UK Covid-19 Inquiry

Module 6:

Care sector

A report by The Rt Hon the Baroness Hallett DBE
Chair of the UK Covid-19 Inquiry

October 2026

HC 645

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Introduction by The Rt Hon the Baroness Hallett DBE

In April 2020, the high number of deaths of people in care homes brought into sharp focus the devastating impact of the Covid-19 pandemic on the adult social care sector. It caused the UK government and devolved administrations to turn their attention to the adult social care sector, as their focus until then had very much been on the response of the healthcare system and 'protecting the NHS'. Given that it was well known that people receiving care were particularly vulnerable to any respiratory disease, let alone a deadly respiratory virus like Covid-19, that shift in focus came too late. Protective measures should have been put in place at the start of a pandemic, not once it had already taken hold.

As has been a constant theme in the Inquiry's reports, a major factor in the failure properly to protect the sector was the failure in pre-pandemic planning. There was confusion about the pandemic plans in existence at national government level, local government level and provider level. Guidance was not tailored to the sector and appeared to ignore the realities of providing care to those in need. Initially, there were poor data available about bed and workforce capacity and about the number of people dying in care homes. This hampered the ability of the four governments of the UK to understand, respond and protect people living and working in care settings.

In the early months of the pandemic, many hospital patients were discharged to care homes without a Covid-19 test and some homes found it extremely difficult to isolate returning or new residents. The sector as a whole experienced difficulties in acquiring personal protective equipment.

Visiting restrictions meant that most in-person regulatory oversight of care homes was paused and there was, at times, limited access to medical care. The restrictions also meant that family and friends were prevented from visiting their loved ones in care homes, causing immense distress and harm. While visits to people at the end of life should have been permitted, this did not always happen. This resulted in many people dying alone without the comfort of their loved ones by their side. For many bereaved, this has led to prolonged grief, feelings of guilt and anger.

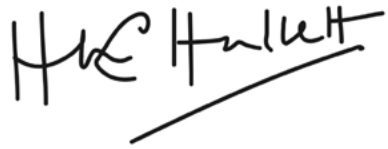
The Covid-19 pandemic exposed and exacerbated the underlying fragility of the adult social care workforce. It entered the pandemic with a high number of staff vacancies and staff turnover, and care workers already working long hours for low pay and in poor working conditions.

Notwithstanding the extraordinary lengths to which care workers went to provide care during the pandemic, it was clear to me that for too long the adult social care sector has been undervalued and under-recognised. This includes workers providing domiciliary care and the many millions of unpaid carers on whom the pandemic placed increased and huge demands. The Inquiry's Terms of Reference do not permit me to consider wider adult social care reform but I hope the Independent Commission on Adult Social Care, chaired by Baroness Casey of Blackstock, will address some of these more systemic issues in England.

When consulting on the Terms of Reference for this Inquiry, I met with bereaved families from across the UK. From my very first meeting with bereaved family members, I realised just how important the investigation into the care sector is to many of them. Over the course of the Inquiry's Module 6 public hearings in June and July 2025, many witnesses spoke movingly about what had happened to them and their families. I thank them, as well as those who shared their stories with the Inquiry's listening exercise, Every Story Matters, and those who agreed to take part in the impact films, for all their contributions. Their accounts put a spotlight on the devastating impact that Covid-19 had on people receiving and providing care and their loved ones.

I am also grateful to the material providers, the 27 Core Participants, their members and representatives and, of course, the Inquiry's secretariat and legal team. Module 6 has gathered more than 170 written statements and more than 100,000 pages of evidence. All of this material has been analysed carefully to produce this Report.

My conclusions about the impact of the Covid-19 pandemic on the adult social care sector in the UK demonstrate clearly why it cannot be allowed to enter the next pandemic in such an unprepared state, that it deserves better recognition and support, and why it is so important that my recommendations are implemented.



The Rt Hon the Baroness Hallett DBE

20 October 2026

Voices

> "*Sheryl died, alone, from Covid. We will never know for sure whether she caught Covid in the care home that was supposed to keep her safe. What we do know is that Covid … was brought into the home by discharged hospital patients in an environment with little PPE* [personal protective equipment] *or effective infection control measures.*"[1]
>
> **Linda Dinsdale, Covid-19 Bereaved Families for Justice UK**

> "*I asked to be able to see my mum, but they refused. It had been 10 months, since I last had physical contact and now, she was gravely ill. In the last few days of her life, I was allowed to be outside the patio door to her room and the staff wheeled her bed closer to me. I stayed there for hours each day in the freezing cold, rain, and snow.*"
>
> "*This is an open-ended trauma, a wound that won't close.*"[2]
>
> **Jane Wier-Wierzbowska, Covid-19 Bereaved Families for Justice UK**

> "*I was devastated and blindsided to discover that when* [Dad] *was most vulnerable, the care home/district nurses had failed to administer the fluids along with the rest of the care package. As a consequence of this neglect, he was dehydrated and in pain … There was a complete lack of support.*"[3]
>
> **Catherine Griffiths, Covid-19 Bereaved Families for Justice Cymru**

> "*I was sent a photo showing Dad talking on the phone to a family member through the lounge window. There is a staff member standing less than two feet away from Dad assisting him in using the phone, the staff member is wearing a long sleeve shirt buttoned at the wrist – no mask, no gloves, no apron, yet I've been told in writing that no-one is allowed in the lounge without a mask. After Dad died I discovered that on the day in question the staff member still had a cough which remained until after Dad's death.*"[4]
>
> **Judith Kilbee, Scottish Covid Bereaved**

1 INQ000614373_0011 para 33
2 INQ000614372_0006, 0009 paras 21, 30
3 INQ000587733_0003 para 12
4 INQ000614380_0005-0006 para 25

"[T]*he end of family visits was detrimental, not just for my mother's mental health from the loss of social contact, but also because it meant that the family could not maintain oversight of the care provided to my mother and the state of her physical health, and there was no one else to provide this external oversight.*"[5]

Agnes McCusker, Northern Ireland Covid-19 Bereaved Families for Justice

"*It was a uniquely vulnerable situation where we were entirely at the mercy of the competence and commitment of staff and managers over whom we had no control.*"

"*I now have even more confidence that when (not if) there's a new pandemic, or when (not if) there's some major climate-induced emergency, my life and those of other disabled people, and particularly people in care homes, will be treated with nothing like the same value and respect as other people's.*"[6]

Douglas Paulley (long-term care home resident)

"*Unpaid carers are seen as 'just what you should be doing' by so many. We sacrifice our entire lives at times to support another. Life is never the same again and it often feels as though our whole identity is lost especially if it is a life long event.*"[7]

Unpaid carer (anonymous)

"*My colleagues and I were experiencing burn out and constant exhaustion, as well as grief and trauma from our experiences caring for residents who had Covid-19.*"[8]

Jacqueline Kitchen (care home worker)

5 INQ000614377_0010 para 25
6 INQ000616666_0003, 0022 paras 12, 101
7 *State of Caring 2022: A Snapshot of Unpaid Care in the UK*, Carers UK, November 2022, p22 (https://www.carersuk.org/reports/state-of-caring-2022-report; INQ000588635)
8 INQ000614382_0009 para 34

> *"I was involved in looking after residents when they were poorly – this was a painful, defeating experience because no matter how ill they were, they could not be transferred to hospital, so there was little I could do for them other than sit with them and hold their hands. I am not a medic so I could not give them anything beyond company and making them comfortable."*[9]
>
> **Senga Walker (care home worker)**

9 INQ000614383_0001-0002 para 3

Executive summary

The Covid-19 pandemic had a devastating impact on the many millions of people across the UK who received adult social care and an equally devastating impact on the millions more who provided that care, whether paid or unpaid. The impact was particularly acute in care homes, where there were more than 43,000 recorded deaths involving Covid-19 between March 2020 and July 2022; Covid-19 was the second leading cause of death in care homes in all four nations of the UK in 2020.

Rhetoric such as the statement of Matt Hancock (Secretary of State for Health and Social Care from July 2018 to June 2021) that the UK government had tried to throw "*a protective ring*" around care homes "*right from the start*" does not accurately reflect the lack of action taken to protect care homes across the UK in March and the first half of April 2020. The UK government and devolved administrations knew, prior to the Covid-19 pandemic, of the extreme vulnerability of care home residents to respiratory viruses. Despite this, care homes received insufficient protection at the time they most needed it.

In March 2020, the UK government and devolved administrations took the decision to expedite the discharge of patients from hospital. While expedited discharges were necessary to free up much-needed hospital beds, the lack of testing capacity meant that patients were discharged from hospital without knowing their Covid-19 status. There was also no vaccine and there were shortages of personal protective equipment (PPE). Isolation was therefore an important infection prevention and control (IPC) measure to stop the spread of Covid-19 in care homes. However, isolation of all patients discharged from hospitals to care homes was not initially advised in March 2020 in England, Wales and Northern Ireland. This was a significant omission. There should also have been better planning to accommodate residents who lived in care homes that were unable to provide safe isolation facilities.

There were also other failures in relation to IPC guidance and the lack of PPE. The IPC guidance introduced at the beginning of the Covid-19 pandemic advised care workers to avoid being within two metres of the person being cared for. This guidance was wholly unrealistic given that most social care is delivered at close quarters. The advice therefore provided little or no protection for either the provider or the recipient of care.

From mid-March 2020, care workers were advised to wear PPE. However, prior to the pandemic, the adult social care sector was responsible for sourcing its own PPE. Care providers, especially domiciliary care providers (providing care at home), therefore did not keep large stocks of PPE and not all providers had relationships with PPE wholesalers. There was also a severe shortage of PPE supplies for the adult social care sector, attributable to a number of factors, including the worldwide shortages of PPE and inadequate supplies in the UK's PPE stockpile. Shortages of PPE supplies, especially in the first wave of the pandemic, led to the wholly unacceptable position that care workers had to work either in unsuitable or poor-quality PPE, or with no PPE at all, and so without the protection they needed. While the UK government and devolved administrations subsequently sought to help the sector access PPE with one-off emergency drops of PPE, and there were hotlines, portals and hubs set up to deal with requests for PPE, none of these steps were without problems.

By mid to late April 2020, testing capacity in each nation allowed all hospital patients discharged to care homes to be tested for Covid-19. Subsequently, testing of both symptomatic care workers and residents was rolled out, followed by wider asymptomatic testing. However, there was widespread concern that discharging patients from hospital without a test introduced Covid-19 to care homes, leading to the deaths of many residents. This led to a number of studies being conducted across the UK, which concluded that admissions to care homes from hospitals were one of a number of routes of ingress for the virus and were unlikely to have been the dominant driver of infections in care homes in the first wave of the pandemic. The precise extent to which hospital discharges seeded infections in care homes could not be determined, due to the lack of testing capacity in the early months.

Other likely routes included transmission via staff and visitors. Each nation of the UK sought to restrict staff movement between care settings, including proposals in England to introduce legislation limiting staff movement. These restrictions presented significant practical challenges, not least the very real potential for there to be insufficient care workers to provide care safely. In a sector where the use of agency and bank staff is not uncommon and low pay and poor working conditions were already prevalent, the restrictions also had a significant adverse effect on staff income. All four governments acknowledged the financial impact that restrictions would have on care workers and so put in place funding to provide some recompense. However, this funding did not always filter through to front-line care workers.

Supporting care workers to self-isolate was also a vital way to prevent the spread of infection. There were welcome changes to sick pay in March to May 2020 in England, Scotland and Northern Ireland which meant that sick care workers and those required to self-isolate received (or should have received) enhanced rates of sick pay or their full normal wage. These changes were not made in Wales until November 2020, which was too late. Given the critical nature of their role, financial support to protect care workers from economic hardship and to mitigate the risk of the virus being spread by staff needs to be in place at the start of any pandemic.

The Covid-19 pandemic also saw the introduction of restrictions on the number of visitors who could enter care homes. Visits by professionals, including healthcare workers, dramatically reduced as UK-wide guidance strongly discouraged all but essential in-person visits. This resulted in care workers stepping in to provide this care. By mid-March 2020, regulatory inspections also decreased significantly as in-person routine inspections of care settings were suspended. As acknowledged by regulators, the absence of routine inspections (along with an absence of visits by loved ones) increased the lack of oversight of care settings and potentially increased the risk of safeguarding concerns, abuse and non-adherence to IPC measures going unnoticed and unreported. The regulators sought to provide support to the care sector via check-in calls and moved to risk-based regulatory activity focusing on higher-risk settings. Remote inspections were trialled but were not a substitute for in-person inspections and generally were considered to be of limited use.

Visits from families and loved ones were also restricted. These restrictions brought into sharp focus the difficult choices that governments and ministers were required to make. To allow visitors into care homes ran the risk of introducing a deadly virus to an already vulnerable population. However, preventing visits caused incalculable harm to residents and their loved ones and often resulted in a significant decline in the health and wellbeing of residents, especially those with complex cognitive conditions such as dementia. The severity of the restrictions and the length of time they were imposed had profound and enduring effects. As some told the Inquiry's listening exercise, Every Story Matters, the restrictions left residents feeling "*isolated*", "*abandoned*" and "*alone*".[1]

Attempts to provide alternatives, such as remote or garden visits, were beneficial for some but not all residents. It was not until the summer of 2020 that visiting restrictions started to ease. Each nation moved to a more localised risk-based approach to visiting, based on the risks visiting posed to individual care homes. With varying infection rates and different circumstances prevailing in care homes, it was inevitable that some care homes would be able to allow more visits than others. It was equally inevitable that this would cause frustration and upset for those residents and families where stricter visiting restrictions remained in place.

The summer of 2020 also brought with it recognition that some family members played an enhanced caring role and provided essential care. The concept of designated visitors, essential carers and care partners was therefore introduced but the importance of this role should have been acknowledged and established sooner.

Although visiting guidance allowed exceptions to be made for end-of-life visits, some families were not permitted to be with their dying loved one. This caused immense upset and harm.

> "*My mother's death in the care home – alone and confused about why her only child appeared to have abandoned her. It absolutely kills me to think about it. I felt, and still feel, angry, powerless and distraught.*"[2]
>
> ***Contributor, Every Story Matters***

Adult social care workers also faced caring for many people who fell seriously ill and died. The pandemic accelerated the need for advance care plans (which record an individual's preferences for future medical care) to be in place. This resulted in sensitive discussions occurring in a hurried manner or not occurring at all. There was no mandatory end-of-life care training for all health and social care professionals working in the adult social care sector in the UK before the Covid-19 pandemic. This resulted in care workers lacking the requisite skills to ensure that advance care plans were discussed in as thoughtful and compassionate a way as possible. Mandatory end-of-life care training is needed.

1 *Every Story Matters: Adult Social Care Sector*, pp8, 14, 37 (INQ000587564)
2 *Every Story Matters: Adult Social Care Sector*, p57 (INQ000587564)

In common with Module 3, the Inquiry heard concerns about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. A DNACPR decision is a clinical decision not to attempt CPR and individuals can also state their wishes in advance. There were concerns that some decisions were made inappropriately, insensitively, without proper consultation and in some cases wholly improperly, based on an individual's age, health condition or a learning disability. While the Inquiry has found no evidence of any UK-wide or nation-specific policy encouraging or condoning the 'blanket' use of DNACPRs and all four governments reiterated that every DNACPR decision should be made on an individual basis, it bears repeating that, as with advance care planning, discussions about DNACPR must be handled sensitively and at a pace that suits the individual.

As the Inquiry has noted in previous Reports, data gaps were a significant problem, particularly in the early months of the pandemic. Data collection, including on the numbers of people receiving care, the workforce and capacity in the sector, was also poor. Given that Exercise Cygnus, a pandemic exercise, recommended the development of methods to assess social care and surge capacity in October 2016, these data should have been available from the start of the Covid-19 pandemic.

Differences in the way mortality data were collected and published meant that real-time data on the number of deaths in care homes in each nation were not available until mid to late April 2020. It was also difficult to ascertain the number of people receiving domiciliary care who had died. The data that are available suggest that more people died at home during the pandemic than prior to the pandemic. This increased the demand for end-of-life care at home but healthcare professionals were not always available to provide it. More end-of-life care therefore had to be provided by people who were untrained, including sometimes by family and friends, without the necessary medication and without appropriate support.

The impact on the approximately 5.8 million unpaid carers across the UK was pronounced, as they had to provide more complex care for longer hours with less – if any – respite care. Unpaid carers are the backbone of care for many millions of people. Some support was made available to them during the pandemic but it came too late and problems identifying unpaid carers made it difficult to deliver support to them.

There were at least 1.5 million care workers providing care during the pandemic, many of whom put their lives at risk to provide care. There were, however, no centrally recorded data on the number of care workers who died from Covid-19. This hindered the ability of the UK government and devolved administrations to understand the severity and transmission of the virus and its impact on the social care workforce.

In addition to working longer hours and taking on more responsibility, care workers witnessed an increase in the number of deaths of people they were caring for. Care workers went to extraordinary lengths to provide care and show compassion to those who were dying. This had a profound and, in some cases, long-lasting impact on workers' health

and wellbeing and led to many workers suffering burn-out and leaving their caring role. A manager of a domiciliary care agency said:

> "*The trauma was so overwhelming that some of these remarkable individuals chose to leave the care profession, unable to overcome the emotional toll of what transpired.*"[3]

The adult social care workforce entered the Covid-19 pandemic in a fragile state with a high number of staff vacancies and staff turnover. When combined with the inevitable absences of staff resulting from sickness, the requirement to self-isolate and burn-out, there was an urgent need to recruit more staff. Workforce appeals and initiatives were launched to encourage people to join the sector but these were not long-term solutions to the wider workforce issues faced by the sector. Wider reform of the sector is not within the Inquiry's remit. Its long-term transformation is already being considered by Baroness Casey's Independent Commission on Adult Social Care in England, which is expected to report in the summer of 2027.

The existence of workforce registers in Scotland, Wales and Northern Ireland had real and tangible benefits during the pandemic. Recently retired care professionals could be easily identified and invited to return to work. They enabled more direct and quicker communication with the workforce to signpost advice, guidance and support and implement workforce training. Registers also provided ministers and other decision-makers with more up-to-date information about the impact of their decisions. Although the introduction of a register in England has been explored by previous UK governments, there is no workforce register in England. The time has now come to introduce a voluntary register in England as a way to professionalise the sector and improve the recognition and retention of the workforce. It will also help with a future emergency response. Entering a pandemic with a less fragile workforce is critical to the ability of the care sector to respond.

Witnesses repeatedly spoke of the need for recognition of the vital work undertaken by the adult social care workforce. The adult social care sector has long considered itself overlooked and undervalued by successive governments; it sees itself as the 'poor relation' of the UK's healthcare systems. The response of the four governments to the Covid-19 pandemic did little, if anything, to dispel that belief.

So many of these problems, as noted by the Inquiry in other Module Reports, were attributable to a lack of pre-pandemic planning. It was unclear whether sector-specific pandemic plans (as opposed to plans for other emergencies, such as power outages or cyber attacks) existed at local government or provider level. UK government and devolved administration planning documents were either incomplete or vague about planning requirements, provided minimal detail and used imprecise terminology. It was therefore unclear who or which organisation was responsible for different aspects of the pandemic response. The fragmented structure of adult social care also meant that ministers had less oversight of the sector and fewer levers to be able to direct what should happen in it. The action taken by the UK government and devolved administrations to try to

3 INQ000587381_0049 para 97.2

protect workers and users of care came too late. These failures were the direct result of an absence of proper pandemic planning for the adult social care sector. It underlines why the recommendations in this Report must be acted upon now before the next pandemic strikes.

The adult social care sector as a whole also appeared to be something of an afterthought, where the mantra of 'protecting the NHS' sometimes came at the expense of the users and providers of care. The failures set out in this Report created environments in care settings in which the virus could spread like wildfire.

The Report makes a number of recommendations to ensure that the UK's adult social care sector is better protected and better equipped to respond to the next pandemic. In summary, the Inquiry recommends:

- **improving arrangements for pandemic planning to ensure clearer structures, roles and responsibilities**;
- **better planning for isolation**;
- **implementing financial support schemes** that are ready to be rolled out to support adult social care staff to self-isolate or to limit staff movement;
- **publishing guidance on visiting restrictions**;
- **maintaining inspection and oversight** by developing protocols to enable inspections to continue, including, where possible, on-site inspections;
- **improving collection of data about deaths in the adult social care sector**;
- **establishing mandatory end-of-life training** for relevant health and social care workers; and
- **recognising and supporting the social care workforce** in England through the introduction of a voluntary register.

A full list of the Inquiry's recommendations is included in Appendix 3.

Chapter 1: Overview of the adult social care sector

Introduction

1.1. It is estimated that about half a million people resided in adult care homes at the start of the coronavirus (Covid-19) pandemic and nearly 1 million people were supported to live in their own homes (domiciliary care). Many millions more were looked after by family, friends and neighbours who provided unpaid care. The adult social care sector also included a range of other settings, such as day centres and supported living accommodation. Yet there is a widely held belief that the adult social care sector is undervalued and under-recognised – that it is seen as the "*Cinderella*" service to healthcare systems.[1]

1.2. This chapter provides an overview of the sector, focusing on care homes, domiciliary care and unpaid care. It examines the introduction of widespread data collection about people in receipt of care, the workforce and capacity in the sector during the pandemic. It also assesses the extent to which the sector was considered in pandemic planning.

1.3. More generally, this Report will examine some of the decisions that may have contributed to the widely held belief that the adult social care sector was not given the priority it deserved. It will consider the widespread perception – particularly at the outset of the pandemic – that healthcare systems in the four nations of the UK (over which the UK government and devolved administrations individually exercise direct control) were prioritised at the expense of the adult social care sector. Social care relating to children is being explored by the Inquiry in Module 8: Children and young people.

The adult social care sector

1.4. As Helen Wildbore (Director of Care Rights UK, a charity focusing on the rights of people in care, from 2019 to 2025) explained, the care sector is hugely diverse, both in the types of care settings and the types of support needed by people who use adult social care.[2] As noted by Professor Dame Jenny Harries (Deputy Chief Medical Officer for England from July 2019 to March 2021), adult social care is also commissioned from a wide variety of independent and private providers, in sharp contrast to the NHS.[3]

1 Vic Rayner 3 July 2025 119/9-16; INQ000528094_0033 para 4.44; Robin Swann 24 July 2025 103/17-104/1; INQ000615082_0034 para 87; Paul Featherstone 28 July 2025 120/3-8; INQ000587381_0001-0002 para 2

2 Helen Wildbore 29 July 2025 54/1-12

3 INQ000587394_0011-0012, 0058 paras 5.5, 9.1. Care services that are not provided directly by local authorities or Health and Social Care trusts are described as services provided by the independent, private, voluntary and third sectors. Not all terms are used consistently across sources and across the UK, and some are used interchangeably, but all mean that the service is delivered by a provider that is independent of local authorities or Health and Social Care trusts.

Users of adult social care

1.5. Most adult care homes are residential homes (which provide accommodation and help with personal tasks) or nursing care homes (which, in addition, provide access to nursing care). Across the UK, as at July 2020, there were 18,075 adult care homes, with 537,656 available beds. The majority of care homes, both in 2020 and more recently in 2025, were for older people (typically defined as those aged 65 and over).[4]

1.6. In 2025, more than 85% of care home residents were likely to have dementia, whether formally diagnosed or not.[5] Exact figures are not consistently collected about the number of adults with learning disabilities receiving adult social care, but support for them requires significant expenditure across the UK.[6]

1.7. There are no UK-wide data about the number of people who receive domiciliary care in their own homes. However, Dr Jane Townson (Chief Executive of the Homecare Association, the UK's membership body for homecare providers, from May 2019) explained that professional providers support nearly 1 million adults across the UK at any given time.[7] The majority of those receiving domiciliary care in the UK are aged 65 and over.[8] As of July 2019, about 9,000 domiciliary care providers were registered with the Care Quality Commission in England. In May 2020, approximately 550 domiciliary care providers were registered with Care Inspectorate Wales, approximately 1,400 were registered with the Care Inspectorate in Scotland, and 300 were registered with the Regulation and Quality Improvement Authority in Northern Ireland.[9]

1.8. Precise data about the number of people receiving unpaid care are also not readily available. Data from 2021 and 2022 suggest that approximately 5.8 million people – usually family, friends and neighbours – provided unpaid care across the UK.

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4 *COVID-19 Mortality and Long-Term Care: A UK Comparison*, D Bell, A Comas-Herrera, D Henderson, S Jones, E Lemmon, M Moro et al, International Long Term Care Policy Network, updated 29 August 2020, pp2, 7, 11 (https://ltccovid.org/wp-content/uploads/2020/08/COVID-19-mortality-in-long-term-care-final-Sat-29-v1.pdf; INQ000325171); 'Care home facts and stats: Settings, population and workforce', carehome.co.uk, 11 November 2025 (https://www.carehome.co.uk/advice/care-home-stats-number-of-settings-population-workforce; INQ000549354_0002). At the beginning of the Covid pandemic period, there were an estimated 500,598 adult care home residents across the UK.

5 INQ000546956_0016, 0021 footnote 3, para 46

6 INQ000587296_0009-0012 paras 18-19, 22, 26, 28. Data are not available for Northern Ireland.

7 INQ000587670_0016 para 63; 'Home care statistics: Number of providers, care users and workforce', Homecare UK, 24 June 2024 (INQ000509601_0002-0003)

8 *Domiciliary Care Services for Adults in Northern Ireland (2020)*, Department of Health (Northern Ireland) and Northern Ireland Statistics and Research Agency, 16 February 2021, p15 (https://www.health-ni.gov.uk/sites/default/files/publications/health/dcs-adults-ni-20_0.pdf; INQ000503361); *Long Term Care and the COVID-19 Crisis in Wales*, S Jones and P Patrignani, International Long Term Care Policy Network, 11 June 2020, p5 (https://ltccovid.org/wp-content/uploads/2020/06/COVID-19-LTC-situation-in-Wales.pdf; INQ000548122); *Free Personal and Nursing Care, Scotland, 2021–22*, Scottish Government, 28 February 2023, p2 (https://www.gov.scot/publications/free-personal-and-nursing-care-scotland-2021-22/pages/main-points-2021-22; INQ000549356); *An Overview of the UK Homecare Market*, Homecare Association, 28 March 2024, pp25, 53 (https://www.homecareassociation.org.uk/asset/2A51F1FC%2DA86D%2D4DDB%2D8470982FF17E8B2D; INQ000571020). Data are from 2018/19 in Wales, 2020 in Northern Ireland, 2021/22 and 2022/23 in Scotland and 2022/23 in England.

9 INQ000475008_0044-0047; INQ000660254_0001. The Care Quality Commission is the regulator for all health and social care services in England; Care Inspectorate Wales regulates all social care and childcare services in Wales; the Care Inspectorate regulates all health and social care, early learning and childcare services in Scotland; the Regulation and Quality Improvement Authority is the regulator for health and social care services in Northern Ireland.

Based on census data from 2021 in England, Wales and Northern Ireland, and from 2022 in Scotland, this included 4.7 million people in England, 311,000 people in Wales, 222,000 people in Northern Ireland and 627,700 people in Scotland. Census data also showed that approximately 1.7 million people were providing significant amounts of unpaid care, at 50 hours or more per week.[10]

The adult social care workforce

1.9. The workforce in the adult social care sector is also diverse. It includes, among others, permanent employees, agency staff, people who work across multiple settings, registered managers and registered nurses.

1.10. Snapshots of the numbers of people working in adult social care across the four nations between 2019 and 2021 show the significant size of this workforce (see Table 1), although comparisons between the four nations are difficult, due to differences in data collection.[11] Based on these figures, it is estimated that more than 1.5 million people worked in adult social care over the course of the pandemic.

Table 1: Snapshot of the adult social care workforce across the UK, various dates between 2019 and 2021

	England (2019/20)[(a)]	Northern Ireland (November 2021)[(b)]	Scotland (2020)[(c)]	Wales (March 2021)[(d)]
Residential care workforce	680,000 (estimated)	14,694 care workers 142 managers	52,920 (care homes for adults)	30,531 (estimated)
Domiciliary care workforce	715,000 (estimated)	13,736 care workers 499 managers	74,870	20,644 (estimated)

Sources: (a) The State of the Adult Social Care Sector and Workforce 2020, Skills for Care, 2020, pp29-30 (INQ000553304); (b) Social Work and Social Care Workforce Analysis, Northern Ireland Social Care Council, 1 November 2021 (https://niscc.info/data-about-the-social-work-and-social-care-workforce; INQ000660246); (c) Scottish Social Service Sector: Report on 2020 Workforce Data, Scottish Social Services Council, 31 August 2021, pp1, 11 (https://data.sssc.uk.com/images/WDR/WDR2020.pdf; INQ000509920); (d) Social Care Workforce Report 2021, Social Care Wales, 13 June 2022, pp10-11 (https://socialcare.wales/cms-assets/documents/Workforce_Report_2021_EN-final.pdf; INQ000498725)

1.11. Prior to and during the pandemic, many care workers worked on zero-hours contracts, meaning that they were not guaranteed any minimum working hours. In England in 2019/20, 24% of the adult social care workforce was employed on zero-hours contracts, including more than 40% of the domiciliary care workforce.[12] A 2019 report confirmed that 11% of the social care workforce in Scotland was on zero-hours contracts.[13] In Wales, responses to a survey conducted in 2020 by the

10 INQ000606894_0002, 0005. These estimates are not broken down by care provided to adults and care provided to children.
11 INQ000475008_0089
12 *The State of the Adult Social Care Sector and Workforce in England*, Skills for Care, October 2020, p40 (INQ000553304)
13 *Fair Work in Scotland's Social Care Sector 2019*, Fair Work Convention, February 2019, p5 (https://www.fairworkconvention.scot/wp-content/uploads/2018/11/Fair-Work-in-Scotland%E2%80%99s-Social-Care-Sector-2019.pdf; INQ000376409)

Welsh Institute for Health and Social Care, a health and care policy research institute, indicated that 22% of care workers employed by local authorities and in the private/independent sector and 4% of care workers in the third sector (which refers to charities, cooperatives, social value organisations and other not-for-profit employers who deliver social care services, outside the local authority and independent sectors) were on zero-hours contracts.[14] Equivalent data on zero-hours contracts are not available for Northern Ireland. While zero-hours contracts may provide flexibility, during the Covid-19 pandemic this often meant that care workers did not have a stable income and might not have qualified for Statutory Sick Pay (see Chapter 3: Protective measures).[15]

1.12. At the outset of the pandemic, staff vacancies also put the sector in a precarious position. In England, in March 2020, there were about 120,000 vacancies in the sector, amounting to 8% of the workforce.[16] In Northern Ireland, as at 31 March 2020, Health and Social Care trusts were recruiting to fill vacancies of 7.8% in the social care workforce (including domiciliary care). This had risen to 12.2% by 31 December 2021.[17] In Scotland, 48% of care homes for adults reported vacancies in 2020, rising to 63% in 2021. In domiciliary care, 59% of services reported vacancies in 2020 and 71% in 2021.[18] Social Care Wales reported 5.3% of jobs in adult residential care as vacant on 31 March 2021.[19] Albert Heaney (Deputy Director General Health and Social Services Group in the Welsh Government from March 2020 to June 2021 and Chief Social Care Officer for Wales from June 2021) explained that the adult social care sector in Wales was in a fragile and vulnerable state going into the pandemic, with a high turnover of staff and a very low-paid workforce.[20] Jeane Freeman (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021) described a similar longstanding position in Scotland, noting significant difficulties in staff recruitment and retention in the care sector there.[21]

14 *Review of Evidence of Variation in Terms and Conditions for Social Care Employment Contracts in Wales*, Welsh Government, 10 September 2020, p57 (https://www.gov.wales/sites/default/files/statistics-and-research/2020-09/review-of-evidence-of-variation-in-terms-and-conditions-for-social-care-employment-contracts-in-wales.pdf; INQ000549358). The survey responses provided details of contract conditions across adult care settings in 14 Welsh local authorities, 53 independent sector organisations (employers who deliver social care services, which are outside the local authority sector and the third sector), 7 third sector organisations and 7 NHS health boards/trusts. The private sector is not defined but appears to be used interchangeably with the independent sector in this source.

15 The Employment Rights Act 2025 (https://www.legislation.gov.uk/ukpga/2025/36/contents) removed the lower earnings limit for Statutory Sick Pay across the UK, with effect from April 2026, and will introduce the right to guaranteed hours for zero-hours workers in England, Scotland and Wales in 2027. See also INQ000660197; *Plan to Make Work Pay and Employment Rights Act: Timeline Update*, Department for Business and Trade, 15 April 2026 (https://www.gov.uk/government/publications/implementing-the-plan-to-make-work-pay-and-employment-rights-act/plan-to-make-work-pay-and-employment-rights-act-timeline-update; INQ000660253).

16 INQ000325232_0001; INQ000587737_0046 para 196

17 *The Review Body on NHS Pay 2026/27 Pay Round*, Department of Health (Northern Ireland), October 2025, pp133-134, Table 48 (https://www.health-ni.gov.uk/sites/default/files/2025-10/NHSPRB%20NI%20Evidence%202026%2027.pdf; INQ000549357). This figure is not broken down by category of social services and may therefore include services outside the scope of this module.

18 *Staff Vacancies in Care Services 2021*, Care Inspectorate and Scottish Social Services Council, November 2022, p12 (https://data.sssc.uk.com/images/StaffVacancies/Staff_vacancies_2021.pdf; INQ000574662)

19 *Social Care Workforce Report 2021*, Social Care Wales, 13 June 2022, pp4, 22 (https://socialcare.wales/cms-assets/documents/Workforce_Report_2021_EN-final.pdf; INQ000498725)

20 Albert Heaney 15 July 2025 119/23-120/13

21 INQ000606530_0021-0022 paras 73-74

1.13. Staff shortages increased throughout the pandemic as care workers became unwell or were required to self-isolate, as care workers told the Inquiry's listening exercise, Every Story Matters.[22]

> "*So not only were you having all the service users becoming poorly, you were having all the staff becoming poorly as well … the shortage of staff was unbelievable.*"[23]
>
> **Care home worker, England, Every Story Matters**

1.14. Despite valiant efforts by staff who continued to work, shortages necessarily affected the quality of care that could be delivered.[24] Similar issues arose in domiciliary care.

> "*I think one particular shift there was something like 20% of the workforce working, because either they had Covid, or they were off with the stress.*"[25]
>
> **Domiciliary care worker, England, Every Story Matters**

1.15. The Inquiry heard of the stress caused by high levels of staff turnover during the pandemic.

> "*The staff turnover was horrendous, we had new carers coming in every day, [which was] difficult for infection control and for staff, to meet new people every day meant we didn't really have solidarity with one another. It felt like we were disposable.*"[26]
>
> **Registered manager, England, Every Story Matters**

1.16. Prior to the pandemic, workforce vacancies and absences meant that care homes often relied on agency workers to ensure that there were safe staffing levels.[27] Agency staff would therefore often work across multiple settings. In February 2020, staff were identified as a possible route of transmission of the virus into care settings.[28] (Staff movement is considered further in Chapter 3: Protective measures.)

22 *Every Story Matters: Adult Social Care Sector*, pp125-126 (INQ000587564); INQ000553880_0001
23 *Every Story Matters: Adult Social Care Sector*, p126 (INQ000587564)
24 See, for example, *Bailed Out and Burned Out? The Financial Impact of COVID-19 on UK Care Homes for Older People and Their Workforce*, Financial Impacts of Covid-19 on Care Homes, 13 April 2023, p12 (https://ficch.org.uk/downloads/1196/ficch-report-mar23-highres.pdf; INQ000518358)
25 *Every Story Matters: Adult Social Care Sector*, p128 (INQ000587564)
26 *Every Story Matters: Adult Social Care Sector*, p132 (INQ000587564)
27 'Staffing issues in care homes have contributed to COVID-19 infections amongst residents', The Health Foundation, 3 July 2020 (https://www.health.org.uk/media-office/press-releases/staffing-issues-in-care-homes-have-contributed-to-covid-19-infections-amongst-residents; INQ000660316_0001-0002)
28 INQ000049363_0002 para 7

Responsibility for the adult social care sector

1.17. Responsibility for setting the overarching policy and legal framework for adult social care across the UK lies with the UK government (for England) and each devolved administration:

- In England, this responsibility rests with the Department of Health and Social Care; in Northern Ireland, it is the Department of Health (Northern Ireland).[29]
- In Wales, the Health and Social Services Group supports "*Welsh Ministers take over perform their policy oversight and expectations*" of the care system.[30]
- For the Scottish Government, social care was in the remit of the Community Health and Care Directorate until June 2020, when the Directorate for Mental Health and Social Care was established. Since December 2021, the Social Care and National Care Service Development Directorate has led on social care policy.[31]

1.18. The delivery of adult social care – for example, organising care assessments and assisting with securing appropriate placements – sits at a level below the four governments of the UK. In England and Wales, local authorities must plan and secure adult social care. This includes assessing whether an adult has needs for care and support. The local authority may then have a duty to meet identified needs, depending on the person's circumstances.[32] In Scotland, local authorities and health boards work together to plan and commission adult community health and social care services. In 31 of 32 local authority areas, this responsibility is delegated to an integration joint board, which uses a single, pooled budget to commission services from territorial health boards and local authorities, operating jointly as health and social care partnerships.[33]

1.19. This division of responsibilities – between the UK government, Welsh Government and Scottish Government and local government – adds a layer of complexity to the systems in England, Wales and Scotland. The Welsh Local Government Association (which represents all 22 local authorities in Wales) explained that managing the conflicting demands between local authorities (which have to address the needs and specific features of their areas) and national government (which is responsible for wider policy) remains a challenge for the sector.[34]

29 INQ000587735_0009-0010 para 34; INQ000613603_0006 para 11; INQ000319643_0004-0005, 0007, 0013 paras 14, 22, 43; INQ000576034_0012 para 42; INQ000606530_0002 para 6
30 INQ000396878_0007 para 16
31 INQ000485979_0006, 0016-0017 paras 20, 58, 60-61; INQ000587342_0023 paras 62-64
32 England: Care Act 2014 (https://www.legislation.gov.uk/ukpga/2014/23/contents), in particular sections 9, 13 and 18; INQ000551798_0011 para 31; Wales: Social Services and Well-being (Wales) Act 2014 (https://www.legislation.gov.uk/anaw/2014/4/contents), in particular sections 19, 32, 34-35
33 INQ000614179_0009-0011, 0034 paras 9-13, 93; Public Bodies (Joint Working) (Scotland) Act 2014 (https://www.legislation.gov.uk/asp/2014/9/contents). The remaining area – shared by The Highland Council and NHS Highland – has adopted an alternative lead agency arrangement, where NHS Highland has responsibility for adult social care services and The Highland Council has responsibility for children's health and social care services (INQ000587833_0006 para 23). Two other local authorities – Clackmannanshire and Stirling – work together as a single integration joint board.
34 INQ000581765_0005

1.20. In Northern Ireland, delivery of health and social care is structurally integrated. The five Health and Social Care trusts (which cover geographical areas and deliver front-line services) are responsible for the provision of both health and social care services, including commissioning care for individuals.[35]

1.21. Care is commissioned by local authorities and Health and Social Care trusts, including from care home and domiciliary care providers. Only a very small percentage of care homes are run by local authorities or Health and Social Care trusts themselves. In 2020, approximately 84% of care homes in Wales were in the private/independent sector.[36] In 2023, more than 93% of care home beds in Northern Ireland were provided by the independent sector (services provided by private organisations).[37] In 2024, about 95% of care home beds in England were provided by the independent sector (private and voluntary).[38] In Scotland in 2025, 84% of residents in care homes for older people were in homes run by the private sector.[39] While data collection periods vary between nations, the majority of domiciliary care is similarly not provided by local authorities or Health and Social Care trusts themselves.[40] This means that governments have far less oversight and control over the adult social care sector than over healthcare systems.

1.22. The adult social care system in England is "*large, fragmented and more distant from Government than services like the NHS*".[41] The Covid-19 pandemic shone a light on the complex lines of accountability in the sector in England. While accountability ultimately rests with the Secretary of State for Health and Social Care, funding is provided by the Ministry of Housing, Communities and Local Government to local authorities.[42] Local authorities commission and organise delivery of care from many thousands of different providers and those providers are regulated by the Care Quality Commission.[43] This complicated arrangement is referred to in a report from the National Audit Office in March 2021.[44]

35 INQ000615082_0011 para 7; INQ000613603_0004, 0010 paras 3, 23; INQ000475008_0017

36 *All Wales Care Home Framework: The Role of Health Board Primary and Community Health Care Services*, National Strategic Programme for Primary Care (NHS Wales), October 2020, p11 (https://phw.nhs.wales/app/uploads/sites/2/2026/01/All-Wales-care-home-framework.pdf; INQ000660234)

37 *Statistics on Community Care for Adults in Northern Ireland (2022–2023),* Department of Health (Northern Ireland), 25 October 2023, pp32, 46 (https://www.health-ni.gov.uk/sites/default/files/publications/health/cc-adults-ni-22-23.pdf; INQ000396788)

38 *Adult Social Care in England: What Next?*, Institute for Fiscal Studies, 10 October 2024, p11 (https://ifs.org.uk/publications/adult-social-care-england-what-next; INQ000514906)

39 *Care Home Census for Adults in Scotland: Statistics for 2015 to 2025*, Public Health Scotland, 28 October 2025, p12 (https://publichealthscotland.scot/publications/care-home-census-for-adults-in-scotland/care-home-census-for-adults-in-scotland-statistics-for-2015-to-2025; INQ000660214)

40 *An Overview of the UK Homecare Market*, Homecare Association, 28 March 2024, pp27, 40, 50, 70 (https://www.homecareassociation.org.uk/asset/2A51F1FC%2DA86D%2D4DDB%2D8470982FF17E8B2D; INQ000571020). Data are from 2017 to 2022 in England, from 2018 to 2019 in Wales and from 2023 in Scotland and Northern Ireland.

41 INQ000090250_0002

42 Between May 2006 and January 2018, the department was known as the Department for Communities and Local Government. In January 2018, it was renamed the Ministry of Housing, Communities and Local Government. In September 2021, it was renamed the Department for Levelling Up, Housing and Communities. In July 2024, the name was reverted to the Ministry of Housing, Communities and Local Government. This Report uses the correct name for the department according to the relevant time period.

43 *Fractured and Forgotten? The Social Care Provider Market in England*, Nuffield Trust, 16 April 2021, p39 (https://www.nuffieldtrust.org.uk/sites/default/files/2021-04/nuffield-trust-social-care-provider-market-web1.pdf; INQ000660274)

44 *The Adult Social Care Market in England*, National Audit Office, 25 March 2021, pp10, 38, paras 15, 2.17 (https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf; INQ000506973)

1.23. Matt Hancock (Secretary of State for Health and Social Care from July 2018 to June 2021) said that there was a "*hodgepodge of accountability*" in England for adult social care services, which meant that the levers that the UK government had were "*weak*".[45] Professor Sir Michael McBride (Chief Medical Officer for Northern Ireland from September 2006) agreed that "*at times we didn't have all the levers that we needed to be able to pull*".[46]

1.24. Ms Freeman told the Inquiry that, in contrast to the health service, there was no power for ministers to direct what should happen in adult social care.[47] Vaughan Gething (Minister for Health and Social Services in the Welsh Government from May 2016 to May 2021) explained that the adult social care sector is "*in a difficult position compared to the NHS where you have one stream of accountability going through the service*".[48]

1.25. Greater oversight of the adult social care sector has been introduced in recent years. In England, the Health and Care Act 2022 introduced new powers to allow the Secretary of State to intervene where they are satisfied that local authorities have failed, or are failing, to discharge their functions.[49] It also introduced a legal duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties under Part 1 of the Care Act 2014 (which outlines the duties and role of local authorities to ensure that care and support are provided to people who need them).[50]

1.26. In April 2026, the Care Quality Commission published the *Assessment Framework for Local Authority Assurance*, outlining how local authorities will be assessed under four separate themes – working with people, support, safety and leadership.[51] The commission obtains feedback, including from the relevant local authority, providers, unpaid carers, and voluntary and community groups. It also speaks directly to a small number of users of care and considers the responses received to its 'Give feedback on care' service.[52] By early June 2026, the vast majority of assessment reports had been published.[53] While this assessment process is still in its infancy and so cannot be fully evaluated, the Inquiry considers that this is a step in the right direction.

45 Matt Hancock 2 July 2025 3/1-6
46 Michael McBride 24 July 2025 82/23-84/6
47 Jeane Freeman 22 July 2025 35/2-18
48 Vaughan Gething 15 July 2025 3/5-4/17
49 Health and Care Act 2022, section 164 (https://www.legislation.gov.uk/ukpga/2022/31/contents); Care Act 2014, sections 72A-B (https://www.legislation.gov.uk/ukpga/2014/23/contents)
50 Health and Care Act 2022, section 163 (https://www.legislation.gov.uk/ukpga/2022/31/contents); Health and Social Care Act 2008, section 46A (https://www.legislation.gov.uk/ukpga/2008/14/contents); Care Act 2014, Part 1 (https://www.legislation.gov.uk/ukpga/2014/23/contents)
51 INQ000660291
52 'How we assess local authorities', Care Quality Commission, 15 May 2026 (https://www.cqc.org.uk/guidance-regulation/local-authorities/how-we-assess; INQ000660290); INQ000398721
53 'Local authority assessment reports', Care Quality Commission, 4 June 2026 (https://www.cqc.org.uk/search/content/7217; INQ000660400). In England, 153 local authorities are designated as councils with adult social services responsibilities (INQ000587382_0044 para 139).

Pandemic planning for adult social care

1.27. Many people who use adult social care services are at heightened risk of severe illness from respiratory viruses and may require hospitalisation as a result.[54] Older adults with social care needs experience a larger number of emergency hospital admissions than those with no care needs.[55] This brings into focus the close inter-relationship between the adult social care sector and healthcare.[56] As the Welsh Government acknowledged, social care plays a "*critical role in helping people to live well and stay well at home, so that they don't need to be admitted to hospital either at all, or as often*".[57]

1.28. When people are supported to receive the best possible health outcomes, pressures on healthcare settings are reduced. NHS England has recognised that, too often, people living with dementia have been admitted to hospital as a result of a lack of appropriate support in residential care and the community.[58] Its *Long Term Plan*, published in 2019, observed that people resident in care homes:

> "*account for 185,000 emergency admissions each year and 1.46 million emergency bed days, with 35–40% of emergency admissions potentially avoidable. Evidence suggests that many people living in care homes are not having their needs assessed and addressed as well as they could be, often resulting in unnecessary, unplanned and avoidable admissions to hospital and sub-optimal medication regimes.*"[59]

1.29. The Welsh Government has reflected its ambition for joined-up health and care services through *A Healthier Wales: Our Plan for Health and Social Care*.[60] In July 2022, the Health and Care Act 2022 created statutory integrated care partnerships in England. These brought together the NHS, local authorities and other partners in social care, as well as the voluntary, community and social enterprise sectors in each of 42 local areas jointly to plan and deliver health and care services. Integrated care partnerships were responsible for developing integrated care strategies for their local population.[61] The Health Bill, which is currently progressing through Parliament, proposes the removal of the requirement for integrated care partnerships.[62] It is too early to predict the impact this could have. However, it risks care providers having

54 INQ000587772_0045 para 4.1
55 'Social care needs linked to higher risk of avoidable hospital admissions, study finds', National Centre for Social Research, 26 January 2026 (https://natcen.ac.uk/news/social-care-needs-linked-higher-risk-avoidable-hospital-admissions-study-finds; INQ000660270)
56 INQ000587739_0016 para 52
57 INQ000549355_0004
58 *The Framework for Enhanced Health in Care Homes*, Version 2, NHS England and NHS Improvement, 31 March 2020, p22, para 7.3.1 (https://www.doncasterlmc.co.uk/wp-content/uploads/2021/04/the-framework-for-enhanced-health-in-care-homes-v2-0.pdf; INQ000589808)
59 *The NHS Long Term Plan*, NHS England and NHS Improvement, 7 January 2019, p15, para 1.13 (https://webarchive.nationalarchives.gov.uk/ukgwa/20230418155402/https:/www.longtermplan.nhs.uk/publication/nhs-long-term-plan; INQ000113233)
60 *A Healthier Wales: Our Plan for Health and Social Care*, Welsh Government, 8 June 2018, updated 2021, p5 (https://www.gov.wales/sites/default/files/publications/2021-09/a-healthier-wales-our-plan-for-health-and-social-care.pdf; INQ000066130)
61 Health and Care Act 2022, section 26 (https://www.legislation.gov.uk/ukpga/2022/31/contents)
62 Health Bill, 14 May 2026, section 23 (https://publications.parliament.uk/pa/bills/cbill/59-02/0009/260009.pdf). The original Bill was proposed on 14 May 2026. For further information regarding this Bill, see https://bills.parliament.uk/bills/4124.

less influence in planning for the delivery of care. Also, frequent changes to structures and legislation affecting the care sector, even if well intended, are likely to create confusion for those involved in the sector and undermine effective planning.

1.30. The adult social care sector should be viewed as part of the UK's critical infrastructure, essential to ensuring that the health and social care needs of a vulnerable part of the population continue to be met. As examined below, planning and pandemic exercises prior to the Covid-19 pandemic did not lead to adequate planning for the impact that a pandemic would have on people using and providing adult social care and how identified risks could be mitigated.

Government planning

1.31. The *UK Influenza Pandemic Preparedness Strategy 2011* (prepared by the UK government and adopted by the devolved administrations) foresaw that there might be particular challenges in maintaining social care services in all but a mild influenza pandemic.[63] However, this acknowledgement failed to translate into meaningful plans at a nation-specific level for how best to protect the care sector from the difficulties it would face.

1.32. The Department of Health and Social Care's 2012 *Health and Social Care Influenza Pandemic Preparedness and Response* (intended to be read in conjunction with the *UK Influenza Pandemic Preparedness Strategy 2011*) focused on the operational aspects of pandemic response in both the health and social care sectors. The longest social care section ran to just four pages.[64] This section was largely mirrored in guidance in Northern Ireland and Wales, in 2013 and 2014 respectively.[65] In Scotland, *Influenza Pandemic Preparedness: Guidance for Health and Social Care Services in Scotland* was still in draft form in 2019, shortly before the pandemic. The section on preparedness and response in adult social care was very short.[66]

1.33. The 2016 National Risk Assessment, conducted by the UK government to assist contingency planning for domestic emergencies, identified that social care was already under significant pressure, especially in respect of the workforce, provider capacity, quality and patient flow. It also noted that an emergency, including an influenza pandemic, would have an additional impact on these existing risk areas.[67]

63 *UK Influenza Pandemic Preparedness Strategy 2011*, Department of Health, 10 November 2011, p50, para 6.4 (https://assets.publishing.service.gov.uk/media/69f335f9161a319cff4fbb60/withdrawn-dh-uk-influenza-pandemic-preparedness-strategy-2011.pdf; INQ000022708); see also *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 4 (https://covid19.public-inquiry.uk/documents/module-1-full-report). Prior to January 2018, the Department of Health and Social Care was known as the Department of Health – the department is referred to throughout this Report using its current name.
64 *Health and Social Care Influenza Pandemic Preparedness and Response*, Department of Health, April 2012, pp4, 36-40, paras 6.39-6.56 (https://assets.publishing.service.gov.uk/media/5a7c2c66ed915d26a930185c/dh_133656.pdf; INQ000022710).
65 *Northern Ireland Health and Social Care Influenza Pandemic Preparedness and Response Guidance*, Version 1, Department of Health, Social Services and Public Safety, January 2013, pp31-35 (https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/pan-flu-ni-hsc-preparedness-response-2012.pdf; INQ000183431); *Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance*, Version 3, Welsh Government, February 2014 (INQ000116503)
66 INQ000148759_0025-0026 paras 8.25-8.29
67 INQ000176770_0006

1.34. Despite this understanding that a pandemic could have a severe impact on adult social care, prior to the arrival of Covid-19, few pandemic exercises had considered, practically, how the sector would respond and cope during a pandemic.

Pandemic exercises

1.35. As outlined in the Inquiry's Module 1 Report, a number of key exercises took place across the UK between 2003 and 2018 to stress-test the UK's pandemic preparedness systems.[68] Small-scale exercises took place in 2003 and 2004 to test the preparedness and response to an outbreak of severe acute respiratory syndrome (SARS). Some of those exercises mentioned the social care sector briefly, while others did not mention it at all.[69]

Social care lessons from exercises

1.36. In Wales, following a pandemic influenza exercise held in April 2009 and the emergence of the 2009 to 2010 H1N1 influenza pandemic ('swine flu'), it was noted in November 2009 that further work was required to enhance the engagement with, and preparedness in, the "*independent care sector*".[70] A further pandemic exercise took place in 2014.[71] Dr Andrew Goodall (Director General of Health and Social Services in the Welsh Government and Chief Executive of NHS Wales from June 2014 to November 2021) agreed that, at the time, capacity in the adult social care sector to cope with a pandemic was the most significant area of concern because it directly went to matters of life and death in care homes.[72]

1.37. In Scotland, in April 2016, Exercise Silver Swan assessed preparedness and response to a pandemic influenza outbreak over a prolonged period. Concerns emerged about the robustness of plans in respect of backup capacity for the provision of social care. The exercise report noted that partners in resilience partnership areas needed to ensure that they had a comprehensive, multi-agency

68 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Appendix 2, Table 7 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
69 INQ000235217_0006, 0009 (two mentions of care homes); INQ000206664 (one mention of nursing homes); INQ000187903 (no mention of the adult social care sector); INQ000128977 (one mention of social care workers); INQ000090431_0012 (one mention of social care)
70 INQ000128976_0014
71 INQ000130469_0060 para 224; INQ000107136_0003
72 Andrew Goodall 4 July 2023 34/9-20; see also *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)

planning framework in place for health and social care to respond to influenza pandemics of varying severities.[73]

1.38. In October 2016, Exercise Cygnus – a major, three-day, cross-government exercise across the UK – took place to test a pandemic-scale response. It identified the following issues in respect of social care:

- In general, further planning was required to "*operationalise current thoughts about how the social care system might cope during a pandemic*".[74]
- The Department for Communities and Local Government, the Department of Health and Social Care, and directors of adult social services should, together with colleagues in the devolved administrations, develop a "*methodology for assessing social care capacity and surge capacity during a pandemic*" (Lesson Identified 18).[75]
- There should be an examination (it was not specified by whom) of the "*possibility of expanding social care real-estate and staffing capacity in the event of a worst case scenario pandemic*" (Lesson Identified 19).[76]

1.39. In March 2017, a Pandemic Flu Readiness Board (co-chaired by officials from the Cabinet Office and the Department of Health and Social Care) was established to oversee the delivery of a cross-government and UK-wide programme to address the recommendations from Exercise Cygnus.[77] The programme was divided into five workstreams, with the Department of Health and Social Care taking the lead on adult social care. The identified work on adult social care capacity remained incomplete by the onset of the Covid-19 pandemic.[78]

1.40. In late 2017, the Department of Health and Social Care commissioned the Association of Directors of Adult Social Services (a membership organisation for local authority adult social care leaders in England) to produce advice and guidance on

73 *Exercise Silver Swan: Overall Exercise Report*, Scottish Government, April 2016, pp3, 14 (https://www.gov.scot/binaries/content/documents/govscot/publications/foi-eir-release/2020/06/foi-202000026935/documents/foi-202000026935-exercise-silver-swan---report---published-version/foi-202000026935-exercise-silver-swan---report---published-version/govscot%3Adocument/FOI-202000026935%2BExercise%2BSilver%2BSwan%2B-%2BReport%2B-%2BPublished%2Bversion.pdf; INQ000103012). Regional resilience partnerships are composed of representatives from Category 1 and Category 2 responders and others as deemed necessary; see INQ000184894_0012 para 40. Under the Civil Contingencies Act 2004, Category 1 responders are those organisations (the emergency services, local authorities and NHS bodies) at the core of the response to most emergencies, which are subject to the full set of civil protection duties. Category 2 responders are organisations (the Health and Safety Executive, transport and utility companies) that are heavily involved in incidents that affect their particular sectors but are less likely to be involved at the heart of planning work. They have a lesser set of duties: cooperating and sharing relevant information with other Category 1 and 2 responders. See the Civil Contingencies Act 2004, Schedule 1 (https://www.legislation.gov.uk/ukpga/2004/36/contents).

74 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016*, Public Health England, 13 July 2017, p24 (https://assets.publishing.service.gov.uk/media/5f8eb911d3bf7f49a1ce842c/exercise-cygnus-report.pdf; INQ000056232). All four governments took part in Exercise Cygnus. While Public Health England delivered the exercise, the Department of Health and Social Care led on the preparation and delivery (INQ000184643_0034, 0061 paras 191, 323).

75 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016*, Public Health England, 13 July 2017, p24 (https://assets.publishing.service.gov.uk/media/5f8eb911d3bf7f49a1ce842c/exercise-cygnus-report.pdf; INQ000056232)

76 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016*, Public Health England, 13 July 2017, p25 (https://assets.publishing.service.gov.uk/media/5f8eb911d3bf7f49a1ce842c/exercise-cygnus-report.pdf; INQ000056232)

77 INQ000195847_0004 para 21; INQ000022748

78 INQ000057522_0014-0015; INQ000195847_0005 para 24; see also INQ000576001_0013-0020 paras 3.15-3.32

planning for an influenza pandemic. The Association of Directors of Adult Social Services produced reports which were shared with the Department of Health and Social Care as well as directors of adult social services in 2018.[79] One report – which focused on the critical information and data needed for directors of adult social services and their partners to plan for and make timely decisions about the reprioritisation of services in response to an influenza pandemic – recognised the importance of forward planning for tracking bed capacity in care homes, capacity for care to be delivered at home and staff sickness levels.[80] A *Guide for Pandemic Flu Planning for Directors of Adult Social Services* was produced and circulated by the Association of Directors of Adult Social Services among its members. However, the association was unclear as to what use the Department of Health and Social Care made of the reports it had produced prior to the pandemic.[81]

1.41. While the Department of Health and Social Care said that the recommendations from the Association of Directors of Adult Social Services helped to inform the pandemic response, the department also confirmed that implementation of those recommendations was paused before the arrival of Covid-19 due to "*other contingencies*".[82] As noted in the Inquiry's Module 1 Report, a number of workstreams for pandemic preparedness were paused to focus resources on the UK government's contingency planning for a 'no deal' exit from the European Union (known as Operation Yellowhammer).[83] Planning for the impact of a pandemic on the adult social care sector, and any steps that could be taken to mitigate this, had stalled.

1.42. The Northern Ireland Pandemic Flu Oversight Group, Wales's Pandemic Flu Preparedness Group and Scotland's Pandemic Flu Preparedness Board (which were established following Exercise Cygnus) had, likewise, not completed their work on the adult social care sector prior to the pandemic.[84] Identified work on social care capacity had not been completed in Scotland.[85] In Northern Ireland, it was determined that further work was required on the *Health and Social Care Influenza Pandemic Surge Guidance*, but this remained incomplete at the onset of the pandemic.[86] Mr Gething agreed that the Welsh Government could have made more progress on issues related to private care home capacity and contingency plans.[87] Having identified concerns about adult social care capacity, all four governments failed adequately to plan for how those identified concerns would be managed in a pandemic.

79 INQ000571608_0024-0025 paras 7.1-7.2; INQ000587735_0017 para 61
80 INQ000080774_0009-0011 section 6
81 INQ000571608_0025 para 7.3; Cathie Williams 23 July 2025 61/11-63/20
82 INQ000587735_0017 para 62
83 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
84 INQ000203352_0012-0013 para 38; Gillian Russell 28 June 2023 70/1-73/4, 76/25-82/9; Frank Atherton 3 July 2023 40/15-43/6, 44/22-49/10, 52/19-53/24
85 INQ000182606_0006-0007 paras 20-21
86 INQ000203352_0012-0013 para 38
87 Vaughan Gething 4 July 2023 139/22-140/3

Lack of sector representation

1.43. Pandemic exercises also suffered from a lack of adult social care sector representation. Key stakeholders, including the Royal College of Nursing, private care home providers and the Association of Directors of Adult Social Services, did not take part in Exercise Cygnus.[88] Likewise, only 8 out of the 42 local resilience forums in England and Wales (which coordinate the response to emergencies by bringing together representatives from local public services, including the NHS, local authorities, emergency services and others) took part.[89] The Local Government Association (a national membership body for local authorities in England and Wales) was not sighted on the conclusions of Exercise Cygnus until it was released in 2020 as a result of legal proceedings brought by another body.[90] The Welsh Local Government Association also had no records of the Welsh Government involving local authorities in Wales in any follow-up action following the exercise.[91]

1.44. Professor Harries said that few people in the Department of Health and Social Care had direct or practical experience of having worked in or with care homes or on the commissioning of care home services, or an understanding of the local connections that would underpin the emergency response in the adult social care sector.[92] This made the involvement of representatives of the sector all the more important.

1.45. UK government ministers were aware that they lacked direct levers over the adult social care sector and that they were not responsible for delivery of adult social care services in the same way as healthcare services. Without adequate involvement of the sector in Exercise Cygnus, key voices with the most comprehensive understanding of adult social care were missing. Without sight of the conclusions of Exercise Cygnus in England, or adequate local authority involvement in follow-up action following the exercise in Wales, the UK government and Welsh Government afforded no opportunity for those who delivered adult social care to act upon its recommendations.

1.46. Even as late as February 2020, there was no adult social care representative in Exercise Nimbus, a UK-wide ministerial desktop exercise commissioned by the Cabinet Office.[93] This exercise imagined a fictional meeting of COBR (the UK government's crisis management centre for responding to whole-system civil emergencies) taking place in April 2020 in order to test decision-making processes and strategies.[94] However, despite COBR having been informed at the end of

88 INQ000177809_0015 para 39; INQ000571608_0025 para 7.3; see also *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
89 Mark Lloyd 12 July 2023 100/1-13; INQ000587394_0006 para 3.7(vi); INQ000587735_0016 para 56; INQ000177802_0010 para 27; *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
90 Mark Lloyd 12 July 2023 102/10-19
91 INQ000177802_0025 para 85
92 INQ000587394_0014-0015 para 5.12
93 Yvonne Doyle 2 November 2023 188/7-189/12; INQ000195891_0001-0003
94 INQ000232194_0044-0045 para 187; INQ000052022; *Summary Note on Exercise Nimbus Novel Coronavirus Preparation*, Public Health England, 12 February 2020 (INQ000273915)

January 2020 that "*the elderly and those with existing health conditions will be disproportionately affected*", this did not lead to an in-depth discussion of the adult social care sector during Exercise Nimbus and there remained little focus on the sector.[95] Mr Hancock, who chaired the fictional meeting, said that this was a ministerial exercise, with Mr Hancock and Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021) representing social care. Although Sir Simon Stevens (later Lord Stevens of Birmingham), Chief Executive of NHS England from April 2014 to July 2021, and another representative attended on behalf of NHS England, there was not an equivalent representative of the social care sector. Mr Hancock told the Inquiry that this was one of the problems.[96]

1.47. Planning at a government level for the impact that a pandemic may have on the adult social care sector following Exercise Cygnus commenced in each nation but remained incomplete. This meant that the specific issues identified in respect of adult social care quickly became matters that had to be addressed after the arrival of Covid-19 in the UK. By this point, it was too late.

1.48. Had there been greater involvement of the sector, this might have ensured a greater focus on the sector in pandemic planning. The Inquiry welcomes the greater involvement of local resilience forums (and local resilience partnerships in Scotland) in Exercise Pegasus, a UK-wide pandemic preparedness exercise that commenced in 2025.[97] However, it is too early to tell whether the UK government and devolved administrations have properly learned one of the key lessons of the pandemic – namely, the need for proper planning and for the full engagement in that planning of those who will be significantly involved in or affected by any response.

Collection of data in the adult social care sector

1.49. Despite Exercise Cygnus having recommended the development of a proper method for assessing social care capacity, the Department of Health and Social Care did not have an England-wide source of operational data about people in receipt of care, the workforce or current spare capacity, prior to the Covid-19 pandemic.[98]

1.50. The NHS England Capacity Tracker, introduced in 2017, was a tool used to give hospitals visibility of the number of vacancies in care homes in England. However, completion of the tracker was voluntary and only about half of regulated care homes

95 INQ000051809_0002 para 1; INQ000195891_0005 para 17; INQ000391226_0003
96 INQ000195891_0001-0002; Matt Hancock 2 July 2025 192/22-194/21
97 'Written statement: Second six-monthly update following the Welsh Government's response to the UK Covid-19 Inquiry's Module 1 Report', Welsh Government, 14 January 2026, p7 (https://www.gov.wales/written-statement-second-six-monthly-update-following-welsh-governments-response-uk-covid-19; INQ000660195); *Pandemic Preparedness and Exercise Pegasus*, NHS England, 16 July 2025 (https://www.england.nhs.uk/long-read/pandemic-preparedness-exercise-pegasus; INQ000657621_0002 para 7); *UK Covid-19 Inquiry – Module 1 Report: Progress Update – January 2026*, Scottish Government, 16 January 2026 (https://www.gov.scot/publications/uk-covid-19-inquiry-module-1-report-progress-update-january-2026/pages/8; INQ000660194_0012)
98 INQ000587738_0003 para 8; *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016*, Version 1, Public Health England, 13 July 2017, p24 (https://assets.publishing.service.gov.uk/media/5f8eb911d3bf7f49a1ce842c/exercise-cygnus-report.pdf; INQ000056232)

in England used it to report vacancies.[99] Similarly, prior to the pandemic, there was no national overview of available bed capacity in care homes in Scotland and, in Northern Ireland, the Regulation and Quality Improvement Authority did not collect information on bed usage and capacity in care homes.[100] Although local authorities in Wales held information on bed capacity among care providers, Welsh ministers did not have access to this information routinely at a nationwide level.[101]

1.51. This meant that systems to collect crucial data on bed capacity in care homes and staffing levels across the wider sector required development once Covid-19 had already arrived in the UK. These data were required to facilitate a cross-government response in each nation. Such data would have informed key decisions such as expedited hospital discharge and the impact this would have on the sector (see Chapter 2: Care home admissions, testing and isolation). Each government had to develop regular, streamlined methods of collecting these data in the middle of the crisis.

Development of capacity data during the pandemic

1.52. In March 2020, in England, the NHS England Capacity Tracker was identified as the most immediate, suitable tool for Covid-19 data collection from care home providers.[102] It was updated to record:

- whether a facility was open, closed or partially closed to admissions;
- the overall status of a facility, with a green, amber and red status for identified risks;
- the number of residents with confirmed or suspected Covid-19;
- staffing numbers by type, including those in full-time posts, vacancies, absences and additional staffing required;
- workforce information and status (ie whether staffing ratios were being met), with a green, amber and red status for identified risks; and
- personal protective equipment (PPE) status, with a green, amber and red status to identify how long the current level of equipment was expected to last.[103]

By 2 April 2020, the Capacity Tracker was described as the "*single mechanism across the country to report bed vacancies and help manage demand*".[104]

99 INQ000110764_0001; INQ000587737_0039 para 163c; INQ000587738_0009, 0011 paras 31-33, 35
100 INQ000546936_0012-0013 para 2.23; INQ000475143_0009 para 29
101 INQ000613908_0020, 0050 paras 55, 124; INQ000183710
102 INQ000587738_0010-0011 para 34
103 INQ000587738_0010-0016 paras 34, 38. The Capacity Tracker was updated throughout the pandemic.
104 *Admission and Care of Residents during COVID-19 Incident in a Care Home*, Version 1, Department of Health and Social Care, Public Health England, Care Quality Commission and NHS, 2 April 2020, pp3, 23-26 (https://www.pathway.org.uk/wp-content/uploads/Admission-and-Care-of-Residents-during-COVID-19-Incident-in-a-Care-Home.pdf; INQ000528401)

1.53. Having identified a gap in respect of data in domiciliary care, an online survey for domiciliary care providers in England was rolled out by the Care Quality Commission, with support from the Department of Health and Social Care, in mid-April 2020.[105] The survey asked providers questions about:

- the number of people using the service and the number with confirmed or suspected Covid-19;
- staffing numbers, including those unable to work as a result of Covid-19;
- current stocks of PPE; and
- whether they had capacity to provide additional care hours and, if so, how many.[106]

From 30 November 2020, this information was incorporated into a new section of the NHS England Capacity Tracker.[107]

1.54. On 26 March 2020, the Welsh Government wrote to care home providers alerting them to the immediate availability of a new online capacity tool to track vacancies in adult care homes.[108] From 4 May 2020, local authorities were asked to complete weekly collections of the following social care workforce data:

- the number of full-time equivalents employed in social services;
- staff absences due to confirmed or suspected Covid-19 or other illness and the numbers of staff who were shielding;
- testing data (numbers of positive tests, negative tests and those awaiting results);
- capacity, including number of students, volunteers and new employees; and
- a green, amber and red rating indicating whether there were sufficient staff to cover essential roles and services.[109]

Local authorities were also asked to collect and provide information on their ability to ensure that adult social care needs were being met.[110]

1.55. On 30 March 2020, the Department of Health (Northern Ireland) identified a need to gather specific monitoring information on care homes.[111] As explained by Professor Sean Holland (Chief Social Work Officer in the Department of Health (Northern Ireland) from July 2010 to October 2022), "*it became really important that we knew, day-to-day, how the system was doing*".[112] On 17 April 2020, Professor Holland

105 INQ000584245_0168-0170 paras 535-538; INQ000525032; INQ000235452_0001-0002
106 INQ000584245_0170-0171 para 540
107 INQ000584245_0172 para 545; INQ000235454_0002-0003
108 INQ000551798_0094-0095 para 334; INQ000500150. While this had been developed independently of the Covid-19 pandemic to be piloted in May 2020, the modified version was aimed at immediately identifying capacity during the pandemic response.
109 INQ000581813; INQ000613908_0050-0051 paras 124-127; INQ000581850; INQ000581817 Table 1
110 INQ000581814 Table 1
111 INQ000560991; INQ000560993
112 Sean Holland 21 July 2025 82/23-83/14

confirmed that work had been undertaken to produce a reporting template.[113] From 22 April 2020, providers were required to make a single daily return to the Regulation and Quality Improvement Authority.[114] In May 2020, guidance outlined that providers were asked to provide information on:

- numbers of occupied and vacant beds (both usable and unusable);
- outbreaks, including Covid-19 cases, and the number of symptomatic residents, residents tested (with a breakdown of positive tests), residents in self-isolation, total residents affected to date, residents hospitalised and resident deaths; and
- information on staff, including new positive cases, current symptomatic cases, staff who have tested positive, staff in self-isolation, and total staff tested and affected to date.[115]

Domiciliary care agencies were not required to provide information relating to staffing and capacity to the Regulation and Quality Improvement Authority.[116]

1.56. In Scotland, providers are required to maintain certain records and notify the Care Inspectorate of death, illness or other events.[117] Between 3 April and 22 June 2020, the Care Inspectorate added a notification requirement for registered services to confirm if they needed urgent staffing support. From 21 April 2020, services were asked to provide a weekly notification of staff absences due to Covid-19 and, from August 2021, this was expanded to include information on all staff vacancies. From 17 April 2020, services were also asked to record every suspected or confirmed case of Covid-19 in a specific notification.[118] From 24 August 2020, all care homes were expected to use a new digital Safety Huddle Tool.[119] The information captured included numbers of staff and residents tested (including numbers positive for Covid-19), care home occupancy, the number of closed care homes and additional information on staffing.[120] From December 2020, the Care Inspectorate provided some specific reporting for the Scottish Government which included the number of Covid-19 cases and staff absences in domiciliary care.[121]

1.57. Ascertaining whether a care home can safely care for its current residents, safely accept new residents and safely isolate residents (for infection prevention and control purposes) requires data on the number of beds (both occupied and available) and the staffing levels. Having access to these data at a sector-wide level in each nation during a pandemic is vital, so that pressures in the adult social care system can be understood and managed. In times of increased pressure on the healthcare

113 INQ000560994_0001; INQ000560995; INQ000613603_0259 para 836
114 INQ000560996_0001; INQ000560997_0001-0002
115 INQ000547851
116 INQ000475143_0012 para 37
117 INQ000475130_0024 para 87; The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, regulations 19, 21 (https://www.legislation.gov.uk/ssi/2002/114/contents/made)
118 INQ000475130_0024-0025, 0194 paras 87-88, Appendix 2, para 13
119 INQ000222894; INQ000324254_0002-0003
120 INQ000300850_0001-0002 para 2; INQ000356747_0020; INQ000346089_0013 para 44
121 INQ000475130_0200, 0202 paras 39, 45

system, governments may wish to see the effective and timely discharge of patients, including to the social care sector. Data on staffing capacity in domiciliary care will provide an indication of whether people can be safely cared for at home. Understanding staffing levels also supports the ability to balance compliance with self-isolation policies for staff with the maintenance of safe staffing levels for effective care.

1.58. Methods to track capacity in the adult social care sector (including methods to determine how surge capacity would be assessed in a pandemic) should have been properly established and fully utilised following Exercise Cygnus by the Department of Health and Social Care, the Department of Health (Northern Ireland) and the Scottish Government and Welsh Government. This work should have been completed prior to 2020. Decision-makers should have had immediate access to this information at the point at which they started making decisions that would impact the sector. In the future, there must be established methods to collect these data prior to a pandemic, so that fully informed decisions can be made from the outset. The more comprehensive the information that is collected, the better informed decisions will be. Plans should identify how the provision of data by care homes, domiciliary care providers or local partners can be streamlined to reduce administrative burdens on data providers.

1.59. Given the importance of these data in both pandemic and non-pandemic times, data collection in the adult social care sector is a pressing priority.

Post-pandemic data collection

1.60. The Inquiry welcomes the steps already taken in England, Scotland, Wales and Northern Ireland to improve the collection of data. However, collection of these data must be fully integrated into pandemic plans.

1.61. In Scotland, work is ongoing to define a "*care home minimum dataset*".[122] In Wales, data collection continues on a monthly basis.[123] In March 2023, the Northern Ireland Social Care Council (the regulatory body for the social care workforce in Northern Ireland) established the Social Care Collaborative Forum. The Inquiry understands that work is being taken forward there to progress a "*regional digital solution for bed capacity*" which will "*improve communication regarding location of available beds*" and provide an improved approach to data-gathering.[124] Since July 2022, in England, all providers regulated by the Care Quality Commission have had a statutory duty to provide mandatory information to the Capacity Tracker. This information includes: "*(i) care home bed vacancies, (ii) workforce resourcing and absences, (iii) vaccination statuses of staff and residents, and (iv) visiting options being supported.*"[125]

122 INQ000549359_0001-0002
123 INQ000613908_0051 para 128
124 INQ000660232; INQ000520343_0001 para 1; INQ000660233
125 INQ000273897_0093 para 396; Health and Care Act 2022, section 99 (https://www.legislation.gov.uk/ukpga/2022/31/contents); Health and Social Care Act 2012, section 277A (https://www.legislation.gov.uk/ukpga/2012/7/contents)

1.62. The Inquiry also notes the publication of the UK government's *Pandemic Preparedness Strategy* in March 2026. The UK government recognises the need to enhance "*communication and data flows between the adult social care, public health and NHS systems*" in England, which includes "*sharing of available beds and service capacity*".[126] However, plans must be translated into action.

Provider and local-level plans

1.63. The Inquiry agrees with Ms Whately, who observed:

> "[Y]*ou need a plan within a care provider … You need a plan at a local authority level. You need a plan at the government level. And you probably need … routine oversight of that process.*"[127]

1.64. Local-level plans sit between plans held by care home providers and domiciliary care providers and agencies on the one hand and those held by the UK government and devolved administrations on the other. The Inquiry heard about two main types of plans at the provider and local levels:

- business continuity plans, which address a wide range of potential incidents (eg cyber attacks) and outline how a body or organisation will maintain essential functions during an emergency;[128] and
- pandemic plans, which specifically focus on preparing for, responding to and mitigating the impacts of a pandemic.[129]

It was not possible to determine whether the terms 'contingency plan' and 'business continuity plan' were used interchangeably, or if they were plans that had different requirements.

Provider-level plans

1.65. There was a confusing picture about precisely which plans providers were meant to have and what the plans were meant to address. The 2012 *Health and Social Care Influenza Pandemic Preparedness and Response* document produced by the Department of Health and Social Care and NHS England provided a high-level list of what should be included in "*care homes plans*" but did not specify who had responsibility for producing or assuring them.[130] This was mirrored in guidance

126 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, pp51-52 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)
127 Helen Whately 17 July 2025 16/5-14
128 INQ000515924_0027
129 See, for example, INQ000647256_0002
130 *Health and Social Care Influenza Pandemic Preparedness and Response*, Department of Health, April 2012, pp4, 39, para 6.54 (https://assets.publishing.service.gov.uk/media/5a7c2c66ed915d26a930185c/dh_133656.pdf; INQ000022710)

published in Wales in 2014.[131] Similar guidance published in Northern Ireland in 2013 included the same list of requirements, but provided more detail, noting that care homes were expected to have appropriate pandemic influenza plans in place and a contingency plan for dealing with an influenza pandemic.[132]

1.66. Some care providers either did not have, or had inadequate, business continuity or pandemic plans. For example, in Scotland, despite it being a condition of their registration with the Care Inspectorate, prior to the pandemic, not all care homes had business continuity plans in place.[133] In England, prior to the pandemic, the Care Quality Commission's guidance stated that, in order to comply with the requirement to provide care safely, providers must be able to manage major incidents and emergencies and have plans with other providers for such incidents and events.[134] However, the Care Quality Commission's current guidance does not specifically require care providers to have pandemic plans; evidence suggests that this was also the case prior to 2020.[135] Before Covid-19, the Department of Health and Social Care noted that there were few resilience experts in the Care Quality Commission, and so the degree to which it could scrutinise providers' business continuity arrangements might be limited.[136]

1.67. A *Rapid Review for Care Homes in Relation to Covid-19 in Wales* (undertaken from July to September 2020) identified that there should be "*continuity plans*" for individual care homes.[137] Prior to publication of the review, seminars were held for local authorities and health boards to discuss the lessons that had been learned during the review and to compile "*action plans*" to build upon its recommendations.[138] The recommendation that every care home should be assisted to have a business continuity plan was well received and reflected in the action plans.[139] The fact that such a recommendation was necessary suggests that there was a lack of adequate provider-level plans prior to the pandemic, despite a pandemic exercise in 2014 stating that care homes were required to have "*robust contingency plans*".[140]

131 *Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance*, Version 3, Welsh Government, February 2014, pp33-34 (INQ000116503)
132 *Northern Ireland Health and Social Care Influenza Pandemic Preparedness and Response Guidance*, Version 1, Department of Health, Social Services and Public Safety, January 2013, pp34-35 (https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/pan-flu-ni-hsc-preparedness-response-2012.pdf; INQ000183431); *Residential Care Homes Minimum Standards*, Department of Health, Social Services and Public Safety, August 2011 (INQ000577519_0075)
133 INQ000148759_0028 para 9.9; INQ000547985_0001
134 INQ000105273_0010-0011 para 2.3.2
135 Cathie Williams 23 July 2025 66/2-23; *Regulations for Service Providers and Managers, Regulation 12: Safe Care and Treatment*, Care Quality Commission, 16 May 2025 (https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-12; INQ000660444)
136 INQ000007482_0021
137 INQ000136964_0013
138 INQ000136964_0002
139 INQ000136964_0040
140 INQ000107136_0003

Local-level plans

1.68. The picture of what adult social care plans should have existed above the provider level but below the level of the four governments of the UK, and what those plans should include, was also confusing. The Civil Contingencies Act 2004 placed local authorities in England, Scotland and Wales under a legal duty to maintain plans to enable an effective response to emergencies.[141] However, in England, it was unclear whether local authorities should have their own influenza plans (which would consider how the services they provided, funded and oversaw would be affected during an influenza pandemic) or if they were only expected to feed into local resilience forum plans. The Department of Health and Social Care's 2012 *Health and Social Care Influenza Pandemic Preparedness and Response* document merely said that social care might face challenges at the height of a pandemic, including as demand for hospital care increased, because discharged patients might require a greater level of care than normal. Therefore:

> "*as part of business continuity plans, local authorities should ensure they have in place arrangements for responding to increased demand for assessments and support alongside reduced capacity to deal with such circumstances*".[142]

This was largely mirrored in similar guidance published in Northern Ireland in 2013 and Wales in 2014. Both documents said that "*arrangements should be in place for responding to increased demand*", without a reference to local authorities.[143]

1.69. In 2013, the Cabinet Office published *Preparing for Pandemic Influenza: Guidance for Local Planners*, which was aimed at "*Local Resilience Fora*".[144] It explained that the:

> "*development, maintenance and testing of local level multi-agency plans plays a crucial role in ensuring that the objectives set out in the* [UK Influenza Pandemic Preparedness Strategy 2011] *can be met in the event of a pandemic*".[145]

This document included a very brief section on adult social care (and a very brief section relating to vulnerable people), with minimal practical guidance for what should be included in plans for adult social care.[146]

1.70. In December 2019, the Cabinet Office published the *National Resilience Standards* for local resilience forums, which, for the first time, related specifically to pandemic influenza. These standards stated that local resilience forums should have pandemic

141 Civil Contingencies Act 2004, section 2 (https://www.legislation.gov.uk/ukpga/2004/36/contents)
142 *Health and Social Care Influenza Pandemic Preparedness and Response*, Department of Health, April 2012, pp36-37, paras 6.40-6.44 (https://assets.publishing.service.gov.uk/media/5a7c2c66ed915d26a930185c/dh_133656.pdf; INQ000022710)
143 *Northern Ireland Health and Social Care Influenza Pandemic Preparedness and Response Guidance*, Version 1, Department of Health, Social Services and Public Safety, January 2013, pp30-32 (https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/pan-flu-ni-hsc-preparedness-response-2012.pdf; INQ000183431); INQ000116503_0031-0032; *Influenza Pandemic Preparedness: Guidance for Health and Social Care Organisations in Scotland* was in draft form in 2019 (INQ000148759).
144 *Preparing for Pandemic Influenza: Guidance for Local Planners*, Cabinet Office, 2013 (INQ000187483_0005)
145 *Preparing for Pandemic Influenza: Guidance for Local Planners*, Cabinet Office, 2013 (INQ000187483_0005)
146 *Preparing for Pandemic Influenza: Guidance for Local Planners*, Cabinet Office, 2013 (INQ000187483_0027, 0031)

influenza plans that set out expectations of social care providers.[147] As outlined in the Inquiry's Module 1 Report, given the proximity to the pandemic, this is unlikely to have had much – if any – practical influence at the onset of the pandemic.[148]

1.71. On 11 February 2020, UK government officials undertook a stocktake of pandemic preparedness in adult social care in England.[149] Sir Christopher Wormald (later Lord Wormald), Permanent Secretary to the Department of Health and Social Care from May 2016 to December 2024, said that this arose from his "*concern that there had been less focus in discussion on adult social care than on the NHS*".[150] Mr Hancock's view that the primary planning responsibility for the response to Covid-19 in adult social care rested with local authorities was noted.[151]

1.72. It was the Department of Health and Social Care's understanding that, further to a request in 2018, local authorities should have a "*flu plan*".[152] Ms Whately said that she had discovered this expectation in late February or early March 2020, when she asked for assurance about the preparedness of the sector. She requested copies of local authority pandemic response plans. On or about 3 March 2020, the Department of Health and Social Care provided her with two examples of influenza plans. These were local resilience forum plans that had been produced by two local authorities, jointly with local NHS teams.[153] Ms Whately found these plans to be inadequate and raised her concerns with Mr Hancock.[154]

1.73. Ms Whately agreed that a review should take place to identify any good plans from local authorities that could be used as templates for other local authorities.[155] Given that the plans provided to Ms Whately were influenza plans, it is reasonable to assume that she was seeking additional influenza plans, rather than any business continuity plans that may have existed. On 5 March 2020, Ms Whately was told by Professor Harries that there were "*hugely detailed plans sitting at local levels*".[156] She was also told by Ros Roughton (Director General for Adult Social Care in the Department of Health and Social Care from April to July 2020) that there were more detailed, Covid-19-specific plans and work was underway with the Ministry of Housing, Communities and Local Government to review and assure those plans.[157]

1.74. It is not clear if this was a reference to individual local authority plans or local resilience forum plans into which local authorities had fed. In any event, no further plans were shared with Ms Whately. As Ms Whately suggested, both on 5 March

147 INQ000576001_0020 para 3.29; *National Resilience Standards*, Cabinet Office, December 2019, version 2 (INQ000047333_0031)
148 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 6 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
149 INQ000587736_0004-0005 para 15
150 INQ000280628_0042-0043 para 83
151 INQ000049363_0002; INQ000587746_0012 para 52; INQ000587736_0004-0005 para 15
152 INQ000049363_0002 para 11; see also INQ000587746_0012 para 52; INQ000183419_0038 para 212
153 INQ000587788_0017 paras 60-61; INQ000327771_0001, 0007-0008, 0026-0027; *Hertfordshire Pandemic Influenza Framework*, NHS England NHS Improvement, Version 4, May 2019 (INQ000233758_0001, 0005-0007, 0049); INQ000233756_0001-0004
154 INQ000587788_0017 para 61; INQ000327767_0001-0002; Helen Whately 17 July 2025 12/12-14/4
155 INQ000587788_0017 para 62; INQ000609933_0005
156 INQ000609933_0004
157 INQ000609933_0004

2020 and to the Inquiry, the most obvious conclusion was that the plans did not exist.[158]

1.75. In early March 2020, Covid-19 was spreading fast and the care sector was looking to the Department of Health and Social Care for help and guidance. Ms Whately and Mr Hancock therefore agreed that the adult social care response to Covid-19 should be led by the UK government.[159] As outlined in a report by the Nuffield Trust (an independent health and social care think tank) in May 2023, it was not sufficiently clear who, or which organisation, was responsible for different aspects of the response for social care in England during February to May 2020. The Nuffield Trust noted the importance of ensuring that clarity about "*responsibilities and leadership for all parts of the system is established both in 'normal' times but particularly in preparation for a future crisis*".[160]

1.76. In Wales, in advance of a civil contingencies preparedness discussion on 4 March 2020, it was noted that directors of social services were reviewing contingency plans and raising awareness with commissioned social care providers.[161] The Inquiry has seen no other evidence about the content of these plans or whether any concerns were identified. Mr Gething relied on his understanding that plans were being reviewed – he explained that it would have been unreasonable for him to have asked to review the plans of all health boards and local authorities.[162]

1.77. In Scotland, Exercise Silver Swan in 2016 had recommended that regional resilience partnerships ensure that multi-agency pandemic influenza plans were produced that included health and social care partnerships.[163] Ms Freeman said that, at the start of the pandemic, she did not have oversight of how many health and social care partnerships had been integrated into local pandemic plans. She agreed that, to ensure the existence and adequacy of those plans and to inform the response of the sector, the relevant minister should have oversight of plans.[164]

1.78. There was, therefore, general confusion at the local and provider levels in England, Scotland and Wales about which plans should have existed prior to the pandemic and what any plans should address. In England, there had been no proper government oversight or evaluation of plans that had been produced prior to the pandemic by or with local authorities. Plans were not in place that had considered how the response might be managed at both the UK government and local government levels. Due to a lack of oversight from the Scottish Government, it is unclear if health and social care partnerships had been fully integrated into

158 Helen Whately 17 July 2025 19/13-21; INQ000609933_0004
159 INQ000587788_0017 para 62; Helen Whately 17 July 2025 19/22-21/22
160 *Building a Resilient Social Care System in England*, Research Report, Nuffield Trust, May 2023 (https://www.nuffieldtrust.org.uk/sites/default/files/2023-05/Building%20a%20resilient%20social%20care%20system%20in%20England.pdf; INQ000553858_0006)
161 INQ000336263_0001; INQ000532383_0009-0010 para 35
162 Vaughan Gething 15 July 2025 21/10-22/12; see also INQ000144842_0002
163 *Exercise Silver Swan: Overall Exercise Report*, Scottish Government, April 2016, p10, para 1.4 (https://www.gov.scot/binaries/content/documents/govscot/publications/foi-eir-release/2020/06/foi-202000026935/documents/foi-202000026935-exercise-silver-swan---report---published-version/foi-202000026935-exercise-silver-swan---report---published-version/govscot%3Adocument/FOI-202000026935%2BExercise%2BSilver%2BSwan%2B-%2BReport%2B-%2BPublished%2Bversion.pdf; INQ000103012)
164 Jeane Freeman 22 July 2025 46/20-48/7

pandemic plans in Scotland. A similar lack of oversight by the Welsh Government meant that it was unclear which, if any, plans produced by or with local authorities or health boards had been reviewed or assured in Wales.

