and stepped up in a number of ways to provide support. This Government funded webinar, the fourth in a series of webinars focused on health inequalities following the publication of the LGA's A Perfect Storm report, will explore the real impact of Covid-19 on mental health and what councils can do to best respond to these challenges.
22/02/2022	Applying behaviour change techniques to the climate emergency, sustainable travel and health inequalities	LGA	978	This webinar will look at how we can use behavioural change techniques in our council services to work with communities and change their behaviour. It will feature councils who have used behavioural change techniques to tackle the biggest challenges of our day – climate emergency and health inequalities and will also look at how the LGA is taking a regional approach in supporting councils to run behaviour change projects to combat these challenges.

23/02/2022	LGA Digital Support Programme Masterclass 3: Digital Discharge	CHIP	128	The LGA Care and Health Improvement Team are pleased to have launched a new Digital Support Offer for Councils. The programme will be delivered by Rethink Partners and co-produced with the sector. To support programme delivery, we have launched a digital resource centre to capture and share content, tools and other resources in one place. This is the third masterclass session of a five-part series exploring the liberation of value from digital in adult social care. The pressure on hospitals has never been greater than now – and stretched capacity in the care market is adding to the challenge. Join us to hear how other councils are using technology to make discharge smoother, safer, timely and as a key moment to bring care technology into people's lives when they might need extra help to recover and regain independence. Reablement services, care providers, NHS partners and voluntary sector all feature in this complex landscape – a real test for collaboration and partnership working.
24/02/2022	The 3rd Covid-19 Adult Safeguarding Insight Project	CHIP	103	This Webinar will present the findings and discussion from the 3rd round of information provided by local authorities on the impact of Covid-19 pandemic on safeguarding activity in England (up to June 2021). The Insight Project was developed to create a national picture regarding safeguarding adults' activity during the pandemic. The first report (Covid-19 Adult Safeguarding Insight Project: Findings and Discussion) provided a picture up until June 2020. The second report provided information up to December 2020. This third report covers the period up to June 2021. The Webinar will feature contributions from participants, sharing their experiences and insights regarding responding to the challenges presented by the pandemic, and how people have continued to be

				safeguarded.
28/02/2022	Safeguarding Adult Review – Embedded Learning and Choice of Methodologies	CHIP	171	This webinar will continue the theme of embedding learning from Safeguarding Adult Reviews, with a presentation by Abigail McGarry and Walter Lloyd-Smith (Norfolk Learning Framework). The webinar will also open up a second theme, namely how Safeguarding Adult Boards might select from the different methodologies available for Safeguarding Adult reviews. Betty Lynch will give a presentation on this theme (Safeguarding Adult Review – a model from Slough).
28/02/2022	Adult Safeguarding & Homelessness Webinar	CHIP	211	This is the first of a series of webinars designed to focus on safeguarding people experiencing homelessness. This webinar will focus on identifying the risks and supporting young people experiencing homelessness. It will open a theme that will run through all three webinars, namely learning from people with lived experience. Here the focus will be on involving people with lived experience in evaluation of services in Oxfordshire. The webinar will also open a theme on social work's contribution to counteracting homelessness. Finally, the webinar will also provide an update on Safeguarding Adult Reviews where homelessness has been a significant component.

28/02/2022	Liberty Protection Safeguards Webinar - East Midlands	CHIP	18	Regional Introductory Q&A Sessions Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the East Midlands local government introductory Q&A session with your questions. These regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel. Q&A Sessions for those planning LPS implementation Are you supporting your council with their planning for LPS implementation? Do you have questions on how it's going to work? Come along to one of our local government Q&A sessions for those planning LPS implementation. There will be a short input on the proposed scheme and then an opportunity to put your questions to a panel. The Teams Live sessions will be held on: If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk

28/02/2022	Liberty Protection Safeguards Webinar - West Midlands	CHIP	52	Regional Introductory Q&A Sessions Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the local government introductory Q&A session with your questions. These regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel. Q&A Sessions for those planning LPS implementation Are you supporting your council with their planning for LPS implementation? Do you have questions on how it's going to work? Come along to one of our local government Q&A sessions for those planning LPS implementation. There will be a short input on the proposed scheme and then an opportunity to put your questions to a panel. If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk

28/02/2022	Liberty Protection Safeguards Webinar - South West Region	CHIP	7	Regional Introductory Q&A Sessions Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the South West Region local government introductory Q&A session with your questions. These regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel. Q&A Sessions for those planning LPS implementation Are you supporting your council with their planning for LPS implementation? Do you have questions on how it's going to work? Come along to one of our local government Q&A sessions for those planning LPS implementation. There will be a short input on the proposed scheme and then an opportunity to put your questions to a panel. If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk

