IN THE MATTER OF

MODULE 6 OF THE COVID – 19 INQUIRY

--

WRITTEN CLOSING SUMISSIONS

FOR

THE LOCAL GOVERNMENT ASSOCIATION

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Contents

Introduction

1. These written closing submissions supplement the oral closing submissions made by counsel for the LGA on the 31st of July 2025. They are set out in two parts, the first addresses some issues emerging from the oral evidence the Inquiry received in this Module, and the second part concerns the LGA's recommendations.

Part A - Issues emerging from the evidence

Council preparedness in 2020

Helen Whately

2. The Inquiry will recall the evidence of Helen Whately, the former the Minister of State for Social Care, to the effect that she could only find the plans of two councils, Hertfordshire and Essex, concerned with the issues in the pandemic but that they "*weren't worth the paper they were written on*".

3. The LGA submits that the Inquiry should approach this evidence with caution, particularly if it is to be understood as a general criticism of local government's preparations for emergencies. At no time, did she seek the LGA's assistance to locate local authority plans for adult social care (ASC) whether generally or to find the best such plans from among the wider local government community.

4. Ms Whately (and indeed Mr Hancock who made a similar point based on her evidence) seem to have been engaged in a somewhat random search for pandemic plans. So, if her evidence demonstrates anything, it is the failure of the DHSC properly to prepare. Had it done so it would have engaged with the sector long before the pandemic and mandated councils to make such plans and then collected them and audited them in some way to ensure that on assessment it was satisfied with their content.

5. That said, the LGA does not accept that this was the extent of emergency planning by councils, whether generally, or for a flu pandemic. Her comments do not correspond to the LGA's knowledge of what was the general situation within English local authorities.

6. The LGA knows that across England, –

a. The emergencies that councils can foresee as possibly occurring will vary according to local circumstances, but also according to the national risk register,
b. Many Councils would have had specific pandemic flu plans, though of course the specificities of COVID – 19 were not anticipated by them any more than by central government,
and
c. Councils will normally have specific emergency plans for the maintenance of ASC in circumstances such as provider failure contingency.

7. So, no council, even one with a high-quality pandemic flu plan, would have been fully prepared for the multitude of unique challenges posed by Covid. If any criticism is appropriate for this it should be directed to the Government's prior failure to involve local authorities and the LGA in the "war-gaming" discussed in Module 1, particularly Operation Cygnus.

8. Any council writing any plan must approach the critical questions of deliverability with an eye to the funds already available and those which might reasonably be expected from central government. However, Ms Whateley's comments shewed no appreciation of the effects of decade of underfunding of local government prior to the pandemic.

Perceptions as to who is responsible for ASC

9. The Inquiry is referred again to the extensive evidence from the LGA and others as to the general perception as to who is responsible for the provision of ASC.

10. Mr Hancock and Ms Whateley's evidence, implying that they were under no obligation to act until she discovered what she viewed as totally inadequate plans requiring the Department to "*get a grip*", is of a piece with the LGA's evidence as to this lack of understanding.

11. Yet the DHSC's laissez – faire approach, to the effect of COVID on ASC, should be contrasted with other previous national issues when DHSC had very clearly taken an early lead, such as dealing with illegal working by irregular immigrants or the possibility of a 'No Deal Brexit', and in respect of which, while taking the

lead, it had worked collaboratively with the LGA, and in turn the LGA had co-ordinated regional responses and communicated collated regional issues.

Mr Hancock on a national leader for ASC

12. Perception issues were also evident when Mr Hancock correctly said that one reason for ASC's problem was that it lacked a national leader occupying a role akin to that which Sir Simon Stevens (now Lord Stevens) had as Chief Executive of NHS England. The LGA agrees that was clearly true at the time. This is one fact on which the LGA and Matt Hancock are agreed, though the conclusions that each draw from this a very different.

13. His evidence on this also begs the question, "Why not?" since as Secretary of State for Health and Social Care, he had the power to create such a post and to appoint a person of similar stature to it.

Was Adult Social Care "an afterthought"?

14. Both Mr Hancock and Whately pushed back firmly on the suggestion that it appeared externally that the DHSC's approach to the protection of ASC was an afterthought. The LGA well knows that the Inquiry will review the evidence and reach its own conclusion as to whether, and if so to what extent, it accepts this counter-narrative.