Plans in Northern Ireland

1.79. In Northern Ireland, Professor McBride said that he reviewed the Covid-19 surge plans of the Health and Social Care trusts (which included surge planning for adult social care) and concluded that the regional coordination needed to be "*much more robust*".[165] He commissioned further work to quality assure the plans in late March 2020.[166]

1.80. A review of those plans, undertaken in July 2020, identified that there had initially been no formal assurance process. The review found that, while extensive work had been completed by the trusts, variations were observed. Gaps were identified – for example, arrangements for the clinical support (such as nursing support) that would be provided to the sector were not always clear.[167] More detailed pandemic planning could have identified the need for formal quality assurance processes and identified the significance of matters such as clinical support for care homes in a pandemic.

Improving planning for the adult social care sector

1.81. Entering the Covid-19 pandemic, it was well understood that the adult social care sector would be severely tested. The heightened vulnerability to respiratory illnesses of many people who draw on social care, the fragmentation of services across different sectors, and the high turnover of staff all contributed to the sector's lack of resilience before Covid-19 arrived. However, pandemic planning had not given adequate consideration to how these risks could be mitigated given the likely impact that a pandemic would have on the sector. Concerns identified – for example, through testing exercises – were not addressed.

1.82. As a result, it took time for the UK government and devolved administrations to establish adequate systems fully and routinely to collect key data about bed capacity in care homes and staffing capacity in the wider sector. These data should have been available before decisions had to be taken. Better data might have led to more informed decisions early in the pandemic response, such as those on expedited hospital discharge (see Chapter 2: Care home admissions, testing and isolation). This would likely also have given decision-makers a fuller understanding of the impact of early decisions.

1.83. Better pandemic planning is needed. There should be clarity on exactly what plans are required by providers and on the plans required at the level between providers

165 Michael McBride 24 July 2025 10/15-12/2
166 Michael McBride 24 July 2025 10/15-12/2; INQ000587671_0054-0055 paras 4.11-4.13
167 INQ000459860_0009-0011 paras 5.1-5.11; Michael McBride 24 July 2025 12/3-15/5

and the governments in each nation, including identifying who is responsible for producing and assuring them. Such plans are necessary to understand and address how different organisations and bodies will work together to mitigate the impact of a pandemic. The UK government's March 2026 *Pandemic Preparedness Strategy* commits to the development of an adult social care pandemic action plan in England by 2027 to respond to future threats. This aims to ensure the necessary clarity of local and England-wide roles and responsibilities. It should also consider how changes to structures set out in the Health Bill may impact on responsibilities for pandemic planning in the care sector.[168] The Inquiry considers that further work is required to ensure that pandemic planning is sufficiently detailed to be of practical utility.

1.84. The Inquiry recommends that the UK government and devolved administrations work with those responsible for the delivery of adult social care (including local authorities, health and social care partnerships, and Health and Social Care trusts and providers) to ensure that there are adequate plans in place for the sector to shape a pandemic response and for collecting the data needed to inform key decisions from the outset of a pandemic.

168 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, pp51-52 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230); Health Bill, 14 May 2026, section 23 (https://publications.parliament.uk/pa/bills/cbill/59-02/0009/260009.pdf)

Recommendation 1: Improved pandemic planning for the adult social care sector

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should each establish clear arrangements for pandemic planning in adult social care. Those arrangements should facilitate the production of pandemic plans for adult social care at the government, local and provider levels.

Plans at a government level should identify:

- the roles and responsibilities of each government in relation to adult social care during a pandemic;
- the requirements for local-level plans, including the roles and responsibilities of local authorities, Health and Social Care trusts, and health and social care partnerships in producing those plans;
- the requirements for provider-level plans;
- how and by whom the adequacy of local and provider-level plans will be assured;
- how bed capacity and staffing levels will be tracked in care homes and domiciliary care; and
- how the adult social care sector will be represented in the pandemic planning of the four governments.

Government pandemic plans for adult social care should be regularly reviewed and tested as part of the pandemic response exercises recommended in the Inquiry's Module 1 Report (Recommendation 6).

Chapter 2: Care home admissions, testing and isolation

Introduction

2.1. As Covid-19 spread, more people became infected, including many who would go on to require hospital treatment. By March 2020, the UK government and devolved administrations considered that emergency measures were necessary to increase hospital capacity across the UK. One of those measures (early hospital discharge) had been set out in the *Coronavirus: Action Plan*, published on 3 March 2020 on behalf of the four nations of the UK.[1] By 12 March 2020, it was estimated that, before the peak of the virus and even with the implementation of measures such as self-isolation, demand for healthcare beds would outstrip supply by 328,000 beds in England, 37,000 beds in Scotland and 24,000 beds in Wales.[2] A policy of expediting the discharge of medically fit hospital patients was introduced in each nation by mid-March.

2.2. However, a lack of testing capacity at this stage of the pandemic meant that, over the following weeks, many patients were discharged to care homes and to their own homes, without knowing whether they had Covid-19. This led to widespread criticism and a concern that expedited discharges contributed to outbreaks of Covid-19 in care homes.

2.3. This chapter examines the basis for expedited hospital discharge policies in March 2020 and the guidance published in each of the four nations of the UK about the isolation of people admitted to care homes following hospital discharge. It provides an overview of each nation's approach to the testing of people discharged from hospital on admission to care homes from mid-April 2020, and considers the impact of expedited discharge on care homes. It also considers the wider introduction of symptomatic testing (testing for those with symptoms) and asymptomatic testing (testing for those without symptoms) for those using and working in adult social care.

Entry of Covid-19 to care homes

2.4. It was obvious from the outset of the pandemic that admitting a person infected with Covid-19 to a care home could introduce the virus to the home and lead to onward transmission. Residents living in close proximity to each other and with underlying health conditions are particularly vulnerable to infectious diseases. Once the virus entered a care home, it was highly likely to spread, with possibly fatal consequences.

2.5. At an adult social care meeting on 11 February 2020 between UK government officials, the three likely ways the virus could enter a care home were identified as infected people moving into homes, staff and visitors. It was agreed that these routes

1 *Coronavirus: Action Plan: A Guide to What You Can Expect Across the UK*, Department of Health and Social Care, 3 March 2020, p19, para 4.48 (https://assets.publishing.service.gov.uk/media/5e5e2e91e90e071110454391/Coronavirus_action_plan_-_a_guide_to_what_you_can_expect_across_the_UK.pdf; INQ000182380)
2 INQ000056209_0001, 0006. Figures were not provided for Northern Ireland.

should be considered in the response to Covid-19.[3] Professor Dame Jenny Harries (Deputy Chief Medical Officer for England from July 2019 to March 2021 and Chief Executive of the UK Health Security Agency from April 2021 to May 2025) said that identification of these routes was a statement of obvious fact.[4]

2.6. In May 2022, the Scientific Advisory Group for Emergencies (SAGE) considered that there were seven potential routes of entry of Covid-19 into care homes (see Figure 1). This chapter primarily focuses on returning residents and new admissions from hospital. The impact of staff movement and visitors (both personal and professional) – the two other routes identified in February 2020 – are considered in Chapter 3: Protective measures, Chapter 4: Visiting restrictions in care homes and Chapter 5: Regulation and safeguarding.

Figure 1: The potential routes of Covid-19 entering care homes, SAGE, May 2022

Source: Consensus Statement on the Association Between the Discharge of Patients from Hospitals and COVID in Care Homes, SAGE, 26 May 2022 (https://www.gov.uk/government/publications/the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes/consensus-statement-on-the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes; INQ000343826_0004)

3 INQ000049363_0002 para 7
4 INQ000587394_0014 para 5.11(a)

Asymptomatic and pre-symptomatic transmission

2.7. By 24 January 2020, SAGE had advised the UK government and devolved administrations that it was likely that Covid-19 could be spread by people who were pre-symptomatic (ie infected but not initially showing any symptoms).[5]

2.8. The four governments were also aware that infected people may be asymptomatic (ie infected but never developing any symptoms). At its meeting on 28 January 2020, SAGE noted that, while there was limited evidence of asymptomatic transmission, early indications implied that some was occurring.[6] That day, Professor (later Sir) Christopher Whitty (Chief Medical Officer for England from October 2019) discussed asymptomatic transmission with the other Chief Medical Officers of the UK, stating that they should "*assume it may be happening*".[7]

2.9. On 28 January 2020, SAGE advised that it would not be useful to test asymptomatic individuals, as a negative test result could not be interpreted with certainty – this accorded with advice from Health Protection Scotland.[8] Public Health Wales advised that there was "*no value*" in testing those without symptoms.[9] Both Professor Whitty and Professor Sir Patrick Vallance (later Lord Vallance of Balham), Government Chief Scientific Adviser from April 2018 to March 2023, agreed in March 2020 that while testing could identify some asymptomatic cases, it would miss a large number of cases and so was not recommended as a way of confirming definitively that a person was not infected.[10]

2.10. Matt Hancock (Secretary of State for Health and Social Care from July 2018 to June 2021) said that the "*initial consensus*" that Covid-19 could not transmit asymptomatically underpinned initial advice given by the Department of Health and Social Care on the management of Covid-19 in care homes.[11] He also relied on scientific advice not to test those who did not have symptoms.[12]

2.11. While scientific advice was not certain that asymptomatic transmission was occurring, as noted in the Inquiry's combined Report relating to Modules 2, 2A, 2B and 2C, there were clear signs by the end of January 2020 to suggest that it was.[13] It was also known from an early stage that the "*elderly and those with existing health conditions*" were at particular risk from Covid-19.[14] The Inquiry acknowledges the constraints on testing capacity at this stage of the pandemic (considered further below). However, the discharge policy involved discharging many potentially

5 INQ000056214_0004 para 4
6 INQ000061510_0003 para 16
7 INQ000282744_0002-0003
8 INQ000061510_0003 para 8; INQ000614179_0109 para 327
9 INQ000336344_0002
10 INQ000238826_0171-0172 paras 516-520
11 INQ000587746_0015 para 70
12 INQ000587746_0015 para 70; see, for example, INQ000233747_0002
13 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance,* UK Covid-19 Inquiry, November 2025, Vol I, Chapter 2 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
14 INQ000051809_0002 para 1

vulnerable patients to care homes, where they would be surrounded by other very vulnerable people. The most sensible way for the UK government and devolved administrations to proceed would have been to adopt a default assumption that not every infected person would necessarily show symptoms and that asymptomatic transmission was occurring and was a potentially significant factor in how the virus was spreading. As the number of confirmed cases grew across the UK in February and early March 2020 (which in itself was an underestimate of the true number of cases), there was a real risk that individuals infected with Covid-19 were entering care homes but presenting without any symptoms. Testing might have had some value, even if limited, as Professors Whitty and Vallance believed.[15]

Hospital discharges

2.12. Timely hospital discharge has two primary objectives: to ensure that there is capacity in the healthcare system to admit and treat people who require acute care; and to remove vulnerable people from hospital settings that pose risks to their health and wellbeing, including a risk of hospital-acquired infections.[16] Managing hospital capacity by discharging medically fit patients is not a new concept and is common in winter and influenza seasons.[17] The provisions contained in the draft Pandemic Influenza Bill in 2019, prepared following Exercise Cygnus in 2016 (a cross-government exercise across the UK to test a pandemic-scale response), acknowledged the importance that timely hospital discharge might play in a future pandemic.[18]

The introduction of discharge policies in March 2020

2.13. Decisions were taken to introduce expedited hospital discharge policies during the first three weeks of March 2020.[19]

Testing capacity in March 2020

2.14. Testing is a crucial element of the public health response to any pandemic. In January 2020, Public Health England developed an accurate diagnostic test

15 'CMO for England announces 25 new cases of coronavirus (COVID-19): 5 March 2020', Department of Health and Social Care, 5 March 2020 (https://www.gov.uk/government/news/cmo-for-england-announces-25-new-cases-of-coronavirus-covid-19-5-march-2020; INQ000237341); INQ000109125_0002 paras 5-6; INQ000109142_0002 para 1; *Modules 2, 2A, 2B, 2C: Core decision-making and political governance,* UK Covid-19 Inquiry, November 2025, Vol I, Chapters 2 and 3 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

16 INQ000587394_0018 paras 5.22-5.23

17 Robin Swann 24 July 2025 105/25-106/6; Jenny Harries 9 July 2025 144/21-145/10

18 INQ000184060_0014 paras 80-81; INQ000587793_0002-0003 para 8

19 The need for expedited discharges was communicated in a letter to leaders across the health and social care sector in Scotland on 6 March 2020 (INQ000470123_0001-0002; see also INQ000553929_0003); encouraged in Wales through a framework of actions announced on 13 March 2020 (INQ000226942; see also INQ000587254_0022-0023 para 95; INQ000299010; INQ000147283_0001 para 6; INQ000492671); recognised in guidance in Northern Ireland dated 13 and 19 March 2020 (INQ000120731_0072; *Health and Social Care (NI) Summary COVID-19 Plan for the Period Mid-March to Mid-April 2020*, Department of Health (Northern Ireland), 19 March 2020, pp10-11 (https://www.health-ni.gov.uk/sites/default/files/publications/health/surge-plans-march-april-2020.pdf; INQ000103714)); and communicated in a letter from NHS England to chief executives and chairs of NHS trusts on 17 March 2020 (INQ000087317_0001-0003; see also INQ000056135_0004, 0008).

for Covid-19.[20] It served a number of purposes in the adult social care sector, including confirming infection, managing outbreaks, guiding isolation requirements, preventing asymptomatic spread and providing surveillance.

2.15. However, as is being considered by the Inquiry in Module 7: Test, trace and isolate, it took time for testing capacity to be scaled up during the pandemic to allow for its deployment across the sector. In the first weeks of March 2020, testing capacity for Covid-19 was limited. On 11 March 2020, Professor Whitty advised COBR that there were an estimated 5,000 to 10,000 cases of Covid-19 in the UK.[21] At that stage, testing capacity in England was about 3,000 tests per day.[22] The devolved nations also had very limited testing capacity in March 2020.[23]

2.16. The limited testing capacity meant that use of tests had to be prioritised. The Department of Health and Social Care, Public Health England and NHS England agreed on 11 March 2020 to prioritise tests for clinical need. This meant that testing was focused on case detection in symptomatic patients requiring critical care or hospital admission.[24] Testing was similarly prioritised in Scotland, Wales and Northern Ireland.[25] On 12 March 2020, the UK government announced that testing of symptomatic people in the wider community would be paused in order to prioritise tests for use in hospitals. Community testing was paused at a similar time in the devolved nations.[26] Testing of care home residents across the UK was therefore limited to small numbers to confirm the existence of an outbreak.[27]

2.17. As explained by Professor Whitty, it was obvious from mid-March 2020 that it would have been ideal to test patients moving from hospitals and other settings to care homes for Covid-19, had testing capacity and turnaround times for testing allowed this.[28] The view of NHS England on 12 March 2020 was that the protection of care home residents, who were highly vulnerable, should be a priority. Their view was that discharging patients who presented with possible Covid-19 symptoms to care homes without a negative test should be avoided.[29] However, in light of limited testing capacity, the Department of Health and Social Care considered that this was not viable.[30] A few days later, on 17 March 2020, it was noted at an internal NHS England meeting that there should be further consideration of the impact on care homes, including "*testing practices at discharge to support safe care home admissions*".[31]

20 INQ000587347_0008-0009, 0011 paras 32-35, 44
21 INQ000056220_0005 para 1
22 INQ000587682_0062-0063 para 241
23 INQ000509418; INQ000280820_0001; INQ000103640_0002; see also INQ000268131_0003
24 INQ000587682_0062-0063 paras 241-242; INQ000087298_0001; INQ000279902
25 INQ000261341_0002; INQ000262104_0002-0003; INQ000587301_0232-0233 para 617
26 INQ000231053_0003; INQ000056221_0005_0007-0008 paras 3, 12; INQ000587301_0075 paras 182-183; 'COVID-19 testing update', Scottish Government, 15 March 2020 (https://www.gov.scot/news/covid-19-testing-update; INQ000571250_0001); INQ000509416_0001-0002; Patrick Vallance 22 May 2025 180/7-17
27 INQ000535015_0029 para 111; INQ000587252_0136 para 11.3.2; *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, revised 21 April 2021, p7 (INQ000101020_0032); INQ000587702_0029 para 89; INQ000587301_0122 para 312(i)
28 INQ000251645_0103 para 7.133
29 INQ000593801_0003-0004
30 INQ000587682_0066 paras 256-257; INQ000270015_0001; INQ000587793_0010 para 38
31 INQ000269992_0004 paras 7.1-7.3

However, the Department of Health and Social Care and Public Health England considered that testing capacity remained insufficient.[32]

A difficult choice

2.18. Decision-makers were therefore faced with an unenviable choice. They could keep patients in hospital pending tests becoming available and run the risk of running out of hospital beds for Covid-19 patients and increasing the risk to vulnerable patients fit for discharge. Alternatively, to free up capacity for Covid-19 patients, they could discharge patients who were potentially Covid-19-positive and run the risk of Covid-19 being introduced to vulnerable residents in care homes.

2.19. Choosing the latter course of action created the perception that hospital capacity was of greater importance to the government than residential and domiciliary care capacity.[33] Mr Hancock explained that it "*was a question of what is the least worst solution to this terrible problem*", and that if a better option had been available, he would have strongly supported it.[34]

2.20. As a result, many thousands of people across the UK were discharged to care homes in the early months of the Covid-19 pandemic (see Table 2).

Table 2: Hospital discharges to care homes in early 2020

Nation	Number discharged to care homes	Percentage discharged to care homes without a test
England[(a)]	c. 25,000 between 17 March and 15 April 2020	Not known
Scotland[(b)]	3,595 between 1 March and 21 April 2020	82% between 1 March and 21 April 2020
Wales[(c)]	1,729 between 1 March and 31 May 2020	96% in March 2020 and 65% in April 2020 (prior to 29 April 2020)
Northern Ireland[(d)]	4,957 in the first two quarters of 2020	Not known

Sources: (a) Readying the NHS and Adult Social Care in England for COVID-19, National Audit Office, 12 June 2020, p11, para 16 (https://www.nao.org.uk/wp-content/uploads/2020/06/Readying-the-NHS-and-adult-social-care-in-England-for-COVID-19.pdf; INQ000114319); (b) Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020, Public Health Scotland, 28 October 2020, p7 (INQ000101020); (c) Coronavirus (COVID-19): Discharges from Hospitals to Care Home Settings, 1 March 2020 to 31 May 2020, Statistics for Wales, undated, pp1, 8 (INQ000271757); (d) Clinical Analysis of Discharge Patterns from HSC Hospitals in NI During Early 2020 and Any Link with COVID-19 Outbreaks in Care Homes, Department of Health (Northern Ireland), 6 November 2020, p20 (https://www.health-ni.gov.uk/sites/default/files/publications/health/Hospital-Discharge-Final-report.pdf; INQ000276408)

Note: The collection of data across the UK varied considerably by nation (in terms both of the data that were available and collected and of collection periods) so direct comparisons cannot be made.

32 INQ000587793_0011 para 39; INQ000587682_0071-0072 para 273
33 INQ000587737_0046 para 196; INQ000325232_0002
34 Matt Hancock 2 July 2025 47/3-48/10, 54/3-17; INQ000232194_0012 para 46

2.21. The decision to introduce expedited hospital discharge was discussed and agreed by Boris Johnson (Prime Minister from July 2019 to September 2022), Mr Hancock and Sir Simon Stevens (later Lord Stevens of Birmingham), Chief Executive of NHS England from April 2014 to July 2021, and was discussed both at COBR and in the UK Cabinet.[35] Mr Hancock explained that the policy was:

> "*formally a government decision. It was signed off by the Prime Minister. It was really driven by Simon Stevens … but it was widely discussed, both in the department, with the NHS, and with the centre.*"[36]

While he said it was the UK government's decision, Mr Hancock said he took responsibility for it and defended it at the time.[37]

2.22. Decisions associated with a focus on hospital discharge were also taken at a government level in Scotland and Wales.[38] In Northern Ireland, the Department of Health (Northern Ireland) was at the centre of the decisions.[39]

2.23. Jeane Freeman (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021) told the Inquiry that, had there been sufficient testing capacity, she would have introduced testing on admission to care homes earlier.[40] Robin Swann, Minister of Health for Northern Ireland from January 2020 to October 2022, acknowledged that the challenge at the time of expedited hospital discharge was the lack of available testing.[41]

2.24. Albert Heaney (Deputy Director General Health and Social Services Group in the Welsh Government from March 2020 to June 2021) agreed that it would have been preferable to test all patients on discharge when guidance was published in April 2020, but that this was not possible due to testing capacity.[42] He explained that this was his view in hindsight and decisions at the time were based on scientific and medical advice and not limited capacity.[43] Vaughan Gething (Minister for Health and Social Services in the Welsh Government from May 2016 to May 2021) said that, in hindsight, testing on discharge from hospital could have eliminated risk and maintained confidence within the residential care sector.[44] However, Mr Gething said that, prior to publication of advice for care homes in Wales in April 2020, he did not receive advice that "*testing of all patients upon discharge will be preferred,*

35 INQ000587793_0006-0009 paras 21-32; INQ000056220_0008-0009 para 15, Decisions, para 2; INQ000056208_0009; INQ000328131_0002; INQ000146639; INQ000056135_0004, 0008; INQ000587682_0061-0064, 0068, 0071-0072 paras 238-240, 244-248, 263, 273. The 11 March 2020 COBR minutes reflected that stopping elective measures could free 30,000 beds and the 17 March 2020 Cabinet minutes reflected that 30,000 people were expected to leave hospital to free up beds. Simon Stevens, Lord Stevens, told the Inquiry that these minutes were mistaken. He explained that the 30,000 figure was anticipated if a number of steps to free up capacity were introduced in conjunction with each other (INQ000587793_0006-0007 para 22).
36 Matt Hancock 2 July 2025 46/15-24
37 Matt Hancock 2 July 2025 46/25-48/10; INQ000587746_0032 para 136
38 INQ000587254_0022-0023 paras 94-95; INQ000553929_0003; INQ000470123_0001-0002; INQ000147441_0002
39 INQ000613603_0018, 0054 paras 50, 174
40 INQ000606530_0050, 0052 paras 194, 203
41 Robin Swann 24 July 2025 105/12-16
42 INQ000551798_0088-0089 para 308
43 Albert Heaney 15 July 2025 138/25-140/17
44 Vaughan Gething 15 July 2025 12/13-16

but there is not the capacity to do so".[45] In light of the evidence from ministers and scientific advisers in the other nations, it is clear that testing capacity must also have influenced the advice and associated decision not to test all people discharged from hospital in Wales in March 2020.

2.25. As explained by the UK's Chief Medical Officers and the Government Chief Scientific Adviser in their *Technical Report on the COVID-19 Pandemic in the UK*, published on 1 December 2022, discharge from hospitals to care homes "*connects 2 high-contact environments, and it was and should remain a high priority for preventive actions in similar pandemics*".[46]

2.26. In the absence of testing people discharged from hospital upon admission to care homes, with evidence of asymptomatic and pre-symptomatic transmission, limited availability of personal protective equipment (PPE) for adult social care settings (see Chapter 3: Protective measures) and no vaccine for Covid-19, it was incumbent upon the UK government and devolved administrations to ensure that precautions were in place when people were admitted to care homes from hospital. Isolation was probably the only truly effective precaution available at that time.

Isolation of residents following hospital discharge

2.27. The isolation of care home residents – whether infectious or potentially infectious – has long been recognised as a routine infection prevention and control measure in the management of respiratory and gastrointestinal infections such as influenza and norovirus.[47] Isolation reduces exposure to other residents and staff who are not providing direct care, and thus aims to reduce the risks of onward transmission.

2.28. Guidance was issued in each of the four nations in March and early April 2020 that outlined the approach to be taken to people admitted to care homes. Care homes in each nation were advised when and for how long care home residents should be isolated on admission (see Table 3).

45 Vaughan Gething 15 July 2025 24/10-20
46 *Technical Report on the COVID-19 Pandemic in the UK*, Department of Health and Social Care, 1 December 2022, p299 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642)
47 INQ000587394_0019 para 5.25

Table 3: Hospital discharge and care home admissions guidance in the four nations of the UK

Nation	Date	Guidance	Isolation guidance for care homes
Scotland	12 March 2020	*COVID-19: Information and Guidance for Social or Community Care and Residential Settings*, Health Protection Scotland (INQ000189305). This was updated a number of times (see INQ000587252_0184)	Advised isolation of residents with confirmed Covid-19 (p6)
	13 March 2020	*Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19*, Scottish Government (INQ000147441)	Advised isolation of all residents in their own rooms "*as much as is practical*" (p3)
	26 March 2020	*Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19*, Version 1.2, Scottish Government (INQ000147440)	Advised isolation of all residents admitted from hospital for 7 days (which could include days spent isolating in hospital) and isolation for 14 days of residents admitted who had been in contact with a known case of Covid-19 (pp5, 7)
England	13 March 2020	*COVID-19: Guidance on Residential Care Provision*, Public Health England (INQ000300278)	Advised isolation of symptomatic residents "*in the same way that they would operate if an individual had influenza*" (p4)
	2 April 2020	*Admission and Care of Residents During COVID-19 Incident in a Care Home*, Version 1, Department of Health and Social Care, Public Health England, Care Quality Commission and NHS (INQ000528401)	Advised isolation of residents admitted from hospital who had tested positive for Covid-19 and had not already completed an isolation period, any resident who developed symptoms and any contacts who had been exposed to a possible or confirmed case (all for 14 days) (pp11-14)

Nation	Date	Guidance	Isolation guidance for care homes
Northern Ireland	17 March 2020	*COVID-19: Guidance for Nursing and Residential Care Homes in Northern Ireland*, Department of Health (Northern Ireland) (INQ000120717)	Advised isolation for symptomatic residents "*in the same way that they would operate if an individual had influenza*" (p8, para 20)
	3 April 2020	Letter from the Health and Social Care Board in Northern Ireland to registered care providers (INQ000370973)	Advised isolation of residents admitted from hospital who had been exposed to Covid-19 for 14 days following the last exposure to the virus and any resident who developed symptoms for 7 days (with 48 hours asymptomatic before leaving their room). The Health and Social Care Board said this reiterated "*previous advice issued via RQIA* [Regulation and Quality Improvement Authority]"; however, the Inquiry has not located that advice (p1)
Wales	9 March 2020	*Guidance for Social or Community Care and Residential Settings on Coronavirus COVID-19*, Welsh Government (INQ000336270)	Advised isolation for 14 days of residents who had been in close contact with a confirmed case of Covid-19 (pp6-7)
	24 March 2020	*Information for Care Facilities Who Have Possible or Confirmed Cases of Covid-19*, Public Health Wales (INQ000520961)	Advised isolation of residents suspected to have Covid-19 (p2)
	8 April 2020	*Admission and Care of Residents During COVID-19 Incident in a Residential Care Setting in Wales*, Public Health Wales (INQ000283271)	Advised isolation of residents admitted from hospital who had tested positive for Covid-19 and had not already completed an isolation period, any resident who developed symptoms, and any contacts who had been exposed to a possible or confirmed case (all for 14 days) (pp11-14)

2.29. Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021) told the Inquiry that she was not involved in the development of the *COVID-19 Hospital Discharge Service Requirements* guidance issued on 19 March 2020 by the UK government and NHS England.[48] In light of the fact that this guidance specifically referred to social care, she believed they should have run it past the minister with responsibility.[49] The Inquiry agrees. The Department of Health and Social Care should have ensured that the Minister for Social Care had greater involvement in the development of the guidance regarding expedited discharge from hospitals, which included discharges to the adult social care sector. This might have ensured a better understanding of the potential impact that the policy and associated guidance would have on the adult social care sector.

Isolation guidance following discharge from hospital

2.30. Professor Harries explained that, in her view, the inability to test hospital patients discharged to care homes would not reasonably have played a significant part in managing transmission rates in care homes in the spring of 2020 because "*the strongest mitigation was a robust isolation period regardless of whether the patient/resident had tested negative or positive at the point of discharge*".[50]

2.31. Yet, despite its importance as a mitigation measure, when the expedited discharge policies were rolled out in March 2020, isolation of all those discharged untested from hospital was not advised. Scotland was the first nation to advise isolation of all people discharged from hospital and admitted to care homes, including those who had not been tested (see Table 3). Following a meeting on 18 March 2020 with Dr Donald Macaskill (Chief Executive of Scottish Care, a membership body representing independent social care providers in Scotland) and advice from Professor Graham Ellis (Deputy Chief Medical Officer for Scotland from September 2021), Ms Freeman agreed that all new admissions to care homes should be isolated. This was reflected in Scottish Government guidance on 26 March 2020.[51]

48 INQ000587788_0018, 0024-0025 paras 65, 91-94; see also *COVID-19 Hospital Discharge Service Requirements*, Department of Health and Social Care, 19 March 2020 (https://assets.publishing.service.gov.uk/media/5f43aa60d3bf7f67ab49afe9/COVID-19_hospital_discharge_service_requirements_2.pdf; INQ000049702)

49 Helen Whately 17 July 2025 30/5-23; INQ000309002_0015-0016 paras 46-48; see also *COVID-19 Hospital Discharge Service Requirements*, Department of Health and Social Care, 19 March 2020, p17 (https://assets.publishing.service.gov.uk/media/5f43aa60d3bf7f67ab49afe9/COVID-19_hospital_discharge_service_requirements_2.pdf; INQ000049702)

50 INQ000587394_0051 para 6.4

51 INQ000606530_0043-0044 para 169; *Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19*, Version 1.2, Scottish Government, 26 March 2020, p7 (https://scottishcare.org/wp-content/uploads/2020/03/COVID-19-ClinicalGuidanceforNursingHomeandResidentialCareResidents-Final26March.pdf; INQ000147440); INQ000249932_0001; INQ000509941_0001; INQ000525319_0008; INQ000509937_0001

2.32. Isolation of people admitted from hospital was not advised until 15 April 2020 in England, not communicated until 22 April in Wales and not advised in Northern Ireland until 26 April.[52]

2.33. When commenting on why isolation for all people admitted to care homes was not introduced sooner, Public Health England said that when the March 2020 hospital discharge policy was introduced, asymptomatic transmission was not considered to pose a sufficiently high risk to justify that kind of quarantine and that it was important to weigh up the benefits and harms of isolation, which came with risks for vulnerable people.[53] While Public Health England was not involved in the drafting of the hospital discharge guidance, it was commissioned by the Department of Health and Social Care to work with NHS England to produce admissions guidance for care homes on 23 March 2020.[54] Professor Fu-Meng Khaw, National Director of Health Protection and Screening Services and Executive Medical Director of Public Health Wales from June 2021, said advice on isolation of patients following discharge evolved as evidence of asymptomatic transmission "*became clear*".[55]

2.34. In Northern Ireland, Heather Reid (Interim Director of Nursing, Midwifery and Allied Health Professionals at the Public Health Agency (Northern Ireland) from May 2023 to November 2025) said that evidence on asymptomatic transmission did not become available until the end of the first week of April 2020.[56] Ms Reid also explained that, generally speaking, the Public Health Agency (Northern Ireland) did not have the capacity, expertise or access to the most up-to-date information to attempt to produce technical guidance from scratch. Technical guidance from other nations was amended to reflect the structures and terminology used in Northern Ireland.[57] As discussed in the Inquiry's combined Module 2ABC Report, the capacity of the Public Health Agency (Northern Ireland) had been steadily eroded in the years leading up to the pandemic and a review published in July 2020 found that there was not "*sufficient resource in the agency to do all of the things which need to be done at this time*".[58]

2.35. Mr Hancock told the Inquiry that the best thing as at 17 March 2020 (the date when NHS England communicated the need for expedited discharge) would have been to treat people discharged from hospital as Covid-19-positive and isolate them. With hindsight, he accepted that this should have been directed by the UK government.[59]

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52 *COVID-19: Our Action Plan for Adult Social Care,* Department of Health and Social Care, 15 April 2020, pp9-10, paras 1.30, 1.32-1.33 (https://assets.publishing.service.gov.uk/media/5e973154d3bf7f412a086070/covid-19-adult-social-care-action-plan.pdf; INQ000299661); INQ000336444_0002; *COVID-19: Guidance for Nursing and Residential Care Homes in Northern Ireland*, Version 2.0, Department of Health (Northern Ireland), 26 April 2020, pp3, 6-7, para 14 (INQ000536254). This guidance was issued to the sector on 26 April 2020; see INQ000522006_0001.

53 INQ000119481_0012

54 INQ000587772_0095-0096 para 7.17

55 INQ000588121_0003-0004 paras 15-17

56 Heather Reid 10 July 2025 127/5-18

57 INQ000587734_0042 para 127

58 *Rapid Review of the Epidemiological Function Within the Public Health Department of the Public Health Agency with a Specific Focus on Contract Tracing*, HSC Leadership Centre for the Public Health Agency (Northern Ireland), July 2020, p25, para 12.5 (INQ000001196); *Modules 2, 2A, 2B, 2C: Core decision-making and political governance,* UK Covid-19 Inquiry, November 2025, Vol II, Chapter 9 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

59 Matt Hancock 2 July 2025 56/10-24

Mr Gething agreed that, in the event of limited testing capacity, isolation should be considered as an additional measure.[60]

2.36. The early introduction of isolation in Scotland is likely to have reduced the risks of people admitted to care homes who were potentially Covid-19-positive infecting others.

2.37. By mid-March 2020, there was sufficient scientific evidence of the potential of both pre-symptomatic and asymptomatic transmission to justify a precautionary approach to the admission to care homes of residents who had been discharged from hospital. The entry and spread of Covid-19 posed significant risks to vulnerable residents and the staff who were caring for them. The Inquiry acknowledges that these risks had to be balanced against the risks that can result from social isolation and loneliness, which are established risk factors in mortality.[61] It is also accepted that it is more difficult to isolate residents with dementia.[62] However, in March 2020, the risks posed by isolation were outweighed by the need to prevent a highly transmissible virus being introduced and rapidly spreading through care homes to residents who were at significant risk of serious illness and death from the virus itself.

2.38. The Department of Health and Social Care, the Welsh Government, the Department of Health (Northern Ireland), Public Health England, Public Health Wales and the Public Health Agency (Northern Ireland) should have advised isolation of all people admitted from hospitals to care homes in March 2020. This would have mitigated the risks posed by pre-symptomatic and asymptomatic transmission.

The ability of care homes to isolate residents

2.39. Once isolation was advised in each nation in March 2020, some care homes were unable to follow the advice and implement effective isolation of residents. The precise numbers of care homes that could not isolate were not known. When making the decision to discharge vulnerable patients to care homes, this was key information to which the UK government and devolved administrations should have had access.

2.40. A number of witnesses from the UK government, devolved administrations, public health agencies and bodies, and the Care Quality Commission acknowledged that not all care homes had adequate isolation facilities and smaller homes in particular would struggle to implement isolation effectively.[63] Across the UK, governments and public health agencies and bodies did not have precise information about the

60 Vaughan Gething 15 July 2025 12/6-13/11
61 INQ000587822_0019 para 69
62 INQ000569775_0019-0020 para 10.5
63 Fu-Meng Khaw 8 July 2025 131/13-23; INQ000587254_0018 para 79; INQ000606530_0049-0050 para 192; INQ000587734_0048 para 151; Matt Hancock 2 July 2025 8/22-9/1, 78/10-24; INQ000584245_0221 para 671

number of care homes that would struggle to isolate residents.[64] The Care Quality Commission in England did not hold this information either.[65]

2.41. In Northern Ireland, some weeks after expedited hospital discharges began, the Regulation and Quality Improvement Authority undertook an assessment of the ability of care homes to isolate people who had been discharged from hospital in Northern Ireland. The findings of 24 April 2020 recognised the challenge of isolating and shielding residents in care homes for people with dementia, learning disabilities and mental health care needs. A small number of care homes in Northern Ireland still used double occupancy rooms.[66]

2.42. In response to surveys conducted after the pandemic, the majority of local authorities in England and Wales, and half of local authorities in Scotland, considered that care homes in their areas were only able to isolate residents returning from hospital to a moderate or small extent.[67]

2.43. Mr Gething recommended that, in the future, there should be more investment to ensure the consistency of isolation facilities in care homes. This would be relevant during influenza seasons and outbreaks of other infectious conditions, even in non-pandemic times.[68] Mr Hancock agreed that every care home should have isolation facilities, and that this should be a requirement for the provision of care.[69]

2.44. The lack of data about the number of care homes that could safely isolate residents echoes the Inquiry's finding in Chapter 1: Overview of the adult social care sector that the UK government and devolved administrations had limited oversight of, or knowledge about, the adult social care sector. For care homes that could not facilitate isolation, it was incumbent upon governments to have alternative plans. During the Covid-19 pandemic, these plans had to be developed mid-crisis.

Use of other facilities to isolate patients on discharge

2.45. Where isolation in a person's intended care home is not possible, other facilities – such as step-down facilities (which provide intermediate care after acute hospital treatment and before returning home or to a usual care home setting) – offer an alternative way to isolate people being discharged from hospital.

2.46. Professor Harries outlined a number of risks associated with discharging patients to alternative settings for isolation. This included the potential to build a higher-risk

64 INQ000587746_0028 para 122(b); INQ000587788_0027-0028 paras 102-103; Susan Hopkins 9 July 2025 54/11-55/10; INQ000587702_0060, 0070 paras 214, 252; Jeane Freeman 22 July 2025 71/18-72/1; Robin Swann 24 July 2025 112/13-18
65 Mary Cridge 7 July 2025 55/8-19
66 INQ000613603_0029 para 88; INQ000522011
67 In England, 149 local authorities responded and 22 in Wales (see INQ000400522_0073); 28 local authorities responded in Scotland (see INQ000587774_0020).
68 INQ000587254_0109-0110 para 389; Vaughan Gething 15 July 2025 87/15-88/8
69 Matt Hancock 2 July 2025 8/18-22

environment, unless there is "*absolutely perfect*" infection prevention and control.[70] For older and frail people, mortality statistics rise each time they are moved. Professor Harries noted that multiple periods of isolation in different settings could also lead to deconditioning (a decline in physical and mental functioning). However, she reflected that not all of these risks are overwhelming and that there are balanced arguments and risks that all need to be considered.[71] The Inquiry considers that, in a pandemic with a highly infectious virus that poses significant risks to care home residents, prior to the development of a vaccine, the benefits of isolating symptomatic or positive residents in settings away from other residents for a relatively short period are, generally speaking, likely to outweigh the risks.

2.47. By 12 March 2020, NHS England was considering the possibility of transferring people suspected of having Covid-19 into alternative facilities for isolation. However, following discussion with the Department of Health and Social Care and care sector representatives, this was not considered to be feasible because adequate facilities, with qualified staff, did not exist.[72]

2.48. On 13 April 2020, Ms Whately raised concerns with Mr Hancock that care homes should not be forced to accept admissions if there was a risk of Covid-19 infection. Some local authorities were already using other venues such as hotels for people who could not be transferred directly to their care home.[73] From 15 April 2020, guidance for care homes in England stated that people who were symptomatic and had tested positive for Covid-19 would complete isolation in alternative, appropriate accommodation secured by local authorities if local care homes could not safely support isolation. The UK government had already announced on 11 March 2020 that £1.3 billion would be made available to support enhanced hospital discharges and guidance confirmed that this could be drawn upon to support alternative isolation arrangements.[74] This policy remained in place for a number of months, but it took time for local authorities to establish a substantial estate of external facilities for isolation.[75]

2.49. In Wales, as outlined to the care sector on 22 April 2020 and formalised in guidance on 29 April 2020, people discharged from hospital who had tested positive for Covid-19, were still symptomatic or had not completed isolation would be transferred to step-down care in local settings identified by health boards and local authorities. They would be tested again to ensure a negative result before admission to a care home.[76] From 25 April 2020, in Northern Ireland, the relevant trust was asked to

70 Jenny Harries 9 July 2025 190/16
71 Jenny Harries 9 July 2025 189/19-191/9
72 INQ000593801_0003; INQ000587682_0066-0067 para 258
73 INQ000274068_0009; Helen Whately 17 July 2025 41/21-43/22
74 *COVID-19: Our Action Plan for Adult Social Care,* Department of Health and Social Care, 15 April 2020, p10, para 1.32 (https://assets.publishing.service.gov.uk/media/5e973154d3bf7f412a086070/covid-19-adult-social-care-action-plan.pdf; INQ000299661); INQ000587737_0038 para 158
75 INQ000067194_0011-0012 para 39
76 INQ000336444_0002; *COVID-19 Hospital Discharge Service Requirements*, Welsh Government and NHS Wales, 29 April 2020, pp1-3 (https://www.gov.wales/sites/default/files/publications/2020-04/update-guidance-of-step-up-step-down-care-arrangements-covid-19.pdf; INQ000081080)

provide accommodation for the isolation of Covid-19-positive patients discharged from hospital, in the event that a care home could not accommodate them.[77]

2.50. The Scottish Government did not introduce a policy requiring the use of step-down facilities for isolation. Ms Freeman explained that this was because of difficulties with the availability of facilities, the impact that moving a person more than once could have and staffing concerns.[78] There were arrangements in some parts of Scotland to accommodate Covid-19-positive residents during their isolation period in settings other than their usual care home.[79] Such facilities were therefore of utility in some areas in Scotland.

2.51. Following discussions with Mr Johnson in September 2020, work commenced on the development of a "*designated settings*" policy in England.[80] The first settings became available for use in November 2020 and guidance on discharges to designated settings was published on 16 December 2020.[81] The guidance outlined that everyone who tested positive on discharge should first be transferred to a designated setting for isolation before then moving to a residential setting.[82] Ms Whately said this was an evolution of existing guidance issued in April 2020.[83] Designated settings were identified by local authorities and had to be approved for use by the Care Quality Commission. Designated settings were required to have the policies, procedures, equipment, staffing and training in place to maintain infection control and support the care needs of residents.[84]

2.52. From 15 December 2020 in Wales, informed by scientific advice, the decision was taken that people with a "*low positive*" result (which indicated that they were "*no longer infectious*") could be discharged back to their home or social care setting – provided 14 days had elapsed since the last positive test or onset of symptoms, they had been free from fever for three days and their other symptoms had shown improvement.[85]

77 INQ000145670; see also *Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland*, Version 2.0, Department of Health (Northern Ireland), 26 April 2020, pp6-7, para 14 (INQ000536254); INQ000442912_0001-0003
78 Jeane Freeman 22 July 2025 72/2-73/12
79 INQ000587717_0005-0006, 0018 paras 14-16, 44; INQ000587766_0005 para 27; INQ000587827_0009 para 29
80 INQ000587737_0063 para 247
81 INQ000587737_0063-0067 paras 248-259; *Discharge into Care Homes: Designated Settings*, Care Quality Commission, Department of Health and Social Care, NHS England and Public Health England, 16 December 2020 (INQ000234652_0001); INQ000325287_0002; INQ000234564; INQ000611438; see also *Adult Social Care: Our COVID-19 Winter Plan 2020/21,* Department of Health and Social Care, September 2020, p2 (https://assets.publishing.service.gov.uk/media/5f6b6385e90e076c210a4819/adult-social-care-winter-plan.pdf; INQ000058216)
82 *Discharge into Care Homes: Designated Settings*, Care Quality Commission, Department of Health and Social Care, NHS England and Public Health England, 16 December 2020, paras 2.4-2.7 (INQ000234652_0003-0005)
83 INQ000587788_0033 para 126; *Discharge into Care Homes: Designated Settings*, Care Quality Commission, Department of Health and Social Care, NHS England and Public Health England, 16 December 2020, para 2.4 (INQ000234652_0003). While the designated settings guidance said it built upon guidance from 2 April 2020, a policy of asking English local authorities to secure alternative accommodation for isolation was not introduced until the publication of the Action Plan on 15 April 2020.
84 INQ000234564_0002; *Discharge into Care Homes: Designated Settings*, Care Quality Commission, Department of Health and Social Care, NHS England and Public Health England, 16 December 2020, para 2.7 (INQ000234652_0004)
85 'Written statement: Discharge arrangements and duration of COVID-19 outbreaks in social care', Welsh Government, 15 December 2020 (https://www.gov.wales/written-statement-discharge-arrangements-and-duration-covid-19-outbreaks-social-care; INQ000227285_0002); *Technical Advisory Group: Updated Consensus Statement on Recommended Testing Criteria for Discharge of Asymptomatic Patients to Care Homes,* Welsh Government, 25 November 2020, p5 (https://www.gov.wales/sites/default/files/publications/2020-12/technical-advisory-group-updated-consensus-statement-on-recommended-testing-criteria-for-discharge-of-asymptomatic-patients-to-care-homes.pdf; INQ000227902)

2.53. Across the UK, there were no contingency plans in place in March 2020 for care homes that could not safely accommodate isolation of residents. In those critical weeks in March and April 2020, when care homes were asked to accept people admitted from hospital, including those who had tested positive or may have been exposed to Covid-19, step-down facilities and designated settings were not introduced as an option for care homes that could not safely implement isolation policies.

2.54. The report produced in 2017 following Exercise Cygnus had recommended that there should be an examination (it was not specified by whom) of the "*possibility of expanding social care real-estate and staffing capacity in the event of a worst case scenario pandemic*".[86] This included the possibility of using other establishments to expand bed capacity in adult social care. Work on that recommendation remained incomplete at the outset of the pandemic.[87] Had it been completed, this might have allowed for the rapid identification of additional capacity for alternative isolation settings in March 2020 and helped ensure the safe isolation of all people admitted to care homes – either in care homes that could accommodate them or in alternative settings.

Isolation facilities in a future pandemic

2.55. The Department of Health and Social Care viewed the designated settings policy as a success and one which would be considered in a future pandemic, subject to clinical advice.[88] A number of witnesses – including Ms Whately, Mr Gething, Dr Maria Rossi (Interim Head of Division for Environmental and Emergency Response in the Clinical and Protecting Health Directorate at Public Health Scotland from March 2020) and Mr Heaney – also agreed that the use of alternative settings for isolation, such as step-down care, should be considered in pandemic planning.[89]

2.56. The Inquiry notes the UK government's commitment in its March 2026 *Pandemic Preparedness Strategy* to developing an actionable plan for England by March 2027, to ensure safe and timely hospital discharges in a pandemic in order to minimise the risk of onward infection. This will include developing plans to expand capacity to discharge patients safely from hospital, including consideration of the use of designated facilities and step-down care.[90]

2.57. Across the UK, there is a need to identify settings for isolation. These are likely to become particularly important where infection rates and high levels

86 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016*, Version 1, Public Health England, 13 July 2017, p25 (https://assets.publishing.service.gov.uk/media/5f8eb911d3bf7f49a1ce842c/exercise-cygnus-report.pdf; INQ000056232)
87 INQ000057522_0014-0015; see also Chapter 1: Overview of the adult social care sector
88 INQ000587737_0066 para 258
89 Helen Whately 17 July 2025 103/14-104/21; Vaughan Gething 15 July 2025 13/12-15/3; Maria Rossi 28 July 2025 93/7-94/14; Albert Heaney 15 July 2025 130/17-131/15
90 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, pp51-53 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)

of transmissibility may overwhelm the ability of some care homes to isolate residents safely. It may not be possible to have standing capacity for such settings in non-pandemic times. The Inquiry therefore recommends that pandemic planning should:

- include provision for how and by whom settings for isolation will be identified and communicated to hospitals and the adult social care sector in each nation;
- consider how those settings could be used quickly if necessary in a future pandemic; and
- outline what steps will be taken to ensure the safe operation of those settings, to minimise the risk of residents and staff being infected and to ensure that standards for the quality and safety of care are maintained.

2.58. Planning for the delivery of settings for isolation requires the close involvement of those who are responsible for the delivery of adult social care in each nation: local authorities in England and Wales, health and social care partnerships in Scotland and Health and Social Care trusts in Northern Ireland. It should also involve representatives of care home providers, who can contribute their wealth of knowledge about how isolation operates in practice. There also needs to be an understanding of which care homes can safely accommodate effective isolation policies, to inform how many settings to facilitate isolation may be required and at what point they may be required. The UK government and devolved administrations should therefore have access to information about which care homes have adequate isolation facilities to accommodate isolating residents. This information should also be accessible to healthcare providers, care home managers, local authorities, health and social care partnerships and Health and Social Care trusts, and should be used to support the discharge process.

2.59. Planning should consider how settings for isolation (which may include designated settings and step-down facilities) can operate as safely as possible. There must be sufficient staff to ensure their safe operation, adequate supplies of PPE and rigorous infection prevention and control measures (see Chapter 3: Protective measures). Discharges should be informed by clinical assessments to weigh up the risks posed to people.

2.60. The Inquiry considers that development of the UK government's commitment to an action plan by March 2027 will partly meet Recommendation 2 below. However, the UK government should set out how it intends to collect data on the availability of isolation facilities in care homes to inform its planning, and ensure that guidance is produced to ensure that isolation settings operate safely.

Recommendation 2: Enable the safe and timely isolation of care home residents, including following discharge from hospital

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should ensure that pandemic plans for adult social care contain practical steps rapidly to scale up isolation facilities for care home residents in a future pandemic.

As a minimum, plans should:

- establish mechanisms to record systematically the availability of isolation facilities in care homes in each nation and keep these up to date;
- identify settings that can be used in a future pandemic to isolate and meet the needs of residents, including those who need to be discharged from hospital into a care home; and
- establish guidance for how these settings can be run to ensure high-quality, safe care and effective infection prevention and control.

Pressure to accept admissions and potential false assurances

2.61. Across the UK, there were concerns that care providers felt pressure to accept new admissions, including of people with confirmed or suspected Covid-19. On 16 March 2020, Ros Roughton (Director General for Adult Social Care in the Department of Health and Social Care from April to July 2020) asked Professor Harries what the approach should be to discharging symptomatic patients to care homes. Ms Roughton said she assumed that discharges would have to be allowed with strict infection control, but this was a significant ethical issue for care home providers.[91] In response, Professor Harries stated:

> "[While] *the prospect is perhaps what none of us would wish to plan for I believe the reality will be that we will need to discharge Covid-19 positive patients into residential care settings.*"[92]

2.62. A draft version of the 2 April 2020 admissions guidance in England (discussed below) included advice from Public Health England that people who had tested positive, but had not yet completed seven days of isolation, should not be transferred to care homes that had no cases of Covid-19. The same was said for patients who had been exposed to Covid-19 but had not yet completed 14 days of isolation, although they could be accepted into a care home if it could implement "*strict*

91 INQ000325243_0001-0002
92 INQ000325243_0001

isolation".[93] However, NHS England raised concerns regarding the draft guidance, including that it would "*frighten the care home sector and create blocks in the system*".[94] It was noted that a UK government priority was to free up hospital beds. The draft guidance was therefore initially amended to say that people with confirmed Covid-19 who had not yet completed seven days of isolation should "*return to their care home with strict isolation procedures*".[95]

2.63. On 28 March 2020, having received the updated draft guidance, Ms Whately queried whether Covid-19-positive or symptomatic patients should be discharged to care homes that did not have cases of Covid-19, expressing concerns that patients would take Covid-19 into care homes. The Department of Health and Social Care responded, stating that care homes may need to accept such cases as a result of capacity concerns but it would expect them to undertake a risk assessment to ensure the availability of appropriate isolation facilities.[96] However, Ms Whately said that, in practice, this did not appear to happen.[97] The final published guidance did not advise that Covid-19-positive patients or those who had been exposed to Covid-19 had to complete isolation before admission to care homes that had no cases of Covid-19.[98]

2.64. On 22 March 2020, in response to concerns that a care home in Wales was being asked to accept patients from a hospital with Covid-19 patients, Mr Heaney confirmed that discharges needed to continue, that there was "*no need for unnecessary testing*" and that "*when discharging people who have a positive coronavirus diagnosis then personal protective equipment should be used*".[99] This advice was clearly predicated on the care home having sufficient PPE, which, as examined in Chapter 3: Protective measures, was not always the case.

2.65. Dr Macaskill said that care homes in Scotland felt undeniable pressure to help NHS Scotland create capacity and referred to the "*constant barrage in the popular media … about how important it was that the social care sector came up to the plate*".[100] He also referred to the pressure resulting from the National Care Home Contract in Scotland (which covered 70% of those in care homes in Scotland). The contract said that a registered care home "*should not ordinarily refuse admission unless there were very clear clinical reasons not to do so*".[101]

2.66. The Inquiry's listening exercise, Every Story Matters, was told by one care home manager in England that they had to accept patients with Covid-19.

93 INQ000591442_0005-0006; INQ000587772_0094-95 para 7.16
94 INQ000119481_0043
95 INQ000591444_0001-0007; INQ000587772_0096 paras 7.18-7.19
96 INQ000575576_0001-0009
97 Helen Whately 17 July 2025 35/22-36/4
98 *Admission and Care of Residents During COVID-19 Incident in a Care Home*, Version 1, Department of Health and Social Care, Public Health England, Care Quality Commission and NHS, 2 April 2020, p13 (https://www.pathway.org.uk/wp-content/uploads/Admission-and-Care-of-Residents-during-COVID-19-Incident-in-a-Care-Home.pdf; INQ000528401)
99 INQ000349197; see also INQ000499629
100 Donald Macaskill 18 January 2024 118/5-119/12
101 Donald Macaskill 18 January 2024 118/5-119/12

> *"I used to get a phone call in the middle of the night to say, 'There's an ambulance going to be coming in and bringing somebody in who's Covid-positive', I had no say in the matter."*[102]
>
> **Registered manager of a care home, England, Every Story Matters**

2.67. Particular phrases in the guidance for, and correspondence with, the adult social care sector in early 2020 were plainly intended to actively encourage care homes to accept admissions to ease pressure on hospital settings. The Scottish Government clinical guidance issued on 26 March 2020 said it was "*imperative*" for care homes to continue to take admissions where clinically safe to do so.[103] The 2 April 2020 care homes admissions guidance issued by the Department of Health and Social Care, with input from Public Health England and the Care Quality Commission, stated that care homes "*need … to continue to make their full capacity available to support the national effort*", which would "*help to save thousands of lives*".[104] In Wales, guidance issued by Public Health Wales on 8 April 2020 stated that the care sector played "*a vital role*" in accepting patients discharged from hospital.[105]

2.68. In Northern Ireland, a letter from Richard Pengelly (Permanent Secretary to the Department of Health (Northern Ireland) from July 2014 to April 2022) to arm's length bodies on 26 March 2020 said "*it will be more important than ever*" for trusts to have effective discharge arrangements in place.[106] While this was not sent directly to providers, the language in this letter may have contributed to pressure being placed on care homes to accept admissions. During its inquiry into the impact of Covid-19 in care homes, the Committee for Health in Northern Ireland heard of a "*palpable sense of pressure to admit patients who may have been COVID-positive*".[107]

102 *Every Story Matters: Adult Social Care Sector*, p65 (INQ000587564)
103 *Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19*, Version 1.2, Scottish Government, 26 March 2020, p1 (https://scottishcare.org/wp-content/uploads/2020/03/COVID-19-ClinicalGuidanceforNursingHomeandResidentialCareResidents-Final26March.pdf; INQ000147440)
104 *Admission and Care of Residents During COVID-19 Incident in a Care Home,* Department of Health and Social Care, Public Health England, Care Quality Commission and NHS, 2 April 2020, p3 (https://www.pathway.org.uk/wp-content/uploads/Admission-and-Care-of-Residents-during-COVID-19-Incident-in-a-Care-Home.pdf; INQ000528401); see also INQ000514955_0002 para 9; INQ000584245_0221-0222 paras 669-675
105 *Admission and Care of Residents During COVID-19 Incident in a Residential Care Setting in Wales*, Public Health Wales, 8 April 2020, p3 (https://content.govdelivery.com/attachments/UKWALES_CSSIW_INT/2020/04/09/file_attachments/1423272/2020%2004%2009%20-%20PHW%20guidance%20-%20Admission%20and%20Care%20of%20Residents%20during%20COVID-19%20Incident%20in%20a%20Residential%20Care%20Setting%20in%20Wales.pdf; INQ000283271); see also INQ000338279_0001
106 INQ000325159_0002
107 *Inquiry Report on the Impact of COVID-19 in Care Homes,* Northern Ireland Assembly, Committee for Health, 21 January 2021, p61 para 200 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/report-and-images/health-committee-inquiry-report-on-impact-of-covid-19-in-care-homes.pdf; INQ000256510)

> "[E]*verywhere was so under pressure and we were being told, 'Well, they reside in your home, that's where they need to be, they're fit for discharge, we need the bed, you need to take them back'. So, you didn't really feel like you could [say no].*"[108]
>
> **Registered manager of a care home, Northern Ireland, Every Story Matters**

2.69. Professor Harries said that, in her experience, the UK government never intended to put pressure on care homes to accept people discharged from hospital.[109] Ms Freeman thought that care homes understood that they could refuse new admissions, and there were instances where they had done so.[110] Professor Khaw said that care homes were not encouraged to accept Covid-19-positive patients.[111] Mr Swann felt that the guidance was clear that care homes could say no to admissions and he would have wanted to ensure that care homes did not feel pressured to accept admissions.[112] The Care Quality Commission said it was "*clear with providers*" that admissions could be refused if certain criteria could not be met and that it supported care homes in those circumstances.[113]

2.70. However, Ms Whately had queried the use of the word "*need*" in the 2 April 2020 admissions guidance, which she said suggested a lack of clarity about how directive the process was.[114] The discharge policy concerned her because care homes were put in a difficult position in which they felt that they were required to admit people discharged from hospital despite being very worried.[115] Ms Whately accepted that the guidance did not clearly express that care homes did not have to take new admissions. She explained that she would make changes on draft guidance but that these would disappear. She tried to mitigate this by writing to local authorities to emphasise that discharged patients did not have to be accepted.[116]

2.71. In June 2020, care home admissions guidance published by the UK government said that no care home would be "*forced*" to take admissions if they could not cope with the impact of a resident's Covid-19 illness for the duration of isolation.[117] The addition of this text suggests that the UK government acknowledged the pressure felt by providers.

108 *Every Story Matters: Adult Social Care Sector*, p70 (INQ000587564)
109 INQ000587394_0032 para 5.56
110 Jeane Freeman 22 July 2025 67/4-68/19
111 INQ000587702_0020-0021 paras 58-60
112 Robin Swann 24 July 2025 113/7-25, 114/10-24, 118/17-25
113 INQ000584245_0221-0222, 0224 paras 669-671, 674-676, 681
114 INQ000575576_0004
115 Helen Whately 17 July 2025 170/2-171/14
116 Helen Whately 17 July 2025 44/21-45/21
117 *Admission and Care of Residents in a Care Home During COVID-19*, Version 2, Department of Health and Social Care, Public Health England, Care Quality Commission, NHS and CARE, 19 June 2020 (INQ000564991_0008); INQ000109460_0001-0003

Potential false assurances in England and Wales

2.72. The guidance issued to care providers in early April 2020 in England and Wales also did not properly reflect the risks posed by asymptomatic transmission. The 2 April 2020 guidance issued by the Department of Health and Social Care (with input from Public Health England and the Care Quality Commission) and the 8 April 2020 Public Health Wales guidance both said that some care home admissions "*may have Covid-19, whether symptomatic or asymptomatic. All of these patients can be safely cared for in a care home if this guidance is followed.*"[118] Looking back, Professor Susan Hopkins (Deputy Director of the National Infection Service at Public Health England from 2018 to 2020) agreed that the wording in this guidance was potentially too reassuring to the sector.[119] Care Inspectorate Wales expressed concerns about this wording and ultimately did not agree to its logo appearing on the guidance.[120]

2.73. The four governments of the UK plainly intended to encourage admissions of people discharged from hospital who had not been tested. In England and Wales, guidance went further and had the potential falsely to reassure care homes that people who were admitted and were Covid-19-positive, including those who might have been asymptomatic (and therefore might not have been tested), could be accepted because they could be safely cared for. Yet, in England, Wales and Northern Ireland, isolation of all new admissions had not been advised and, in any event, across the UK it was known that not all care homes would be able safely to isolate people admitted to care homes and residents. Care homes were encouraged to accept untested or Covid-19-positive people (and sometimes both), which led to risks of transmission that some care homes did not have the ability to mitigate sufficiently.

2.74. The focus on capacity in healthcare services and the phrases used in respect of the care sector also likely contributed to the belief that the adult social care sector was the undervalued "*Cinderella*" service within healthcare systems (see Chapter 8: Recognition and protection).[121]

118 *Admission and Care of Residents During COVID-19 Incident in a Care Home*, Version 1, Department of Health and Social Care, Public Health England, Care Quality Commission and NHS, 2 April 2020, p4 (https://www.pathway.org.uk/wp-content/uploads/Admission-and-Care-of-Residents-during-COVID-19-Incident-in-a-Care-Home.pdf; INQ000528401); INQ000584245_0221-0222 paras 669-675; *Admission and Care of Residents During COVID-19 Incident in a Residential Care Setting in Wales*, Public Health Wales, 8 April 2020, p3 (https://content.govdelivery.com/attachments/UKWALES_CSSIW_INT/2020/04/09/file_attachments/1423272/2020%2004%2009%20-%20PHW%20guidance%20-%20Admission%20and%20Care%20of%20Residents%20during%20COVID-19%20Incident%20in%20a%20Residential%20Care%20Setting%20in%20Wales.pdf; INQ000283271)

119 Susan Hopkins 9 July 2025 46/9-47/17

120 INQ000198288_0001-0002; INQ000198281_0001; INQ000198569_0002-0003; INQ000569773_0072-0073 para 219. While Health Protection Scotland's guidance on 17 April 2020 contained similar assurances, risks were mitigated by the fact that mandatory isolation of admissions had already been advised. *COVID-19: Information and Guidance for Social or Community Care and Residential Settings*, Version 1.7, Public Health Scotland, 17 April 2020 (INQ000189304_0013); *Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19*, Version 1.2, Scottish Government, 26 March 2020, pp5-7 (https://scottishcare.org/wp-content/uploads/2020/03/COVID-19-ClinicalGuidanceforNursingHomeandResidentialCareResidents-Final26March.pdf; INQ000147440)

121 Vic Rayner 3 July 2025 119/16

Further evidence of asymptomatic transmission

2.75. In March and April 2020, two significant studies evidenced the potential significance of pre-symptomatic and asymptomatic transmission of Covid-19 in care homes. On 27 March 2020, the US Centers for Disease Control and Prevention published an early release of a study conducted in care homes in Washington State, USA. It suggested that residents who were asymptomatic or pre-symptomatic with Covid-19 had the potential to be substantially contagious to others.[122] On 3 April 2020, it published a statement citing recent studies, which said:

> "[A] *significant portion of individuals with coronavirus lack symptoms ('asymptomatic') and … even those who eventually develop symptoms ('pre-symptomatic') can transmit the virus to others before showing symptoms.*"[123]

2.76. In April 2020, Public Health England undertook a study of six care homes in London which reported an outbreak of Covid-19 between 10 and 13 April. Phase 1 of the study (all phases being known collectively as the 'Easter 6' study) involved swabbing of residents and staff over the Easter weekend (the study was not commenced earlier as a result of limited testing capacity).[124] Professor Hopkins explained that initial results first became available on 15 April 2020. She explained that the collective study provided the strongest evidence yet to show that it was likely the virus was being transmitted asymptomatically.[125] Final results of Phase 1 of the study showed that, across the six care homes: 39.9% of residents were Covid-19-positive and only 27.1% of those were symptomatic at the time of testing; and 20.4% of staff were Covid-19-positive but 56.9% remained asymptomatic at the time of testing.[126] Professor Hopkins said that the collective study:

> "*underpinned the need for reprioritisation of testing to enable testing of both symptomatic and asymptomatic residents and staff where COVID-19 outbreaks were suspected, and the introduction of asymptomatic testing for ASC* [adult social care] *staff and visitors*".[127]

122 'Asymptomatic and presymptomatic SARS-CoV-2 infections in residents of a long-term care skilled nursing facility – King County, Washington, March 2020', A Kimball, KM Hatfield, M Arons, A James, J Taylor, K Spicer et al, *Morbidity and Mortality Weekly Report* (2020), 69(13), 377–381, p378 (https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm?s_cid=mm6913e1_w; INQ000224063)
123 *Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission*, Centers for Disease Control and Prevention, 3 April 2020 (https://stacks.cdc.gov/view/cdc/86440; INQ000660308)
124 INQ000587772_0029-0030 paras 3.31-3.33; INQ000587737_0008 para 25.a. The Easter weekend in 2020 fell between Friday 10 April and Monday 13 April. Phase 2 "*involved additional sampling in four care homes reporting a single suspected … or confirmed case of COVID-19*" and Phase 3 "*aimed to assess the presence of silent infection and transmission in five additional London care homes with no suspected or confirmed cases of COVID-19*" (see INQ000587772_0030 paras 3.34-3.35).
125 INQ000587772_0031, 0133 paras 3.36, 11.13. An interim report was produced, dated 22 April 2020; see INQ000120155.
126 'Investigation of SARS-CoV-2 outbreaks in six care homes in London, April 2020', SN Ladhani, JY Chow, R Janarthanan, J Fok, E Crawley-Boevey, A Vusirikala et al, *The Lancet* (2020), 26(100533), p3 (https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30277-7/fulltext; INQ000089681)
127 INQ000587772_0031 para 3.36. Professor Hopkins also outlined the limitations of the study; see INQ000587772_0031 para 3.37.

Introduction of further testing in adult social care settings

2.77. Throughout March and early April 2020, the number of confirmed and suspected Covid-19 patients in hospital increased substantially.[128] The discharge of untested hospital patients to care homes therefore posed an increasing risk.

Testing of patients discharged from hospitals to care homes

2.78. By mid-April 2020, testing capacity had increased in each nation – to 38,766 tests per day by 15 April in England, 1,556 per day by 16 April in Northern Ireland, 1,300 per day by 16 April in Wales, and 2,988 per day by 20 April in Scotland.[129] As testing capacity increased, each government updated its discharge policies to introduce testing of all patients admitted to care homes from hospital.

2.79. Mr Hancock said that, following the US Centers for Disease Control and Prevention's statement on 3 April 2020 that asymptomatic transmission was likely to be occurring, he immediately contacted Professor Whitty and asked him to update his advice in light of the new information.[130] Following a conversation with Professor Whitty on 13 April 2020, Professor Vallance commissioned a rapid review of the effectiveness of testing people who were asymptomatic. The review concluded that asymptomatic testing was an important measure for controlling the virus and was being used elsewhere in the world. The following morning, Professor Vallance asked Professor Whitty to share this paper with Mr Hancock.[131] On 14 April 2020, Professor Whitty recommended testing all people admitted to care homes; however, he explained that putting this recommendation into practice was dependent upon testing capacity, which was unrealistic in early April.[132] On 15 April 2020, the Department of Health and Social Care published *COVID-19: Our Action Plan for Adult Social Care*, which confirmed a move to testing for all those discharged from hospitals to care homes. Isolation of those with a negative test result for 14 days was recommended.[133] Mr Hancock explained that, by 15 April 2020, testing capacity had been increased to allow introduction of the policy.[134]

2.80. On 15 April 2020, in Wales, ministers acknowledged that Care Forum Wales and Care Inspectorate Wales were concerned about discharges to care homes and testing on discharge. It was noted that there was planning in England to address these issues

128 INQ000101934; *Public Health Scotland COVID-19 Statistical Report,* Public Health Scotland, 22 June 2020, p8 (https://publichealthscotland.scot/media/6794/20-06-24-covid19-publication_report.pdf; INQ000147513); INQ000485721_0177-0178 paras 445-446; INQ000254239
129 INQ000587746_0017 para 77; INQ000376883_0001; INQ000195567_0002; INQ000341764_0001
130 INQ000587746_0016-0017 para 75
131 INQ000238826_0172 paras 521-522; INQ000087177; INQ000229000
132 INQ000587746_0017 para 76; INQ000093326_0003, 0009; INQ000292604; INQ000251645_0103 para 7.133; INQ000292608_0001-0002
133 *COVID-19: Our Action Plan for Adult Social Care*, Department of Health and Social Care, 15 April 2020, pp9-10 paras 1.30, 1.33 (https://assets.publishing.service.gov.uk/media/5e973154d3bf7f412a086070/covid-19-adult-social-care-action-plan.pdf; INQ000299661)
134 INQ000587746_0017 para 77

to boost confidence in the sector.[135] That day, Public Health Wales was informed that Dr Frank Atherton (later Sir Frank Atherton), Chief Medical Officer for Wales from August 2016 to January 2025, and Mr Heaney wanted a revised approach to testing as soon as possible.[136] On 22 April 2020, Dr Atherton and Mr Heaney confirmed to providers and local authorities (and others) that all people who were discharged from hospital to care homes would be tested and that 14 days' isolation would be required for those who had tested negative.[137] Evidence suggests that the policy began to be implemented from about 22 April 2020.[138]

2.81. Updated guidance on hospital discharge requirements was published by the Welsh Government on 29 April 2020 and formalised the policy change.[139] This took too long. Mr Gething accepted that there was an unnecessary delay from 15 April 2020, when the decision was taken to test all patients discharged from hospital to care homes, to 29 April 2020, when the guidance was published. He said that having the guidance earlier would have helped with successfully implementing the decision.[140] Mr Heaney stated that the Welsh Government was "*deeply apologetic*" for the delay.[141]

2.82. Following the updated policy position in England, Version 3 of the *Covid-19 Interim Protocol for Testing for Covid-19* became operational in Northern Ireland on 19 April 2020.[142] It outlined that hospital patients must be tested 48 hours prior to discharge to a care home but this "***must not hold up a timely discharge***" (emphasis in original).[143] This policy change was communicated to, among others, chief executives of Health and Social Care trusts on 25 April 2020.[144] Updated guidance was issued on 26 April 2020 by the Department of Health (Northern Ireland). The guidance also confirmed that all new residents in care homes should be isolated for 14 days.[145]

2.83. On 20 April 2020, Professor (later Sir) Gregor Smith (Interim Chief Medical Officer for Scotland from April to December 2020 and Chief Medical Officer for Scotland from December 2020) advised Ms Freeman and Nicola Sturgeon (First Minister of Scotland from November 2014 to March 2023) that he had reviewed the position and concluded that "*blanket testing of all admissions to care homes prior to their admission is not advised at this stage*".[146] The advice suggested that polymerase chain reaction (PCR) tests could provide false reassurances and a positive test may

135 INQ000336415_0002-0003
136 INQ000336416
137 INQ000336444_0002; see also INQ000227087
138 INQ000587702_0065 para 232; Vaughan Gething 15 July 2025 32/17-33/7
139 *Covid-19 Hospital Discharge Service Requirements*, Welsh Government and NHS Wales, 29 April 2020 (https://www.gov.wales/sites/default/files/publications/2020-04/update-guidance-of-step-up-step-down-care-arrangements-covid-19.pdf; INQ000081080)
140 Vaughan Gething 15 July 2025 32/17-33/7
141 Albert Heaney 15 July 2025 143/21-144/22. Updated Public Health Wales guidance for care homes was published on 1 May 2020; see *Guidance to Prevent COVID-19 Among Care Home Residents and Manage Cases and Outbreaks in Residential Care Settings in Wales*, Public Health Wales, 1 May 2020, pp4-6, section 3.1 (INQ000520926)
142 INQ000613603_0142-0143 para 495
143 INQ000103724_0003
144 INQ000145670_0001-0002
145 *Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland*, Version 2.0, Department of Health (Northern Ireland), 26 April 2020, pp3, 6-7, para 14 (INQ000536254); INQ000613603_0202-0203 para 680
146 INQ000249330_0002 para 7

not have an impact on how residents would be treated.[147] Nonetheless, Ms Freeman explained that she wanted to go further and at a quicker pace, because she appreciated how vulnerable the care home population was and she wanted to provide maximum support and oversight.[148] The following day, she announced that Covid-19 patients should have two negative tests before discharge to care homes.[149] Updated Public Health Scotland guidance on 29 April 2020 confirmed that, if testing was not possible or results were not available, people admitted from hospital should be isolated for 14 days.[150]

Testing of admissions from the community

2.84. The updated discharge testing policies in each of the four nations also addressed the testing of residents from the community upon admission. On 12 April 2020, Ms Whately asked that *COVID-19: Our Action Plan for Adult Social Care* specifically address people admitted from the community who might have Covid-19, including the use of testing to confirm this.[151] During internal discussions, officials in the Department of Health and Social Care agreed that people moving from their own home to care homes were at much lower risk of Covid-19 because they would have been isolating for the last three weeks. The UK government's intention was to introduce testing of people admitted from the community when testing capacity allowed.[152] The Action Plan did not introduce such testing, but indicated that it would follow at a later date. The Action Plan did note that providers "*may wish*" to isolate such admissions for 14 days.[153] On 19 June 2020, updated admissions guidance published by the UK government said that new admissions from the community "*should*" be isolated.[154] Testing people on admission from the community who were asymptomatic was not introduced in England until 14 August 2020.[155]

2.85. In contrast, testing of all people admitted from the community was introduced earlier, in late April 2020, by the devolved administrations.[156] This should be given

147 INQ000249330_0001-0002 paras 5-8
148 INQ000606530_0048 paras 184-187
149 'Coronavirus (COVID-19) update: Health Secretary's statement 21 April 2020', Scottish Government, 21 April 2020 (https://www.gov.scot/publications/coronavirus-covid-19-update-health-secretarys-update-tuesday-21-april-2020; INQ000292544_0003)
150 *COVID-19: Information and Guidance for Care Home Settings*, Version 1.1, Public Health Scotland, 29 April 2020, p9 (INQ000189332). The guidance noted that testing may not always have been possible – for example, if it caused distress to a person. It also confirmed that any positive patient should be isolated for 14 days and have two negative tests. On 1 April 2020, Health Protection Scotland's functions were transferred to a new body, Public Health Scotland. The Scottish Government asked Public Health Scotland to continue to use the Health Protection Scotland branding until March 2022 to ensure consistency of messaging (INQ000587252_0005-0006, 0101 paras 1.2.1-1.2.4, 8.2.8).
151 INQ000327831_0002
152 INQ000565711_0002-0003; INQ000292608_0001-0002; see also INQ000093326_0009
153 *COVID-19: Our Action Plan for Adult Social Care*, Department of Health and Social Care, 15 April 2020, pp9-10 paras 1.30, 1.34 (https://assets.publishing.service.gov.uk/media/5e973154d3bf7f412a086070/covid-19-adult-social-care-action-plan.pdf; INQ000299661)
154 *Admission and Care of Residents in a Care Home During COVID-19*, Version 2, Department of Health and Social Care, Public Health England, Care Quality Commission, NHS and CARE, 19 June 2020 (INQ000564991_0027)
155 *Admission and Care of Residents in a Care Home During COVID-19*, Version 2, Department of Health and Social Care, Public Health England, Care Quality Commission, NHS and CARE, 14 August 2020, p44 (INQ000325286)
156 'Coronavirus (COVID-19) update: Health Secretary's statement 21 April 2020', Scottish Government, 21 April 2020 (https://www.gov.scot/publications/coronavirus-covid-19-update-health-secretarys-update-tuesday-21-april-2020; INQ000292544_0003); *COVID-19: Information and Guidance for Care Home Settings*, Version 1.1, Public Health Scotland, 29 April 2020, p9 (INQ000189332); INQ000227087_0001-0002 para 3; INQ000145670_0001-0002

consideration in a future pandemic – particularly where there is widespread community transmission. If sufficient testing is not available, at the very least, isolation should be advised. Isolation of people admitted from the community should have been advised in stronger terms earlier in England.

Wider testing of care home residents and social care staff

Symptomatic testing

2.86. In March and early April 2020, while there was some testing of symptomatic care staff across the UK, testing capacity was insufficient to test all symptomatic staff.[157] From mid-April, once testing capacity allowed, testing of symptomatic residents and staff working in adult care homes was expanded across the UK.[158]

Asymptomatic testing

2.87. The Easter 6 study provided clear evidence of the benefits of asymptomatic testing in care homes. Testing could identify asymptomatic or pre-symptomatic infections of both care home residents and staff (who regularly move between settings) and lead to the implementation of infection prevention and control measures to control further transmission.

2.88. On 28 April 2020, Public Health England produced a testing options paper which explained that the care sector was experiencing large numbers of cases and that the role of asymptomatic infections may be underestimated.[159] This was shared with officials in Wales and Northern Ireland.[160] That same day, the UK government announced that testing would be expanded to asymptomatic staff and residents in care homes.[161] Testing whole care homes began in England in May 2020. On 11 May 2020, an online portal was introduced for care homes to request testing (initially prioritised for care homes for people aged over 65 or with dementia).[162] That day, the UK government published *Our Plan to Rebuild: The UK Government's COVID-19 Recovery Strategy*, which promised that every care home for people aged over 65

157 'COVID-19 testing to get key workers back to work', Scottish Government, 24 March 2020 (https://www.gov.scot/news/covid-19-testing-to-get-key-workers-back-to-work; INQ000496422_0001-0002); INQ000362315_0001; INQ000613603_0152 para 520; INQ000268131_0003; INQ000527904_0002; INQ000563032_0001 para 4; INQ000336405_0001

158 *COVID-19: Our Action Plan for Adult Social Care*, Department of Health and Social Care, 15 April 2020, pp9, 14, paras 1.27, 2.8 (https://assets.publishing.service.gov.uk/media/5e973154d3bf7f412a086070/covid-19-adult-social-care-action-plan.pdf; INQ000299661); INQ000606530_0028-0029, 0053-0054 paras 97-99, 102, 207; INQ000613603_0142-0143 paras 493-495; *Inquiry into the Impact of the Covid-19 Outbreak, and Its Management, on Health and Social Care in Wales: Report 1*, Welsh Parliament, Health, Social Care and Sport Committee, July 2020, p39, para 131 (https://senedd.wales/media/ks1jxizq/cr-ld13304-e.pdf; INQ000349686); INQ000227087_0002 para 4

159 INQ000500175_0001

160 INQ000500174

161 'Health and Social Care Secretary's statement on coronavirus (COVID-19): 28 April 2020', Department of Health and Social Care, 30 April 2020 (https://www.gov.uk/government/speeches/health-and-social-care-secretarys-statement-on-coronavirus-covid-19-28-april-2020; INQ000106391_0005); INQ000279763; see also INQ000232194_0083-0084, 0088 paras 348(f), 366

162 INQ000309002_0026 paras 76-77; INQ000050399; INQ000594271

would be offered testing for residents and staff by 6 June 2020.[163] By 8 June 2020, test kits had been distributed to all care homes in England.[164]

2.89. In Wales, on 30 April 2020, draft ministerial advice for Mr Gething stated that Public Health Wales considered that serial testing (ie repeated testing of the same person over a period of time) of asymptomatic care workers would help prevent the introduction of Covid-19 into care homes. The draft advice therefore included an option to introduce serial testing of asymptomatic care workers in care homes free of Covid-19.[165]

2.90. The final version of the ministerial advice sent to Mr Gething and Mark Drakeford, First Minister of Wales from December 2018 to March 2024, on 1 May 2020 did not include the option for serial asymptomatic testing of care workers. However, it did make clear that Public Health Wales considered that testing of asymptomatic staff in care homes could help prevent the introduction of Covid-19 into care homes.[166] Both the draft and the final advice noted that testing all care home residents alone would require 25,000 extra tests and that further modelling for policy decisions would be required. Both also stated: "*Expanding into asymptomatic individuals still lacks the evidence base to support this being the best use of testing capacity.*"[167]

2.91. The final advice recommended that the Welsh Government test all residents (both symptomatic and asymptomatic) in care homes with more than 50 beds and in those where an outbreak occurred.[168] This recommendation was followed and announced the next day, and included staff.[169] The advice reflected Dr Atherton's understanding of how the UK government intended to prioritise testing in care homes.[170]

2.92. On 12 May 2020, SAGE concluded (with medium confidence, meaning that there was a reasonable degree of certainty with evidence to support the conclusion but some important gaps) that there was a strong scientific rationale to test all residents and staff working in care homes (including those without cases of Covid-19), given the strong evidence of asymptomatic transmission in those settings.[171] On 13 May 2020, testing in Wales was extended to care homes with an ongoing outbreak

163 *Our Plan to Rebuild: The UK Government's COVID-19 Recovery Strategy*, HM Government, May 2020, p35 (https://assets.publishing.service.gov.uk/media/5ebbc6e1d3bf7f5d364bfbcf/Our_plan_to_rebuild_The_UK_Government_s_COVID-19_recovery_strategy.pdf; INQ000198892); INQ000255836_0105 para 390
164 *Coronavirus (COVID-19) Testing in Care Homes: Statistics to 8 July 2020*, Department of Health and Social Care, 16 July 2020 (https://www.gov.uk/government/publications/coronavirus-covid-19-testing-in-care-homes-statistics-to-8-july-2020/coronavirus-covid-19-testing-in-care-homes-statistics-to-8-july-2020; INQ000565820_0001); INQ000587738_0025 para 64
165 INQ000367481_0001; INQ000367482_0005 para 20
166 INQ000353847_0005 para 21
167 INQ000367482_0005-0006 paras 19-21, 25; INQ000353847_0003_0004 paras 20, 23, 27. Statistical models are tools for analysing complex data, identifying patterns and informing evidence-based decision-making where direct measurement is not possible. Figures from modelling are estimates only, and different statistical models will produce different outcomes. These estimates are not based on direct observations. They are therefore limited by the underlying assumptions used in the models and are subject to uncertainty.
168 INQ000353847_0003-0006, 0010-0011 paras 9, 21-22, 27; INQ000367483; INQ000336476
169 INQ000551798_0149 para 508; 'Written statement: Coronavirus testing in care homes', Welsh Government, 2 May 2020 (https://www.gov.wales/written-statement-coronavirus-testing-care-homes; INQ000182440)
170 INQ000551798_0147-0149 paras 503-506; INQ000383855_0002; INQ000500209; INQ000069037_0001-0002
171 INQ000253601_0006

that had started prior to 2 May.[172] Wider asymptomatic testing in care homes was announced in Wales, Northern Ireland and Scotland throughout May and June 2020. This included regular testing of care home staff in Wales and Scotland.[173]

The Vivaldi 1 study

2.93. Professor Hopkins approached Professor Laura Shallcross (Professor of Public Health and Translational Data Science at University College London from 2021) in early May 2020 about the need for a study to provide information on the burden of Covid-19 infections on care homes in England, to inform policy decisions. The Vivaldi 1 study ran from 26 May to 19 June 2020 and surveyed 5,126 care homes for those aged over 65 in England, and the survey responses were then linked to Covid-19 test results.[174] On 3 July 2020, initial results identified that 80.9% of residents who tested positive for Covid-19 were asymptomatic.[175]

2.94. On 3 July 2020, the UK government announced that routine testing would begin in care homes in England for those aged over 65 or with dementia.[176] However, on 31 July 2020, it was confirmed that the rollout would be delayed.[177] Professor Vic Rayner (Chief Executive Officer of the National Care Forum from 2016) said that, in practice, it took until October 2020 for routine asymptomatic testing to be rolled out to all care homes for people under 65 in England.[178]

2.95. On 28 July 2020, informed by the findings of the Vivaldi 1 study, Mr Swann announced the introduction of a regular programme of testing in care homes in Northern Ireland to begin from 3 August 2020.[179] Routine asymptomatic testing of staff in care homes was further increased in Northern Ireland in November 2020.[180]

172 INQ000551798_0150-0151 para 512; INQ000368564
173 'Written statement: COVID-19 testing in care homes update', Welsh Government, 16 May 2020 (https://www.gov.wales/written-statement-covid-19-testing-care-homes-update; INQ000182446); INQ000551798_0154 paras 524-525; 'Enhanced safety for health and social care staff', Scottish Government, 23 June 2020 (https://www.gov.scot/news/enhanced-safety-for-health-and-social-care-staff; INQ000509949_0001); 'Testing to be available to all care home residents and staff – Minister', Department of Health (Northern Ireland), 18 May 2020 (https://www.health-ni.gov.uk/news/testing-be-available-all-care-home-residents-and-staff-minister; INQ000103704). In Northern Ireland, from 24 April 2020, all residents and staff in a care home with a new outbreak were eligible for testing, regardless of symptoms (INQ000613603_0143-0144 paras 496-497). In Scotland, on 1 May 2020, Ms Sturgeon announced that all residents and staff, regardless of symptoms, would be offered testing in care homes where there was a confirmed case of Covid-19. There would also be sample testing including of asymptomatic residents and staff in care homes with no cases (INQ000606530_0034 para 121).
174 INQ000613177_0004-0005, 0014 paras 9-10, 27; INQ000587772_0032, 0035, 0037 paras 3.39, 3.49-3.50, 3.55; *Vivaldi 1: COVID-19 Care Homes Study Report*, Department of Health and Social Care, 3 July 2020 (https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report; INQ000211984_0003). The study was initially split into two workstreams. The Inquiry has received conflicting dates for when the study concluded. The Inquiry believes the correct date to be 19 June 2020.
175 *Vivaldi 1: COVID-19 Care Homes Study Report*, Department of Health and Social Care, 3 July 2020 (https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report; INQ000211984_0003)
176 'Regular retesting rolled out for care home staff and residents', Department of Health and Social Care, 3 July 2020 (https://www.gov.uk/government/news/regular-retesting-rolled-out-for-care-home-staff-and-residents; INQ000308732_0001-0002); 'Coronavirus (COVID-19): getting tested update', Department of Health and Social Care, 6 July 2020 (INQ000509793)
177 INQ000051405
178 INQ000475131_0035 para 7.10
179 INQ000276488_0003; INQ000613603_0145-0146 paras 502-505; INQ000268157
180 INQ000613603_0147 para 507

Domiciliary care

2.96. Regular asymptomatic testing of people working in domiciliary care was also introduced in each nation of the UK, but later than for people working in care homes.