28/02/2022	Liberty Protection Safeguards Webinar - Question & Answer Sessions	CHIP	1131	Regional Introductory Q&A Sessions Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the local government introductory Q&A session with your questions. These regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel. Q&A Sessions for those planning LPS implementation Are you supporting your council with their planning for LPS implementation? Do you have questions on how it's going to work? Come along to one of our local government Q&A sessions for those planning LPS implementation. There will be a short input on the proposed scheme and then an opportunity to put your questions to a panel. If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk

01/03/2022	Carers and Safeguarding Briefing Note: A Resource for People Working with Carers	CHIP	179	Across the UK today an estimated 6.6 million people are carers and increasing numbers of us have carer roles to a greater or lesser extent in our personal lives. Carers make a huge contribution to the lives of the people in the UK they support, and to the communities around them. However, carers need access to practical and emotional support to enable them to provide good and safe care, as well as looking after their own wellbeing. There are concerns about the increased stress and risks posed for unpaid carers as a result of the Covid 19 pandemic. There has been a significant increase in the numbers of new unpaid carers during the pandemic who have taken up caring roles during the lockdowns. For existing carers, many have had to provide additional care, with reduced day and short breaks services This webinar will launch a new briefing note for people working with carers. The briefing note has been developed in co-production with carers and practitioners, with the aim of producing a document for practice which is useful, concise and accessible but, most importantly, which reflects and respects the lived experience of carers. The webinar will have an introduction from Dr. Adi Cooper, followed by contributions from Carers UK and practitioners from Cheshire East Council (one of the quoted good practice examples in the document) and chaired by the author of the briefing note, Teresa Bell, Independent Chair of Safeguarding Adults Boards.

02/03/2022	Learning Lunch 2nd March	CHIP	46	Join us for our next Learning Lunch, where Sarah Mitchell will lead a discussion on how relationships and joint working have changed, and mostly improved, over the past two years. Sarah will share learning drawn from the Care and Health Improvement Programme's support work with leadership teams, and health and care systems over the pandemic, along with leaders from two systems reflecting on how their ways of working have changed for the better. These sessions are all about learning together and sharing best practice, whilst hopefully you get an opportunity to grab some lunch and listen. We look forward to you joining us.
07/03/2022	Liberty Protection Safeguards Webinar - North East Region	CHIP	43	Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the North East regions local government introductory Q&A session with your questions. These regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk
07/03/2022	Liberty Protection Safeguards Webinar - Eastern Region	CHIP	6	Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the Eastern Region local government introductory Q&A session with your questions. These regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel. This is a free Teams Live Event.

				If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk
07/03/2022	Liberty Protection Safeguards Webinar - Yorkshire and Humber	CHIP	21	Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the Yorkshire & Humber local government introductory Q&A session with your questions. The regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel This is a free Teams Live Event If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk

08/03/2022	How the Effective use of Information and Intelligence Enables Successful Commissioning	CHIP	156	The Care and Health Improvement Programme are delivering a programme of events where a wide range of experts will share their knowledge about different topics related to market viability and market shaping. Previous events have focused on 'Effective commissioning relationships', 'Joint Commissioning and the 'Legal and Regulatory Framework for ASC Commissioning' and in total have seen over 250 commissioners and local government colleagues join. The latest in this series focused on the role of information and intelligence within adult social care commissioning. It is crucial that social care commissioners can access, analysis and utilise accurate and relevant information and intelligence about their local communities, markets and individuals. The session will feature examples from councils that have utilised intelligence to support their strategic commissioning approach and taken an innovative approach to doing so. They will talk about the learning and benefits of utilising intelligence within commissioning as well as how they dealt with barriers and challenges when doing so, both internally and externally. This will include Bristol City Council work on their alongside their development partner, Itelligent-i. This webinar will also introduce CHIP's upcoming Commissioning Intelligence Framework, hosted on the LG Inform platform, which will support commissioners and strategic decision makers to review data from their local area, understand the state of their population and care market and contrast this nationally and regionally and to use this intelligence to help reflect on the effectiveness and impact of current commissioning arrangements.

09/03/2022	LGA Digital Support Programme Masterclass 4: Digital Access for All	CHIP	127	The LGA Care and Health Improvement Team are pleased to have launched a new Digital Support Offer for Councils. The programme will be delivered by Rethink Partners and co-produced with the sector. To support programme delivery, we have launched a digital resource centre to capture and share content, tools and other resources in one place. This is the fourth masterclass session of a five-part series exploring the liberation of value from digital in adult social care. When we consider the application of digital to enhance the lives of the people we support are we also considering all the barriers to this – the seen and the unseen? How does digital bias influence the decisions we make and how do we really place individuals at the heart of our considerations? Assumptions are easy to make and in this session, with the help of Lincolnshire County Council, we help you to question these and to explore how to get under the bonnet of the data that is available and truly understand what your staff, providers, partners and individuals requiring support actually need. Join us at 10-11:30am on 9 March to learn more. Details for the final masterclass session are below: Masterclass 5: Working with the Care Market