15. The LGA knows that it will look at the evidence of its CE Joanna Killian and will also consider that of those other important witnesses who described how events unfolded as they tried to keep the necessary provision of ASC safe and effective. While the detail of that evidence will be very important, in these closing comments the LGA simply says that nearly every witness outside government has spoken about ASC in those terms.

The role of LRFs

16. The Inquiry already well knows that under the Civil Contingencies Act, it is the LRFs that have the principal responsibility for emergencies at the local level. The evidence in relation to their activities provides another counterpoint to Ms Whateley's evidence.

17. For instance, the Inquiry is asked to recall the evidence of Cathie Williams, formerly joint Chief Executive of the Association of Directors of Adult Social Services, who said–

> *"…We…*[ADASS]*…did a survey as part of our pan flu work which had responses from 80 DASSs. The question related to LRF rather than council plans for pan flu and of those that responded just 7% felt they were inadequate. Of course, a proportion of DASSs felt that LRFs were too distant and with the benefit of having gone through the pandemic I would speculate that it's possible that they would change those plans now."*

The speed at which councils passed on funding

18. The LGA does not recognise the criticism expressed by Dr Jane Townson OBE: Chief Executive, of the Homecare Association, who suggested in her evidence that some councils were slow in passing on funding to providers.

19. Joanna Killian has already explained that the first tranche of funding to local authorities was neither ringfenced nor just for ASC, so given that local authorities faced multiple pressures, it is likely that it would not have always been passed on to ASC providers, but that is not a cause for criticism.

20. It is true that later tranches of funding were ringfenced for infection control and workforce and were also subject to very detailed grant conditions. For that reason, local authorities had to be careful in how they could account for it and so DHSC grant conditions did sometimes cause local delay. The key point here is that the subsequent DHSC audit showed that the money was used for its intended purpose.

21.

Lack of levers

22. Some witnesses have also suggested that central government lacked the necessary 'levers' to protect ASC during the pandemic. The LGA submits that this comment is an over-simplification and is to a degree disingenuous. In the next paragraphs the LGA reminds the Inquiry of some particular 'levers'.

<u>Care Act obligations</u>

23. The LGA has given extensive evidence in relation to the obligations under the Care Act. This Act ended council discretion to set eligibility thresholds and

created a national minimum threshold. It also requires councils to offer deferred payment agreements to eligible people.

Financial issues

24. The funding through the Integration Transformation Fund (and the Better Care Fund which it became) was contingent on central sign-off and plans meeting national metrics. Similarly with the Improved BCF, councils risked losing some of that funding if Delayed Transfers of Care targets weren't met. Further, the precept is arguably a compulsory earmarking of revenue.

Regulatory

25. DHSC instructed CQC to conduct c.20 Local Area Reviews on delayed transfers of care in 2017-18

Further points from Mr Hancock's evidence

Data

26. Councils have had to submit regular data returns so, the suggestion in Matt Hancock's evidence that tying Infection Control Funding to councils providing data returns during the pandemic was "innovative" was inept and may reflect more closely on his knowledge of the obligations on councils.

"Rocket up social care" and other exaggerations

27. Other comments in the evidence from both Mr Hancock and Ms Whately were wide of the mark. It was said for instance said that the DHSC '*gripped'* adult social care. Both said that the lack of '*levers'*, combined with their '*shock'* at the '*poor quality*' of councils' plans and preparedness, led them to '*put a rocket up social care*' and take control nationally.

28. By their choice of language their comments might seem powerful, but the LGA would caution the Inquiry to be careful to reach its own conclusions unmoved by hyperbole. Such language may have its place in political discourse but is not appropriate to the task facing the Inquiry which must cooly judge the evidence.

29. Perhaps these former Ministers expressed themselves in this way to seek to provide a counter narrative to the very extensive evidence that the Inquiry received about the failures at both the political level and within the DHSC to

provide effective national coordination in the early months of the pandemic in 2020.

30. Indeed, comments, expressed in such an exaggerated way, do great disservice to the many and substantial efforts of councils and their partners in leading work locally. The Inquiry team is referred again to the statement of Joanna Killian in this Module which explains the financial context for local government, the failure to engage it national resilience planning, and yet just how much work was done by it.

Dr. Jane Townson's criticism concerning accountability and reductions in care

31. Dr Townson criticised a lack of accountability within the sector. It will be recalled that the gist of these comments were to the effect that Government would point to councils as having the statutory duties while councils would point to a lack of funding. In this way, she argued nobody takes responsibility, the buck is constantly passed, and people are ignored. She also said (when talking about easements) that councils are constantly looking at ways to reduce people's care.