2.97. Testing capacity in May 2020 was considered to be insufficient to roll out regular, asymptomatic testing for domiciliary care workers in England.[181] A study conducted by Public Health England in July 2020 found that the estimated prevalence of Covid-19 in domiciliary care workers was 0.1%. However, Public Health England acknowledged limitations to the study and said the results should be used with caution. Regular testing of all domiciliary care workers was not recommended at this time.[182] On 9 November 2020, advice to Ms Whately noted rising rates of community transmission and therefore recommended a change in approach to testing in domiciliary care.[183] Regular PCR testing of domiciliary care workers began on 23 November 2020. It was anticipated that lateral flow tests (a portable test with quick results) would create greater capacity in the near future.[184] Dr Jane Townson (Chief Executive of the Homecare Association from May 2019) said that the delay in adopting regular asymptomatic testing left providers unable to identify and isolate cases early, which created significant risks for staff and users of care.[185]

2.98. On 9 July 2020, a paper that supported routine asymptomatic testing of domiciliary care workers was submitted to the Welsh Government's Testing Cell. However, the Testing Cell did not consider the paper at that time. Mr Heaney said his officials and care provider representatives continued to "*press*" for the inclusion of domiciliary care workers in regular testing.[186] He believed that it took much longer than it should have done to establish these workers as a priority group for testing.[187] On 4 December 2020, Mr Gething announced that regular lateral flow testing of health and social care workers, including asymptomatic domiciliary care workers, would commence on an incremental basis from 14 December 2020.[188]

2.99. As a result of increased testing capacity, on 25 November 2020, the Scottish Government confirmed that regular testing of the domiciliary care workforce would begin on 18 January 2021.[189] The Scottish Government cited logistical issues prior to the commencement of this testing, including confirmation that people would be able to self-test using lateral flow tests.[190] In the winter of 2020, when Covid-19 prevalence

181 INQ000109382_0002, 0005 paras iv, 13-14
182 *Pilot Point Prevalence Survey of COVID-19 Among Domiciliary Care Staff in England*, Public Health England, July 2020, pp14-15 (https://assets.publishing.service.gov.uk/media/5f033c86d3bf7f768e27c69f/COVID-19_PPS_of_domicillary_care_060720.pdf; INQ000611426)
183 INQ000058913_0002-0003 paras 2-4; see also Matt Hancock 2 July 2025 152/12-153/12
184 INQ000587737_0093 para 350; INQ000058913_0002-0003 paras 5, 8
185 INQ000587670_0054 para 203
186 INQ000500347; INQ000532383_0048-0049 paras 115-117
187 INQ000389958_0040 para 143
188 'Written statement: Covid-19 testing of health and social care workers and hospice staff', Welsh Government, 4 December 2020 (https://www.gov.wales/written-statement-covid-19-testing-health-and-social-care-workers-and-hospice-staff; INQ000420995); INQ000144929_0009-0010
189 INQ000520510_0001-0002
190 INQ000614179_0240 para 734

was high and when testing capacity allowed, the UK government, Scottish Government and Welsh Government introduced regular testing of domiciliary care workers, which included the use of lateral flow tests. In the event of a future pandemic that is known to pose risks to the adult social care sector, domiciliary care workers should be included in regular testing programmes as soon as capacity allows.

2.100. In November 2020, in Northern Ireland, it was concluded that it would not be feasible to provide the same level of testing to domiciliary care workers as to those in care homes and that wider testing of domiciliary care workers would need to await testing developments, including the availability of lateral flow tests.[191] Regular asymptomatic testing for domiciliary care workers directly employed by Health and Social Care trusts was not rolled out until March 2021 and it was not confirmed until 17 August 2021 that lateral flow testing was available specifically to asymptomatic workers employed by independent domiciliary care providers.[192] Professor Sir Michael McBride (Chief Medical Officer for Northern Ireland from September 2006) said that, in April 2021, lateral flow tests were made available to the general public and access for domiciliary care workers in the independent sector was formally communicated in August 2021. He also cited logistical difficulties in identifying and registering domiciliary care workers for testing. He said that, if it had been possible to introduce widespread testing of domiciliary care workers earlier, the Department of Health (Northern Ireland) would have done so.[193] However, these difficulties could have been foreseen and plans put in place to ensure that all domiciliary care workers were included in regular asymptomatic testing as soon as capacity allowed.

2.101. It took time to roll out symptomatic and asymptomatic testing for residents and staff in adult social care in each of the four nations. Regular testing in the adult social care sector may prove crucial in a future pandemic and should be considered as soon as capacity allows. While testing was limited, other protective measures were essential (see Chapter 3: Protective measures).

Impact of expedited discharge without testing on transmission in care homes

2.102. A number of studies were undertaken across the UK which tried to assess whether – and, if so, to what extent – the admission of hospital patients to care homes resulted in rising infection rates in care home settings.

2.103. Preliminary analysis from the Vivaldi 1 study indicated that new admissions to care homes and the number of residents discharged back to care homes from hospital – and the subset of these who tested positive for Covid-19 – might be associated with

191 INQ000437616_0002
192 INQ000520334_0001-0002; INQ000615082_0075 para 231; Michael McBride 24 July 2025 98/17-22
193 Michael McBride 24 July 2025 95/25-101/19

increased risk of infection in residents and staff. However, that question could not be reliably answered for the following reasons:

- Questions about hospital discharge were "*poorly completed*" and there was a risk of "*recall bias*" (people not accurately reporting details due to issues with memory or subjective interpretations).
- There were missing data on the number of people who had been discharged from hospital, including those who had been discharged to care homes.
- "[E]*xtremely limited*" testing led to a "*significant under-ascertainment of Covid-19 cases in residents and staff*", making it difficult to determine potential onward transmission from discharged residents.
- The Vivaldi research team was "*unable to account for other routes of transmission*".
- The research team was overstretched and under pressure to produce results.[194]

2.104. Professor Shallcross explained that the Vivaldi 1 study was not designed to address comprehensively the relative importance of each route of transmission of Covid-19 into care homes, nor was it possible to create a study that could do so at that time. Therefore, Vivaldi 1 could not provide evidence on this.[195]

2.105. On 6 November 2020, a report was produced for the Department of Health (Northern Ireland) by Dr Niall Herity (Consultant Cardiologist at the Belfast Health and Social Care Trust). It concluded that outbreaks of Covid-19 in care homes corresponded more closely with hospital admission rates for Covid-19 (which provided an indication of transmission and infection rates in the wider community) than with the number of people who were discharged from hospitals to care homes.[196] Professor McBride said the report was "*a descriptive piece*", subject to limitations including the limited numbers of tests undertaken early in the pandemic.[197] He considered it highly likely that some care home outbreaks were caused, or exacerbated by, discharges from hospital. He thought it "*unwise to attribute undue significance to one mode of entry into a care home without the evidence base for it*".[198]

2.106. On 28 October 2020, a report commissioned by Ms Freeman and produced by Public Health Scotland (which had succeeded Health Protection Scotland in April 2020) concluded that, when considered on its own, hospital discharge was associated with an increased risk of an outbreak. However, it said: "[A]*fter accounting*

194 INQ000613177_0017-0019 paras 38-39
195 INQ000613177_0019-0022 paras 40, 43
196 *Clinical Analysis of Discharge Patterns from HSC Hospitals in Northern Ireland During Early 2020 and Any Link with COVID-19 Outbreaks in Care Homes,* Department of Health (Northern Ireland), 6 November 2020, p2 (https://www.health-ni.gov.uk/sites/default/files/publications/health/Hospital-Discharge-Final-report.pdf; INQ000276408)
197 Michael McBride 24 July 2025 35/12-16
198 Michael McBride 24 July 2025 34/15-35/16, 91/23-92/2

for care home size and other care home characteristics, the estimated risk of an outbreak reduces and is not statistically significant."[199]

2.107. Following a letter received from Ed Humpherson, Director General for Regulation at the Office for Statistics Regulation from January 2014, a revised version of the report was republished on 21 April 2021. This clarified that a "*small effect*" from hospital discharges on care home outbreaks could not be ruled out.[200] Both versions of the report acknowledged that testing in care homes in March and April 2020 was limited and, prior to testing all symptomatic residents, the "*numbers of positive tests will be less than the true number of cases*".[201] Even when all symptomatic residents were tested, the number of positive tests was still "*likely to be less than the true number of cases*".[202] The republished report also explained that lack of sequencing data available in Scotland for the first three months of the pandemic limited the ability to determine if an admission from hospital could have been responsible for starting an outbreak or introducing further lines of infection in a care home.[203]

2.108. In July 2021, following a request from the Department of Health and Social Care and the SAGE Social Care Working Group, Public Health England published findings that suggested:

> "[T]*he impact of suspected hospital associated seeding on care home outbreaks appears to be relatively small, potentially contributing to 1.6% of all care home outbreaks.*"[204]

Professor Hopkins acknowledged that, as a result of limited testing in March and April 2020, "*clearly this was an underestimate, but we did not know and we cannot know in retrospect what the real estimate was*".[205] The findings also suggested that the mitigation measures introduced on 15 April 2020 (testing on discharge and isolating those awaiting results) "*may have supported the decline seen in these types of outbreaks, contributing to an overall reduction in care home cases*".[206]

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199 *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, p22 (INQ000147514)
200 *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, revised 21 April 2021, p24 (INQ000101020); INQ000346839; INQ000286863; Maria Rossi 28 July 2025 110/9-112/18
201 *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, revised 21 April 2021, p26 (INQ000101020); *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, p24 (INQ000147514)
202 *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, revised 21 April 2021, p26 (INQ000101020); *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, p24 (INQ000147514)
203 *Discharges from NHS Scotland Hospitals to Care Homes Between 1 March and 31 May 2020*, Public Health Scotland, 28 October 2020, revised 21 April 2021, p50 (INQ000101020)
204 *A Data Linkage Approach to Assessing the Contribution of Hospital-Associated SARS-CoV-2 Infection to Care Home Outbreaks in England, 30 January to 12 October 2020*, Public Health England, July 2021, p16 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005583/Nosocomial_Seeding_OF_care_home_outbreaks_report_Official_Sensitive-3.pdf; INQ000234332)
205 Susan Hopkins 9 July 2025 80/7-85/6
206 *A Data Linkage Approach to Assessing the Contribution of Hospital-Associated SARS-CoV-2 Infection to Care Home Outbreaks in England, 30 January to 12 October 2020,* Public Health England, July 2021, p3 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005583/Nosocomial_Seeding_OF_care_home_outbreaks_report_Official_Sensitive-3.pdf; INQ000234332)

2.109. Public Health Wales produced two papers relevant to hospital discharge. The findings of one, published in February 2021, concluded that large care homes were at considerably greater risk of outbreaks and, after adjustments were made for care home size, "*a discharge from hospital was not associated with a significant increase in risk*".[207] However, it was not possible to determine if the introduction of Covid-19 that led to an outbreak was from a discharged hospital patient.[208] The findings of another paper, published in March 2022, suggested that the highest risk of the introduction of Covid-19 to care homes came from interaction with the community. However, the paper acknowledged that factors, including limited testing and rising community transmission, meant that it was not possible to conclusively estimate the effect of rapid hospital discharge on transmission.[209]

2.110. On 26 May 2022, SAGE published its *Consensus Statement on the Association Between the Discharge of Patients from Hospitals and COVID in Care Homes*. It concluded that hospital discharges without testing was:

> "*highly likely to have caused some outbreaks or been one of the often multiple introductions of infection to care homes which experienced an outbreak. However, it is highly unlikely to have been the dominant driver of all care home outbreaks in wave 1.*"[210]

2.111. SAGE acknowledged that there were important data limitations, including low and variable levels of testing during the first wave of the pandemic, and that no nation in the UK could easily and completely identify who was resident in care homes or who was discharged from hospital to care homes.[211] It did, however, recommend:

> "*In any future epidemic with high consequence in older and vulnerable people, greater consideration should be given to minimising potential exposure in care homes. This includes consideration of how to safely transfer existing or new residents to care homes from hospitals or from the community.*"[212]

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207 'Risk factors for outbreaks of COVID-19 in care homes following hospital discharge: A national cohort analysis', C Emmerson, JP Adamson, D Turner, MB Gravenor, J Salmon, S Cottrell et al, *Influenza and Other Respiratory Viruses* (2021), 15(3), 371-380, p371 (https://onlinelibrary.wiley.com/doi/10.1111/irv.12831; INQ000213185)

208 'Risk factors for outbreaks of COVID-19 in care homes following hospital discharge: A national cohort analysis', C Emmerson, JP Adamson, D Turner, MB Gravenor, J Salmon, S Cottrell et al, *Influenza and Other Respiratory Viruses* (2021), 15(3), 371-380, pp371, 376-378 (https://onlinelibrary.wiley.com/doi/10.1111/irv.12831; INQ000213185)

209 'Intensity of COVID-19 in care homes following hospital discharge in the early stages of the UK epidemic', J Hollinghurst, L North, C Emmerson, A Akbari, F Torabi, C Williams et al, *Age and Ageing* (2022), 51(5), pp1-2 (https://doi.org/10.1093/ageing/afac072; INQ000224072)

210 *Consensus Statement on the Association Between the Discharge of Patients from Hospitals and COVID in Care Homes*, SAGE, 26 May 2022 (https://www.gov.uk/government/publications/the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes/consensus-statement-on-the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes; INQ000343826_0002)

211 *Consensus Statement on the Association Between the Discharge of Patients from Hospitals and COVID in Care Homes*, SAGE, 26 May 2022 (https://www.gov.uk/government/publications/the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes/consensus-statement-on-the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes; INQ000343826_0018-0019)

212 *Consensus Statement on the Association Between the Discharge of Patients from Hospitals and COVID in Care Homes*, SAGE, 26 May 2022 (https://www.gov.uk/government/publications/the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes/consensus-statement-on-the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes; INQ000343826_0007)

2.112. The limited testing of people discharged from hospital to care homes in the early months of the pandemic meant that the impact of untested hospital discharges on the introduction and spread of Covid-19 in care homes could not be fully and reliably assessed in studies undertaken in each nation. Without such data, no proper analysis of the likely impact could take place. However, while the impact cannot be confidently quantified, untested patients who were infected with Covid-19 and discharged to care homes are highly likely to have introduced infections or contributed to further transmission of the virus in those settings. Therefore, additional precautions were required when the expedited discharge policies were introduced.

Protection of people using adult social care

2.113. The expedited discharge policies were fraught with risk. People were discharged into care homes without knowing their Covid-19 status and without the added precaution of advice to isolate all people admitted from hospitals in England, Wales and Northern Ireland until mid to late April 2020. Some care homes into which people were discharged could not implement isolation policies safely and no alternatives were in place to mitigate this. In those circumstances, the use of infection prevention and control measures and PPE become all the more important. Whether those measures were sufficient to protect care home residents is considered in the next chapter of this Report.

2.114. In a future pandemic, hospital discharges to care homes must be done as safely as possible. Steps must be taken to prevent the pandemic disease from entering care homes and infecting a highly vulnerable population. There must be plans in place to ensure the safe isolation of residents who may pose a risk of infection and transmission. Planning must start now.

Chapter 3: Protective measures

Introduction

3.1. Severely limited testing capacity and the absence of a vaccine during the early months of the Covid-19 pandemic meant that other protective measures were required to keep those using and working in adult social care safe.

3.2. It was well known before the pandemic that influenza and other respiratory illnesses are "*a major cause of hospitalisation, morbidity, and death among the elderly*".[1] Older adults make up a significant portion of those using adult social care (see Chapter 1: Overview of the adult social care sector). However, preventing transmission of a potentially deadly virus is far from straightforward. Not all viruses spread in the same way and viruses can spread rapidly in care homes due to prolonged close contact between residents, patients and care workers, "*which in itself is a critical and necessary part of the resident's daily care*".[2] Prevention is also difficult because staff often work in multiple settings.[3]

3.3. This chapter examines some of the infection prevention and control (IPC) measures used during the Covid-19 pandemic in adult social care to try to stop or reduce the spread of disease. It focuses, in particular, on guidance about the use of IPC, the supply and use of personal protective equipment (PPE) and the steps taken to limit care workers inadvertently spreading Covid-19 in and between care settings. This includes the provision of funding to support those who were ill or otherwise self-isolating.

Infection prevention and control in adult social care

3.4. Whatever the route of transmission of a virus, IPC measures are key protective measures, central to ensuring that care is provided to residents in ways that mitigate the risks of infection insofar as possible.[4] In addition to isolation (see Chapter 2: Care home admissions, testing and isolation), measures include hand hygiene, respiratory hygiene (using a tissue to catch coughs and sneezes and disposing of the tissue safely) and regular cleaning of surfaces, equipment, clothing and bed linen. PPE is also a major element of IPC as it protects the wearer from the risk of infection (and can also help prevent the wearer from spreading infection to other people).[5]

3.5. Another important IPC measure is ventilation (ie the introduction of fresh air). Given that adult social care is delivered indoors and often at close range, ventilation can

1 INQ000223342_0004
2 INQ000587772_0022 para 3.4
3 INQ000587702_0089 para 338
4 Further details regarding IPC measures are set out in *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-3-full-report). Measures include both standard infection control precautions (basic IPC measures that should be used in all care settings to reduce the risk of infection from known and unknown risks) and transmission-based precautions (measures required when dealing with a specific pathogen, which vary depending on the relevant disease and route of transmission); INQ000474282_0020, 0043 paras 1.35-1.36, 1.38, 4.8.
5 INQ000474282_0012-0013 paras 1.16-1.17

help to reduce the build-up of infectious particles.[6] However, not all buildings are built or equipped in such a way that fresh or better-quality air can be introduced easily, and there is a tension between the positive effects of ventilation in reducing the amount of infection in a closed setting and the risk of exposing recipients of care, especially older people, to particularly hot or cold temperatures.[7]

3.6. This was not an easy balance to strike during the pandemic. Covid-19 guidance for care homes in England and Northern Ireland in March 2020 and in Scotland in April 2020 advised that, as a general IPC measure, windows should be opened where it was appropriate to do so.[8] Guidance from the Welsh Government in March 2020 recommended opening windows for ventilation in a room where a person was isolating when unwell and it was believed they had been exposed to Covid-19.[9] Visiting guidance issued in each nation in the winter of 2020 also included references to ventilation.[10] The Inquiry has not seen references to the importance of ventilation in care home guidance issued by Public Health Wales prior to March 2021 – it should have been included from a much earlier stage.

3.7. Before the arrival of Covid-19, a range of IPC guidance was available throughout the UK to support adult social care settings in dealing with outbreaks of infectious diseases, including influenza and other respiratory diseases.[11] However, Covid-19 was a new virus with different characteristics, knowledge of which took time to evolve. The care sector needed to know whether pre-existing guidance was applicable or whether new IPC guidance should apply.

Timeliness of guidance

3.8. From January 2020, representatives of the adult social care sector were calling for specific Covid-19 guidance. Professor Vic Rayner (Chief Executive Officer of the National Care Forum from 2016, a membership organisation representing not-for-profit social care and support providers) received reports of growing concerns from care providers in January 2020 about what action they should be taking to prepare for Covid-19. She contacted the Department of Health and Social Care on 24 January and was advised that the best guidance to share with members was guidance produced for healthcare professionals.[12] The guidance from Public Health England for healthcare professionals at that time had been developed from previous guidance for dealing with Middle East respiratory syndrome (MERS) and treated Covid-19 as a high consequence infectious disease. This meant that suspected or confirmed Covid-19 cases needed to be treated in specialist facilities (including

6 INQ000474276_0088-0089 para 234
7 *Technical Report on the COVID-19 Pandemic in the UK*, Department of Health and Social Care, 1 December 2022, p303 (https://www.gov.uk/government/publications/technical-report-on-the-covid-19-pandemic-in-the-uk; INQ000101642); INQ000614378_0002 para 4
8 INQ000120717_0006 para 14; INQ000325233_0004-0005; INQ000509950_0009 para 4
9 INQ000336270_0005
10 INQ000113033_0005; INQ000147436_0018; INQ000276330_0001; INQ000081676_0020
11 INQ000587772_0046-0048 paras 4.3-4.10; INQ000606530_0044 para 171; INQ000587702_0006-0007 para 24; INQ000474282_0039 para 3.9; INQ000615082_0054 para 158
12 INQ000532335_0004-0006

high-level isolation units) and healthcare workers had to comply with strict IPC requirements.[13] Guidance for primary care advised that people with suspected cases should be isolated as soon as possible and should not be allowed to use communal bathrooms.[14]

3.9. On 29 January 2020, COBR (the UK government's national crisis management centre for responding to whole-system civil emergencies) agreed that planning for a reasonable worst-case scenario should be informed by the additional information that the "*elderly and those with existing health conditions will be disproportionately affected*".[15] All four UK health ministers attended.[16] On 4 February 2020, the Scientific Advisory Group for Emergencies (SAGE) noted: "*WN-CoV* [Wuhan novel coronavirus] *appears to mirror a flu mortality curve, with most deaths among the over-60s.*"[17]

3.10. UK government officials undertook a stocktake of pandemic preparedness in adult social care in England on 11 February 2020. They recognised that there was a need to raise awareness of the risks that Covid-19 could pose to the sector to promote prevention. It was agreed that the Deputy Chief Medical Officer would draft clinical advice for care homes with a Covid-19 case as soon as possible.[18]

3.11. Specific Covid-19 guidance for community care and residential settings was published on 25 February 2020 by Public Health England and on 27 February by the Department of Health (Northern Ireland) (which closely reflected the Public Health England guidance with adaptations to make it relevant to Northern Ireland).[19]

3.12. In Scotland and Wales, no Covid-19-specific guidance for care homes was published in February 2020. In Wales, initially, advice was provided to individual care homes by a specific team in Public Health Wales (based on the 2016 *Infection Prevention and Control in Care Homes – All Wales Guidance*). This contained guidance on standard IPC and isolation of symptomatic residents.[20] However, Helen Hough (a former care home owner and member of Covid-19 Bereaved Families for Justice Cymru)

13 INQ000474282_0035, 0066 paras 2.6, 6.16; INQ000325222; 'Public health officials issue coronavirus guidance for primary care', GPonline, 22 January 2020 (https://www.gponline.com/public-health-officials-issue-coronavirus-guidance-primary-care/infections-and-infestations/infections-and-infestations/article/1671627; INQ000660259_0001-0002); INQ000114313. Covid-19 was declassified as a high consequence infectious disease on 19 March 2020 following a recommendation from the Advisory Committee on Dangerous Pathogens; see INQ000115534; INQ000226885; INQ000119498; INQ000087332; *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-3-full-report).

14 'Public health officials issue coronavirus guidance for primary care', GPonline, 22 January 2020 (https://www.gponline.com/public-health-officials-issue-coronavirus-guidance-primary-care/infections-and-infestations/infections-and-infestations/article/1671627; INQ000660259_0001-0002); INQ000114313 0002

15 INQ000051809_0002 para 1

16 INQ000056226_0001-0003; INQ000391226_0003. The reasonable worst-case scenario is a tool used for planning purposes to illustrate the worst manifestation of a risk that can reasonably be expected potentially to occur based on current information and data.

17 INQ000051925_0003 para 21; INQ000249526_0041-0042 para 129. A representative from Health Protection Scotland attended the meeting (INQ000274125_0006-0007 Table 2). There was no representative from Wales or Northern Ireland; however, the minutes were shared with a number of officials in the Department of Health (Northern Ireland) the following day (INQ000425579_0001). The Inquiry understands that the minutes were shared with the Government Chief Scientific Advisers in Wales and Scotland (INQ000238826_0214 para 662).

18 INQ000587736_0004-0005 para 15; INQ000049363_0002 para 6

19 INQ000223341; INQ000103695; INQ000613603_0024 para 72

20 INQ000587702_0005-0007 paras 20-24; INQ000538643_0022-0025, 0037

explained that, although in February 2020 "*we were all talking about Covid*",[21] the sector received little to no guidance or communications from the Welsh Government. She said that in "*early 2020*" her care home in Wales was not told how to manage an outbreak and so they relied on her existing nursing training and knowledge to implement IPC measures as best they could.[22]

3.13. On 26 February 2020, Mary Wimbury (Chief Executive of Care Forum Wales) emailed Dr Frank Atherton (later Sir Frank Atherton, Chief Medical Officer for Wales from August 2016 to 2025) raising concerns from care providers that they had not received any specific up-to-date advice on how to deal with an outbreak of Covid-19.[23] Ms Wimbury emailed again on 2 March 2020 noting that, in the absence of other information, it was assumed that advice would be as per the Public Health England guidance for care homes.[24] It was not until 9 March 2020 that the Welsh Government published guidance for community care and residential settings.[25]

3.14. Concerned by the absence of practical advice for the sector in February 2020, Scottish Care (a membership body representing independent social care providers in Scotland) published its own guidance on 24 February.[26] Jeane Freeman (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021) and Nicola Sturgeon (First Minister of Scotland from November 2014 to March 2023) were advised on 11 March 2020 that urgent advice tailored to the sector was required.[27] Health Protection Scotland's guidance for community care and residential settings was not published until 12 March.[28]

3.15. It was known by the end of January 2020 that Covid-19 would have a disproportionate impact on older adults and those with pre-existing conditions, who are found in high concentrations in care homes. Early guidance on handling a confirmed or suspected Covid-19 case was therefore crucial to ensure that those working in adult social care knew what IPC measures to implement to protect both themselves and residents.

3.16. The existing Covid-19 healthcare guidance, first published in January 2020, was of minimal practical benefit to the care sector because self-isolation was generally problematic in care homes and, in some care homes, residents might share facilities such as bathrooms. As Professor Rayner had informed the Department of Health and Social Care in February 2020, guidance did not sufficiently address the particular concerns of the adult social care sector. She described the need for

21 INQ000587639_0003-0004 para 14
22 INQ000587639_0013-0014 para 63
23 INQ000183760; see also INQ000517219_0003-0004, 0031 paras 10, 91
24 INQ000183761_0002-0003
25 INQ000336270
26 INQ000509530_0005 paras 15-16; INQ000223106. This guidance was based on Covid-19 advice from Public Health England and the measures advised for norovirus and influenza in care homes.
27 INQ000343808_0001-0002 paras 2-9
28 INQ000189305; INQ000614179_0095-0096 paras 283-285

guidance tailored to adult social care as imperative.[29] The differences between delivery of care in healthcare and social care settings should be considered during pandemic planning, and guidance tailored for social care settings should be available as quickly as possible, rather than the sector having to rely on healthcare guidance.

3.17. Specific guidance for adult social care came too late across the UK. It should have been published in early February 2020. Unsurprisingly, the sector was seeking reassurance in uncertain times. Guidance could have briefly explained what was then known about the virus and that scientific understanding was evolving. It could have reminded care homes of any existing guidance where appropriate. This would have helped allay concerns of providers and provided reassurance that they were acting on the best advice and information available at that time.

Flaws in care sector guidance

3.18. Once published in late February and early March 2020, Covid-19 guidance produced for the care sector suffered from a number of flaws, as analysed below.

Insufficiently tailored guidance

3.19. The close contact nature of social care requires care workers to help care users with daily activities such as washing, dressing and eating.[30] It should therefore have been obvious that initial IPC guidance for adult social care was insufficiently tailored to the practical realities of how adult social care is delivered when it recommended in England, Northern Ireland and Wales:

> "[T]*he best way to reduce any risk of infection for anyone is good hygiene and avoiding direct or close contact (within 2 metres) with any potentially infected person.*"[31]

3.20. In England, on 19 February 2020, a draft of Covid-19 care home guidance was shared with a number of bodies involved in the delivery of adult social care, including the National Care Forum, the Care Quality Commission and the Local Government Association.[32] In its comments on the draft guidance on 20 February 2020, the Local Government Association explained that this advice would "*not work for personal care*".[33] Claire Sutton (Head of Independent Health and Social Care at the Royal College of Nursing from August 2022) described it as impossible to implement

29 INQ000532335_0003; INQ000325222_0006, 0012; 'Public health officials issue coronavirus guidance for primary care', GPonline, 22 January 2020 (https://www.gponline.com/public-health-officials-issue-coronavirus-guidance-primary-care/infections-and-infestations/infections-and-infestations/article/1671627; INQ000660259_0001-0002); INQ000114313_0002
30 INQ000226184_0068 para 193; INQ000325228_0004-0005
31 INQ000223341_0005; INQ000103695_0005; INQ000336270_0005
32 INQ000051199_0003-0004
33 INQ000051205; see also INQ000049518 row 5

because one could not provide "*direct care and support, to individuals if you can't get within 2 metres of them*".[34]

3.21. On 8 March 2020, Ros Roughton (Director General for Adult Social Care in the Department of Health and Social Care from April to July 2020) acknowledged that avoiding close contact was "[c]*learly … not possible for many of our care workers*".[35] Professor Dame Jenny Harries (Deputy Chief Medical Officer for England from July 2019 to March 2021) said that the two-metre guidance reflected an "*inherent tension*" between "*advising steps which were thought to be protective*" and "*accepting that for many close personal care simply could not be withdrawn*".[36]

3.22. Updated guidance for care homes issued in England (13 March 2020) and in Northern Ireland (17 March 2020) acknowledged that much of the care delivered in care homes requires close personal contact.[37]

3.23. In times of crisis, there will be little time for consultation because guidance must be issued quickly. This underlines the importance of consulting the sector in pre-pandemic discussions about guidance that might be needed and the practical considerations to be taken into account. As Professor Susan Hopkins (Deputy Director of the National Infection Service at Public Health England from 2018 to 2020) stated, it is important to have principles for guidance laid out in advance of an emergency, "*so that we are able to bring in stakeholders' views, the lived view*" to help people to understand the reasons behind the guidance.[38]

3.24. The UK government's *Pandemic Preparedness Strategy* published in March 2026 recognised that guidance provided in England during the pandemic was not always appropriate for the sector. When tested during Exercise Pegasus (a UK-wide pandemic preparedness exercise that commenced in 2025), the clarity of IPC guidance for adult social care remained an issue. The Inquiry welcomes the practical steps being put in place by the UK government to enhance the effectiveness of IPC guidance.[39] The devolved administrations are encouraged to do the same.

Inadequate communication of risk in England and Northern Ireland

3.25. In mid-February 2020, there was a growing concern that sustained transmission of Covid-19 was already present in the UK. Sustained transmission was described to COBR as the spread of infection across communities, not just within households.[40] On 11 February 2020, the Scientific Pandemic Influenza Group on Modelling,

34 Claire Sutton 29 July 2025 13/2-19; see also INQ000587639_0004 para 18
35 INQ000325228_0004-0005
36 INQ000587394_0023 para 5.36
37 INQ000325233_0003-0004; INQ000120717_0008 para 22
38 Susan Hopkins 9 July 2025 101/4-10
39 *Pandemic Preparedness Strategy: Building our Capabilities*, Department of Health and Social Care, 25 March 2026, pp60-61 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)
40 INQ000056214_0004 para 2

Operational sub-group (SPI-M-O, a sub-group of SAGE) advised SAGE of "*a realistic probability that there is already sustained transmission in the UK, or that it will … become established in the coming weeks*".[41]

3.26. On 17 February 2020, there were differing views in SPI-M-O about the likelihood of sustained transmission in the UK, with some believing that it would soon become established and others believing that it was already present.[42] If sustained transmission was occurring by mid-February 2020, infected people, such as staff and visitors, may have already been entering care homes on a regular basis.[43] However, the IPC guidance issued by Public Health England and the Department of Health (Northern Ireland) at the end of February 2020 failed to warn of the risk of sustained transmission and, in fact, went further, stating that it was "*very unlikely that anyone receiving care in a care home or the community will become infected*".[44]

3.27. The guidance expressly stated that it was "*intended for the current position in the UK where there is currently no transmission of COVID-19 in the community*".[45] The inclusion of this wording did not reflect the scientific advice that there may have already been sustained transmission in the UK or that it would become established in the very near future. This guidance therefore failed to communicate the risk that care workers in care homes might shortly have to deal with both staff and residents exhibiting symptoms of Covid-19.

3.28. Matt Hancock (Secretary of State for Health and Social Care from July 2018 to June 2021) said that, at that time, he would have changed the wording from "*very unlikely*" that those using adult social care "*will become infected*" to the present rather than future tense (ie it is very unlikely that those using adult social care will 'be' infected).[46] He said that he could not understand the choice of words when "*it was so clear that we were running into a major problem*".[47] With hindsight, Professor Hopkins agreed that the guidance should have highlighted the possibility of future transmission.[48]

3.29. In a future pandemic, guidance should accurately communicate risks and should be updated in a timely manner in the event of significant new information or evidence.

41 INQ000448761; INQ000237386_0001-0002 paras 1, 13. Representatives from Public Health England and Professor Sir Michael McBride (Chief Medical Officer for Northern Ireland from September 2006) were sent a copy of the SPI-M-O consensus statement.
42 INQ000310090_0002 para 16; INQ000310089_0001; INQ000421704_0081-0082 para 176
43 The Inquiry's combined Report relating to Modules 2, 2A, 2B and 2C concluded that, factually, by mid-February 2020, there was likely sustained community transmission in the UK; see *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Chapter 2 (https://covid19.public-inquiry.uk/documents/module-2-full-report). The analysis in this chapter is based upon the scientific advice that was available at the time.
44 INQ000223341_0002, 0005; INQ000103695_0002, 0005
45 INQ000223341_0002; INQ000103695_0002
46 Matt Hancock 2 July 2025 28/13-31/7
47 Matt Hancock 2 July 2025 32/20-25
48 Susan Hopkins 9 July 2025 14/14-17/1, 28/24-29/18

Failure to advise preparatory measures

3.30. Guidance provided to healthcare settings in January 2020 recommended that staff who might be involved in the investigation or management and care of possible cases should familiarise themselves with IPC measures and should be trained in donning and doffing (putting on and taking off) PPE.[49] By contrast, advice to care providers in England and Northern Ireland in February 2020 stated that there was "*no need to do anything differently in any care setting at present*".[50] As explained above, this advice was predicated on there being "*no transmission of COVID-19 in the community*", despite the known risks that sustained transmission might have already been occurring or would occur in the very near future.[51]

3.31. In Wales, guidance published on 9 March 2020 stated that no different steps were required but said that staff should be reminded about good practice on routine infection control.[52] In Scotland, guidance published on 12 March 2020 stated that, when dealing with a probable or confirmed Covid-19 case, staff must comply with all infection control procedures set out in the guidance and the *National Infection Prevention and Control Manual* adopted in Scotland. It also included guidance on the donning and doffing of PPE.[53]

3.32. By mid-February 2020, there was a growing concern that a potentially fatal virus was already, or would very shortly become, established in the community. Guidance in each nation should have been published in February 2020 that advised care staff to familiarise themselves with IPC policies and the correct way to don and doff PPE. This was particularly significant because these were matters with which staff working in adult social care were less familiar.

Training in infection prevention and control measures

Skills and training in adult social care prior to the pandemic

3.33. The Inquiry heard that, prior to the pandemic, workers in the adult social care sector did not always have training on, exposure to and familiarity with the use of IPC measures.[54] Professor Harries told the Inquiry that, while adult social care settings in England were expected routinely to manage infections, IPC skills and capacity were probably weaker than in the NHS. There were recognised systemic weaknesses, including the fact that the majority of care in care homes is provided by non-clinical staff.[55]

49 INQ000325222_0003-0004 para 3
50 INQ000223341_0010-0011 para 18; INQ000103695_0012
51 INQ000223341_0002; INQ000103695_0002
52 INQ000336270_0002 para 2
53 INQ000189305_0007, 0017
54 See, for example, INQ000475143_0051 para 186
55 INQ000587394_0034-0035 para 5.63

3.34. Dr Gee Yen Shin, Professor Dinah Gould and Dr Ben Warne (expert witnesses on IPC) explained that training on PPE was especially important for staff safety as PPE needed to be removed in a specific order to minimise the risk to the staff member.[56] The 2022 *Technical Report on the COVID-19 Pandemic in the UK*, produced by the UK's Chief Medical Officers and Chief Scientific Advisers, noted that, while PPE had been used in the adult social care sector prior to the pandemic, its universal use during the pandemic "*required updates in knowledge, skills and practices in care homes in line with practices previously standard only in specific acute healthcare settings*".[57]

3.35. If care workers did not know how to wear and use PPE properly, its effectiveness would be undermined.

Training during the Covid-19 pandemic

3.36. During the pandemic, the UK government and devolved administrations acknowledged that more (and better-quality) IPC training was necessary in adult social care. The Inquiry notes that, prior to the pandemic, the UK government and devolved administrations were not directly responsible for overseeing or organising the delivery of training in adult social care.[58] However, during the pandemic, the UK government and devolved administrations recognised that additional training was required and therefore took steps to ensure that the care sector was provided with training resources and support. That additional training on IPC and PPE measures was not widely and consistently delivered until after the first UK lockdown. By then, Covid-19 was already spreading quickly and care workers had been left unprepared.

3.37. In Scotland, an enhanced system of oversight by a multidisciplinary team in each NHS health board region was introduced in mid-April 2020. Local teams were able to offer care home providers clinical support on matters including IPC and the appropriate use of PPE.[59] Ms Freeman said that, prior to the pandemic, she had presumed that staff in Scotland were consistently trained on the 2012 *National Infection Prevention and Control Manual* and that it was being applied. However, from "*early in the pandemic response*", she said that it became clear that this was not consistently the case and, had she known that, the Scottish Government could have introduced "*wraparound support*" for the sector at an earlier point.[60]

3.38. On 29 April 2020, NHS England agreed to deliver training and education on IPC, including PPE, to care homes in England in May 2020. By 29 May 2020, 99.96% of

56 INQ000474282_0033 para 1.77
57 *Technical Report on the COVID-19 Pandemic in the UK*, Department of Health and Social Care, 1 December 2022, p301 (https://www.gov.uk/government/publications/technical-report-on-the-covid-19-pandemic-in-the-uk; INQ000101642); see also Ruth Allen 3 July 2025 35/19-36/13
58 INQ000136825_0002 paras 4-5; INQ000613603_0014 para 39; INQ000309003_0020 para 76; INQ000485024_0006-0007 paras 13-17; INQ000547784_0001, 0006, 0032-0033; INQ000577519_0004, 0075; INQ000528402_0021-0022, 0079-0080; *The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance*, Department of Health and Social Care, January 2015, p20 (INQ000114400)
59 INQ000614179_0106-0107 paras 317-320; INQ000364126; INQ000614180_0016 para 38
60 Jeane Freeman 22 July 2025 52/16-53/6, 77/9-78/16

care homes either had received or declined training or had assured IPC and PPE procedures in place.[61]

3.39. Professor Sir Michael McBride (Chief Medical Officer for Northern Ireland from September 2006) stressed the importance of "*skilling up*" health and social care staff in Northern Ireland.[62] He acknowledged that there should have been more enhanced IPC training for social and healthcare workers in Northern Ireland before the pandemic.[63] Free IPC training was offered to care homes and domiciliary care providers from April 2020 by the Health and Social Care Clinical Education Centre. The Department of Health (Northern Ireland) also sent IPC nurses to provide training and the Chief Nursing Officer developed training videos.[64] Health and Social Care trusts supported local care providers by, for example, providing PPE training and sharing their IPC resources.[65]

3.40. In Wales, some health boards that had not ordinarily done so offered IPC and PPE training and advice to care homes.[66] The Welsh Government agreed funding to deliver an IPC training programme that was established in early 2021.[67]

3.41. These developments were welcome, but they came too late. Had the UK government and devolved administrations recognised the importance of adequate IPC training in the adult social care sector from late January 2020 and acted with sufficient urgency to ensure that additional training was provided, greater protection could have been provided for both staff and users of adult social care. As Professor Harries noted, a greater focus on IPC in care homes could have provided better pandemic preparedness and prevented unnecessary infection.[68]

3.42. The UK government's March 2026 *Pandemic Preparedness Strategy* commits to enhancing guidance and training on IPC in adult social care.[69] There is a clear need for adult social care staff to receive regular training in IPC measures and the donning and doffing of standard PPE in advance of the next pandemic, to ensure that new staff are trained and that existing staff keep their skills up to date. The introduction of a workforce register for adult social care workers in England to assist with the delivery of training in the sector, including during a pandemic, is considered in Chapter 8: Recognition and protection.

61 INQ000587682_0031-0033, 0104-0105 paras 126-129, 382-389; INQ000330954_0010 para 3; INQ000564753_0001-0003
62 Michael McBride 24 July 2025 24/21-25/20
63 Michael McBride 24 July 2025 80/24-81/9
64 INQ000613603_0023-0024, 0140, 0256-0257 paras 71, 486, 826-827; INQ000208770_0007 paras 17, 19; INQ000120717_0009-0010 paras 27-29; INQ000585042_0033. The Northern Ireland Social Care Council also provided free IPC training (INQ000613603_0256-0257 para 827).
65 See, for example, INQ000586007_0022, 0046, 0048 paras 74, 201, 208
66 INQ000587702_0082 paras 307-308
67 INQ000576034_0031 para 76
68 INQ000587394_0034-0035 para 5.63
69 *Pandemic Preparedness Strategy: Building our Capabilities*, Department of Health and Social Care, 25 March 2026, pp52-53, 61-62 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)

Provision of personal protective equipment

3.43. As outlined in Chapter 2: Care home admissions, testing and isolation, despite isolation being a key IPC measure, some care homes were unable to isolate residents safely. Where isolation could not be complied with safely, PPE became all the more important as a way to protect staff and users of care from becoming infected.

3.44. Most nursing and personal care involved close or hands-on contact, often repeatedly throughout the day.[70] Care is frequently delivered by multiple care givers, including by some who work in more than one setting.[71] Some people receiving care could not tolerate wearing face coverings or could not wear them consistently.[72] These factors increased the risk of transmission of Covid-19. PPE worn by staff was therefore often the sole barrier preventing transmission during close contact and as a result was critical in adult social care during the pandemic.

Personal protective equipment guidance in March and early April 2020

3.45. On 13 March 2020, the UK's public health bodies and the Department of Health and Social Care published guidance for healthcare settings. This guidance stated that transmission of Covid-19 was "*mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces*".[73] All healthcare workers dealing with confirmed or suspected cases were advised to wear standard fluid-resistant surgical masks for close contact and, more generally, PPE was advised where a task or procedure carried a risk of exposure to Covid-19.[74]

3.46. At about this time, guidance on PPE was issued in each nation for dealing with confirmed, suspected and symptomatic Covid-19 cases in care homes and domiciliary care (see Table 4). This guidance coincided with decisions being taken to expedite the discharge of hospital patients, including to care homes (see Chapter 2: Care home admissions, testing and isolation).

70 INQ000226184_0068 para 193; INQ000325228_0004-0005
71 INQ000614375_0003 para 10; INQ000280058_0012-0013 para 38
72 INQ000587672_0004 para 3.7; INQ000587296_0038 para 120; INQ000546956_0064 para 157
73 INQ000325350_0007 para 2.1
74 INQ000325350_0016 para 5.4; INQ000587736_0009-0010 para 40

Table 4: PPE guidance for dealing with confirmed, suspected and symptomatic Covid-19 residents in adult social care in the four nations of the UK in March 2020

Nation	Date	Guidance	Setting	PPE advised
Scotland	12 March 2020	*COVID-19: Information and Guidance for Social or Community Care and Residential Settings*, Health Protection Scotland (INQ000189305)	Care homes, domiciliary care	Apron, gloves and fluid-resistant surgical face mask, full face visors upon a risk assessment (confirmed or suspected cases) (p8)
England	13 March 2020	*COVID-19: Guidance on Residential Care Provision*, Public Health England (INQ000325233)	Care homes	Apron, gloves and fluid-repellent surgical face mask, eye protection if a risk of splashing (symptomatic cases) (p4)
	13 March 2020	*Covid-19: Guidance on Home Care Provision*, Public Health England (INQ000325235)	Domiciliary care	Apron, gloves and fluid-repellent surgical face mask, eye protection if a risk of splashing (symptomatic cases) (pp3-4)
Northern Ireland	17 March 2020	*Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland*, Department of Health (Northern Ireland) (INQ000120717)	Care homes	Public Health England guidance, including fluid-resistant surgical face mask "*when dealing with COVID-19*" (p7, para 16)
	17 March 2020	*Covid-19: Guidance for Domiciliary Care Providers in Northern Ireland*, Department of Health (Northern Ireland) (INQ000353600)	Domiciliary care	Apron, gloves and fluid-repellent surgical mask, eye protection if a risk of splashing (symptomatic cases), Public Health England guidance "*when dealing with COVID-19*" (pp6-7, paras 14, 16)

Nation	Date	Guidance	Setting	PPE advised
Wales	19 March 2020	Letter to care providers, Welsh Government (INQ000336310)	Care homes, domiciliary care	Apron, gloves and fluid-resistant surgical mask, appropriate eye protection upon a risk assessment (residents with acute respiratory infection or influenza-like illness) (pp1, 4)
	24 March 2020	*Information for Care Facilities who Have Possible or Confirmed Cases of Covid-19*, Public Health Wales (INQ000520961)	Care homes	Apron, gloves and fluid-resistant surgical mask, appropriate eye protection upon a risk assessment (confirmed or suspected Covid-19 cases) (p3)

3.47. UK-wide IPC guidance was updated on 2 April 2020 to reflect the fact that Covid-19 was confirmed as widespread in the community. Health and social care workers were also advised to wear gloves and aprons and, upon a risk assessment, fluid-resistant surgical face coverings and eye protection, when providing direct personal care (within two metres) to people who had confirmed or suspected Covid-19.[75]

The pandemic stockpile and personal protective equipment in the adult social care sector prior to Covid-19

3.48. Adult social care is predominantly delivered by providers that are independent of local authorities and Health and Social Care trusts. As a result, prior to and at the outset of the pandemic, most care providers in the UK were expected to secure and provide their own PPE.[76] Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021) reflected that there did not appear to be a plan to make sure care providers would be able to supply their staff with PPE in the event of a pandemic.[77]

3.49. Some providers had small amounts of PPE stocked prior to the pandemic, while others ordered PPE as and when it was needed, meaning that they kept very little stock. Many providers lacked the physical space to store spare PPE. This was especially true for many domiciliary care providers.[78] Not all providers had relationships with PPE wholesalers.[79] Experience of using different items of PPE prior to Covid-19 varied in the sector.[80]

75 INQ000571763_0040 para 144; INQ000348325_0001-0006, 0009; INQ000080939; see also INQ000325351
76 *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021, p14, para 3.2 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876); INQ000532383_0012 para 40; INQ000348882_0008, 0012; INQ000322760_0001
77 INQ000535015_0036 para 131
78 INQ000535015_0011 para 35; INQ000517219_0025 para 72; INQ000587670_0051 para 191
79 INQ000475131_0038 para 7.23
80 INQ000614375_0006 para 25; INQ000587639_0015 para 72; INQ000475131_0038 para 7.23

3.50. Following the 2009 to 2010 H1N1 influenza pandemic ('swine flu'), the UK government established the UK's pandemic stockpile. The stockpile included PPE such as masks, gowns and gloves, which was allocated and stored in each of the four nations according to population size. The stock was intended only for use in hospitals, for dealing with symptomatic cases, and was designed to last for 15 weeks, the expected duration of a single wave of an influenza pandemic.[81] As outlined in the Inquiry's Module 5 Report, which examines the procurement of PPE in detail, the stockpile had been prepared for a different pandemic from the one that arrived. It also contained significant quantities of expired stock, and the target volumes of stock were not being met. The combination of all these factors meant that the stockpile was insufficient to meet the demands of the Covid-19 pandemic generally, let alone the shortages of PPE supplies in adult social care.[82]

Supply of personal protective equipment to adult social care settings during the pandemic

3.51. PPE could only protect if it was available in sufficient quantity and was of adequate quality. During the early months of the pandemic, global demand for PPE surged and many adult social care organisations struggled to acquire the necessary PPE to comply with guidance.[83] Professor Rayner characterised access to PPE during this period as particularly chaotic.[84] Albert Heaney (Deputy Director General Health and Social Services Group in the Welsh Government from March 2020 to June 2021) described providing PPE in Wales as one of the most significant challenges of the entire pandemic.[85]

3.52. The UK government and devolved administrations were aware of PPE supply issues in adult social care in March 2020. As explained by Vaughan Gething (Minister for Health and Social Services in the Welsh Government from May 2016 to May 2021), at that time "*global supply chains were collapsing*".[86]

3.53. To address the difficulties, the UK government and devolved administrations each took steps to procure PPE and distribute it to the sector. The procurement and distribution of healthcare equipment are devolved (or, in Northern Ireland, 'transferred') matters and are generally carried out by the central procurement bodies in each of the four nations of the UK: Supply Chain Coordination Ltd (in England), NHS National Services Scotland (in Scotland), NHS Wales Shared Services

81 INQ000474864_0072-0073 paras 305-310; INQ000506956_0038-0039 paras 155-162; INQ000521969_0008, 0013 paras 23.4, 43-44; INQ000514103_0009-0010 paras 19-21; INQ000571763_0017, 0035 paras 64b, 127
82 *Module 5: Procurement*, UK Covid-19 Inquiry, July 2026, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-5-full-report)
83 INQ000485979_0012; see also, for example, INQ000614375_0010 para 39; INQ000475131_0038-0039 para 7.26; INQ000587673_0003 para 11
84 INQ000475131_0013 para 3.2a
85 INQ000551798_0127 para 442
86 INQ000587254_0044 paras 169-170; INQ000615082_0078-0079 para 242; INQ000606530_0074-0075 para 276; INQ000587788_0054 para 213; INQ000421858_0031-0032 paras 125-126

Partnership (in Wales) and the Business Services Organisation's Procurement and Logistics Service (in Northern Ireland).[87]

England

3.54. The Department of Health and Social Care took steps to release stock from the pandemic stockpile to the adult social care sector in March 2020. Following a change in guidance about face masks in adult social care on 13 March, the department distributed 300 face masks free of charge to each of more than 25,000 care homes between about 18 and 24 March 2020.[88] Mr Hancock said that this was "*all the resources that were available at the time, given the clinical prioritisation of PPE into hospitals*".[89] While the Inquiry recognises that stocks were exceptionally limited at this time, the National Care Association noted that, in a residential care home with 40 beds, 300 masks "*provided just 36 hours of protection*", which it said highlighted the severe shortages faced in meeting ongoing safety needs during the pandemic.[90] Following the delivery, care providers were advised to continue to source other PPE from their usual suppliers.[91]

3.55. On 21 March 2020, the National Supply Disruption Response hotline (intended for emergency provision of PPE), first established on 16 March 2020, was expanded to a 24/7 service.[92] The demand for PPE through the hotline was such that, in March 2020, Ms Whately described it as being overwhelmed with calls.[93] The Department of Health and Social Care said that more than half a million items of PPE were dispatched within the first week of the hotline being set up and that the largest number of requests received between March and October 2020 came from the adult social care sector.[94] The National Care Forum reported, however, that many providers experienced difficulty accessing supplies through the hotline. Some reported being referred to "*the cycle of doom*", where they were advised by the hotline to contact their usual suppliers, only then to be referred back to the hotline.[95]

3.56. A Homecare Association survey revealed that, by early April 2020, 80% of domiciliary care providers lacked sufficient PPE.[96] Dr Jane Townson (Chief Executive of the Homecare Association from May 2019) said that a lack of PPE meant some care workers were "*forced … to deliver care without appropriate protection*".[97] Vulnerable people who were shielding in their homes sometimes chose not to

87 INQ000539153_0055, 0057-0059 paras 175, 183, 186-189
88 INQ000587736_0011 para 46; INQ000106256
89 Matt Hancock 2 July 2025 114/15-115/13
90 INQ000515683_0007-0008 para 25a
91 INQ000106256
92 INQ000587737_0024-0025 paras 91-96; INQ000114942
93 INQ000535015_0015 para 52
94 INQ000587737_0025 paras 98-99
95 INQ000572355_0003
96 INQ000587670_0051, 0156 paras 189, 667; INQ000581157_0004-0005, 0008. While the majority of responses were from providers that operated in England, some responses were received from providers in Wales, Scotland and Northern Ireland.
97 INQ000587670_0122 para 517

let carers in because they did not have appropriate PPE.[98] As a result, some people were left without the care and support they needed.

3.57. In April 2020, the Department of Health and Social Care launched a pilot of an online portal (known as the 'PPE portal'). This new central distribution portal enabled registered community healthcare, care home and domiciliary care providers to order PPE supplies online. Phased registration began with smaller domiciliary and care home providers (all had been invited to register by 5 June 2020); registration of all providers in England was complete by September 2020. The portal continued to be developed to ensure that it met the needs of its users. For example, in September 2020, more types of PPE were made available and order limits were adjusted. It remained in use until 2024.[99]

3.58. On 15 May 2020, the Department of Health and Social Care launched the Infection Control Fund of £600 million. Guidance in June 2020 confirmed that 25% of the funding could be used on wider IPC measures, including the purchase of additional PPE by providers or local authorities.[100] On 20 July 2020, Mr Hancock agreed to provide all social care services in England with free PPE. Prior to this date, the department had focused largely on emergency provision of PPE.[101] This was a huge undertaking. A review in November 2021 by Sir David Pearson (Chair of the Social Care Sector COVID-19 Support Taskforce) outlined that, by 9 May 2021, about 2.2 billion items of free PPE had been provided through the portal to adult social care providers, that stakeholders were unanimous in praising the improvements, and that barely any providers were reporting shortages.[102] The free PPE scheme was extended on several occasions and ended when stocks were depleted in March 2024.[103]

Northern Ireland

3.59. In Northern Ireland, the remit of the Business Services Organisation's Procurement and Logistics Service was extended to procuring PPE for the entire social care sector, not just for those social care services that were provided directly by Health and Social Care trusts.[104] Interim guidance issued by the Department of Health (Northern Ireland) on 12 March 2020 asked trusts to support independent adult

98 INQ000587670_0045 para 162
99 INQ000587737_0029-0030 paras 121-125; INQ000587736_0018-0019 para 85; *Official Statistics: Experimental Statistics – Personal Protective Equipment Distributed for Use by Health and Social Care Services in England: Quarterly Update to 30 September 2022*, Department of Health and Social Care, 13 October 2022, pp7-8 (https://www.gov.uk/government/statistics/ppe-distribution-england-quarterly-update-to-30-september-2022/experimental-statistics-personal-protective-equipment-distributed-for-use-by-health-and-social-care-services-in-england-quarterly-update-to-30-sept; INQ000235007); see also *Module 5: Procurement*, UK Covid-19 Inquiry, July 2026, Chapter 2 (https://covid19.public-inquiry.uk/documents/module-5-full-report)
100 INQ000587788_0081 para 324; INQ000565715_0006
101 INQ000587737_0033 para 135
102 *Adult Social Care in England: Covid-19: A Review of the 2020 to 2021 Winter Plan and Subsequent Actions – What More Should Be Done?*, Department of Health and Social Care, November 2021, pp19-20 (https://assets.publishing.service.gov.uk/media/618250788fa8f52981d40f01/Adult-Social-Care-in-England-Winter-Plan-2020-2021-Review-David-Pearson-accessible.pdf; INQ000279947)
103 INQ000587737_0033-0034 paras 136-141
104 INQ000514103_0008-0009, 0065-0066 paras 15, 17, 202, 205

social care providers that were unable to source PPE for themselves.[105] In March 2020, the department decided that trusts should make PPE available free of charge to the adult social care sector, which was confirmed in guidance on 17 March 2020.[106]

3.60. Professor Sean Holland (Chief Social Work Officer in the Department of Health (Northern Ireland) from July 2010 to October 2022) acknowledged that there were PPE shortages across the health and care sector, including in independent care homes, "*well into April 2020*".[107] A care home manager in Northern Ireland reported that it was not until May 2020 that they had full PPE for a week.[108] Robin Swann (Minister of Health for Northern Ireland from January 2020 to October 2022 and from February to May 2024) said he deeply regretted the fact that the Northern Ireland care sector did not have adequate supplies of PPE in the initial weeks of the pandemic. Mr Swann recommended that each jurisdiction should have PPE plans that clearly set out "*the support the sector will receive, how they will receive it and a clear chain of responsibility and command*".[109]

Scotland

3.61. Following discussions on 13 March 2020, the Scottish Government confirmed that national pandemic stocks should be made available to social care organisations as a stock of last resort. From the week commencing 17 March 2020, PPE was provided to the sector from pandemic stocks free of charge for both top-up and emergency provision if usual supply routes were unsuccessful. PPE was distributed through local PPE hubs.[110] A triage helpline was introduced on 19 March 2020 to help manage the system.[111] However, a GMB Scotland trade union survey of its private care members on 30 March 2020 found that 76% had not been provided with appropriate PPE.[112] Scottish Care reported on 13 April 2020 that the hub model worked better in some areas than others and that some providers were having difficulties accessing PPE.[113]

3.62. On 17 April 2020, Ms Freeman announced that all care homes would receive a top-up of at least a week's supply of aprons, masks and gloves, which were delivered by 23 April.[114] On 25 April, the Scottish Government announced that, from 27 April, where normal supply routes were not successful, local hubs would distribute PPE to the entire social care sector.[115] Caroline Lamb (Director General for Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland from January

105 INQ000103696_0006 para 7
106 INQ000613603_0127 para 436; INQ000120717_0003 para 4d; INQ000353600_0004 para 6
107 INQ000613603_0132 para 451
108 INQ000362016_0014
109 INQ000615082_0087 para 269
110 INQ000521969_0025, 0083 para 94; INQ000614179_0174, 0262 paras 526, 803
111 INQ000606530_0054, 0075 paras 208, 278
112 INQ000569884_0025 para 86
113 INQ000259905_0001
114 INQ000498141_0033 para 91
115 'Extending PPE access to all social care providers', Scottish Government, 25 April 2020 (https://www.gov.scot/news/extending-ppe-access-to-all-social-care-providers; INQ000225990_0001); INQ000260899_0001-0005

2021 to August 2026) told the Inquiry that this model, referred to as the enhanced hub model, created a more stable and equitable distribution of PPE for social care.[116]

Wales

3.63. Mr Gething confirmed on 19 March 2020 that NHS Wales Shared Services Partnership's remit was being expanded to include procuring PPE and supplying it to social care settings in Wales. While arrangements were scaled up, providers could seek urgent assistance from local health boards if they had a confirmed case of Covid-19.[117] From March 2020, PPE provided to the adult social care sector was free of charge.[118]

3.64. On 25 March 2020, the Welsh Government confirmed that it had released supplies from the stockpile to local health boards for distribution to care providers. From 2 April 2020, Welsh ministers had oversight of the supply of PPE to adult social care through PPE ministerial meetings.[119] Issues with supply continued, with Mr Gething confirming on 21 April that Wales had enough items of stock to last only for a few days.[120] Mr Gething said that, by 7 May 2020, about two-thirds of social care PPE needs were being met via NHS Wales Shared Services Partnership (with the other third obtaining PPE by other routes).[121] The Welsh Local Government Association reported that operational arrangements were relatively stable by June 2020.[122]

3.65. In Northern Ireland, Scotland and Wales, supply and distribution issues appeared to have been largely resolved by about May 2020. Resolution of these issues took longer in England, but, once established and operating successfully, the PPE portal significantly improved access to PPE in the care sector.

Front-line experiences of personal protective equipment supply

3.66. In responses to surveys conducted after the pandemic, 87% of English local authorities, 55% of Welsh local authorities and 47% of Scottish local authorities reported that it had been "*very difficult*" or "*fairly difficult*" for care providers to access PPE in the first six months of the pandemic.[123]

3.67. Despite the efforts in each nation to quickly expand the provision of PPE to the adult social care sector, inadequate supplies of PPE, particularly in the first wave of the pandemic, left care workers insufficiently protected. Ms Whately stated that care

116 INQ000614179_0174-0175 para 526
117 INQ000587254_0044-0045 paras 169-171; INQ000252549
118 'A billion items of PPE issued to keep NHS and social care staff safe', Welsh Government, 30 September 2021 (https://www.gov.wales/billion-items-ppe-issued-keep-nhs-and-social-care-staff-safe; INQ000470738_0001)
119 INQ000587254_0045-0046 paras 174, 176; INQ000299063
120 INQ000391237_0139-0140 para 530
121 INQ000587254_0028 para 112; Vaughan Gething 15 July 2025 75/20-76/24
122 INQ000613908_0068
123 A total of 148 local authorities responded in England and 22 in Wales; see INQ000400522_0045. Thirty local authorities responded in Scotland; see INQ000587774_0012.

workers "*were having to go to work and try and care for people without even the level of PPE that the public health team thought they should have*".[124]

3.68. Without adequate access to PPE, adult social care staff resorted to making PPE themselves or trying to repurpose it from other items. Some care workers reported using "*festival waterproof ponchos*", painters' overalls, and gloves purchased from Amazon, DIY shops and other retailers.[125] Others fashioned home-made PPE from fabric, bin bags, bed linen and other household items.[126] Some used laminated plastic to make face masks and elastic from leggings to tie them around their heads.[127] Being unable to access PPE left some care services sourcing PPE from veterinary or construction industry suppliers or calling around asking for PPE from local businesses and neighbours.[128] Some social care workers were asked by employers to reuse single-use masks or not to use them at all. The Inquiry's listening exercise, Every Story Matters, heard the experience of people working in care homes.

> "*I could see NHS staff in masks and full protective wear, we had paper masks which we were told to only wear when you are providing personal care to the most vulnerable as the care home did not have enough stock.*"[129]
>
> **Care home worker, England, Every Story Matters**

3.69. PPE was also crucial to ensuring that people using care felt reassured and were protected during the pandemic.

> "*I felt better that they were wearing PPE and they were giving us protection so we wouldn't catch anything as well … it was reassuring.*"[130]
>
> **Person with care and support needs, England, Every Story Matters**

3.70. The Inquiry's Module 5 Report explored in more detail the difficulties in distribution of PPE across the UK and noted the significant resources and effort made by the UK government and devolved administrations to rapidly scale up the procurement of PPE at a time of global shortages. However, had the UK government and devolved administrations properly taken into account the adult social care sector in their pre-pandemic stockpile planning and considered how PPE would be supplied to

124 Helen Whately 17 July 2025 5/6-19; see also INQ000535015_0034 para 124
125 INQ000587673_0003 para 11; INQ000587639_0016 para 74
126 INQ000587670_0052 para 194; INQ000587639_0016 para 75; INQ000614378_0007 para 21
127 INQ000474919_0049 para 145
128 INQ000587670_0052 para 194; INQ000572355_0004; *Every Story Matters: Adult Social Care Sector*, p113 (INQ000587564); INQ000614378_0007 para 21
129 *Every Story Matters: Adult Social Care Sector*, p114 (INQ000587564); see also INQ000474919_0049 para 147; INQ000569884_0021-0022 para 76
130 *Every Story Matters: Adult Social Care Sector*, p110 (INQ000587564)

the sector in an emergency, front-line adult social care staff would have had access to the critical PPE they needed at an early stage.[131]

3.71. The next pandemic could be both longer and more deadly. The care sector may require emergency provisions of PPE as it did during the response to the Covid-19 pandemic. In its Module 5 Report, the Inquiry therefore recommended that the UK government and devolved administrations:

- maintain a minimum three-month supply of PPE for the entire health and social care sectors; and
- create a strategy for domestic manufacturing and international procurement of healthcare equipment.[132]

Concerns that personal protective equipment was requisitioned for healthcare settings

3.72. Problems accessing PPE in adult social care were particularly acute during the first wave of the pandemic, when there were concerns that healthcare settings were taking precedence for supplies of PPE.

3.73. On 19 March 2020, in England, the organisations and groups that attended the first adult social care workforce meeting (which included attendees from the Homecare Association, Care England, the Association of Directors of Adult Social Services, the Local Government Association, Skills for Care, Social Work England and the Care Quality Commission) were told that the NHS and social care organisations would have equal priority as distribution of PPE was stepped up.[133] However, front-line care providers and workers reported instances of suppliers redirecting PPE intended for the care sector to the NHS or refusing to supply organisations outside the NHS.[134] On 25 March 2020, in Wales, Mr Gething confirmed a need to ensure that access to PPE stock was reserved for the use of front-line healthcare staff.[135]

3.74. On 31 March 2020, at a meeting of the PPE oversight board chaired by Professor Harries, a prioritisation framework was discussed that set out priority groups for PPE "*based on risk of contact with those who had COVID-19, the closeness of contact if present and whether the workforce was defined as critical*".[136] Prioritisation of PPE based on this framework was subsequently agreed by all four nations on 2 April 2020. The highest category of need was acute healthcare settings and settings

131 *Module 5: Procurement*, UK Covid-19 Inquiry, July 2026, Chapters 1 and 2 (https://covid19.public-inquiry.uk/documents/module-5-full-report)
132 *Module 5: Procurement*, UK Covid-19 Inquiry, July 2026, Chapter 3 (https://covid19.public-inquiry.uk/documents/module-5-full-report)
133 INQ000119095
134 INQ000475131_0038 para 7.24; INQ000572355_0004
135 'Written statement: Personal Protective Equipment (PPE)', Welsh Government, 25 March 2020, p2 (https://www.gov.wales/written-statement-personal-protective-equipment-ppe; INQ000299063)
136 INQ000587737_0022 para 83

where aerosol generating procedures were conducted, followed by (among others) other hospital wards and adult social care.[137]

3.75. On 31 March 2020, Ms Whately's private office received a list of collated concerns from PPE suppliers, who explained that they had prioritised the NHS, which had left "*social care providers with nothing*".[138] One supplier reported that its PPE had been "[r]*equisitioned for the NHS or requisitioned for the national supply stock*".[139] Another said that it would only deal with NHS hospitals given the high demand. One reported having been told that certain products had to be ring-fenced for the NHS as sanctioned by the UK government.[140]

3.76. On 3 April 2020, Mr Gething heard concerns from council leaders that the NHS in Wales was being prioritised for PPE over social care settings. The Deputy Chief Medical Officer (Wales) explained that PPE guidance was based on a risk assessment, and that the risk to those working in adult social care settings "*is likely to be less than in hospital settings since residents are self-isolating and visitors are banned*".[141] Mr Gething was informed that steps had been taken to provide PPE to care homes with suspected cases.[142] Public Health Wales advised that PPE guidance for the care sector in Wales was consistent with other parts of the UK.[143] Mr Gething said that he was sensitive to concerns about prioritisation of PPE and information was published about supplies of PPE being provided to the adult social care sector to provide reassurance.[144]

3.77. In response to surveys conducted after the pandemic, 44% of local authorities in England, 27% of Welsh local authorities and 38% of Scottish local authorities reported that orders of PPE were diverted to the NHS "*very often*" or "*fairly often*" in the first six months of the pandemic.[145]

3.78. In a survey conducted by the National Association of Care and Support Workers, one member reported feeling like the prioritisation of PPE for hospitals was because "*care home residents weren't worth saving*".[146] The manager of a care home in Northern Ireland said that PPE only started to be received from the relevant Health and Social Care trust in late April 2020. They said it was stressed to trusts repeatedly that the community and care homes were extremely vulnerable and needed PPE first to prevent spread; however, "*the acute settings of hospitals all seemed to get first*

137 INQ000587737_0022 paras 82-84; INQ000551548_0001; INQ000083701. While the minutes are dated 3 April 2020, the Inquiry understands that the meeting took place on 2 April 2020. Attendees from the devolved administrations are not noted. INQ000083635_0002-0003; INQ000215183; INQ000083113_0003; INQ000273984_0002-0003 para 6. The term 'aerosol generating procedures' refers to medical procedures (such as intubation) that were considered, by virtue of the activity itself, to cause the production of infectious aerosols even where ordinary aerosol transmission was not considered to be occurring.
138 INQ000327798; INQ000535015_0017 para 61
139 INQ000327799
140 INQ000327799
141 INQ000349300_0003
142 INQ000349300_0003-0004
143 INQ000615618_0004; INQ000615619
144 Vaughan Gething 15 July 2025 69/5-24
145 A total of 147 local authorities responded in England and 22 in Wales; see INQ000400522_0046-0047. Twenty-nine local authorities responded in Scotland; see INQ000587774_0013.
146 INQ000569768_0024-0025 para 89; INQ000518387_0038

before the care homes".[147] Dr Townson accused the UK government of redirecting the supply of PPE for domiciliary care and putting care workers disproportionately at risk compared with health sector colleagues.[148]

3.79. Mr Hancock explained that there was clinical prioritisation, which was based on advice, but he did not agree that supplies of PPE to the NHS were being prioritised "*at the expense*" of the care sector.[149] While Mr Hancock was aware that people "*felt there was a prioritisation, and that the NHS hoarded PPE*", he said that the evidence he saw pointed to a situation of desperately short supply in which "*everyone was trying to get their hands on PPE, and if they got their hands on PPE then they would tend to hold on to it*".[150] Ms Whately was told by officials in the Department of Health and Social Care that there was no "*national instruction*" that the NHS should be prioritised over social care.[151] Ms Lamb said that the Scottish Government focused very much on what would be the requirement in healthcare settings prior to the pandemic.[152]

3.80. It is clear that, when PPE supplies were limited in March and April 2020, the UK government and devolved administrations agreed that acute healthcare settings were the priority for receipt. Had there been better planning for the provision of PPE to all settings, this may not have been necessary. Once more stock became available, governments tried to ensure that other healthcare settings and adult social care were given equal priority. However, given the sheer volume of reports of PPE being diverted to healthcare systems, the belief persisted that the UK government and devolved administrations failed to prioritise the important role of PPE in the care sector to protect users and staff.

Quality and suitability of personal protective equipment

3.81. During the pandemic, problems with poor-quality PPE were common in the adult social care sector – the PPE available was described to Every Story Matters as "*awful*" and "*out of date*" – and left care workers worrying about the risk of infection.[153] UNISON (a public services union that represents members in the social care sector) described problems with quality and access to PPE as "*multiple and coming from all over the country*".[154] As explored in the Inquiry's Module 3 and Module 5 Reports, these problems were not unique to adult social care.[155]

147 INQ000587747_0006 para 11A
148 INQ000587670_0052 para 197
149 Matt Hancock 2 July 2025 117/12-17
150 Matt Hancock 2 July 2025 117/18-118/4
151 Helen Whately 17 July 2025 52/25-54/2
152 Caroline Lamb 14 November 2024 82/24-83/15
153 *Every Story Matters: Adult Social Care Sector*, p115 (INQ000587564)
154 INQ000569884_0020 para 74
155 *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 2 (https://covid19.public-inquiry.uk/reports/module-3-full-report); *Module 5: Procurement*, UK Covid-19 Inquiry, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-5-full-report)

3.82. Care UK said that it had serious concerns regarding the quality of PPE provided by the UK government. For example, face masks that were initially provided had ties that detached from the mask "*on many occasions*".[156] Care UK said that it had much more confidence in the quality of equipment provided by the end of the summer of 2020.[157]

3.83. In response to surveys conducted after the pandemic, 41% of English local authorities, 45% of Welsh local authorities and 17% of Scottish local authorities reported that their council or local care providers had experienced orders of poor-quality PPE "*very often*" or "*fairly often*" in the first six months of the pandemic.[158]

3.84. The manager of a care home in England said that they:

> "*never knew what the quality was going to be like until it arrived. I remember batches of aprons that didn't have a hole for the head, there were aprons without ties and gloves that broke as soon as you put your hand in. Some aprons were cut on a slant so when you opened them up there was only half an apron … Some PPE … had to be put in the bin straight away as they were completely unusable and unsafe.*"[159]

3.85. The Inquiry's Module 5 Report considered in more detail the need to ensure the quality of PPE in the pandemic stockpile and recommended that the UK government and devolved administrations make changes to emergency healthcare equipment regulations (which include PPE) to clarify the inspection process and to quality-assure the expanded pandemic stockpile.[160]

Limiting the risk of Covid-19 transmission by staff

3.86. As set out in Chapter 2: Care home admissions, testing and isolation, care workers entering care settings were, inadvertently, one of the routes by which Covid-19 could be spread to people receiving and working in adult social care. Staff had been recognised as a potential route of transmission by the Department of Health and Social Care on 11 February 2020.[161] The initial results of the Vivaldi 1 study (which considered Covid-19 infection in care homes), published on 3 July 2020, did not provide evidence on the relative importance of all routes of transmission in care homes but did point to the important role of staff in transmission of infection.[162]

156 INQ000569776_0008 para 4.7
157 INQ000569776_0008 para 4.7
158 A total of 147 local authorities responded in England and 22 in Wales; see INQ000400522_0046. Twenty-nine local authorities responded in Scotland; see INQ000587774_0013.
159 INQ000587748_0008-0009 para 35
160 *Module 5: Procurement*, UK Covid-19 Inquiry, July 2026, Chapter 3 (https://covid19.public-inquiry.uk/documents/module-5-full-report)
161 INQ000049363_0002 para 7
162 INQ000613177_0021 para 43; INQ000211984

3.87. Care workers move in and between residents' rooms and communal areas in care homes and can work across multiple care homes, settings and agencies. The use of agency staff to cover sickness absences was not uncommon. Larger providers moved care workers between care homes located in different regions and across borders to help with staff shortages.[163] Some social care staff had part-time jobs in other industries.[164] Domiciliary care workers frequently travelled to several different homes during a working day.[165] The risks of cross-infection were therefore inherent in the system and so steps were taken by care providers, the UK government and the devolved administrations to try to reduce those risks.

Cohorting

3.88. Restricting staff movement in care settings was part of the IPC toolkit for controlling the transmission of infectious respiratory diseases.[166] During the pandemic, limiting movement in care settings was primarily done by grouping or 'cohorting' staff to restrict workers moving between symptomatic and non-symptomatic residents.[167]

3.89. Ms Hough described splitting the home she managed in Wales into three sections, including one that was designated for symptomatic residents. Staff were divided into groups and allocated to work in a particular section. She believed this system helped reduce infection. However, it was difficult to maintain when staff members had to cover absences, sometimes for another team.[168] The Inquiry also heard of other initiatives to restrict staff movement in care homes. One care home in England described dividing its two units – one a nursing unit and one a dementia unit – into "*bubbles*" so that staff would remain in one "*bubble*" and not walk into other areas of the home. The home also allocated specific lavatories and changing areas to staff.[169] However, variations in the size and layout of care homes meant it was not possible for all care homes to implement cohorting.[170]

3.90. In domiciliary care, some providers arranged their workforce into teams, with one caring for people with Covid-19 and the other caring for people without Covid-19. However, this was difficult to implement when testing was limited and a person's Covid-19 status was unknown. The nature of domiciliary care also meant that many care workers had to deliver care in multiple people's houses during a shift.[171]

163 See, for example, Michael McBride 24 July 2025 43/13-23; INQ000614380_0005 para 21; INQ000613603_0108 para 369
164 Christina McAnea 8 July 2025 186/11-16
165 INQ000587670_0089 para 372
166 See, for example, INQ000223342_0014
167 INQ000283271_0007, 0011 para 6, Annex C; *Admission and Care of Residents during COVID-19 Incident in a Care Home*, Department of Health and Social Care, Public Health England, Care Quality Commission and NHS, 2 April 2020, pp7, 11, para 5, Annex C (https://www.pathway.org.uk/wp-content/uploads/Admission-and-Care-of-Residents-during-COVID-19-Incident-in-a-Care-Home.pdf; INQ000528401); INQ000189305_0011; INQ000536254_0035
168 INQ000587639_0013-0014 paras 63-64
169 INQ000587674_0002-0003 para 8
170 INQ000618192_0009
171 INQ000587670_0078, 0123 paras 320, 521

3.91. While cohorting was a useful IPC measure for providers that were able to implement it, those that were unable to do so needed to rely on other IPC measures to try to protect staff and residents.

Limiting staff movement between care settings

3.92. Restricting staff movement gave rise to significant concerns about how the sector would be able to maintain safe levels of care. Before the Covid-19 pandemic, many care providers already had difficulties finding sufficient numbers of staff to provide care to people in care homes and at home.[172] During the pandemic, large numbers of the workforce were absent through self-isolation or ill-health, making workforce shortages all the greater.[173]

3.93. The tension between limiting staff movement and the need to provide safe levels of care was acknowledged by a number of witnesses. Professor Harries said that the problem was very difficult to solve. She explained that to isolate care workers completely could mean that "*a care home might fall over*".[174] She said the precarious state of the social care workforce was a problem throughout the pandemic.[175] Professor McBride described balancing safe staffing levels while dealing with high levels of staff absence as challenging.[176] When asked how best to balance the provision of care with the need to restrict staff movement, Professor McBride said that planning for interventions needed to start now. He acknowledged that underlying issues around remuneration and recognition needed to be addressed and said that there needed to be a mechanism to track staff movements readily.[177]

3.94. One member of the National Association of Care and Support Workers said that there was "*no choice but to move around because everywhere was so under staffed*".[178] Another said that short staffing and self-isolation policies meant it was "*essential for care workers to work in different places*" to ensure that care could be provided.[179] Having the correct PPE was identified as one factor that would have reduced the risk of spreading the virus via staff movement.[180] Dr Townson described how, in domiciliary care, at times more than a quarter of an organisation's staff were isolating. She said that, in light of existing workforce shortages, this became a serious issue, with many providers finding it difficult to cover shifts.[181]

172 INQ000518420_0005
173 See, for example, INQ000553880_0001
174 Jenny Harries 29 November 2023 23/23-24/3
175 Jenny Harries 29 November 2023 23/23-24/14
176 INQ000587671_0117-0118 para 7.21
177 Michael McBride 24 July 2025 40/14-41/4, 42/10-18
178 INQ000518420_0059
179 INQ000518420_0061
180 INQ000518420_0058-0061
181 INQ000587670_0049 para 180

Guidance on limiting staff movement

3.95. Notwithstanding these inherent difficulties, guidance was issued across the UK seeking to limit the risk of staff spreading the virus. As Ms Lamb told the Inquiry, stopping staff movement in and between care settings was critical to minimise the risk of infection from Covid-19.[182] Scotland was the first nation to issue guidance on limiting staff movement in adult social care when, on 12 March 2020, guidance from Health Protection Scotland stated that the use of bank or agency staff in care homes and in domiciliary care "*should be avoided wherever possible*".[183]

3.96. In Northern Ireland, guidance dated 26 April 2020 stated:

> "*As far as possible homes should seek to limit turnover in staff they use and seek to limit the number of staff moving between different homes. This might include block booking agency staff to ensure consistency.*"[184]

3.97. In England, Department of Health and Social Care guidance – *Coronavirus (Covid-19): Care Home Support Package*, dated 15 May 2020 – stated that "*all possible steps*" should be taken by providers to "*minimise staff movement between care homes, to stop infection spreading between locations*".[185]

3.98. In May 2020, the Welsh Government received scientific advice that staff movement between care homes should be prevented if at all possible, acknowledging that this could put significant economic strain on the sector.[186] Mr Heaney explained that the Welsh Government was not in a position to prevent the movement of care workers at that time because this would have led to insufficient levels of staffing to deliver care.[187] It was not until 17 August 2020 that the Welsh Government advised that staff movement in social care settings should be restricted. In a letter to local authorities, directors of social services and managers of adult care homes, Mr Heaney acknowledged the steps already taken by social care settings to minimise movement of the workforce and noted that "*up to 90% of workers from agencies are allocated to a single setting*".[188] The letter stated that, in addition to cohorting staff, providers should ensure that staff worked in only one care home.[189]

3.99. However, in about late 2020 or early 2021, workforce shortages due to shielding, sickness and childcare responsibilities resulted in Social Care Wales publishing advice supporting mutual aid to enable staff movement between neighbouring

182 INQ000614179_0152 para 442
183 INQ000189305_0007, 0011
184 INQ000536254_0012 para 43
185 *Coronavirus (Covid-19): Care Home Support Package*, Department of Health and Social Care, 15 May 2020, pp4-5 (INQ000325278)
186 INQ000336503
187 INQ000551798_0126 para 439
188 INQ000509286_0001
189 INQ000509286_0001-0002

local authorities. Mr Heaney said that the situation was extremely challenging and that mutual aid was crucial to ensure that care continued to be provided.[190]

3.100. Mr Hancock acknowledged that limiting staff movement in domiciliary care would have required those workers to "*only work with one person or a smaller number of people, and that would probably have been impractical*".[191] The Scottish Government's *Adult Social Care Winter Preparedness Plan 2020–21* continued to encourage a reduction in staff movement in domiciliary care. It also required agency staff for care homes with cases of Covid-19 to self-isolate for 14 days before moving to another setting.[192]

3.101. While the UK government and devolved administrations attempted to reduce transmission risk in adult social care by discouraging staff movement between care settings, this proved to be very difficult because of staffing pressures and the need to ensure that care could be delivered. Given that care workers will almost inevitably be a means by which a pandemic disease can enter care settings, a future pandemic may again necessitate efforts to limit staff movement. This reinforces the need to plan for restrictions on staff movement and to encourage the recruitment and retention of adult social care staff (see Chapter 8: Recognition and protection).