14/03/2022	Safeguarding Adult Review - Quality Markers Launch	CHIP	212	This is the third in a series of webinars that aim to demonstrate how progress is being made in responding to the recommendations set out in the National Safeguarding Adult Review Analysis. The SAR Quality Markers are a national resource to support everyone involved in commissioning, conducting and quality assuring SARs. SCIE has refreshed the Quality Markers in light of feedback from people using them, the SAR national analysis and developing practice. In addition, two new Quality Markers have been added: Quality Marker 14 Publication and dissemination and Quality Marker 15: Improvement Action and Evaluation of Impact. This webinar will launch the refreshed resources. Join us to hear details of additional support to help you embed the SAR Quality Markers and hear from speakers on experiences of using them. The launch marks the start of a new cycle of on-going development of the SAR Quality Markers. A schedule for feedback and review will also be shared.
14/03/2022	Liberty Protection Safeguards Webinar - London	CHIP	78	Regional Introductory Q&A Sessions Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the London local government introductory Q&A session with your questions. The regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel. If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk

14/03/2022	Liberty Protection Safeguards Webinar - National LPS Session 1	CHIP	36	Q&A Sessions for those planning LPS implementation Are you supporting your council with their planning for LPS implementation? Do you have questions on how it's going to work? Come along to our National LPS Session 1 local government Q&A sessions for those planning LPS implementation. There will be a short input on the proposed scheme and then an opportunity to put your questions to a panel. This is a free Teams Live Event. If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk
14/03/2022	Liberty Protection Safeguards Webinar - North West Region	CHIP	40	Regional Introductory Q&A Sessions Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the North West regions local government introductory Q&A session with your questions. This regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk
14/03/2022	Adult Safeguarding & Homelessness Webinar - 2	CHIP	36	As part of the adult safeguarding and homelessness series, this second webinar will continue to examine the role of social workers in working with people experiencing homelessness. There will be a focus on taking a gender-informed approach to women's homelessness and challenging conventional assumptions about homelessness. Finally, on the theme of learning from people with lived experience, a presentation will challenge commonly held assumptions.

23/03/2022	LGA Digital Support Programme Masterclass 5: Working with the Care Market	CHIP	132	The LGA Care and Health Improvement Team are pleased to have launched a new Digital Support Offer for Councils. The programme will be delivered by Rethink Partners and co-produced with the sector. To support programme delivery, we have launched a digital resource centre to capture and share content, tools and other resources in one place. This is the final masterclass session of a five-part series exploring the liberation of value from digital in adult social care. Many councils and ICS's are recognising the opportunity and imperative of working differently with care providers on the digital agenda – including care technology. Covid-19 saw some real shifts but there is much more to do. The opportunities for real benefits for providers and their customers are significant – but there are many barriers and challenges in this work: culture, risk, funding, skills, priorities. This is the next frontier for digital and care technology. Join us to hear how councils from the West Midlands have been working with different parts of the care market in different ways – to really try to make a difference to people's lives and to support our partners in the care market. Join us at 10-11:30am on 23 March to learn more.
24/03/2022	Liberty Protection Safeguards Webinar - South East Region	CHIP	146	Regional Introductory Q&A Sessions Are you a front-line worker in council Children's Services or Adult Social Care? Are you new to LPS? Want to learn more? Come along to the South East region local government introductory Q&A session with your questions. These regional Q&A sessions will provide a short input on the proposed scheme and then an opportunity to put your questions to a panel. If you have any questions for the panel or require further information on specific topics you wish to cover within these sessions, please email: chip@local.gov.uk

24/03/2022	Liberty Protection Safeguards Webinar - National LPS Session 2	CHIP	84	Q&A Sessions for those planning LPS implementation Are you supporting your council with their planning for LPS implementation? Do you have questions on how it's going to work? Come along to one of our National LPS Session 2 local government Q&A session for those planning LPS implementation. There will be a short input on the proposed scheme and then an opportunity to put your questions to a panel.
07/04/2022	Home Care Cost of Care Toolkit Demonstration and Q+A - Session 1	CHIP	83	This session, led by the Care and Health Improvement Programme, will provide councils and commissioning teams with a practical demonstration of the Homecare Cost of Care Toolkit which gives greater insight into how the tool operates and what is required to complete it. The second half of the session will give colleagues the opportunity to raise any questions or concerns that they have with the toolkit. The session will feature colleagues from ARCC HR Ltd, who developed the tool and provided the license for use alongside CHIP. The toolkit has been developed to support councils to conduct cost of care exercises for home care, in partnership with their local providers, which under the conditions of the Market Sustainability and Fair Cost of Care Fund, all councils must complete by September 2022. These webinars are the first element of a support offer that councils can access to help with their work on cost of care and to meet the DHSC funding conditions. We are keen to hear your views on the support that would be most useful to you (and your local home care providers).