32. The LGA asks the Inquiry to take care before accepting her evidence while recognising it requires careful analysis, as to this -

Accountability

33. Overall, this is an unfair characterisation of the vast work councils do with people drawing on care and support, providers and other partners, all underpinned by local democratic accountability.

Reductions in care

34. The suggestion that this leads to a reduction in care is an oversimplification of a complex situation. The overall demand for care will fluctuate. During the pandemic some did not want to rely on the provision of local authority care and made other arrangements getting the right support from the voluntary sector or making private arrangements. Just because there is a reduction in a person's care package it cannot be inferred that a council is in some way defaulting on its ASC obligations.

Issues with Care Act easements

35. The LGA's CE Joanna Killian was questioned on Care Act easements by Kate Beattie KC, and Danny Friedman KC. The latter went close to implying in his oral closing statement that councils broke the law in their use of easements by for instance not using the legislation but nonetheless unlawfully reducing provision. The LGA wishes to make clear that this not the LGA's understanding of what happened at all.

36. Giving evidence on behalf of ADASS Cathie Williams SAID –

> *"I am 100 per cent confident that nobody [acted] maliciously or in an underhand way. They were simply trying to juggle the staffing and the resources they had."*

37. Likewise, Michelle Dyson, Director General for Adult Social Care said she did not think that Councils abused easements legislation.

38. The LGA can see that some might have perceived that this was happening (such as day centres closing because of lockdown, or families opting not to access care for fear of transmission from the community) but in reality, it was as a matter of the proper management of provision in the context of the practical reality of dealing with the pandemic.

39. Moreover, it must be remembered that the Care Act provides for flexibility (such as how to conduct assessments of needs), where this was possible within the Act there was no need for a formal easement.

Planning for a future pandemic

Criticisms and comments

40. Matt Hancock argued that three years into the Inquiry, the position is worse, not better, in respect of sector preparedness. He suggested there should be no care home today that doesn't have isolation facilities and said that it should be a legal requirement for every care home to have a stock of PPE.

41. Many challenged both ideas from a feasibility perspective. Further relevant evidence included -

a. Ruth Allen (BASW) said that for future pandemic preparedness, social workers should be immediately put on the same footing as others in terms of profile, status, importance, etc.

b. Vic Rayner (National Care Forum) said that decision-making groups in a future pandemic should involve providers and people drawing on care from the outset.

c. Mary Cridge (CQC) said that in a future pandemic, CQC should have priority access to PPE and testing so that inspections/visits could continue. In terms of guidance, she said that Government guidance shouldn't be health guidance tweaked for adult social care; rather, it should be bespoke and practical guidance coproduced between providers, councils/commissioners, people accessing care and CQC (who could "perhaps" take a lead role in that process).

d. Prof Susan Hopkins (UKHSA and previously PHE) said that adult social care should be a far more central consideration/concern in a future pandemic. She also said that UKHSA teams are already working with the adult social care sector on planning for the infectious diseases of the future, precisely to avoid guidance that is delayed and/or constantly updated.

e. Chris Llewelyn (WLGA) said that it "makes sense" that, in a future pandemic, there should be no discharge to care homes without there first being a test of the individual. He qualified this by saying it would depend on the circumstances of the pandemic, but that testing/quarantining facilities should be "minimum requirements". He also talked powerfully about the need for adult social care to be a central feature of Government attention in a future pandemic.

f. Cathie Williams (ADASS) said that councils should have a role in planning for a future pandemic.

The DHSC's future plans

42. The Inquiry will recall the following exchange between CTI and Michelle Dyson, the Director General for Adult Social Care -

> **CTI Ms Carey**: *"What about now? What, if any, efforts have been done from the department's perspective to ensure that local authority plans are robust enough, adequate enough? Pick whichever word you choose."*
>
> **Michelle Dyson**: *"I think that will be picked up in our pandemic preparedness strategy that the department is going to publish."*
>
> **CTI Ms Carey**: *"And do you know when that is going to be published, or roughly?"*
>
> **Michelle Dyson**: *"I'm not sure exactly but I know we're planning to publish that, and then alongside it there will be five plans for each of the five different routes of transmission, starting with a respiratory plan."*

43. It is indeed correct that the DHSC has begun to engage in planning for a future pandemic; its main activity will be to run an exercise (called Exercise Pegasus) in the autumn of 2025, to explore the impact on the social care sector and to test responses to various scenarios.