Attempted legislation to restrict staff movement

3.102. Mr Hancock said that in May 2020 it was not possible to introduce legislation to restrict staff movement. He said that not only did it take time to introduce legislation but officials had advised him that there was a risk that some providers would be forced to operate with unsafe staffing levels.[193] However, following agreement at a Covid-19 Operations Committee meeting in September 2020, the Department of Health and Social Care proposed that The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 be amended to require care home providers not to use staff (whether agency, temporary or otherwise) who attended more than one health or social care setting. The proposal included an exception: where a provider had insufficient staff to provide safe care, people who also worked in another health or social care setting could be employed "*for as long as is reasonably necessary to make alternative arrangements*".[194]

3.103. Between 13 and 23 November 2020, the Department of Health and Social Care ran a consultation on these proposals. More than half the respondents (55%) believed that the proposals had the potential to reduce staff movement. However, 86% of respondents believed that the proposals would be difficult to implement and 68% believed that exceptions would need to be used at least weekly. Respondents also had concerns that the legislation would cause financial hardship and affect staff

190 INQ000551798_0126-0127 para 440
191 Matt Hancock 2 July 2025 113/5-8
192 INQ000614179_0153 para 446; INQ000249502_0007
193 INQ000587746_0035, 0038 paras 152, 166; INQ000292617_0002 paras 7-8; see also Matt Hancock 2 July 2025 97/1-18
194 INQ000059167_0002-0003 paras 1-2. The Covid-19 Operations Committee was a UK Cabinet sub-committee that met from May 2020 to drive the policy and operational aspects of the Covid-19 response.

wellbeing, and could lead to a risk of burn-out.[195] The Nuffield Trust's response said that care homes had already "*been brought to their knees during the first wave of the pandemic*" and in the absence of timely support had struggled to continue to deliver services.[196] It also believed that domiciliary care workers should be exempt to ensure the sustainability of those services, provided that adequate PPE and testing were made available.[197] In its response, the Homecare Association stated that the policy was mistaken and likely to be unworkable or not policed effectively.[198]

3.104. By December 2020, a submission to Ms Whately noted that approximately one-third of care homes were experiencing outbreaks of Covid-19. The Department of Health and Social Care maintained that proposed legislation continued to be an important mechanism in helping to reduce the risk of Covid-19 outbreaks and infections. It cited research by the Cabinet Office into a small sample of homes that had not experienced outbreaks, which identified no staff movement as a good practice measure.[199]

3.105. Mr Hancock said that, by about late December 2020, the Treasury was reluctant to fund a scheme to support staff affected by the proposed regulation. On 7 January 2021, Mr Hancock said he accepted that a full ban would not be possible "*because of opposition from key system partners*", particularly in light of both the vaccine rollout and the decision to bring in a further lockdown.[200] Guidance against staff movement between care homes was, however, maintained.[201]

3.106. Ms Freeman said she was not sure that mandating the restriction of staff movement in Scotland would be feasible, given that care was provided by both the public and private sectors.[202] Ms Lamb said that introducing guidance was quicker and she thought legislation would be complex.[203] Professor McBride likewise thought that introducing legislation in Northern Ireland might not be quick and that it could disproportionately impact low-paid workers and women. He said that, while it may be "*very tempting to reach for the lever which says, '*[m]*ake something mandatory and it will happen'*", in his experience that was not always the case.[204]

3.107. As the consultation responses made clear, introducing legislation during the pandemic to restrict staff movement would have posed significant practical difficulties for the adult social care sector. The UK government and devolved administrations did, however, put in place funding to mitigate financial difficulties caused to care workers and providers.

195 INQ000059167_0003
196 INQ000553878_0003
197 INQ000553878_0002
198 INQ000571022_0001
199 INQ000059167_0004 paras 4-7
200 INQ000587746_0037 paras 160-161
201 INQ000587746_0037 para 161
202 Jeane Freeman 22 July 2025 98/9-12
203 Caroline Lamb 22 July 2025 150/4-10
204 Michael McBride 24 July 2025 41/8-42/9

Funding to support limiting staff movement

3.108. It was widely acknowledged that limiting staff movement could materially affect the financial circumstances and earnings of both care workers and care providers. People who worked in multiple settings could lose a significant source of income, and restricting staff to one care setting also required providers to ensure that there was sufficient workforce capacity, which often meant a need to employ additional staff.[205]

3.109. In England and Scotland, specific funds were made available to try to cover the costs of limiting staff to one care home. There were three funding streams in England:

- The Infection Control Fund of £600 million was launched by the Department of Health and Social Care on 15 May 2020.[206] It was paid to local authorities in two instalments (May and July 2020) to distribute to care providers to meet the additional costs of restricting staff to work in only one care home and to pay the wages of those self-isolating.[207] The Infection Control Fund was extended to March 2021, with £546 million paid in two instalments in October and December 2020.[208]
- The Workforce Capacity Fund was announced on 16 January 2021. This allocated £120 million of ring-fenced funding to local authorities and could be spent directly by local authorities or passed on to care providers with the aim of increasing the size of the workforce in care homes and domiciliary care. It had to be spent by 31 March 2021.[209]
- From 29 March 2021, the Infection Control Fund and the Rapid Testing Fund (introduced on 23 December 2020 to support increased lateral flow testing in care homes) were consolidated into the Infection Control and Testing Fund. This fund of £341 million required local authorities to pass on a proportion of their allocations to every care provider in their local area. The restriction of staff movement remained one intended aim of the funding.[210]

3.110. There were mixed reports about whether these funding regimes fully achieved their intended aims. To be eligible for funding from the Infection Control Fund, care homes had to complete the Capacity Tracker (an online tool to collect data on care home capacity and other relevant information).[211] In July 2020, Capacity Tracker data suggested that 90% of care homes had taken action to restrict staff movement between settings, compared with 78% at the end of May 2020.[212] However, technical issues prevented some providers from completing the Capacity Tracker, which put their funding at risk. Some providers complained that they had not received funding

205 INQ000059167_0002, 0004 paras 2, 8-9; INQ000553295_0001-0002; INQ000543049_0040-0041 para 215
206 INQ000587788_0081 paras 324-326
207 INQ000587737_0038 para 161; INQ000106466_0001-0003
208 INQ000235006_0001-0002
209 INQ000587737_0105-0106 paras 410-412; INQ000325305_0001; INQ000059731_0001
210 INQ000587737_0040-0043 paras 169-179; INQ000576743_0005
211 INQ000587737_0039 para 163c; INQ000565715_0006-0007
212 INQ000292626_0011

from the Infection Control Fund via their local authority, and some local authorities reported delays in being able to distribute funding to providers.[213]

3.111. The Workforce Capacity Fund led to the recruitment of just under 40,000 staff.[214] This was remarkable in the context of a pandemic. In response to a survey conducted between 13 July and 10 August 2021, 64% of 59 local authorities that participated either agreed or strongly agreed that the fund helped to reduce staff movement between care homes and health and care settings.[215] A review in November 2021 by Sir David Pearson found that stakeholders welcomed the fund but felt that it was introduced late. They believed that, if the funding had been introduced a few months earlier, it would have lowered the chance of a small number of staff who tested positive for Covid-19 continuing to work in care homes.[216]

3.112. The Homecare Association described the Infection Control and Testing Fund as unpredictable and time-consuming to administer, but also said that it was invaluable in terms of maintaining workforce capacity and morale and, without this funding, many services would not have remained viable.[217]

3.113. The Scottish Government's *Adult Social Care Winter Preparedness Plan 2020–21*, published on 2 November 2020, stated that "*providers will now be required to demonstrate they have done everything they can to limit staff movement*".[218] This required robust recording of unavoidable staff movement. The plan committed up to £50 million to help care providers implement these requirements and acknowledged that it "*will be important that every effort is made to ensure any measures do not negatively impact on individual members of this vital workforce*".[219]

3.114. The Inquiry has seen no evidence that funding in Northern Ireland and Wales was ring-fenced specifically to help restrict the movement of staff between care settings. However, substantial funding was provided throughout the course of the pandemic to the adult social care sector in both nations, including for IPC measures, which could include restricting staff movement.[220]

3.115. The funding to restrict staff movement in England was welcomed by the sector and there is evidence that, overall, it had the intended effect of reducing staff movement between care settings. There were, however, some issues with access to and distribution of the funding. Planning across the UK for a future pandemic where

213 INQ000587737_0044-0045 paras 186-189
214 INQ000587737_0106 para 414b
215 INQ000328150_0001-0004; INQ000587737_0107 para 414c
216 *Adult Social Care in England: Covid-19: A Review of the 2020 to 2021 Winter Plan and Subsequent Actions – What More Should Be Done?*, Department of Health and Social Care, November 2021, pp9, 14 (https://assets.publishing.service.gov.uk/media/618250788fa8f52981d40f01/Adult-Social-Care-in-England-Winter-Plan-2020-2021-Review-David-Pearson-accessible.pdf; INQ000279947)
217 'Findings of Homecare Association member survey, April 2022', Homecare Association, 1 June 2022, p3 (https://www.homecareassociation.org.uk/resource/shortage-of-homecare-and-unmet-need-impact-of-cost-of-living-and-removal-of-covid-19-grants.html; INQ000574061)
218 INQ000249502_0007
219 INQ000249502_0007
220 INQ000615082_0112-0118 paras 344-366; INQ000587254_0068-0080 paras 249-293

staff are a potential vector of transmission should include the issue of how funds to restrict staff movement (such as for providers to hire additional staff, or cover the additional costs of ensuring that workers only work in one setting) will be provided. The earlier this funding can be introduced, the greater the impact it is likely to have.

Funding to support sick or self-isolating care workers

3.116. As noted in the Inquiry's combined Report relating to Modules 2, 2A, 2B and 2C, many people in low-paid professions had no option but to continue working during the pandemic. This was especially true in the adult social care sector, where low levels of pay meant care workers faced the increased risk of infection from Covid-19 and increased financial hardship when self-isolating.[221]

3.117. The UK government and devolved administrations therefore took steps to limit the risk of Covid-19 being spread by individuals who felt they had to continue to work when they should have been isolating (whether positive, symptomatic or a close contact). This included changes made in the March 2020 budget which meant that employees self-isolating due to Covid-19 were entitled to Statutory Sick Pay from the first day of their absence from work (as opposed to day four).[222] The changes came into force in all four nations later that month.[223] However, some people, for example those on zero-hours contracts (see Chapter 1: Overview of the adult social care sector), might not have qualified for Statutory Sick Pay.[224] Since the pandemic, the Employment Rights Act 2025 has removed the lower earnings limit for Statutory Sick Pay and the waiting period to qualify (with effect from April 2026) in the UK.[225]

3.118. Each government also introduced grants for people required to self-isolate. The Discretionary Support self-isolation grant was available in Northern Ireland from 25 March 2020. The UK government introduced a £500 Test and Trace Support Payment on 28 September 2020 and similar schemes were introduced in Scotland in October 2020 and Wales in November 2020.[226] These schemes are considered further in Module 7: Test, trace and isolate.

221 Albert Heaney 15 July 2025 119/23-120/1; see also *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 10 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
222 INQ000661269_0013-0014 para 44; INQ000236874_0005; INQ000655668_0008 para 2.9; INQ000655668_0029, 0032-0033 paras 6.20, 6.32
223 INQ000655668_0033-0034 paras 6.33, 6.37; The Statutory Sick Pay (Coronavirus) (Suspension of Waiting Days and General Amendment) Regulations 2020 (No. 374) (https://www.legislation.gov.uk/uksi/2020/374/contents/made); The Statutory Sick Pay (General) (Coronavirus Amendment) Regulations 2020 (https://www.legislation.gov.uk/uksi/2020/287/contents/made); The Statutory Sick Pay (Coronavirus) (Suspension of Waiting Days and General Amendment) Regulations (Northern Ireland) 2020 (https://www.legislation.gov.uk/nisr/2020/54/contents/made); The Statutory Sick Pay (General) (Coronavirus Amendment) Regulations (Northern Ireland) 2020 (https://www.legislation.gov.uk/nisr/2020/32/contents/made)
224 INQ000569768_0034 para 129
225 Employment Rights Act 2025 (https://www.legislation.gov.uk/ukpga/2025/36/contents); *Plan to Make Work Pay and Employment Rights Act: Timeline Update*, Department for Business and Trade, 15 April 2026 (https://www.gov.uk/government/publications/implementing-the-plan-to-make-work-pay-and-employment-rights-act/plan-to-make-work-pay-and-employment-Employment Rights Act 2025rights-act-timeline-update; INQ000660253)
226 INQ000575999_0011-0012, 0017-0018, 0020 paras 32, 64, 69, 78. In Wales, the scheme came into effect in November 2020 but was backdated to October (INQ000587570_0034 para 106).

3.119. Specific funding was also provided for the adult social care sector to limit both the financial loss to the care worker and the risk of onward transmission of Covid-19.

Top-up to Statutory Sick Pay

3.120. Care sector members of UNISON described Statutory Sick Pay as "*low level*", which placed care workers under pressure to work when they were meant to be isolating.[227] Some people continued to work when symptomatic, feeling unwell or having been exposed to Covid-19, while others were reluctant to test in case they received a positive result.[228] Professor Rayner said that one of the biggest issues for National Care Forum members was insufficient funding to ensure that staff were consistently paid higher than Statutory Sick Pay "*to guarantee staff isolation*".[229] The National Care Forum and trade unions were concerned that guidance was introduced "*without the funding to make it possible for people to isolate*", which Professor Rayner said was a repeated problem throughout the pandemic.[230]

3.121. During the pandemic, funding was therefore made available to care providers to enable them to pay staff a higher wage (ie a wage above the minimum sick pay required by law). Sometimes referred to as Enhanced Statutory Sick Pay, funding was made available in England, Scotland and Northern Ireland in May and June 2020 as follows:

- Part of the Infection Control Fund introduced in England on 15 May 2020, and extended on a number of occasions, was intended to ensure that social care staff who were self-isolating received their normal wages.[231] This supplemented £1.6 billion of initial funding that had been made available to local authorities in March 2020, in part to ensure that adult social care staff who were self-isolating did not lose out financially.[232] However, that money had not been ring-fenced specifically for adult social care.[233] The Vivaldi 1 study found that care homes that did not pay full sick pay were more likely to have infections in both residents and staff.[234]

227 INQ000587569_0020 para 74
228 INQ000587569_0020-0021, 0039-0040 paras 74, 127; INQ000586665_0021 para 133; INQ000569768_0034 para 129; Joanna Killian 28 July 2025 130/3-23; Caroline Abraham 16 July 2025 11/9-18; INQ000571608_0071 para 14.23; INQ000107206_0004; INQ000587670_0072, 0126 paras 290, 533; INQ000546936_0032-0033 para 4.30
229 INQ000475131_0041 para 7.31
230 INQ000475131_0041 para 7.31
231 INQ000106466_0003; INQ000587737_0038-0040 paras 161-168
232 *COVID-19: Our Action Plan for Adult Social Care*, Department of Health and Social Care, 15 April 2020, p17, para 2.26 (https://assets.publishing.service.gov.uk/media/5e973154d3bf7f412a086070/covid-19-adult-social-care-action-plan.pdf; INQ000299661)
233 INQ000090769_0001, 0004 para 22). A further £1.6 billion of funding (which was not ring-fenced) for local authorities was announced on 18 April 2020; see 'Government pledges extra £1.6 billion for councils', Ministry of Housing, Communities and Local Government, 18 April 2020 (https://www.gov.uk/government/news/government-pledges-extra-16-billion-for-councils; INQ000106361_0001-0006).
234 INQ000613177_0005-0008 paras 12, 15. The study was initially split into two workstreams.

- On 24 May 2020, Ms Freeman announced funding for Scottish social care workers to receive sick pay above the statutory level when self-isolating following a positive Covid-19 test. This funding, known as the Social Care Staff Support Fund, remained in place until 31 March 2023. Payments were backdated to 23 March 2020 and staff were paid directly by social care providers, which could recoup additional costs.[235]
- In Northern Ireland, on 2 June 2020, Mr Swann announced a £11.7 million financial package, which was in part to enable care homes to pay staff who were on sick leave for reasons related to Covid-19 80% of their salary.[236] A further £700,000 was provided to support enhanced sick pay from 1 July to 31 December 2021.[237]

3.122. The funding of the response to the Covid-19 pandemic is being considered in detail by the Inquiry in Module 9: Economic response.

Front-line experience

3.123. Surveys conducted by the National Association of Care and Support Workers highlighted some of the barriers faced by workers in accessing Enhanced Statutory Sick Pay. For example, to be eligible for funding, a polymerase chain reaction (PCR) test result had to be submitted and, as is being considered in Module 7, they were not always available to order.[238]

3.124. Not all staff received full wages when sick or self-isolating.[239] The Department of Health and Social Care noted that the proportion of providers that reported paying staff full wages in England during isolation rose from 37% in May 2020 to 63% in July 2020.[240] However, in August 2020, UNISON reported results of a recent survey it had undertaken in which this figure was reported as only 25% of employers (it is not known how many people took part in this survey).[241] According to the Department of Health and Social Care, as at April 2021, data obtained from the Capacity Tracker showed that the proportion of care homes paying full wages for staff who were isolating was 83.6%.[242]

3.125. The Inquiry heard about the stress and anxiety that care workers felt when receiving only basic sick pay. One care worker said that they had to borrow money "*to make it through Christmas*" as a result of receiving basic Statutory Sick Pay when self-

235 INQ000569884_0006 para 27; INQ000592012_0003; INQ000606530_0064-0065 paras 244, 247. This funding was also sometimes referred to as the Social Care Support Fund.
236 'Minister announces £11.7m care home support package', Department of Health (Northern Ireland), 2 June 2020 (https://www.health-ni.gov.uk/news/minister-announces-ps117m-care-home-support-package; INQ000103701_0001-0002)
237 INQ000615082_0114-0115 paras 351-352
238 INQ000569768_0036 para 137
239 INQ000571608_0071 para 14.24
240 INQ000051381_0001
241 INQ000119075_0003; INQ000569768_0036 para 136
242 *Adult Social Care in England: Covid-19: A Review of the 2020 to 2021 Winter Plan and Subsequent Actions – What More Should Be Done?*, Department of Health and Social Care, November 2021, pp14 (https://assets.publishing.service.gov.uk/media/618250788fa8f52981d40f01/Adult-Social-Care-in-England-Winter-Plan-2020-2021-Review-David-Pearson-accessible.pdf; INQ000279947)

isolating and the practical difficulties in obtaining the information that was required to receive a £500 isolation grant.[243]

3.126. While the Infection Control Fund helped some domiciliary care providers maintain full pay for staff who were isolating, Dr Townson said that access to it was varied. She said that initially the fund "*heavily favoured residential care settings*" and some local authorities did not provide any of this funding to domiciliary care providers.[244] She explained that access to the fund improved in later funding rounds.[245]

3.127. Scottish Care reported long delays in payments being reimbursed via the Social Care Staff Support Fund. The Convention of Scottish Local Authorities, which viewed additional funding as a vital part of support for the adult social care sector, worked with the Scottish Government, trade unions and Scottish Care to try to resolve this issue.[246] Results from a survey carried out by the Convention of Scottish Local Authorities indicated that, of the 30 local authorities that responded, 15 reported that the workforce experienced "*increased financial hardship*" during periods of illness or self-isolation and 18 said the same issue was experienced by domiciliary care workers.[247]

Enhanced Statutory Sick Pay in Wales

3.128. It was not until 1 November 2020 that the Covid-19 Statutory Sick Pay Enhancement Scheme was introduced in Wales. The scheme provided funding for care homes and domiciliary care providers to ensure that care workers received full pay if they were self-isolating, had symptoms of Covid-19 or tested positive.[248] The scheme was extended to August 2022.[249] When asked why the Enhanced Statutory Sick Pay Scheme was introduced later in Wales than in other parts of the UK, Mr Gething said that there were huge pressures on Welsh Government budgets at this time.[250] Mr Gething explained that the Barnett formula meant there was no financial certainty to be able to increase sick pay funding until later in the pandemic. He said that he would have:

> "*liked us to have been in a position to have confirmed the position on sick pay earlier, but there was a level of real caution and concern that our budgets would be changed later in the year and we would find ourselves not able to meet the commitments that we wanted to make*".[251]

243 INQ000587381_0051-0052 para 97.5
244 INQ000587670_0061 para 233
245 INQ000587670_0061-0062, 0086 paras 233, 237, 361-362
246 INQ000509530_0030 para 115; INQ000546936_0034 para 4.32
247 INQ000587774_0009, 0011. The question did not ask about a particular time period of the pandemic.
248 INQ000581755
249 INQ000617056_0036 para 136
250 INQ000587254_0073-0074 para 270
251 Vaughan Gething 15 July 2025 42/10-43/7. The Barnett formula is used by the UK Treasury to calculate the annual block grants for the Scottish Government, the Welsh Government and the Northern Ireland Executive.

When asked to consider Scotland and Northern Ireland, which were subject to similar financial pressures yet introduced schemes earlier, Mr Gething repeated that there was a level of caution and he "*would definitely have wanted that scheme to have come in earlier than it did*".[252]

3.129. Given the importance of ensuring that care workers who needed to self-isolate were not financially disadvantaged and remained away from work, the provision of Enhanced Statutory Sick Pay in Wales came too late.

Future funding for adult social care in a pandemic

3.130. Care workers in each nation would have benefited from an earlier introduction of funding to support them when they were required to self-isolate as a result of Covid-19. Ensuring that care workers received adequate funding to self-isolate was particularly important to control infection rates. In July 2020, evidence suggested that care homes "*that paid sick leave immediately when someone had to self-isolate, had Covid case levels around 13% lower tha*[n] *care homes that did not*".[253]

3.131. In the event that a future pandemic requires care workers to self-isolate, the UK government and devolved administrations will need to implement a package of financial support that enables high-risk, low-income care workers to self-isolate. As set out in the Inquiry's combined Module 2ABC Report, governments must plan for adequate financial provision to ensure that people have the economic ability to comply with self-isolation, and there must be mechanisms in place for payments.[254] Those mechanisms should support the introduction of rapid changes to financial support and ensure that any additional funds reach care workers. The Inquiry therefore recommends that planning for this financial support begins now so that there is an emergency funding mechanism in place ready to stand up at the beginning of a pandemic.

3.132. The UK government and devolved administrations should also have plans to introduce funding to limit the movement of staff in the event that they are identified as a route of transmission in a future pandemic. This may include, for example, funding for providers to hire additional staff and funding to restrict staff to working in one setting. Financial support schemes should be designed in partnership with representatives from the adult social care sector, who can bring experience of how the delivery of care and staffing arrangements operate in practice.

252 Vaughan Gething 15 July 2025 43/8-44/5
253 INQ000188738_0030 para 133
254 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 10 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

Recommendation 3: Financial support to adult social care staff to self-isolate or to limit working across multiple sites

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should put in place financial support schemes that should be made available and that can be implemented at the start of a future pandemic:

- to protect adult social care staff against financial loss as a result of compliance with mandatory self-isolation rules; and
- to ensure that adult social care providers and staff can comply with rules or guidance restricting the number of sites at which adult social care staff may work during a pandemic.

The following principles should apply:

- There should be clear and straightforward guidance about eligibility criteria, application processes and payment arrangements for the support schemes.
- Information about the introduction of support schemes and how adult social care staff and providers can receive support should be communicated clearly and made available in accessible formats.
- Mechanisms should be in place to monitor the effectiveness of the support schemes.

These financial support schemes should be designed in partnership with representatives from across the adult social care sector.

Chapter 4: Visiting restrictions in care homes

Introduction

4.1. Care homes are where many people "*live out their lives, with as much independence as their own unique situation permits and as much dignity, compassion and care as society can provide*".[1] It is therefore unsurprising that the decision in March 2020 to impose visiting restrictions in care homes across the UK was one of the most emotive and controversial aspects of the Covid-19 pandemic response.[2]

4.2. In the absence of testing or a vaccine in the early months of the Covid-19 pandemic, restrictions on visits were considered an essential measure to mitigate the risk of infectious people inadvertently transmitting the virus to residents and those providing care.[3] Decisions to restrict visits and access were taken at national and local government level and by individual care homes.

4.3. This approach was not new. Visiting restrictions have previously been used to manage outbreaks of infectious diseases such as norovirus and seasonal influenza.[4] However, such restrictions were typically of short duration, as outbreaks rarely exceeded two weeks.[5] The prolonged visiting restrictions during the Covid-19 pandemic were therefore unprecedented.[6] The need to protect highly vulnerable residents from infection had to be balanced against ensuring dignity and quality of life for residents and the availability of the support of their loved ones when they needed it most.[7] The longer the restrictions persisted, the harder it became to achieve the right balance.

4.4. This chapter examines the decisions taken to restrict visiting from loved ones and in-person healthcare in care homes and whether the right balance was struck. It also considers the impact on residents.

The importance of visiting

4.5. The importance of visiting cannot be overstated. Family and loved ones fulfil a central role in the life and everyday care of residents.[8] They may spend hours encouraging residents to eat and drink and providing necessary help – for example,

1 *Visiting Guidance for Adult Care Homes in Scotland,* Scottish Government, 25 June 2020, p2 (https://scottishcare.org/wp-content/uploads/2020/06/Care-home-visiting-guidance-final-20.06.25.pdf; INQ000147431)
2 *Visiting Guidance for Adult Care Homes in Scotland,* Scottish Government, 25 June 2020, p2 (https://scottishcare.org/wp-content/uploads/2020/06/Care-home-visiting-guidance-final-20.06.25.pdf; INQ000147431)
3 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, pp296-297 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642); Jenny Harries 9 July 2025 192/25-193/13; see also Chapter 6: The impact on unpaid carers, care workers and care providers
4 INQ000614378_0013 para 43(i); *Managing Outbreaks of Acute Respiratory Illness in Care Homes*, Health Protection Agency, October 2012, p14 (INQ000539000)
5 INQ000587252_0128 para 10.1.1
6 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p305, point 2 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642)
7 Matt Hancock 2 July 2025 161/16-22
8 INQ000475131_0023 para 4.8

in 'toileting', washing, brushing hair and teeth, shaving and dressing.[9] While spending time in a care home, they may also be able to spot signs of abuse, neglect or other safeguarding issues.[10]

4.6. Visits are also important for residents' mental wellbeing through stimulation, the connection to the outside world and the maintenance of relationships.[11] Visits from loved ones are often integral to a person's sense of identity.[12] Julia Jones, co-founder of John's Campaign (a group that advocates and campaigns for the rights of people with dementia across different care settings), stated: "[V]*isits from those who matter most are an integral part of an individual's sense of identity and self-worth*."[13]

4.7. For people with complex cognitive conditions, such as dementia and learning disabilities, or communication difficulties, visits are critically important. Sustained interaction and connection with familiar faces helps to preserve cognitive function, reduce isolation and agitation, and improves emotional wellbeing beyond standard care.[14] Professor Sube Banerjee, expert witness on the care and treatment of people with dementia and their families, described this supportive function as "*very special*", noting that its absence causes deterioration, potential depression, loss of skills and more rapid disease progression.[15]

4.8. The continued, regular presence of loved ones is therefore not merely a comfort to residents, but a crucial element of care that actively sustains physical and mental wellbeing and is likely to slow the pace of cognitive and physical decline.

Restrictions on visiting

4.9. Scientific and public health advice in the early months of the pandemic focused upon the risks of Covid-19 infection. Visitors represented a potential route of infection into care homes, whose residents faced a very high risk of death or serious illness from Covid-19.[16] Care homes were identified as a "*substantially higher risk setting for COVID-19*" due to the vulnerable nature of the population and the indoor environments in which the infection could spread.[17] The risk of transmission of Covid-19 through a visit was not confined to the resident being visited but also affected other residents.[18]

9 Caroline Abrahams 16 July 2025 28/18-21; INQ000514104_0006 para 17
10 INQ000584245_0115-0116 para 359
11 INQ000587788_0065 para 269
12 INQ000514104_0006 para 17
13 INQ000514104_0006 para 17
14 Sube Banerjee 23 July 2025 37/22-38/17; INQ000587928_0009-0011 paras 55-64; INQ000587296_0042 para 139; *Every Story Matters: Adult Social Care Sector,* pp10, 36, 47-49 (INQ000587564)
15 Sube Banerjee 23 July 2025 37/22-38/17
16 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p296 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642); see also Chapter 1: Overview of the adult social care sector
17 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p296 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642)
18 Jenny Harries 9 July 2025 192/25-193/05

4.10. In the absence of adequate diagnostic testing, tracing capacity, a vaccine or treatment, and with limited supplies of personal protective equipment (PPE), visiting restrictions were one of a range of measures across all four nations of the UK "*concentrated on trying to prevent ingress and minimise transmission*".[19]

4.11. Policy decisions about visiting restrictions were taken by the UK government and devolved administrations, informed by scientific advice, and then published in guidance.[20]

4.12. Visiting guidance was introduced and evolved at different times across the UK. Initial Public Health England guidance dated 25 February 2020 advised that care home managers and infection prevention and control specialists undertake risk assessments of visits.[21] By 23 March 2020, when the mandatory UK-wide lockdown was introduced, each government had advised restrictions on visiting in care homes to facilitate essential visits only.[22] Scottish guidance issued on 26 March 2020 extended the guidance to permit visits to residents with dementia experiencing distress.[23]

4.13. Many care homes had already pre-emptively decided to restrict visiting by this point. This was likely due to the growing public awareness of the risks posed by the pandemic, in particular the risks to people aged over 70, or with underlying conditions, and the broader government guidance on social distancing and shielding.[24]

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19 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p297 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642); *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol I, Chapters 2 and 4 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

20 Matt Hancock 2 July 2025 37/15-18; INQ000587772_0107 para 8.1; INQ000613603_0198-0200 paras 672-675; INQ000615082_0095-0096 paras 294-296; *COVID-19: Guidance for Nursing and Residential Care Homes in Northern Ireland,* Version 2.6, Department of Health (Northern Ireland), 11 September 2020, p51-52, paras 1.3-1.4 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/doh-correspondence/guidance-for-nursing-and-residential-care-homes-in-northern-ireland---sept-2020.pdf; INQ000514710); INQ000606530_0013 para 46; INQ000614179_0265-0266 paras 811-815; INQ000587702_0079-0080 para 296

21 INQ000587737_0067 para 262; *Guidance for Social or Community Care and Residential Settings on COVID-19,* Public Health England, 25 February 2020, p9 (https://www.gov.uk/government/publications/guidance-for-social-or-community-care-and-residential-settings-on-covid-19/guidance-for-social-or-community-care-and-residential-settings-on-covid-19; INQ000223341)

22 *Interim Guidance for Social or Community Care and Residential Settings on COVID-19 at 12/03/2020,* Department of Health (Northern Ireland), 12 March 2020, pp12-13, para 15.6 (https://www.health-ni.gov.uk/sites/default/files/publications/health/COVID-19-Guidance-Social-Community-Residential-Care.pdf; INQ000103696); INQ000587737_0067-0068 para 263; INQ000147441_0002-0003; INQ000587254_0055-0056 paras 207, 209

23 *Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19*, Scottish Government, 26 March 2020, p2 (https://scottishcare.org/wp-content/uploads/2020/03/COVID-19-ClinicalGuidanceforNursingHomeandResidentialCareResidents-Final26March.pdf; INQ000429281). This was further extended in May 2020 for those with learning disabilities or autism, where absence would cause distress: see *National Clinical and Practice Guidance for Adult Care Homes in Scotland During the Covid-19 Pandemic,* Version 1.3, Scottish Government, 15 May 2020, p12, para 8.7 (https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2020/03/coronavirus-covid-19-clinical-and-practice-guidance-for-adult-care-homes/documents/clinical-guidance-for-nursing-home-and-residential-care-residents/clinical-guidance-for-nursing-home-and-residential-care-residents/govscot%3Adocument/National%2BClinical%2BGuidance%2Bfor%2BCare%2BHomes%2BCOVID-19%2BPandemic-%2BMASTER%2BCOPY%2B-%2BFINAL%2B-%2B15%2BMay%2B2020.pdf; INQ000383486)

24 INQ000587678_0004 para 5.1; INQ000587788_0070 para 275; *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p301 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642); INQ000517219_0017 para 50; INQ000474918_0011 para 28; INQ000475130_0158-0159 para 587; INQ000343808; see also *Modules 2, 2A, 2B, 2C: Core decision-making and political governance,* UK Covid-19 Inquiry, November 2025, Vol I, Chapters 2 and 3 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

4.14. By the end of April 2020, guidance recommending strict restrictions was in place across the UK. In practice, this amounted to care homes being 'locked down'; visits only took place in exceptional circumstances. In England, Wales and Northern Ireland, this was effectively limited to end-of-life visits.[25]

4.15. Professor Ian Hall (Academic Co-Chair of the Care Home Working Sub-Group, which became the Social Care Working Group of the Scientific Advisory Group for Emergencies (SAGE)) explained that scientific advice and models in April and May 2020 concentrated on infection risks and not psychological impacts of isolation from loved ones, and that the benefits of social visits were not easily scientifically quantifiable.[26]

4.16. While the focus on infection risks was understandable (given the vulnerability of the residents in care homes to a respiratory virus), Heléna Herklots, Older People's Commissioner for Wales from August 2018 to August 2024, considered that the decision to restrict visiting "*did not take account of the harm to health and wellbeing from older people being isolated*".[27]

4.17. Given the acute nature of the threat posed, with death likely for many infected residents, protection of life was paramount. Care home providers and policy-makers therefore had little choice but to be cautious and to impose the restrictions, notwithstanding the hugely damaging impact on residents, their loved ones and staff. The Inquiry accepts that the initial decisions taken to restrict visits were rational and broadly appropriate in principle. Indeed, some loved ones of care home residents told the Inquiry's listening exercise, Every Story Matters, that they recognised that the restrictions were necessary.

> "*None of us knew what to do, so they were very strict and had they not been, we would have lost more lives.*"[28]
>
> **Loved one of a care home resident, Scotland, Every Story Matters**

4.18. However, whether restrictions on visiting remained appropriate, as knowledge of the virus and the impact of continued restrictions on residents developed, is considered further below.

25 INQ000587737_0068-0069 para 266; Vaughan Gething 15 July 2025 78/20-79/10; INQ000613603_0202-0203 para 680; *COVID-19: Guidance for Nursing and Residential Care Homes in Northern Ireland*, Version 2.0, Department of Health (Northern Ireland), 26 April 2020, pp18-19, para 72 (INQ000536254)
26 INQ000587822_0018 paras 65-66
27 INQ000514106_0029 para 139
28 *Every Story Matters: Adult Social Care Sector,* p49 (INQ000587564)

A greater understanding of risk and harms

4.19. In the summer of 2020, testing capacity expanded and a greater understanding of the impact of the visiting restrictions developed. At this point, the UK was emerging from the first lockdown, with rates of infection decreasing and a loosening of societal restrictions.[29] Visiting restrictions were reviewed and amended in an attempt to enable more visiting, resulting in:

- a move to a more localised approach, with a focus on infection rates in the relevant area and risk assessments in individual care homes;[30]
- the identification of individual named, designated or essential visitors;[31] and
- the consideration and facilitation of other forms of visits, including the use of technology or physical barriers for in-person visits.[32]

The move to a localised approach

4.20. The initial restrictions had proceeded on the basis that "*all footfall*" in care homes "*brought risk with it*".[33] From June 2020, growing concerns about the impact of continued and prolonged isolation on residents and a better understanding of the risk posed by visitors prompted a shift towards more localised, individual, risk-based decision-making and staged reintroduction of visiting.[34]

4.21. In Wales, from 25 June 2020, care home providers were encouraged to facilitate outdoor visiting, with an emphasis on individual needs and the minimisation of harms.[35] Scottish guidance of the same date recommended that directors of public health assess the appropriateness of visiting by considering the wider risk environment and that each care home should conduct an individual risk assessment against an overarching framework.[36] Guidance in Northern Ireland published on 30 June 2020 placed responsibility on managers to permit visiting based on factors such as the care home's ability to maintain social distance, safety and regional hospital capacity. During an outbreak, visiting was only permitted in exceptional circumstances.[37]

29 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol I, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
30 *Visits to Care Homes: Guidance for Providers,* Welsh Government, 25 June 2020, pp13-14, Appendix 6 (INQ000081250); *Update on Policies for Visiting Arrangements in Care Homes*, Department of Health and Social Care, 22 July 2020 (INQ000325285_0004-0006); INQ000587737_0070-0071 paras 269-270b
31 *Visiting Guidance for Adult Care Homes in Scotland,* Scottish Government, 25 June 2020, pp4-5 (https://scottishcare.org/wp-content/uploads/2020/06/Care-home-visiting-guidance-final-20.06.25.pdf; INQ000147431); INQ000103667_0007 paras 6.69-6.11; INQ000587737_0070 para 268
32 INQ000587254_0056-0057 paras 208, 211
33 Michelle Dyson 16 July 2025 158/6-11
34 Claire Sutton 29 July 2025 47/4-6; INQ000152376_0001-0004
35 *Visits to Care Homes: Guidance for Providers,* Welsh Government, 25 June 2020, pp4-6, 13 (INQ000081250)
36 INQ000606530_0081-0082 paras 298-299
37 INQ000103667_0004, 0011, 0013, 0024-0025 paras 5.3, 1.4

4.22. In England, changes to visiting restrictions were introduced by the end of July 2020. On 3 July 2020, the Department of Health and Social Care published the high-level findings of the Vivaldi 1 study, which considered Covid-19 infection in care homes.[38] The findings indicated that staff were a point of entry for Covid-19 and played an important role in transmission of infection.[39] According to Professor Hall, it could be inferred from this that allowing family visiting may not lead to a substantial increase in risk.[40]

4.23. This was reflected in ministerial and scientific advice. On 8 July 2020, a departmental submission to Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021) noted anecdotal evidence of residents "*fading away*".[41] The submission also noted some evidence of the negative impact of restrictions and the psychological benefits of visits.[42] Scientific advice considered that, as the prevalence of Covid-19 fell in the community, the benefits of visits would outweigh the risks.[43] This led to guidance issued on 22 July 2020 in England, which set out principles for a localised approach and the need for a dynamic risk assessment by directors of public health. The guidance also included principles for care homes to apply in developing policies for visits, including limiting visits to a single visitor.[44]

4.24. By mid-September 2020, there was no "*strong evidence*" of visitors posing a particularly high risk of transmission of Covid-19, and evidence did not suggest such visits were a dominant cause of outbreaks in care homes.[45] Modelling estimated that allowing visiting would have a "*marginal impact*" (a median increase of one additional case in an outbreak of about 30 cases in a medium-sized care home).[46] Research indicated that the risk presented by loneliness and isolation to residents was "*likely an order of magnitude higher*" than that posed by the risk of infection.[47] Accordingly, UK government advisers supported limited visits to be guided by directors of public health and also by risk assessments.[48]

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38 *Vivaldi 1: COVID-19 Care Homes Study Report,* Department of Health and Social Care, 3 July 2020 (https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report; INQ000211984)

39 *Vivaldi 1: COVID-19 Care Homes Study Report,* Department of Health and Social Care, 3 July 2020 (https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report; INQ000211984); INQ000613177_0007, 0020 paras 15, 41

40 INQ000587822_0018 para 66

41 INQ000327939_0002 para 5

42 INQ000327939_0002-0003 paras 5-6

43 INQ000327939_0003 para 6

44 Helen Whately 17 July 2025 152/4-19; *Update on Policies for Visiting Arrangements in Care Homes,* Department of Health and Social Care, 22 July 2020 (INQ000325285)

45 INQ000587394_0040-0041 para 5.79

46 INQ000587394_0040-0041, 0044 paras 5.79, 5.84(ii); *Paper Regarding Advice on Testing Strategy to Reduce Transmission in Care Homes,* Social Care Working Group, 21 September 2020, pp3-4 paras 4.3, 6.1 (https://assets.publishing.service.gov.uk/media/5f7ef3208fa8f51e7cddef93/S0780_Social_Care_Working_Group_update_paper.pdf; INQ000074994). Statistical models are tools for analysing complex data, identifying patterns and informing evidence-based decision-making where direct measurement is not possible. Figures from modelling are estimates only, and different statistical models will produce different outcomes. These estimates are not based on direct observations. They are therefore limited by the underlying assumptions used in the models and are subject to uncertainty.

47 INQ000587822_0019 para 72

48 INQ000587737_0074-0075 para 285

4.25. During the autumn and winter of 2020, guidance across the UK began to place greater emphasis on the promotion of visits and the avoidance of an 'across the board' prohibition or restrictions on visiting that applied without exception or consideration of individual circumstances – often referred to as 'blanket bans'.[49] For example, in Northern Ireland, guidance outlined a variety of possible visiting arrangements dependent upon local infection rates.[50]

4.26. In England, a significant update was made on 1 December 2020, when guidance advised that the starting point should be one of supporting and enabling visits where safe to do so, with testing prior to entry.[51] Guidance issued in Wales on 23 December 2020 similarly encouraged the facilitation of visits wherever possible.[52]

4.27. Nonetheless, specific concerns were raised in relation to the use of blanket bans. In a November 2020 survey conducted by John's Campaign, 41% of respondents reported complete bans on visitors in care homes.[53] On 16 December 2020, the Care Quality Commission advised that blanket bans would be treated as a risk indicator of a closed culture, investigated and inspected if necessary.[54] It concluded after investigation that none of the 27 concerns raised with it were "*genuine*" blanket bans, noting that the majority were the product of miscommunication or a lack of understanding about restrictions in the event of an outbreak.[55]

4.28. Whether or not there were many blanket bans in existence, towards the end of 2020 visiting still remained restricted in many care homes. This could be attributed to:

- the underlying emphasis in much of the guidance that visiting was "*the exception not the rule … with alternatives sought wherever possible*";[56]
- local or institutional circumstances, such as the ability of care homes to facilitate visiting, infection prevention and control measures and the prevalence of outbreaks;[57]

49 *Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland,* Department of Health (Northern Ireland), 22 September 2020, p24, para 1.4 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/doh-correspondence/visiting-guidelines.pdf; INQ000256450); INQ000613603_0205 para 690; INQ000587737_0078 para 298; INQ000587254_0063 para 231; INQ000520560_0001-0002; *Visiting by Family and Friends – Guidance for Adult Care Homes in Scotland*, Scottish Government, 12 October 2020, pp1-10 (https://www.fife.gov.uk/__data/assets/pdf_file/0021/49125/Item-5-Appendix-c-Visiting-by-Family-and-Friends-for-Adult-Care-Homes-in-Scotland.pdf; INQ000147434)
50 INQ000613603_0205 para 690; *Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland,* Department of Health (Northern Ireland), 22 September 2020, p24, para 1.4 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/doh-correspondence/visiting-guidelines.pdf; INQ000256450)
51 INQ000587737_0078 para 298
52 INQ000587254_0063 para 231
53 INQ000514104_0019 para 51
54 INQ000584245_0173, 0114-0115 paras 551, 354, 359: "*CQC defines a 'closed culture' as 'a poor culture that can lead to harm, including human rights breaches, such as abuse*"; "[T]*he risk of the development of closed cultures within services had been exacerbated during the pandemic, with more services becoming closed environments due to a lack of visitors*"; see Chapter 5: Regulation and safeguarding
55 INQ000584245_0182-0183 para 571
56 INQ000587394_0036-0038 paras 5.69, 5.71
57 *Visits to Care Homes: Guidance for Providers*, Welsh Government, 25 June 2020 (updated 17 December 2020), p5 (INQ000081676); INQ000587772_00113 paras 8.18-8.19; *Update on Policies for Visiting Arrangements in Care Homes,* Department of Health and Social Care, 15 October 2020, pp1-3 (https://webarchive.nationalarchives.gov.uk/ukgwa/20201017101502/https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus/update-on-policies-for-visiting-arrangements-in-care-homes; INQ000325289)

- rising rates of infection in the second wave of Covid-19 and the imposition of wider societal restrictions in response, including circuit breakers and lockdowns;[58] and
- conflicts in guidance and risk assessments at regional, local and institutional levels.[59]

> "*All in-person visits of any kind were then again banned by the care home during the Omicron lockdown, during which my mother died in January 2021. The care home complied strictly with the lockdown rules at the time of her death by permitting me to visit her in person and have physical contact with her for the first time since March 2020, but dressed head to toe in PPE, for just 30 minutes as she lay dying – but she was comatose and by then it was too late for us to speak.*"[60]
>
> **Daughter of a care home resident, Every Story Matters**

4.29. As the Covid-19 pandemic continued into 2021, each nation in the UK sought to introduce 'overarching frameworks' to ensure a return to visiting arrangements equivalent to those prior to the pandemic. This was against the backdrop of the rollout of the vaccine, with prioritisation of residents in a care home for older adults and their carers, and a greater understanding of managing risk. There was also increased availability of both testing and PPE.[61]

4.30. Each of the four governments considered the localised approach with delegated decision-making to be the appropriate model, with local public health and care providers best placed to assess risk and residents' needs.[62] Given the diverse nature of the sector and the variations in the care home estate, the localised approach was understandable. A system that allows for variation, depending on local infection rates or individual risk in specific care homes, is significantly more balanced and proportionate than blanket bans or restrictions imposed at a national level. However,

58 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol I, Chapters 6 and 7 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
59 INQ000515683_0010 para 32c
60 *Every Story Matters: Adult Social Care Sector*, p57 (INQ000587564)
61 *Open with Care: Supporting Meaningful Contact in Care Homes*, Scottish Government, 24 February 2021, pp4-5 (https://webarchive.nrscotland.gov.uk/20240421101022/https://www.gov.scot/publications/open-care-supporting-meaningful-contact-care-homes/documents; INQ000147437); *Guidance on Care Home Visiting*, Department of Health and Social Care, 5 March 2021 (INQ000325310_0001-0003); *Visits to Care Homes: Guidance for Providers,* Welsh Government, 14 May 2021 (INQ000338239_0003); INQ000615082_0104 para 324; *Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland*, Department of Health (Northern Ireland), 13 January 2021 (https://www.health-ni.gov.uk/sites/default/files/publications/health/covid-19-regional-principles-for-visiting-effective-15-01-2021.PDF; INQ000276331); *Visiting with Care: A Pathway*, Version 1.03, Department of Health (Northern Ireland), 20 October 2021 (INQ000591871)
62 INQ000587788_0072 para 285; INQ000615082_0099 para 305; INQ000606530_0080 para 293; INQ000587254_0060-0061 paras 221, 225

the localised approach led to variation in guidance and visiting policies across the UK and between individual care homes in the same area.[63]

Interpretation of guidance

4.31. While a degree of variation in visiting restrictions was inevitable, there were significant concerns that the guidance was being inconsistently interpreted and applied.

4.32. Some care homes continued to restrict visiting as a result of overly restrictive interpretations of guidance and concerns about the impact of further transmission of Covid-19 into care homes on the welfare of residents.[64] Others considered that the measures introduced to facilitate visiting, as discussed below, were costly, unrealistic or required significant amounts of resource and time.[65] Care Home Relatives Scotland told the Inquiry that restrictions became "*a complete postcode lottery of care … Some care home providers based in England would apply the English guidance within their Scottish homes.*"[66]

4.33. The variations in restrictions – justified or not – caused much distress, particularly for end-of-life visits.[67] Some care homes interpreted 'end of life' very narrowly to mean within hours or less of impending death, and some providers refused visits – depriving residents of the opportunity of being with loved ones and saying final goodbyes.[68] The impact upon residents and their loved ones was devastating. End-of-life visits should be facilitated in all but the most truly exceptional of circumstances.

> "[The grief] *breaks our hearts as we feel he was deserted at the very time he needed us.*"[69]
>
> **Bereaved family member of a care home resident, Wales, Every Story Matters**

63 INQ000606530_0082 paras 300-301; *Guidance on Care Home Visiting,* Department of Health and Social Care, 22 March 2022, pp12-13 (https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus/update-on-policies-for-visiting-arrangements-in-care-homes; INQ000564786); INQ000569773_0086 para 257; *Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland,* Department of Health (Northern Ireland), 22 September 2020, pp26-27, para 2.3 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/doh-correspondence/visiting-guidelines.pdf; INQ000256450); INQ000587254_0059-0060, 0063 paras 220-221, 231; INQ000509530_0023 para 89
64 INQ000509530_0017-0018, 0023 paras 61, 64-65, 89; INQ000514104_0053, 0055 paras 124, 130
65 INQ000572015_0025 para 82
66 INQ000544828_0017-0018 paras 81-82
67 INQ000509547_0001 para 3
68 INQ000514104_0069-0075 paras 171-185; Stephen Barclay 30 July 2025 54/19-55/2
69 *Every Story Matters: Adult Social Care Sector,* p97 (INQ000587564)

4.34. Conflict between national, local and individual care home guidance and policies also produced and exacerbated inconsistencies and frustrations and undermined the ability of care home managers to take localised individual decisions. Nadra Ahmed, Executive Co-Chair of the National Care Association from 2001, explained:

> "*The national Public Health England (PHE) guidelines often conflicted with local health authority interpretations, leaving care providers confused about which advice to follow. Some local authorities imposed stricter rules than national guidance, while others were more lenient. This inconsistency caused difficulties in implementing a uniform approach to visitation, as care homes had to navigate conflicting advice on what precautions (such as PPE use, handwashing, or ventilation) should be prioritised.*"[70]

4.35. The multitude of guidance and policies that was applicable at any one time also resulted in uncertainty and confusion among recipients of care, visitors, providers, local government and public health bodies.[71] Announcements of changes in visiting guidance, with subsequent delays in issuing the underlying guidance, resulted in a mismatch between public understanding of the situation and the action that care providers were instructed to take.[72] This caused distress and created additional pressures on providers.[73] The frequent updating of guidance also made implementation difficult.[74]

4.36. It is inevitable that guidance will be amended as circumstances change and knowledge develops, and that the localised approach and the use of discretion may well result in different approaches being taken to visiting. There is, therefore, a need for decision-makers and care home providers to have the benefit of clear guidance and principles to ensure that discretion is exercised fairly and any variation is justifiable.

4.37. In a future pandemic or health emergency, the UK government and devolved administrations must provide guidance and principles relating to visiting care home residents that is as clear and consistent as possible and publicly available. There must also be a concerted effort to ensure better communication between government and local and individual providers in order to avoid the uncertainty and confusion experienced during the Covid-19 pandemic.

70 INQ000515683_0010 para 32c; see also INQ000475131_0024 para 4.14
71 INQ000515683_0020 para 72; INQ000509530_0023 para 88; INQ000475131_0014 para 3.4; INQ000517219_0014 para 44; INQ000514104_0053 para 125; INQ000515683_0010 para 32c
72 INQ000475131_0014-0015 para 3.4; INQ000517219_0014 para 44; see also INQ000569774_0022-0024 paras 9.2, 10.4
73 INQ000515683_0009 para 30
74 INQ000517219_0014 para 44

Alternative forms of visiting

4.38. By April 2020, guidance across the UK sought to encourage alternatives to in-person visiting.[75] Some providers were resourceful and innovative in developing alternative forms of facilitating visiting.[76] These alternatives were not a replacement for in-person visits but were preferable to no visits. However, many took time to develop and they were not suitable for all.

4.39. Visits conducted through a window presented challenges in terms of the ability of residents to hear or understand their loved ones.[77] Guidance encouraged the use of Perspex screens or physical barriers to enable visitors and residents to be in the same room, but this was dependent on the layout of the care home.[78] Where the use of screens either in the home or in a bespoke pod was possible, the evidence of impact was mixed. Described to Every Story Matters as a "*blessing*" for some residents and visitors, for others it caused distress, confusion and created the "*impression of prison visiting*".[79] Garden and outdoor visits, while cost-effective, were dependent on the weather, staff intensive and not always appropriate, with the requirement to be socially distanced sometimes leading to distress.[80]

4.40. Each of these measures presented challenges both for residents and for care providers. They could not cater appropriately for residents who were not well enough to leave their beds, had limited mobility, were susceptible to cold or had dementia, learning disabilities or cognitive decline.[81] The ability to implement measures depended on facilities and the ability of care providers – who were under significant financial pressure – to pay for them.[82]

4.41. Greater use of technology to enable remote visits with loved ones was promoted, with schemes and initiatives introduced to ensure that care homes were able to facilitate digital contact.[83] Again, this was not suitable for all. Some residents and visitors did not have access to the required technology or had cognitive and sensory impairments, including poor eyesight and hearing. For them, the effective use of technology was sometimes difficult or impossible.[84] Establishing consistent and

75 INQ000587788_0070 para 277; INQ000613603_0202-0203 para 680; INQ000614179_0270-0271 paras 829-830; INQ000587254_0055-0056 para 207
76 INQ000517219_0019 para 53
77 INQ000614372_0003 para 12; *Every Story Matters: Adult Social Care Sector,* p49 (INQ000587564); INQ000587788_0075-0076 para 299
78 INQ000113033_0003, 0005; *Guidance on Care Home Visiting*, Department of Health and Social Care, 14 May 2021 (https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus; INQ000325333_023); 'New guidance to support safe care home visits during lockdown', Department of Health and Social Care, 4 November 2020 (https://www.gov.uk/government/news/new-guidance-to-support-safe-care-home-visits-during-lockdown; INQ000564789_0002)
79 *Every Story Matters: Adult Social Care Sector,* pp9, 51, 55 (INQ000587564); INQ000572015_0025 para 82
80 INQ000551798_0107-0108 para 380; *Every Story Matters: Adult Social Care Sector,* p55 (INQ000587564)
81 INQ000572015_0025 para 82
82 INQ000572015_0025 para 82; INQ000515683_0009, 0012 paras 32(a), 32(b), 39(c)
83 INQ000498681_0001; INQ000244767_0001
84 Sube Banerjee 23 July 2025 41/11-19*; Every Story Matters: Adult Social Care Sector,* p59 (INQ000587564); INQ000614377_0004 para 10; INQ000587596_0007 para 24

sufficient internet connection was also challenging in some care homes, due to their architecture, age or size of the estate.[85]

> "[H]*ow does a 90-year-old know how to use an iPad and talk to you on a Zoom call? I've got pictures of the Zoom calls where we're trying to talk to her and she just kept on disappearing.*"[86]
>
> **Loved one of a care home resident, England, Every Story Matters**

4.42. Not all care homes could facilitate remote visits or do so while maintaining privacy.[87] Remote alternatives placed a significant administrative burden on staff.[88] Many residents required staff support, which prompted concerns about contact being supervised.[89]

4.43. The experience of remote calls led to some residents becoming distressed. However, some relatives found video calls easier to handle emotionally than window visits or in-person visits without touch.[90] Others reported that the experience of video calls or watching their loved one decline via a screen was "*deeply distressing*".[91]

4.44. The use of technology was useful in supporting social contact and in mitigating some of the harms of isolation.[92] It may be the only tool available in future pandemics. However, it undoubtedly had significant limitations.[93] As with other alternatives, remote contact is no substitute for in-person, face-to-face visits with physical contact and the benefits these bring to residents. In-person visits should be prioritised where possible.

Named visitors, designated visitors, essential care givers and care partners

4.45. Alongside the move to localised risk assessments, guidance across the four nations also evolved to allow a specified relative, family member or friend to visit in order to perform an enhanced caring role. This role was defined and referred to differently across the UK, with terms such as 'care partner' or 'essential care giver' being

85 Helen Hough 1 July 2025 107/2-3; Stephen Barclay 30 July 2025 30/6-7
86 *Every Story Matters: Adult Social Care Sector,* p59 (INQ000587564)
87 *Every Story Matters: Adult Social Care Sector,* pp9, 54-55 (INQ000587564)
88 INQ000587678_0004 para 5.4
89 *Every Story Matters: Adult Social Care Sector,* p55 (INQ000587564); INQ000587637_0015-0016 para 47; Jane Wier-Wierzbowska 1 July 2025 15/18-23
90 *Every Story Matters: Adult Social Care Sector,* pp55-56, 58 (INQ000587564)
91 INQ000614372_0005 para 19
92 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p305 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642)
93 INQ000515683_0020 para 71

used.[94] This Report adopts the term 'essential carer'. This role allowed for support of vulnerable residents in everyday tasks – such as eating, drinking, washing, taking medication and exercising – to overcome social isolation.[95]

4.46. The essential carer role, or that of a single named essential visitor, had been discussed and contemplated at the outset of the initial restrictions in England and Scotland but not introduced.[96] In England, this was because clinical guidance at the time focused on the importance of reducing footfall in care homes.[97] In Scotland, guidance published on 13 March 2020 suggested that less-frequent visiting by a named relative could be considered. However, visiting was subsequently suspended on 26 March 2020 and only permitted in exceptional circumstances – for example, essential visits for those with dementia who were experiencing distress.[98]

4.47. The essential carer role was eventually incorporated into the guidance across all four nations. Guidance in Scotland dated 25 June 2020 introduced "*essential*" and "*designated*" visitors, with designated visitors being allowed to visit residents outdoors or indoors depending on the wider societal restrictions.[99] Advice on 15 September 2021 provided for a named nominated visitor who, with agreement, could provide care.[100] Welsh guidance dated 28 August 2020 allowed residents to nominate a designated visitor and a deputy who could visit indoors, provided the care home was not experiencing a Covid-19 outbreak.[101] Guidance published in Northern Ireland on 22 September 2020 recommended one face-to-face visit per week by one person and introduced the concept of a "*care partner*", unless healthcare services were at a significant risk of being overwhelmed.[102] From 8 March 2021, guidance in England enabled every resident to nominate a "*single named visitor*" to have regular visits, subject to testing and infection prevention and control measures, and separately an "*essential care giver*" for some.[103] This followed lobbying in November 2020 and February 2021 from organisations representing

94 *Visiting Guidance for Adult Care Homes in Scotland,* Scottish Government, 25 June 2020, pp4-5 (https://scottishcare.org/wp-content/uploads/2020/06/Care-home-visiting-guidance-final-20.06.25.pdf; INQ000147431); *Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland,* Department of Health (Northern Ireland), 22 September 2020, pp11, 14 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/doh-correspondence/visiting-guidelines.pdf; INQ000256450); *Update on Policies for Visiting Arrangements in Care Homes*, Department of Health and Social Care, 22 July 2020 (INQ000325285_0003, 0006); *Visits to Care Homes: Guidance for Providers*, Version 3, Welsh Government, 28 August 2020, pp5-7 (INQ000337012); *Guidance on Care Home Visiting*, Department of Health and Social Care, 5 March 2021 (INQ000325310_0002, 0015)
95 Heather Reid 10 July 2025 145/21-146/17; INQ000613603_0229 para 738
96 INQ000614179_0270 para 827; INQ000587788_0071 para 279
97 INQ000587788_0071 para 279
98 INQ000614179_0270-0271 paras 827, 829-830
99 *Visiting Guidance for Adult Care Homes in Scotland,* Scottish Government, 25 June 2020, pp4-5 (https://scottishcare.org/wp-content/uploads/2020/06/Care-home-visiting-guidance-final-20.06.25.pdf; INQ000147431)
100 INQ000614179_0272, 0275 paras 835, 847; INQ000509972_0004
101 INQ000551798_0107 para 379
102 INQ000613603_0205, 0228-0229 paras 690, 734; *Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland,* Department of Health (Northern Ireland), 22 September 2020, pp11, 14 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/doh-correspondence/visiting-guidelines.pdf; INQ000256450)
103 INQ000587737_0081-0082 paras 311, 313; *Guidance on Care Home Visiting*, Department of Health and Social Care, 5 March 2021 (INQ000325310_0002,0015); *COVID-19 Response – Spring 2021*, HM Government, February 2021, p30, para 96 (https://assets.publishing.service.gov.uk/media/6033cfdae90e076607c1bf18/COVID-19_Response_-_Spring_2021.pdf; INQ000185087_0034)

relatives, carers and providers, calling for the creation of a 'key visitor' or essential care giver role.[104]

4.48. While limiting the number of essential carers put strain on family relationships and undoubtedly placed a significant responsibility on essential carers, allowing them to visit would have had a very positive impact on the residents and the care they received.[105]

4.49. Tensions however arose from the operation of the guidance alongside wider societal restrictions in each nation. In September 2020, for example, soon after the essential carer role was introduced in Wales, broader legal restrictions led to the suspension of designated visits in many areas.[106] Guidance in Scotland and Northern Ireland envisaged that the role could be suspended in times of outbreak or high levels of infection and transmission.[107]

4.50. Later guidance in 2021 provided for an individualised assessment of risk at the care home level. For example, there was a presumption in England that essential carer visits should continue in the event of an outbreak and Scottish guidance allowed a named visitor to visit a resident in their room during a managed Covid-19 outbreak.[108]

4.51. Some guidance lacked clarity about which residents could have an essential carer and what the role entailed. For example:

- The March 2021 guidance in England stated that an "*essential care giver*" was available to "*residents with the highest care needs*", without any further definition.[109]
- The Independent Care Homes Scotland group explained: "*What might be an 'essential visit' or 'meaningful contact' in one care home might not be the same in another.*"[110]
- Professor Fu-Meng Khaw, National Director of Health Protection and Screening Services and Executive Medical Director of Public Health Wales from June 2021, accepted that the key role of family members as care givers or essential carers was not "*clearly defined in the initial stages*".[111]

104 INQ000475131_0025 paras 4.17.1, 4.17.5; 'National lockdown must not include locking out care home visitors', National Care Forum, 1 November 2020 (https://www.nationalcareforum.org.uk/wp-content/uploads/2020/11/20201102-FINAL-Visiting-in-Care-Homes-Joint-Call-for-action-with-signatories.pdf; INQ000532365); 'Joint statement: Deadline for action on care home visiting', Age UK, John's Campaign, National Care Forum, Relatives and Residents Association, Rights for Residents, and Registered Nursing Homes Association, 9 February 2021 (https://johnscampaign.org.uk/post/joint-statement; INQ000532368)
105 *Every Story Matters: Adult Social Care Sector,* pp52-53 (INQ000587564)
106 INQ000551798_0108-109 para 381
107 *Visiting Guidance for Adult Care Homes in Scotland,* Scottish Government, 25 June 2020, p4 (https://scottishcare.org/wp-content/uploads/2020/06/Care-home-visiting-guidance-final-20.06.25.pdf; INQ000147431); *Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland,* Department of Health (Northern Ireland), 22 September 2020, pp14, 24-25 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/doh-correspondence/visiting-guidelines.pdf; INQ000256450)
108 *Guidance on Care Home Visiting*, Department of Health and Social Care, 5 March 2021 (INQ000325310_0005); INQ000614179_0272 para 836; INQ000509972_0004
109 *Guidance on Care Home Visiting*, Department of Health and Social Care, 5 March 2021 (INQ000325310_0002)
110 INQ000576044_0011 para 21
111 INQ000587702_0078 para 288

- Similar challenges relating to the definition of a 'care partner' were reported by the Belfast Health and Social Care trust, which explained that it was open to interpretation by care home managers, resulting in confusion.[112]

4.52. There were also complaints in Northern Ireland about inconsistent implementation of the guidance and, separately, from providers of care who considered that they were not able to facilitate implementation of the care partner scheme safely, or that it was an unreasonable demand. This led to "*frustration*" on the part of Robin Swann (Minister of Health for Northern Ireland from January 2020 to October 2022 and from February to May 2024). Further guidance on the role was issued in November 2020 following further consultation, with measures put in place to improve implementation.[113]

4.53. In a future pandemic, visits from essential carers should be available to all residents where possible and should be distinct from considerations regarding general visiting. There was a failure during the Covid-19 pandemic to implement this as soon as possible. Had there been better engagement with staff, care home residents and loved ones in pandemic planning, the UK government and devolved administrations would have better understood, at the outset of the pandemic, the vital role of family members and loved ones as essential carers. Even if uncertainty about transmission and risks in the early part of the pandemic meant immediate introduction of the role was not possible, pre-pandemic planning might have allowed for clarification of the role, quicker implementation at an appropriate time, and may have significantly reduced the harm caused by isolation.

4.54. In March 2022, the Scottish Health and Social Care Standards (which set out what people should expect when using health, social care or social work services in Scotland) were amended to allow residents to nominate relatives or friends to visit in person and to be involved in care during an outbreak.[114] The Care Reform (Scotland) Act 2025, known as 'Anne's Law', is now in force in Scotland, along with accompanying regulations and a statutory code of practice. Among other visiting provisions discussed below, Anne's Law requires care homes to identify at least one person as an 'essential care supporter' with a legal presumption that suspension of such visits is likely to cause serious harm to the resident's health or wellbeing.[115] The document entitled *Anne's Law Code of Practice* explains:

112 INQ000586007_0068 para 315
113 INQ000615082_0103-0104 para 312-317, 319, 321; Sean Holland 21 July 2025 70/23-75/12
114 INQ000475130_0168 para 622; *Health and Social Care Standards: My Support, My Life*, Scottish Government, 9 June 2017, p15, paras 5.16-5.17 (https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/06/health-social-care-standards-support-life/documents/health-social-care-standards-support-life/health-social-care-standards-support-life/govscot%3Adocument/health-social-care-standards-support-life.pdf: INQ000320086)
115 Care Reform (Scotland) Act 2025, section 14 (https://www.legislation.gov.uk/asp/2025/9/contents); The Care Home Services (Visits to and by Care Home Residents) (Scotland) Regulations 2026 (https://www.legislation.gov.uk/ssi/2026/166/contents/made); *Anne's Law Code of Practice: The Care Home Services (Visits to and by Care Home Residents) (Scotland) Regulations 2026*, Scottish Government, 31 March 2026 (https://www.gov.scot/publications/annes-law-code-practice-care-home-services-visits-care-home-residents-scotland-regulations-2026-31-march-2026/documents; INQ000660427)

> "[I]*n practice, this means that in every situation where a suspension of visiting is being considered, each individual resident's needs and circumstances must be taken into account.*"[116]

4.55. This legal duty to identify an essential care supporter for every care home resident in Scotland is a positive step. The UK government, Welsh Government and Northern Ireland Executive should consider the introduction of equivalent guidance or regulatory duties and standards.

Healthcare visits

4.56. While the initial restrictions did not prevent healthcare professionals from entering care homes, UK-wide guidance strongly discouraged in-person routine or ad hoc visits unless they were essential.[117] Primary care GPs, nurses and other healthcare professionals reduced the frequency with which they visited people in care homes (and at home).[118] For example:

- Between 25 March 2020 and 30 June 2020, the Welsh Government stated that GPs did not have to conduct routine visits, patient reviews within 28 days of admission, unscheduled care or medication reviews, and were to reduce all non-essential visits.[119]
- The Public Health Agency (Northern Ireland) reported that during the first wave of the pandemic, 42% of residents' needs were not met or only partially met by external healthcare professionals.[120]

> "*I was refused in-person GP appointments for a period of over two years.*"[121]
>
> **Person with care and support needs, Wales, Every Story Matters**

4.57. Action was taken to enable healthcare professionals to return to care homes with varied success. The Care Inspectorate in Scotland and Healthcare Improvement Scotland carried out targeted inspections of care homes, which considered the physical, wellbeing and healthcare needs of residents from May 2020, but clinical support was still not provided consistently.[122] Only 4 of 29 local authorities in

116 *Anne's Law Code of Practice: The Care Home Services (Visits to and by Care Home Residents) (Scotland) Regulations 2026*, Scottish Government, 31 March 2026 (https://www.gov.scot/publications/annes-law-code-practice-care-home-services-visits-care-home-residents-scotland-regulations-2026-31-march-2026/documents; INQ000660427)
117 INQ000336332; Helen Whately 17 July 2025 158/23-159/2; INQ000147441_0002-0003; INQ000615082_0110 para 336; INQ000120717
118 INQ000514104_0085 para 218; INQ000587670_0071 para 285; *Pandemic Patient Experience II: From Lockdown to Vaccine Roll-out*, The Patients Association, April 2021, p6 (https://www.patients-association.org.uk/Handlers/Download.ashx?IDMF=835c8fb6-71f2-41e3-8e44-489216762cf6; INQ000273425); INQ000587748_0012 para 51; INQ000591762
119 INQ000587254_0066 para 244; INQ000252810_0001, 0004; INQ000514308_0005
120 *Care Homes & Covid-19: The Lived Experience of Care Home Residents, Their Relatives and Staff During First Wave of the Covid-19 Pandemic*, Public Health Agency, September 2020, p32 (INQ000416806)
121 *Every Story Matters: Adult Social Care Sector,* p153 (INQ000587564)
122 INQ000614179_0286-0288 paras 890-892, 894; Kevin Mitchell 8 July 2025 90/3-16

Scotland reported that visits by healthcare professionals had not been limited between March 2020 and June 2022.[123] In contrast, by June 2020, providers in Wales described an improving situation, with increased in-person visits. Enhanced services (including weekly ward rounds, multidisciplinary teams and patient reviews) were directed in July 2020 – although the Inquiry heard in relation to one Welsh care home that it continued to face challenges getting a GP to attend in person in 2021.[124]

4.58. An acceleration of some measures contained in the long-term NHS Enhanced Health in Care Homes programme was announced in England in May 2020 to provide support to care homes with the Covid-19 response. This provided for: weekly 'check-ins' of care homes, personalised care and support plans for care home residents, remote monitoring of residents with suspected or confirmed Covid-19, and the identification of a named clinical lead.[125] From 1 October 2020, further measures were introduced, including a more comprehensive requirement to carry out weekly 'home rounds' for care home residents.[126] There was, however, significant local variation to implementation, with some areas reporting it working well and others less so.[127]

4.59. Ms Whately recalled receiving reports showing that having access to a named GP "*didn't make a difference with some care homes … so I suspect that there was variability in how it was implemented*".[128]

4.60. Technology was also used to facilitate access to healthcare, with a significant proportion of healthcare consultations being carried out remotely during the pandemic.[129] Some care homes reported positive experiences of remote consultations, particularly with regard to medication requests or in reducing the risks of transmission from in-person visits.[130] Remote consultations, however, were not suitable or appropriate for all patients.[131] For some residents, remote consultations were challenging and affected their mental health as they struggled to engage, became frustrated or considered that they were not being heard, understood or

123 INQ000587774_0016
124 INQ000587254_0066-0067 paras 246-247; *Care Inspectorate Wales (CIW) Survey: COVID-19 Impact on Adult Care Providers Weeks 12 to 13 (15th June to 28th June 2020)*, Care Inspectorate Wales, no date, p4 (INQ000514051); Helen Hough 1 July 2025 106/17-107/3; *The Primary Medical Services (COVID-19 Care Homes) (Directed Enhanced Services) (Wales) Directions 2020*, Welsh Government, 1 July 2020, p5 (https://www.gov.wales/primary-medical-services-covid-19-care-homes-directed-enhanced-services-wales-directions-2020; INQ000469013)
125 INQ000587737_0086-0087 paras 329-330
126 *Learning from Covid-19: Lessons from NHS England and Improvement's Response to the Pandemic*, NHS England and NHS Improvement, 20 June 2023 (INQ000226890); INQ000562866
127 *Adult Social Care in England: Covid-19: A Review of the 2020 to 2021 Winter Plan and Subsequent Actions – What More Should Be Done?*, Department of Health and Social Care, November 2021, pp42-43 (https://assets.publishing.service.gov.uk/media/618250788fa8f52981d40f01/Adult-Social-Care-in-England-Winter-Plan-2020-2021-Review-David-Pearson-accessible.pdf; INQ000279947)
128 Helen Whately 17 July 2025 161/3-8; *Social Care Sector COVID-19 Support Taskforce: Final Report, Advice and Recommendations,* Department of Health and Social Care, 12 October 2020, p33 (https://www.gov.uk/government/publications/social-care-sector-covid-19-support-taskforce-report-on-first-phase-of-covid-19-pandemic/social-care-sector-covid-19-support-taskforce-final-report-advice-and-recommendations; INQ000582696)
129 INQ000587675_0005 para 22; INQ000587669_0011 para 14.1; INQ000587768_0033 para 134; *Every Story Matters: Adult Social Care Sector,* pp153-154 (INQ000587564); INQ000509768_0007
130 INQ000587669_0012 para 14.3; Charlotte Hudd 3 July 2025 164/5-16; INQ000517219_0016 paras 47-48; *COVID-19 Insight: Issue 3*, Care Quality Commission, July 2020 (https://www.cqc.org.uk/sites/default/files/20200715%20COVID%20IV%20Insight%20number%203%20slides%20final.pdf; INQ000518408_0008-0009)
131 INQ000546956_0013 para 22

seen.[132] Much of the burden fell on care workers to facilitate remote GP consultations, to explain symptoms over the phone, and sometimes to provide treatment.[133] Care home workers described feeling as though they had taken on the role of doctors and nurses, without the proper training or necessary qualifications.[134] One care home manager noted the resultant lack of proper assessment and subsequent impact on diagnosis and treatment: "*We were taking basic observations … but we were not able to listen to someone's chest, a key observation in diagnosing a chest infection.*"[135]

4.61. Similarly, Professor Banerjee explained the importance of in-person multidisciplinary assessments for people with dementia. The absence of assessments meant that:

> "[T]*here was a cohort of individuals … whose diagnosis was missed, and we still are reaping the problems that come from that, and a cohort of people whose diagnosis was delayed.*"[136]

As a result, it was likely that less accurate, lower-quality diagnoses were made.[137]

4.62. Residents also had other conditions that were difficult to manage without in-person specialist care and treatment or rehabilitative support.[138] For example, visits from district and specialist nurses, podiatrists and physiotherapists were severely disrupted during the pandemic, as many professionals were redeployed to work in hospitals or critical care, and there was no adequate remote alternative.[139]

4.63. Many residents experienced a deterioration in their physical and mental health. The nature and severity of health conditions worsened as activity and movement decreased and there was less or unavailable support, diagnosis and treatment, including pain relief.[140]

4.64. There were potentially avoidable hospital admissions resulting from GPs not being "*prepared to visit a care home*".[141] This placed even greater pressures on those providing care and the hospitals.[142] Where they were unable to access healthcare services, staff and residents reported feeling "*unsupported and exposed*".[143]

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132 *Every Story Matters: Adult Social Care Sector,* pp153-154 (INQ000587564)
133 INQ000517219_0016-0017 para 49; INQ000587677_0009 para 14; *Every Story Matters: Adult Social Care Sector,* pp153-157, 160-161 (INQ000587564)
134 *Every Story Matters: Adult Social Care Sector,* p156 (INQ000587564); see also Chapter 6: The impact on unpaid carers, care workers and care providers
135 INQ000587676_0005 para 24
136 Sube Banerjee 23 July 2025 25/19-22
137 Sube Banerjee 23 July 2025 24/21-25/25
138 Caroline Abrahams 16 July 2025 21/1-8; INQ000268199_0004 para 7; INQ000517219_0016 para 47
139 Sube Banerjee 23 July 2025 29/1-19; INQ000050789_0007, 0023; INQ000243163_0001; *Every Story Matters: Adult Social Care Sector,* pp160-161 (INQ000587564)
140 Caroline Abrahams 16 July 2025 21/4-5
141 *Care Inspectorate Wales (CIW) Survey: COVID-19 Impact on Care Providers Weeks 7 and 8 (11th May to 24th May 2020)*, Care Inspectorate Wales, 27 May 2020 (INQ000509288_0003); Melanie Minty 14 July 2025 181/21-182/2
142 See, for example, *Every Story Matters: Adult Social Care Sector,* p148 (INQ000587564); INQ000474426_0026-0027 paras 5.6-5.7
143 INQ000517219_0017 para 49

4.65. Planning for a future pandemic should facilitate continued access to healthcare, except in truly exceptional circumstances. Visiting policies should also allow for healthcare professionals to visit and include practical measures to minimise the risk of transmission by the provision of adequate PPE. While remote consultations may be appropriate in some circumstances, these should not replace in-person visits where these can be facilitated without undue risk.

4.66. On 6 April 2024, the Care Quality Commission's fundamental standard on visiting was introduced in England (known as regulation 9A). The provisions mandate that, even during exceptional circumstances like a pandemic, visits by healthcare professionals and social workers should be permitted if a delay would be detrimental to the resident.[144] The Inquiry welcomes this change and encourages its adoption across the other nations of the UK.

Visiting out

4.67. Leaving care homes for social visits or healthcare appointments (known as 'visiting out') is also an important part of residents' lives.[145] Explicit guidance on visits out, however, was not issued in Scotland until September 2020, and in England, Wales and Northern Ireland until December 2020.[146]

4.68. The issue had been raised earlier in England, with Public Health England advising the Department of Health and Social Care in July 2020 that enabling visits out would require further consideration given the different level of risks posed.[147] This was followed on 6 August 2020 by further advice with a recommendation to publish visiting out guidance as soon as possible.[148]

4.69. Throughout 2020, the applicable guidance across the four nations required residents to isolate for 14 days upon their return to care homes. With the exception of the Scottish guidance, the requirement for isolation was also included in the specific visiting out guidance when introduced, with no consideration of individual needs, circumstances or risk.[149]

144 *Supporting Safer Visiting in Care Homes During Infectious Illness Outbreaks,* UK Health Security Agency, 15 April 2024 (https://www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks; INQ000611193_0002, 0005)
145 *Visits out of Care Homes*, Department of Health and Social Care, 7 April 2021 (INQ000325320_0002-0003)
146 INQ000587788_0076 para 300; INQ000514104_0037 para 101; *Visits out of Care Homes*, Department of Health and Social Care, 1 December 2020 (INQ000325292_0001-0002); *Care Homes – Christmas Family Visiting (23–27 December 2020),* Department of Health (Northern Ireland), 9 December 2020, p1 (https://www.health-ni.gov.uk/sites/default/files/publications/health/Care-homes-Christmas-visiting.pdf; INQ000276329); *Christmas Visits to Care Homes: Frequently Asked Questions,* Welsh Government, 18 December 2020, p4 (INQ000081680); *Open with Care: Supporting Meaningful Contact in Care Homes*, Scottish Government, 24 February 2021, p15 (https://webarchive.nrscotland.gov.uk/20240421101022/https://www.gov.scot/publications/open-care-supporting-meaningful-contact-care-homes/documents; INQ000147437)
147 INQ000562869_0001-0006
148 INQ000562889
149 *Visits out of Care Homes*, Department of Health and Social Care, 1 December 2020 (INQ000325292_0004); *Care Homes – Christmas Family Visiting (23–27 December 2020),* Department of Health (Northern Ireland), 9 December 2020, p1 (https://www.health-ni.gov.uk/sites/default/files/publications/health/Care-homes-Christmas-visiting.pdf; INQ000276329); INQ000081680_0004; *Open with Care: Supporting Meaningful Contact in Care Homes*, 24 February 2021, p16 (https://webarchive.nrscotland.gov.uk/20240421101022/https://www.gov.scot/publications/open-care-supporting-meaningful-contact-care-homes/documents; INQ000147437); INQ000496557_0019

4.70. The lack of guidance resulted in an assumption on the part of some care providers that visiting out was not permitted. In England, this had the consequence that some residents "*did not leave their care homes or even their rooms for months on end*", with a severe impact upon their mental and physical health.[150] Even when guidance expressly included reference to visiting out, the wider societal restrictions in place throughout the winter of 2020/21 combined with ongoing restrictive visiting out guidance meant that residents remained confined to their care homes.[151]

4.71. The effect of a lack of visiting out was described by an anonymous caller to the Care Rights UK advice line in April 2021:

> "*Grandma has not been able to leave her care home for over a year now. She has dementia and prior to the lockdown she was very fit and active. She just wants to go for a walk with us. Although she is not one to complain, she tells me 'they won't let me out, it's like a prison'. She asks me 'will I be stuck in here for the rest of my life?' saying she would rather end it all now.*
>
> *I can't bring myself to take Grandma out knowing she would have to endure the suffering of isolation afterwards. When the home had an outbreak, she had to quarantine in her room, which had a grave impact on her mental wellbeing. She became withdrawn and took to her bed, seeing no reason to get up.*"[152]

4.72. The Inquiry recognises that the situation was evolving and that the protection of all residents of care homes was a primary concern. However, the delay in providing effective guidance on visits out caused great distress and harm to residents and their loved ones. In a future pandemic, guidance must address such visits from the outset, with clear and appropriate advice on balancing the risk of infection against risk of harm.

4.73. The Inquiry notes that in England and Wales, regulations introduced on 6 April 2024 provide that people residing in care homes must not be discouraged from taking visits out of the care home.[153] Similar support and provision is made within Anne's Law, the regulations and Code of Practice which apply to visits to and by care home residents in Scotland.[154] This is to be welcomed. The Northern Ireland Executive should introduce equivalent duties on adult care home providers.

150 INQ000514104_0041 para 111
151 INQ000514104_0041 paras 111-113
152 INQ000514104_0043-0044 para 119
153 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9A(2) (https://www.legislation.gov.uk/uksi/2014/2936/contents); *Supporting Safer Visiting in Care Homes During Infectious Illness Outbreaks,* UK Health Security Agency, 15 April 2024 (https://www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks; INQ000611193_0002, 0005)
154 *Anne's Law Code of Practice: The Care Home Services (Visits to and by Care Home Residents) (Scotland) Regulations 2026,* Scottish Government, 31 March 2026 (https://www.gov.scot/publications/annes-law-code-practice-care-home-services-visits-care-home-residents-scotland-regulations-2026-31-march-2026/documents; INQ000660427)

Post-pandemic developments in respect of visiting

4.74. The fundamental role played by visitors has subsequently been recognised and reflected in regulations and guidance across the UK.

4.75. In Scotland, Anne's Law has ensured that visits can only be suspended where essential to prevent a risk to life, health or wellbeing.[155] Where visiting has been suspended, care homes are under an obligation to take all reasonable steps to eliminate or substantially mitigate the risk so that visits can resume as soon as practicable. Visiting must be allowed to continue at end of life, where a resident has suffered a significant deterioration in physical or mental condition, or where suspension is causing, or is likely to cause, serious harm to the resident's health or wellbeing, and that harm outweighs the risk. Care homes are required to notify the Care Inspectorate when they suspend visits into or out of the home.[156]

4.76. In England and Wales, regulations were introduced on 6 April 2024, to ensure that visits must be facilitated for people receiving care or treatment in a care home, hospital or hospice, unless there are exceptional circumstances (regulation 9A of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).[157] Breaches may result in regulatory action including loss of registration.[158]

4.77. Guidance produced by the UK Health Security Agency in April 2024, in the context of regulation 9A, sets out the following guiding principles:

- contact with relatives and friends is "*fundamental to care home residents' health and wellbeing*";[159]
- restrictions should only be imposed if a visit would "*pose a significant risk to the health or wellbeing*" of residents "*which cannot be mitigated*";[160]
- any such restrictions should be "*time limited, proportionate to each specific outbreak and risk based*"; and
- the wellbeing of residents should be prioritised when visiting restrictions are contemplated.[161]

155 *The New Health and Social Care Standards for Visiting and Staying Connected: Guidance for Providers,* Care Inspectorate, 31 March 2022 (INQ000320174); Care Reform (Scotland) Act 2025 (https://www.legislation.gov.uk/asp/2025/9/contents); The Care Home Services (Visits to and by Care Home Residents) (Scotland) Regulations 2026 (https://www.legislation.gov.uk/ssi/2026/166/regulation/5/made); *Anne's Law Code of Practice: The Care Home Services (Visits to and by Care Home Residents) (Scotland) Regulations 2026*, Scottish Government, 31 March 2026 (https://www.gov.scot/publications/annes-law-code-practice-care-home-services-visits-care-home-residents-scotland-regulations-2026-31-march-2026/documents; INQ000660427)
156 Care Reform (Scotland) Act 2025, section 14 (https://www.legislation.gov.uk/asp/2025/9/contents)
157 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9A (https://www.legislation.gov.uk/uksi/2014/2936/contents)
158 INQ000584245_0058 para 167
159 *Supporting Safer Visiting in Care Homes During Infectious Illness Outbreaks,* UK Health Security Agency, 15 April 2024 (https://www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks; INQ000611193_0001)
160 *Supporting Safer Visiting in Care Homes During Infectious Illness Outbreaks,* UK Health Security Agency, 15 April 2024 (https://www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks; INQ000611193_0002)
161 *Supporting Safer Visiting in Care Homes During Infectious Illness Outbreaks,* UK Health Security Agency, 15 April 2024 (https://www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks; INQ000611193_0003)

4.78. In March 2026, the Department of Health and Social Care published a review of regulation 9A of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review noted that the regulation has had a "*positive effect in clarifying expectations for providers, reinforced best practice and prompted organisations to review their processes*".[162] The review did, however, identify that:

> "[M]*ore needs to be done to address gaps in awareness and understanding, variation in decision making, and weaknesses in monitoring and enforcement to ensure that the intentions of Regulation 9A are fully realised in practice.*"[163]

The regulation is a welcome first step but requires further work, which the UK government has already recognised.