12/04/2022	Home Care Cost of Care Toolkit Demonstration and Q+A - Session 2	CHIP	97	This session, led by the Care and Health Improvement Programme, will provide councils and commissioning teams with a practical demonstration of the Homecare Cost of Care Toolkit which gives greater insight into how the tool operates and what is required to complete it. The second half of the session will give colleagues the opportunity to raise any questions or concerns that they have with the toolkit. The session will feature colleagues from ARCC HR Ltd, who developed the tool and provided the license for use alongside CHIP. The toolkit has been developed to support councils to conduct cost of care exercises for home care, in partnership with their local providers, which under the conditions of the Market Sustainability and Fair Cost of Care Fund, all councils must complete by September 2022. These webinars are the first element of a support offer that councils can access to help with their work on cost of care and to meet the DHSC funding conditions. We are keen to hear your views on the support that would be most useful to you (and your local home care providers).
20/04/2022	Home Care Cost of Care Toolkit Demonstration and Q+A - Session 3	CHIP	123	This session, led by the Care and Health Improvement Programme, will provide councils and commissioning teams with a practical demonstration of the Homecare Cost of Care Toolkit which gives greater insight into how the tool operates and what is required to complete it. The second half of the session will give colleagues the opportunity to raise any questions or concerns that they have with the toolkit. The session will feature colleagues from ARCC HR Ltd, who developed the tool and provided the license for use alongside CHIP. The toolkit has been developed to support councils to conduct cost of care exercises for home care, in partnership with their local providers, which under the conditions of the Market Sustainability and Fair Cost of Care Fund, all councils must complete by September 2022. These webinars are the first element of a support offer that councils can access to help with their work on cost of care and to meet the DHSC funding conditions. We are keen to hear your views on the support that would be most useful to you (and your local home care

				providers).
22/04/2022	System leaders innovation event	CHIP		strategic workforce planning
25/04/2022	Adult Safeguarding & Homelessness Webinar - Session 3	CHIP	138	In the third of the Adult Safeguarding and Homelessness series, we will explore multiple exclusion homelessness through the lens of trauma and, continuing the theme of learning from people with lived experience, there will be an extended presentation on using the arts as a means of co-production of strategies and services for preventing and counteracting homelessness.
25/04/2022	Care Provider Home Care Cost of Care Toolkit Demonstration and Q+A - Session 1	CHIP	156	This session, led by the Care and Health Improvement Programme, will provide care providers with a practical demonstration of the Homecare Cost of Care Toolkit which will give greater insight into how the tool operates and what is required to complete it. The second half of the session will give providers the opportunity to raise any questions or concerns that they have with the toolkit. The session will feature colleagues from ARCC HR Ltd, who developed the tool and provided the license for use alongside CHIP. These sessions are the first element of a support offer that care providers and councils can access to help with their work on cost of care and to meet the DHSC requirements for Cost of Care Exercises. We are keen to hear your views on the support that would be most

				useful to you.
04/05/2022	Learning Lunch 4th May	CHIP	241	Please join us to hear about the work which has been developing in the Midlands Region: Rehabilitation, Reablement and Recovery – designing a model to get the best outcomes for the people we serve, presented by Dr Ian Sturgess. This webinar will discuss how the Midlands Region have been developing a model for the future. Dr Sturgess brings a wealth of experience from working in this field in both the UK and abroad. His people-centred approach has helped to broaden thinking within the sector. This session will be chaired by NR Care and Health Improvement Advisor in the LGA's Care and Health Improvement Programme. NR the Care and Health Improvement Advisor, will introduce the Midland's work, which has been a real partnership between the NHS and Local Government.
11/05/2022	Understanding health and care reforms	LGA	544	This webinar will look at how we can use behavioural change techniques in our council services to work with communities and change their behaviour. It will feature councils who have used behavioural change techniques to tackle the biggest challenges of our day – climate emergency and health inequalities and will also

				look at how the LGA is taking a regional approach in supporting councils to run behaviour change projects to combat these challenges.
11/05/2022	Care Provider Home Care Cost of Care Toolkit Demonstration and Q+A - Session 2	CHIP	378	This session, led by the Care and Health Improvement Programme, will provide care providers with a practical demonstration of the Homecare Cost of Care Toolkit which will give greater insight into how the tool operates and what is required to complete it. The second half of the session will give providers the opportunity to raise any questions or concerns that they have with the toolkit. The session will feature colleagues from ARCC HR Ltd, who developed the tool and provided the license for use alongside CHIP. These sessions are the first element of a support offer that care providers and councils can access to help with their work on cost of care and to meet the DHSC requirements for Cost of Care Exercises. We are keen to hear your views on the support that would be most useful to you.
11/05/2022	Childhood Obesity Trailblazer: Sustaining the test and learn approach	CHIP	45	At the heart of the Childhood Obesity Trailblazer Programme (COTP) has been the Test and Learn ethos. It is an important principle of the programme which is intended to create a space in which councils and their partners are able to test innovative approaches in the knowledge that not all of them will succeed and that there is valuable learning from this. As the COTP reaches the end of its third and final year, and the end of its funding period, the topic of focus has not only been on how local action against Childhood Obesity can be sustained, but also how this test and learn approach can be sustained. So what lessons can the Trailblazers share about this? And what experiences and insights can you contribute to this conversation that can help the Trailblazers and other authorities and partnerships embed and continue this approach in their work?