44. The DHSC is involving the LGA, ADASS and provider representative organisations in the planning for this event, which is a great improvement on the situation when Exercise Cygnus was carried out before the pandemic and engagement was far more limited.

45. Alongside this, DHSC is also producing guidance on specific issues that are not specifically pandemic planning but are potentially related. For instance, e draft UKHSA guidance on combating Multidrug Resistant Organisms has been shared with a limited number of people in the sector with an ability to see each other's comments and with a realistic deadline for comments. This does give some evidence of learning from Covid and having a somewhat more collaborative process.

Part B - Key messages and WS recommendations

46. The LGA refers to paragraph [850] onwards in, and to the whole of Appendix 5 of, the witness statement of Joanna Killian in this Module where the LGA's extensive recommendations are set out in detail.

Sustainable funding and meaningful reform

47. **ASC must be urgently prioritised for sustainable funding and meaningful reform** that is genuinely coproduced with councils, providers, the voluntary sector and, most importantly, people who draw on care and support.

48. While many witnesses in this Module have rightly referenced the Casey Commission in respect of the future of adult social care, but that is a multi-year process when action is needed now.

49. For that reason, the Inquiry should urge Government to work with councils and the sector now to agree a shared position on the resources, capacity and system changes that would make a tangible difference to the functioning of adult social care in both an emergency and non-emergency state.

50. It must be recognised that to address the decades of underfunding and consequent marginalisation of ASC Government should be 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.

51. Provision should be made now to fund in full, and with genuinely new funding, the outcome of the Fair Pay Agreement as one part of the solution for tackling recruitment and retention challenges among the care workforce.

Parity of esteem for ASC and the NHS

52. Adult social care must have **parity of esteem with the NHS** in a future health emergency. A government that understands this can play a key role in both maximising social care's contribution to a future pandemic response and helping the public better understand and recognise social care's value to people and communities.

53. Achieving this could take different routes but the LGA suggests, as a minimum, a mandatory cross-Whitehall and NHS programme of induction for new and existing senior civil servants and officials whose departments have an interface with the adult care and support sector. Such an induction, which could be delivered by senior local government figures, would aim to increase understanding of adult social care's operational and policy imperatives, but would also aim to ensure the sector features appropriately in government's internal and public-facing communications

The full range of ASC provision must be recognised

54. Government must recognise 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. This should be a core element of all relevant planning.

55. So, Government should be embarking on a major awareness raising campaign to help the public better understand the vital role and importance of adult social care for people, communities – all of us – as part of building a shared foundation for a more ambitious service/sector in the future.

56. It should be implementing measures to address the disproportionate harm experienced by people from minority communities and have strong policies in place of us to minimise that risk in the first place.

57. And it should ensure, to the greatest extent possible, that a partner, spouse or child is able to be with their loved ones in a care setting, particularly during end-of-life care.

Full engagement with local government to give effect to policy

58. Government, Whitehall and the NHS should work closely and regularly with local government to ensure that **translating policy into practice** is both possible and desirable.

59. This could take a number of forms but must start from a position of seeing local government as an equal and trusted partner in responding to emergencies and include –

a. Far better involvement of local government in the imminent Exercise Pegasus initiative.

b. A seat at the table of all relevant ongoing or ad hoc working groups concerned with pandemic planning and groups that are stood up at the outset of the next pandemic. This should include senior LGA representation at relevant COBR meetings.

c. Co-design and co-production of all relevant guidance in respect of pre-pandemic planning and new guidance that might be required during the next pandemic.

Getting risk management right

60. To ensure the effective translation of policy into practice, Government, Whitehall and the NHS must work very closely with local government to agree a **proportionate approach to the balance of risk** in making decisions that are designed to keep people safe and decisions that are designed to keep people connected to loved ones and reassured of their wellbeing.

61. Care Act easements, visiting restrictions and the suspension of the CQC's routine inspections are just three examples of the difficult judgements that had to be made during the pandemic, and which could have benefitted from greater engagement with local government.

62. So, it is necessary to 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.

63. A linked point is to ensure that regional, ICS and local emergency response systems and plans are regularly reviewed, tested, and updated.

64. 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, it is necessary to 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 individuals and families.

65. The role of LRFs in a major health emergency must be confirmed and resourced appropriately.

66. As part of planning arrangements, it is necessary to 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.

67. Lastly, it is necessary to 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.

ROBIN ALLEN KC

Cloisters

21 August 2025