4.79. More work is also necessary in Northern Ireland. The *Care Standards for Nursing and Residential Homes* (dated December 2022) provide that "*residents can have visitors at any reasonable time*".[164] The language of a 'reasonable time' is likely to be too vague to assist in a future pandemic. The Northern Ireland Executive should, as a minimum, introduce equivalent duties to those in England, Scotland and Wales for adult care home providers.[165]

The impact of visiting restrictions

4.80. Visiting restrictions had immediate and, in some cases, devastating effects on residents, their families and those providing care. Professor Vic Rayner, Chief Executive Officer of the National Care Forum from 2016, told the Inquiry:

> "[I]*solation caused by restrictions on visits from loved ones is intrinsically harmful and we have heard over and over again the extreme anguish this caused … for staff, families and residents.*"[166]

The *Technical Report on the COVID-19 Pandemic in the UK* – produced in 2022 by the UK's Chief and Deputy Chief Medical Officers, the UK Chief Scientific Adviser and the National Medical Director, NHS England – recorded that visiting restrictions

162 *Review of Regulation 9A: Visiting and Accompanying in Care Homes, Hospitals and Hospices,* Department of Health and Social Care, 18 March 2026 (https://www.gov.uk/government/calls-for-evidence/review-of-cqc-regulation-9a-visiting-and-accompanying-in-care-homes-hospitals-and-hospices/outcome/review-of-regulation-9a-visiting-and-accompanying-in-care-homes-hospitals-and-hospices; INQ000660275_0003)
163 *Review of Regulation 9A: Visiting and Accompanying in Care Homes, Hospitals and Hospices,* Department of Health and Social Care, 18 March 2026 (https://www.gov.uk/government/calls-for-evidence/review-of-cqc-regulation-9a-visiting-and-accompanying-in-care-homes-hospitals-and-hospices/outcome/review-of-regulation-9a-visiting-and-accompanying-in-care-homes-hospitals-and-hospices; INQ000660275_0003)
164 *Care Standards for Nursing Homes,* Department of Health (Northern Ireland), December 2022, Standard 8, criterion 2, p33 (https://www.rqia.org.uk/wpfd_file/care-standards-for-nursing-homes-december-2022; INQ000506170)
165 INQ000613603_0199 para 673; *Care Standards for Nursing Homes,* Department of Health (Northern Ireland), December 2022, pp33-34, Standard 8 (https://www.rqia.org.uk/wpfd_file/care-standards-for-nursing-homes-december-2022; INQ000506170); *Residential Care Homes: Minimum Standards,* Version 1.2, Department of Health (Northern Ireland), December 2022, Standard 2 (INQ000506171_0015)
166 INQ000475131_0022 para 4.7

resulted in "*loneliness, isolation and deconditioning as well as stress and distress for residents, staff and loved ones*".[167]

Impact on residents

4.81. The impact of visiting restrictions for weeks and months on residents was profound, causing considerable trauma and long-term ramifications.[168] For many, the absence of visits from relatives meant that the care home no longer felt like their home.[169] Residents and relatives alike talked about care homes becoming prisons.[170] A profound sense of isolation developed, with some residents reporting that they felt abandoned.[171]

4.82. The Inquiry heard evidence that residents living in care homes thrived on the routine of visits.[172] The implementation of visiting restrictions resulted in disruption, confusion and distress, particularly for those residents who could not understand why the restrictions were in place.[173] For some residents, this manifested in challenging or unusual behaviour, particularly for people with dementia and people with learning disabilities.[174]

> "*They were very up and down emotionally. Very confused. Didn't really understand … if one was, like, stressed, or off their baseline, it would then antagonise the other one and they would become stressed. Then it was about trying to calm them down and stuff.*"[175]
>
> **Support worker, Every Story Matters**

4.83. Alternative forms of visiting also presented their own challenges and caused distress.[176]

167 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p299 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642)
168 INQ000572015_0024 para 79; INQ000475131_0022 para 4.7
169 Jane Wier-Wierzbowska 1 July 2025 09/25-10/03
170 *Every Story Matters: Adult Social Care Sector,* pp9, 182 (INQ000587564)
171 INQ000231915_0001; see also *Every Story Matters: Adult Social Care Sector,* pp14, 57, 143 (INQ000587564)
172 INQ000614377_0004-0005 para 10; INQ000587596_0007 para 23
173 INQ000572015_0024 para 79; INQ000587296_0042 para 139; INQ000587637_0016 para 51; INQ000614377_0004 para 8
174 INQ000492343_0001; INQ000587296_0042 para 139
175 *Every Story Matters: Adult Social Care Sector,* p174 (INQ000587564)
176 INQ000614377_0004 para 8

> "*My son has severe autism … I was unable to visit him for 24 weeks, we couldn't visit through a window … as he would not understand and so become upset it was a choice between keeping him calm or upsetting us all by seeing him through a window.*"[177]
>
> **Loved one of a care home resident, England, Every Story Matters**

> "*We were allowed to see them in the garden, but … we weren't allowed to touch her, but … she wanted to hold our hands, and she got upset, and it got emotional for her, so we then really didn't go and see her actually because it then got harder for her and she got more upset.*"[178]
>
> **Loved one of a care home resident, Scotland, Every Story Matters**

4.84. The impact on residents was not limited to emotional, social or behavioural responses – there was evidence of deterioration in physical and functional capacity.[179]

> "[My loved one] *was in sound mind when she went into that home, all she could do was she couldn't use her legs … And within the time she was there to the time that Covid hit, and she was confined, when I went in when they thought she was dying, she was unrecognisable … She'd lost so much weight, she was lying on the bed, her eyes were closed, they'd open but she could only just mumble stuff.*"[180]
>
> **Bereaved family member of a care home resident, England, Every Story Matters**

4.85. Professor Banerjee reported a more rapid decline in residents with dementia.[181] Some older people with dementia in care homes could not remember their family members when they were able to visit them again.

177 *Every Story Matters: Adult Social Care Sector,* p49 (INQ000587564)
178 *Every Story Matters: Adult Social Care Sector,* p54 (INQ000587564)
179 *Pulse Check Report: Experience of Residents, Relatives and Staff Within Care Homes Across Northern Ireland, Informing the Development of the Care Homes Visiting Pathway*, Patient Client Council and Public Health Agency, 2021 (INQ000583246_0013); *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p299 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642)
180 *Every Story Matters: Adult Social Care Sector,* p77 (INQ000587564)
181 INQ000546956_0066 para 166

> "*People with dementia, they just forgot who they were. They still spoke about them, but when they were there in front of them, they didn't know who it was, which was quite sad. It was hard for the families too.*"[182]
>
> **Care home worker, England, Every Story Matters**

4.86. As a result, family members expressed a feeling of lost time and connection with their relatives who had dementia.[183] Professor Banerjee told the Inquiry that it was likely that had people with dementia retained access to their main family carer, their quality of life would have been better, and the decline in their illness may have been mitigated. He explained that they would have been happier, more content and ultimately required less care.[184] This observation applies more broadly to all residents.

4.87. The relationship between visits and emotional and physical health was encapsulated by the experience of one contributor to Every Story Matters of visiting their relative.

> "*She could not understand why she could only see me only through the window … she stopped eating because she was depressed by life without visitors, and very brief care visits from the staff.*"[185]
>
> **Bereaved family member of a care home resident, Scotland, Every Story Matters**

4.88. Professor Chris Hatton and Professor Richard Hastings, expert witnesses on learning disabilities, explained that feelings of abandonment for people with learning disabilities were exacerbated because there was "*no sense of when things might ever come back*".[186] They also described how "*people's worlds became incredibly small*", resulting in a long-lasting impact on residents with learning disabilities and a reduction in self-reported quality of life.[187]

4.89. When visits were reinstated, relatives were often shocked at the extent of the deterioration in their loved ones. Out of respondents to a survey conducted by John's Campaign, 80% noted deterioration in their relatives' physical or mental health.[188] The resumption of in-person visits also resulted in distress.

182 *Every Story Matters: Adult Social Care Sector,* p53 (INQ000587564)
183 INQ000546956_0066 para 165
184 Sube Banerjee 23 July 2025 55/17-56/05
185 *Every Story Matters: Adult Social Care Sector,* p10 (INQ000587564)
186 Chris Hatton 28 July 2025 185/10-22
187 Chris Hatton 28 July 2025 182/24-183/03, 183/13-184/03; INQ000587296_0050 paras 180-181
188 INQ000514104_0019 para 51

> "*It was dreadful. He didn't want me to go. Half an hour, for somebody with dementia, was no time. Trying to explain what had been happening, where I had been and meeting up again after months … was so difficult. He was in pieces when I left his room and I was in pieces.*"[189]
>
> **Loved one of a care home resident, England, Every Story Matters**

Impact on families and loved ones

4.90. Restrictions also affected family members and loved ones. Feelings of guilt at being unable to visit and support relatives were common.[190]

> "*My mother's death in the care home – alone and confused about why her only child appeared to have abandoned her. It absolutely kills me to think about it. I felt, and still feel, angry, powerless and distraught.*"[191]
>
> **Daughter of a care home resident, England, Every Story Matters**

4.91. In some cases, the limited cognitive abilities and lack of understanding of some residents meant that they "*simply did not understand the significance of what was going on*", and so the restrictions affected family and loved ones more keenly than the resident.[192]

4.92. Where visits were permitted, they were often limited to a short period of time, which contributed to anxiety and upset and prevented visitors from performing their essential caring role.[193] As Jane Wier-Wierzbowska, a member of Covid 19 Bereaved Families for Justice UK, said about her mother:

> "*It was heartbreaking not to be able to touch her and hold her and be able to explain what was happening. I could see an escalation of her deterioration …* [it was] *deeply distressing.*"[194]

Ms Wier-Wierzbowska described her experience as "*an open-ended trauma, a wound that won't close*".[195]

189 *Every Story Matters: Adult Social Care Sector,* p56 (INQ000587564)
190 *Report of the Social Care Taskforce's Older People and People Affected by Dementia Advisory Group,* Department of Health and Social Care, 18 September 2020, p2 (https://assets.publishing.service.gov.uk/media/5f6492cf8fa8f5106ef9be6f/5_Older_People_and_People_Affected_by_Dementia_Advisory_Group_report_accessible.pdf; INQ000109754); *Every Story Matters: Adult Social Care Sector,* p50 (INQ000587564); INQ000546956_0066 para 165
191 *Every Story Matters: Adult Social Care Sector,* p57 (INQ000587564)
192 INQ000587678_0004 para 5.3
193 *Every Story Matters: Adult Social Care Sector,* p57 (INQ000587564)
194 INQ000614372_0005 paras 18-19
195 INQ000614372_0009 para 30

4.93. Physical barriers also caused distress to some family members.

> "*Seeing my relative in this room divided by a Perspex screen was just dreadful, not being able to physically touch him, or speak to him properly. It was just distressing. It was almost worse than not seeing him at all.*"[196]
>
> **Loved one of a care home resident, England, Every Story Matters**

4.94. Professor Banerjee stated that visiting restrictions led to a "*growth of anger in family carers*" who felt that they had missed out on important and limited quality time with their loved ones.[197] Family carers also reported a loss of trust in the care home system and the government.[198] The loss of trust was in part because of concerns that hidden harms, abuse and deterioration in a resident's condition would go unnoticed, with a lack of reassurance that measures were in place to identify these issues.[199] This was compounded in some circumstances by a lack of communication from the care home as to their relatives' wellbeing, with updates sometimes being limited to generalities that the resident was "'*okay' or 'comfortable*'".[200] However, examples of good practice were also noted, such as online portals (where photos could be shared and updates provided) or messaging platforms – as are typically used by early years care providers and schools.[201] Where visiting restrictions are necessary in the future, it is essential that communication between residents, providers and relatives is facilitated to provide reassurance.

Impact on people providing care

4.95. The imposition of strict visiting restrictions also significantly affected those providing care to residents in a care home.

4.96. Staff took on an enhanced role with additional responsibilities, alongside caring for residents who were mentally and physically affected by the restrictions.[202] For many, relationships developed beyond the normal carer role in the absence of visits from relatives.

196 *Every Story Matters: Adult Social Care Sector,* p55 (INQ000587564)
197 INQ000546956_0067 para 167
198 INQ000546956_0067 para 167
199 INQ000231915_0001; INQ000572015_0041 para 144
200 INQ000546956_0067 para 166
201 INQ000546956_0067 para 166
202 Helen Whately 17 July 2025 157/21-158/04

> "*We became more than just the residents' carers; our relationship with them grew during that time, we became their family when their own were no longer allowed to visit. We loved them, like our own.*"[203]
>
> **Care home worker, Northern Ireland, Every Story Matters**

4.97. This increased role led to greater trauma, guilt and grief when the residents they cared for deteriorated or died.[204] Many care workers were exposed to traumatic experiences and significantly greater numbers of deaths in very difficult circumstances, and without adequate training.[205]

> "*We literally had to call the family in at the last minute, so that they could say goodbye and then they had to leave, it was awful, it was absolutely awful. I don't think I would've put up with it if it was my family.*"[206]
>
> **Care home worker, Every Story Matters**

4.98. The increased pressures and understandable frustration on the part of family members also resulted in difficulties and friction between families and care providers and, in some instances, abusive behaviour towards care home staff.[207] Reverend Charlotte Hudd, a member of the Royal College of Nursing, described having to navigate conflicting wishes of families, with some wanting visits and others seeking stricter lockdowns of the care home. Some families expressed frustration about the delayed implementation of government-announced changes to visiting policies while care homes worked out logistics and risk assessments. She explained that "*the tough work of mediation*" fell on care workers.[208]

4.99. Family carers and care staff experienced feelings of "*abandonment, stress and burnout*".[209]

203 *Every Story Matters: Adult Social Care Sector,* p9 (INQ000587564)
204 *Every Story Matters: Adult Social Care Sector,* pp47-48, 50 (INQ000587564); INQ000587382_0158 para 573
205 These matters are considered further in Chapter 6: The impact on unpaid carers, care workers and care providers and Chapter 7: Deaths and end of life.
206 *Every Story Matters: Adult Social Care Sector,* p160 (INQ000587564)
207 INQ000587678_0004 para 5.2; *Every Story Matters: Adult Social Care Sector,* p55 (INQ000587564); INQ000587382_0158 para 573; INQ000509530_0023 para 87
208 INQ000614378_0003 paras 5, 7; see also INQ000587395_0017 para 56
209 INQ000546956_0067 para 167; INQ000587395_0017-0018 para 57

Planning for a future pandemic

Balancing of harms

4.100. The introduction and continuation of visiting restrictions involved balancing the need to protect vulnerable residents – from the potentially fatal risk of Covid-19 infection – with the impact of restrictions on residents, their families and care workers, as set out above.[210]

4.101. Views about restrictions among residents, their relatives and staff varied. Some people considered that visits to care homes should not take place due to the risks of infection. Others considered that the harms caused by the resulting isolation were too great and outweighed the benefits.[211] The views of someone approaching the end of life might be very different from a young person with care needs.

4.102. Many witnesses acknowledged that it was difficult to balance the benefits and harms of visiting restrictions and noted that there was no ideal solution.[212] As subsequently noted in the *Technical Report on the COVID-19 Pandemic in the UK*, reducing the risk of transmission of Covid-19 in care homes "*involved some of the most complex trade-offs of risk to individuals of any part of the pandemic*".[213]

4.103. The overwhelming imperative at the outset of the pandemic was to protect life. This necessitated the introduction of the visiting restrictions. It was, however, clear from at least early April 2020 that visiting restrictions were likely to be required for prolonged and unprecedented periods of time.[214]

4.104. As the Covid-19 pandemic progressed, for many, the harms caused by the absence of visits outweighed the potential risks of infection. The risk of harm from restricting visits and consequent isolation was obvious from the outset, not least because isolation and loneliness were known and established risk factors in mortality.[215] The extent of that harm was however significantly worsened by the length of time that visiting restrictions were necessary. Much of this harm could have been mitigated with planning and innovation to enable a swifter introduction of remote, window and outdoor visits, and the use of temporary structures and practical adaptations in care homes (such as screens).

210 Matt Hancock 2 July 2025 23/23-24/5; INQ000587737_0067 para 260; Heather Reid 10 July 2025 148/5-9; INQ000613603_0198-199 para 672; INQ000587254_0064-0065 para 237; Vaughan Gething 15 July 2025 80/14-21; INQ000606530_0079 para 290
211 See, for example, INQ000509530_0023 para 88; INQ000504053_0018 paras 5.10, 5.12
212 INQ000587746_0048 para 219; *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p305 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642); INQ000613908_0073 para 188; INQ000614179_0266 para 814
213 *Technical Report on the COVID-19 Pandemic in the UK,* Department of Health and Social Care, 1 December 2022, p297 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642)
214 INQ000068683_0005 para 23; INQ000248853_0048-0049 para 5.157(10)
215 INQ000587822_0019 para 69; INQ000572015_0024 para 79

4.105. The pandemic has laid bare the importance of visiting and the catastrophic impact of visiting restrictions for many. It has also highlighted the need for clear guidance from the UK government and devolved administrations as to the principles to be applied in deciding whether to introduce visiting restrictions. The absence of such guidance resulted in inconsistencies across care homes and placed care homes in invidious positions in seeking to balance the risk to their residents, causing inevitable confusion and distress.

4.106. Had there been detailed guidance setting out the core principles governing visiting restrictions from the outset, the difficulties encountered might have been more readily managed, with the result that less harm was caused.

Guidance and decision-making

4.107. In a future public health emergency, decision-makers should start from the presumption that the harm caused by anything other than short-term isolation to residents may well be as significant, grave and devastating as the risks posed by the infection. Visiting guidance should be issued that considers the impact of isolation on those living in care homes, particularly on people with dementia, cognitive and communication disabilities, and on those at end of life. The guidance should be created with input from government departments, healthcare bodies, local authorities and those impacted by the guidance.

4.108. It should set out the guiding principles and provide advice based on the type of pathogen and level of transmission and infection (when available), along with other relevant factors such as availability of PPE, testing and vaccines. Guidance and restrictions should be reviewed regularly at national, local and care home levels and they should be relaxed as soon as circumstances allow.

4.109. Guidance should draw a distinction between more general, in-person visits and those providing essential care. Visits by essential carers should be maintained throughout any pandemic, unless the circumstances make it impossible or the risk is simply too great. Where possible, in-person visits with wider family and loved ones should also be planned for, facilitated and promoted. The individual circumstances of each care home mean that workable alternatives to in-person visiting should also be considered in advance.

4.110. This guidance should also recognise that the decisions about visiting individual residents should be made by care home managers who are informed by the principles set out – alongside local guidance, including that from directors of public health or their equivalents. Decisions on how to facilitate visiting safely should rest with the individual care homes, who can take into account the circumstances of their settings as well as local infection rates. As the principles set out in the guidance issued on 5 March 2021 in England stated:

> "*Each care home is unique in its physical layout, surrounding environment and facilities. Residents vary in their needs, health and current wellbeing. Care home managers are best placed to decide how their care home can best enable visiting in line with this guidance and in a way that meets the needs of their residents both individually and collectively.*"[216]

4.111. Finally, there is a need for greater understanding of the levels of risk and trade-offs that care home residents and their relatives are prepared to withstand to protect themselves. Some individuals may prefer to prioritise their quality of life and ability to be with their relatives over the enhanced (and, in some cases, extreme) risk of premature death or serious illness. Others may wish to preserve life at all costs. Care home providers should be prepared to have these conversations with residents and their loved ones, where appropriate, and ascertain wishes and feelings. Families and loved ones' views may align or be different from those of the resident. Issues of capacity are likely to arise and create further complexities if such an exercise is embarked upon during a pandemic. The views of residents and relatives will inevitably not be determinative – not least given the wider risks to other vulnerable residents and staff in the care home and the likelihood of competing wishes in the same care home or the same family. Views may also change. They will nonetheless be an important factor to be weighed in the balance and must be taken into account.

4.112. The Inquiry recommends that clear guidance for the implementation of visiting restrictions in care homes in a future pandemic, taking into account all these factors, is developed and published by the UK government, Scottish Government, Welsh Government and Northern Ireland Executive.

216 *Guidance on Care Home Visiting*, Department of Health and Social Care, 5 March 2021 (INQ000325310_0003); see also Claire Sutton 29 July 2025 47/16-48/23

Recommendation 4: Visiting restrictions

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should publish guidance for the implementation of visiting restrictions in care homes in a future pandemic.

The guidance should be led by the following core principles:

- Measures applied should be the least restrictive possible, both in terms of severity and the length of time for which they apply.
- Residents should have the right to in-person visitors, except in the most grave or exceptional of circumstances.
- Restrictions should be decided upon and applied at the most local level possible, based on local risk assessments and considering individual circumstances.
- Communications with the public, care home residents and loved ones must clearly explain the measures in place and their purpose.

People who work in and use social care should be closely involved in developing this guidance.

Chapter 5: Regulation and safeguarding

Introduction

5.1. Ensuring that adults are enabled to live a life free from abuse or neglect "*cannot be achieved by any single agency*".[1] As the Local Government Association explained: "*Safeguarding adults is everybody's business. We all have a role to play in ensuring that everyone in our communities is treated with dignity and respect.*"[2] Local authorities and councils, regulators, care providers and workers, healthcare professionals, families and friends provide complementary and overlapping oversight, enabling the identification, escalation and addressing of safeguarding concerns.

5.2. During the Covid-19 pandemic, the role of regulators in keeping adults who use social care safe came under some scrutiny. The regulators in each nation of the UK play a central role and share the same aims: to ensure the provision of safe, high-quality care, maintain standards and drive improvement.[3]

5.3. This chapter focuses on the decision taken by the regulators to suspend routine in-person inspections in care homes in March 2020 and the subsequent move to a risk-based inspection programme. It also considers the impact of the Covid-19 pandemic on registration and enforcement activities, and the extent to which regulators were successful in their core function of safeguarding.

The social care regulators

5.4. Adult social care is independently regulated in each of the four nations of the UK: in England, by the Care Quality Commission;[4] in Scotland, by the Care Inspectorate;[5] in Wales, by Care Inspectorate Wales;[6] and in Northern Ireland, by the Regulation and Quality Improvement Authority.[7] Although responsibilities vary between the regulators, each is responsible for regulation of care homes and providers of domiciliary care (care provided in people's own homes).[8]

1 INQ000584245_0118-0119 para 368

2 *Safeguarding Roles and Responsibilities: Safeguarding Is Everybody's Business*, Local Government Association, 23 May 2023 (https://www.local.gov.uk/publications/safeguarding-roles-and-responsibilities-safeguarding-everybodys-business; INQ000660192_0001)

3 Health and Social Care Act 2008, section 3(1) (https://www.legislation.gov.uk/ukpga/2008/14/contents); Public Services Reform (Scotland) Act 2010, section 45(2) (https://www.legislation.gov.uk/asp/2010/8/contents); Regulation and Inspection of Social Care (Wales) Act 2016, section 4(a) (https://www.legislation.gov.uk/anaw/2016/2/contents); The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, Article 4(2)(b) (https://www.legislation.gov.uk/nisi/2003/431/contents/made). See, for example, *Regulation and Inspection of Social Care (Wales) Act 2016 – Code of Practice for Inspection of Regulated Services*, Care Inspectorate Wales, August 2019, p3, para 1.6 (INQ000496074) in relation to Care Inspectorate Wales's Code of Practice.

4 INQ000584245_0006 para 6; Health and Social Care Act 2008 (https://www.legislation.gov.uk/ukpga/2008/14/contents)

5 INQ000475130_0004 para 16; Public Services Reform (Scotland) Act 2010, section 44(1) (https://www.legislation.gov.uk/asp/2010/8/section/44). The legal name of the Care Inspectorate is Social Care and Social Work Improvement Scotland.

6 INQ000569773_0002 para 3

7 INQ000188742_0013-0014 para 2.21; INQ000475143_0002 para 8

8 INQ000569773_0002 para 7; INQ000584245_0006-0007 para 8; INQ000475130_0003-0004 paras 10, 12; *Regulation and Inspection of Social Care (Wales) Act 2016 – Code of Practice for Inspection of Regulated Services*, Care Inspectorate Wales, August 2019, p3, para 1.6 (INQ000496074); Gillian Baranski 7 July 2025 144/23-145/2; 'Framework document, regarding the reform of the health and social care system in Northern Ireland', Department of Health, Social Services and Public Safety, September 2011, p13, para 2.21 (INQ000188742)

5.5. Regulation is achieved primarily through:

- the use of robust registration processes;
- ongoing assessment, which includes undertaking both routine and responsive (or intelligence-led) inspections alongside one another; and
- clear, progressive and proportionate enforcement.

5.6. Across the UK, registration serves as the foundation of regulation, requiring providers to meet specific standards and legal requirements before they can operate. Robust registration processes are therefore central to effective regulation, providing initial assurance and quality control of providers of regulated adult social care. Regulators may grant or refuse registration applications. To reflect the importance of ensuring safe, high-quality care, operating a care setting or service without registration with the relevant regulator is a criminal offence.[9]

5.7. Inspections often form part of registration processes and are also conducted subsequently to assess ongoing compliance with regulations as well as the quality of care delivered. Inspections, whether routine or risk-based, gather evidence to evaluate whether providers meet the required standards and identify areas for improvement. Inspections are also used to determine whether enforcement actions – such as improvement notices, penalties or registration cancellations – are necessary to address risks and protect service users.[10]

5.8. Enforcement is aimed at improving the quality of care services and safeguarding individuals from harm. It ensures that providers meet fundamental standards of quality and safety. Each regulator uses enforcement powers to address breaches of regulations and to hold providers accountable for failures that put users of care services at risk.[11]

Regulatory approaches during the pandemic

5.9. As a consequence of the Covid-19 pandemic, and in accordance with its own priorities, each regulator significantly adapted its ordinary regulatory processes from March 2020.

9 INQ000584245_0007, 0043-0045, 0047 paras 12, 119, 121-123; Health and Social Care Act 2008, sections 8, 10 (https://www.legislation.gov.uk/ukpga/2008/14/contents); The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, section 3, Schedule 1 (https://www.legislation.gov.uk/uksi/2014/2936/contents/made); INQ000475143_0022-0023 paras 73-75; The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, sections 8, 10, 11, 12 (https://www.legislation.gov.uk/nisi/2003/431/contents/made); The Domiciliary Care Agencies Regulations (Northern Ireland) 2007, Parts II, IV (https://www.legislation.gov.uk/nisr/2007/235/contents/made); INQ000569773_0014 para 47; Regulation and Inspection of Social Care (Wales) Act 2016, sections 4, 5, Schedule 1 (https://www.legislation.gov.uk/anaw/2016/2/contents); Public Services Reform (Scotland) Act 2010, sections 59, 80, Schedule 12 (https://www.legislation.gov.uk/asp/2010/8/contents)

10 INQ000475130_0032-0033 para 102; INQ000569773_0020, 0023 paras 66, 77; INQ000584245_0068-0072 paras 206-213; INQ000475143_0031-0033 paras 105-115

11 INQ000475130_0005-0006 para 21; INQ000569773_0002, 0023 paras 3, 77; INQ000475143_0024, 0045-0046 paras 81, 165-166; INQ000584245_0133-0145 paras 410-453

Northern Ireland

5.10. Regulation in Northern Ireland faced its own particular challenges. The Inquiry was told that the Regulation and Quality Improvement Authority entered the Covid-19 pandemic with significant challenges, including "*dysfunctional*" relations between its board members, its management team and the Department of Health (Northern Ireland).[12] This dysfunctionality was compounded by the department's decision on or about 18 March 2020 to redeploy the authority's senior leadership staff to other areas of the Covid-19 response (initially temporarily, but none of them returned).[13] The authority explained that this had a significant impact on its work, in particular on its core functions of registration, regulation and inspection in relation to care homes and domiciliary care.[14]

5.11. On 18 June 2020, the Regulation and Quality Improvement Authority's board resigned, citing concerns about the conduct of the Department of Health (Northern Ireland).[15] A subsequent independent report questioned the legal authority of the department to redeploy staff and found that, notwithstanding the unique circumstances brought about by the pandemic, the department's actions "*showed a lack of respect to the* [authority] *and its Board*".[16] It concluded that the board's resignation, along with the redeployment of senior staff, left the authority lacking the full strategic leadership and oversight to effectively manage its normal business.[17] The department's actions undoubtedly undermined the authority's independence and its ability to fulfil its statutory function in the time of a public health emergency.[18]

Registration

5.12. During the pandemic, each regulator sought to be flexible in its approach to registration and to relax some of the pre-pandemic regulatory requirements. This was in order to support the adult social care sector in its Covid-19 response and enable additional capacity to be created without being delayed by the normal registration or variation processes. Registration provisions were altered, or a pragmatic approach was adopted, to allow temporary registration arrangements for new care services or to allow existing providers to vary their services.[19] The aim of quicker registration was to increase the number of care providers and, in turn, increase the number of available bed spaces. Allowing variations to services meant

12 INQ000475143_0020 para 66
13 INQ000475143_0014-0015 paras 45-46
14 Briege Donaghy 7 July 2025 89/6-7; INQ000475143_0017 paras 56-58
15 INQ000475143_0018-0019 paras 61-62
16 *Independent Review into the Circumstances of Board Member Resignations in the RQIA*, Onboard, 8 December 2020, p8, para 27 (https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-rqia-report.pdf; INQ000260638_0013)
17 INQ000475143_0020 para 66
18 A partnership agreement between the Regulation and Quality Improvement Authority and Department of Health (Northern Ireland) was subsequently signed in about July 2025 (see Briege Donaghy 7 July 2025 93/17-22).
19 INQ000584245_0050-0051 paras 134-135; *Covid-19 – Registration Principles and Decision-Making Framework*, Care Quality Commission, no date, pp1-2 (INQ000398702); INQ000501204_0001; INQ000569773_0016-0019 paras 54-63; INQ000475130_0062-0063 para 222; INQ000475143_0039-0041 paras 135, 139-140; *Care Home Report: Key themes from Our Work Completed in Registered Care Home Services for Adults and Older People Between 1 April 2020 and 31 December 2022*, Care Inspectorate, no date, p13 (INQ000320180)

a provider could expand the number and type of residents for whom it was allowed to care by way of a speedier process.

5.13. Despite these steps, the Inquiry heard some evidence that there were significant delays in registration.[20] For example, in Northern Ireland, the redeployment of senior managerial staff (discussed above), as well as internal governance and staffing issues at the Regulation and Quality Improvement Authority, had a material impact on registration in the early stages of the pandemic.[21] The initial processing of applications was also slower, as processes to enable identities to be verified by video call took time to develop and implement.[22]

5.14. During the pandemic, initial regulatory adjustments provided flexibility and support to help secure and expand capacity during the critical acute phase. Delays in registration, however, had implications for users of care who faced the risk of harm in the absence of available services.

Inspections

5.15. Prior to the Covid-19 pandemic, each regulator undertook routine monitoring and inspection of adult social care. The regulators broadly followed the same processes for inspections, which involved information-collation and inspection-planning, the inspection itself, feedback and the publication of a report.[23] Inspections took various forms, including full inspections (a comprehensive inspection evaluating all key areas), focused inspections (a targeted inspection typically triggered by identified concerns) and thematic inspections (examining a specific issue, such as medication management). Inspections were normally unannounced and in person.[24]

5.16. Regulatory requirements provided for maximum intervals between inspections. Inspection intervals varied from annual inspections to between 6 and 30 months – depending on the regulator, the service being provided, and other factors such as the outcome of previous inspections, ratings and the length of registration.[25] In England, where care homes were previously rated as 'good' or 'outstanding', they were to be inspected within 30 months. For care homes rated 'inadequate', a follow-up inspection took place within 6 months, and newly registered services were typically inspected between 6 and 12 months from the date of registration.[26] In Wales, the timing of routine inspections depended on the nature of the service

20 *Care Quality Commission: Regulatory Performance in Homecare*, Homecare Association, August 2024, pp4, 6 (INQ000571057); INQ000475143_0017 para 58
21 INQ000475143_0017 para 58
22 INQ000475143_0024 para 82
23 INQ000475143_0032-0033 paras 108-115; INQ000569773_0020 para 66; INQ000475130_0012-0013, 0034 paras 42-43, 108; INQ000584245_0064 para 187
24 INQ000584245_0069 para 206.1.4; *Regulation and Inspection of Social Care (Wales) Act 2016 – Code of Practice for Inspection of Regulated Services*, Care Inspectorate Wales, August 2019, p11, paras 4.11-4.12 (INQ000496074); INQ000475143_0032 para 108; INQ000475130_0034 para 107
25 INQ000569773_0019-0020 Table 3; INQ000584245_0068 para 203; INQ000475143_0031 paras 105-106; INQ000475130_0034 para 107
26 INQ000584245_0068 para 203

combined with an assessment of whether the service required a routine, early or priority inspection. Intervals ranged from 6 to 18 months.[27] The regulatory regime in Northern Ireland provided for care homes to be inspected a minimum of twice within a 12-month period and domiciliary care agencies to be inspected annually.[28] Regulations in Scotland required annual inspections for care homes and support services providing personal care or domiciliary care.[29]

5.17. In addition to routine inspections, each regulator conducted responsive inspections based on intelligence and potential risk of harm, and services could be inspected at any time.[30] Inspections supplemented other forms of reporting – for example, annual returns from providers to the Care Quality Commission.[31]

Decisions to suspend routine inspections

5.18. In early March 2020, the Care Quality Commission in England and the Care Inspectorate in Scotland scaled back inspection activity, by cancelling or postponing planned and routine inspections, and by moving to a risk-based approach. These decisions came at a time when – given the pressures facing the health and social care sector and public health advice to minimise footfall in care homes – various organisations (predominantly healthcare organisations, including the British Medical Association and the NHS Confederation) were calling for a pause to inspections generally.[32]

5.19. Initially, it was anticipated that these measures would be temporary and time-limited.[33] As at 10 March 2020, Care Inspectorate Wales intended to continue with planned inspections, although this was subject to daily review.[34] In Northern Ireland, on 13 March, a direction was sought from the Department of Health (Northern Ireland) to reduce the Regulation and Quality Improvement Authority's inspection activity.[35]

5.20. The position evolved quickly. By mid-March 2020, each of the regulators had suspended routine inspections of care homes; but inspections were still to be carried out where there were concerns or reports of potential harm or abuse.[36] Each regulator also decided that a risk-based approach to inspections – based on proactive identification of high-risk services and factors influencing levels of risk,

27 INQ000569773_0019-0020 Table 3
28 INQ000475143_0031 paras 105-106
29 INQ000475130_0034 para 107
30 Mary Cridge 7 July 2025 5/14-18; Gillian Baranski 7 July 2025 147/18-148/3; INQ000584245_0068 para 204; INQ000475143_0032 para 109; INQ000475130_0044, 0046 paras 143, 150
31 INQ000584245_0066 para 196
32 INQ000584245_0074-0075, 0078-0084 paras 218, 220, 234-257; INQ000475130_0060, 0067 paras 213, 238
33 INQ000475130_0060 para 213
34 INQ000497197_0001; Gillian Baranski 7 July 2025 149/19-22
35 INQ000439341_0001-0006
36 INQ000475130_0067 para 238; Kevin Mitchell 8 July 2025 36/14-37/1; INQ000584245_0083 para 253; Gillian Baranski 7 July 2025 149/23-150/7; INQ000569773_0025-0026 para 86; INQ000103688_0001; INQ000475143_0035 paras 119-121; INQ000501204_0001; INQ000501664_0001; Briege Donaghy 7 July 2025 98/4-23

rather than a fixed period of time – was appropriate.[37] Each regulator operated a risk-based regulatory framework prior to the pandemic. The approach during the pandemic adapted and built upon this.[38]

5.21. The decisions to suspend routine inspections were taken primarily on the following grounds:

- the potential risk of transmission by inspectors to residents, those in receipt of care and staff through in-person inspections (including the risks of introducing Covid-19 into care homes and potential onward transmission);
- the potential risk of infection to the inspector; and
- the need to provide support to care providers, including by allowing them to concentrate on providing care in challenging circumstances (without the focus on a potential inspection).[39]

5.22. The decisions to stop routine inspections were supported by public health advice at the time and agreed or supported by the UK government and devolved administrations.[40] It was not without precedent. For example, in 2018, as a result of respiratory illnesses and influenza, routine inspections for certain healthcare services were suspended by the Care Quality Commission and replaced with risk-based inspections.[41] However, as with the suspension of visiting (discussed in Chapter 4: Visiting restrictions in care homes), previous suspensions of routine inspections were for short periods of time.[42]

5.23. Each regulator acknowledged the tension between maintaining the safety of care recipients through routine in-person inspections, the pressures placed upon providers and the significant risk that inspections would spread Covid-19, which could lead to serious illness or death. Mary Cridge, Director of Adult Social Care at the Care Quality Commission from July 2022, told the Inquiry:

> "*Our intent was always to balance the value to be gained from a full physical inspection with the risk posed by inspectors moving between services, alongside the recognition that every provider was operating an 'exceptional' service.*"[43]

Gillian Baranski, Chief Inspector of Care Inspectorate Wales from October 2016, explained that it was:

37 INQ000584245_0075 para 222; INQ000398833_0001; INQ000501204_0001; INQ000501664_0001; Briege Donaghy 7 July 2025 98/10-14; INQ000103688_0001
38 INQ000584245_0074-0076 paras 217-218, 221, 224; INQ000475143_0004, 0018, 0035-0036 paras 15b, 60d, 122; INQ000475130_0045-0046 paras 147, 151; INQ000569773_0029 para 98
39 INQ000475130_0067-0068 paras 238-240; Gillian Baranski 7 July 2025 152/9-21; Matt Hancock 2 July 2025 154/15-156/7
40 INQ000475130_0061, 0068 paras 217, 239; INQ000497198_0001; INQ000584245_0084-0085 paras 256-259; INQ000587788_0100 para 400; INQ000103688_0001
41 INQ000584245_0074 para 217
42 'CQC responds to increased pressure on health and social care by pausing some routine inspections', Care Quality Commission, 10 January 2018, updated 12 May 2022 (https://www.cqc.org.uk/news/stories/cqc-responds-increased-pressure-health-social-care-pausing-some-routine-inspections; INQ000398815)
43 INQ000584245_0075 para 222

> "*appropriate to enable local authorities and to providers to give them the space and the opportunity to concentrate on looking after people in their care, rather than worrying about a potential inspection*".[44]

5.24. Significant concerns were, however, raised about the lack of oversight that resulted from the suspension of routine inspections. The Relatives and Residents Association (now Care Rights UK, a charity focused on promoting the rights of older people using care services) wrote to the Care Quality Commission explaining that residents felt "*totally abandoned*".[45] Scottish Care described the stopping of inspections by the Care Inspectorate as creating "*a degree of suspicion and distrust*".[46] Eddie Lynch, Commissioner for Older People for Northern Ireland from June 2016 to December 2024, described the decision of the Regulation and Quality Improvement Authority to cease inspections as leaving "*care homes to their own devices save for telephone advice and self-reported monitoring*".[47] Mr Lynch considered that a single inspector entering a care home would have been a "*reasonable risk*".[48]

5.25. In practice, however, an individual inspector was responsible for more than one care home or service.[49] Professor Sir Michael McBride, Chief Medical Officer for Northern Ireland from September 2006, told the Inquiry:

> "[T]*here were also significant risks with individual care home inspectors, who individually inspected 30 to 40 care homes, moving from care home to care home in terms of introducing infection. So it was about controlling the risks that we could control.*"[50]

5.26. The extent to which inspectors may have posed a transmission risk and the ways in which risks could have been mitigated remain unclear. While the benefits of an inspection undertaken by a single additional visitor would potentially outweigh any additional risk, there were risks associated with spreading Covid-19 between care homes. In such a scenario there may be mitigation measures that can be put in place – for example, single rather than multiple inspectors on an inspection, isolation periods between visits to different care homes, or testing prior to in-person inspection, and the provision of personal protective equipment (PPE) where available.[51] Potential measures to mitigate the risks of transmission should be considered in future planning.

5.27. Given the risk of death or serious illness for many residents, the initial decision to suspend inspections was a reasonable one. At that stage, however, it was not envisaged that restrictions would last as long as they did, or that there would be no

44 Gillian Baranski 7 July 2025 152/9-21
45 INQ000231915_0001
46 INQ000520523_0004
47 INQ000474926_0049-0050 para 149
48 INQ000474926_0049-0050 para 149
49 Briege Donaghy 7 July 2025 100/12-23
50 Michael McBride 24 July 2025 65/3-9
51 INQ000520523_0004-0005

return to routine in-person inspections for the duration of the pandemic. The risks of harm from failures in safeguarding – including unsafe infection prevention and control (IPC) practices, abuse or other failings such as inadequate end-of-life care – were significant. Alternatives to inspections were not in place and so had to be developed during the course of the pandemic.

Move to a support function

5.28. Following the suspension of routine inspections, each regulator sought to develop policies, processes, tools and guidance to underpin a risk-based approach to inspections, along with new assurance approaches that deliberately limited on-site activity. Along with the focus on risk-based regulatory activity in care homes, each regulator prioritised and established additional support functions to assist care providers.

5.29. In Northern Ireland, the Regulation and Quality Improvement Authority established a Services Support Team and the Care Inspectorate in Scotland established a response team to act as a central resource. These teams were intended to answer questions and to provide and explain guidance and advice.[52] Similarly, in England, the Care Quality Commission's inspection team was to provide guidance and advice to care providers and act as a conduit.[53] Care Inspectorate Wales explained that it sought to provide support and gain feedback to assist in understanding the pressures across Wales and those placed upon services, including the identification of any specific problems.[54]

5.30. In providing support, each regulator saw its role as having changed fundamentally.[55] Ms Baranski explained that, in Wales, "*at that stage, it seemed more important that we should be checking in and providing support, rather than our normal regulatory oversight*".[56] In relation to England, the Care Quality Commission explained at the time that its role would shift to "*acting as a source of intelligence and conduit between health and social care*".[57]

5.31. The Inquiry heard that the provision of support was broadly welcomed by the sector, including some people in receipt of care.[58] Joanne Sansome, a member of Disability Action Northern Ireland (a charity working with disabled people in Northern Ireland), told the Inquiry that the Regulation and Quality Improvement Authority "*acted as a good source of the information and advice which was not always available through published guidance*".[59]

52 INQ000475143_0065 para 245; INQ000475130_0078 para 283
53 INQ000398833_0001
54 INQ000569773_0028 para 93
55 INQ000398833_0001; INQ000475130_0078 para 283; INQ000569773_0028 para 93; INQ000475143_0065 para 245
56 Gillian Baranski 7 July 2025 156/13-15
57 INQ000398833_0001-0002
58 INQ000475143_0066 para 251; INQ000517219_0022 para 63
59 INQ000520343_0035 para 113

5.32. In Northern Ireland, however, the support came at the inevitable expense of other regulatory activities. For example, on 11 May 2020, Mr Lynch wrote to Robin Swann, Minister of Health for Northern Ireland from January 2020 to October 2022 and from February to May 2024. While noting the value of the new advisory role of the Regulation and Quality Improvement Authority, Mr Lynch raised concerns and sought assurances that, notwithstanding the repurposing of the authority, alternative measures were nonetheless in place to ensure care standards and safety in care homes.[60] Briege Donaghy, Chief Executive of the Regulation and Quality Improvement Authority from July 2021, explained that the authority's support role, combined with the ceasing of routine regulatory activity, fundamentally altered its routine regulatory purpose.[61] She observed that it is possible for the authority both to support and inspect, and that this "*shouldn't be at the expense of inspections*".[62] The provision of support should not impede oversight or safeguarding functions where capacity and safety allow. Had there been adequate emergency plans in place, the regulators might have been better able to provide effective support and regulatory oversight and safeguarding.

5.33. Common to each regulator was the introduction of supportive check-in calls and additional contact with providers of adult social care. From 30 March 2020, Care Inspectorate Wales instituted weekly (fortnightly from 22 April 2020) check-in calls.[63] The Care Inspectorate in Scotland increased contact to weekly or sometimes daily calls, depending on individual risk and support needs.[64] In Northern Ireland, the Regulation and Quality Improvement Authority's Service Support Team provided support and guidance to providers both by making proactive contact and in response to providers contacting them.[65] Later, on 4 May 2020, the Care Quality Commission introduced the Emergency Support Framework in England. Calls under the framework were similarly intended to be supportive conversations between the registered manager and the inspector and used to inform ongoing assessment of the provider and next steps, including whether to inspect.[66]

5.34. Although this contact was intended initially primarily to be supportive, as the pandemic progressed, the calls took on more of an oversight and regulatory function. For example, in August 2020, the Care Inspectorate Wales calls were replaced by monthly "*monitoring calls*", which were described as more closely resembling regulatory activity.[67] The Care Inspectorate in Scotland used the calls to carry out scrutiny checks and progressed to the use of 'Near-Me' video consultation, which enabled observation and examination of the care home's environments,

60 INQ000250249_0001
61 INQ000475143_0084 para 302
62 Briege Donaghy 7 July 2025 118/10-12
63 INQ000569773_0028 paras 93, 95
64 *The Care Inspectorate's Role: Purpose and Learning During the Covid-19 Pandemic*, Care Inspectorate, no date, pp4-5 (INQ000320177); INQ000475130_0068-0069 paras 239-240
65 *The Impact of COVID-19 on Care Homes in Northern Ireland February 2020 to July 2020*, Regulation and Quality Improvement Authority, October 2020, pp14-15 (https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/additional-papers/rqia---the-impact-of-covid-19-on-care-homes-in-ni-feb-oct-2020.pdf; INQ000256550)
66 INQ000584245_0087, 0093, 0097 paras 264, 279-280, 288
67 Gillian Baranski 7 July 2025 162/2-22

systems and practices.[68] From June 2021, the Care Quality Commission instituted Direct Monitoring Activity calls in England, a form of assessment accompanying an expansion of its monitoring approach "*to build capacity to inspect where higher risk* [was] *identified*".[69]

5.35. Some care providers reported finding these calls to be of minimal use. Julie Parkinson, manager of a domiciliary care agency, said that she received one call from her Care Quality Commission inspector, which she considered "*to be neither helpful nor supportive*", with no "*tangible support*" or acknowledgement of things done well.[70] Helen Hough, former care home owner and member of Covid-19 Bereaved Families for Justice Cymru, told the Inquiry that, although she had weekly calls, Care Inspectorate Wales "*did little to assist*".[71]

5.36. Other care providers found the calls to be more useful. The Regulation and Quality Improvement Authority, in its *Lessons Learned Report*, highlighted that regular check-in telephone calls were among the strengths of its pandemic response in Northern Ireland.[72] Some providers of care considered that the Services Support Team in Northern Ireland provided "*valuable assistance*".[73] Members of the Homecare Association reported a high level of support for domiciliary care from the Regulation and Quality Improvement Authority.[74] The Care Quality Commission and Care Inspectorate Wales also received positive feedback.[75]

5.37. Kevin Mitchell, Executive Director of Assurance and Improvement at the Care Inspectorate in Scotland from August 2015, explained that the contacts and calls:

> "*would never do all that an inspection would do, but they certainly, I think, were as much as we could do in the circumstances … they would never replace an inspection*".[76]

This was echoed by the Care Quality Commission. Ms Cridge told the Inquiry that, while the calls under the Emergency Support Framework provided some insight, this was not comparable to the understanding gained from an inspection.[77] The use of calls was one of the only realistic alternatives available to the regulators once routine inspections were suspended.

68 INQ000475130_0068-0069 para 242; see also Kevin Mitchell 8 July 2025 45/12-46/19
69 INQ000584245_0104-0105 paras 317-324
70 INQ000614375_0016 para 62
71 INQ000587639_0013 para 62
72 *RQIA and Covid-19: Lessons Learned Report – Summary and Action Plan*, Regulation and Quality Improvement Authority, no date (INQ000256645)
73 INQ000475143_0066 para 251
74 INQ000587670_0046 para 169
75 INQ000235513_0008; INQ000525060_0002-0003; INQ000517219_0022 para 63
76 Kevin Mitchell 8 July 2025 46/25-47/7
77 Mary Cridge 7 July 2025 22/12-23/5

A risk-based approach to inspections

5.38. After the initial decision to suspend in-person routine inspections, all four regulators moved to systems for identifying and prioritising higher-risk services and harm, with in-person inspections where considered necessary. These processes developed and were refined throughout the pandemic, as more comprehensive and enhanced forms of risk assessment were introduced.[78]

5.39. In England, alongside the Emergency Support Framework model, the Care Quality Commission initially introduced a 'decision to assess process' for cases concerning harm, abuse, or human rights breaches, which could bypass the framework in cases of "*extreme risk*".[79] This process was used until July 2020, when it was replaced by the Care Quality Commission with a set of 'Principles and Triggers' for entering a care home during lockdown easing. One principle was the increased use of on-site assessments and inspections as the prevalence of Covid-19 decreased. The Care Quality Commission subsequently introduced a number of different approaches designed to improve the way it monitored care homes, as well as a more comprehensive form of risk assessment with improved modelling.[80]

5.40. In Scotland, from early March to 19 June 2020, the Care Inspectorate required care services to notify it of potential and confirmed cases of Covid-19 and of staffing levels, to enable oversight and the deployment of support and resources.[81] From mid-April 2020, it also developed an enhanced system of assurance assessment and a framework so that, by 1 May 2020, an initial assessment of each care home in Scotland had taken place.[82] In order to reduce the risk of transmission, inspection visits were only permitted "*where absolutely necessary, and on a risk assessed basis*".[83] Further tools were developed, along with enhanced monitoring procedures for homes experiencing an outbreak.[84] The requirement to seek agreement from the directors of public health caused conflict on occasion between them and the Care Inspectorate, initially prevented an inspection of a care home considered to be in "*a critical position*", and resulted in the need for significant negotiations and discussion in urgent situations.[85]

5.41. From May 2020, Care Inspectorate Wales introduced a system to enable inspectors to look at care settings with Covid-19 outbreaks and identify higher-risk services that might need increased monitoring and an inspection.[86] Care Inspectorate Wales also

78 INQ000584245_0095, 0101, 0103-0104 paras 283-284, 302-304, 313, 317; INQ000320168_0001; INQ000475130_0044, 0072 paras 143, 259; INQ000569773_0029-0030 paras 98-100; 'Providing assurance on the quality and safety of services during the COVID-19 pandemic', statement, Care Inspectorate Wales, May 2020 (INQ000501663); INQ000475143_0037-0038 para 129
79 INQ000584245_0095 paras 283-284
80 INQ000584245_0094-0096, 0101, 0103-0104 paras 281, 285, 302-304, 313, 317
81 INQ000475130_0069-0070 paras 248, 251; *The Care Inspectorate's Role: Purpose and Learning During the Covid-19 Pandemic*, Care Inspectorate, no date, pp4-5 (INQ000320177)
82 INQ000320168_0001
83 INQ000320168_0001
84 INQ000475130_0044, 0072 paras 143, 259
85 INQ000475130_0096-0098 paras 338-342; Kevin Mitchell 8 July 2025 52/9-53/3
86 INQ000569773_0029 para 98

published guidance on its approach to independent scrutiny and assurance.[87] In the event that it was not satisfied with the provider's response and actions, the provider was referred to a Securing Improvement and Enforcement Panel for consideration of subsequent action.[88]

5.42. In Northern Ireland, in August 2020, the Regulation and Quality Improvement Authority introduced a risk assessment tool to guide decision-making on inspection type. Factors such as a significant outbreak of infection, a decrease in available workforce and any information received indicating poor IPC practices were all matters that may have led to on-site inspections being undertaken.[89]

5.43. The changes to the routine inspection regime caused concern and confusion about whether all in-person inspections had been stopped during the pandemic and over the role to be played by the regulators.[90] It is vital for public confidence that changes to inspection activity during a future pandemic are clearly communicated to the public, and that the rationale is clearly explained.

Infection prevention and control inspections

5.44. The central importance of IPC was reflected in the number of concerns raised with regulators in the first few months of the pandemic.[91] This included, for example, concerns about staff working while unwell, staff movement, poor infection control practices, social distancing and isolation practices, and access to and use of PPE.[92]

5.45. In May 2020, the Scottish Government announced arrangements for multi-disciplinary teams to scrutinise and support care homes. This included IPC measures and provided for joint Care Inspectorate and Healthcare Improvement Scotland inspections.[93] Jeane Freeman (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021) told the Inquiry that the role of the Care Inspectorate changed, with a focus on inspections to support IPC.[94] Care homes were potentially subject to multiple inspections by different agencies – for example, from the Care Inspectorate and, separately, an NHS-established inspection team.[95] One Scottish care home manager reported experiencing suicidal feelings, owing to the pressures on them that increased following such a visit.[96] Scottish Care told the

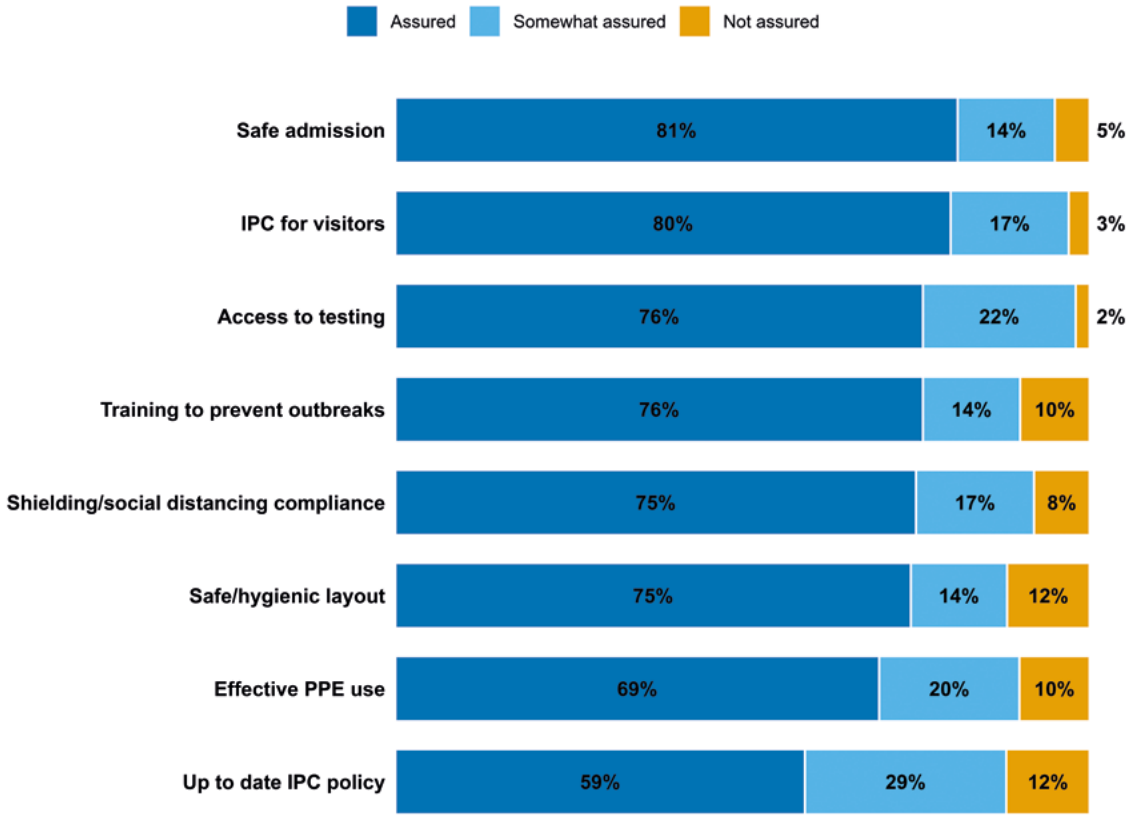
87 INQ000501663
88 INQ000569773_0030 para 100
89 INQ000475143_0037-0038 para 129
90 See, for example, INQ000520523_0006
91 See, for example, INQ000584245_0150 para 470
92 INQ000398754_0001; 'Regulating during COVID-19 – why raising concerns about care is more important than ever', Care Quality Commission, 17 June 2020 (https://www.cqc.org.uk/news/stories/regulating-during-covid-19-why-raising-concerns-about-care-more-important-ever; INQ000398848_0002); INQ000438186_0005
93 'Coronavirus (COVID 19): Enhanced professional clinical and care oversight of care homes', Scottish Government, 17 May 2020, p2 (INQ000320169)
94 INQ000606530_0014 para 51
95 INQ000509530_0033 para 129
96 INQ000509530_0034 para 133

Inquiry that, as a consequence of this approach, contradictory guidance and advice was provided to care homes.[97]

5.46. In August 2020, in England, the Care Quality Commission carried out a thematic review of 300 care homes where the care home was considered to have managed well. The aim was to identify good IPC practice.[98] The thematic review found that very few care homes were not managing well and required a more in-depth inspection, and the Care Quality Commission was assured, or somewhat assured, of effective IPC in more than 90% of care homes across the areas of inspection.[99]

5.47. During the first half of August 2020, in response to concerns raised about the safety and quality of care, the Care Quality Commission also undertook 59 high-risk inspections of care homes. The commission recorded in its September 2020 report that, in a number of them, it was not fully assured of effective IPC measures (see Figure 2).

Figure 2: Percentage of care homes in England assured by IPC measures, August 2020



Source: COVID-19 Insight: Issue 4, Care Quality Commission, September 2020 (https://www.cqc.org.uk/system/files?file=20200916_covidinsight_issue04.pdf; INQ000235474_0010)

Note: Combined totals may not equal 100% due to rounding.

97 INQ000509530_0033 para 129
98 INQ000584245_0160-0161 paras 506.1, 508.1
99 *COVID-19 Insight: Issue 4*, Care Quality Commission, September 2020 (https://www.cqc.org.uk/system/files?file=20200916_covidinsight_issue04.pdf; INQ000235474_0009-0010)

5.48. Some IPC policies contained out-of-date information as they had not been updated since 2019 (or since the early stages of the pandemic), which posed a risk to the staff and residents of the care home. Some care homes lacked risk assessments for people from Black and ethnic minority groups and from others who were at higher risk; and, where there were risk assessments, these had not been actioned. In some care homes, PPE was not worn, or was worn incorrectly, and there were limited supplies of it, resulting in staff not changing their masks.[100] It is likely that similar problems were present during the earlier months of the pandemic, with the resulting risk and harm to care home residents and staff.

5.49. From September 2020, in Northern Ireland, the Regulation and Quality Improvement Authority also conducted a series of IPC-focused inspections.[101] From October 2020, in England, the Care Quality Commission adopted a new policy of automatically inspecting any care home with credible information about IPC problems, regardless of its rating.[102]

5.50. The Inquiry heard some evidence that, in Scotland, the emphasis on IPC created friction and conflict between care providers and regulators, with significant deterioration in working relationships and morale.[103] Donald Macaskill, Chief Executive of Scottish Care, attributed this to:

- the decision to establish inspections focused solely on IPC;
- new scrutiny requirements;
- the submissions by the Care Inspectorate of the inspection reports to the Scottish Parliament before they were provided to the care home; and
- the failure to engage fully with the sector when developing and implementing new criteria for IPC inspections and disseminating information about the changes.

He told the Inquiry that there was inadequate consideration of the practical challenges for care homes, such as the need for on-the-job training and the wide variations in settings, staff experience and knowledge.[104] As with the move to a support function more generally, there was a tension between the provision of support by regulators for IPC measures and their seeking to perform a regulatory oversight and enforcement role.

5.51. Mr Macaskill explained that, prior to the pandemic, the regulatory model of the Care Inspectorate in Scotland involved engagement and collaboration. However, he said that the experience of providers during the pandemic was one increasingly focused

100 *COVID-19 Insight: Issue 4*, Care Quality Commission, September 2020 (https://www.cqc.org.uk/system/files?file=20200916_covidinsight_issue04.pdf; INQ000235474_0013-0014)
101 INQ000475143_0054 para 196
102 INQ000584245_0162 para 510
103 INQ000509530_0035-0036 para 136
104 INQ000509530_0035-0036 para 136

on scrutiny, which had a negative impact on the improvement in quality seen prior to the pandemic.[105]

5.52. More broadly, it was acknowledged that many decisions and pieces of guidance were often issued without the involvement of the care sector or those using care. For example, not all decisions to cease inspections followed consultations – Care Inspectorate Wales did not consult.[106] In England, the Care Quality Commission observed that the lack of consultation made various changes for the sector difficult to understand, follow and implement. The commission acknowledged that the resulting pressure placed on the sector could not be underestimated; it considered that, without co-production of advice and guidance, there was a risk that the guidance would not be effective.[107] Consultation with stakeholders is desirable where possible.

Remote inspections

5.53. Where inspections were undertaken, each regulator sought to utilise or pilot technology to conduct them, either remotely or as part of a blended approach (a remote inspection followed by a site visit).[108]

5.54. Each regulator told the Inquiry that remote or blended inspections were no substitute for those undertaken in person. Ms Cridge underscored the value of in-person inspections and the insight that is obtained from them. She explained:

> "*There are the sights, the sounds, the smells, frankly … an opportunity to observe care being delivered, to get a sense of the place, of the atmosphere, to observe the interactions between staff and those receiving care.*"[109]

Mr Mitchell told the Inquiry that, although there were benefits to be drawn from the use of remote technology, the Care Inspectorate in Scotland concluded that inspections in Scotland should be carried out on-site to the extent possible.[110] Ms Baranski was "*not convinced*" of the utility of remote inspections in Welsh adult care homes (or domiciliary care).[111] In Northern Ireland, blended inspections were considered to be time-consuming and ineffective, with the Regulation and Quality Improvement Authority reporting that care homes found difficulties in facilitating them.[112] Consequently, blended inspections were phased out.[113]

105 INQ000509530_0036 para 137
106 INQ000569773_0025-0026 para 86
107 INQ000587795_0014-0015 paras 48, 50
108 INQ000569773_0033 para 109; INQ000475143_0038 para 131; Kevin Mitchell 8 July 2025 33/2-12, 34/6-12; Mary Cridge 7 July 2025 110/1-24
109 Mary Cridge 7 July 2025 6/18-23
110 Kevin Mitchell 8 July 2025 33/2-12, 34/10-12
111 Gillian Baranski 7 July 2025 169/25-170/13; INQ000569773_0034 para 113
112 Briege Donaghy 7 July 2025 110/18-19
113 INQ000475143_0038-0039 para 132

5.55. There were also significant challenges with the use of technology in adult social care and in care homes. For some people receiving care, however, the use of remote inspections may have conferred additional benefits over and above in-person inspections. Ms Sansome explained that, when inspectors met with residents in the doorways of their rooms, this afforded little privacy, and staff and residents were unable to provide confidential feedback. In her view, the use of remote technology would have been more effective as it would have enabled residents to speak freely from inside their own rooms.[114] However, some residents may not have been able to use the technology at all or may have required assistance from staff.

5.56. When inspections of domiciliary care services were carried out, the sufficiency and utility of inspections remained ambiguous. For example, in Northern Ireland, the Regulation and Quality Improvement Authority's inspections of domiciliary care providers were limited to the operating office of the provider.[115] In England, the Care Quality Commission similarly piloted remote inspections of domiciliary care agency offices.[116]

5.57. In-person inspections should be prioritised and facilitated wherever possible. However, in a future public health emergency, the risks of harm arising from in-person inspections may be so great that remote inspections are the only alternative option. It is imperative that regulators are able to hear from residents, staff and care providers first-hand, undiluted and unmoderated. There is a need, therefore, to embed the use of technology across the adult social care sector, to the extent possible, to develop a level of familiarity and skill.

Testing and inspections

5.58. The Inquiry heard some evidence about limited Covid-19 testing eligibility for inspectors. Testing was unavailable to Care Inspectorate Wales until June 2020. At that point, inspectors were advised to request a test either through the UK government website or their local health board.[117] In England, throughout 2020, staff at the Care Quality Commission only had access to the same type and level of testing available for members of the public. For example, on 14 August 2020, it was announced that Care Quality Commission inspectors did not meet the criteria for weekly asymptomatic testing. Concerns were raised, not least with regard to their potential to "*become 'super spreaders' as they* [were] *likely to be visiting more than one home in a day*".[118] Significant engagement with the Department of Health and Social Care followed before access to regular asymptomatic testing was introduced, when weekly polymerase chain reaction (PCR) testing became available in December 2020.[119] In Scotland, it was not until 11 January 2021 that there was a

114 INQ000520343_0013 para 42
115 INQ000475143_0038-39 para 132
116 Mary Cridge 7 July 2025 36/3-18, 44/1-7
117 INQ000569773_0031 para 105
118 INQ000525624_0001-0002
119 INQ000587795_0008-0011 paras 23, 25-26, 34

requirement for all inspectors to test negative prior to entering care homes for older people.[120]

5.59. Testing during a pandemic is an essential tool in enabling inspections and, in turn, ensuring the safeguarding of those in receipt of care. Where testing capacity is sufficient and inspections are possible, consideration should be given to the prioritisation of inspectors conducting in-person inspections. Similar considerations apply to inspectors regarding designation as key workers and prioritisation for PPE and vaccinations. Without access to testing and PPE, the risk of transmitting an infectious disease cannot be mitigated or removed. The UK government, devolved administrations and regulators will need to consider and make choices about balancing the relative risks and resources. Advance pre-pandemic planning is essential.

Post-pandemic inspection activity

5.60. The suspension of routine inspections saw a dramatic drop in the number of inspections across the UK, but each regulator subsequently resumed its inspection activity in accordance with its regulatory approach.

5.61. Inspection numbers in England and Northern Ireland remained significantly below pre-pandemic volumes, attributed in part to a lasting shift towards risk-based regulatory models, along with a backlog of regulatory activity (see Table 5).[121] In Northern Ireland, the requirement of twice-annual inspections was not met, although the regulatory requirement was not changed. The Regulation and Quality Improvement Authority told the Inquiry that this was in part because the pandemic acted as a catalyst towards the adoption of a risk-based approach.[122] The data indicate that Wales and Scotland eventually returned to, or surpassed, pre-pandemic numbers of inspection. These totals, however, often included repeat visits to the same services – sometimes up to four times – to ensure that improvements had been made.[123]

120 INQ000475130_0113 para 411
121 INQ000475143_0034 para 117; INQ000584245_0073 para 215
122 INQ000475143_0034 para 117
123 Kevin Mitchell 8 July 2025 55/6-23; INQ000569773_0042 Table 6

Table 5: The number of inspections in the four nations of the UK, 2019 to 2021

Nation	Prior to the pandemic (2019/20)	Pandemic low (2020/21)	Post-pandemic
England (Care Quality Commission)[a]	8,155 (2019)	4,793 (2020)	Did not return to pre-pandemic levels (3,296 in 2023)
Scotland (Care Inspectorate)[b]	1,129	603	Returned to pre-pandemic levels (1,151) in 2022/23 (including a number of repeat inspections)
Northern Ireland (Regulation and Quality Improvement Authority)[c]	1,408	860	Did not return to pre-pandemic levels (1,099 in 2024)
Wales (Care Inspectorate Wales)[d] Note: a small number of these may have been inspections of children's homes)	1,052	308	Surpassed pre-pandemic levels by 2022/23 (1,203) (including a number of repeat inspections)

Sources: (a) INQ000584245_0073 para 215; (b) INQ000475130_0206 Table 6; (c) INQ000475143_0034 Table 7; (d) INQ000569773_0041 Table 5

Enforcement

5.62. As with registration, there was a 'light touch' approach to enforcement. For example, on 12 March 2020, Ian Trenholm (Chief Executive of the Care Quality Commission in England from 2018 to 2024) wrote to Matt Hancock (Secretary of State for Health and Social Care from July 2018 to June 2021), setting out the commission's approach to enforcement. Mr Trenholm explained that the Care Quality Commission did not anticipate undertaking significant enforcement action during the pandemic. He confirmed that the commission would, however, act to keep people safe if intelligence indicated serious harm or abuse.[124]

5.63. Across England, Wales and Northern Ireland, each regulator consequently decreased its level of enforcement action during 2020. The number of regulatory actions undertaken by the Care Quality Commission in England reduced by just under 60%, from 7,522 in 2019 to 3,298 in 2020.[125] Similarly, the number of quality improvement plans issued by the Regulation and Quality Improvement Authority in Northern Ireland and priority action notices issued by Care Inspectorate Wales saw notable decreases in the year ending 31 March 2021.[126] These decreases were most likely a result of the different approach to enforcement, competing priorities and the general reduction in regulatory activity, particularly inspections.

124 INQ000525082_0002
125 INQ000567487
126 INQ000475143_0046-0047 Table 8; INQ000569773_0046-0047 Table 11

5.64. By contrast, in Scotland, enforcement notices significantly increased in the years ending March 2021 and March 2022, before decreasing in the years ending March 2023 and March 2024.[127] The causes of this are not clear but may, in part, be a consequence of new procedures adopted by the Care Inspectorate immediately prior to the pandemic, following a review of enforcement activity. Although rollout of the revised procedures was put on hold as a consequence of the need to train staff and the impact of Covid-19, the Care Inspectorate was able to use the period during the pandemic to 'test' them.[128]

5.65. Enforcement is a powerful tool in the regulatory framework, central to both the protection of those receiving regulated adult social care and the promotion of improvements in the quality of care. The Inquiry heard limited evidence of the extent to which enforcement powers were utilised by each regulator or affected by the pandemic. It is, therefore, unclear whether problems were identified but not subject to enforcement actions, and whether the lack of enforcement affected safety and the risk of harm.

Prioritisation of care homes

5.66. The vulnerability of care home residents to serious illness or death as a consequence of Covid-19 infection, and the fact that care homes were considered to be high-risk environments for the spread of infection – together with the potential for undetected harm – meant that care homes were, in some instances, prioritised. This was to the detriment of domiciliary care, where there were fewer inspections and less support offered.[129]

5.67. Dr Jane Townson, Chief Executive of the Homecare Association from May 2019, said she considered that domiciliary care was neglected in the focus on other services.[130] The Care Quality Commission was described by one provider as being "*completely AWOL* [absent without leave] *and provided absolutely no help or advice*" to domiciliary care providers.[131] By June 2024, 60% of domiciliary care services in England either had never been assessed by the Care Quality Commission or had a rating that was between four and eight years old.[132] Dr Townson thought that, as at May 2025, there remained outstanding safeguarding issues that had not been investigated.[133] Ms Cridge accepted that the commission could have done more for domiciliary care providers.[134]

127 INQ000475130_0207 Table 9
128 INQ000475130_0047 paras 153-154
129 Kevin Mitchell 8 July 2025 79/1-81/3; INQ000475130_0155 para 577. For example, of 657 inspections between April 2020 and March 2021 by the Care Inspectorate in Scotland, only 44 were of domiciliary care providers; Mary Cridge 7 July 2025 43/21-44/2; INQ000587670_0036 para 120
130 INQ000587670_0046, 0110 paras 168, 170, 464
131 *Care Quality Commission: Regulatory Performance in Homecare*, Homecare Association, August 2024, p24 (INQ000571057)
132 *Care Quality Commission: Regulatory Performance in Homecare*, Homecare Association, August 2024, p4 (INQ000571057)
133 INQ000587670_0113 para 474
134 Mary Cridge 7 July 2025 43/21-44/2

5.68. It is crucial to ensure that domiciliary care is not neglected and that planning incorporates robust measures to be established by each regulator to ensure support, standards of care and safety for people in receipt of care in their own home, wherever circumstances allow.

Risk of harm

5.69. There were significant concerns across the adult social care sector that the decision to reduce regulatory activity, and, in particular, limit routine and in-person inspections, undermined effective safeguarding and oversight.[135]

5.70. In April 2020, the Association of Directors of Adult Social Services expressed alarm that inspections could be stopped at the point when, in its view, monitoring was more important than ever. It pointed to the need to consider the rise in infections, deaths, staffing shortages, and increases in the abuse of older and disabled people.[136]

5.71. Professor Vic Rayner, Chief Executive Officer of the National Care Forum from 2016, considered that the move to a risk-based model resulted in oversight being withdrawn from adult social care services throughout the pandemic.[137] This was a view shared more widely by organisations including Care Rights UK, John's Campaign and the Patients Association, who felt that the Care Quality Commission "*abdicated responsibility*".[138] They considered that instead of a proper balance being struck, "*those needing care were abandoned in the name of infection control*".[139]

5.72. The absence of routine regulatory inspections was compounded by the suspension of in-person visits from family, loved ones, and health and other care workers, which would otherwise also play an additional supervisory and oversight role. Unsurprisingly, there was a significant reduction in safeguarding referrals – particularly in the initial period when routine regulatory inspections were paused and lockdown restrictions were at their most severe.[140]

Foreseeability

5.73. The Inquiry heard that, as restrictions eased, there was a recognised likelihood of an increase in safeguarding concerns and identification of harm that had previously gone unseen. The UK government, for example, was aware that Hourglass, a charity that runs a helpline for older people who are victims of abuse, had experienced a rise in calls of at least 30% during the first lockdown. This included a sharp rise

135 Joanna Killian 28 July 2025 32/18-33/4
136 INQ000103761_0004
137 INQ000475131_0032 para 6.1(a)
138 INQ000514104_0097 para 250;
139 INQ000514104_0097 para 250; see also INQ000587670_0110 para 464
140 *Themes and Learning from ADASS Members on the Local Response to COVID-19 in Spring and Early Summer 2020*, Association of Directors of Adult Social Services, 1 October 2020, p11, para 52 (INQ000103777)

in reports of neglect, particularly in care homes.[141] The Department of Health and Social Care was concerned about an increase in safeguarding referrals as lockdown restrictions began to ease and professionals recommenced contact.[142] Similar concerns were expressed by the Local Government Association, the Association of Directors of Adult Social Services and the National Independent Safeguarding Board Wales (which provides support to and advises safeguarding boards, reports on safeguarding arrangements and makes recommendations to ministers of the Welsh Government).[143]

5.74. Regulators also envisaged increases in safeguarding concerns. On 1 July 2020, the Care Quality Commission told Helen Whately MP, Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021, that a "*spike*" in cases involving safeguarding issues was likely, as services that had been unable to cope were identified. While Ms Whately agreed with the decision to cease routine inspections, she "*did not agree that this was done at the risk of neglect/abuse to residents*".[144]

5.75. Ms Whately told the Inquiry that she received no sense of the scale of the problem or of how many safeguarding concerns were likely to be uncovered – it was a "*black box or hole*".[145] She knew that there was a risk of neglect, but this was the first time she had been formally told of it happening.[146] Ms Whately was also informed of one care home that had been closed as a result of a lack of safety and basic failures.[147]

5.76. Subsequent analysis by the Local Government Association recorded that reported safeguarding concerns in England dropped markedly during the initial months of the pandemic, and below those of the comparable period in 2019, before returning to – and then exceeding – normal levels in July 2020. The pattern of decreases in safeguarding concerns during periods of restrictions, and increases when restrictions were relaxed, was replicated across the various waves of the pandemic in England.[148] The Local Government Association recorded concerns that safeguarding issues were not being identified and were under-reported.[149] It noted that the nature and type of safeguarding enquiries broadly remained the same, with the most prevalent relating to neglect. There was, however, a notable variance between domiciliary care and that in care homes. Enquiries related to risk in an individual's own home had "*increased markedly*", while those in care homes had decreased.[150]

141 INQ000327917_0003
142 INQ000327917_0002
143 *COVID-19 and Safeguarding Adults: Frequently Asked Questions*, Local Government Association, p3, Question 3 (https://www.local.gov.uk/sites/default/files/documents/COVID-19%20safeguarding%20adults%20FAQs%20final.pdf; INQ000581228); INQ000299648_0005; INQ000571608_0038-0039 para 10.9; https://safeguardingboard.wales/about-the-board
144 INQ000609960_0001-0003
145 Helen Whately 17 July 2025 111/3-15, 113/10-114/18; INQ000609960_0002; INQ000524915_0002
146 Helen Whately 17 July 2025 117/24-119/01
147 INQ000609960_0002
148 *COVID-19 Adult Safeguarding Insight Project – Third Report (December 2021)*, Local Government Association, 2 October 2021, pp14-15 (https://www.local.gov.uk/publications/covid-19-adult-safeguarding-insight-project-third-report-december-2021; INQ000509872)
149 INQ000587382_0158 para 574
150 *COVID-19 Adult Safeguarding Insight Project: Findings and Discussion*, Local Government Association, December 2020, p8 (https://www.local.gov.uk/sites/default/files/documents/25.177_Insight%20Project_layout_FINAL%20WEB.pdf; INQ000115383)

5.77. The suspension and subsequent limiting of in-person inspections is likely to have contributed to both the under-reporting and under-identification of safeguarding issues. The pattern of reporting of safeguarding concerns, alongside the comparative differences from the years preceding the pandemic, also provides some evidence for there having been delays in the recognition and identification of safeguarding issues.[151] Delays may have resulted in more severe consequences for those receiving care.[152]

5.78. A particular concern was an increase in 'closed cultures', defined by the Care Quality Commission as poor cultures that can lead to harm (including human rights breaches) such as abuse.[153] Evaluations of the commission's Emergency Support Framework as well as later risk assessment frameworks identified concerns about their effectiveness. In particular, they identified concerns with the utility of remote monitoring methods in identifying closed cultures, along with the ability of closed cultures to develop in those circumstances.[154] The commission's evaluation of its Closed Cultures Project described the pandemic as creating a "*hotbed*" in which closed cultures could develop and thrive.[155] Approximately 19% of a sample analysis of Care Quality Commission inspections up until 14 July 2020 raised closed cultures as an issue.[156]

5.79. The risk of significant harm (to residents in care homes and people using adult social care) going unchecked in the absence of the normal regulatory safeguards – combined with the lack of external oversight from other organisations, visitors and loved ones – was subsequently borne out when inspections resumed and the number of inspections increased.

Harm and concerns

5.80. The Care Quality Commission completed 17 in-person inspections in England between 17 March and 17 June 2020. It conducted a further 51 inspections in adult social care services by 14 July 2020.[157] Upon a sample analysis, the most common initial reason for inspection was where there were safeguarding concerns (39.47%). The most common theme to emerge was "*lack of oversight/poor governance*", with impacts on safety, service delivery and IPC practice.[158] The most commonly

151 *COVID-19 Adult Safeguarding Insight Project: Findings and Discussion*, Local Government Association, December 2020, p10 (https://www.local.gov.uk/sites/default/files/documents/25.177_Insight%20Project_layout_FINAL%20WEB.pdf; INQ000115383)
152 *COVID-19 Adult Safeguarding Insight Project – Third Report (December 2021)*, Local Government Association, 2 October 2021, p2 (https://www.local.gov.uk/publications/covid-19-adult-safeguarding-insight-project-third-report-december-2021; INQ000509872)
153 INQ000584245_0114 para 354
154 *Evaluation of CQC's Closed Cultures Project*, Care Quality Commission Research and Evaluation Team, November 2021, pp18-19, 30, paras 1.6.5, 1.7 (INQ000524976)
155 *Evaluation of CQC's Closed Cultures Project*, Care Quality Commission Research and Evaluation Team, November 2021, p30, para 1.7 (INQ000524976)
156 INQ000235513_0005; see also *COVID-19 Insight: Issue 12*, Care Quality Commission, July 2021, pp21-23 (https://www.cqc.org.uk/system/files?file=20210721%20COVID%20IV%20Insight%20issue%2012%20slides.pdf; INQ000235481)
157 'Regulating during COVID-19 – why raising concerns about care is more important than ever', Care Quality Commission, 17 June 2020, p2 (https://www.cqc.org.uk/news/stories/regulating-during-covid-19-why-raising-concerns-about-care-more-important-ever; INQ000398848); INQ000584245_0099 para 296
158 INQ000584245_0099 para 296

breached regulations related to safe care and treatment, and good governance.[159] That included identifying cases of "*extremely poor and unsafe care, with people's most basic needs not being met*", poor management of medication, and unsafe assessment and support.[160] Numbers of inspections increased dramatically from August 2020 onwards, but these were still considerably below pre-pandemic levels.[161]

5.81. In Scotland, on-site inspections resumed on 4 May 2020 as a result of serious concerns arising with regard to one specific care home. The same care home was subsequently reinspected on 12 and 13 May 2020. The concerns related to the lack of use of PPE, incorrect advice regarding the use of such equipment, hygiene, contaminated food, and management and leadership oversight. Enforcement action was subsequently taken, and in due course the care home was sold and registration transferred to NHS Scotland. Legal proceedings were then concluded by the Care Inspectorate.[162] On 14 May, plans were finalised to inspect a further six care homes over the weekend of 15 to 17 May 2020, again as a consequence of significant concerns being raised. Of the six homes, those concerns were confirmed in one. The identified issues related to IPC practice, general cleanliness and hygiene, fluids and risk of dehydration, and leadership. In the remaining five homes, no major concerns were identified, with some noted as providing good or excellent practices.[163]

5.82. Despite the number of inspections significantly reducing throughout the pandemic, the number of priority action notices issued by Care Inspectorate Wales in response to non-compliance with regulations saw a significant increase, indicating potentially unsafe practices and the pressures on care homes.[164]

5.83. Grave harm was uncovered in one particular care home in England. In June 2019, the care home was rated as 'requiring improvement', and it was found to have breached regulations relating to safe care and treatment and good governance. This resulted in conditions being placed on its registration.[165] When inspected in May 2020, 10 residents were removed due to medical concerns and 5 residents were admitted to hospital. A further 14 residents were identified as being dehydrated, of which 8 required hospital treatment, with the other residents receiving rehydration treatment in another care home.[166] All remaining residents were moved to alternative care providers. The following was documented:

159 INQ000584245_0099 para 296
160 *COVID-19 Insight: Issue 3*, Care Quality Commission, July 2020 (https://www.cqc.org.uk/sites/default/files/20200715%20COVID%20IV%20Insight%20number%203%20slides%20final.pdf; INQ000518408_0012)
161 INQ000584245_0073, 0085-0086 paras 215, 260
162 INQ000475130_0132-0133 paras 494-502
163 INQ000475130_0138 para 516; INQ000536495_0001-0002
164 *Chief Inspector's Annual Report 2021–22*, Care Inspectorate Wales, p25 (https://www.careinspectorate.wales/sites/default/files/2022-10/221020-annual-Report-2021-22-EN.pdf; INQ000509652); INQ000569773_0041 Table 5
165 *Amicura Limited – Temple Court Care Home: Inspection Report*, Care Quality Commission, 28 October 2020, pp3, 16 (https://api.cqc.org.uk/public/v1/reports/e4b894ef-9afd-48b8-8db5-be42edda82c3?20201029130000; INQ000660191)
166 INQ000235513_0010

"• *One person being found unresponsive and requiring IV fluids*

- *One person found with multiple bruises, faulty bed, pad and bed sheets soaked and drank 600ml of fluids as soon as they were offered*
- *One person found in soaking wet bed with skin damage due to urine burns and necrotic foot and required intravenous antibiotics.*
- *One person found in a bed with severe pressure sores on feet that had been caused by the bed being too small for him*
- *One person described* [as receiving] *end of life care, denied food and fluids, who is now flourishing in new environment*
- *One person found on dining room floor with dried blood on their head*"[167]

More general concerns included missed appointments for fast-track cancer care, infected wounds requiring treatment, severe malnourishment requiring urgent medical intervention, and a lack of knowledge of care and health needs. There were multiple incidents of uninvestigated and unexplained bruising. People had lost mobility as a consequence of being confined to their beds and were left in wet beds. The Care Quality Commission found there to have been a "*complete lack of person centred care and dignity*".[168]

5.84. Separately, there were reports of relatives and loved ones reporting cases of neglect and abuse, including bruises, unclean clothing, incontinence issues, dehydration and sexual assault. Pressure sores and acute infections were also discovered during visits.[169] In Northern Ireland, in January 2021, the Patient and Client Council (an independent public body representing the interests of the public in health and social care services) received a report of deterioration in a non-verbal woman's physical and mental state, which resulted in hospitalisation being attributed to neglect.[170]

5.85. The Care Inspectorate in Scotland found that, in one care home, staff had failed to recognise the need for end-of-life care and, consequently, residents had not received necessary end-of-life anticipatory medications to ease pain and suffering.[171]

5.86. The Relatives and Residents Association (now Care Rights UK) recorded callers to its helpline reporting finding faeces over a care home resident's bedding and the walls, and faeces on a resident's toothbrush. There was a further report of a care home

167 INQ000235513_0010
168 INQ000235513_0009-0010
169 INQ000587611_0012, 0018-0019 paras 54, 84-87, 90-92
170 INQ000256397
171 INQ000475130_0173 para 638; *Thornlea Nursing Home, Care Home Service: Inspection Report*, Care Inspectorate, 14 December 2020, pp2-4 (INQ000520597)

resident having lost teeth, which had gone undetected.[172] Families were recorded as feeling powerless in protecting their loved ones.[173]

Regulatory activity in future public health emergencies

5.87. While the initial suspension of on-site and routine inspections was a reasonable response, it was fraught with difficulties. The introduction of supportive calls – and the subsequent evidence that these could not be, and were not, the same as inspection – highlighted a critical gap in assurance during a period of extreme pressure. Regulatory authorities adapted existing models and created new approaches to assessing risk, but much of this work came weeks or months after the initial decisions to suspend routine inspections were taken. It involved substantial work at a time when the adult social care system was under immense pressure. The time for doing this work was before the pandemic. Better planning is required.

5.88. During the initial months of the Covid-19 pandemic, the lack of adequate oversight meant external checks on care homes and domiciliary care providers were reduced – heightening the risk to users of care. The extent of the risk of harm to users of care (and staff) and of actual harm that went undetected is difficult to ascertain. However, it is clear that harm resulted, and the risk of harm in a future public health emergency is real. While some aspects of regulatory activity may necessarily be scaled back, safeguarding activity must be prioritised.

5.89. It was recognised that regulatory activity and inspection were critical – especially in the event of a public health emergency – and should be continued where possible.[174] The Care Quality Commission observed that, in England, in-person inspections were integral and should be protected.[175] The Regulation and Quality Improvement Authority in Northern Ireland stressed that, during a crisis, regulatory activity was more important, not less.[176]

5.90. There is no substantive alternative to on-site inspections, which provide "*a rich tapestry of information* [and are] *certainly not a box-ticking exercise*".[177] Intelligence and ongoing close contact can, however, play an important role in being able to respond flexibly where circumstances do not allow for on-site inspections.[178] Ms Donaghy suggested that:

> "[R]*ather than an abrupt end to inspection,* [the regulators] *should leverage up the intelligence-based approach, reducing the scheduled* [inspections]*, so that there's a portfolio of inspection approaches available.*"[179]

172 INQ000273439_0002-0003
173 INQ000587611_0012 para 54
174 Kevin Mitchell 8 July 2025 57/12-15
175 INQ000587795_0013-0014 paras 41, 44.2
176 INQ000475143_0082 para 294
177 Mary Cridge 7 July 2025 7/15-16
178 Mary Cridge 7 July 2025 27/25-28/2, 33/9-11
179 Briege Donaghy 7 July 2025 109/19-22

5.91. The Care Quality Commission was similarly clear that intelligence – from people in receipt of care, their loved ones, the staff and care providers – is invaluable.[180] However, where care homes or services are effectively closed, intelligence-gathering – as seen in the decrease in safeguarding reports during periods of greater restrictions – falls away.