				This webinar will be a conversation between Trailblazer representatives and colleagues across the public health sector. We encourage your contributions and active participation in the conversation
12/05/2022	CHIP - Autism strategy one year on	LGA	331	At a time of significant and complex change across health and social care, this webinar will convene expert speakers to outline the main proposals for reform, piece them together into a coherent whole, and draw out the key themes running through them. It will focus on the opportunities and implications for local government in the Health and Care Bill, the adult social care white paper, the Build Back Better Plan, the integration white paper and the forthcoming health disparities white paper. It will be of particular interest to senior policy makers in local government, the NHS and national policy organisations.
17/05/2022	Addressing the leading risk factors for ill-health	LGA	136	A healthy population is a national asset. Yet even prior to the pandemic, gains in life expectancy had stalled and inequalities were widening. Grace Everest (Policy Fellow, The Health Foundation) will explore the findings of her report “Addressing the leading risk factors for ill health” and point towards future policy priorities to truly level-up health.

19/05/2022	Care Provider Home Care Cost of Care Toolkit Demonstration and Q+A - Session 3	CHIP	353	This session, led by the Care and Health Improvement Programme, will provide care providers with a practical demonstration of the Homecare Cost of Care Toolkit which will give greater insight into how the tool operates and what is required to complete it. The second half of the session will give providers the opportunity to raise any questions or concerns that they have with the toolkit. The session will feature colleagues from ARCC HR Ltd, who developed the tool and provided the license for use alongside CHIP. These sessions are the first element of a support offer that care providers and councils can access to help with their work on cost of care and to meet the DHSC requirements for Cost of Care Exercises. We are keen to hear your views on the support that would be most useful to you.
24/05/2022	Quarantine Hotels and International Travel	CHIP	200	Webinar for Chief Executives. Topic, Quarantine Hotels and International Travel
06/06/2022	LPS – Focus on the Consultation Sessions	CHIP	25	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation.
07/06/2022	Learning Lunch 7 June 2022	CHIP	270	Our next Learning Lunch will be on Tuesday 7 June 2022 from 1pm to 2pm. Come and join us at our next Learning Lunch to hear from Professor John Bolton on reablement and rehabilitation as part of a reablement strategy.
08/06/2022	Community Mental Health Framework	LGA	205	This webinar will provide a detailed outline of the new Community Mental Health Framework and demonstrate how it is being implemented in local areas. It will highlight the importance of elected members in promoting good community mental health services in their local areas. Speakers will include NHSE, Rethink and the

				Association of Mental Health Providers.
09/06/2022	LPS – Focus on the Consultation Sessions	CHIP	19	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation
10/06/2022	Workforce wellbeing: focus on… mental health after COVID-19 (1 of 5)	LGA	162	This is the first in our series of our roundtable events giving workforce wellbeing leads an opportunity to get together and share their successes and brainstorm challenges in their work. Join our interactive event to discuss how we can support our employees' mental health as we deal with the impact of a global pandemic and transition to living and working with Covid.
13/06/2022	LPS – Focus on the Consultation Sessions	CHIP	17	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation

13/06/2022	Safeguarding Adult Review and Discriminatory Abuse	CHIP	217	Discriminatory Abuse refers to any form of abuse of neglect in adult safeguarding that is underpinned by prejudice and may affect adults who have care and support needs and additional protected characteristics. Although it is rarely reported in safeguarding enquiry practice or safeguarding adult reviews (SARs), several SARs outline scenarios that correlate with discriminatory abuse. Karl Mason's (Lecturer in Social Work at Royal Holloway, University of London) presentation will provide an overview of findings from a review of SARs and will recommend that the language of discriminatory abuse may help to explore the particular dynamics of prejudice experienced by those who have been affected. Margaret Flynn (Chair of the National Mental Capacity Forum) will draw from adult reviews and consider "discriminatory selection," that is, the selection of a victim because of their membership of a particular group. The nature of the injuries sustained by the victim, the palpable harm inflicted on the broader target community and the harm to society at large will be considered. She will question the adequacy of "learning lessons" as a response to discriminatory abuse." We know from data that discriminatory abuse has continued to be the lowest reported category of abuse (proportionately). We also know from the National Analysis of Safeguarding Adults Reviews (SAR) April 2017 – March 2019 of the links to protected characteristics, and the suggested improvements needed, both for SARs and for practice. There is an essential role for Safeguarding Adult Boards (SABs) to play in ‘knowing the discriminatory abuse picture’ for their area. Heidi Gibson's (Durham Safeguarding Adults Partnership - Business Manager) presentation aims to share some of the work of the Durham Safeguarding Adults Partnership in gaining that understanding and identifying gaps or areas for improvement.