5.92. The benefits of on-site inspection do nonetheless need to be balanced against the potential risks that inspections might pose. There may be situations where on-site inspections cannot be safely undertaken, due to the risks to the people using care, staff and inspectors simply being too great.[181]

5.93. The Inquiry therefore recommends that regulators take steps to ensure that they have practical and adaptable plans and protocols to maintain regulatory oversight and to enable inspections – in some form – to continue to take place in future pandemics. These protocols should be guided by the following core principles:

- individual risk assessments to determine whether on-site inspections are safe and proportionate, considering the geographical area and care setting in question;
- regulators to work closely with individual providers to find, wherever possible, bespoke solutions that enable inspections to take place;
- the identification of clear channels of communication between care providers and regulators that can be maintained at all times during a future pandemic; and
- the involvement of care providers, staff, people who use care services, their families and loved ones in developing the protocols.

Recommendation 5: Maintaining regulatory oversight of care quality and safety in a public health emergency

The Care Quality Commission in England, Care Inspectorate Wales, the Care Inspectorate in Scotland and the Regulation and Quality Improvement Authority in Northern Ireland should each develop adaptable protocols for carrying out on-site, hybrid and remote inspections in a future public health emergency.

These protocols should be guided by the core principle of continuing on-site inspections where possible. They should also clearly identify processes to minimise:

- the risk of transmission when on-site inspections are carried out; and
- the risk of safeguarding issues going unidentified where remote or hybrid inspections are carried out.

Regulators should regularly review these protocols to ensure that they remain practical and effective.

180 Mary Cridge 7 July 2025 16/16-22
181 Kevin Mitchell 8 July 2025 57/12-15; INQ000587795_0013 para 42

Chapter 6: The impact on unpaid carers, care workers and care providers

Introduction

6.1. The impact of the Covid-19 pandemic on people working in adult social care cannot be overstated. Millions of unpaid carers and care workers showed extraordinary dedication and compassion as they worked tirelessly caring for people who were very unwell or dying, often with limited resources or support. Without the support and care of family and friends during the pandemic, health and social care services could have been quickly overwhelmed.[1] One care worker told the National Association of Care and Support Workers in a survey: "*We did what was needed to be done. If care workers had withdrawn … the most vulnerable people would not have survived. We did not have a choice.*"[2]

6.2. For many care workers in England, Scotland and Wales, this came at a considerable risk to their own health and lives. The data suggest that they had a significantly higher risk of dying from Covid-19 than the general population or people in other occupations.[3]

6.3. The Covid-19 pandemic also created a multitude of challenges for the thousands of social care providers (the organisations that deliver social care). Many needed emergency funding due to increasing costs, and support with workforce shortages that jeopardised their existence and ability to deliver care.

6.4. This chapter considers the impact of the Covid-19 pandemic on the people and organisations delivering social care and the support available to them. It also examines the issues with collecting data about the number of care workers who died.

The impact of the pandemic on unpaid carers

The number and identification of unpaid carers

6.5. The Covid-19 pandemic highlighted the importance of being able to identify unpaid carers to provide them with information and to ensure that they could access support. It was (and remains) difficult, though, to ascertain the number of people providing unpaid care. Census data from 2021 and 2022 suggest approximately 5.8 million people were providing unpaid care in the UK. However, many people do not self-identify as a carer and so would not necessarily be counted in the census

1 INQ000588638_0001
2 INQ000518420_0060
3 'Coronavirus (COVID-19) related deaths by occupation, England and Wales: Deaths registered up to and including 20 April 2020', Office for National Statistics, 11 May 2020, p2 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregistereduptoandincluding20april2020; INQ000503378); INQ000514105_0009 para 30; INQ000273805_0012 para 16. In Northern Ireland, the proportion of deaths in the health and social care workforce was lower than in the general population. However, occupation stated on a death certificate should be interpreted with caution, as it is self-reported and may not reflect the deceased's occupation at the time of death; for example, they may have been retired, unemployed or in a different job.

data.[4] There is no register of unpaid adult carers held in any of the four nations of the UK.

6.6. Carers UK estimated that the Covid-19 pandemic could result in an additional 4.5 million people providing care.[5] An increase in people's social care needs, concerns about letting social care professionals into homes for fear of infection and the reduction in the availability of social care services are likely reasons for this growth.[6]

6.7. Problems identifying unpaid carers meant that the Department of Health (Northern Ireland) had to send a leaflet about the support available to unpaid carers to every household. According to Robin Swann, Minister of Health for Northern Ireland from January 2020 to October 2022, it would help with disseminating information in future if there was a central register of unpaid carers that healthcare providers could add to and unpaid carers could apply to join.[7]

6.8. In England, records held by the Department for Work and Pensions, local authorities and GPs helped to identify unpaid carers, but the data from the latter two sources were not comprehensive.[8] Helen Whately MP, Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021, said that the UK government had limited knowledge about who was an unpaid carer.[9] In August 2020, the Carers Advisory Group encouraged NHS England (supported by the UK government) to implement a requirement that all GP practices have a system for identifying carers within three months.[10] There is no evidence to suggest that this was implemented.[11]

6.9. In Wales, work had begun before the pandemic to enhance unpaid carers' and healthcare professionals' knowledge about what a caring role entails and their right to support. A similar campaign was launched in Scotland in December 2020.[12]

6.10. There should be better systems across the UK to identify unpaid carers in order to improve communication and access to support for them in a future pandemic. The UK government's *Pandemic Preparedness Strategy* published in March 2026 has committed to improving the identification of unpaid carers in England through digital

4 'Facts about carers (last updated March 2025)', Carers UK, March 2025, pp2, 18 (https://www.carersuk.org/media/mmobpcmx/facts-about-carers-march-2025-final.pdf; INQ000606894). Census data, polling and surveys rely on self-identification.
5 INQ000058016_0001
6 INQ000587612_0016 para 37; INQ000614179_0178 para 537; *Caring Behind Closed Doors: Six Months On: The Continued Impact of the Coronavirus (COVID-19) Pandemic on Unpaid Carers*, Carers UK, October 2020, p8 (https://www.carersuk.org/media/cptbrdal/caring-behind-closed-doors-six-months-on.pdf; INQ000239445)
7 Robin Swann 24 July 2025 137/3-15
8 Emily Holzhausen 16 July 2025 71/6-9, 71/24-72/5
9 Helen Whately 17 July 2025 75/10
10 INQ000588638_0005 para 21. The Carers Advisory Group provided independent advice to the Department of Health and Social Care's Social Care Sector COVID-19 Support Taskforce.
11 Emily Holzhausen 16 July 2025 68/18-22
12 *From Covid to Co-Delivery: Carer Aware Delivery and Impact 2020-24*, Carer Aware, July 2024, pp4, 8 (https://carers.org/downloads/carer-aware-impact-report---english---hr.pdf; INQ000660299); INQ000614179_0183 para 553

means and to provide them with support during a pandemic.[13] The Inquiry welcomes this. The devolved administrations should explore practical, reliable ways to improve identification, such as through GP records or healthcare provider apps.[14]

Personal protective equipment for unpaid carers

6.11. Most unpaid carers in the UK had to buy their own personal protective equipment (PPE), but the increased cost of PPE (where it was available) meant that many could not afford it.[15] Unpaid carers were concerned that not wearing PPE might increase their risk of becoming unwell with Covid-19 and prevent them from carrying out their caring role.[16] This caused understandable concern and anxiety. An unpaid carer said:

> "*I think as unpaid carers we should be given some level of support in the provision of PPE – although I appreciate that there is currently a shortage – what would happen if, as an unpaid carer, I was taken ill?*"[17]

6.12. From 17 March 2020, Health and Social Care trusts in Northern Ireland were encouraged to provide unpaid carers with PPE where it was required.[18]

> "[W]*e were provided with masks and gloves … that didn't cost us anything and … buffered the problem [of not being able to find PPE].*"[19]
>
> **Unpaid carer, Northern Ireland, Every Story Matters**

6.13. From 26 April 2020, unpaid carers in Scotland could access free PPE from a local hub; eligibility was based on need.[20] Unpaid carers in Wales might have been eligible to receive free PPE through their local authority from around the end of June 2020 if: the person being cared for or someone in their household had symptoms of Covid-19; the individual being cared for or the carer was shielding; or the carer could not access PPE through their usual routes.[21] Unpaid carers providing "*hands on care*"

13 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, p53 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)
14 *Module 4: Vaccines and therapeutics*, UK Covid-19 Inquiry, April 2026, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-4-full-report)
15 INQ000587612_0032 paras 88-89; Emily Holzhausen 16 July 2025 59/7-12
16 *Caring Behind Closed Doors: Forgotten Families in the Coronavirus Outbreak*, Carers UK, April 2020, p17 (https://www.carersuk.org/media/a5dpp3ng/caring-behind-closed-doors-forgotten-families-in-the-coronavirus-outbreak.pdf; INQ000176237)
17 *Caring Behind Closed Doors: Forgotten Families in the Coronavirus Outbreak*, Carers UK, April 2020, p20 (https://www.carersuk.org/media/a5dpp3ng/caring-behind-closed-doors-forgotten-families-in-the-coronavirus-outbreak.pdf; INQ000176237)
18 *COVID-19: Guidance for Domiciliary Care Providers in Northern Ireland*, Department of Health (Northern Ireland), 17 March 2020, para 8 (INQ000353600_0004)
19 *Every Story Matters: Adult Social Care Sector*, p113 (INQ000587564)
20 'Advice sheet for: Local PPE hubs, health and social care partnerships, and local carers' centres', Scottish Government, 26 April 2020, pp1-2 (https://www.eastrenfrewshirecarers.co.uk/wp-content/uploads/2020/04/Advice_sheet_for_Hubs_and_Carers_Centres_PPE_for_unpaid_carers_April_2020.pdf; INQ000496485); INQ000606530_0076 paras 279-280
21 INQ000587254_0053 para 198; INQ000336705_0001-0003, 0005

in Northern Ireland should have been provided with disposable gloves and aprons from 3 August 2020.[22]

6.14. During a pilot programme between December 2020 and January 2021, some unpaid carers in England were offered free PPE by the Department of Health and Social Care. However, not many unpaid carers used the service and, when they did, the demand could be met by stocks of PPE already held by local authorities.[23] Issues with identifying unpaid carers are likely to have contributed to the low uptake.[24] From 9 February 2021, unpaid carers in England who cared for a person outside their household could access free PPE from their local authority. However, yet again, there was limited uptake of this offer. PPE was considered by carers' organisations as less of a priority at this time due to the vaccine rollout and access to tests. In addition, the department's adult social care PPE team suggested that local authorities and local resilience forums might not have been promoting the offer of free PPE to unpaid carers for fear of unmanageable demand.[25]

6.15. The millions of unpaid carers who could not afford to source their own PPE still needed to be able to access it to protect themselves and the people for whom they cared during the pandemic. Unpaid carers are very likely to need PPE during a future pandemic; therefore, it should form part of pandemic planning. Unpaid carers should be able easily to access information about how to obtain and use PPE.

Support for unpaid carers

6.16. Unpaid carers needed support to assist them with changes to the type of care they were required to provide and to manage the increase in financial and emotional pressure they felt.

Clinical care support

6.17. Difficulties accessing health and social care services meant that, throughout the Covid-19 pandemic, many unpaid carers had to provide more complex and clinical care for which they were not prepared.[26] In April 2020, a survey of more than 5,000 unpaid carers in the UK found that 24% were helping more with medication and 11% were providing more medical care, such as administering injections and changing dressings.[27] Six months into the pandemic, unpaid carers reported to Carers UK that

22 *COVID-19: Advice for Informal (Unpaid) Carers and Young Carers During COVID-19*, Department of Health (Northern Ireland), 3 August 2020, p13 (https://westerntrust.hscni.net/wp-content/uploads/wpfd/preview_files/COVID-19-ADVICE-FOR-INFORMAL-UNPAID-CARERS-AND-YOUNG-CARERS-DURING-CO(8073bd4ed0fe0c330290c58056a2cd5e).pdf; INQ000276428)
23 INQ000587737_0036-0037 paras 150-152; INQ000110355_0004 para 5a
24 Helen Whately 17 July 2025 74/22-75/10
25 INQ000587737_0037 para 155; INQ000328127_0001
26 INQ000587612_0016 paras 36-37
27 *Caring Behind Closed Doors: Forgotten Families in the Coronavirus Outbreak*, Carers UK, April 2020, pp6, 9 (https://www.carersuk.org/media/a5dpp3ng/caring-behind-closed-doors-forgotten-families-in-the-coronavirus-outbreak.pdf; INQ000176237)

more healthcare appointments were taking place remotely and increased support from GPs would be helpful.[28] Unpaid carers described their experiences:

> "*During lockdown my mother's mobility has decreased due to her not being able to do any activities … I am trying to work full time from her home whilst caring for her and giving medications a district nurse would do.*"[29]

> "*I feel that my GP surgery is not helpful or supportive at all, and they made my life very hard over the lockdown. Getting appointments is a nightmare.*"[30]

6.18. Unpaid carers responding to a survey by Carers UK described how they became the sole carer for their family member. One explained how her husband (who used a wheelchair) usually had two care workers visit their home three times a day, but when these visits stopped, she became responsible for the entirety of his care. Another said:

> "*I have cancelled Mum's care calls, four a day, two care workers, to reduce the amount of people entering Mum's home. I have moved in with her, for the shielding period, and I'm providing the care she needs.*"[31]

Financial support

6.19. Financial pressures on unpaid carers increased, as they had to buy PPE and their household bills rose.[32] Research by Carers UK estimated that 21.5% of people providing unpaid care to someone outside their own household experienced some degree of financial strain in April and May 2020.[33] In some cases, the impact could be life-changing. Responding to a survey by Carers UK, one unpaid carer reported: "[W]*ith my* [disabled] *son home full-time my household bills have trebled.*" Another said: "[M]*y savings that I have spent 30 years trying to build up for retirement are now vanishing to pay the bills.*"[34]

28 *Caring Behind Closed Doors: Six Months On: The Continued Impact of the Coronavirus (COVID-19) Pandemic on Unpaid Carers*, Carers UK, October 2020, pp19, 22 (https://www.carersuk.org/media/cptbrdal/caring-behind-closed-doors-six-months-on.pdf; INQ000239445)
29 *Caring Behind Closed Doors: Six Months On: The Continued Impact of the Coronavirus (COVID-19) Pandemic on Unpaid Carers*, Carers UK, October 2020, p9 (https://www.carersuk.org/media/cptbrdal/caring-behind-closed-doors-six-months-on.pdf; INQ000239445)
30 *Caring Behind Closed Doors: Six Months On: The Continued Impact of the Coronavirus (COVID-19) Pandemic on Unpaid Carers*, Carers UK, October 2020, p22 (https://www.carersuk.org/media/cptbrdal/caring-behind-closed-doors-six-months-on.pdf; INQ000239445)
31 *Caring Behind Closed Doors: Forgotten Families in the Coronavirus Outbreak*, Carers UK, April 2020, p7 (https://www.carersuk.org/media/a5dpp3ng/caring-behind-closed-doors-forgotten-families-in-the-coronavirus-outbreak.pdf; INQ000176237)
32 *State of Caring 2019: A Snapshot of Unpaid Care in the UK*, Carers UK, July 2019, p6 (https://www.carersuk.org/media/khgkb3fs/state-of-caring-2019-report.pdf; INQ000577450); INQ000587612_0025-0026, 0032 paras 63-64, 89
33 *Caring and COVID-19: Financial Wellbeing*, Centre for International Research on Care, Labour and Equalities, June 2020, p2 (https://www.carersuk.org/media/ckjdpkqo/caring-and-covid-19-financial-wellbeing.pdf; INQ000588631)
34 INQ000587612_0025-0026 paras 63-64

6.20. In England, Wales and Scotland, additional financial support was made available to unpaid carers but not all were eligible to receive this.[35] Difficulties with identification meant there were no direct payments for unpaid carers in Northern Ireland.[36]

Respite for unpaid carers

6.21. Respite care provides an essential break for unpaid carers. During the Covid-19 pandemic, respite care in the form of community day services, activities or overnight care closed or reduced their services. Family and friends were also less able to provide support to unpaid carers.[37] As a result, many unpaid carers provided care for prolonged periods of time without a break, often affecting their own wellbeing.[38] This led to a significant number of unpaid carers experiencing or being on the brink of burn-out.[39]

> "*At one point, I was probably only getting about four hours sleep a day for months and it just became the norm. I thought I was all right, but I was absolutely exhausted.*"[40]
>
> **Unpaid carer living with the person they cared for, Northern Ireland, Every Story Matters**

> "*The burden of working maybe 14 or 15 hours a day, seven days a week and caring for my parents who were both shielding, I became burned out. One day, I just started to cry.*"[41]
>
> **Unpaid carer, Northern Ireland, Every Story Matters**

6.22. Unpaid carers described feeling anxious and afraid about what would happen in the event that they could no longer provide care to their loved ones.[42] One carer, six months into the pandemic, said:

> "*I have struggled hugely being with my husband 24/7 unable to have a break from caring. There are times I think I can't go on, but of course I have to. Sometimes I don't want to wake up in the morning.*"[43]

35 INQ000587612_0026-0028 paras 66-68
36 Robin Swann 24 July 2025 152/8-11
37 INQ000587612_0014-0015 para 33; INQ000475047_0015, 0017 paras 59, 66
38 INQ000614179_0178 para 537; INQ000587612_0017 paras 38-39
39 *Caring Behind Closed Doors: Forgotten Families in the Coronavirus Outbreak*, Carers UK, April 2020, p6 (https://www.carersuk.org/media/a5dpp3ng/caring-behind-closed-doors-forgotten-families-in-the-coronavirus-outbreak.pdf; INQ000176237)
40 *Every Story Matters: Adult Social Care Sector*, p33 (INQ000587564)
41 *Every Story Matters: Adult Social Care Sector*, p33 (INQ000587564)
42 *Breaks or Breakdown: Carers Week 2021 Report*, Carers Week, June 2021, p27 (https://www.carersuk.org/media/f5ah1fze/carers-week-2021-research-report.pdf; INQ000239456)
43 INQ000587612_0017 para 38

6.23. According to a survey of directors of adult social services in England, 64% said that Covid-19 had led to an increase in the number of individuals presenting with social care needs to local authorities due to carer breakdown, sickness or unavailability between March and May 2020.[44] In the summer of 2020, unpaid carers in England said that the most urgent issue was the reopening of services for respite.[45]

6.24. There was also concern about the potential impact of subsequent outbreaks of Covid-19. A report by the Association of Directors of Adult Social Services in October 2020 identified that:

> "[D]*uring a second or subsequent wave, energy levels may not be as great and respite services may be even more important … they may also be needed during, rather than after, the wave.*"[46]

The report suggested that ongoing review and consideration of the need for respite for unpaid carers was necessary.[47]

6.25. Some alternative support was available. Just over half of local authorities in England offered telephone welfare checks, counselling services and practical support to unpaid carers.[48] In Scotland, from May 2020, unpaid carers could access a digital wellbeing hub that was established for people working or volunteering in health and social care services.[49] A Carer ID card was used by 42,000 unpaid carers in Northern Ireland from June 2020, which, among other things, provided proof of carer status.[50] Guidance for unpaid carers in Wales in August 2020 encouraged use of online and telephone support services.[51] While some unpaid carers may have benefited from the additional support, many were unable to access it and it was not always targeted to their needs.[52]

6.26. There was some funding to restart or expand respite and support services for unpaid carers. For example:

- The Scottish Government established a £500,000 fund for local carer organisations in April 2020 to transition to online working. Additional funding to expand support was granted in January 2021 and in January and April 2022.[53]

44 *ADASS Autumn Survey 2020*, Association of Directors of Adult Social Services, November 2020, pp6, 8 (https://www.adass.org.uk/wp-content/uploads/2024/06/adass-autumn-survey-report-2020_final-website.pdf; INQ000514933)
45 INQ000588638_0004 para 16
46 INQ000103777_0010 para 44
47 INQ000103777_0009 paras 41-42
48 INQ000587382_0232 para 845
49 'Unique support for health and social care', Scottish Government, 11 May 2020 (https://www.gov.scot/news/unique-support-for-health-and-social-care; INQ000509951_0001)
50 INQ000613603_0105 paras 355-356. This figure includes young carers.
51 INQ000081179_0007
52 INQ000587612_0030 paras 75-76; *Our Recovery Plan for Unpaid Carers*, Carers UK, 24 July 2020, p10 (https://www.carersuk.org/media/mzklupye/carers_uk_-_recovery_plan_for_carers_-_july_2020_-_vfinal.pdf; INQ000239470)
53 INQ000614179_0182-0183 paras 549, 554-555

- From around June 2020, the Welsh Government provided Carers Wales with £50,000 to extend its mental health support for unpaid carers. Additional funding was granted in April and September 2021.[54]
- The Department for Digital, Culture, Media and Sport granted £500,000 to the Carers Trust at the start of 2021 (matched by a charitable foundation), which was used to support almost 7,000 unpaid carers to access breaks and respite.[55]
- Funding could be accessed by community and voluntary sector organisations supporting unpaid carers in Northern Ireland from September 2021 to May 2023.[56]

6.27. Despite the additional funding and alternative support, unpaid carers reported that they were unable to take a break and their mental health deteriorated, which threatened their ability to continue to provide care. UK-wide surveys undertaken by Carers UK during the first half of 2021 found that 72% of unpaid carers still had not had a break from their caring role since the start of the pandemic. In addition, 74% reported that their caring role had left them feeling exhausted and 35% felt unable to continue with their caring responsibilities.[57] In November 2021, a review in England noted that unpaid carers' needs had continued to increase at the same time as access to support had reduced, including the suspension or reduction of respite services. The need for unpaid carers to have a break was identified again.[58]

6.28. The *Independent Review of Adult Social Care in Scotland* (known as the Feeley Review), commissioned by the Scottish Government and published in February 2021, found that carers needed better, more consistent support to carry out their caring role, with regular breaks.[59] The Care Reform (Scotland) Act 2025 requires local authorities to ensure that carers can have a break if they cannot do so on their own.[60] This is a positive development.

6.29. The reduction in respite services during the Covid-19 pandemic added to the extraordinary pressures on unpaid carers. Many felt abandoned and unsupported. Pandemic planning must consider how social care services can continue to support unpaid carers and, where temporary closures are necessary, how unpaid carers will be able to access alternatives. Reopening respite services should be prioritised.

54 INQ000598534_0060 para 204; INQ000103916_0001; INQ000551798_0076-0077 paras 266-267
55 INQ000475047_0009 para 34; 'Carers Trust awarded £1 million to support thousands of exhausted unpaid carers', Carers Trust, 13 January 2021 (https://carers.org/news-and-media/news/post/99-carers-trust-awarded-1-million-to-support-thousands-of-exhausted-unpaid-carers; INQ000660298)
56 INQ000615082_0120 paras 371-371a
57 INQ000587612_0017 para 39; *Breaks or Breakdown: Carers Week 2021 Report*, Carers Week, June 2021, p31 (https://www.carersuk.org/media/f5ah1fze/carers-week-2021-research-report.pdf; INQ000239456). Of the 2,850 carers and former carers who responded to the survey, 71% lived in England.
58 *Adult Social Care in England: COVID-19: A Review of the 2020 to 2021 Winter Plan and Subsequent Actions – What More Should Be Done?*, Department of Health and Social Care, November 2021, p32 (https://assets.publishing.service.gov.uk/media/618250788fa8f52981d40f01/Adult-Social-Care-in-England-Winter-Plan-2020-2021-Review-David-Pearson-accessible.pdf; INQ000279947)
59 *Independent Review of Adult Social Care in Scotland*, Scottish Government, 3 February 2021 (https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2021/02/independent-review-adult-social-care-scotland/documents/independent-review-adult-care-scotland/independent-review-adult-care-scotland/govscot%3Adocument/indep; INQ000280640)
60 INQ000614179_0312 para 980; INQ000606530_0095 para 337; Care Reform (Scotland) Act 2025, section 8 (https://www.legislation.gov.uk/asp/2025/9/contents)

Improvements to the identification of unpaid carers will ensure that, during a future pandemic, there can be direct communication and targeted support.

The impact of the pandemic on care workers

6.30. Care workers witnessed and were personally affected by the impact of the Covid-19 pandemic on the vulnerable people they supported.

Staff moving into care homes

6.31. During the pandemic, some care workers moved into the care home they worked in.[61] A care home manager said:

> "*I moved into the home as staff were either getting Covid or were too scared to come into work. I was here 24 hours a day and it was absolutely draining, mentally and physically. But we had no choice.*"[62]

A care home owner in Wales described 39 members of staff moving into the care home for 12 days during the early stages of the pandemic to deal with the lack of PPE and testing.[63]

6.32. This had an impact on care workers' mental health and wellbeing and on their family members.[64] Reverend Charlotte Hudd worked as a nurse in a care home. When 95% of the staff were absent, she moved into the home and provided 24/7 clinical care for 10 days to 20 residents with complex needs or Covid-19, some of whom were approaching the end of life. While a single resident would usually receive one-to-one care with five or six nurses caring for the other residents, staff shortages meant that they had to:

> "*prioritise nutrition, continence -- and so they were seeing even less of us. That was really hard. And I would hear at night sometimes, the person next door to my room crying … 'Where is everybody?' That was quite distressing.*"[65]

Reverend Hudd's experience led to her suffering post-traumatic stress disorder.[66]

6.33. The fact that some care workers felt they had little choice but to move into the care home in which they worked demonstrates their commitment and dedication to the people for whom they were caring.

61 INQ000585008_0016 para 43; INQ000509530_0046 para 188; Helen Hough 1 July 2025 134/23-25
62 INQ000509768_0008
63 *Care Home Voices: A Snapshot of Life in Care Homes in Wales During Covid-19*, Older People's Commissioner for Wales, 21 June 2020, p19 (https://olderpeople.wales/library/Care_Home_Voices_Report_e.pdf; INQ000181725)
64 INQ000585008_0032-0033 para 126
65 INQ000614378_0004-0005 paras 9-10; Charlotte Hudd 3 July 2025 158/22-159/2
66 Charlotte Hudd 3 July 2025 169/5-8

Witnessing death

6.34. The number of people dying in care homes during the Covid-19 pandemic placed enormous strain on care workers, who often had to provide end-of-life care to multiple residents at the same time.[67] For example, one care home lost 19 residents from a dementia unit (two-thirds of its residents) in two weeks; and there was a point where four residents died on one day. Another care home lost almost half of its residents in three weeks, some of whom had lived in the home for many years. The manager of the home said that the residents who died "*had become part of our family so it was devastating for my team*".[68] A care home worker described 30 residents dying and, during one shift, 5 residents were all close to the end of life. The staff went between them to check that they were comfortable, clean and still breathing.[69]

6.35. Many care workers, understandably, experienced deep distress when people they cared for died.[70]

> "*Staff were sitting on video calls with families, saying their last goodbye to their loved ones. That was horrendous … staff were crying with the residents, because it was just so emotional for them. They were holding their hands until they died.*"[71]
>
> **Care home worker, Northern Ireland, Every Story Matters**

> "*It was horrible, we were the ones sat there, holding their hand as they were dying. We were the ones ringing family to say, 'Your mum's passed away this morning.'*"[72]
>
> **Domiciliary care worker, England, Every Story Matters**

6.36. Visiting restrictions meant it was common for care home staff to have to contact a resident's loved ones to inform them that the resident was dying or had died. This had a lasting impact:

67 INQ000515683_0016 para 53
68 INQ000509768_0006, 0009
69 INQ000587381_0050 para 97.3
70 INQ000509768_0006, 0009; INQ000614378_0011 para 33; INQ000587639_0018-0019 para 87; INQ000475131_0018 para 3.12b
71 *Every Story Matters: Adult Social Care Sector*, p13 (INQ000587564)
72 *Every Story Matters: Adult Social Care Sector*, p89 (INQ000587564)

"*I will never forget having to ring a relative to tell her that her mother had died and she just screamed at me. Every time that I ring a relative to deliver bad news, I still think of that phone call.*"[73]

"*I was talking to families I barely knew – calling to introduce myself and then on the next call saying, 'your mum is taking her last breaths'. It's something that you never get over.*"[74]

6.37. Care staff also experienced the deaths of colleagues. A care home manager said:

"*It was one of the hardest things I have ever done, getting staff together in the middle of this massive challenge to tell them that one of their colleagues, who was really highly thought of, had passed away … I never dreamed I would have to go through the awful experience of telling my team that one of their colleagues had died a second time.*"[75]

6.38. The experience of Covid-19 for so many care workers was summarised by one contributor to the Inquiry's listening exercise, Every Story Matters.

> "*I feel sad for the ones we lost and that they didn't get the end of life care they deserved, I feel sad for the good staff we lost because they were scared of getting Covid, my heart breaks for the families that didn't get to say goodbye and I'm sad for me being stuck with the memories of the worst things I've ever had to endure with barely any support.*"[76]
>
> **Senior care worker in a residential care home, Wales, Every Story Matters**

6.39. Caroline Abrahams, Charity Director of Age UK from 2012, said that it must have been an "*absolutely shattering experience*" for care workers to have to look after so many people who were dying.[77] The scale of death and suffering witnessed by social care staff during the Covid-19 pandemic was unlike anything they had seen before. Many were alone with someone in their last few moments of life.

Additional responsibilities

6.40. Not all care homes or domiciliary care providers (which provide a range of services to support an individual in their own home) typically provide clinical or end-of-life care. However, during the pandemic, an absence or reduction in visits by healthcare professionals meant that care workers took on additional clinical responsibilities.

73 INQ000509768_0008
74 INQ000509768_0014
75 INQ000509768_0008, 0010
76 *Every Story Matters: Adult Social Care Sector*, p143 (INQ000587564)
77 Caroline Abrahams 16 July 2025 21/14-19

> "*I felt like we were on our own, health professionals didn't want to know, mental health teams, dietitians, continence nurses didn't visit anymore.*"[78]
>
> **Senior care home worker, Wales, Every Story Matters**

> "[W]*e suddenly had to become nurses.*"[79]
>
> **Care home worker, England, Every Story Matters**

6.41. Many care workers had not received training for the clinical or 'delegated' tasks that they were asked to do, which included wound care and providing insulin injections.[80] Access to training and support from healthcare professionals was inconsistent during the pandemic.[81] A care home manager in Scotland said that district nurses provided training and were available on the phone if required.[82] Julie Parkinson, manager of a domiciliary care agency, said:

> "*I felt we received a very poor response from GP services, which were responding to a crisis of their own but failed to consider those of us working in the community. I feel that this made life extremely and unnecessarily difficult for us.*"[83]

6.42. Undertaking delegated tasks increased the burden on care workers and, without proper training or support, the risk of a poor outcome for users of care services.[84] However, regular contact between healthcare professionals and care workers provided an opportunity to raise clinical concerns and receive advice.[85]

6.43. In July 2020, Skills for Care (the independent workforce development and planning body for social care in England) developed two short guides to support care workers undertaking delegated tasks; it issued further guidance in 2021 which set out the conditions for delegating a task. Since the pandemic, guiding principles have

78 *Every Story Matters: Adult Social Care Sector*, p143 (INQ000587564)
79 *Every Story Matters: Adult Social Care Sector*, p156 (INQ000587564)
80 INQ000587670_0043-0044 paras 154-155; INQ000614375_0005-0006 para 22; INQ000509530_0021 para 79; INQ000475131_0022 paras 4.3-4.4; INQ000587677_0009 para 14; *Social Care Sector COVID-19 Support Taskforce: Final Report, Advice and Recommendations*, Department of Health and Social Care, 12 October 2020 (https://www.gov.uk/government/publications/social-care-sector-covid-19-support-taskforce-report-on-first-phase-of-covid-19-pandemic/social-care-sector-covid-19-support-taskforce-final-report-advice-and-recommendations; INQ000582696_0022-0023). A delegated task is one that a healthcare professional delegates to a care worker.
81 INQ000059225_0001-0002; INQ000569768_0038 para 146; *Healthcare Experiences of Care Home Residents During the Covid-19 Pandemic*, Care Rights UK, 13 July 2023, p19 (https://static1.squarespace.com/static/6419e3a87662ef5ed1f8ff63/t/650846e87913ed3d207c9e10/1695041257318/Healthcare+survey+July+2023.pdf; INQ000273449); INQ000504053_0016 paras 5.2-5.3
82 INQ000587677_0009 para 14
83 INQ000614375_0014-0015 para 59
84 *Healthcare Experiences of Care Home Residents During the Covid-19 Pandemic*, Care Rights UK, 13 July 2023, p19 (https://static1.squarespace.com/static/6419e3a87662ef5ed1f8ff63/t/650846e87913ed3d207c9e10/1695041257318/Healthcare+survey+July+2023.pdf; INQ000273449)
85 INQ000504053_0016 para 5.3; INQ000587670_0044 para 157; Charlotte Hudd 3 July 2025 164/5-16

been developed.[86] Despite this, Skills for Care said that there remains a lack of infrastructure, incentives and clinical capacity to support care workers to safely carry out delegated tasks if required to do so again.[87] While the progress on training in this area is welcome, there need to be sufficient numbers of nurses and clinical staff working in adult social care (and healthcare) to direct and supervise care workers to carry out delegated tasks.

6.44. Care home managers and staff also had to keep abreast of and implement guidance provided to the adult social care sector. This guidance was updated frequently and sometimes at short notice as scientific understanding of Covid-19 developed. The Inquiry was told how it was difficult to keep up with the changes while also responding to other challenges presented by the pandemic.[88]

6.45. In recognition of the additional responsibilities and longer hours worked during the pandemic, care workers became eligible for a one-off payment of £500 in Scotland in late 2020 and in Northern Ireland in early 2021.[89] In Wales, care workers were eligible to receive payments of £500 in June 2020 and March 2021.[90] Although the payment had a negative impact on some care workers' benefits and not all received it promptly, it was an important way of recognising their invaluable contribution during the pandemic.[91]

6.46. While the UK government did not make a one-off payment to care workers in England, some providers used other funding to pay them a bonus.[92] The Care Workers' Charity said that the UK government's decision showed a lack of recognition, contributed to widespread feelings of neglect and was a disincentive to staying in or joining the sector.[93]

Support for care workers' mental health and wellbeing

6.47. The impact of the Covid-19 pandemic on the mental health and wellbeing of many people working in social care was significant and, for some, long-lasting.[94] Analysis

86 INQ000543049_0057 paras 286-287; *Research Into Social Care Workers Undertaking Healthcare Interventions*, Skills for Care, February 2022, p3 (https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Delegated-healthcare-interventions/Research-into-social-care-workers-undertaking-healthcare-interventions.pdf; INQ000660242); INQ000059225_0001-0002. The 2021 guidance was commissioned by the Department of Health and Social Care.
87 INQ000543049_0057 para 288
88 INQ000587669_0004 para 7.5; INQ000587673_0002 para 7; INQ000614375_0006 para 23
89 INQ000614179_0165-0166 para 492: the payment was announced in Scotland on 30 November 2020; INQ000276341: on 19 January 2021, it was agreed that a payment of "*up to £500*" would be made in Northern Ireland.
90 INQ000587254_0075-0076 paras 276, 279-280
91 INQ000587670_0103-0104 para 435
92 *Workforce Recruitment and Retention Funds: Outcomes and Findings*, Department of Health and Social Care, 26 January 2023 (https://www.gov.uk/government/publications/workforce-recruitment-and-retention-funds-outcomes-and-findings/workforce-recruitment-and-retention-funds-outcomes-and-findings; INQ000565775_0008)
93 INQ000586665_0015 para 79
94 INQ000569768_0043, 0047 paras 166, 177; INQ000543049_0031-0032 para 169

of the medical records of 15,725 domiciliary care workers in Wales found that, by the end of November 2021, 34% required support for a mental health condition.[95]

6.48. Some social care staff felt unable to continue in their role. A manager of a domiciliary care agency said:

> "[T]*he trauma was so overwhelming that some of these remarkable individuals chose to leave the care profession, unable to overcome the emotional toll of what transpired.*"[96]

6.49. The UK government and devolved administrations provided some psychological and wellbeing support for social care staff:

- The Care Workforce app launched in England in May 2020. It closed in March 2021 due to low uptake, the costs involved and issues with compliance.[97]
- A wellbeing helpline was available in Scotland from July 2020, the Workforce Specialist Service (psychological support) launched in February 2021, and funding to support the wellbeing of the health and social care workforce was announced in June 2021.[98]
- In July 2020, there was a programme in Northern Ireland to introduce 'rainbow rooms' (dedicated reflection spaces for care home staff), and resources with information and advice on health and wellbeing were delivered to care homes.[99]
- A Samaritans helpline for health and social care workers in Wales was accessible from August 2020.[100]

6.50. Professor Vic Rayner, Chief Executive Officer of the National Care Forum from 2016, said that the services and resources provided by the Department of Health and Social Care and NHS England were not always suitable for the sector, as they were created for clinical settings and NHS staff, who were not facing the same issues as care workers.[101] Additionally, some care workers did not have an NHS email address to be able to access the resources.[102] The fragmented nature of the workforce also made it difficult to communicate with care workers about the support available, which limited its effectiveness.[103]

6.51. The mental health support available in England and Scotland for social care staff during the pandemic has been described by representatives in the care sector as

95 'Impact of the COVID-19 pandemic on domiciliary care workers in Wales, UK: A data linkage cohort study using the SAIL Databank', R Cannings-John, S Schoenbuchner, H Jones, FV Lugg-Widger, A Akbari, L Brookes-Howell et al, *BMJ Open* (2023), 13(e070637), pp1, 4 (https://doi.org/10.1136/bmjopen-2022-070637; INQ000581749)
96 INQ000587381_0049 para 97.2
97 INQ000587737_0113-0114 paras 441-443
98 INQ000614180_0091 paras 297-298; INQ000578133_0022-0023
99 INQ000615082_0168-0169 para 548
100 INQ000587254_0081 para 300
101 INQ000475131_0018 para 3.11d
102 Claire Sutton 29 July 2025 36/19-25
103 INQ000543049_0031 para 166

"*insufficient*", of "*varying quality*" and inadequate.[104] Care workers in England often felt that they were an afterthought.[105]

6.52. Voluntary and independent organisations acted quickly to provide vital support.[106] Mental health charities operated a 24/7 telephone and text support service for all UK front-line and key workers – 'Our Frontline' – from April 2020 to November 2021.[107] Specific support for care home managers was available in Wales (from Age Cymru, Care Home Cymru and others) and in England (from Skills for Care) from November 2020 to February 2021.[108] Skills for Care said that the text support service in England was described as "*useful*" and "*relevant*".[109]

6.53. Some migrant workers were fearful that seeking professional help could have an effect on their employment and visa status. Kanlungan (a charity consisting of several Filipino and South-East and East Asian community organisations) therefore offered mental health support to migrant workers in the social care sector.[110]

6.54. Many care workers felt the impact later in the pandemic or after it had ended, at a time when support was no longer available, as one contributor told Every Story Matters.[111]

> "*[The] mental challenge that I faced, as things wound down, was as a result of what we all went through … we thrived off of the emergency of having to deal [with it] and respond to things [then], but it took its toll some years later.*"[112]
>
> **Registered manager, England, Every Story Matters**

6.55. For some, the impact was particularly severe, leading to post-traumatic stress and suicidal thoughts. The Inquiry was told of care workers who died by suicide.[113]

6.56. The impact and ongoing effects of the Covid-19 pandemic on the social care workforce demonstrate the need for governments to plan for better psychological and emotional support for care workers in future to help mitigate the risk of more people leaving the profession.

104 INQ000509530_0049-0050 para 204; *Adult Social Care in England: COVID-19: A Review of the 2020 to 2021 Winter Plan and Subsequent Actions – What More Should Be Done?*, Department of Health and Social Care, November 2021, p15 (https://assets.publishing.service.gov.uk/media/618250788fa8f52981d40f01/Adult-Social-Care-in-England-Winter-Plan-2020-2021-Review-David-Pearson-accessible.pdf; INQ000279947)
105 INQ000475131_0018 para 3.11d
106 Paul Featherstone 28 July 2025 121/17-122/5; INQ000543049_0014-0015 paras 68, 71-72; INQ000587657_0103 para 352
107 INQ000587657_0106-0107 para 362; *Our Frontline: Campaign Impact Report*, Mind, February 2022, p4 (https://shout.ams3.cdn.digitaloceanspaces.com/mentalhealthinnovations/media/documents/Our_Frontline-_final_impact_report.pdf; INQ000660345)
108 INQ000509808_0036 para 95; INQ000543049_0029-0030 paras 157-159
109 INQ000543049_0030 para 160
110 INQ000474919_0056-0057 para 174; Francesca Humi 29 July 2025 114/23-115/9
111 INQ000543049_0031-0032 paras 168-169; INQ000569774_0013 para 6.2
112 *Every Story Matters: Adult Social Care Sector*, p146 (INQ000587564)
113 INQ000509530_0034, 0046-0047 paras 133, 190, 193; INQ000569774_0013 para 6.2; INQ000587639_0024-0025 paras 114, 117

The impact of the pandemic on care providers and local authorities

6.57. In addition to coping with the emergence of a novel, highly transmissible virus, care providers also had to contend with additional workforce shortages and increased costs.

6.58. Although a number of measures were introduced to manage staff shortages and increase capacity in the workforce, there were very real concerns that providers would have to close or would have insufficient resources to deliver care to those who needed it. This would have increased the pressure on healthcare providers, unpaid carers and community organisations.

Viability of care providers during the pandemic

6.59. Prior to the Covid-19 pandemic, across the UK, the adult social care sector had experienced the closure of services and shortages of care provision.[114] Care homes and domiciliary care providers therefore encountered a perfect storm during the pandemic as the number of people being cared for and income declined, at the same time as outgoings increased.[115]

6.60. The decline in the number of people using adult social care services is likely to have been caused by the increase in care home deaths and fewer people entering care homes due to fear that they may become infected or would be prevented from seeing their loved ones.[116] For example:

- Occupancy rates in care homes in England declined from 87% in April 2020 to between 79% and 82% in August 2020, and to between 76% and 81% by August 2021.[117]
- Some care homes in Wales were operating below 50% occupancy during the pandemic (the majority needed approximately 90% occupancy to be viable).[118]
- In Scotland, occupancy rates in care homes reduced from 89.9% in December 2019 to 83.2% in December 2020, and improved only marginally to 84.3% by December 2021.[119]
- Several care homes in Northern Ireland experienced a significant decline in the number of residents and had problems filling beds.[120]

114 INQ000475008_0044-0047 para 50
115 INQ000509530_0031-0032 paras 120-121; INQ000587670_0045, 0056-0057 paras 162, 213; INQ000515683_0016 para 55; INQ000581141_0003; INQ000543049_0063 para 303b
116 INQ000581141_0003; Jane Townson 14 July 2025 14/7-14; INQ000587670_0045 para 162; INQ000543049_0063 para 303b
117 INQ000543049_0062-0063 paras 301c, 303b
118 INQ000275642_0002 para 7
119 INQ000320180_0012
120 INQ000615082_0116 para 355

6.61. There were also concerns about the viability of domiciliary care providers. UK-wide analysis by the Homecare Association in April 2020 estimated that domiciliary care providers could experience a loss of income of 15% and incur additional costs of 22% due to PPE and staffing, for example.[121] In June 2020, the Welsh Government noted the immediate concern of representatives in the sector about the impact of reduced demand for domiciliary care.[122] As at 10 July 2020, almost 4,000 domiciliary care packages in Northern Ireland had been stopped as a result of the pandemic.[123]

6.62. The UK government and devolved administrations took steps at different times to provide additional funding to support care homes and domiciliary care providers with the decline in demand.

6.63. In Northern Ireland, an income support guarantee was available to care homes from 17 March 2020 to the end of July 2021 and, in response to feedback from the sector about additional costs, a lump sum payment for care homes was announced by the Department of Health (Northern Ireland) on 27 April 2020.[124] On 23 March 2020, representatives of domiciliary care providers in Northern Ireland requested urgent support from the Chief Medical Officer and the Department of Health (Northern Ireland) following a considerable number of cancellations.[125] Funding for domiciliary care providers was made available from 5 May to 31 October 2020, with conditions.[126]

6.64. Local authorities in Wales could use the Local Government Hardship Fund from the end of April 2020 to support care homes that were unable to operate fully after a Covid-19 death, but it did not apply to all types of funded care until 5 August 2020.[127] This led one Welsh care home to consider closure in July 2020.[128] Care home managers had different experiences accessing the funds. One manager described how the widening of the fund in August 2020 saved them and the care home group.[129] Another manager said:

> "*Financially crippled by loss of residents, unable to receive money from government as* [local authority] *won't release any money to us, homes will go under as already struggling because of underfunding of social care before Covid, now we don't stand a chance.*"[130]

121 INQ000571018_0003
122 INQ000116594_0001, 0005 para 10
123 INQ000276409_0004 para 10
124 INQ000615082_0112-0113, 0116 paras 344, 355
125 INQ000397066_0002-0003
126 INQ000615082_0116-0117 para 357. Independent domiciliary care providers were eligible for the fund, which was backdated to April 2020.
127 INQ000587254_0069-0070 paras 252, 254, 256. The fund was backdated to April 2020 and applied to the first six months of the 2020/21 financial year.
128 INQ000183763_0007
129 INQ000587672_0006 para 6.1
130 *Care Home Voices: A Snapshot of Life in Care Homes in Wales During Covid-19*, Older People's Commissioner for Wales, 21 June 2020, p21 (https://olderpeople.wales/library/Care_Home_Voices_Report_e.pdf; INQ000181725)

Funding for domiciliary care providers in Wales was announced at the start of August 2020.[131]

6.65. In response to concerns from the sector, the Scottish Government made financial support (also referred to as 'sustainability payments') available to social care providers from 12 May 2020. Some care homes that were under-occupied as a direct result of the pandemic could claim additional payments.[132]

6.66. Many local authorities in England paid domiciliary care providers based on planned activity (rather than in arrears) from April 2020, which the Homecare Association described as "*pivotal*" in sustaining these services during the pandemic.[133] The Infection Control Fund in England (which operated from 15 May 2020 to 31 March 2022) was intended to help all care providers stay financially viable when they had reduced occupancy. However, grants from the fund had to cover many additional costs, including infection prevention and control measures.[134]

6.67. The Homecare Association described how they felt that access to additional funding favoured care homes. Smaller providers were particularly vulnerable to closure, as they did not have the financial protection of some larger organisations.[135] The impact in England was seen during 2021, when the demand for domiciliary care returned at the same time as staff vacancies increased and there were significant problems with recruitment. Domiciliary care providers reported that demand had exceeded supply, as some were unable to continue with their existing workload or take on new clients. In August 2021, only 70% of 843 domiciliary care providers in England were able to meet the existing needs of care recipients.[136]

6.68. Financial arrangements governing the amount of funding that care providers receive for each individual in their care are complex and outside the scope of this Report. However, given that the UK government and devolved administrations knew before the pandemic that the care sector was in a precarious position, it was foreseeable that a significant and sudden increase in costs and a decline in demand could threaten the viability of many care providers who were already struggling.

Problems accessing funding for care providers

6.69. The purpose, timing and conditions attached to additional funding for care providers varied across the UK. Generally, funding was intended to cover additional costs

131 INQ000587254_0070 para 256. The fund was backdated to April 2020 and applied to the first six months of the 2020/21 financial year.
132 INQ000509530_0028-0029 paras 107-108; INQ000614179_0156-0158 paras 459-461, 464, 466
133 INQ000587670_0057 para 214; 'Temporary funding for adult social care providers during the COVID-19 crisis', Local Government Association, no date (https://www.local.gov.uk/temporary-funding-adult-social-care-providers-during-covid-19-crisis; INQ000581358_0005)
134 INQ000587788_0114 para 56; INQ000587737_0038, 0040 paras 161, 168
135 INQ000587670_0076, 0086 paras 310, 360
136 INQ000587670_0045, 0157-0158 paras 164, 672; 'Homecare workforce shortages continue: Findings of a second Homecare Association member survey, August 2021', Homecare Association, 13 September 2021 (https://www.homecareassociation.org.uk/resource/homecare-workforce-shortages-continue.html; INQ000574055_0001-0002)

or lost income due to Covid-19. Funding for the adult social care sector is also considered in Chapter 3: Protective measures. Wider funding is examined by the Inquiry in Module 9: Economic response.

6.70. Covid-19 funding packages were provided by the four governments, with restrictions or conditions on how it could be spent, to local authorities and trusts to distribute to the sector.[137] While the funding differed, there were nationwide and local issues that care providers consistently experienced:

- Funds were slow to reach some parts of the sector and the providers most in need.[138] A care home owner in Northern Ireland said that financial support from the Health and Social Care trust (via the government and Public Health Agency) came too late.[139] The Independent Health and Care Providers (Northern Ireland) said that the funding processes were "*at times slow and time-consuming*".[140]
- There were inconsistencies between local authorities as to the proof of expenditure care providers were required to submit to access funds.[141] Each of the 22 local authorities in Wales had different processes and conditions.[142]
- Some requests from local authorities and trusts for proof were also disproportionate. A provider in Wales had to provide 60 payslips to evidence a spend of £2,000.[143] Reporting and gathering the evidence was a significant administrative burden for providers when resources were already stretched, and absorbed some of the funds.[144]
- Nationwide restrictions about how the funds could be spent did not always correspond to the care providers' needs at the time.[145] In England, funds could not be used to purchase high-efficiency particulate air (HEPA) filters until the end of 2021.[146]

6.71. From December 2020, Scottish Government funding was focused on supporting providers with additional costs incurred by the pandemic and was intended to be more targeted and less administratively burdensome.[147] However, a lack of capacity to process claims led to some payments being delayed by over a year, particularly during later pandemic peaks.[148]

137 INQ000614179_0157 para 464; INQ000615082_0114 para 350; INQ000551798_0062 para 209; INQ000587788_0010, 0081 paras 34, 326
138 INQ000587737_0038, 0043 paras 160, 180b; INQ000517219_0035 para 107; INQ000532331_0036 para 127; INQ000400522_0079; INQ000268163_0002-0003; INQ000268154
139 INQ000587747_0009-0010 para 22
140 INQ000532331_0036 para 127
141 INQ000587737_0043 para 180a
142 INQ000517219_0020 para 56
143 INQ000183763_0007
144 INQ000587737_0043 para 180a; INQ000587382_0180-0181 para 641; INQ000475131_0028 para 4.21; INQ000587747_0009-0010 para 22
145 INQ000587382_0180 para 641
146 Vic Rayner 3 July 2025 114/3-11
147 INQ000614179_0157-0158 para 464
148 INQ000509530_0029-0030, 0032-0033 paras 113, 123, 125; Nicola Dickie 21 July 2025 134/19-135/14

6.72. While the funding had to respond to the needs of the sector, the delays in decisions at a national level to extend funding (including extensions only being made very close to, or after, the funding period had ended) prevented care providers and local authorities from being able to undertake long-term planning.[149] Providers in England described funding coming to an end as akin to approaching a "*cliff edge*".[150] The National Care Forum said that it was "*unhelpful, insufficient, inefficient and bureaucratic*" for the funding to be drip-fed to the sector, and the Association of Directors of Adult Social Services agreed that the funding arrangements were problematic.[151]

6.73. Additional funding was a lifeline for many care providers, but there was a lack of advance planning by the UK government, Welsh Government, Scottish Government and Department of Health (Northern Ireland) about the financial support that might be needed to remain sustainable and to meet increasing costs caused by a pandemic. As a result, financial packages were developed in response to concerns from the sector about the ability to remain open. The barriers and challenges providers encountered in trying to access the funds could have been mitigated by advance planning and better engagement with the sector.

6.74. Michelle Dyson (Interim Director General of Adult Social Care at the Department of Health and Social Care from September 2020, permanent from May 2021 to July 2025) told the Inquiry that the UK government now has the ability to deliver funding directly to care providers, without the need to go through a local authority.[152] This should help improve access to funding during a pandemic for care providers in England. The devolved administrations are encouraged to explore options for the distribution of targeted funding to different parts of the social care sector.

Workforce capacity during the pandemic

6.75. At the outset of the pandemic, high levels of staff vacancies and turnover in the social care sector meant that the workforce was fragile and lacking resilience; it therefore struggled to cope with the additional demands caused by the pandemic.[153]

6.76. Despite the decline in occupancy in some care homes, pre-existing staff shortages and an increase in workforce absences during the pandemic led to concerns that providers would have insufficient workforce capacity to deliver care.[154] For example, in March 2020, care providers in England reported that 15% to 25% of their workforce was absent for reasons related to Covid-19.[155]

149 INQ000509530_0030, 0033 paras 115, 126; INQ000268170; INQ000116594_0001-0002; INQ000571608_0071 para 14.26; INQ000532331_0018 para 63
150 INQ000587382_0178 para 637
151 INQ000475131_0029 para 4.26; INQ000571608_0006 para 2.2k
152 Michelle Dyson 16 July 2025 181/13-18
153 INQ000543049_0061, 0065 paras 299d-299e, 305a-305b; INQ000613908_0020-0021 para 57a; INQ000614179_0079 para 228; INQ000615082_0033 paras 84-85
154 INQ000475131_0009-0010 para 2.3; INQ000587670_0048-0049 para 179
155 INQ000543049_0059-0060 paras 294-296a

6.77. Many care homes relied on agency staff to increase staff capacity. Although agency staff provided valuable support, they were more expensive for providers and often needed training and supervision so could not always fill the gap caused by absences.[156] There were also insufficient numbers of agency staff.[157]

6.78. Initiatives to increase the number of people available to work in adult social care included the following:

- A social care workforce appeal in Northern Ireland between April 2020 and the spring of 2021 placed 900 people in temporary positions in social care, social work, allied health, pharmacy and psychology.[158]
- A recruitment portal was operated by the Scottish Social Services Council from 14 April 2020 to 1 February 2022. Only 40 people had been employed when it closed.[159]
- In August 2021, the Welsh Government funded a social care recruitment campaign that led to a 27% increase in job applications. It is not clear whether the advice in October 2021 to continue the funding was followed.[160]

6.79. The Department of Health and Social Care aimed to increase the adult social care workforce in England by 20,000 within three months of 15 April 2020. As part of this initiative, it funded 'Join Social Care', a recruitment hub and online training platform. The platform launched in May 2020 and, by June 2020 (the last point at which data were collected by the department), 471 people had completed the training.[161] The department had no way to assess whether the target of 20,000 workers was met.[162]

6.80. The Workforce Capacity Fund (considered in Chapter 3: Protective measures) led to the recruitment of almost 40,000 staff in England.[163] When the fund ceased at the end of March 2021, the Department of Health and Social Care did not apply for additional funding because it understood that there was reduced pressure on care homes and that fewer staff were testing positive for Covid-19.[164] However, during the summer of 2021, there was an increase in workforce absences, due in part to stress, anxiety and depression. By September 2021, the National Care Forum and Homecare Association reported an immediate workforce crisis due to large-scale absences and people leaving the sector.[165] This was attributed to a combination of:

156 INQ000515683_0016 para 54; Charlotte Hudd 3 July 2025 161/7-9, 22-25
157 INQ000111776_0001
158 INQ000615082_0123 para 381
159 INQ000614179_0151-0152 paras 440-441
160 INQ000551798_0203 para 699
161 INQ000587737_0103-0104 paras 401-402
162 *Readying the NHS and Adult Social Care in England for COVID-19*, National Audit Office, 12 June 2020, p12, para 18 (https://www.nao.org.uk/wp-content/uploads/2020/06/Readying-the-NHS-and-adult-social-care-in-England-for-COVID-19.pdf; INQ000114319)
163 INQ000587737_0106 para 414b
164 INQ000587788_0084 para 337
165 INQ000569774_0015 paras 6.9-6.10; INQ000587670_0069 para 277; INQ000111776_0001

> "*total burn out and exhaustion from the last few months, growing levels of mental health, poverty amongst the workforce triggering departures for better paid work*".[166]

6.81. The Department of Health and Social Care requested urgent funding from the UK government to support local authorities and care providers to retain and enhance capacity in the workforce and, in October 2021, the Workforce Recruitment and Retention Fund was introduced.[167] However, the department's own analysis concluded:

> "*The funds did not have a measurable positive or negative impact on overall recruitment during the funded period (although they may have had an impact later on). Feedback highlighted that the lead-in time or fund period was too short to have a tangible impact on recruitment activities.*"[168]

6.82. Although the various recruitment initiatives and additional funding provided some short-term solutions to ongoing staff recruitment and retention issues, they did not help to maintain permanent staff to make the workforce more resilient later in the pandemic or during a future pandemic.[169]

6.83. It is likely that additional people will be needed to work in the adult social care sector in a future pandemic. Plans should be developed by the Department of Health and Social Care, Welsh Government, Scottish Government and Department of Health (Northern Ireland) in conjunction with local authorities, trusts and the sector to ensure that capacity can be increased at pace.

The use of easements in England, Wales and Scotland

6.84. During the Covid-19 pandemic, local authorities in England, Wales and Scotland were expected to comply with their legal duties to carry out needs and financial assessments for people who may require social care and to provide that care and support.[170] However, where pressure on the workforce and the level of demand meant that they could not do so, local authorities could implement measures known as 'easements'.

6.85. Introduced by legislation in England, Scotland and Wales from the start of April 2020, easements allowed local authorities to streamline resources and prioritise care for

166 INQ000111776_0001
167 INQ000587737_0108-0109 paras 419, 422
168 INQ000587737_0109-0110 para 426d
169 INQ000571608_0059 para 13.13; Michelle Dyson 16 July 2025 137/22-138/6
170 Care Act 2014 (England) (https://www.legislation.gov.uk/ukpga/2014/23/contents); Social Services and Well-being (Wales) Act 2014 (https://www.legislation.gov.uk/anaw/2014/4/contents); Social Work (Scotland) Act 1968 (https://www.legislation.gov.uk/ukpga/1968/49/contents); Social Care (Self-directed Support) (Scotland) Act 2013 (https://www.legislation.gov.uk/asp/2013/1/contents); Carers (Scotland) Act 2016 (https://www.legislation.gov.uk/asp/2016/9/contents)

those who needed it most.[171] For example, in England, easements meant that a small local authority would not have to undertake a detailed assessment if it received up to 200 new assessment referrals each week and 20% of its staff were unavailable.[172] Easements were intended to be used only when absolutely necessary and full services were to be restored as soon as it was reasonably practicable to do so.[173]

6.86. Easements were not introduced in Northern Ireland, as Health and Social Care trusts were permitted from 26 March 2020 to interpret, with some flexibility, the guidance on assessments and reviews.[174]

6.87. In April 2020, representatives in the care sector raised concerns that it was unclear how easements should be implemented, leaving decisions open to interpretation and potential legal challenge.[175] Local authorities that used easements received interest and some criticism from the media and representative groups.[176]

6.88. In practice, easements were rarely used. In Scotland, between four and six local authorities used easements at any one time up until they were suspended on 30 November 2020.[177] Easements were not used by any local authority in Wales; they were suspended in December 2020.[178] In England, 8 out of the 152 local authorities used easements. They had not been used for over a year when they expired in July 2021.[179]

6.89. Before the Covid-19 pandemic, local authorities in England could use existing flexibilities in the Care Act 2014 to ensure that they complied with their legal

171 INQ000551798_0185-0186 paras 641a-641f, 644; INQ000587737_0150, 0153 paras 571-572, 582; INQ000546936_0034-0035 paras 4.34-4.35; 'Adult social services during the COVID-19 pandemic: Guidance', Welsh Government, 1 May 2020 (INQ000081088_0003); *Coronavirus (COVID 19): Changes to Social Care Assessments: Statutory Guidance for Local Authorities on Sections 16 and 17 of the Coronavirus Act 2020 as Updated on 6 Nov*, Scottish Government, November 2020, pp6-7 (https://www.gov.scot/publications/coronavirus-covid-19-changes-social-care-assessments-statutory-guidance-local-authorities-sections-16-17-coronavirus-act-2020-updated-6-nov; INQ000582761). Easements were introduced through the Coronavirus Act 2020.
172 INQ000587737_0151-0152 paras 576a, 578a
173 INQ000587737_0152 para 579; 'Adult social services during the COVID-19 pandemic: Guidance', Welsh Government, 1 May 2020 (INQ000081088_0002); *Coronavirus (COVID 19): Changes to Social Care Assessments: Statutory Guidance for Local Authorities on Sections 16 and 17 of the Coronavirus Act 2020 as Updated on 6 Nov*, Scottish Government, November 2020, p6 (https://www.gov.scot/publications/coronavirus-covid-19-changes-social-care-assessments-statutory-guidance-local-authorities-sections-16-17-coronavirus-act-2020-updated-6-nov; INQ000582761)
174 INQ000613603_0176-0177 para 596
175 Ruth Allen 3 July 2025 18/10-13; INQ000103777_0012 para 59a; *Briefing on Social Care and COVID-19 Emergency Powers*, Health and Social Care Alliance Scotland (the ALLIANCE), 1 July 2020, p2 (https://www.alliance-scotland.org.uk/blog/resources/alliance-briefing-paper-on-social-care-and-covid-19-emergency-powers; INQ000590367)
176 INQ000571608_0056 para 13.4; INQ000587382_0188 paras 668-669
177 *Coronavirus Acts: First Report to Scottish Parliament (June 2020)*, Scottish Government, 9 June 2020, p57, para 7.2.2.6 (https://webarchive.nrscotland.gov.uk/public/20250703173138/https://www.gov.scot/publications/coronavirus-acts-two-monthly-report-scottish-parliament/pages/8/#s722; INQ000346153); *Coronavirus Acts: Second Report to Scottish Parliament (August 2020)*, Scottish Government, 11 August 2020, p99, para 7.3.2.6 (https://webarchive.nrscotland.gov.uk/public/20250702235639/https://www.gov.scot/publications/coronavirus-acts-second-report-scottish-parliament/pages/9/#Section7.3.2; INQ000346154); *Coronavirus Acts: Third Report to Scottish Parliament (October 2020)*, Scottish Government, 6 October 2020, pp114-115, para 7.3.2.6 (https://webarchive.nrscotland.gov.uk/public/20250702224054/https://www.gov.scot/publications/coronavirus-acts-third-report-scottish-parliament/pages/8/#sec7.3.2; INQ000346155); *Coronavirus Acts: Fourth Report to Scottish Parliament (December 2020)*, Scottish Government, 9 December 2020, p127, para 7.3.2.6 (https://webarchive.nrscotland.gov.uk/public/20250706051921/https://www.gov.scot/publications/coronavirus-acts-fourth-report-scottish-parliament/pages/8/#s7.3.2; INQ000346156); *Coronavirus (COVID 19): Changes to Social Care Assessments: Statutory Guidance for Local Authorities on Sections 16 and 17 of the Coronavirus Act 2020 as Updated on 6 Nov*, Scottish Government, November 2020, p5 (https://www.gov.scot/publications/coronavirus-covid-19-changes-social-care-assessments-statutory-guidance-local-authorities-sections-16-17-coronavirus-act-2020-updated-6-nov; INQ000582761)
178 INQ000551798_0188 para 650
179 INQ000587788_0011, 0013 paras 36, 46-48

duties.[180] This could include conducting assessments virtually or rescheduling reviews. It is likely that local authorities relied on the flexibilities during the pandemic with which they were familiar, rather than using easements.[181] It is not possible to know how many local authorities used flexibilities or for how long, as they were not monitored.[182]

6.90. Since 1 April 2023, in England, the Care Quality Commission has had a duty to inspect and monitor the way in which local authorities exercise their responsibilities under the Care Act 2014 and to publish a report of the assessment.[183] This has potential to improve the oversight and accountability of its implementation.[184]

6.91. Easements may be required in a future pandemic and, in conjunction with the adult social care sector, should be prepared for in advance. This will help to ensure that there is more transparency and greater understanding about when it is appropriate to use easements. It is also important to monitor and record where easements are used to target support in those areas and ensure that a full service resumes promptly.

Vaccination as a condition of deployment

6.92. In December 2020, vaccines for Covid-19 became available across the UK and front-line care workers were in a priority group.[185] Although there was widespread support for the vaccination programme in the care sector, vaccine uptake by care workers in care homes was initially below the level that government scientific advisers recommended was needed to result in a sustained reduction in positive tests.[186]

6.93. In response to the low uptake, on 16 June 2021, the UK government announced that a mandatory Covid-19 vaccination policy would be introduced in care homes. The policy came into effect from 11 November 2021 and required anyone working in a Care Quality Commission registered care home in England to have two doses of a Covid-19 vaccine unless medically exempt.[187] On 9 November 2021, the UK government stated its intention to extend the policy to all care workers working in

180 Cathryn Williams 23 July 2025 86/11-23
181 INQ000587737_0159 para 605; INQ000587382_0188 para 669
182 Helen Whately 17 July 2025 205/24-206/10; Michelle Dyson 16 July 2025 190/18-191/17
183 INQ000584245_0054 para 148
184 Helen Whately 17 July 2025 206/11-14, 206/24-207/4; Michelle Dyson 16 July 2025 180/5-13
185 *Joint Committee on Vaccination and Immunisation: Advice on Priority Groups for Covid-19 Vaccination*, Department of Health and Social Care, 30 December 2020 (https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020/joint-committee-on-vaccination-and-immunisation-advice-on-priority-groups-for-covid-19-vaccination-30-december-2020; INQ000354469_0006-0007); see also *Module 4: Vaccines and therapeutics*, UK Covid-19 Inquiry, April 2026, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-4-full-report)
186 INQ000587670_0068 para 268; INQ000587381_0027 para 59; INQ000587788_0089 para 357. The advice from scientific advisers was also that more than 75% and ideally 80% to 90% of staff and residents had to have had or been offered the vaccine.
187 'Everyone working in care homes to be fully vaccinated under new law to protect residents', Department of Health and Social Care, 16 June 2021 (https://www.gov.uk/government/news/everyone-working-in-care-homes-to-be-fully-vaccinated-under-new-law-to-protect-residents; INQ000086730); INQ000587737_0137-0140 paras 535a-535c, 538

registered settings in England, including domiciliary care, unless medically exempt.[188] However, on 1 March 2022, it was announced that the extension would not come into force and the existing policy for care home workers would end on 15 March 2022.[189] A mandatory vaccination policy was not introduced in Scotland, Wales or Northern Ireland. Further detail on the policy and approach taken in the devolved administrations is considered in the Inquiry's Module 4 Report.[190]

6.94. In October 2021, the Department of Health and Social Care acknowledged that introducing the vaccination as a condition of deployment risked exacerbating the workforce pressures in adult social care.[191] The department had predicted that approximately 37,000 care workers could leave the sector. According to the Capacity Tracker (which recorded data on the social care sector in England), the workforce fell by 19,300 between July and December 2021. It is not possible to know the number of staff who left or were dismissed as a result of the policy, as the reasons for workforce departures were not systematically collected.[192]

6.95. The Inquiry heard that some staff left their job as a result of the policy. For example:

- A manager of a domiciliary care agency said that care workers resigned because they were unhappy about the policy.[193]
- One care home lost 3 of its 51 members of staff when the policy was introduced and another lost 5.[194]
- Five of the eight care home managers who participated in research commissioned by the Cabinet Office said staff had left due to the policy.[195]
- A care home manager told Every Story Matters that half of their care workers left, some of whom had worked at the home for years.[196]

6.96. Preparing for and implementing the policy and managing workforce shortages created an additional financial and administrative burden for care providers and managers at a time when resources were already strained.[197]

188 'Government to introduce COVID-19 vaccination as a condition of deployment for all frontline health and social care workers', Department of Health and Social Care, 9 November 2021 (https://www.gov.uk/government/news/government-to-introduce-covid-19-vaccination-as-a-condition-of-deployment-for-all-frontline-health-and-social-care-workers; INQ000086799)
189 'Regulations making COVID-19 vaccination a condition of deployment to end', Department of Health and Social Care, 1 March 2022 (https://www.gov.uk/government/news/regulations-making-covid-19-vaccination-a-condition-of-deployment-to-end; INQ000257312)
190 *Module 4: Vaccines and therapeutics*, UK Covid-19 Inquiry, April 2026, Chapter 6 (https://covid19.public-inquiry.uk/documents/module-4-full-report)
191 INQ000587737_0143-0144 para 549
192 INQ000587737_0148 para 567
193 INQ000587381_0048 para 97.2
194 INQ000587748_0002, 0015 paras 5, 66; INQ000509768_0014
195 INQ000587737_0148-0149 paras 568-569
196 *Every Story Matters: Adult Social Care Sector*, p128 (INQ000587564)
197 *Wrong Policy, Wrong Time: Findings from an NCF Member's Survey Exploring the Impact of Vaccination as a Condition of Deployment in Care Homes (VCOD) on Providers*, National Care Forum, February 2022, pp3-5, 7 (https://www.nationalcareforum.org.uk/wp-content/uploads/2022/03/NCF-Costs-of-VCOD-Slidepack-Final.pdf; INQ000572380); INQ000614375_0008 para 30

> *"We had a dilemma; a couple of staff didn't want to have a vaccine. So, they were more or less told, 'Well if you don't have your vaccine then you can't work,' so that caused other upsets and arguments."*[198]
>
> **Registered manager of a care home, England, Every Story Matters**

> *"I resigned from my post as I did not agree with forced vaccinations of my staff … I find it morally indefensible to coerce people to have any medical intervention."*[199]
>
> **Registered manager of a care home, England, Every Story Matters**

6.97. The Workforce Recruitment and Retention Fund was intended, among other things, to reduce workforce pressures, including those caused by the vaccination as a condition of deployment policy.[200] However, the fund could not mitigate the distrust and division the policy had fostered. There was particular concern in the sector that the initial policy did not apply to all staff working in care settings or to NHS staff.[201] Sir Sajid Javid (Secretary of State for Health and Social Care from June 2021 to July 2022) accepted that the policy would have contributed to workforce pressures but maintained that it was the right policy at the time.[202]

6.98. While the rationale for mandatory vaccination was to save lives and protect the vulnerable, the policy was introduced at a time when the social care sector was already experiencing staff shortages and low morale. It undoubtedly increased the pressure on care providers and led to social care staff leaving the sector. As noted in the Inquiry's Module 4 Report, a focus on increasing vaccine confidence among the social care workforce in areas of low uptake would have been more effective.[203]

Mortality data in the adult social care workforce

6.99. There was a greater risk of Covid-19 mortality for the social care workforce than for the general population, due to difficulties preventing transmission of infection in care homes and the close physical contact needed when providing care. In addition, many care workers often work in multiple care settings and so were more likely to be exposed to the virus. These factors meant that it was foreseeable that the social care workforce would be vulnerable to mortality from a pandemic virus.[204]

198 *Every Story Matters: Adult Social Care Sector*, p17 (INQ000587564)
199 *Every Story Matters: Adult Social Care Sector*, p128 (INQ000587564)
200 INQ000587737_0144-0145 para 554
201 INQ000586665_0017 paras 99-100; INQ000569774_0019 para 7.1; INQ000509768_0017; INQ000587737_0149 para 569
202 Sajid Javid 14 July 2025 67/8, 75/10-11
203 *Module 4: Vaccines and therapeutics*, UK Covid-19 Inquiry, April 2026, Chapter 6 (https://covid19.public-inquiry.uk/documents/module-4-full-report)
204 INQ000587702_0089 para 338

6.100. Despite the evident vulnerability of the workforce, prior to and during the pandemic, the data on the number of care workers who died from Covid-19 were not centrally recorded and the available data were not always accurate or comprehensive.

Recording occupation in mortality data during the pandemic

6.101. Data about deaths of care workers play an important role in understanding the severity and transmission of a virus and ensuring that the workforce is protected. During the Covid-19 pandemic, mortality data by occupation were collected in two ways. The first relied on the information provided when a death was registered and the second required social care providers to report the death. There were important caveats to the data collected through both methods.

Registration of deaths

6.102. The UK's statistics agencies – National Records of Scotland, the Office for National Statistics, and the Northern Ireland Statistics and Research Agency – collected data on deaths involving Covid-19 by occupation by relying on the information provided when the death was registered.[205] However, in England, Wales and Northern Ireland, the deceased's occupation was not always recorded on a death certificate and, where it was, it was not always up to date.[206]

6.103. At the outset of the pandemic, the statistics agencies' analysis of mortality rates by occupation was not available. As the pandemic progressed, these data became available but were not consistently reliable or comparable:

- On 11 May 2020, the Office for National Statistics first published provisional data on registered deaths by occupation. They showed that in England and Wales, up to 20 April 2020, there had been 98 care worker deaths. The data were published only twice more up to January 2021.[207] Separate figures for Wales were first published on 26 June 2020.[208]
- On 17 June 2020, National Records of Scotland first published a monthly analysis of registered deaths, which showed that care worker death rates between March and May 2020 were 25 per 100,000, compared with 20 per 100,000 for all occupations.[209]

205 INQ000474699_0027 para 53; INQ000514105_0009 para 30; INQ000553814_0049 para 176
206 INQ000474699_0028 para 55; 'Coronavirus (COVID-19) related deaths by occupation, England and Wales: Deaths registered up to and including 20 April 2020', Office for National Statistics, 11 May 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredupto andincluding20april2020; INQ000503378_0003, 0009-0010)
207 INQ000553814_0033 para 124; 'Coronavirus (COVID-19) related deaths by occupation, England and Wales: Deaths registered up to and including 20 April 2020', Office for National Statistics, 11 May 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredupto andincluding20april2020; INQ000503378_0001, 0007-0008). This group included care workers and domiciliary care workers aged 20 to 64 years old. The figures include deaths involving Covid-19 registered between 9 March and 20 April 2020.
208 INQ000572013_0057 para 160
209 INQ000514105_0009 para 30. This group included social care workers aged 20 to 64 years old and for whom a valid occupation was provided on the death certificate.

- The Northern Ireland Statistics and Research Agency first published a count of the number of deaths by occupation in June 2020, when it reported that there had been five Covid-19-related deaths in healthcare or care-related occupations. In September 2024, it was reported that nine care workers had Covid-19-related deaths between March 2020 and June 2022.[210]

Notification by care providers

6.104. At the outset of the pandemic, care providers, trusts and health boards were not required or asked to report the deaths of care workers. This changed at different times in each nation and notifications of deaths had to be provided to the regulator or relevant government department.

6.105. From 17 April 2020, care providers in Scotland were requested to notify the Care Inspectorate of a staff Covid-19 death.[211] Providers also had to report confirmed or presumed Covid-19 deaths to the Crown Office and Procurator Fiscal Service from 21 May 2020 (applied retrospectively).[212]

6.106. Health boards and care home providers in Wales were asked to report care home worker deaths to Public Health Wales from 23 April 2020, but this was not mandatory and did not capture all deaths. Public Health Wales said that, as the pandemic progressed, the data became less complete and their accuracy could not be guaranteed.[213]

6.107. From 12 May 2020, Health and Social Care trusts in Northern Ireland were requested to report the number of care workers who had died with or from Covid-19 to the Department of Health (Northern Ireland) on a daily basis.[214] However, there was no way of ensuring that all trusts provided the data and, when they did, the data were not verified or collated.[215]

6.108. In late May 2020, the Department of Health and Social Care asked care providers in England to notify them by email of a staff Covid-19 death.[216] Joanna Killian, Chief Executive of the Local Government Association from March 2024 to July 2026, said that they were concerned about the email being missed and no action being taken.[217] Ms Whately recalled that the Department of Health and Social Care obtained estimates of the number of deaths or data about mortality in the workforce through a compensation scheme.[218] This led to significant discrepancies in the

210 INQ000474699_0028 para 55. This group includes care workers and domiciliary care workers.
211 INQ000475130_0024-0025 para 88a
212 INQ000475130_0146 para 546. This applied where the virus might have been contracted in the course of the individual's employment.
213 INQ000587702_0086, 0088 paras 326-327, 331
214 INQ000490088
215 Michael McBride 24 September 2024 78/24-79/2
216 INQ000587382_0218 para 787
217 Joanna Killian 28 July 2025 40/3-11
218 INQ000587788_0023 para 85c

number of care worker deaths held by the Department of Health and Social Care (about 60) and the Office for National Statistics (200) as at June 2020.[219]

6.109. Developments in the routine collection of reliable data on Covid-19 deaths in the adult social care workforce were slow, inconsistent and inadequate across the UK. This meant that the number of deaths in the workforce and any potential increased mortality risks were not identified as quickly as they could have been.

Recording ethnicity in mortality data during the pandemic

6.110. Data recording the ethnicity of people who die with a pandemic virus are key to understanding whether it has a disproportionate impact on a specific ethnic group. This is particularly important for the adult social care workforce, where a significant proportion of workers are from an ethnic minority group.[220] For example, in London, 67% of the adult social care workforce was from an ethnic minority background (in April 2020) and in England it was 22% (according to data from 2020/21).[221]

6.111. Throughout the pandemic, mortality rates were higher in ethnic minority groups than in the White British population in the UK.[222] A review of disparities in the risk and outcomes of Covid-19 by Public Health England found that people from ethnic minorities may be more exposed to the virus and are more likely to be diagnosed through their occupation and living conditions.[223]

6.112. In June 2020, Public Health England recommended mandatory collection of "*comprehensive and quality*" ethnicity data, including on death certificates, and that these data should be "*readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME* [Black, Asian and minority ethnic] *communities*".[224] Public Health England considered that this could help to make a significant difference to the lives and experiences of these communities.

6.113. The Frontline Migrant Health Workers Group said that mortality data on migrant care workers would have been crucial to understand the impact of the pandemic on this group and encouraged better collection of such data in future.[225] The Local

219 INQ000587381_0034 para 80
220 *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups*, Public Health England, June 2020, p22 (https://assets.publishing.service.gov.uk/media/5ee761fce90e070435f5a9dd/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf; INQ000176354); see also *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 10 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
221 'Ethnic minority deaths and Covid-19: What are we to do?', The King's Fund, 30 April 2020 (https://www.kingsfund.org.uk/insight-and-analysis/blogs/ethnic-minority-deaths-covid-19; INQ000215522_0002); *The State of the Adult Social Care Sector and Workforce in England, 2021*, Skills for Care, October 2021, pp3, 81 (INQ000553305)
222 INQ000271436_0025 para 87
223 *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups*, Public Health England, June 2020, p6 (https://assets.publishing.service.gov.uk/media/5ee761fce90e070435f5a9dd/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf; INQ000176354)
224 *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups*, Public Health England, June 2020, p10 (https://assets.publishing.service.gov.uk/media/5ee761fce90e070435f5a9dd/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf; INQ000176354)
225 INQ000474919_0024 para 65

Government Association advocated for local authorities to have access to mortality data in order to serve diverse communities effectively.[226]

6.114. Since the start of 2012, the ethnicity of the deceased person has been collected, on a voluntary basis, when a death is registered in Scotland.[227] The Office for National Statistics linked data from the 2011 census and, later, the 2021 census in England with death certificates to obtain some information about the ethnicity of people who died from Covid-19.[228]

6.115. In Northern Ireland, only the country of birth was (and continues to be) requested on death certificates. The Northern Ireland Statistics and Research Agency considered that this information could be more meaningful than ethnicity data due to the small ethnic minority population in Northern Ireland. However, it acknowledged that place of birth did not equate to ethnicity.[229]

6.116. As part of Public Health Wales's data collection during the pandemic, ethnicity was requested, but, for reasons unknown, it was unavailable for one in four reported deaths.[230] In its combined Report relating to Modules 2, 2A, 2B and 2C, the Inquiry noted that in Wales there were no datasets allowing for any meaningful comparison of the impact of the Covid-19 pandemic on occupation or ethnicity.[231]

6.117. During the pandemic, there was insufficient collection of ethnicity and occupation data on death certificates in the UK. As a result, the increased Covid-19 mortality risk among care workers in a particular ethnic group was not identified as quickly as it could have been. Death certificates in England and Wales now record ethnicity if it has been self-declared in medical records.[232] Despite some improvements to the collection of ethnicity data, across the UK, comprehensive and consistent data collection is needed to understand the impact of a pandemic on ethnic minority groups.[233]

226 Joanna Killian 28 July 2025 40/6-22
227 *Module 2 Hearings: Written Closing Statement on Behalf of the Scottish Ministers*, 15 January 2024, pp13-14, para 39 (https://covid19.public-inquiry.uk/documents/module-2-closing-statement-on-behalf-of-the-scottish-minister); see also *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 10 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
228 INQ000553814_0039 para 139
229 INQ000474699_0027 para 53
230 INQ000587702_0088 para 332
231 Stephanie Howarth 29 February 2024 129/12-18; see also *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 10 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
232 *An Overview of the Death Certification Reforms*, Department of Health and Social Care, updated 14 August 2024 (https://www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms; INQ000548292_0005-0006); see also *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 10 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
233 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 10 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

Future collection of mortality data for the social care workforce during a pandemic

6.118. The fragmented nature of the adult social care sector is one of the primary barriers to the collection of data. Care providers also had to respond to many additional requests for data during the pandemic, which have been documented throughout this Report. Notwithstanding this, it is important to have data about the deaths of care workers to ensure that the workforce is protected and to understand the severity and transmission of the virus. The Trades Union Congress, the Royal College of Nursing and the Local Government Association agreed that the collection of mortality data for care workers needs to be improved.[234]

6.119. The Public Health Agency (Northern Ireland) said that mortality data for social care staff could be available in future by linking the workforce register with healthcare records and that it would be a useful source of information to understand infections in care workers and to inform guidance.[235] The collection and publication of these data could also be one way of showing that care workers are valued and recognised (see Chapter 8: Recognition and protection).

6.120. In its Module 3 Report, the Inquiry recommends the development of mechanisms to improve the collection and publication of data about the deaths of healthcare workers during a pandemic and that such data should be comparable across the four nations of the UK.[236] There should be equivalent data collected for the adult social care sector. The Inquiry recommends that these data be collected during a pandemic. Any mechanism for collecting the data must be simple and quick, and not impose a disproportionate burden on care providers.

Recommendation 6: Collection of data about deaths of adult social care workers during a pandemic

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should develop mechanisms to collect, analyse and publish data systematically about the deaths of adult social care workers during a pandemic. The data must be comparable across the four nations of the UK.

The mechanisms should be developed with the adult social care workforce regulators, public health agencies and employers of care workers.

234 INQ000587381_0044 para 96.21; Claire Sutton 29 July 2025 11/1-19; Joanna Killian 28 July 2025 40/7-14
235 INQ000587734_0036-0037 para 112
236 *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Recommendation 8 (https://covid19.public-inquiry.uk/documents/module-3-full-report)

Chapter 7: Deaths and end of life

Introduction

7.1. The vulnerability of people using adult social care was widely known before the Covid-19 pandemic. In general, the age and underlying health conditions of adult social care users mean that they have a higher risk of serious illness and death from respiratory diseases than the general population. This resulted in a significant increase in the number of people who died in care homes and at home during the Covid-19 pandemic. This chapter examines the delay in establishing and publishing the number of Covid-19 deaths in people who used adult social care services.

7.2. While social care staff went to extraordinary efforts to provide compassionate end-of-life care, some people did not experience a dignified death. Many people died alone without the comfort or support of their loved ones in their final days and last moments. Bereaved families still question the circumstances of their loved ones' deaths and feel guilty for not being present. Their grief was compounded by the Covid-19 restrictions, which prevented them from giving their loved one the funeral they would have wished for and deserved.

7.3. There were also concerns that decisions on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were made for people using adult social care services without proper consultation or a personalised assessment. This chapter considers how advance care planning and DNACPR decision-making might be improved in adult social care in the future. It also looks at the changes to end-of-life care and whether the social care workforce had the necessary training and skills.

Understanding deaths in adult social care

7.4. At the start of the Covid-19 pandemic, there were concerns about the ability to access accurate data on Covid-19 deaths of care home residents and of people receiving domiciliary care who died at home.

7.5. The importance of these data cannot be overemphasised. Comprehensive and reliable mortality data enable decision-makers to understand the true impact and severity of a pandemic. The data can inform decisions and guidance about how and when to protect and support people who are vulnerable to a pandemic virus, such as those using adult social care services. They can also be used to evaluate the impact of interventions such as expedited discharges from hospital to a care home.