14/06/2022	Discriminatory Abuse Roundtable for SAB Chairs and Managers	CHIP	63	The Care and Health Improvement Programme would like to invite Safeguarding Adult Board Chairs and Managers to focus on important issues surrounding discriminatory abuse on the 14th of July 2022 (between 2:00 and 4:00pm) particularly how we: • share strategic approaches and operational improvements to better report/understand discriminatory abuse; • build shared understandings of discriminatory abuse; • share good practice/strategic approaches/structures; • understand barriers to recognition, naming and reporting discriminatory abuse and/or • build relationships, discuss and act on discriminatory abuse with partner agencies/departments (such as the Police/Community Safety for example)
16/06/2022	LPS – Focus on the Consultation Sessions	CHIP	23	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation
23/06/2022	LPS – Focus on the Consultation Sessions	CHIP	27	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation
24/06/2022	LPS – Focus on the Consultation Sessions	CHIP	14	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation

27/06/2022	LPS – Focus on the Consultation Sessions	CHIP	83	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation
29/06/2022	Fair Cost of Care Exercises: Provider Engagement	CHIP	127	This session is aimed at council commissioners, ASC finance teams and any colleagues within councils involved in fair cost of care exercises. Any third-party organisations that have been commissioned by councils to support these exercises are also welcome to attend. The session aims to provide a variety of information and support, from different perspectives, in relation to provider engagement in fair cost of care exercises. There are 4 parts to the session: CHIP perspective – Sharing information about the DHSC grant funding conditions and the expectations on councils in relation to provider engagement and sharing experience and best practice from across the country Provider perspective - Representative from the Care Provider Alliance talking about the message they are giving to providers to encourage their participation and the challenges and issues being raised by providers and how these can be overcome. Home Care Cost of Care Tool developer perspective – Sharing their experience of running cost of care exercises (in the past and at present), their views on the practicalities of provider involvement, advice on how councils can maximise provider engagement and the sector wide benefits cost of care exercises can deliver. Q and A and wider discussion – The second half of the session will be an opportunity for attendees to share their questions and for the Panel to respond with their thoughts and advice.

30/06/2022	LPS – Focus on the Consultation Sessions	CHIP	95	DHSC and MoJ have now launched the long-awaited public consultation on the Liberty Protection Safeguards. DHSC has published a further newsletter (see here), which includes a link to the consultation webpage and can be shared widely to publicise the consultation. This webinar series was a chance for Q and A on the consultation
30/06/2022	Home Care Cost of Care Tool Drop-In Session 1	CHIP	77	This session is aimed at supporting care providers to complete the Home Care Cost of Care Toolkit It will consist of the tool developers talking through some of the key issues and questions they have received regarding the Home Care Tool and enabling providers ask any questions they have also. Recordings of these sessions will be made available. The topics addressed will include: Accounting for Agency pay & enhancements Adapting the model for different service types Understanding the impact of rurality / geography on cost Understanding the impact of varying visit times on cost In the meantime, please check out the Home Care Tool Helpdesk FAQs and Home Care Tool Demonstrations
	Roughly 180 events, webinars and conferences	**LGA/CHIP**	**32,653**	

Appendix 4 – Case studies

LGA Case Studies: Public health on the frontline - responding to Covid-19

In a series of interviews, directors of public health from across the country talk about the local response to Covid-19. Below are a series of extracts from interviews, relating to the scope of Module 6.

1) Interview with Professor Dominic Harrison, former Director of Public Health, Blackburn with Darwen Borough Council

Published 23 December 2021

"There have been some really frustrating moments," said Professor Harrison, who retires in April. "Government policy and its response to Covid-19 has been very centralised and the result has been damaging for areas like mine. What may appear nationally to be a sensible decision can have very different results in some areas compared to others. That has been particularly felt in Blackburn with Darwen – and has simply widened inequalities." (**Exhibit JK4/206 – INQ000581288**)

2) Interview with Professor Eugene Milne, Newcastle City Council Director of Public Health

Published 7 May 2020

Professor Milne says the issue that is causing him most concern at the moment is how to protect those in care homes. "They have a very high number of high-risk individuals. It is taking up a lot of my thinking.

"We have outbreaks at more than 20 homes – about 40% of the total in the city. It is very troubling. We are trying to coordinate an approach across a lot of different partners to improve the way they are shielded from the virus."

He is particularly concerned about the limitations with testing.

"There are basically four main reasons to do testing: one is clinical diagnosis – so we know how best to treat the patient and whether a patient is suffering Covid-19 or something else; then there is screening to detect new cases control outbreaks; thirdly, to allow people back to work; and finally for surveillance, to see what is circulating in the community.

"I am most concerned with the second of those – the potential for testing to find cases when they are asymptomatic but spreading virus."

'We need to test staff without symptoms'

He said he was struck by research published in the journal Nature Medicine that suggested close to half of infections were passed on by pre-symptomatic or asymptomatic patients. "I would like to test care home staff who are not showing symptoms – I think it is only through that that we will be able to bring outbreaks under control and potentially stop them happening in the first place. But the national guidance at the moment says we can't test people without symptoms."