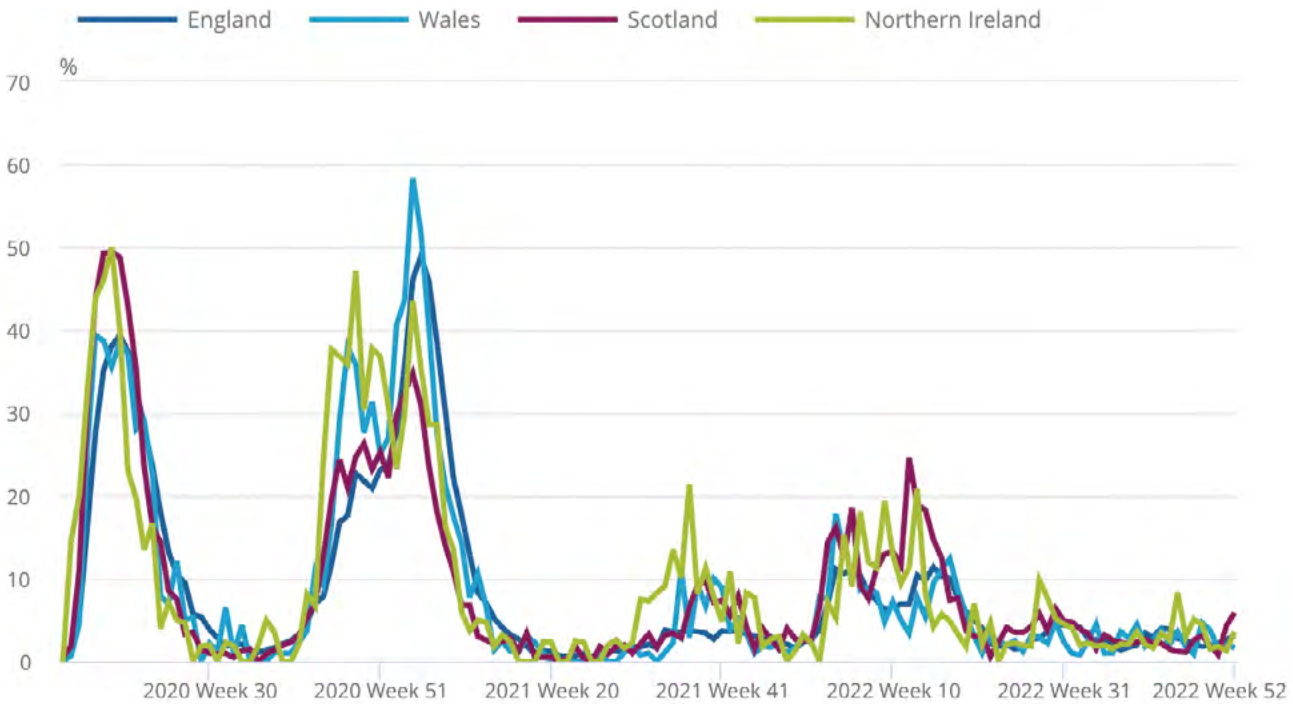
Mortality data for care homes

7.6. During the pandemic, 43,088 care home residents died with Covid-19 mentioned on their death certificate, comprising:

- 35,868 deaths in England;
- 4,272 in Scotland;
- 1,961 in Wales; and
- 987 in Northern Ireland.[1]

7.7. There were sharp increases in the proportion of deaths in care homes that involved Covid-19 in the early months of the pandemic and again from late 2020 to early 2021 (see Figure 3).[2] Covid-19 was the second leading cause of death in care homes in all four nations of the UK in 2020.[3]

Figure 3: Percentage of care home deaths involving Covid-19 registered weekly, by nation, 2020 to 2022



Source: Deaths in Care Homes, UK: 2015 to 2021 (Final) 2022 (Provisional) (INQ000355549_0018-0019). See 'Notes' in source for an explanation of how these data were calculated.

1 *Deaths in Care Homes, UK*, Office for National Statistics, 15 March 2023 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/datasets/deathsincarehomesuk; INQ000584980). The figures for 2015 to 2021 were final; the figures up to July 2022 were provisional. Figures are calculated from the Office for National Statistics data tables using the closest dates to the scope of Module 6 (1 March 2020 to 28 June 2022) as follows: England and Wales: 13 March 2020 to 1 July 2022; Scotland: 16 March 2020 to 3 July 2022; Northern Ireland: 20 March 2020 to 1 July 2022.

2 *Deaths in Care Homes, UK: 2015 to 2021 (Final), 2022 (Provisional)*, Office for National Statistics, 15 March 2023, Figure 4 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/deathsincarehomesuk2015to2021final2022provisional/2023-03-15; INQ000355549)

3 *Deaths in Care Homes, UK: 2015 to 2021 (Final), 2022 (Provisional)*, Office for National Statistics, 15 March 2023, p2 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/deathsincarehomesuk2015to2021final2022provisional/2023-03-15; INQ000355549)

7.8. There was no central mechanism for collecting data about care home residents who died of Covid-19. Mortality data were obtained from three different sources:

- regulators who were notified of the death of a care home resident by care providers;[4]
- statistics agencies who used information provided when a death was registered; and
- reporting systems and reports that were developed during the pandemic by public health agencies in Wales, England and Northern Ireland in response to an identified need for more timely mortality data to monitor trends in Covid-19 infection.[5]

7.9. The utility of the data, however, was limited by issues with their timeliness and the different ways in which they were collected.

Timely access to data

7.10. The UK government and devolved administrations could not access comprehensive mortality data for care home residents for some weeks after the first registered Covid-19 care home death, and it was months before the data distinguished between Covid-19 deaths and deaths from other causes.

7.11. The first Covid-19-related care home deaths were registered in mid-March 2020 in England, Wales and Scotland and in the final week of March 2020 in Northern Ireland.[6] As they did not have access to mortality data for care homes at this time, Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021) explained that this contributed to feeling as if they "*were operating in the dark about the extent of the pandemic in care homes*".[7]

7.12. The Care Inspectorate in Scotland provided, initially, a daily summary of Covid-19 deaths in care services to the Scottish Government from mid-March 2020.[8] From June 2020, care home providers were required to report a confirmed or suspected

4 The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, regulation 21 (https://www.legislation.gov.uk/ssi/2002/114/contents/made); The Nursing Homes Regulations (Northern Ireland) 2005, regulation 30 (https://www.legislation.gov.uk/nisr/2005/160/contents/made); The Residential Care Homes Regulations (Northern Ireland) 2005, regulation 30 (https://www.legislation.gov.uk/nisr/2005/161/contents); The Care Quality Commission (Registration) Regulations 2009, regulation 16 (https://www.legislation.gov.uk/uksi/2009/3112/contents); The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017, regulation 60 (https://www.legislation.gov.uk/wsi/2017/1264/contents)

5 INQ000587702_0084 para 316; INQ000587772_0140-0141 para 11.29; INQ000587734_0051 para 160. Public Health England was abolished and replaced by the UK Health Security Agency in October 2021.

6 *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*, Office for National Statistics, 28 February 2022 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsregisteredbetweenweekending20march2020andweekending21january2022; INQ000325347_0026); INQ000507855_0002; INQ000474699_0046 para 7

7 INQ000587788_0024 para 89

8 INQ000475130_0200 para 39

Covid-19 death to the Care Inspectorate within 24 hours, which the Care Inspectorate shared weekly with the Scottish Government.[9]

7.13. From 26 March 2020, Health and Social Care trusts in Northern Ireland were requested to report to the Public Health Agency (Northern Ireland) any deaths occurring within 28 days of a positive Covid-19 test, with an option to report the place of death.[10] However, Robin Swann (Minister of Health for Northern Ireland from January 2020 to October 2022 and from February to May 2024) said that he only received these data up to 19 April 2020 and that they were not specific to care homes.[11]

7.14. The data for England and Wales provided by the Office for National Statistics included the place of death from 7 April 2020.[12] While these data were comprehensive, a delay between the death occurring and being registered (usually seven days) meant that some deaths were not included in the weekly figures until 11 days afterwards.[13]

7.15. In England, the delay in the registration of deaths, and the fact that care providers did not always promptly report deaths during the pandemic, created a discrepancy in the figures provided to the UK government and, in April 2020, under-reporting of care home deaths by the Care Quality Commission.[14] Ms Whately said that it was not until 9 April 2020 that she received the "*correct*" data from the Care Quality Commission showing care home (and domiciliary care) deaths.[15] Ms Whately described being "*extremely concerned*" by the data, adding:

> "[W]*hilst it was not possible at this early stage to be able to say that all of those additional deaths were as a result of Covid-19, the spike in deaths was so stark that I could only conclude that the pandemic had contributed significantly to the increased death rate.*"[16]

7.16. Care Inspectorate Wales developed a care home deaths report that was available from 15 April 2020 and shared daily with the Welsh Government from 29 April 2020.[17] It was not until 9 November 2020 that the report separated Covid-19 deaths and deaths from other causes.[18] Health boards in Wales were asked (but not required) to report Covid-19-related deaths of care home residents to Public Health Wales from 23 April 2020 and the data were provided daily to the Welsh Government and

9 INQ000475130_0028 para 88(j)
10 INQ000587734_0051 paras 160-161
11 INQ000615082_0019 para 39
12 INQ000572013_0031 para 107. The data included deaths registered up to the week ending 27 March 2020.
13 INQ000273897_0014 para 58; INQ000553814_0026 para 113
14 *Deaths Involving COVID-19 in the Care Sector, England and Wales,* Office for National Statistics, 15 May 2020, p4 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto1may2020andregisteredupto9may2020provisional; INQ000252648); INQ000565864_0004; INQ000273897_0014 para 58
15 INQ000587788_0023 para 85(d)
16 INQ000587788_0023 para 86
17 INQ000660077_0001-0002 paras 4-5
18 INQ000660077_0001 para 2

health boards.[19] However, Public Health Wales told the Inquiry that, as the pandemic progressed, the data it received became less complete and more varied as health boards adopted different systems and methods for reporting, which might have contributed to under or over-reporting.[20]

7.17. The Northern Ireland Statistics and Research Agency published weekly data about registered Covid-19-related deaths by place, including care homes, from 24 April 2020.[21] The Department of Health (Northern Ireland) asked for more frequent reporting in May 2020 but the Northern Ireland Statistics and Research Agency was unable to do so for a number of reasons, which included the time it took to register deaths and analyse the data as well as a lack of resources.[22]

7.18. If the UK government and devolved administrations had been able to access comprehensive data about Covid-19 deaths among care home residents from early March 2020, it could have informed the timing of policy decisions and guidance on matters such as infection prevention and control, testing and personal protective equipment. The Local Government Association, the Commissioner for Older People for Northern Ireland, the Welsh Local Government Association and the National Care Forum agreed that the data could have informed policy and helped providers and local authorities to protect care home residents.[23]

Differences in data collection

7.19. It is not possible to compare data across the UK or produce a UK-wide figure for care home resident deaths, due to the significant differences in the way mortality data were collected and the definitions adopted in adult social care.[24] Across the UK, it was not always clear that different measures were used to calculate the number of deaths, which was difficult for those relying on the data.[25]

7.20. In any event, some care home residents died in hospital, not in the care home. While the data collected by the statistics agencies for England, Wales and Northern Ireland identified care home residents who died in hospital, the data for Scotland did not.[26] The Public Health Agency (Northern Ireland) reported 501 care home deaths, which did not include people who died in a location other than a care home

19 INQ000587702_0084-0086 paras 317, 323, 326
20 INQ000587702_0084-0086 paras 319, 327
21 INQ000474699_0022-0023 para 48
22 INQ000474699_0020-0021 paras 44, 44(i), 44(iv)
23 INQ000587382_0192 para 682; INQ000474926_0027-0028 para 84; INQ000108917_0002; INQ000475131_0030-0031 para 5.3
24 *Deaths in Care Homes, UK: 2015 to 2021 (Final), 2022 (Provisional)*, Office for National Statistics, 15 March 2023, pp2, 6-7 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/deathsincarehomesuk2015to2021final2022provisional/2023-03-15; INQ000355549); INQ000572013_0034-0035 paras 114-115, Table 1
25 *Improving Health and Social Care Statistics: Lessons Learned from the COVID-19 Pandemic*, Office for Statistics Regulation, October 2021, p18 (https://osr.statisticsauthority.gov.uk/wp-content/uploads/2021/10/Improving-health-and-social-care-statistics-lessons-learned-from-the-COVID-19-pandemic.pdf; INQ000092812)
26 *Deaths in Care Homes, UK: 2015 to 2021 (Final), 2022 (Provisional),* Office for National Statistics, 15 March 2023, p6 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/deathsincarehomesuk2015to2021final2022provisional/2023-03-15; INQ000355549)

or those who died with a clinical diagnosis of Covid-19. The Public Health Agency acknowledged that this was an underestimate compared with the 1,281 deaths recorded by the Northern Ireland Statistics and Research Authority.[27]

Future collection of mortality data for care home residents

7.21. The Public Health Agency (Northern Ireland) considers that the collection, sharing and linking of data during a pandemic needs to be improved in order to understand the impact of the virus and to inform public health advice.[28] Professor Fu-Meng Khaw (National Director of Health Protection and Screening Services and Executive Medical Director of Public Health Wales from June 2021) told the Inquiry that a single point of registration and collection of mortality data would be helpful, particularly during the early stages of a pandemic, when it is critical to be able to monitor how serious and infectious a virus could be.[29]

7.22. At the start of the Covid-19 pandemic, policy decisions to protect vulnerable people living in care homes could not be informed by timely, accurate data. Although there were some improvements in the collection of mortality data in adult social care as the pandemic progressed, it was vital that national and local decision-makers had early access to real-time, reliable and comparable data to understand and monitor the effect of Covid-19 in care homes.

7.23. Each of the UK government, Welsh Government, Scottish Government and Northern Ireland Executive should develop a single, consistent measure for daily reporting of deaths in care homes from a pandemic virus. It should be possible to compare the data across the UK. It is also important to have clear definitions with an explanation about the different collection methods and any limitations to the data. This will help to ensure that the data are readily available and easily understood in future.

Mortality data for people using domiciliary care services

7.24. Between late March to late April 2020 and early January to mid-February 2021, the number of people dying at home increased and stayed above average after the pandemic peaks had subsided.[30] In England and Wales, there were more than 59,000 more deaths at home between March 2020 and 28 May 2021 (a 39% increase from the 2015 to 2019 average). The King's Fund (an independent charity) said that these data strongly suggest that the large number of people dying at home would likely have died in hospital outside of a pandemic.[31] In Scotland, the proportion

27 INQ000587734_0053-0054 paras 169-171. The Public Health Agency (Northern Ireland) identified people who died in a residential or care home within 28 days of a positive Covid-19 test between 28 March 2020 and 12 May 2022. The Northern Ireland Statistics and Research Agency identified the number of deaths of care home residents involving Covid-19, including where they occurred outside of the care home, up to 13 May 2022.
28 INQ000587734_0054 para 172
29 Fu-Meng Khaw 8 July 2025 117/8-11, 20-24
30 INQ000587295_0043-0044 para 146
31 INQ000574106_0001-0003

of deaths at home increased from 25.6% (10,433) in 2019 to 31.4% (14,538) in 2020.[32] Similarly, in Northern Ireland, excess deaths at home (the difference between the actual and expected number of deaths) accounted for 77.9% of the total excess deaths between March 2020 and December 2022.[33]

7.25. Domiciliary care providers in Scotland and England are required to notify the regulator when a person to whom they provide care dies.[34] However, during the pandemic, the data were not comprehensive or always accessible. For example, providers only had to report it if the person died while they were receiving care.[35] In England, between 10 April and 9 June 2020, there were 6,523 deaths of recipients of domiciliary care; this was more than double the three-year average. Of these deaths, 819 (12.6%) involved Covid-19.[36] The data were only published (in England) on two occasions (15 May and 3 July 2020).[37]

7.26. The majority of deaths at home in the four nations of the UK were not described as related to Covid-19, in part due to the lack of testing early in the pandemic. Therefore, the number of deaths at home due to Covid-19 is likely to be higher than reported.[38]

7.27. Mortality data about people receiving domiciliary care during a pandemic are vital to inform policy decisions on protective measures for people using social care services and the staff delivering care, including the distribution of resources and support for end-of-life care. Each of the UK government, Welsh Government, Scottish Government and Northern Ireland Executive must establish mechanisms to collect mortality data for people who use domiciliary care services and die at home from a pandemic disease. Care Inspectorate Wales and the Regulation and Quality Improvement Authority in Northern Ireland should consider introducing a requirement on domiciliary care providers to report the death of a person using their services from a pandemic virus.

32 *Fairer Care at Home, The Covid-19 Pandemic: A Stress Test for Palliative and End of Life Care in Scotland*, KE Sleeman, J Leniz, JM Davies, AE Bone, S Pask, RL Chambers et al, Better End of Life, July 2022, p6 (https://www.mariecurie.org.uk/document/covid-fairer-care-at-home-in-scotland; INQ000349001)
33 INQ000587734_0054-0055 paras 176, 179, Figure 1
34 The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, regulation 21 (https://www.legislation.gov.uk/ssi/2002/114/contents/made); The Care Quality Commission (Registration) Regulations 2009, regulation 16 (https://www.legislation.gov.uk/uksi/2009/3112/contents); INQ000584245_0061 paras 175, 178; INQ000500346_0002 para 5; INQ000475143_0026 paras 87-88
35 INQ000553814_0037-0038 para 135c; The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, regulation 21 (https://www.legislation.gov.uk/ssi/2002/114/contents/made)
36 *Deaths Involving COVID-19 in the Care Sector, England and Wales: Deaths Occurring up to 12 June 2020 and Registered up to 20 June 2020 (Provisional)*, Office for National Statistics, 3 July 2020, p22 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional; INQ000252649)
37 INQ000553814_0037-0038 para 135c
38 INQ000587295_0043-0044 para 146

Advance care planning in adult social care

7.28. Advance or anticipatory care planning involves discussing and recording an individual's preferences for future medical care. This may include how and where they want to be cared for and treatments that they would or would not want.[39]

7.29. Guidelines on advance care planning produced in 2018 by the National Institute for Health and Care Excellence (often referred to as NICE) state that input from a clinician may be appropriate in some circumstances. Therefore:

> "*Skilled practitioners need to be able to have sensitive conversations with people in the context of a trusting and collaborative relationship, and provide the person with clear and accessible information to help them make these important decisions.*"[40]

7.30. Discussions about plans for advance care should be conducted at a pace that suits the individual and involve their loved ones (where possible).[41]

Advance care planning during the Covid-19 pandemic

7.31. Pressures on the adult social care and healthcare sectors meant that it was more difficult to have sensitive conversations about advance care at a suitable pace during the pandemic. As a result, there were concerns that people had or may have been rushed into making a decision.[42] A consultant in palliative medicine in Scotland said that, while it was important for advance care planning to be done quickly during the pandemic, "*it wasn't always done at the right time, right place, or by the right person*".[43]

7.32. Professor Stephen Barclay, expert witness on end-of-life care, said that there was evidence that hurried discussions had created a misunderstanding about the reason for advance care plans (some people thought that it was because of their age or health, or because of rationing) and that the quality of these conversations had deteriorated.[44]

7.33. Visiting restrictions meant that some discussions about advance care did not happen in person or with family members present.[45] A person with care and support needs

39 INQ000587295_0010 para 21
40 *Decision-Making and Mental Capacity*, National Institute for Health and Care Excellence, 3 October 2018, p14 (https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917; INQ000582899)
41 INQ000587295_0010-0011, 0073 paras 21-22, 229
42 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, p17 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
43 'Understanding and addressing challenges for advance care planning in the COVID-19 pandemic: An analysis of the UK CovPall survey data from specialist palliative care services', A Bradshaw, L Dunleavy, C Walshe, N Preston, RL Cripps, M Hocaoglu et al, *Palliative Medicine* (2021), 35(7), 1225-1237, p7 (https://journals.sagepub.com/doi/full/10.1177/02692163211017387; INQ000660252)
44 Stephen Barclay 30 July 2025 35/9-13
45 INQ000587295_0065 para 205

told the Inquiry's listening exercise, Every Story Matters, how it felt to receive a call from their GP.

> "*I received a phone call from my GP surgery, this telephone call put the greatest fear into me yet … I was asked if I had discussed my end of life wishes with my loved ones. Like did I want to go into hospital or stay at home … This terrified me.*"[46]
>
> **Person with care and support needs, Scotland, Every Story Matters**

7.34. Additionally, not everyone received the support or information they needed to make an informed plan. The Care Quality Commission was told that, in England:

> "[O]*lder people, people with dementia and people with a learning disability … were not supported to the extent they needed to be in advance care planning conversations, or given the information they needed in an accessible way.*"[47]

These factors understandably created confusion and distress for the individual, their loved ones and clinicians during a period of heightened anxiety.[48]

7.35. Professor Barclay and fellow expert witness on end-of-life care Professor Katherine Sleeman said that people's experience during the pandemic demonstrated the importance of discussions about advance care taking place in non-pandemic times, so that a plan is already in place. They reported a care home manager's view that the lack of advance care planning before the pandemic had created "*chaos, confusion, and obstacles that caused undue suffering*".[49]

7.36. Advance care planning should be encouraged outside of a pandemic; greater public engagement on this topic will lead to a better understanding of its importance.

Personalised planning for advance care

7.37. On 1 April 2020, a statement by the Royal College of General Practitioners, British Medical Association, Care Quality Commission and Care Provider Alliance stressed that:

46 *Every Story Matters: Adult Social Care Sector*, p15 (INQ000587564)
47 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp4, 29, 41 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
48 INQ000587295_0065, 0070-0072 paras 205, 220, 224
49 INQ000587295_0013, 0070-0071 paras 30, 220

> "*The importance of having a personalised care plan in place, especially for older people, people who are frail or have other serious conditions has never been more important than it is now during the COVID-19 Pandemic.*"[50]

While the statement was a reminder to health and social care professionals that advance care plans must continue to be made on an individual basis according to need, this did not always happen during the pandemic.

7.38. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is used in England and Scotland to complement the advance care planning process. It enables an individual and their clinician to establish which treatments (including cardiopulmonary resuscitation or CPR) would and would not benefit the patient. It can be completed in a hospital, care home or the community. A ReSPECT form may be used to record the outcome of the discussion.[51]

7.39. There were examples of the ReSPECT process not being followed during the pandemic, such as forms completed without proper engagement or a personalised assessment.

> "*These calls for the ReSPECT forms were done all over the phone and to see residents that we care for being told that they weren't going to get any treatment because of their age, or disabilities or anything, it was just heartbreaking. That was the most traumatic.*"[52]
>
> **Care home worker, England, Every Story Matters**

> "*October 2020, there were just blanket ReSPECT forms done for everybody. They would literally just fill these forms out for the person and automatically decide, so everybody over a certain age was automatically … deemed, to not be worth reviving … every ReSPECT form had no comments, or no signatures from residents.*"[53]
>
> **Registered manager of a care home, England, Every Story Matters**

7.40. Some of the communications during the pandemic did not encourage a discussion about advance care planning and could have been interpreted as putting undue pressure on an individual to make a plan.[54] Residents of a care home received a letter from a GP on 24 March 2020, which stated:

50 INQ000400508
51 INQ000343994_0014, 0016 paras 61, 61a, 61c, 71-73; INQ000587295_0011 para 24
52 *Every Story Matters: Adult Social Care Sector*, p96 (INQ000587564)
53 *Every Story Matters: Adult Social Care Sector*, p95 (INQ000587564)
54 INQ000505521_0001-0002

> "[W]*here no decision has previously been made during advanced planning discussion (including the failure of relatives to return complete documents) and no completed document is returned within a suitable time frame, a best interests decision may well be made by the clinicians involved in your/your relatives care if you/they become unwell.*"[55]

7.41. Prior to and during the pandemic, there was no mandatory training on advance care planning for all social care workers in England, Scotland and Northern Ireland. This remains the case. In Wales, domiciliary care workers providing direct care were required to have, or be working towards, a qualification that included training about advance care planning. This training was not mandatory for residential care home workers providing direct care in Wales until October 2022.[56]

7.42. In England, Scotland and Northern Ireland, additional guidance and resources were made available to support the workforce in advance care planning during the pandemic.[57] However, in a report in January 2021, the Northern Ireland Assembly's Committee for Health noted that some care home staff said they had felt pressure to lead a conversation on this topic and needed more training and medical input. It recommended training in advance care planning for relevant professionals.[58]

7.43. The Care Quality Commission recorded in March 2021 that there was an evident risk of inappropriate decision-making and unsafe care or treatment if health and care staff were not fully informed about advance care planning.[59] In March 2022, *Universal Principles for Advance Care Planning* was jointly published by a number of health and social care organisations and was intended for anyone involved in discussions about advance care and implementing a plan. It also emphasised the importance of training and education for health and social care professionals undertaking such discussions.[60] The Inquiry endorses the calls for training.

7.44. Some of the problems encountered with advance care planning during the pandemic may have been avoided had the health and social care professionals involved in the discussions received appropriate training. This would have equipped them with the necessary knowledge and skills to engage with people in a sensitive way.

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55 INQ000505520_0002; INQ000474414_0029 para 18.1.3. The letter was sent by a GP surgery to a care home and it was shared with the Royal Mencap Society.
56 INQ000659971_0002-0003. Domiciliary care workers had to be registered with Social Care Wales from March 2020.
57 INQ000659970_0005; INQ000659972_0006-0007 para 16; *e-End of Life Care for All e-Learning Programme*, Skills for Care, p1 (https://www.skillsforcare.org.uk/Developing-your-workforce/Care-topics/End-of-life-care/e-End-of-Life-Care-for-All-e-ELCA-elearning-programme.aspx; INQ000660250)
58 *Inquiry Report on the Impact of Covid-19 in Care Homes*, Northern Ireland Assembly Committee for Health, 21 January 2021, pp19-20, para 49, recommendation 36 (https://www.niassembly.gov.uk/assembly-business/committees/2017-2022/health/reports/report-care-homes; INQ000256510)
59 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp4-5 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
60 *Universal Principles for Advance Care Planning*, Age UK et al, March 2022 (https://www.england.nhs.uk/wp-content/uploads/2022/03/universal-principles-for-advance-care-planning.pdf; INQ000339327_0005, 0015)

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions

7.45. Whether a person should undergo CPR in the event that their heart stops beating is a clinical decision that must be made by a healthcare professional. Ideally, the decision should be made in advance with the individual as part of a holistic discussion about their wishes for future care and treatment.[61] They may be supported by loved ones and care workers. CPR can be effective if someone is otherwise fit and healthy, but it is unlikely to be successful and may cause more harm than good for people with a progressive terminal condition, a serious life-limiting illness or physical frailty.[62]

7.46. Where a person's preference is not to undergo CPR, or a clinician considers that CPR would not be appropriate, a DNACPR form should be completed (on paper or digitally) and placed on their medical file.[63]

7.47. Since 2001 and during the pandemic, UK-wide professional guidance on DNACPR decision-making has stated that:[64]

- DNACPR decisions should be based on an individualised assessment of the patient's health and that "[b]*lanket policies that deny CPR or apply CPR to groups of people, for example to all patients in a hospice, nursing home or particular hospital ward, or to people above or below a certain age, are unethical and probably unlawful*";[65]
- communication with the patient, and (unless they have requested otherwise) those close to them, must be clear, accurate, honest and timely;[66] and
- a DNACPR decision applies only to CPR and does not equate to a decision to decline any other element of care or treatment ('do not treat').[67]

61 *Protect, Respect, Connect – Decisions About Living and Dying Well During Covid-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp8-9 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
62 INQ000587295_0012 paras 26-27
63 *Decisions Relating to Cardiopulmonary Resuscitation*, British Medical Association, Resuscitation Council UK and Royal College of Nursing, 3rd edition (1st revision), 2016, pp5-6 (https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf; INQ000331016). Further detail about how DNACPR decisions are documented and recommended improvements to this process are set out in *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 7 (https://covid19.public-inquiry.uk/documents/module-3-full-report).
64 INQ000412890_0053 para 187
65 *Decisions Relating to Cardiopulmonary Resuscitation*, British Medical Association, Resuscitation Council UK and Royal College of Nursing, 3rd edition (1st revision), 2016, p9 (https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf; INQ000331016)
66 *Decisions Relating to Cardiopulmonary Resuscitation*, British Medical Association, Resuscitation Council UK and Royal College of Nursing, 3rd edition (1st revision), 2016, p4 (https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf; INQ000331016)
67 *Decisions Relating to Cardiopulmonary Resuscitation*, British Medical Association, Resuscitation Council UK and Royal College of Nursing, 3rd edition (1st revision), 2016, pp5-6, 10 (https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf; INQ000331016)

7.48. The Inquiry heard that, during the pandemic, some DNACPR decisions were not based on a personalised assessment, were made without proper consultation with the individual or their loved ones and were wrongly interpreted as decisions not to treat.

'Blanket' DNACPR decisions for groups of people

7.49. Early in the pandemic, a number of sources, including the media, reported concerns that DNACPR decisions were being applied to groups of people in adult social care (often referred to as 'blanket' DNACPRs) based on age, disability or health conditions and not on an individualised clinical assessment.[68]

7.50. The Inquiry also heard examples of GPs adopting a blanket approach to DNACPR decisions:

- Helen Hough, former care home owner and member of Covid-19 Bereaved Families for Justice Cymru, said that GPs made a DNACPR decision for all of their patients in mid-March 2020. In two cases, the residents' families contacted the GP and the DNACPR was removed.[69]
- A bereaved family member told Every Story Matters what they observed: "*As lockdown started being discussed, the priority of the GPs for the care homes was to move all residents onto DNACPRs. At no point was there any discussion on best ways to support or treat residents with Covid. Blanket DNACPRs rather than asking 'how will we treat people?'*"[70]
- A care home worker in Wales told Every Story Matters: "*Our local doctor put a blanket DNACPR on all his patients to stop them taking up beds in the hospital which families contested.*"[71]
- The Care Quality Commission reported that one GP surgery in England sent letters to care homes for people with learning disabilities about making blanket DNACPR decisions. The letters were later retracted.[72]
- One individual with care and support needs in Wales told Every Story Matters that she was "*still shaken to the very core of my being, that they imposed 'Do Not Resuscitate' notices on those of us with a significant disability or over a certain age*".[73]

68 Mary Cridge 7 July 2025 127/9-17; INQ000509530_0026 para 96; INQ000474926_0044 paras 133-134
69 INQ000587639_0006 paras 24-25
70 *Every Story Matters: Adult Social Care Sector*, p92 (INQ000587564)
71 *Every Story Matters: Adult Social Care Sector*, p15 (INQ000587564)
72 *Protect, Respect, Connect – Decisions about Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, p22 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492). See also analysis of DNACPR decisions in healthcare for people with learning disabilities in: *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom,* UK Covid-19 Inquiry, March 2026, Chapter 7 (https://covid19.public-inquiry.uk/documents/module-3-full-report)
73 *Every Story Matters: Adult Social Care Sector*, p15 (INQ000587564)

7.51. There are no formal records of the number of DNACPR decisions that were made during the pandemic. Evidence submitted to the Care Quality Commission by 2,048 adult social care providers in England showed that the number of people in these settings with a DNACPR in place increased from 16,876 to 26,555 between 17 March 2020 and December 2020. Of those providers, 119 (6%) felt that people in their care had been subject to blanket DNACPR decisions, which the Care Quality Commission described as concerning. In its final report, published in March 2021, the Care Quality Commission recorded: "[W]e *heard evidence from people, their families and carers that there had been 'blanket' DNACPR decisions in place*."[74]

7.52. The high number of reports of blanket DNACPR decisions led to concerns that there might have been national instructions to adopt this approach, but the UK government and devolved administrations said that they did not authorise such a policy.[75] The Care Quality Commission found no evidence of any instruction and neither has the Inquiry.[76] Nevertheless, there were many reports of their inappropriate use.[77] DNACPR decisions made during the pandemic based on a person's age, disability or health conditions, or without a personalised assessment to consider the person's wishes and feelings, caused considerable distress and confusion for the individual, their loved ones and staff. This was unacceptable and must not happen again.

Response to concerns about DNACPR decisions during the pandemic

7.53. On 1 April 2020, the Royal College of General Practitioners issued a UK-wide joint statement with the British Medical Association, the Care Provider Alliance and the Care Quality Commission. The statement emphasised that it was essential that DNACPR decisions be made on an individual basis, in consultation with the patient (or family members where the patient lacked capacity) and as part of advance care planning.[78] Similar communications to the health and social care sectors followed in April 2020 from the UK government, Welsh Government and Scottish Government and from the Commissioner for Older People for Northern Ireland.[79]

7.54. In June and September 2020, the Department of Health (Northern Ireland) issued guidance highlighting the need for a DNACPR decision to be made with a GP and

74 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp4, 13, 21-22 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
75 Michelle Dyson 16 July 2025 163/22-25; INQ000606530_0086 para 315; Albert Heaney 15 July 2025 63/18-22; Michael McBride 24 July 2025 72/8-10
76 Mary Cridge 7 July 2025 76/9-14
77 See, for example, *Every Story Matters: Adult Social Care Sector*, pp15, 92-93 (INQ000587564); *Chief Inspector's Annual Report 2020–21*, Care Inspectorate Wales, p9 (https://www.careinspectorate.wales/sites/default/files/2021-08/210818-chief-inspectors-annual-report-2020-2021-en.pdf; INQ000501726); *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp11-12 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492); INQ000474926_0045 para 137; INQ000587296_0026 para 80
78 INQ000400508
79 INQ000606530_0086-0087 paras 316-317; INQ000192705_0001-0002; INQ000300106_0001-0002; INQ000474926_0046 para 140

clearly explained to individuals and family members.[80] Despite the guidance, reports of blanket DNACPR decisions persisted in Northern Ireland.[81]

7.55. Concerns also continued to be raised elsewhere in the UK. For example, in November 2020, the Scottish Government had to provide materials on DNACPR decisions to Age Scotland to help it respond to queries and direct people to advice and support.[82] The message that a DNACPR decision should be individualised had to be repeated in March 2021 by NHS England and the Welsh Government.[83] The repeated messaging on the need for personalised assessments suggests that there remains a gap in medical training.

Reviews of DNACPR decisions during the pandemic

7.56. In October 2020, the Department of Health and Social Care commissioned the Care Quality Commission to review how DNACPR decisions had been made during the pandemic. The Care Quality Commission analysed the implementation of DNACPR guidance, including in primary care and care homes in England.[84] Its interim report, published in November 2020, found that there had been confusion and miscommunication about the application of DNACPRs and that the providers appeared to be overwhelmed. The Care Quality Commission said that there was evidence of unacceptable and inappropriate DNACPR decisions being made at the start of the pandemic, but, following a quick response to the issue, there was no evidence to suggest that it had continued on a widespread basis. The Care Quality Commission said that all care providers should ensure that any DNACPR decision had been made appropriately.[85]

7.57. Care Inspectorate Wales recorded in its annual 2020/21 report that there had been blanket DNACPR decisions made early in the pandemic, which it described as extremely concerning.[86] It did not investigate individual reports of blanket DNACPRs, but Gillian Baranski, Chief Inspector of Care Inspectorate Wales from October 2016, said that it would have taken action if it had become an issue in the care sector.[87]

80 INQ000353597_0001, 0013-0014; INQ000381325_0001, 0030
81 INQ000587671_0178-0179 para 14.3; Eddie Lynch 23 July 2025 186/19-187/9
82 INQ000614179_0296-0297 para 924
83 INQ000339282; INQ000227370
84 INQ000587737_0164 para 627
85 *Review of Do Not Attempt Cardiopulmonary Resuscitation Decisions During the COVID-19 Pandemic*, Care Quality Commission, November 2020, p2, paras 1-5 (https://www.cqc.org.uk/sites/default/files/20201204%20DNACPR%20Interim%20Report%20-%20FINAL.pdf; INQ000235491)
86 *Chief Inspector's Annual Report 2020–21*, Care Inspectorate Wales, pp5, 9 (https://www.careinspectorate.wales/sites/default/files/2021-08/210818-chief-inspectors-annual-report-2020-2021-en.pdf; INQ000501726)
87 Gillian Baranski 7 July 2025 192/7-17, 193/12-13

7.58. Jeane Freeman, Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021, told the Inquiry:

> "*I do not recall any instances where there did in fact appear to have been a blanket use of DNACPRs* [in Scotland] *but there were some instances where a DNACPR decision appeared on a patient record where neither patient or family were aware.*"[88]

The Care Inspectorate in Scotland said that it was unaware of specific allegations being made about DNACPR decisions, so it did not carry out an investigation.[89]

7.59. In Northern Ireland, Mr Swann said that he was aware that two trusts (the Belfast and the Western Health and Social Care trusts) had regularly reviewed DNACPRs.[90] The latter told the Inquiry that it was unable to comment on DNACPR decisions in care homes.[91]

7.60. Briege Donaghy, Chief Executive of the Regulation and Quality Improvement Authority in Northern Ireland from July 2021, said DNACPRs were "*not an issue raised with us very much*".[92] In preparation for the Inquiry, the Regulation and Quality Improvement Authority searched its records from between March 2020 and March 2021, but none of the 8,500 issues raised with it related to DNACPR decisions in care homes.[93]

7.61. Some Core Participants asked the Inquiry to recommend an investigation into DNACPR decisions made during the pandemic.[94] The Inquiry has carefully considered the request, recognising that these concerns may reflect the distress that individuals, families and communities experienced. However, such an investigation would require a manual review of the hospital and care home records of each individual. Given the demands on health and social care services, this would be a disproportionate use of limited resources, in the Inquiry's view. However, the Inquiry acknowledges the importance of these concerns and the need for continued scrutiny, learning and appropriate safeguards in relation to DNACPR decisions.

Communications about DNACPR decision-making

7.62. While it may be appropriate – particularly during a pandemic – to encourage people to consider and discuss their future care and treatment, including DNACPR decisions, some of the communications sent during the pandemic failed to raise the topic of

88 INQ000606530_0088 para 321
89 Kevin Mitchell 8 July 2025 99/3-4
90 Robin Swann 24 July 2025 159/6-14
91 INQ000474929_0026 para 157
92 Briege Donaghy 7 July 2025 133/2-3
93 Briege Donaghy 7 July 2025 133/9-21
94 *Module 6 Closing Submissions on Behalf of COVID-19 Bereaved Families for Justice UK and NI COVID-19 Bereaved Families for Justice*, COVID-19 Bereaved Families for Justice UK and NI COVID-19 Bereaved Families for Justice, 8 September 2025, p63, recommendation 27 (https://covid19.public-inquiry.uk/documents/joint-closing-submissions-from-covid-19-bereaved-families-for-justice-uk-and-northern-ireland-covid-19-bereaved-families-for-justice-dated-8-september-2025)

DNACPR in a thoughtful and sensitive manner. One letter from a GP surgery to care home residents in England stated:

> "*The chances of success in CPR for a patient with advanced disease or frailty are virtually zero. CPR is therefore not appropriate for the vast majority of these people and should only be attempted if it is considered that it may be successful. For these reasons, many people decide in advance not to have CPR, and choose to be allowed to have a natural and peaceful death.*"[95]

Professor Barclay described the contents and tone of this letter as "*shocking*".[96]

7.63. There were also occasions where people felt pressured to agree to a DNACPR.[97] Respondents to a Care Rights UK survey in 2023 described their feelings about making a DNACPR decision during the pandemic:

> "*Coerced to comply.*"

> "*I felt my brother was forced to sign documents with respect to my mother.*"

> "[I] *was advised this was in mum*['s] *best interest … felt like I didn't know enough about it and just accepted I should do it. Felt guilty afterwards and wasn't sure I made the right decision.*"[98]

7.64. There were communications about DNACPR that came without warning.[99] Catherine Griffiths, a member of Covid-19 Bereaved Families for Justice Cymru, received a call from a GP early in the pandemic about her 86-year-old father who lived in a care home. He had dementia but was otherwise in good physical health. Ms Griffiths said that the GP had only just met her father and told her that a DNACPR should be in place. She described this experience as "*brutal*".[100]

7.65. Susan Lyons (a member of John's Campaign, Care Rights UK and the Patients Association) told the Inquiry about two letters she had received from a GP asking about her daughter, Sarah's, CPR preferences. Sarah was in her twenties at the time and has learning difficulties. Mrs Lyons said that she was incandescent when she received the first letter early in the pandemic, and Sarah did not agree to a DNACPR. She described feeling shock and horror when she received a second letter in October 2021.[101]

95 INQ000505520_0002
96 Stephen Barclay 30 July 2025 42/3-5
97 INQ000181738; INQ000584245_0198 para 613.4; INQ000474926_0044 para 133
98 *Healthcare Experiences of Care Home Residents during the Covid-19 Pandemic*, Care Rights UK, 13 July 2023, p15 (https://static1.squarespace.com/static/6419e3a87662ef5ed1f8ff63/t/650846e87913ed3d207c9e10/1695041257318/Healthcare+survey+July+2023.pdf; INQ000273449)
99 *Protect, Respect, Connect – Decisions about Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, p17 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492); INQ000532331_0037 para 127
100 INQ000587733_0001 para 1; Catherine Griffiths 30 July 2025 73/20, 74/2-8, 75/2
101 Susan Lyons 10 July 2025 175/12-17, 175/25-176/21; INQ000587637_0023-0024 paras 79-80; INQ000612650_0001

7.66. The Scottish Government sent a letter to the social care sector on 13 March 2020 that encouraged anticipatory care plans to be put in place "*for as many residents as possible (and ideally all residents)*".[102] It also said that, where appropriate, there should be a DNACPR decision that is communicated to residents and carers.[103] GPs in Scotland telephoned their patients who lived in care homes to discuss DNACPR (in the context of anticipatory care plans). Some residents felt anxious that this was an indicator of access to intensive care being restricted.[104] In response to concerns, on 10 April 2020, the Scottish Government clarified that it was not a requirement to discuss DNACPR during anticipatory care planning.[105] Ms Freeman, who signed the 13 March letter, said that the wording was based on the presumption that those reading the letter were familiar with anticipatory care planning, but she accepted that it could have been interpreted more widely than intended.[106]

7.67. Family members who were not included in discussions about DNACPR recounted feeling fearful about what could be happening without their knowledge, which was compounded by restrictions on visiting and reduced contact.[107]

> "*The GP asked for a DNACPR to be in place, my dad knew about this and the possible consequences, he wanted to live, he didn't want one. Then I found out the GP had visited again unannounced with a DNACPR request and they never mentioned it to me.*"[108]
>
> **Bereaved family member, Scotland, Every Story Matters**

7.68. The Care Quality Commission report in March 2021 noted that, during the pandemic, some DNACPR decisions in England had been made remotely without consulting the individual and that discussions had occurred at short notice. It said that this reduced the extent to which the decisions were personalised and contributed to misunderstandings as to what DNACPR meant.[109]

7.69. The Care Quality Commission review highlighted the importance of DNACPR decisions being part of a wider discussion about advance care planning.[110] Professors Barclay and Sleeman agreed and emphasised the need to prioritise

102 INQ000147441_0003
103 INQ000147441_0001, 0003-0004
104 INQ000613178_0005 para 26; INQ000606530_0085 paras 311, 313
105 INQ000606530_0086 para 316
106 Jeane Freeman 22 July 2025 94/22-95/6
107 Helen Wildbore 29 July 2025 96/23-97/9
108 *Every Story Matters: Adult Social Care Sector*, p15 (INQ000587564)
109 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp17, 40-41 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
110 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, p3 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)

these conversations in non-pandemic times to reduce the need for them to take place during an emergency.[111]

Improving DNACPR discussions and decisions

7.70. Following its review of DNACPR decisions in England, the Care Quality Commission concluded in March 2021 that "*a lack of training and support for staff, and how confident they were in holding these conversations, has impacted on the quality of people's experiences*".[112] It recommended that:

> "*clinicians, professionals and workers must have the knowledge, skills and confidence to speak with people about, and support them in, making DNACPR decisions*".[113]

7.71. To achieve this, the Care Quality Commission suggested that clear and consistent training, standards and guidance be developed in England.[114] From September 2021, social care workers could access resources from Skills for Care on best practice for DNACPR decision-making, including effective communication strategies and adopting a person-centred approach.[115] Since November 2023, the Care Quality Commission has followed a Single Assessment Framework that requires care providers in England to demonstrate how care users' rights are being protected in relation to DNACPR. The framework is also intended to help providers to manage and maintain effective oversight of DNACPR decisions.[116] This is a welcome development that has the potential to improve practice in this area. The regulators in Wales, Scotland and Northern Ireland are encouraged to consider adopting a similar approach.

DNACPR decisions interpreted as 'do not treat'

7.72. The UK-wide professional guidance on DNACPR decision-making explicitly stated that a DNACPR decision applies only to CPR and does not equate to a decision to decline any other care or treatment.[117]

111 INQ000587295_0013 para 30
112 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, p41 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
113 *Protect, Respect, Connect –- Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, p42 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
114 *Protect, Respect, Connect – Decisions About Living and Dying Well During COVID-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp41-42 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
115 INQ000543049_0010 paras 51-54
116 INQ000584245_0133, 0212 paras 409, 648.3-648.4; *Our New Single Assessment Framework,* Care Quality Commission, 18 July 2022, pp1-3 (https://www.cqc.org.uk/news/our-new-single-assessment-framework; INQ000398529); Mary Cridge 7 July 2025 54/12-23
117 *Decisions Relating to Cardiopulmonary Resuscitation,* British Medical Association, Resuscitation Council UK and Royal College of Nursing, 2016, p6 (https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf; INQ000331016)

7.73. In surveys undertaken by the Care Quality Commission in December 2020, 44% of the 544 people who responded said that someone they cared for or a relative had experienced unfair or discriminatory treatment while making a DNACPR decision during the pandemic.[118] In one case, a care home resident in Wales, who had Covid-19 symptoms and a DNACPR in place, was told by a GP or paramedic that he would not be taken to hospital. The care home said that the GP who saw the resident did not put support or pain relief in place to ease suffering and, when the resident died, within 24 hours, he was described as "*struggling to breathe and in effect slowly suffocating to death*".[119]

7.74. Some DNACPR decisions were interpreted by healthcare professionals as a decision not to take a person to hospital or not to provide them with treatment ('do not treat').[120] This was unacceptable, particularly at a time when people were fearful that medical decisions were being made due to limited resources and rationing.[121]

End-of-life care for people in adult social care

7.75. End-of-life care is intended to help people to live as well as possible during the last months or year of their life and to die with dignity. However, during the pandemic, not all adults in social care were able to access end-of-life care and the workforce did not have sufficient training and support to deliver the care required. There were also issues with supplies of medication for people at the end of life. Experts described the Covid-19 pandemic as a "*stress test*" for end-of-life care.[122]

Changes to end-of-life care during the pandemic

7.76. Routine and systematic collection of data on the number of people receiving end-of-life care in the UK was not undertaken before or during the Covid-19 pandemic.[123] Professor Barclay explained that this lack of data meant that governments had a reactive approach to end-of-life care, when it needed to be proactive.[124] For example, initially there was very little, if any, focus on how end-of-life care would continue to be provided in social care settings and how to manage the symptoms associated with dying from Covid-19. This may have contributed to equipment, medicine and staff shortages that led to many people not receiving the care they needed and dying with avoidable symptoms and distress.[125]

118 *Protect, Respect, Connect – Decisions About Living and Dying Well During Covid-19; CQC's Review of 'Do Not Attempt Cardiopulmonary Resuscitation' Decisions During the COVID-19 Pandemic*, Care Quality Commission, 18 March 2021, pp13, 25 (https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf; INQ000235492)
119 INQ000500163_0001-0003
120 Stephen Barclay 30 July 2025 38/10-15; INQ000479878_0015 para 25; INQ000587295_0072 para 227
121 INQ000587295_0071 para 221a
122 *Fairer Care at Home, The Covid-19 Pandemic: A Stress Test for Palliative and End of Life Care in England*, Better End of Life, July 2022, p11 (https://www.mariecurie.org.uk/document/covid-fairer-care-at-home-in-england; INQ000349000)
123 INQ000587295_0026 para 83
124 Stephen Barclay 30 July 2025 14/12-24
125 INQ000587295_0074 para 232

7.77. While 99.56% of GP practices in England reported that they kept a register of patients who needed end-of-life care and support in 2022/23, it is not known if the data are comprehensive or accurate. This data collection does not exist in Scotland, Wales or Northern Ireland.[126] The use of registers is encouraged and could be used to prepare for the allocation and distribution of resources for end-of-life care in future pandemics.

End-of-life care at home

7.78. More people than usual, some of whom were very unwell, required end-of-life care at home during the Covid-19 pandemic. At the same time, visiting restrictions meant that there were fewer in-person health and social care visits.[127] The responsibility for providing care and medication at the end of life fell on many unpaid carers and family members.[128] Professor Barclay described how extremely distressing it could be to administer drugs to a loved one who was close to the end of life and who died shortly after: "*I know, as a doctor,* [it] *is emotionally very challenging. What it must be like for a family carer I think is very different.*"[129]

7.79. During a 2021 survey by Marie Curie (a UK end-of-life charity), three-quarters of bereaved carers reported that a loved one had died at home without all of the care and support they needed. Further, 76% of bereaved carers felt that they had not been offered all of the care and support they required.[130]

> "*I remember when Daddy was dying and thinking, 'Why are we here doing this on our own? Why is there not someone coming in and helping us? We don't know what we're doing. We don't know how to look after a man dying.'*"[131]
>
> **Bereaved family member, Northern Ireland, Every Story Matters**

126 INQ000587295_0026 para 84
127 INQ000587295_0053 paras 170-171
128 Stephen Barclay 30 July 2025 24/20-25/1; *Better End of Life 2021: Dying, Death and Bereavement During Covid-19 Research Report*, Marie Curie, April 2021, p37 (https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2021/better-end-of-life-research-report.pdf; INQ000348998); INQ000353677_0033 para 86; *Inquiry: Experiences of Palliative and End of Life Care in the Community During the COVID-19 Pandemic*, Cross Party Group on Hospice and Palliative Care, January 2023, p24 (https://hospiceuk-files-prod.s3.eu-west-2.amazonaws.com/s3fs-public/2023-01/CPG%20Inquiry%20into%20experiences%20of%20end%20of%20life%20during%20pandemic.pdf; INQ000183756)
129 Stephen Barclay 30 July 2025 25/4-11
130 'Charity warns three out of four home deaths during pandemic did not get the care they needed', Marie Curie, 8 April 2021 (https://www.mariecurie.org.uk/media/press-releases/charity-warns-three-out-of-four-home-deaths-during-pandemic-did-not-get-the-care-they-needed; INQ000587867_0001)
131 *Every Story Matters: Adult Social Care Sector*, p79 (INQ000587564)

> "*[My husband] wanted to go into [a nursing home] and they couldn't take him. [So we cared for him at home], an end of life care nurse or doctor … rang him about every five or six weeks … every little problem that he had, they'd just order a load of drugs … I felt that somebody could've come to visit him from end of life care.*"[132]
>
> **Bereaved family member, England, Every Story Matters**

7.80. Where support from health and social care professionals was available, it made a significant difference.

> "*We had the support of the district nurses which was fantastic. They were coming around every day for the first couple of weeks, advising us and giving medications [including 'just in case'] end of life medication which would ease her suffering [if needed]. I did feel we were pretty well supported.*"[133]
>
> **Bereaved family member, Wales, Every Story Matters**

7.81. The voluntary sector plays a key role in supporting people who are providing end-of-life care to someone at home. For example, Marie Curie extended its free telephone support lines to anybody affected by death and bereavement during the pandemic.[134] The health and social care sectors need to work with the voluntary sector to develop future support and information on this topic for unpaid carers and family members.[135] This is vital at a time of increased anxiety and distress and will help to ensure that people who receive end-of-life care at home during a pandemic have the best possible chance of experiencing a dignified death.

End-of-life care in care homes

7.82. Many care homes do not usually provide nursing or medical care. In the UK, more than 70% of care homes are residential and rely on specialist services and primary care to deliver and advise on clinical matters, including end-of-life care. Between March and May 2020, care home deaths in the UK increased rapidly by 220% (from 2,451 to 7,911).[136] Care workers had to take on responsibility for providing end-of-life care, including alleviating distressing symptoms, supporting recovery and

132 *Every Story Matters: Adult Social Care Sector*, p13 (INQ000587564)
133 *Every Story Matters: Adult Social Care Sector*, p88 (INQ000587564)
134 INQ000353677_0006 para 21a
135 INQ000353677_0033 para 86; INQ000588638_0027; *Caring Behind Closed Doors: Forgotten Families in the Coronavirus Outbreak*, Carers UK, April 2020, p26 (https://www.carersuk.org/media/a5dpp3ng/caring-behind-closed-doors-forgotten-families-in-the-coronavirus-outbreak.pdf; INQ000176237)
136 'The influence of care home registration type and size on senior care leader's confidence to provide palliative and end-of-life care: An explanatory sequential mixed methods study', I Tunnard, KE Sleeman, A Bradshaw, AE Bone, CJ Evans, *BMC Palliative Care* (2024), 23(1), 213, p2 (https://pmc.ncbi.nlm.nih.gov/articles/PMC11340158/pdf/12904_2024_Article_1525.pdf; INQ000660171)

anticipating the end of life, for the first time, without the required knowledge and skills.[137] This made it crucial that they could access external support.[138]

7.83. Care home staff went to extraordinary lengths to ensure that residents received compassionate care at the end of life. A care home manager described how a care worker would lie in bed with a resident to provide comfort when they were dying.[139] Ms Hough said that staff in her care home would sit with a dying resident throughout the night and always worked to ensure that they had the necessary medication and equipment to provide a dignified death.[140]

7.84. A bereaved family member responding to a survey by the Patients Association described the care that their relative received:

> "[T]*he care home staff did not leave my relative's side during the last 24 hours of their life; they made sure someone was with them at all times. The compassion shown was second to none.*"[141]

7.85. In a 2021 study, care home managers (the majority of whom worked in England) reported difficulties delivering high-quality, personalised end-of-life care during the pandemic, particularly when there were staff shortages. The study also found that managers who received advice from GPs and specialists felt able to support their staff to provide end-of-life care. However, the remote delivery of healthcare services during the pandemic increased the burden on care home workers and reduced access to support. Remote consultations were not always a suitable alternative and, in some instances, care homes lacked the technology to facilitate them.[142] Professor Barclay described his experience of conducting ward rounds via remote technology:

> "[G]*oing from room to room … I found it really distressing that there was a patient who was, from what I could see on the screen, in the very final few hours of life, and there was the family next to them, but I couldn't be there.*"[143]

7.86. It is highly likely that care home workers will be required to provide more end-of-life care in a future pandemic. To do so, they must be properly equipped with the necessary knowledge and skills. The health and social care sectors must work together to ensure that care workers delivering end-of-life care in care homes can continue to access support, guidance and information (see Chapter 4: Visiting restrictions in care homes).

137 Stephen Barclay 30 July 2025 12/14-24, 23/3-6; INQ000509808_0028 para 74
138 INQ000587295_0051 para 163
139 INQ000509768_0006
140 INQ000587639_0009-0010 paras 42-45, 49
141 *Pandemic Patient Experience: UK Patient Experience of Health, Care and Other Support During the Covid-19 Pandemic*, The Patients Association, September 2020, p39 (https://www.patients-association.org.uk/Handlers/Download.ashx?IDMF=2fdaa424-8248-4743-a4d5-fe1d3f403d20; INQ000273424)
142 INQ000587295_0050-0054 paras 160-162, 167, 172; *Inquiry: Experiences of Palliative and End of Life Care in the Community During the Covid-19 Pandemic*, Cross Party Group on Hospice and Palliative Care, January 2023, p34 (https://hospiceuk-files-prod.s3.eu-west-2.amazonaws.com/s3fs-public/2023-01/CPG%20Inquiry%20into%20experiences%20of%20end%20of%20life%20during%20pandemic.pdf; INQ000183756)
143 Stephen Barclay 30 July 2025 30/23-31/4

Access to emergency end-of-life care outside care homes

7.87. During the pandemic, some people living in care homes were not taken to hospital for end-of-life care when they should have been or would have been previously.[144]

7.88. Judith Kilbee, a member of Scottish Covid Bereaved, described how her father's physical health deteriorated at the start of May 2020 following a Covid-19 diagnosis. She recalled how upsetting it was to hear that the care home was told by 111 (a telephone service providing advice about non-life-threatening illness or injury) that a resident testing positive for Covid-19 would not be taken to hospital and to order an 'end-of-life pack'.[145]

7.89. Some GPs sent letters to care home residents confirming that it would not be appropriate to take them to hospital if they had Covid-19.[146] In Scotland, for example, one letter said:

> "*We would plan to continue to nurse our patients … and not to transfer them to hospital. Sadly if they are so unwell as to require breathing support from a ventilator it is unlikely that given their frailty they would survive.*"[147]

7.90. Decisions to restrict care home residents' access to end-of-life care in hospital during the pandemic caused great distress and upset. This decision must always be based on a clinical assessment of the individual's condition and treatment needs.

Medication at the end of life

7.91. At the end of life, medication can be prescribed to ease pain and anxiety and reduce nausea. It may be placed in an individual's private home or in a care home, to be used if needed. This practice, known as anticipatory prescribing, significantly increased during the pandemic due to concerns that people might die from Covid-19 in distress before medication could be obtained.[148] Professor Barclay said that this led to shortages of medication and it came very close to running out.[149]

7.92. Medication shortages are likely to have led to people receiving inadequate symptom control or pain relief at the end of life.[150]

144 *Healthcare Experiences of Care Home Residents During the Covid-19 Pandemic*, Care Rights UK, 13 July 2023 pp5, 7, 21 (https://static1.squarespace.com/static/6419e3a87662ef5ed1f8ff63/t/650846e87913ed3d207c9e10/1695041257318/Healthcare+survey+July+2023.pdf; INQ000273449)
145 INQ000614380_0007 paras 29-30
146 INQ000505520_0001-0002
147 INQ000591762
148 INQ000587295_0010 paras 18-19
149 Stephen Barclay 30 July 2025 22/2-12, 22/24-23/2, 23/7-8
150 INQ000587295_0061, 0074 paras 197, 232; *Inquiry: Experiences of Palliative and End of Life Care in the Community During the Covid-19 Pandemic*, Cross Party Group on Hospice and Palliative Care, January 2023, p35 (https://hospiceuk-files-prod.s3.eu-west-2.amazonaws.com/s3fs-public/2023-01/CPG%20Inquiry%20into%20experiences%20of%20end%20of%20life%20during%20pandemic.pdf; INQ000183756)

> "*Sometimes, you'd go to a patient that was struggling with their breathing. We didn't have the medications, because there was [a] short supply, because they were going to the hospitals … So, we were running out of medications, so patients were passing away in pain, struggling.*"[151]
>
> **Community nurse, England, Every Story Matters**

7.93. At the start of the pandemic, there were strict rules to prevent medication being repurposed (medication prescribed for one patient cannot be used by or administered to another patient).[152] While this ensured patient safety, some medication went to waste at a time when supplies were limited. Caroline Abrahams, Charity Director of Age UK from 2012, described the impact on care home residents and staff:

> "[It] *led to people dying in care homes not in a dignified way, not in a pain-free way, and it put the professionals working there … very often not medically qualified people … in a horrible, horrible position when they had a lot of people there who needed those drugs, they weren't able to share them from one person to another.*"[153]

7.94. At different times in April and May 2020, the rules temporarily changed in the UK to allow end-of-life medications to be repurposed in care homes.[154] Although the temporary measures were not regularly used in practice, Professor Barclay described the changes as "*an outbreak of common sense*" and said they relieved some of the pressures on care homes.[155]

7.95. While some action was taken to ensure that access to end-of-life medications continued, it was inevitable that a virus with a high mortality rate, such as Covid-19, would significantly increase demand for these medications and, without proper planning, this could lead to medication shortages.[156] For this reason, each government should develop plans to ensure, as far as possible, that, during a pandemic, there continues to be access to medications commonly given as part of end-of-life care.

151 *Every Story Matters: Adult Social Care Sector*, p82 (INQ000587564)
152 INQ000587295_0068 para 219
153 Caroline Abrahams 16 July 2025 25/3-10
154 INQ000587295_0068-0069 para 219; INQ000587682_0172-0173: 23 April 2020 in England; INQ000485721_0306: 30 April 2020 in Wales; INQ000475130_0172 para 634: April 2020 in Scotland; INQ000346742_0016: 20 April 2020 in Northern Ireland
155 Stephen Barclay 30 July 2025 23/9-23; INQ000587295_0068-0069 para 219
156 INQ000576034_0065 para 185; INQ000319607_0009, 0017 paras 43, 98

Training on end-of-life care for health and social care professionals

7.96. It is difficult to judge when a person is at the end of their life and in need of end-of-life care, particularly for older people and those who are more frail. A GP or consultant is best placed to make a prognosis.[157] However, during the Covid-19 pandemic, they were not always available and the task fell to others.

7.97. A 2021 study found that care home managers and clinical leads were more confident in delivering end-of-life care where they had received training or had established ways of providing this type of care. A residential care home manager said:

> "[W]*e had the experience of [delivering palliative and end-of-life care] in the home to begin with, and training … I think if we hadn't … had that prior we would really have struggled.*"[158]

Some care home leaders reported that the training they received was inadequate, not tailored or not sufficiently timely.[159]

7.98. Health and social care professionals were signposted to resources, developed during the pandemic, on delivering and supporting end-of-life care.[160] For example, in March 2020, Marie Curie, Hospice UK, the Royal College of Nursing and the Royal College of General Practitioners published a Covid End of Life Community Charter with ethical guidelines for providing care to people affected by Covid-19.[161]

Post-pandemic developments in training

7.99. There have been developments in end-of-life care training in Wales, Scotland and Northern Ireland since the pandemic, but not all training is mandatory or applies to all health and social care professionals working in adult social care settings. There is no evidence of developments being made in England. Such developments include the following:

- Since October 2022, residential care home workers in Wales have been required to have or be working towards a qualification that includes training on end-of-life care.[162]

157 INQ000587295_0014-0015 paras 32-33
158 'The influence of care home registration type and size on senior care leader's confidence to provide palliative and end-of-life care: An explanatory sequential mixed methods study', I Tunnard, KE Sleeman, A Bradshaw, AE Bone, CJ Evans, *BMC Palliative Care* (2024), 23(1), 213, pp4-5 (https://pmc.ncbi.nlm.nih.gov/articles/PMC11340158/pdf/12904_2024_Article_1525.pdf; INQ000660171)
159 INQ000587295_0052 para 168
160 INQ000543049_0011-0012 paras 57-58, 60; INQ000587670_0160-0161 paras 678-679; INQ000659970_0003-0004; INQ000659972_0006-0007 paras 14, 16; INQ000517219_0021 para 59
161 INQ000587657_0096-0097 para 323
162 INQ000659971_0001-0002

- The *All Wales Competency Framework for Adult Palliative and End of Life Care 2025* provides the competencies required of healthcare professionals to deliver end-of-life care but does not specifically apply to social care staff.[163]
- The *Palliative Care Education Framework* was updated in 2025 for health and social care workers in Scotland and includes 'care around dying'. It is not mandatory.[164]
- The *Social Care Workforce Strategy 2025–2035* (Northern Ireland) includes an ambition for a mandatory qualification, with a module on end-of-life care, for all newly registered social care workers. While the qualification has been available since September 2024, it is not mandatory for all care workers.[165]

7.100. Professors Barclay and Sleeman recommend that end-of-life care be mandatory in training for all health and social care professionals. They suggest that the training include communication skills and how staff can help people to access support.[166] The Association for Palliative Medicine of Great Britain and Ireland agreed that a healthcare workforce with more knowledge and training on end-of-life care would ensure better care during a future pandemic.[167] Helen Wildbore (Director of Care Rights UK from 2019 to 2025) said:

> "[L]*ooking to the future, we need proper training on end-of-life care for care workers … we need to embed that last year of life as standard practice, and we need to ensure that people's choices and autonomy around how they want to end their lives are respected.*"[168]

The need to improve training on end-of-life care was also supported by the Royal College of Nursing, Covid-19 bereaved groups, John's Campaign, Care Rights UK, the Patients Association, Scottish territorial health boards and the Care Professional Organisation (formerly known as the National Association of Care and Support Workers).[169]

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163 *All Wales Competency Framework for Adult Palliative and End of Life Care 2025*, NHS Wales, p4 (https://heiw.nhs.wales/files/final-all-wales-end-of-life-care-framework-oct-2025; INQ000660248)
164 INQ000660249_0003, 0006: 'Care around dying' replaces the term 'end-of-life care' in the Framework.
165 INQ000659972_0009-0011 paras 22, 24-26; *Social Care Workforce Strategy 2025–2035*, Department of Health (Northern Ireland), 12 December 2024 (https://www.health-ni. gov.uk/sites/default/files/2024-12/doh-social-care-strategy-2025-2035.pdf; INQ000660500)
166 Stephen Barclay 30 July 2025 13/3-11; INQ000587295_0075 para 235
167 INQ000257330_0008-0009 para 31(i)
168 Helen Wildbore 29 July 2025 92/5-11
169 Claire Sutton 29 July 2025 33/8-16; *Module 6 Closing Submissions on Behalf of COVID-19 Bereaved Families for Justice UK and NI COVID-19 Bereaved Families for Justice*, COVID-19 Bereaved Families for Justice UK and NI COVID-19 Bereaved Families for Justice, 8 September 2025, p63, recommendation 26 (https://covid19.public-inquiry.uk/documents/joint-closing-submissions-from-covid-19-bereaved-families-for-justice-uk-and-northern-ireland-covid-19-bereaved-families-for-justice-dated-8-september-2025); *Module 6 Closing Submissions on Behalf of John's Campaign, the Patients Association, Care Rights UK*, John's Campaign, Patients Association and Care Rights UK, 8 September 2025, p21, para 68 (https://covid19.public-inquiry.uk/documents/closing-submissions-from-johns-campaign-care-rights-uk-and-the-patients-association-dated-8-september-2025); *Module 6 Closing Submissions on Behalf of the National Association of Care and Support Workers*, National Association of Care and Support Workers, 8 September 2025, p14, paras 45, 47 (https://covid19.public-inquiry.uk/documents/closing-submissions-from-national-association-of-care-and-support-workers-dated-8-september-2025); Covid Bereaved Families for Justice Cymru Closing Submissions 30 July 2025 178/12-18; *Module 6 Closing Submissions for the Scottish Territorial and Special Health Boards*, Scottish Territorial and Special Health Boards, pp18-19, para 61 (https://covid19.public-inquiry.uk/documents/closing-submissions-from-scottish-territorial-health-boards-undated)

7.101. Two reports published in November 2024 advocated for more education and training for health and adult social care staff in these areas. The Coalition of Frontline Care urged the UK government to "[m]*ake a radical change in the care for older people nearing the end of life, by investing in training and support for the frontline health and care workforce*".[170] The National Confidential Enquiry into Patient Outcome and Death (an independent body aiming to improve the quality of healthcare) recommended that end-of-life care be a core competency during training for patient-facing health and social care staff.[171]

7.102. The Covid-19 pandemic demonstrated the need for training in a number of matters relating to end of life. The training should be tailored to the different roles and responsibilities that health and social care professionals have during advance care planning and DNACPR decision-making.[172]

7.103. People nearing the end of life are entitled to dignity in death and their loved ones are entitled to know that they received the best care possible. Whether discussing advance care plans or DNACPRs or providing end-of-life care in the final days and hours of an individual's life, a more knowledgeable and confident adult social care workforce will help ensure that there is high-quality end-of-life care.

Recommendation 7: Mandatory end-of-life care training for health and social care professionals

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should establish mandatory training for health and social care professionals looking after people in the adult social care sector who are nearing the end of life.

The training should be developed in conjunction with health and social care regulators and provide, at a minimum:

- an understanding and enhanced knowledge of how to deliver high-quality end-of-life care as well as the support available; and
- communication skills to be able confidently to conduct and document conversations about advance care and, where appropriate to the professional's role, decisions on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

170 *End of Life Care Is Everyone's Business*, Coalition of Frontline Care, November 2024, p12 (https://www.goldstandardsframework.org.uk/wp-content/uploads/2025/05/Coalition-of-Frontline-Care-Report-November-2024-compressed-26.11.2.pdf; INQ000532382)
171 *Planning for the End: A Review of the Quality of Care Provided to Adult Patients Towards the End of Life*, National Confidential Enquiry into Patient Outcome and Death, 21 November 2024, pp4, 7 (https://www.ncepod.org.uk/2024eolc/Full%20report_end%20of%20life%20care.pdf; INQ000660247)
172 *Decisions Relating to Cardiopulmonary Resuscitation*, British Medical Association, Resuscitation Council UK and Royal College of Nursing, 2016, p27 (https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf; INQ000331016)

Chapter 8: Recognition and protection

Introduction

8.1. Millions of people will require care as an adult at some stage of their life, whether provided in their own home, a care home or both. It is unsurprising, therefore, that adult social care has been described as "*a vital public service that's the backbone of communities*".[1]

8.2. However, the Inquiry heard that, while the healthcare systems in the four nations of the UK have significant public visibility, people do not think about social care until they actually need it.[2] The adult social care workforce has been described as invisible because much of its work is undertaken behind closed doors in people's homes and in care homes.[3] As a result, the sector feels that it is a "*Cinderella*" service, with healthcare services prioritised at the expense of adult social care.[4]

8.3. These feelings were evident, if not exacerbated, during the Covid-19 pandemic. Cathryn Williams, Chief Executive of the Association of Directors of Adult Social Services (a membership organisation for local authority adult social care leaders in England) from January 2015 to July 2024, said: "[O]*riginally 'clap for carers' became 'clap for the NHS', and I think that led to everybody feeling less valued.*"[5] The Inquiry's listening exercise, Every Story Matters, heard from domiciliary care workers.

> "*The NHS were not the only heroes. The quiet, underpaid, overworked, undervalued, overlooked domiciliary care workers were and still are [heroes too]!*"[6]
>
> **Domiciliary care worker, England, Every Story Matters**

8.4. A registered nurse in a care home in Scotland told the Scottish Covid-19 Inquiry: "*Social care staff felt a bit put out because it was all clapping for NHS … The NHS were like the ones who saved us and we were just getting on with it.*"[7]

8.5. As a result, the contribution that adult social care workers in both care homes and domiciliary care (delivered in a person's home) make to society often goes unrecognised and is undervalued. This chapter considers the role of the adult social care workforce, which is large and varied – comprising, among others, care home and domiciliary care workers, registered managers and registered nurses. It considers the arguments for and against introducing a voluntary workforce

1 Vic Rayner 3 July 2025 119/14-19
2 Paul Featherstone 28 July 2025 119/20-21; INQ000660177_0001-0004
3 Paul Featherstone 28 July 2025 119/13-19
4 Vic Rayner 3 July 2025 119/14-19; INQ000528094_0033 para 4.44; Robin Swann 24 July 2025 103/17-104/1; INQ000615082_0034 para 87; Paul Featherstone 28 July 2025 120/3-8; INQ000587381_0001-0002 para 2
5 Cathryn Williams 23 July 2025 106/2-6
6 *Every Story Matters: Adult Social Care Sector*, p142 (INQ000587564)
7 INQ000587773_0003-0004 para 23

register for care home and domiciliary care workers in England; registration already exists in Northern Ireland, Scotland and Wales.

8.6. This chapter also examines the statements made by some ministers that decisions in the early months of the pandemic were taken to protect care homes and that vulnerable individuals had been at the forefront of their decisions.

Recognition of the adult social care workforce

8.7. As outlined in Chapter 1: Overview of the adult social care sector, there were a large number of vacancies in the adult social care workforce at the outset of and during the Covid-19 pandemic. The shortages have often been attributed to poor working conditions, including zero-hours contracts, low pay and limited opportunities for career development. These systemic issues mean that social care is not always seen as an attractive career option.[8]

8.8. The Covid-19 pandemic highlighted and exacerbated challenges that already existed with identifying, contacting, retaining and recruiting people to work in adult social care. By September 2021, an "*immediate crisis*" was identified in England due to staff absences and workers leaving the profession.[9] In addition, Professor Sube Banerjee, Dr Nicolas Farina and Dr Ben Hicks (expert witnesses on the care and treatment of people with dementia and their families) explained that care workers were exposed to traumatic events during the pandemic, such as high death rates of people using care, which could contribute to workforce losses.[10] Chapter 6: The impact on unpaid carers, care workers and care providers considers these matters in greater detail.

8.9. A number of witnesses spoke of the urgent need for better recognition and professionalisation of the adult social care workforce. For example, the Trades Union Congress recommended that higher levels of respect and recognition and greater access to formal professional qualifications would reduce vacancies and turnover.[11] Introducing a workforce register for care workers in both care homes and domiciliary care in England is one way to improve professionalisation, recognition, retention and future emergency responses in adult social care.

8 INQ000569768_0005-0006 paras 15a-c, 16; INQ000587670_0131-0132 para 561; Christina McAnea 8 July 2025 172/13-173/3; INQ000475008_0088 para 91
9 INQ000111776_0001
10 INQ000546956_0013 para 26
11 INQ000587381_0042 para 96.10; see also Vic Rayner 3 July 2025 119/9-13; Paul Featherstone 28 July 2025 145/6-146/3

Workforce registers in the UK

8.10. Mandatory registration of both care home and domiciliary care workers is already a requirement in Northern Ireland, Scotland and Wales (see Table 6).[12] In some instances, registration was initially voluntary. By contrast, there is currently no registration of care home and domiciliary care workers in England.

Table 6: Summary of requirements for social care workers to register and practise in the four nations of the UK, September 2022

	Northern Ireland	Scotland	Wales	England
Registration fee	£30 (renew every 5 years)	£25 (renew every 5 years)	£30 (renew every 3 years)	N/A
Care home workers	Voluntary from 2011; mandatory from 2014	Mandatory from 2015	Voluntary from 2020; mandatory from October 2022	N/A
Domiciliary care workers	Voluntary from 2015; mandatory from 2017	Mandatory from 2020	Voluntary from 2018; mandatory from 2020	N/A
Timeframe to achieve registration once started in post	Within 6 months	Within 6 months	Within 12 months	N/A
Title protected in law	No	No	Yes	N/A
Standards/ code of conduct	*Standards of Conduct and Practice for Social Care Workers*	*Code of Practice for Social Service Workers and Employers*	*Code of Professional Practice for Social Care*	Expected to abide by a code of conduct
Post-registration training and learning	90 hours (15 days), over 5 years	60 hours (10 days), over 5 years	90 hours (15 days), over 5 years	N/A

12 Regulation and Inspection of Social Care (Wales) Act 2016, section 80, Schedule 1 (https://www.legislation.gov.uk/anaw/2016/2/contents); The Social Care Wales (Specification of Social Care Workers) (Registration) Regulations 2016, regulation 3 (https://www.legislation.gov.uk/wsi/2016/1235/contents); The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017, regulation 35 (https://www.legislation.gov.uk/wsi/2017/1264/contents); The Social Care Wales (Specification of Social Care Workers) (Registration) (Amendment) Regulations 2018, regulation 4 (https://www.legislation.gov.uk/wsi/2018/192/contents/made); The Regulated Services (Service Providers and Responsible Individuals) (Wales) (Amendment) Regulations 2022, regulation 3 (https://www.legislation.gov.uk/wsi/2022/832/contents/made); The Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013, regulation 5 (https://www.legislation.gov.uk/ssi/2013/227/contents); The Registration of Social Workers and Social Service Workers in Care Services (Scotland) Amendment Regulations 2017, regulation 2 (https://www.legislation.gov.uk/ssi/2017/193/contents/made); Health and Personal Social Services Act (Northern Ireland) 2001, section 8(3) (https://www.legislation.gov.uk/nia/2001/3/contents); The Northern Ireland Social Care Council (Social Care Workers Prohibition) and Fitness of Workers Regulations (Northern Ireland) 2013, regulation 4 (https://www.legislation.gov.uk/nisr/2013/225/contents); The Northern Ireland Social Care Council (Social Care Workers Prohibition) and Fitness of Workers (Amendment) Regulations (Northern Ireland) 2017, regulation 4 (https://www.legislation.gov.uk/nisr/2017/207/contents/made)

	Northern Ireland	Scotland	Wales	England
Mandatory qualifications	No, but intention to introduce this	Yes (within 5 years)	Yes (within 3 years)	Voluntary care certificate
Previous experience	Not required for registration – must hold offer of employment	Not required for registration – must hold offer of employment	If no qualification, must have competence certified by manager	N/A
Occupational regulator	Northern Ireland Social Care Council	Scottish Social Services Council	Social Care Wales	N/A (Skills for Care oversees workforce development)

Source: New Horizons: What Can England Learn from the Professionalisation of Care Workers in Other Countries?, Nuffield Trust, September 2022, pp69-70 (https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/1662995727-nuffield-trust-new-horizons-web.pdf; INQ000548131)

Benefits of registration for care workers

8.11. A number of organisations, interest groups and individuals closely involved in the work of the adult social care sector support the introduction of a workforce register for England. They believe a register would help to professionalise the sector by supporting people working in social care to develop their careers through education, training and qualifications. This, in turn, should help to improve recruitment into and retention of the workforce, which will ensure that it is more stable and resilient in a future pandemic.

8.12. Caroline Abrahams, Charity Director of Age UK from 2012, explained that providing social care is a highly skilled task undertaken by people who are hugely committed to their work. She said that care work deserves to be professionalised, which likely requires registration.[13] Dr Jane Townson (Chief Executive of the Homecare Association from May 2019), Mary Cridge (Director of Adult Social Care at the Care Quality Commission from July 2022) and Professor Vic Rayner (Chief Executive Officer of the National Care Forum from 2016, a membership organisation for not-for-profit social care and support providers) recognised the benefits that registration could bring.[14]

8.13. The Nuffield Trust (an independent health and social care think tank) commented that, although it was "*early days*", registration in Northern Ireland was having a positive impact on both the workforce and retention.[15] It said the growing interest in

13 Caroline Abrahams 16 July 2025 33/15-34/13
14 INQ000587670_0143 para 609; Mary Cridge 7 July 2025 58/22-59/14; INQ000475131_0062-0063 para 10.13vi
15 'Supporting those who deliver social care: What can England learn from the rest of the UK?', Nuffield Trust, 15 April 2020 (https://www.nuffieldtrust.org.uk/news-item/supporting-those-who-deliver-social-care-what-can-england-learn-from-the-rest-of-the-uk; INQ000553856_0003)

professionalisation (including registration) in England is based on the rationale that it would attract new entrants, support workforce retention by offering more opportunities for career progression and help to develop a strong professional identity for social care workers, facilitated by registration and adherence to common professional standards.[16]

8.14. The Nuffield Trust reviewed the use of workforce registers in the UK and internationally. It concluded that registration and consistent access to training and development opportunities in social care could help to address inequalities in career progression and earnings and attract people from under-represented groups.[17] A number of other professions, such as nurses, have registration requirements.[18] Social workers have had a professional register and a protected title (to be a 'social worker' one must be qualified and registered) across the UK since the early 2000s.[19] The Nuffield Trust considered that professional registration has "*instilled greater public awareness of social workers as professionals*".[20]

8.15. However, there are possible disadvantages to a register, the most significant of which is a potential reduction in the number of people willing to work in the adult social care sector.

Risk of loss to the workforce

8.16. There is some evidence that the introduction of a register for adult social care workers could risk the loss of some of the workforce. However, none of the concerns were expressed to the Inquiry as definitive reasons against the introduction of registration and, in parts of the UK where registers are operating, the concerns are being addressed.

8.17. Joanna Killian, Chief Executive of the Local Government Association from March 2024 to July 2026, was concerned that an onerous bureaucratic registration system would force people out of the market. However, she emphasised the importance of engagement with the sector. She said that, if registration recognised those working in adult social care as a strong and capable profession, the Local Government Association would endorse it.[21] Provided any system devised for registration is simple and easy to access and use, this should not therefore prove to be a major hurdle.

16 INQ000475008_0039
17 *New Horizons: What Can England Learn from the Professionalisation of Care Workers in Other Countries?*, Nuffield Trust, September 2022, pp4-6 (https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/1662995727-nuffield-trust-new-horizons-web.pdf; INQ000548131)
18 INQ000587657_0019 para 75
19 INQ000572015_0002-0003 paras 8-9
20 *New Horizons: What Can England Learn from the Professionalisation of Care Workers in Other Countries?*, Nuffield Trust, September 2022, p20 (https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/1662995727-nuffield-trust-new-horizons-web.pdf; INQ000548131)
21 Joanna Killian 28 July 2025 42/5-17

8.18. Francesca Humi, who gave evidence on behalf of the Frontline Migrant Health Workers Group, raised concerns that a registration requirement of care workers with "*really precarious immigration status … would prevent a lot of people from entering the sector*".[22] This is an undoubted risk, but, as Ms Humi acknowledged: "[C]*are should be regulated in a way that improves health outcomes for both patients and workers.*"[23] Furthermore, the risk could be mitigated by making a register voluntary at the beginning and only made mandatory once the workforce had adapted to it and seen the benefits of it.

8.19. The Nuffield Trust highlighted concerns that fees and training requirements could act as barriers to existing and potential workers joining the register. However, in light of the limited available data on staff turnover broken down by profession, it explained that it is unclear whether the introduction of registration in other nations has in fact exacerbated existing levels of turnover for care workers specifically. The Nuffield Trust cited evidence from Wales that some registration fees for social care remained outstanding by March 2021, but it also noted that, while some people left the register in Wales in 2020/21, staff turnover levels in Wales compared "*quite favourably*" with those in England in 2022.[24] The barrier may not be insurmountable.

8.20. A report in Scotland from 2019 outlined that approximately one in five care providers had suspended staff because they had not achieved registration qualifications. However, there was also evidence that almost a quarter of care homes and more than 1 in 10 domiciliary care providers had avoided suspending workers through positive engagement with regulatory and inspection colleagues, usually by agreeing extensions of time to complete qualifications.[25] This concern is therefore being addressed by collaborative working.

Wider benefits of a workforce register during a pandemic

8.21. The existence of workforce registers in other professions and registers of adult social care workers in the devolved nations had a number of important benefits during the response to Covid-19.

8.22. Early in the pandemic, the nursing register allowed the Nursing and Midwifery Council to identify nurses who had recently left the register as a potential resource to increase capacity in the NHS.[26] Likewise, in Scotland, the register for adult social care workers meant that the Scottish Social Services Council had access to people who had recently left the register to ask if they would return. According to Kevin Mitchell,

22 Francesca Humi 29 July 2025 134/13-16
23 Francesca Humi 29 July 2025 134/19-20
24 *New Horizons: What Can England Learn from the Professionalisation of Care Workers in Other Countries?*, Nuffield Trust, September 2022, p22 (https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/1662995727-nuffield-trust-new-horizons-web.pdf; INQ000548131). By 2021, in Wales, registration was mandatory for domiciliary care workers and voluntary for care home workers.
25 *Qualifying Care: An Exploration of Social Care Registration Qualifications in Scotland,* Scottish Care, March 2019, p20 (https://scottishcare.org/wp-content/uploads/2020/03/Qualifying-Care-Final.pdf; INQ000660176)
26 INQ000479043_0023-0024 paras 99-105. While there were practical difficulties in progressing applications for returning healthcare workers, these were unrelated to the register.

Executive Director of Assurance and Improvement at the Care Inspectorate in Scotland from August 2015, this was extremely worthwhile during the pandemic.[27]

8.23. In Northern Ireland, Professor Sean Holland (Chief Social Work Officer in the Department of Health (Northern Ireland) from July 2010 to October 2022) said that the existence of a register during the pandemic meant that the department could communicate with the workforce and that learning resources could also be shared directly with the workforce.[28] The register in Wales was used alongside healthcare records to analyse the impact of the Covid-19 pandemic on 15,725 domiciliary care workers. This included collating how many workers had tested positive for, or died from, Covid-19 and how many received care for a mental health diagnosis.[29] Registers for adult social care were also used in the devolved nations to implement continuing professional development for care workers on topics such as infection control.[30]

8.24. By contrast, in England, the pandemic exposed a number of difficulties that could have been addressed by the existence of a workforce register. The UK government had no direct route of communication or contact with the social care workforce.[31] There was also no central record of care workers' qualifications, training or experience, which meant that it was not possible to track who had completed infection prevention and control training.[32] As Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021) summarised, there were:

> "*around one and a half million people looking after extremely vulnerable people … we don't know who that workforce is, we have no way of contacting them, and we don't know what their qualifications are*".[33]

8.25. The lack of data about care workers likewise made workforce planning in the sector more difficult.[34] Matt Hancock, Secretary of State for Health and Social Care from July 2018 to June 2021, said that a workforce register would have assisted the government during the pandemic, including in relation to matters such as the distribution of personal protective equipment (PPE) and sick pay.[35]

8.26. A review by the Nuffield Trust in May 2023 identified that, without a register, local authorities did not have an accessible source of information to identify the social care workforce. This was problematic during community outbreaks and led to delays in implementing infection control measures, such as rapid tracing of close contacts

27 Kevin Mitchell 8 July 2025 48/19-49/6
28 Sean Holland 21 July 2025 13/5-21
29 *The Impact of COVID-19 on the Health of Domiciliary Care Workers in Wales*, Public Health Wales, pp7-9 (https://www.cardiff.ac.uk/__data/assets/pdf_file/0010/2672470/OSCAR-Results-Booklet.pdf; INQ000581750)
30 INQ000475008_0107 para 106.3
31 Caroline Abrahams 16 July 2025 34/16-25; Michelle Dyson 16 July 2025 147/21-148/4
32 INQ000587788_0109 para 26
33 Helen Whately 17 July 2025 137/5-15
34 INQ000587670_0131 para 557
35 Matt Hancock 2 July 2025 174/20-175/13

who worked in social care. As a result, "*transmission of infections via staff from the community was not always acted on quickly*".[36]

8.27. The practical benefits that a workforce register in England could have during a future pandemic include:

- the rapid identification of recent leavers from the sector who may be willing to return to help with the pandemic effort;[37]
- ensuring that people with particular skills and experience are deployed in areas where they are most needed;[38]
- an improved understanding of how many workers work across multiple care settings;[39]
- more timely, widespread and direct dissemination of information, advice and support to care workers;[40]
- the rapid identification of the adult social care workforce, so that they can be given priority access to vaccinations where necessary;[41] and
- ensuring that training and professional development is kept up to date and transportable, so that the information could move with the care worker to any new employer.[42]

8.28. Clear and timely data and information on the workforce in the adult social care sector are particularly useful when decisions need to be taken quickly in response to a rapidly changing situation. Importantly, such data and information can also help decision-makers to assess and understand the impact of their decisions. Workforce registers can also facilitate communication directly with the sector, to ensure that it has the most up-to-date information.

A workforce register for England

8.29. The idea of an adult social care workforce register is nothing new. It has been explored by the UK government a number of times since 2008 and calls for registration grew during the pandemic. In 2021, the Department for Work and

36 *Building a Resilient Social Care System in England: What Can Be Learnt from the First Wave of Covid-19?*, Nuffield Trust, May 2023, p55 (https://www.nuffieldtrust.org.uk/sites/default/files/2023-05/Building%20a%20resilient%20social%20care%20system%20in%20England.pdf; INQ000553858)
37 Paul Featherstone 28 July 2025 134/15-135/2
38 Paul Featherstone 28 July 2025 133/18-134/4, 135/3-7
39 INQ000475008_0120-0121 para 135
40 Caroline Abrahams 16 July 2025 34/16-25; Paul Featherstone 28 July 2025 134/5-14; *New Horizons: What Can England Learn from the Professionalisation of Care Workers in Other Countries?*, Nuffield Trust, September 2022, p57 (https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/1662995727-nuffield-trust-new-horizons-web.pdf; INQ000548131)
41 Matt Hancock 2 July 2025 175/5-8
42 Helen Whately 17 July 2025 137/21-138/14; Christina McAnea 8 July 2025 191/10-192/9; Caroline Abrahams 16 July 2025 34/4-13

Pensions' In-Work Progression Commission called for a central body to register care workers, to manage their training and ongoing professional development.[43]

8.30. The size of the workforce in England means significant planning and resources would be required to implement a mandatory register.[44] On behalf of the Department of Health and Social Care, in April 2021, Skills for Care (an independent strategic workforce development body for adult social care in England) explored the development of a voluntary register to provide the UK government with a method for contacting adult social care workers directly. Skills for Care advised that it could be a first step towards registration, with some long-term benefits if "*accompanied by clear incentives and long-term investment*".[45] On 8 April 2021, the Workforce Advisory Group (established by the Department of Health and Social Care and bringing together representatives from the sector) expressed uncertainty about whether the workforce would engage with a register if it was not voluntary.[46] It is not clear if any further work on a voluntary register took place during 2021.

8.31. An approach that works in the devolved nations may not necessarily work in England, given, for example, the larger workforce. There are also concerns that registration may disincentivise some people from joining the profession or could lead to some workers leaving. However, the Inquiry concludes that the benefits of registration set out above outweigh this potential harm, particularly in the context of a pandemic. It agrees with those who suggest that one way to avoid the risk of people leaving the profession would be to start by introducing a voluntary register. If there is proper engagement with the sector in developing such a register, some of the risks may be mitigated.

8.32. As explained by the Nuffield Trust, beginning with a voluntary scheme and phasing in a mandatory scheme (as in Wales and Northern Ireland) might help to reduce the risk of existing staff leaving. The Nuffield Trust stated that support from employers, regulators and trade unions can help to ensure that staff understand their responsibilities and reduce anxiety about registration.[47] The National Care Association said that the sector may feel encouraged to move towards mandatory registration once the benefits, such as for data collection, are clear.[48]

8.33. A Workforce Strategy Oversight Executive Group, consisting of organisations representing adult social care, has been established by Skills for Care.[49] The group

43 *New Horizons: What Can England Learn from the Professionalisation of Care Workers in Other Countries?*, Nuffield Trust, September 2022, pp13-14 (https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/1662995727-nuffield-trust-new-horizons-web.pdf; INQ000548131); *Supporting Progression out of Low Pay: A Call to Action*, In-Work Progression Commission, July 2021, p52 (https://assets.publishing.service.gov.uk/media/60dc9683e90e07717483843f/supporting-progression-out-of-low-pay.pdf; INQ000660175)
44 INQ000475008_0039
45 INQ000543049_0048 paras 247-247a
46 INQ000525564_0002
47 *New Horizons: What Can England Learn from the Professionalisation of Care Workers in Other Countries?,* Nuffield Trust, September 2022, pp21-23 (https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/1662995727-nuffield-trust-new-horizons-web.pdf; INQ000548131)
48 Nadra Ahmed 21 July 2025 178/12-20
49 'A workforce strategy for adult social care in England: Oversight executive group', Skills for Care, July 2024 (https://www.skillsforcare.org.uk/Workforce-Strategy/Overview/Oversight-executive-group.aspx; INQ000660174_0001-0002)

considered that workforce registration is "*key to the public recognising the sector as the professionals that they are, important for public safety and for development of people working in social care*".[50] However, it noted that there is insufficient evidence from other countries of the impact of registration on the workforce and, due to the size of the workforce in England, "*the cost-benefit argument is not clear enough yet*".[51] The group announced that it would gather evidence on the impacts and potential models of a social care workforce registration scheme during a 2025 scoping exercise.[52]

8.34. The Care Professional Organisation (formerly known as the National Association of Care and Support Workers) has now developed an independent voluntary Care Professional Register for England.[53] The register is open to all care professionals who work in England. The registration process is described as straightforward and takes just a few minutes to complete. Each registered user receives a unique PIN and digital registration badge.[54] The register displays a registered care worker's full name, their unique registration PIN, the date of their registration and their current registration status (either active or inactive). Other personal data are not displayed.[55] Paul Featherstone (Chair and Founder of the National Association of Care and Support Workers from March 2016) explained that one of the aims of the voluntary register is to professionalise the care worker role:

> "[W]*e see it as a statement of their professionalism, that they take accountability for their actions … it raises the profile of care working as a profession, alongside the individual care worker … it gives a certain prestige … to the work that we do.*"[56]

8.35. Accordingly, the Inquiry recommends that the UK government should implement a voluntary register for adult social care workers in England as a step towards improving professionalisation, recognition and retention of the workforce. A workforce register is likely also to be of great assistance in future emergency responses. For example, in a future pandemic, it would provide a better understanding of staff movement in the sector and it may help with initiatives to expand the workforce. It would also allow for rapid identification of the workforce and greater communication with the sector, and may assist in the delivery of additional training.

50 'A workforce strategy for adult social care in England: Transform', Skills for Care, July 2024 (https://www.skillsforcare.org.uk/Workforce-Strategy/Recommendations-and-commitments/Transform.aspx; INQ000660178_0002)
51 'A workforce strategy for adult social care in England: Transform', Skills for Care, July 2024 (https://www.skillsforcare.org.uk/Workforce-Strategy/Recommendations-and-commitments/Transform.aspx; INQ000660178_0002)
52 'A workforce strategy for adult social care in England: Transform', Skills for Care, July 2024 (https://www.skillsforcare.org.uk/Workforce-Strategy/Recommendations-and-commitments/Transform.aspx; INQ000660178_0002)
53 Paul Featherstone 28 July 2025 135/11-138/3; INQ000569768_0011 para 33
54 'Why join: Why join the Care Professional Register', Care Professional Organisation, no date (https://careprofessionalorganisation.co.uk/why-join; INQ000660268)
55 'Search the Care Professional Register: Find a registered care professional', Care Professional Organisation, no date (https://careprofessionalorganisation.co.uk/search-the-register; INQ000660319)
56 Paul Featherstone 28 July 2025 136/11-25

8.36. The design of the register should consider the most appropriate funding model. Broadly speaking, registration fees could be funded by individual workers, their employers or the government. In most professions, the individual worker pays the fees (eg doctors, nurses and social workers). However, this would place an extra burden on adult social care workers in what is already a relatively low-paid profession and could deter new entrants to the profession. The UK government should consider the impact that registration fees may have on retention and recruitment and consider which funding model can best minimise those risks.

8.37. The Inquiry heard a range of views as to which organisation, body or agency should be responsible for a workforce register in England. There was a consensus that it must be reliable and respected.[57] The Inquiry recommends that the UK government work with the sector and those organisations and groups most closely involved in the delivery of adult social care, both to inform the development of the register and to determine the most appropriate body or organisation to operate it. As is established best practice, where possible and appropriate, users of care should also be consulted. The UK government should work with the Care Professional Organisation, Skills for Care and the Workforce Strategy Oversight Executive Group to understand and build upon the work that has already been undertaken. The UK government may also find it beneficial to learn from the experiences of introducing registration requirements in the devolved administrations.

8.38. Mandatory registration of care workers in Northern Ireland and Wales was phased in over the course of two to three years. The number of domiciliary and care home workers in England is much larger (see Chapter 1: Overview of the adult social care sector). Once the voluntary register has been operating for an extended period of no more than five years, a cost–benefit analysis of the impact of voluntary registration should be conducted to help decision-makers determine whether registration should be made mandatory. This will also allow time to consider whether the UK government wishes to introduce the professional regulation (ie of qualifications and conduct) of workers in adult social care.

57 Caroline Abrahams 16 July 2025 35/1-4; Helen Whately 17 July 2025 139/24-140/1

Recommendation 8: A voluntary workforce register for adult social care workers

The UK government should implement a voluntary workforce register for adult social care workers in England, in order to strengthen the professionalisation and recognition for those working in the care sector. This should be developed in conjunction with social care staff, providers, commissioners and oversight bodies.

This should formalise the ongoing work to improve workforce progression and retention and any learning from registration schemes in Northern Ireland, Scotland and Wales.

The design of the register should consider:

- the most appropriate body or agency to operate the register, including processing applications, data-sharing and publication;
- the benefits and requirements of joining the register, including the best means to incentivise membership; and
- the funding model that will support the establishment and operation of the register.

The voluntary register should be implemented within two years of the publication of this Report.

Once the voluntary register has been operating for no more than five years, the UK government should undertake a full cost–benefit analysis of the workforce register and review whether membership should become mandatory.

Workforce strategies and wider reform

8.39. While workforce registers have been identified as one way of improving professionalisation, recognition and retention of the adult social care profession, wider issues relating to recruitment, training opportunities and career progression must be addressed. Without wider reform, issues with retention and encouraging new individuals to join the workforce are likely to remain.

8.40. Although recommendations about wider reform are outside the scope of this Inquiry, an effective response to a future pandemic will depend on governments addressing the systemic issues that affect the long-term resilience of the adult social care sector. Longer-term demographic changes will also require consideration of fundamental questions about how services are organised and funded to ensure that they remain sustainable and can meet future needs. The work that has already commenced in recognition of this across the UK, in the form of workforce strategies and legislative change, should be continued. Such steps will help to build a resilient workforce.

8.41. In March 2022, the Scottish Government announced a *National Workforce Strategy for Health and Social Care in Scotland*. The strategy recognises:

> "[S]*ustained actions are required from planning for and attracting into the workforce through to support and development of our workforce, supporting and delivering Recovery, Growth and Transformation of our workforce.*"[58]

The strategy requires health boards, local authorities, and health and social care partnerships to submit three-year workforce plans. The aim is to improve capacity planning and the quality of workforce data so that gaps and pressures can be more easily identified.[59]

8.42. The Skills for Care 2024 'A Workforce Strategy for Adult Social Care in England' included a number of recommendations for retaining and attracting more people into the social care workforce. Some of its recommendations are directed at the sector itself, while others require government action (such as additional funding).[60]

8.43. In June 2025, Skills for Care confirmed that more than half of its recommendations were either complete or in progress.[61] While there has been no formal response from the UK government, some recommendations that involve government input are currently being implemented. For example, following collaboration between the Department of Health and Social Care and Skills for Care, the Care Workforce Pathway was launched in January 2024. This pathway marks:

> "*the first time the care sector has seen a universal career structure setting out the knowledge, skills, values and behaviours required to deliver high-quality, personalised care and support*".[62]

58 *National Workforce Strategy for Health and Social Care in Scotland*, Scottish Government, March 2022, p3 (https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2022/03/national-workforce-strategy-health-social-care/documents/national-workforce-strategy-health-social-care-scotland/national-workforce-strategy-health-social-care-scotland/govscot%3Adocument/national-workforce-strategy-health-social-care-scotland.pdf; INQ000102994)
59 *National Workforce Strategy for Health and Social Care in Scotland*, Scottish Government, March 2022, pp45-48 (https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2022/03/national-workforce-strategy-health-social-care/documents/national-workforce-strategy-health-social-care-scotland/national-workforce-strategy-health-social-care-scotland/govscot%3Adocument/national-workforce-strategy-health-social-care-scotland.pdf; INQ000102994)
60 'A workforce strategy for adult social care in England: Summary of recommendations and commitments', Skills for Care, July 2024 (https://www.skillsforcare.org.uk/Workforce-Strategy/Overview/Summary-of-recommendations-and-commitments.aspx; INQ000660186_0001-0003); 'A workforce strategy for adult social care in England: Recommendations and commitments', Skills for Care, July 2024 (https://www.skillsforcare.org.uk/Workforce-Strategy/Recommendations-and-commitments/Recommendations-and-commitments.aspx; INQ000660185_0001)
61 'Celebrating one year of the Workforce Strategy for Adult Social Care', Skills for Care, July 2025 (https://www.skillsforcare.org.uk/Workforce-Strategy/Supporting-resources/News-and-blogs.aspx#OneYearOn; INQ000660184_0004)
62 'Care workforce pathway for adult social care: Overview', Department of Health and Social Care, updated 16 July 2026 (https://www.gov.uk/government/publications/care-workforce-pathway-for-adult-social-care/care-workforce-pathway-for-adult-social-care-overview; INQ000660183_0003)

8.44. Skills for Care described the aims of the pathway:

> "*to help address recruitment and retention issues by providing a shared vision for the workforce and a recognised platform to support career progression and individual learning, making the sector a more attractive place to work*".[63]

8.45. The Inquiry encourages the UK government to consider the remaining recommendations of 'A Workforce Strategy for Adult Social Care in England' to identify what further action it can take to address outstanding issues in the adult social care workforce.

8.46. In 2024, the Welsh Government set out the second phase of its 10-year workforce strategy (announced in October 2020) with the *Social Care Workforce Delivery Plan 2024 to 2027*. It recognises: "[T]*here is much more to do to ensure our workforce feel valued and has the best possible support available*."[64] Improving the wellbeing of the workforce is integral to the delivery plan. The plan also commits the Welsh Government to developing frameworks to improve recruitment and retention in the sector and a training 'passport' that travels with the individual. It acknowledges a need for complete information about the workforce and more sophisticated modelling to support workforce planning.[65]

8.47. In December 2024, the Department of Health (Northern Ireland) published the *Social Care Workforce Strategy 2025–2035*, which sets out how it intends to attract, grow, retain and develop the social care workforce to make it a more attractive career.[66] This will include effective planning and creating a learning culture with access to qualifications and development opportunities.[67] The strategy has been recognised by the Northern Ireland Social Care Council (which maintains the register) as an opportunity to "*formally recognise the social care workforce's development and learning and value them in a way we never have before*".[68]

8.48. In January 2025, the UK government announced that Louise Casey, Baroness Casey of Blackstock, had been asked to chair an Independent Commission on Adult Social Care in England. Working with people receiving support, their families, care workers and those involved in the delivery of care, the commission will "*make clear recommendations for how to rebuild the adult social care system to meet the*

63 'The Care Workforce Pathway', Skills for Care, no date (https://www.skillsforcare.org.uk/Developing-your-workforce/Care-workforce-pathway/The-Care-Workforce-Pathway.aspx; INQ000660318_0002)
64 *Social Care Workforce Delivery Plan 2024 to 2027*, Social Care Wales, June 2024, pp1, 3 (https://socialcare.wales/about-us/workforce-strategy/social-care-delivery-plan-2024-to-2027; INQ000660181); 'Written statement: Launch of "A Healthier Wales: Our Workforce Strategy for Health and Social Care"', Welsh Government, 22 October 2020 (https://www.gov.wales/written-statement-launch-healthier-wales-our-workforce-strategy-health-and-social-care; INQ000660320)
65 *Social Care Workforce Delivery Plan 2024 to 2027*, Social Care Wales, June 2024, pp6-8, 21-23, 32-33 (https://socialcare.wales/about-us/workforce-strategy/social-care-delivery-plan-2024-to-2027; INQ000660181)
66 *Social Care Workforce Strategy 2025–2035*, Department of Health (Northern Ireland), 12 December 2024 (https://www.health-ni.gov.uk/sites/default/files/2024-12/doh-social-care-strategy-2025-2035.pdf; INQ000660500)
67 'Health minister publishes 10-year Social Care Workforce Strategy', Department of Health (Northern Ireland), 12 December 2024 (https://www.health-ni.gov.uk/news/health-minister-publishes-10-year-social-care-workforce-strategy; INQ000660180_0001-0002)
68 'Health minister publishes 10-year Social Care Workforce Strategy', Department of Health (Northern Ireland), 12 December 2024 (https://www.health-ni.gov.uk/news/health-minister-publishes-10-year-social-care-workforce-strategy; INQ000660180_0003)

current and future needs of the population".[69] The Inquiry welcomes the establishment of the Independent Commission on Adult Social Care in England.

8.49. Urgent action is required across the UK to recognise the important role played by all those who work in adult social care. Care workers should no longer feel as though they operate behind closed doors. It is a workforce that deserves to be valued and respected by all of society at all times – not just in an emergency.

The protection of care home residents and staff

Messaging

The rhetoric

8.50. Ministers in each of the four nations understood from early in the pandemic that Covid-19 had the greatest impact on older people (see Chapter 3: Protective measures). They also knew of the risks of serious illness and death posed to those residing in adult care homes in particular. Decision-makers in each nation said that they tried to prioritise care homes in their decisions during the pandemic.

8.51. On 3 March 2020, Mark Drakeford (First Minister of Wales from December 2018 to March 2024) told the Senedd (the Welsh Parliament) that the impact of the virus was more significant among older people and people with other conditions that compromised their immune systems. Mr Drakeford acknowledged that those individuals were found in greater concentrations in care homes and said that the Welsh Government was "*very alert*" to the particular challenges in Wales and was "*taking action already to make sure that people at that front line have all the best information and are able to respond to the spread of this virus*".[70]

8.52. On 13 March 2020, Vaughan Gething (Minister for Health and Social Services in the Welsh Government from May 2016 to May 2021) announced a framework of actions in Wales, including a policy of expedited hospital discharge. The briefing he received on 13 March said that arrangements to ensure system readiness were needed to protect vulnerable groups and that the:

> "*overriding priority is to ensure: health protection; the safeguarding of vulnerable groups; staff welfare; to ensure NHS and social care preparedness; and systems resilience*".[71]

69 'New reforms and independent commission to transform social care', Department of Health and Social Care, 3 January 2025 (https://www.gov.uk/government/news/new-reforms-and-independent-commission-to-transform-social-care; INQ000546140_0003); https://caseycommission.co.uk

70 'Oral statement: Plenary – Fifth Senedd, Mark Drakeford', Welsh Government, 3 March 2020 (https://record.assembly.wales/Plenary/6260#C276377; INQ000321248_0012)

71 INQ000299010_0001-0003; INQ000587254_0022-0023 para 95; INQ000492671

8.53. Commenting on the decision to introduce the framework of actions, Mr Gething said:

> "*As ever, the most vulnerable in Wales were at the heart of the decision-making … We were mindful that Wales has a larger older population than the other home nations. This was also reflected in the age profiles within the health and social care workforce. The measures announced were taken directly to protect those vulnerable groups.*"[72]

When asked about this comment, Mr Gething said that "*whole-society choices*" were made to protect the most vulnerable, where, in managing the risks, it was necessary to understand the balance of harm in every choice that was made.[73]

8.54. At a meeting of the Scottish Cabinet on 3 March 2020, it was noted that coronavirus had "*a disproportionately serious effect on those in their 70s, 80s and over*".[74] Jeane Freeman (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021) said that, given that the virus put individuals in receipt of adult social care at the greater risk of harm, it was her primary objective to minimise the number of infections and deaths of people in the sector.[75]

8.55. Professor Sir Michael McBride, Chief Medical Officer for Northern Ireland from September 2006, said that there was an awareness of the risk posed to care home residents from Covid-19 "*at an early stage*".[76] On 8 April 2020, handwritten notes from a meeting of the Northern Ireland Executive recorded Robin Swann (Minister of Health for Northern Ireland from January 2020 to October 2022 and from February to May 2024) informing the Executive that care homes had been prioritised from the outset.[77]

8.56. At a daily press conference on 15 May 2020, Mr Hancock said:

> "*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.*"[78]

He explained the measures taken by the UK government:

> "*We set out our first advice in February, and as the virus grew, we strengthened it throughout. We've made sure that care homes have the resources they need to control the spread of infection … this week we've made a further £600 million available to care homes in England. This comes on top of the £3.2 billion we made available in March and April … We've put extra infection control*

72 INQ000587254_0023 para 96
73 Vaughan Gething 15 July 2025 99/2-100/16
74 INQ000232901_0005 para 19(e)
75 INQ000606530_0016 para 55
76 INQ000587671_0091 para 6.39
77 INQ000065725_0009; INQ000587671_0147 para 8.42; INQ000615082_0077 para 237
78 'Coronavirus press conference (15 May 2020)', YouTube, 15 May 2020, 5:43-5:56 (https://www.youtube.com/watch?v=vM-2DsysyQI)

procedures in place, and prioritised testing in care homes. We test any resident returning to a care home from hospital, and all residents with symptoms, and all social care colleagues and members of their households if they have symptoms. Together these measures have saved lives … All care home residents and staff in England, both those with symptoms and those without are now being tested … Throughout, the NHS has been supporting care homes with infection control training, and advice, and support on, for instance, PPE usage. We're putting in place a named clinical lead for every care home in England … Whilst this is progress there is so much more to do."[79]

8.57. On 24 June 2020, Mr Swann was quoted in a public announcement on behalf of the Department of Health (Northern Ireland) as saying that there was:

> "*no doubt that Covid-19 has hit our care homes very hard. They have been and will continue to be to the fore in all our efforts against this virus. We must do everything we can to protect them.*"[80]

8.58. In April 2021, Ms Freeman said in a BBC podcast that the Scottish Government's failures were as a result of not understanding the social care sector well enough and so it "*didn't respond quickly enough to what was needed in our care homes*".[81] She also said that the Scottish Government:

> "*didn't take the right precautions to make sure that older people leaving hospital going into care homes were as safe as they could be and that was a mistake … I might argue we couldn't do anything other than we did … But it still created a real problem for those older people and for the others who lived in care homes and for the staff who worked in care homes.*"[82]

When asked by the Inquiry about her remarks on the podcast, Ms Freeman said: "[R]*eflecting on it now, I don't believe there was a delayed response from us.*"[83]

The reality

8.59. Mr Hancock said that, while his use of the phrase 'protective ring' was:

> "*clearly a piece of rhetoric, we really did do our best to take all of the actions we could to protect those in care homes from the virus in incredibly difficult circumstances*".[84]

79 'Coronavirus press conference (15 May 2020)', YouTube, 15 May 2020, 5:56-9:53 (https://www.youtube.com/watch?v=vM-2DsysyQI)
80 'Work underway to learn from care home Covid-19 experiences', Department of Health (Northern Ireland), 24 June 2020 (https://www.health-ni.gov.uk/news/work-underway-learn-care-home-covid-19-experiences; INQ000103713_0001-0002)
81 'COVID in Scotland: Government "failed" social care sector during pandemic', BBC News, 8 April 2021 (https://www.bbc.co.uk/news/uk-scotland-56680666; INQ000351043_0002)
82 'COVID in Scotland: Government "failed" social care sector during pandemic', BBC News, 8 April 2021 (https://www.bbc.co.uk/news/uk-scotland-56680666; INQ000351043_0001-0003)
83 Jeane Freeman 22 July 2025 58/10-59/2
84 INQ000587746_0034 para 148

He told the Inquiry: "[W]*hat I said is that we had tried. It was not possible to protect as much as I would have wanted.*"[85] Mr Hancock reflected:

> "[I]*t was a form of words rather than the substance … what you should look at is the policy support that was put in place from the centre … and … the other options available, given the clinical advice I had at the time, were worse.*"[86]

8.60. Mr Hancock's statement may well have been a piece of rhetoric, but his choice of words did not reflect what was happening in care homes in the first weeks and months of the pandemic. Much of the action to which Mr Hancock referred did not take place from the start. For example, testing all people discharged from hospital into care homes only began in mid-April 2020 and the Infection Control Fund was introduced in mid-May 2020. The delivery of infection prevention and control training by the NHS also took place in May 2020. By the time Mr Hancock made this statement, thousands of people had died in care homes in England. Between 10 April (the first day on which data were collected using the Care Quality Commission's new method of identifying deaths involving Covid-19) and 8 May 2020, the Care Quality Commission had received notification of 12,409 deaths involving Covid-19.[87]

8.61. Professor Sir Jonathan Van-Tam, Deputy Chief Medical Officer for England from October 2017 to March 2022, said a "*ring is a circle without a break in it*".[88] He said that "*if you want to achieve that, you have to close off the three routes of ingress*" to care homes, which he identified as new or returning admissions from hospital and the community, visitors and care home workers.[89] He said that this required more testing, more resources for isolating individuals in both hospitals and care homes, and far more stringent policies on care home workers moving in and out of homes.[90] During the Inquiry's Module 2 hearings, Mr Hancock accepted that the protective measures put in place in England did not constitute an unbroken circle, stating that it is "*quite clear from the evidence that Professor Van-Tam is right*".[91]

8.62. Ms Killian said that the "*notion of a 'protective ring' was known to be simply not true*".[92] She said this "*caused deep concern and distress for families, as well as for sector professionals seeking to perform their duties*".[93] Ms Abrahams was of the view that "*promises of a 'protective ring' around care homes did not materialise*" in the early stages of the pandemic in either policy or practice.[94] She referred, for example,

85 Matt Hancock 2 July 2025 57/18-58/6
86 Matt Hancock 2 July 2025 64/4-18
87 'Deaths involving Covid-19 in the care sector, England and Wales: Deaths occurring up to 1 May 2020 and registered up to 9 May 2020 (provisional)', Office for National Statistics, 15 May 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto1may2020andregisteredupto9may2020provisional; INQ000235416_0001-0009). In England, the number of deaths among care home residents in 2020 had increased in comparison with the previous year (see Figure 2).
88 INQ000269203_0124 para 9.16
89 INQ000269203_0123 para 9.16
90 INQ000269203_0123-0124 paras 9.15-9.16; see also INQ000049363_0002 para 7
91 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025 (https://covid19.public-inquiry.uk/documents/module-2-full-report); Matt Hancock 30 November 2023 196/11-20
92 INQ000587382_0023-0024 para 56
93 INQ000587382_0023-0024 para 56
94 INQ000509808_0024 para 63

to the fact that there was no published strategy for the sector in England until mid-April 2020, no routine collection of real-time data and a lack of access to PPE.[95]

8.63. While significant measures were introduced to protect care homes later in the pandemic, it cannot be said that care homes were protected from the outset in any nation of the UK. As outlined in the Inquiry's combined Report relating to Modules 2, 2A, 2B and 2C, the pandemic generally was not taken seriously enough in the UK until it was too late, and February 2020 was a lost month.[96] The same can be said in respect of adult social care.

Lack of protection

Control and understanding

8.64. Entering the pandemic, the UK government and devolved administrations had limited oversight, control and understanding of the adult social care sector. It was also known that the sector was likely to face serious consequences from a pandemic. Despite this, there was a woeful lack of planning for the impact of a pandemic on the sector. Had there been established and adequate mechanisms to collect capacity data fully and routinely, early decisions – including the expedited discharge of hospital patients, which led to many admissions to the care sector – could have been better informed. Importantly, the impact on the sector may have been more fully understood. Early guidance for care homes did not consider the practical realities of the ways in which care is delivered.

Testing

8.65. Testing in adult social care was essential for the early implementation of effective infection prevention and control measures in care homes, to try to prevent entry of the virus into care homes or to mitigate its effects once it arrived. While the scientific advice on the value of asymptomatic testing evolved during the pandemic, the reality is that limited testing capacity led to delays in testing people discharged from hospitals to care homes and wider symptomatic and asymptomatic testing of staff and residents.

Discharge from hospitals to care homes

8.66. There were concerns that healthcare settings were prioritised at the expense of care homes in respect of both hospital discharges and PPE. When the expedited discharge policies were introduced in each nation, there were no contingency plans in place to accommodate Covid-19-positive or symptomatic residents who could not be cared for in their intended care home. This was in spite of a general awareness

95 INQ000509808_0024-0025 paras 63-65; Caroline Abrahams 16 July 2025 11/3-21
96 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol I, Chapter 2 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

among decision-makers and advisers in each nation that some care homes would be unable to implement effective isolation policies. Care homes were instead encouraged to accept people who had not been tested and felt pressure to accept those who were symptomatic or Covid-19-positive to free up hospital capacity. Isolation of all people admitted from hospital, a key protective measure, was not advised in England, Wales and Northern Ireland until mid to late April 2020.

Personal protective equipment

8.67. In the first weeks and months of the pandemic, PPE was prioritised for acute healthcare settings. While each government took steps to provide free PPE to care homes during the pandemic, the stark reality is that, during the early weeks and months of the pandemic, care homes simply did not have access to enough PPE to keep both staff and residents safe.

Support for isolation

8.68. For workers on low pay, financial support during isolation is highly significant. The Inquiry heard that some care workers may have felt the need to work when they were unwell (including with symptoms of Covid-19) or when they should have been isolating, simply to make ends meet. Some were scared to test, fearing a positive result that would require them to stay off work. Across the UK, it took time to introduce funding to ensure that care staff received full pay if they were required to isolate. There was a particular delay in introducing this funding in Wales. Some workers experienced difficulties in obtaining the funding that was introduced.

Healthcare

8.69. Ms Abrahams said that there were some naive assumptions by the UK government about how well equipped care homes were to deal with people who had both care and medical needs.[97] In particular, from March to May 2020, healthcare professionals reduced the frequency with which they attended care homes, with guidance issued that healthcare visits should take place only if they were necessary or essential. There is evidence that a number of care home residents were left with unmet health needs. Initially there was very little, if any, focus on how end-of-life care would be provided in care homes and how the symptoms associated with dying from Covid-19 could be managed. Many people did not receive the care they needed and died with avoidable symptoms and distress.

97 Caroline Abrahams 16 July 2025 11/21-24

Resilience

8.70. In respect of Northern Ireland, Professor McBride said that, in hindsight, more could have been done in the lead-up to the pandemic to improve the resilience of the sector and more could have been done during the pandemic to protect care homes.[98] Both could have – and should have – been done across the UK.

Protection in the future

8.71. The allocation of resources and public money is a matter for policy-makers, and the broader reform of the adult social care sector is not for this Inquiry to determine.

8.72. However, during the Covid-19 pandemic, adult social care staff and the people to whom they provided care bore the appalling cost of being an unrecognised and unprotected part of society. Care home residents in particular faced a high risk of serious harm from the virus, isolation from family and friends, and distressing and lonely deaths. Yet, particularly in the first few months of the pandemic, they were simply not protected.

8.73. The UK government and devolved administrations must develop plans now for any future pandemic response to ensure that this never happens again. As noted by the UK's Chief Medical Officers and the Chief Scientific Adviser in their *Technical Report on the COVID-19 Pandemic in the UK*, published on 1 December 2022, care home residents are very likely to be at high risk of serious disease in any future respiratory disease epidemic.[99] The UK government and devolved administrations must improve their understanding of the sector and consult those providing care in, working in and using the care sector. The recommendations in this Report are intended as a package of measures that should be introduced to ensure that the impact of a future pandemic on the adult social care sector is properly considered in advance, so that greater protection can be ensured right from the start.

98 INQ000587671_0095 para 6.46; Michael McBride 24 July 2025 80/10-81/3

99 *Technical Report on the COVID-19 Pandemic in the UK*, Department of Health and Social Care, 1 December 2022, pp304-306 (https://assets.publishing.service.gov.uk/media/63bd35b78fa8f55e3ac750c4/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf; INQ000101642); INQ000587671_0120-0122 para 7.24

Appendix 1: The background to this module and the Inquiry's methodology

Background

A1.1. The Right Honourable Boris Johnson MP, Prime Minister from July 2019 to September 2022, formally established the UK Covid-19 Inquiry in June 2022 to examine the preparations for and response to the Covid-19 pandemic in the UK and to learn lessons for the future. In December 2021, he appointed The Right Honourable the Baroness Hallett DBE, a retired judge of the Court of Appeal, as its Chair.

A1.2. On 28 June 2022, the Prime Minister issued the final Terms of Reference for the Inquiry, establishing it under the Inquiries Act 2005.[1] The Inquiry formally opened on 21 July 2022 to:

> "*examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the Inquiry's formal setting-up date, 28 June 2022*".[2]

A1.3. To ensure a full and focused examination of the wide range of issues covered in the Terms of Reference and to produce regular reports, the Inquiry's investigation has been divided into sections or 'modules'. Each module gathers evidence, designates Core Participants and has both preliminary hearings (at which decisions about the procedure for the conduct of its investigations and public hearings are made) and full public hearings where evidence is heard. Details of public hearings are published by the Inquiry.[3]

A1.4. The Inquiry's public hearings concluded on 5 March 2026. Five investigation reports have already been published (see Table 7).

1 See 'Covid-19 Inquiry Terms of Reference', UK Covid-19 Inquiry, 20 July 2022 (https://covid19.public-inquiry.uk/documents/terms-of-reference), which includes translations of the Inquiry's Terms of Reference; for the Inquiries Act 2005, see https://www.legislation.gov.uk/ukpga/2005/12/contents. A separate inquiry is taking place in Scotland, which will evaluate areas where policy was devolved to the Scottish Government, as set out in its Terms of Reference. The UK Covid-19 Inquiry works with the Scottish Covid-19 Inquiry to avoid duplication of work where possible.

2 'Covid-19 Inquiry Terms of Reference', UK Covid-19 Inquiry, 20 July 2022 (https://covid19.public-inquiry.uk/documents/terms-of-reference)

3 For further information, see 'Structure of the Inquiry', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/structure-of-the-inquiry)

Table 7: Module reports published by the Inquiry

Module	Publication date
Module 1: The resilience and preparedness of the United Kingdom (https://covid19.public-inquiry.uk/documents/module-1-full-report)	18 July 2024
Modules 2, 2A, 2B, 2C: Core decision-making and political governance (https://covid19.public-inquiry.uk/documents/module-2-full-report) Note: This report brought together the work of four distinct modules – Modules 2 (UK), 2A (Scotland), 2B (Wales) and 2C (Northern Ireland).	20 November 2025
Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom (https://covid19.public-inquiry.uk/documents/module-3-full-report)	19 March 2026
Module 4: Vaccines and therapeutics (https://covid19.public-inquiry.uk/documents/module-4-full-report)	16 April 2026
Module 5: Procurement (https://covid19.public-inquiry.uk/documents/module-5-full-report)	14 July 2026

A1.5. The modules that are yet to publish reports are:

- Module 7: Test, trace and isolate[4]
- Module 8: Children and young people[5]
- Module 9: Economic response[6]
- Module 10: Impact on society[7]

A1.6. A public inquiry is established to examine the facts and to find out exactly what happened. It is an inquisitorial, not an adversarial, process. The conclusions and recommendations in each report are based on an objective assessment of the totality of the evidence received by the Inquiry.

Module 6

A1.7. This Report concerns the impact of the Covid-19 pandemic on the publicly and privately funded adult social care sector in the four nations of the UK. The adult social care sector provides a range of services to help support the physical,

4 'Test, trace and isolate (Module 7)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/test-trace-and-isolate-module-7)
5 'Children and young people (Module 8)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/children-and-young-people-module-8)
6 'Economic response (Module 9)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/economic-response-module-9)
7 'Impact on society (Module 10)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/impact-on-society-module-10)

emotional and social needs of adults and older people. This support can be provided in a variety of settings, including in people's own homes, in care homes or in a number of other places such as day centres or supported housing. For the purposes of Module 6, the Inquiry focused on care homes, domiciliary care and unpaid care.

Outline of Scope

A1.8. As described in its Outline of Scope, Module 6 focused primarily on the consequences of government decision-making for those living and working in the adult social care sector.[8] In particular, the matters examined encompassed:

- the impact of the pandemic on people's experience of the adult social care sector;
- the structure of the adult social care sector and the key bodies involved in the UK government and devolved administrations at the start of and during the pandemic;
- the key decisions made by the UK government and devolved administrations in respect of the adult social care sector, including the decisions relating to the discharge of people from hospitals into adult care and residential homes in the early stages of the pandemic;
- the management of the pandemic in adult care and residential homes;
- the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and communication with recipients of care and their loved ones about the recipient of care's condition and treatment, including discussions and decisions about DNACPRs;
- changes to the regulatory inspection regimes in the adult social care sector;
- deaths related to infection by Covid-19, including the deaths of recipients of care and staff; and
- infection prevention and control measures for those providing care in the home, including by unpaid carers.

Core Participants

A1.9. In accordance with rule 5 of the Inquiry Rules 2006 and the Inquiry's Core Participant Protocol, the Chair designates a number of Core Participants – individuals, organisations or institutions with a specific interest – in each module.[9] Core Participants have enhanced rights in the Inquiry process, including receiving disclosure of documents, being represented, making legal submissions and suggesting lines of enquiry. They are also able to apply to the Inquiry for funding to cover legal and other costs.

8 'Module 6: Provisional Outline of Scope', UK Covid-19 Inquiry, 12 December 2023 (https://covid19.public-inquiry.uk/documents/module-6-provisional-outline-of-scope)
9 The Inquiry Rules 2006, rule 5 (https://www.legislation.gov.uk/uksi/2006/1838/contents/made); 'Core Participant Protocol', UK Covid-19 Inquiry, 21 July 2022 (https://covid19.public-inquiry.uk/documents/uk-covid-19-inquiry-core-participant-protocol)

A1.10. In Module 6, the Inquiry received 53 applications for Core Participant status, and the Chair designated 27 Core Participants.[10]

Table 8: Module 6 Core Participants

Name of organisation/individual	Date of designation
Association of Directors of Adult Social Services, Local Government Association and Welsh Local Government Association	8 February 2024 8 February 2024 8 February 2024
British Association of Social Workers	8 February 2024
Care England, Homecare Association and National Care Forum	8 February 2024 8 February 2024 8 February 2024
Care Inspectorate (Scotland)	8 February 2024
Care Quality Commission	8 February 2024
Convention of Scottish Local Authorities	26 February 2024
Covid-19 Bereaved Families for Justice Cymru	8 February 2024
Covid-19 Bereaved Families for Justice UK	8 February 2024
Department of Health and Social Care	8 February 2024
Disability Rights UK, Disability Action Northern Ireland, Disability Wales and Inclusion Scotland	8 February 2024
Frontline Migrant Health Workers Group (United Voices of the World, Independent Workers Union of Great Britain and Kanlungan Filipino Consortium)	8 February 2024
John's Campaign, Care Rights UK and Patients Association	8 February 2024
National Association of Care and Support Workers	8 February 2024
Northern Ireland Covid-19 Bereaved Families for Justice	8 February 2024
Northern Ireland Department of Health	8 February 2024
Public Health Agency for Northern Ireland	6 March 2024
Public Health Scotland	27 February 2024
Public Health Wales	27 February 2024
Regulation and Quality Improvement Authority	8 February 2024
Royal College of Nursing	8 February 2024
Scottish Care	8 February 2024
Scottish Covid Bereaved	8 February 2024
Scottish Health Boards (Scottish territorial and special health boards)	26 February 2024
Scottish Ministers	8 February 2024

10 'Module 6: List of Core Participants', UK Covid-19 Inquiry, 13 March 2024 (https://covid19.public-inquiry.uk/documents/list-of-module-6-core-participants)

Name of organisation/individual	Date of designation
Trades Union Congress	8 February 2024
UK Health Security Agency	27 February 2024
Welsh Government	8 February 2024

Public access to Inquiry proceedings

A1.11. In keeping with its public nature and the Chair's commitment to conduct the Inquiry in as open and transparent a manner as possible, arrangements were made for the hearings to be accessible to all who wished to follow them. The hearings were broadcast via livestream on the Inquiry's website or its YouTube channel (where they remain accessible) and members of the public were able to watch the hearings in person.[11]

Evidence gathering

A1.12. In Module 6, the Inquiry issued 186 requests for evidence pursuant to rule 9 of the Inquiry Rules 2006, to 184 organisations and individuals. It received and considered 177 witness statements and 11,831 documents, containing 103,020 pages. The Inquiry also reviewed and disclosed material provided for other modules and deemed relevant to its Scope. In total, 17,196 documents, comprising 235,291 pages, were disclosed to Core Participants.

A1.13. The Inquiry received statements from a sample of 14 individual care homes chosen from a variety of care homes across the UK, taking into account factors including geographical spread, size and demography. This enabled the Inquiry to gain a broader understanding of the experience of those working in care homes and of the impact of the Covid-19 pandemic on providers of adult social care across the UK.

A1.14. The Inquiry also sent requests to a number of individuals from Core Participant groups who were particularly affected by the Covid-19 pandemic for evidence about the impact it had on them. Those contacted included recipients of adult social care, bereaved families, charity groups, workers' organisations and professional membership organisations. The Inquiry received 22 such statements, all of which have been published.

Every Story Matters

A1.15. As set out in the Terms of Reference, the Inquiry regards it as critical to its work to listen to and carefully consider the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. The Inquiry has done this

11 'Care Sector (Module 6) – Public Hearings', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/hearings/care-sector-module-6-public-hearings/; https://www.youtube.com/@UKCovid-19Inquiry/videos)

in a number of different ways, including through its listening exercise, Every Story Matters, the largest public engagement exercise by a UK public inquiry. It heard from thousands of people about their experiences of the pandemic.

A1.16. Stories were shared with the Inquiry through a webform (including accessible versions), a series of events across the UK and interviews with under-represented groups.[12] Those aged 18 or older were invited to share as much or as little of their pandemic experience as they felt able, without the formality of giving evidence or attending a public hearing. More than 58,000 stories were shared with the Inquiry. The sharing of these experiences has helped the Inquiry to understand events and their impact and has aided the development of recommendations that could reduce suffering in the future. Experiences shared with the Inquiry were analysed and reports – called records – have been produced highlighting the themes that emerge, and telling people's stories in their own words. Every Story Matters records have been used in evidence in relevant modules of the Inquiry.[13] The record relating to Module 6 has been published as *Every Story Matters: Adult Social Care Sector*. This has been referenced in this Report and has been published on the Inquiry website.[14]

Disclosure to Core Participants and publication of materials

A1.17. The Inquiry's approach to documents is set out in its Protocol on Documents, which explains key principles for the delivery of documents to the Inquiry, including requests for documents or witness statements pursuant to rule 9 of the Inquiry Rules 2006.[15] This should be read with the Inquiry's Protocol on the Redaction of Documents, which details the approach to the redaction of documents for the purposes of both disclosure to Core Participants and publication.[16]

A1.18. The Inquiry discloses all witness statements and documents it considers relevant to Core Participants in full, subject to any redactions applied in accordance with the Inquiry's Protocol on the Redaction of Documents.[17] To comply with section 18 of the Inquiries Act 2005, the Chair is taking reasonable steps to ensure that members of the public are able to view documents provided to the Inquiry and attend Inquiry hearings.[18] All documents shown on screen during the course of the hearings appear in the YouTube recording of the evidence and are published on the Inquiry's website at the end of each day. The witness statements of those who give evidence each day are also published in full. Since the conclusion of the hearings, the Chair has granted

12 'Every Story Matters', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/every-story-matters)
13 The Inquiry's Every Story Matters records can be found at: https://covid19.public-inquiry.uk/every-story-matters/records
14 INQ000587564
15 'Protocol on Documents', UK Covid-19 Inquiry, 29 July 2022 (https://covid19.public-inquiry.uk/documents/protocol-on-documents); The Inquiry Rules 2006 (https://www.legislation.gov.uk/uksi/2006/1838/article/9/made)
16 'Inquiry Protocol on the Redaction of Documents', UK Covid-19 Inquiry, 18 October 2022 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-the-redaction-of-documents)
17 'Inquiry Protocol on the Redaction of Documents', UK Covid-19 Inquiry, 18 October 2022 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-the-redaction-of-documents)
18 Inquiries Act 2005, section 18 (https://www.legislation.gov.uk/ukpga/2005/12/contents)

permission for the publication of further materials, including those referenced in this Report, where she has been satisfied it is necessary to do so.[19]

A1.19. In the event of an objection to the disclosure or publication of relevant material, an application must be made to the Chair for a restriction order in accordance with section 19 of the Inquiries Act 2005, following the Inquiry's Protocol on Applications for Restriction Orders.[20] In Module 6, the Chair issued restriction orders dated 1 July 2025 and 18 August 2025 concerning the inadvertent publication of irrelevant and sensitive material and redacted material.[21]

The instruction of expert witnesses

A1.20. To assist the Inquiry in Module 6, five expert witnesses were appointed by the Inquiry in relation to a number of topics, including adults with learning disabilities, dementia and palliative and end-of-life care.

Table 9: Expert witnesses

Topic	Expert(s) appointed	Expert report
Dementia	Professor Sube Banerjee MBE (Professor of Dementia at the University of Nottingham)	INQ000546956
Palliative and end-of-life care	Professor Katherine Sleeman (Laing Galazka Chair in Palliative Care, King's College London) Professor Stephen Barclay (Clinical Lead in End-of-Life Care for the Cambridgeshire and Peterborough Integrated Care System)	INQ000587295
Adults with learning disabilities	Professor Chris Hatton (Professor of Social Care at Manchester Metropolitan University) Professor Richard Hastings (Professor of Psychology Health and Social Care at the University of Birmingham)	INQ000587296

Witnesses at public hearings

A1.21. Witnesses are invited by the Inquiry to provide a statement if they have evidence relevant to a particular module. They give evidence under oath or affirmation and

19 'Documents', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/documents)
20 Inquiries Act 2005, section 19 (https://www.legislation.gov.uk/ukpga/2005/12/section/19); 'Inquiry Protocol on Applications for Restriction Orders', UK Covid-19 Inquiry, 18 October 2022 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-applications-for-restriction-orders)
21 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 1 July 2025 (https://covid19.public-inquiry.uk/documents/restriction-order-on-the-publication-of-material-pursuant-to-section-19-of-the-inquiries-act-2005-dated-1-july-2025); 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 18 August 2025 (https://covid19.public-inquiry.uk/documents/module-6-general-restriction-order-dated-18-08-2025)

are questioned by Counsel to the Inquiry. Counsel to Core Participants can also ask questions with the Chair's permission pursuant to rule 10 of the Inquiry Rules 2006.[22]

A1.22. At its public hearing in Module 6 between 30 June and 31 July 2025, the Inquiry heard evidence from 57 witnesses, including representatives of bereaved and other impact groups, charities and unions, adult social care workers, care home operators, representative bodies, government ministers and government officials.

Table 10: Module 6 witnesses from whom the Inquiry heard evidence

Witness (organisation)	Date of evidence
Jane Wier-Wierzbowska (member of Covid-19 Bereaved Families for Justice UK)	1 July 2025
Judith Kilbee (member of Scottish Covid Bereaved)	1 July 2025
Agnes McCusker (member of Northern Ireland Covid-19 Bereaved Families for Justice)	1 July 2025
Helen Hough (former care home owner and member of Covid-19 Bereaved Families for Justice Cymru)	1 July 2025
Professor Laura Shallcross MBE (Professor of Public Health and Translational Data Science from 2021 and Director of the Institute of Health Informatics at University College London from September 2023)	1 July 2025
Matt Hancock (Secretary of State for Health and Social Care from July 2018 to June 2021)	2 July 2025
Dr Ruth Allen (Chief Executive Officer of the British Association of Social Workers from 2016 to September 2025)	3 July 2025
Professor Vic Rayner OBE (Chief Executive Officer of the National Care Forum from 2016)	3 July 2025
Reverend Charlotte Hudd (member of the Royal College of Nursing)	3 July 2025
Mary Cridge (Director of Adult Social Care at the Care Quality Commission from July 2022)	7 July 2025
Briege Donaghy (Chief Executive of the Regulation and Quality Improvement Authority in Northern Ireland from July 2021)	7 July 2025
Gillian Baranski (Chief Inspector of Care Inspectorate Wales from October 2016)	7 July 2025
Julie Parkinson (member of the National Association of Care and Support Workers)	8 July 2025
Kevin Mitchell (Executive Director of Assurance and Improvement at the Care Inspectorate in Scotland from August 2015)	8 July 2025

22 The Inquiry Rules 2006, rule 10 (https://www.legislation.gov.uk/uksi/2006/1838/contents/made)

Witness (organisation)	Date of evidence
Professor Fu-Meng Khaw (National Director of Health Protection and Screening Services and Executive Medical Director of Public Health Wales from June 2021)	8 July 2025
Christina McAnea (General Secretary of UNISON from January 2021 to January 2026, on behalf of the Trades Union Congress)	8 July 2025
Professor Susan Hopkins CBE (Deputy Director of the National Infection Service at Public Health England from 2018 to 2020, National Strategic Response Director for COVID-19 at Public Health England from September 2020 to September 2021, Chief Executive Officer at the UK Health Security Agency, Interim Chief Medical Advisor to the UK Health Security Agency from October 2021 and Chief Medical Advisor from June 2022 to 2025)	9 July 2025
Professor Dame Jenny Harries DBE (Deputy Chief Medical Officer for England from July 2019 to March 2021)	9 July 2025
Dr Chris Llewelyn (Chief Executive of the Welsh Local Government Association from January 2019)	10 July 2025
Professor Ian Hall OBE (Professor of Mathematical Epidemiology and Statistics at the University of Manchester from 2021 and Academic Co-Chair of the Care Home Working Sub-Group, which became the Social Care Working Group of the Scientific Advisory Group for Emergencies (SAGE))	10 July 2025
Heather Reid (Interim Director of Nursing, Midwifery and Allied Health Professionals at the Public Health Agency (Northern Ireland) from May 2023 to November 2025)	10 July 2025
Susan Lyons (member of John's Campaign, Care Rights UK and the Patients Association)	10 July 2025
Dr Jane Townson OBE (Chief Executive of the Homecare Association from May 2019)	14 July 2025
Sir Sajid Javid (Secretary of State for Health and Social Care from June 2021 to July 2022)	14 July 2025
Heléna Herklots CBE (Older People's Commissioner for Wales from August 2018 to August 2024)	14 July 2025
Melanie Minty (Senior Policy Advisor at Care Forum Wales from 2012)	14 July 2025
Vaughan Gething (Minister for Health and Social Services in the Welsh Government from May 2016 to May 2021)	15 July 2025
Albert Heaney CBE (Chief Social Care Officer for Wales from June 2021 and Deputy Director General Health and Social Services Group in the Welsh Government from March 2020 to June 2021)	15 July 2025
Caroline Abrahams CBE (Charity Director of Age UK from 2012)	16 July 2025
Emily Holzhausen CBE (Director of Policy and Public Affairs, Carers UK)	16 July 2025

Witness (organisation)	Date of evidence
Michelle Dyson CB (Interim Director General of Adult Social Care at the Department of Health and Social Care from September 2020, permanent from May 2021 to July 2025)	16 July 2025
Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021)	17 July 2025
Professor Sean Holland (Chief Social Work Officer in the Department of Health (Northern Ireland) from July 2010 to October 2022)	21 July 2025
Nicola Dickie (Director of People Policy at the Convention of Scottish Local Authorities from October 2021)	21 July 2025
Nadra Ahmed CBE (Executive Co-Chair of the National Care Association from 2001)	21 July 2025
Alasdair Donaldson (member of Adult Social Care Policy team at the Department of Health and Social Care from April to October 2020, NHS Test and Trace from October 2020 to June 2021 and Chief of Staff to the Director General, Strategy and Policy at the UK Health Security Agency from June 2021 to October 2022)	22 July 2025
Jeane Freeman OBE (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021)	22 July 2025
Caroline Lamb (Director General for Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland from January 2021 to August 2026)	22 July 2025
Cathryn Williams (Chief Executive of the Association of Directors of Adult Social Services from January 2015 to July 2024)	23 July 2025
Alwyn Jones (President of the Association of Directors of Social Services Cymru from December 2022 to March 2024)	23 July 2025
Eddie Lynch (Commissioner for Older People for Northern Ireland from June 2016 to December 2024)	23 July 2025
Professor Sube Banerjee MBE (Professor of Dementia at the University of Nottingham from 2023)	23 July 2025
Professor Sir Michael McBride (Chief Medical Officer for Northern Ireland from September 2006)	24 July 2025
Robin Swann (Minister of Health for Northern Ireland from January 2020 to October 2022 and from February to May 2024)	24 July 2025
Joanna Killian (Chief Executive of the Local Government Association from March 2024 to July 2026)	28 July 2025
Dr Maria Rossi (Interim Head of Division for Environmental and Emergency Response in the Clinical and Protecting Health Directorate at Public Health Scotland from March 2020)	28 July 2025
Paul Featherstone (Chair and Founder of the National Association of Care and Support Workers from March 2016)	28 July 2025

Witness (organisation)	Date of evidence
Professor Chris Hatton (Professor of Social Care at Manchester Metropolitan University)	28 July 2025
Claire Sutton (Head of Independent Health and Social Care at the Royal College of Nursing from August 2022)	29 July 2025
Helen Wildbore (Director of Care Rights UK from 2019 to 2025)	29 July 2025
Francesca Humi (Frontline Migrant Health Workers Group Affiliate – Kanlungan)	29 July 2025
Joanne Sansome (member of Disability Action Northern Ireland)	29 July 2025
Professor Stephen Barclay (Clinical Lead in End-of-Life Care for the Cambridgeshire and Peterborough Integrated Care System from 2010)	30 July 2025
Catherine Griffiths (member of Covid-19 Bereaved Families for Justice Cymru)	30 July 2025
Linda Dinsdale (member of Covid-19 Bereaved Families for Justice UK)	30 July 2025
Gregory McQuitty (member of Covid-19 Bereaved Families for Justice Northern Ireland)	30 July 2025
Rhona Arthur (member of Scottish Covid Bereaved)	30 July 2025

Criticisms

A1.23. Rule 13(3) of the Inquiry Rules 2006 prevents the inclusion of any "*explicit or significant criticism of a person*" in this Report unless a warning letter has been sent and the relevant person has been given a reasonable opportunity to respond.[23] Warning letters were issued to persons identified in accordance with rule 13 and also with the Inquiry's Protocol on Warning Letters.[24] The Chair considered the responses to those letters before finalising this Report.

The Inquiry team

A1.24. The Chair was greatly assisted in Module 6 by the Inquiry team of counsel, solicitors, paralegals and other members of the secretariat.

23 The Inquiry Rules 2006, rule 13(3) (https://www.legislation.gov.uk/uksi/2006/1838/contents/made)
24 'Inquiry Protocol on Warning Letters', UK Covid-19 Inquiry, 21 February 2025 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-warning-letters)

Table 11: Module 6 Counsel team

Role	Name
Lead Counsel	Jacqueline Carey KC
Junior Counsel	Joanne Cecil KC Bo-Eun Jung Laura Paisley Natasha Shotunde Alice Hands Andrew Beech

Terminology and references

A1.25. The nature of the subject matter means that the evidence considered by the Inquiry contains technical and specialist language, which the Inquiry has tried to minimise in this Report. A number of witnesses and documents also used a range of abbreviations and acronyms. To avoid any confusion and to assist the reader, the Inquiry has set out names and other key phrases in full in this Report; a detailed glossary is also included at Appendix 2.

A1.26. Some terminology that is particularly key to understanding this Report is listed below for ease of reference.

Key terminology

A1.27. The virus that causes the coronavirus disease known as Covid-19 is SARS-CoV-2. However, where this specificity is not necessary, in accordance with the practice of the World Health Organization, the Inquiry uses 'Covid-19' to refer to both the virus and the disease.

A1.28. Although the first Covid-19 patients in the UK were announced on 31 January 2020 and the outbreak was not characterised by the World Health Organization as a pandemic until 11 March 2020, for clarity this Report refers to the time period beginning with the arrival of Covid-19 in the UK as the 'Covid-19 pandemic'.

A1.29. The Covid-19 pandemic required action by both the UK government and devolved administrations. Wales, Scotland and Northern Ireland each have a legislature and executive elected by their own electorates (referred to in this Report as the 'devolved administrations'). Although each devolution settlement is different, each administration is responsible for a range of matters, including health, education and transport. England has no legislature of its own – instead, the UK Parliament legislates on both UK-wide, 'reserved' (ie not devolved) issues such as defence and foreign affairs and legislates for England on issues devolved to other nations. The UK

Parliament also, at times, legislates for other groupings – for example, in England and Wales on issues of justice.

A1.30. The UK government is responsible for all aspects of government policy in England. At the time of the Covid-19 pandemic, the Department of Health and Social Care was responsible for policy on health and adult social care matters in England (and on a UK-wide basis for a few issues that are not otherwise devolved). Prior to January 2018, the Department of Health and Social Care was known as the Department of Health – for clarity, the department is referred to throughout this Report using its current name.

A1.31. 'The NHS' is the term used to refer collectively to the publicly funded national healthcare systems in England, Scotland and Wales, comprising the NHS in England, NHS Scotland and the NHS in Wales (also known as NHS Wales). In Northern Ireland, the publicly funded healthcare system is Health and Social Care (Northern Ireland), with health and social care integrated under a single framework. In this Report, the term 'healthcare systems in the four nations' is used to describe the healthcare systems across the UK.

A1.32. Prior to the pandemic, responsibility for responding to public health challenges in Scotland was divided between a number of different bodies. As part of the Public Health Reform programme, Public Health Scotland was launched on 1 April 2020. It brought together three legacy bodies: NHS Health Scotland, Health Protection Scotland (part of NHS National Services Scotland) and the Information Services Division (also part of NHS National Services Scotland). As a result, at an early stage of the pandemic, all staff and functions of those legacy bodies transferred to Public Health Scotland, with limited exceptions (the Antimicrobial Resistance and Healthcare Associated Infection function and a number of corporate services staff from NHS Health Scotland that remained in NHS National Services Scotland). Accordingly, questions relating to the public health response in Scotland were directed to both Public Health Scotland and NHS National Services Scotland.

A1.33. References to 'R' in public health communications during the Covid-19 pandemic – and references to 'R' in this Report – are generally references to Rt: the average number of people that a single infected person passes a virus on to at a particular time point, taking into account current levels of immunity and the extent of social mixing.[25]

References

A1.34. References such as 'Caroline Abrahams 16 July 2025 21/4-5' or 'INQ000572015_0025 para 82' in the footnotes of this Report relate to material that is available on the Inquiry's website.[26]

25 INQ000252450_0013 para 2.15
26 'What is the UK Covid-19 Inquiry?', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk)

A1.35. The transcripts of the Inquiry's hearings are referenced by person, hearing date, and internal page and line numbers. For example, 'Caroline Abrahams 16 July 2025 21/4-5' refers to the evidence of Caroline Abrahams on 16 July 2025, page 21, lines 4 to 5.

A1.36. Documentary evidence is referenced by the document's number and, where relevant, page and paragraph numbers. For example, 'INQ000572015_0025 para 82' refers to document INQ000572015, page 25, paragraph 82.

A1.37. Publicly available documents are listed in the footnotes with both their wider internet and Inquiry website links. For example:

> *Care Home Census for Adults in Scotland: Statistics for 2015 – 2025*, Public Health Scotland, 28 October 2025, page 11 (https://publichealthscotland.scot/media/35666/2025-chc-report_final.pdf; INQ000660214).

Appendix 2: Glossary

Term (including acronym)	Description
Adult social care	The adult social care sector provides care in a range of settings, including in adult care homes and in people's own homes. The type of care provided includes help with personal tasks and nursing care.
Advance care plan	An umbrella term for a document in which an individual records their priorities and decisions about future medical care and treatment, in the event of a medical emergency or critical, life-threatening illness.
Asymptomatic	Having an infection but not showing any symptoms.
Asymptomatic testing	Testing for those without symptoms.
British Medical Association	A trade union and professional body for doctors and medical students in the UK.
Cabinet Office	A ministerial UK government department, supported by 29 agencies and public bodies. It supports the Prime Minister, ensures the effective running of government and takes the lead in certain critical policy areas.
Cardiopulmonary resuscitation (CPR)	The process of attempting to restart a patient's heart in the event that it stops pumping (ie a cardiac arrest).
Care home	An institution providing accommodation and personal care for people who are no longer able to live independently.
Care Inspectorate	The regulator for all health and social care, early learning and childcare services in Scotland. The legal name of the Care Inspectorate is Social Care and Social Work Improvement Scotland.
Care Inspectorate Wales	The regulator for all social care and childcare services in Wales.
Care Quality Commission	The regulator for all health and social care services in England.
Care Rights UK	A charity focusing on the rights of people in care.
Chief Medical Officer	A qualified medical practitioner, the most senior government adviser on health matters, and the professional head of all directors of public health in local government and the medical profession in government. There is a Chief Medical Officer for each of England, Wales, Scotland and Northern Ireland. The Chief Medical Officer for England is the UK government's chief medical adviser.
Chief Nursing Officer	The Chief Nursing Officer for England provides clinical and professional leadership for all nurses and midwives in England (with the exception of public health and adult social care nurses), including the 350,000 nurses and midwives who work for the NHS and who make up the largest group of the total NHS workforce.

Term (including acronym)	Description
Chief scientific advisers	Senior science advisers, working in most government departments, who provide oversight and assurance of science capability and activities.
Clinically extremely vulnerable	People identified by the UK government in March 2020 as having medical conditions that meant they were particularly likely to develop severe illness or to die from Covid-19.
Clinically vulnerable	People identified by the UK government in March 2020 as having medical conditions that might make them likely to develop severe illness from Covid-19, although not with the same predictability or to the same extent as the clinically extremely vulnerable.
COBR	The UK government's national crisis management centre for responding to whole-system civil emergencies. It provides the coordination mechanism through which the UK government responds quickly to emergencies that require urgent decision-making. Its name was originally derived from its location in the Cabinet Office Briefing Rooms.
Community transmission	When a disease is spreading in the community and the specific source is unknown (for instance, it cannot be linked to a traveller from abroad).
Comorbidities	The co-occurrence of two or more long-term conditions in a person.
Coronaviruses	A family of viruses that cause respiratory illnesses in people.
Covid-19	The disease caused by the coronavirus SARS-CoV-2.
Covid-19 Bereaved Families for Justice UK	A UK-wide campaign group representing the interests of bereaved family members of individuals who died from Covid-19.
Covid-19 Bereaved Families for Justice Cymru	A group dedicated to campaigning for and giving a voice to those bereaved by Covid-19 in Wales.
Dashboard	A visual display of data.
Delay	Taking actions to slow the spread of a pathogen, reduce peaks of infection and control the timing of peaks.
Department of Health and Social Care	A ministerial UK government department with overall responsibility for health and care services. It sets strategy, funds and oversees the health and care system in England, with equivalent counterparts in the devolved nations. Known prior to January 2018 as the Department of Health – for clarity, the department is referred to throughout this report using its current name.

Term (including acronym)	Description
Department of Health (Northern Ireland)	A devolved government department in the Northern Ireland Executive with a statutory responsibility to promote the physical and mental health and social wellbeing of people in Northern Ireland. Also responsible for the prevention, diagnosis and treatment of illness. Until 9 May 2016, the department was known as the Department of Health, Social Services and Public Safety, but it is referred to in this Report as the Department of Health (Northern Ireland) unless specifically referring to before May 2016.
Devolved administrations	The governments of Scotland, Wales and Northern Ireland.
Devolved nations	Scotland, Wales and Northern Ireland.
Disability	A physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	A DNACPR notice may be recorded on a patient's file where a patient with capacity wishes to record their preference not to undergo CPR in the event of a cardiac arrest, or where the treating clinician considers that CPR would be futile in the circumstances.
Domiciliary care	A range of services put in place to support an individual in their own home. This could include personal care, household tasks or skilled nursing.
End-of-life care	Holistic support for people nearing the end of their life, including symptom control to make them more comfortable.
Epidemic	A sudden increase in incidence of a disease that is higher than expected in a geographical region.
Ethnic minorities	All ethnic groups except the White British group (ethnic minorities include White minorities, such as Gypsy, Roma and Traveller groups).
Excess deaths	The number of additional deaths in a time period above the number that would usually be expected for that period, based on the mortality data of recent years.
The Executive Office Northern Ireland	A devolved Northern Ireland government department in the Northern Ireland Executive with principal policy responsibility for civil contingencies matters. The ministers with overall responsibility for the department are the First Minister and deputy First Minister.
Exercise Cygnus	An October 2016 exercise assessing the UK's preparedness and response to a pandemic influenza outbreak.
Exercise Nimbus	A February 2020 UK-wide ministerial desktop exercise to test decision-making processes and strategies.

Term (including acronym)	Description
Exercise Pegasus	A UK-wide pandemic preparedness exercise that commenced in 2025.
Exercise Silver Swan	A series of exercises delivered across Scotland in April 2016 to assess the preparedness and response of Scotland's local and national arrangements to a pandemic influenza outbreak over a prolonged period.
First Minister, Northern Ireland Executive	The First Minister and deputy First Minister are joint chairs of the Northern Ireland Executive. All statutory functions assigned to the First Minister and deputy First Minister by the Northern Ireland Act 1998 must be exercised jointly.
First Minister of Scotland	Head of the Scottish Government, responsible for the overall development, implementation and presentation of the administration's policies and for promoting and representing Scotland at home and overseas.
First Minister of Wales	Head of the Welsh Government, responsible for the overall development and coordination of Welsh Government policy.
Four governments	The four governments of the UK: the UK government, Scottish Government, Welsh Government and Northern Ireland Executive.
Four nations	The four nations of the UK: England, Scotland, Wales and Northern Ireland.
Government Chief Scientific Adviser	The Government Chief Scientific Adviser is responsible for providing scientific advice to the Prime Minister and members of the Cabinet, advising the government on aspects of policy on science and technology, and ensuring and improving the quality and use of scientific evidence and advice in government.
Health and Social Care (Northern Ireland)	The publicly funded healthcare system in Northern Ireland, with health and social care integrated under a single framework.
Health and social care partnerships	Partnerships between health boards and local authorities in Scotland, operating jointly in 31 of 32 local authority areas to provide health and social care services.
Health and Social Care trusts	Health and social care services in Northern Ireland are provided by five Health and Social Care trusts. A sixth trust, the Northern Ireland Ambulance Service, provides ambulance services for the region.
Health Protection Scotland	Part of NHS National Services Scotland. Responsible for implementing operational decisions made by the Scottish Government, developing guidance and producing detailed statistics and analysis of data. On 1 April 2020, functions of Health Protection Scotland were transferred to a new body, Public Health Scotland.

Term (including acronym)	Description
Healthcare systems	The system of healthcare in each of the four nations of the UK, comprising the NHS in England, the NHS in Wales (NHS Wales), NHS Scotland, and Health and Social Care (Northern Ireland).
High consequence infectious disease	An acute infectious disease which: • can transmit in the community and may be difficult to detect rapidly; • typically has a high case fatality ratio (the percentage of people diagnosed with a disease who die from it) and few or no prophylactic or therapeutic drugs; and • therefore requires an enhanced individual, population and system response.
HM Treasury	A ministerial UK government department that acts as the economic and finance ministry, maintaining control over public spending and setting the direction of UK economic policy.
Homecare Association	The UK's membership body for homecare providers.
Infection prevention and control (IPC)	Measures that aim to stop a virus from spreading in a particular environment or to inactivate it so that it cannot cause an infection.
Influenza (flu)	A viral respiratory infection that infects humans and several other host species globally. It causes both seasonal endemic waves of infection and, when new strains emerge against which the population has less immunity, may cause more severe epidemics or pandemics.
Integrated care partnerships	An integrated care partnership is a statutory joint committee in England formed between the NHS and local authorities, established under the Health and Care Act 2022, to deliver a joined-up strategy for health, public health and social care services.
Intensive care unit	A type of hospital ward that provides specialised care for critically ill patients, such as mechanical ventilation for respiratory failure.
Interventions	Any activity undertaken with the objective of improving human health by preventing disease, by curing or reducing the severity or duration of an existing disease, or by restoring function lost through disease or injury.
Joint Committee on Vaccination and Immunisation	A scientific committee that advises UK health departments on immunisation.
Key worker	Someone whose work was critical to the Covid-19 response. This was relevant to testing eligibility and the ability of the children of such workers to attend early years and education settings during school closures.

Term (including acronym)	Description
Lateral flow test	A type of molecular test to detect an active infection. These tests do not require processing in a laboratory and results are available within minutes.
Local authority	An administrative body in local government that provides public services in a local area.
Local Government Association	A national membership body for local authorities in England and Wales.
Local resilience forums	Multi-agency partnerships in England and Wales made up of local responders. The principal mechanism in England and in Wales for emergency preparedness and cooperation between agencies. Their main purpose is to ensure that local responders are able effectively to act on the duties imposed upon them under the Civil Contingencies Act 2004.
Lockdown	A mandatory stay-at-home order, a legal prohibition placing blanket restrictions on the whole population (apart from specified activities) for the purpose of limiting the spread of a disease.
Middle East respiratory syndrome (MERS)	The disease caused by Middle East respiratory syndrome coronavirus (MERS-CoV).
Ministry of Housing, Communities and Local Government	A ministerial UK government department, supported by 22 agencies and public bodies, which is responsible for housing, communities and local government. It was known by its current name from July 2024, but also from January 2018 to September 2021. From May 2006 to January 2018, it was known as the Department for Communities and Local Government, and from September 2021 to July 2024 as the Department for Levelling Up, Housing and Communities. It is referred to in this Report by the correct name for the relevant time period or, for references that span name changes, by its current name.
Mitigation	A strategy aiming to use limited but effective interventions to delay and minimise the peak of waves of infections and to reduce their size. The goal is primarily to spread pressure on the healthcare system over a longer time period, while accepting that a similar number of people will become infected eventually.
Modelling	Statistical models are tools for analysing complex data, identifying patterns, and informing evidence-based decision-making where direct measurement is not possible. Figures from modelling are estimates only, and different statistical models will produce different outcomes. These estimates are not based on direct observations. They are therefore limited by the underlying assumptions used in the models and are subject to uncertainty.

Term (including acronym)	Description
Morbidity	The condition of suffering from illness. Comorbidities or multi-morbidities are sometimes used to refer to when someone has more than one condition at the same time.
Mortality	A term that means death.
Mortality rate	An expression of the number of deaths for a given cause divided by the whole population.
Mutual aid	The process of different healthcare organisations sharing resources at times of high demand.
National Audit Office	The UK's independent public spending watchdog. The National Audit Office supports Parliament in holding government to account and helps improve its high-quality audits. It is independent of government and the Civil Service.
National Care Forum	A membership organisation for not-for-profit social care and support providers.
National Institute for Health and Care Excellence (NICE)	An executive non-departmental public body sponsored by the Department of Health and Social Care. Its role is to improve patient outcomes by producing national guidance and advice, and quality standards that set out what high-quality and cost-effective care should look like.
NHS	The term used to refer collectively to the publicly funded healthcare systems in England, Scotland and Wales, comprising the NHS in England, NHS Scotland and the NHS in Wales (also known as NHS Wales). The publicly funded healthcare system in Northern Ireland is Health and Social Care (Northern Ireland).
NHS England	An executive non-departmental public body, sponsored by the Department of Health and Social Care, that leads and oversees the NHS in England. It is responsible for the operation of the NHS in England and for implementing healthcare strategy developed by the Department of Health and Social Care.
NHS in Wales (NHS Wales)	The NHS in Wales is made up of local health boards, trusts (including Public Health Wales) and special health authorities (Health Education and Improvement Wales and Digital Health and Care Wales). The local health boards are responsible for planning, securing and delivering all healthcare services for the benefit of their resident population in a specific geographical area. The term 'NHS Wales' is commonly used to refer collectively to local health boards, trusts and special health authorities in Wales, although there is no central legal entity with this name.

Term (including acronym)	Description
NHS Scotland	The publicly funded healthcare system in Scotland, made up of geographical health boards and non-geographical special boards, and supported by NHS National Services Scotland (known from 1 April 2026 as Public Services Delivery Scotland) and Healthcare Improvement Scotland.
Northern Ireland Covid-19 Bereaved Families for Justice	A branch of the UK-wide Covid-19 Bereaved Families for Justice. Represents bereaved relatives of individuals who died from Covid-19 in Northern Ireland.
Northern Ireland Executive	The Northern Ireland Executive is the administrative branch of the Northern Ireland Assembly, the devolved legislature for Northern Ireland. It is responsible for matters including enterprise, trade and investment, agriculture and rural development, education, health, policing and justice, environment and regional development.
Northern Ireland Social Care Council	The regulatory body for the social care workforce in Northern Ireland.
Nuffield Trust	An independent health and social care think tank.
Nursing home	An institution providing accommodation, personal care and nursing to individuals with complex medical conditions or severe learning disabilities.
Office for National Statistics	The UK's largest independent producer of official statistics and the recognised national statistical institute of the UK.
Operation Yellowhammer	The UK government's contingency planning for a 'no deal' exit from the European Union.
Outbreak	The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season.
Pandemic	An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.
Pandemic Flu Readiness Board	A cross-government board set up to oversee pandemic flu preparedness in light of the lessons learned from Exercise Cygnus.
Pathogens	Infectious organisms, such as viruses, bacteria or parasites, that can produce a disease.
Permanent Secretary	A senior civil servant responsible for the day-to-day running of a government department. In the UK government and in Northern Ireland there is a Permanent Secretary for each government department. There is a single Permanent Secretary for each of the Scottish Government and Welsh Government.

Term (including acronym)	Description
Personal protective equipment (PPE)	Equipment that minimises exposure to hazards. In health and social care, it ranges from basic items such as aprons, gowns and disposable gloves to specialised items such as face shields and respirator masks.
Polymerase chain reaction (PCR) test	A specialised laboratory method used to increase the amount of DNA or RNA in a sample so that there is enough to test it. PCR tests are used to detect RNA in samples from people to establish if the samples contain SARS-CoV-2 virus.
Pre-symptomatic	When a person has been infected with a disease but no symptoms have yet appeared.
Prevalence	A measurement that expresses the proportion of people who have a disease at or during a given time period. Prevalence rates for disease are calculated by dividing the number of cases by the total number of people in the sample.
Prime Minister of the UK	The leader of the UK government, ultimately responsible for the policy and decisions of the UK government.
Priority groups	Groups of people identified by the Joint Committee on Vaccination and Immunisation who are given the vaccine before it is available for the general population.
Public health	The science and art of preventing disease, prolonging life and promoting health through organised efforts of society.
Public Health Agency (Northern Ireland)	Established under the Health and Social Care (Reform) Act (Northern Ireland) 2009. Responsible for the improvement of health and social wellbeing, reducing health inequalities in Northern Ireland, health protection and service development.
Public Health England	An executive agency of the Department of Health and Social Care until it was replaced by the UK Health Security Agency and Office for Health Improvement and Disparities in October 2021. It was responsible for all aspects of public health.
Public Health Scotland	Scotland's national public health body, working to prevent disease, prolong healthy life and promote health and wellbeing. Preceded prior to 1 April 2020 by Health Protection Scotland.
Public Health Wales	An NHS trust which aims to protect and improve health and wellbeing and reduce health inequalities in Wales.
Reasonable worst-case scenario	A tool used for planning purposes to illustrate the worst manifestation of a risk that can reasonably be expected to occur based on current information and data.
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)	An advanced care planning document currently used in parts of England, parts of Scotland and in Northern Ireland, which records personalised recommendations for a person's clinical care.

Term (including acronym)	Description
Regional resilience partnerships	The key planning and preparedness bodies on the ground in Scotland. Regional resilience partnerships support multi-agency coordination at a regional level and are made up of several local resilience partnerships, which support local working arrangements and maintain local liaison.
Regulation and Quality Improvement Authority	The regulator for a wide range of health and social care services in Northern Ireland.
Regulations	A type of secondary legislation.
Restrictions	Restrictions on movement, gatherings, operating businesses and international travel. Can be voluntary (such as advice to wear face coverings) or mandatory (such as lockdowns and border restrictions).
Risk	The possibility of a harmful event. In the context of civil emergency preparedness and resilience, an event, person or object that could cause loss of life or injury, damage to infrastructure, social and economic disruption or environmental degradation.
Risk assessment	A systematic process for evaluating the likelihood of a potential risk occurring and the potential impact it would have, were it to happen.
Royal College of Nursing	A nursing union and professional body.
Scientific Advisory Group for Emergencies (SAGE)	An advisory group convened to provide independent scientific advice to support decision-making in COBR in the event of a national emergency.
Scientific Pandemic Influenza Group on Modelling (SPI-M)	A sub-group of SAGE that provided expert advice to the UK government based on infectious disease modelling and epidemiology. (In 2022, it became the Scientific Pandemic Infections Group on Modelling.)
Scientific Pandemic Influenza Group on Modelling, Operational sub-group (SPI-M-O)	An operational sub-group of SAGE, set up during the 2009 to 2010 H1N1 influenza pandemic ('swine flu'), which was stood up again during the Covid-19 pandemic.
Scottish Covid Bereaved	A group representing bereaved relatives of individuals who died from Covid-19 in Scotland.
Scottish Government	The devolved administration for Scotland.
Secretary of State	A Cabinet minister in charge of a government department.
Self-isolation	Staying at home because of a suspected or confirmed infection.
Severe acute respiratory syndrome (SARS)	The disease caused by the SARS-CoV-1.
Severe acute respiratory syndrome coronavirus 1 (SARS-CoV-1)	The coronavirus that causes SARS. It is closely related to SARS-CoV-2.

Term (including acronym)	Description
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	The coronavirus that causes the disease known as Covid-19.
Shielding	An intervention introduced to support those who are clinically extremely vulnerable and therefore considered to be most at risk of serious illness from, for example, Covid-19.
Social distancing	Measures to reduce the contact people have with each other, which may include temporary restrictions on socialising in public places such as entertainment or sports events, restricting use of non-essential public transport, or recommending more home working.
Surge capacity	The ability of a healthcare system to manage and respond to unpredictable and sudden increases in demand for healthcare services.
Swab test and self-swabbing	A type of self-sampling that uses a technique to take samples from the nose and throat for testing.
Symptomatic	Showing symptoms following an infection.
Symptomatic testing	Testing for those with symptoms.
Trades Union Congress	A federation of trade unions in England and Wales.
Transmissibility	The ability of a pathogen, such as a virus, to spread from one person to another.
Transmission	The process by which a pathogen, such as a virus, spreads from one infected person to another.
UK government	The central government for the UK, headed by the Prime Minister. The UK government is responsible for non-devolved policy matters across the UK. (The Scottish Government, Welsh Government and Northern Ireland Executive are separate from the UK government and are responsible for devolved policy matters in their respective nations.)
UK Health Security Agency	An executive agency, established in April 2021 and sponsored by the Department of Health and Social Care, responsible for public health protection and infectious disease capability.
UK Influenza Pandemic Preparedness Strategy 2011	The UK's emergency response strategy for dealing with an influenza pandemic.
Unpaid care	Providing care and support to a friend, family member or neighbour without receiving financial compensation.
Vaccination	Protecting individuals from a disease by treating them with a vaccine.

Term (including acronym)	Description
Vaccine	Vaccines train the immune system to recognise a pathogen and to produce antibodies to defend the body from it at the next encounter.
Variant	As a virus replicates, it can accumulate mutations. A version of the virus with these mutations is called a 'variant'. Mutations may facilitate transmission or impact the effectiveness of vaccines, treatments or immunity resulting from previous infection.
Ventilation	The process of introducing fresh air into indoor spaces while removing stale air.
Virus	A parasitic infectious agent that replicates only inside the cells of an organism.
Vivaldi 1 study	A study by University College London, the Office for National Statistics and Public Health England which ran in May and June 2020 and surveyed 5,126 care homes for those aged over 65 in England. Survey responses were then linked to Covid-19 test results.
Vulnerable groups	Groups within the population who were particularly susceptible to Covid-19 or to decisions made by the UK government and devolved administrations to reduce transmission. They were categorised by the UK government as 'clinically vulnerable' or 'clinically extremely vulnerable'.
Welsh Government	The devolved administration for Wales.
World Health Organization	A specialised agency of the United Nations responsible for international public health.

Appendix 3: List of recommendations

Chapter 1: Overview of the adult social care sector

Recommendation 1: Improved pandemic planning for the adult social care sector

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should each establish clear arrangements for pandemic planning in adult social care. Those arrangements should facilitate the production of pandemic plans for adult social care at the government, local and provider levels.

Plans at a government level should identify:

- the roles and responsibilities of each government in relation to adult social care during a pandemic;
- the requirements for local-level plans, including the roles and responsibilities of local authorities, Health and Social Care trusts, and health and social care partnerships in producing those plans;
- the requirements for provider-level plans;
- how and by whom the adequacy of local and provider-level plans will be assured;
- how bed capacity and staffing levels will be tracked in care homes and domiciliary care; and
- how the adult social care sector will be represented in the pandemic planning of the four governments.

Government pandemic plans for adult social care should be regularly reviewed and tested as part of the pandemic response exercises recommended in the Inquiry's Module 1 Report (Recommendation 6).

Chapter 2: Care home admissions, testing and isolation

Recommendation 2: Enable the safe and timely isolation of care home residents, including following discharge from hospital

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should ensure that pandemic plans for adult social care contain practical steps rapidly to scale up isolation facilities for care home residents in a future pandemic.

As a minimum, plans should:

- establish mechanisms to record systematically the availability of isolation facilities in care homes in each nation and keep these up to date;
- identify settings that can be used in a future pandemic to isolate and meet the needs of residents, including those who need to be discharged from hospital into a care home; and
- establish guidance for how these settings can be run to ensure high-quality, safe care and effective infection prevention and control.

Chapter 3: Protective measures

Recommendation 3: Financial support to adult social care staff to self-isolate or to limit working across multiple sites

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should put in place financial support schemes that should be made available and that can be implemented at the start of a future pandemic:

- to protect adult social care staff against financial loss as a result of compliance with mandatory self-isolation rules; and
- to ensure that adult social care providers and staff can comply with rules or guidance restricting the number of sites at which adult social care staff may work during a pandemic.

The following principles should apply:

- There should be clear and straightforward guidance about eligibility criteria, application processes and payment arrangements for the support schemes.
- Information about the introduction of support schemes and how adult social care staff and providers can receive support should be communicated clearly and made available in accessible formats.
- Mechanisms should be in place to monitor the effectiveness of the support schemes.

These financial support schemes should be designed in partnership with representatives from across the adult social care sector.

Chapter 4: Visiting restrictions in care homes

Recommendation 4: Visiting restrictions

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should publish guidance for the implementation of visiting restrictions in care homes in a future pandemic.

The guidance should be led by the following core principles:

- Measures applied should be the least restrictive possible, both in terms of severity and the length of time for which they apply.
- Residents should have the right to in-person visitors, except in the most grave or exceptional of circumstances.
- Restrictions should be decided upon and applied at the most local level possible, based on local risk assessments and considering individual circumstances.
- Communications with the public, care home residents and loved ones must clearly explain the measures in place and their purpose.

People who work in and use social care should be closely involved in developing this guidance.

Chapter 5: Regulation and safeguarding

Recommendation 5: Maintaining regulatory oversight of care quality and safety in a public health emergency

The Care Quality Commission in England, Care Inspectorate Wales, the Care Inspectorate in Scotland and the Regulation and Quality Improvement Authority in Northern Ireland should each develop adaptable protocols for carrying out on-site, hybrid and remote inspections in a future public health emergency.

These protocols should be guided by the core principle of continuing on-site inspections where possible. They should also clearly identify processes to minimise:

- the risk of transmission when on-site inspections are carried out; and
- the risk of safeguarding issues going unidentified where remote or hybrid inspections are carried out.

Regulators should regularly review these protocols to ensure that they remain practical and effective.

Chapter 6: The impact on unpaid carers, care workers and care providers

Recommendation 6: Collection of data about deaths of adult social care workers during a pandemic

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should develop mechanisms to collect, analyse and publish data systematically about the deaths of adult social care workers during a pandemic. The data must be comparable across the four nations of the UK.

The mechanisms should be developed with the adult social care workforce regulators, public health agencies and employers of care workers.

Chapter 7: Deaths and end of life

Recommendation 7: Mandatory end-of-life care training for health and social care professionals

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should establish mandatory training for health and social care professionals looking after people in the adult social care sector who are nearing the end of life.

The training should be developed in conjunction with health and social care regulators and provide, at a minimum:

- an understanding and enhanced knowledge of how to deliver high-quality end-of-life care as well as the support available; and
- communication skills to be able confidently to conduct and document conversations about advance care and, where appropriate to the professional's role, decisions on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

Chapter 8: Recognition and protection

Recommendation 8: A voluntary workforce register for adult social care workers

The UK government should implement a voluntary workforce register for adult social care workers in England, in order to strengthen the professionalisation and recognition for those working in the care sector. This should be developed in conjunction with social care staff, providers, commissioners and oversight bodies.

This should formalise the ongoing work to improve workforce progression and retention and any learning from registration schemes in Northern Ireland, Scotland and Wales.

The design of the register should consider:

- the most appropriate body or agency to operate the register, including processing applications, data-sharing and publication;
- the benefits and requirements of joining the register, including the best means to incentivise membership; and
- the funding model that will support the establishment and operation of the register.

The voluntary register should be implemented within two years of the publication of this Report.

Once the voluntary register has been operating for no more than five years, the UK government should undertake a full cost–benefit analysis of the workforce register and review whether membership should become mandatory.

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