There are other steps that are being taken to protect care home residents. "Care homes are 'cohorting' to keep residents apart and we are doing our best to ensure there are sufficient stocks of PPE – that has been a skin-of-the-teeth operation at times.

"The guidance changed just before Easter – more equipment was needed for those working in the community. It made it very hard.

"We are also using step-down facilities so when patients are discharged from hospital they can isolate for an appropriate period.

"There is a fear that patients coming out of hospital are bringing the virus into care homes. I am not sure how often that is true – but by using step-down facilities we can give people some confidence and guard against infections acquired in hospital. I think staff passing on the virus unwittingly is a bigger issue – and that is why I would want to do asymptomatic staff testing."

Regionally the North East is trying to bring more coordination to the testing regime. There are three local resilience forums across the regions that are working together with the local hospitals.

"The approach to testing nationally has not been very coherent. We are not using the full capacity that is there. We have Public Health England, hospital labs and a drive-thru facility at IKEA in Newcastle. We are trying to get a grip on it across the region." (**Exhibit JK4/207 – INQ000581369**)

3) Interview with Professor Jim McManus, Hertfordshire County Council Director of Public Health

Published 7 May 2020

Professor McManus said his team have been working hard to develop guidance, briefings and support for local services and people. Webinars have been run and project managers

despatched to work with individual council departments, as well as providing technical and public health leadership across over 25 workstreams from care homes to modelling numbers of people likely to die.

A toolkit was developed for enabling the district councils, police and partners to use the new and existing public health powers, including sharing lawyers and paperwork. Meanwhile, a dedicated plan aimed at cocooning fire-fighters was drawn up early, which was intended to stop the infection getting to them and protect service capability as much as possible. (**Exhibit JK4/208 – INQ000492913**)

4) Interview with Colin Cox, Director of Public Health, Cumbria County Council

Published 22 June 2020

Mr Cox said he is pleased that local government is now being involved more. "In the early days, we were really struggling to get information from national bodies like NHS England. They were saying they could not give us details about deaths, when locally we knew people had died. An over-centralised approach has been a bit of a hallmark of the national response.

"That all changed in May. We were told local government was going to be in charge locally. The problem was that this announcement came after the government had already eased restrictions. It would have been better to have the local outbreak management plans and Test and Trace in place before lockdown was relaxed. It was back-to-front really.

"But it is too easy to be critical when you are in the middle of a pandemic like this. We need to learn quickly, but let's avoid throwing blame around at this point. I am sure there will be an inquiry in the future that will quite rightly ask questions about whether things could have been done better. For example, whether planning for restarting contact tracing at scale started early enough."

The lack of involvement of councils in the early days meant Cumbria has had to look at ways to navigate the challenges through local workarounds. This has involved working with local hospital trusts to provide wider access to testing in the early days.

"Care homes have been a significant concern – at one point we had as many as 30 homes at one time with at least one confirmed case. We put in place an outbreak control team to provide advice and support to them, including offering testing of all residents through local swabbing teams and labs. This meant we were doing whole-home testing before it was introduced nationally. (**Exhibit JK4/209 – INQ000581368**)

5) Interview with Jason Strelitz, Director of Public Health, Newham Council

Published 22 June 2020

Like many areas, care home outbreaks have proved challenging. But Newham has begun to get on top of them by using social care facilities and a community hospital to provide intermediate step-down facilities.

The council was also able to offer whole care home testing ahead of the national roll-out by working with the local GPs and the hospital trust. I&S

Meanwhile, Newham was able to support the sector on PPE thanks to the work done by one of the public health consultants working hand-in-hand with a procurement team who worked together to buy in supplies – and Newham now has enough equipment to last few months.

Mr Strelitz said: "I think we have learnt a lot in this period. We have not seen any outbreaks in care homes for a number of weeks. I think we understand better now how to work together to protect them now.

"But, of course, our future success depends on keeping the virus at bay. If there is a lot of virus circulating in the community, it becomes harder to protect care homes as we know once it is in a care home it is very hard to get it out." (**Exhibit JK4/210 – INQ000581359**)

6) Interview with Matthew Ashton, Liverpool City Council Director of Public Health

Published on 29 May 2020

Mr Ashton is particularly proud of the work done with care homes. Liverpool was part of a pilot with Public Health England that saw testing of all residents and staff introduced to capture asymptomatic cases – the success prompted ministers to agree to the policy nationwide.

"We prevented a number of outbreaks. We tested everyone in care homes where there was no outbreaks and then re-tested a few weeks ago. We probably helped prevent cases at four or five care homes and I'm very pleased with that piece of work." (**Exhibit JK4/138 - INQ000504857**)

Appendix 5 – Detailed recommendations

Pre-pandemic challenge	Recommendations for the future of ASC	Recommendations for a future pandemic	Future pandemic issues in scope
Acute financial pressure	Address the decades of underfunding and consequent marginalisation of ASC by working collaboratively and urgently with the sector to understand the full extent of current pressures, their consequences, and the level of funding needed to stabilise the short-term as a downpayment on longer-term sustainability.	Work immediately with the ASC sector to get a shared understanding of likely cost pressures and the consequences for people drawing on ASC and the workforce. Allocate funding as early as possible, with as few conditions as possible, and clarify its extension or cessation with as much notice as possible.	Quantum, duration and conditions of funding. Workforce wellbeing.
	Fund in full, and with genuinely new funding, the outcome of a Fair Pay Agreement as one part of the solution for tackling recruitment and retention challenges in the care workforce.	Make funding available early and as needed over time to fund measures which protect and support the emotional and mental wellbeing of the care workforce.	
Government understanding, and public perception of, ASC	Recognise, and plan on the clear understanding that, ASC supports adults of all ages, in different settings and with a range of different conditions or support requirements for living a good life. Embark on a major awareness raising campaign to help the public better understand the vital role and importance of ASC for people, communities, and all of us, as part of building a shared foundation for a more ambitious service/sector in the future.	Recognise that people drawing on social care can live with families, carers and volunteers who all need empathy, kindness, prioritisation and support in a crisis. Implement measures to address the disproportionate harm experienced by people from minority communities and have strong policies in place to minimise that risk in the first place. Seek alternatives to, and understand and mitigate the	Support for and focus on all adults and all care settings. Minority communities. Isolation and loneliness. End-of-life care.

Pre-pandemic challenge	Recommendations for the future of ASC	Recommendations for a future pandemic	Future pandemic issues in scope
		consequences of, long term isolation and separation (as a mechanism to control risk), on the mental and physical wellbeing of clinically vulnerable people, their families, carers and close communities. Avoid, if possible, a scenario that prevents a partner, spouse or child being unable to be with their loved ones during end-of-life care in a care setting.	
Lack of parity between the NHS and ASC	Put the value and impact of social care – in its own right – on a par with the NHS by making clear reference to the inter-relationship with ASC in all relevant NHS policy and strategy work (e.g. 10 Year Plan).	Ensure that the importance of ASC in keeping the nation safe is a central feature of government plans, messaging and communication, alongside similar messaging about and for the NHS. Never permit acute settings to discharge people into residential and other care settings where clinically vulnerable people live, without fail safe testing and isolation regimes, robust guidance, and workforce support. Plan for the use of alternative settings, rather than put people at risk. Treat the NHS and ASC as equals in access to and distribution of PPE, testing and vaccination.	Hospital discharge. PPE, testing, vaccination.

Pre-pandemic challenge	Recommendations for the future of ASC	Recommendations for a future pandemic	Future pandemic issues in scope
Government prioritisation of ASC and commitment to wider reform	Translate action on the above recommendations into government prioritisation of ASC, including specific work to plan for ASC in the next pandemic: • Ensure that mechanisms are in place to test preparedness for a future pandemic with representatives from the LGA, councils, DASSs, and DPHs: at the heart of scenario planning; participating in major national planning events; involved in national lessons learned processes and actively engaged in planning for readiness. • Linked, ensure that regional, ICS and local emergency response systems and plans are regularly reviewed, tested, and updated. • While recognising the wide disease pathologies that might cause a pandemic (or other significant health events), and therefore the different interventions that might be required, agree the most likely impact scenarios for community and social care, and then develop clear operational/clinical/public health/care guidance to support, treat, protect and care for clinically vulnerable people living in care homes, their own homes, or other settings. Prioritise interventions for these	Enact all plans, processes, guidance, structures and coordinating groups which emanate from all work described left.	Guidance, coordination and pandemic management.

Pre-pandemic challenge	Recommendations for the future of ASC	Recommendations for a future pandemic	Future pandemic issues in scope
	individuals and families. • Confirm the role of LRFs in a major health emergency, and resource appropriately. • As part of planning arrangements, map and agree the groups, partnerships, roles, relationships, and processes that need to be stood up (between central and Local Government, and the NHS, UKHSA, representative bodies etc) at a time of crisis, to most rapidly agree and share guidance and support, with input from all relevant professional and representative bodies. This should provide for meaningful input of 'ground truth' stories to ensure relevance, impact, utility, and gaps, during an event. • Determine, implement and maintain the necessary shared systems, access, and data management protocols to enable agencies to share information and knowledge in the most secure, fast, and real-time environment.		
	Recognise the huge contribution that ASC makes to people, communities and the economy, including its dedicated and talented workforce, and finally tackle the issue of reform with determination, hope and ambition.	There is no set recommendation here. Rather, if an ambitious and credible plan for ASC reform is developed and implemented, many of the challenges described here and	

Pre-pandemic challenge	Recommendations for the future of ASC	Recommendations for a future pandemic	Future pandemic issues in scope
		throughout this witness statement would already be on the way to being addressed.	