HOUSE OF COMMONS

Health and Social Care Committee
Science and Technology Committee

Oral evidence: Coronavirus: lessons learnt, HC 877

Tuesday 13 October 2020

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Watch the meeting

Members present:

Health and Social Care Committee: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Sarah Owen; Dean Russell; Laura Trott.

Science and Technology Committee: Greg Clark; Aaron Bell; Mark Logan; Graham Stringer; Zarah Sultana.

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Witnesses

I: Theresa Steed, Home Manager, Tunbridge Wells Care Centre; Philip Scott, Carer; and Helen Spalding, Carer.

II: Jane Townson, Chief Executive, UK Homecare Association; Kathy Roberts, Chair, Care Providers Alliance; and Professor David Oliver, Geriatric Consultant, Royal Berkshire NHS Foundation Trust.

III: Professor Jane Cummings, Adult Social Care Testing Director, Department of Health and Social Care; Michelle Dyson, Director General, Adult Social Care, Department of Health and Social Care; David Pearson CBE, Chair, Social Care Support Taskforce, Department of Health and Social Care; and Helen Whately, Minister of State (Minister for Care), Department of Health and Social Care.

Examination of witnesses

Witnesses: Theresa Steed, Philip Scott and Helen Spalding.

Chair: Good morning and welcome to a joint inquiry by the Health and Social Care Committee and the Science and Technology Committee of the House of Commons. Today, we are opening our inquiry into lessons to be learnt from the coronavirus pandemic.

My name is Jeremy Hunt. This is a joint inquiry, and I am pleased to welcome my co-Chair, Greg Clark—we will alternate the hosting of these sessions—along with Committee members from both Select Committees. My Committee has focused regularly on the social care sector because of a worry that it is too often overlooked. I am delighted that our very first topic in this inquiry is what the Covid-19 lessons are for the social care sector.

We have some very distinguished witnesses this morning, including the Minister responsible for social care, Helen Whately. First, we are going to hear from some people directly impacted by what has happened during the pandemic: Philip Scott, whose mother has dementia and was put in a care home 250 miles away from where he lives; Helen Spalding, who cares for her daughter Maja, who has a genetic condition which means that she has significant care needs; and Theresa Steed, who is the manager of a care home called the Tunbridge Wells Care Centre.

Mark Logan will ask a few questions of Philip Scott.

Q1 **Mark Logan:** Before I begin, I declare an interest in the social care sector.

Good morning, Mr Scott, and thank you for making the time this morning to come to this joint Select Committee. How has your mum been doing, and what has been the impact of lockdown on Sylvia?

Philip Scott: My mother has quite severe Alzheimer's. In some ways, it is difficult to know exactly what she is feeling because she finds it very difficult to express herself. However, the last time I was able to give mum a hug and hold her hand, along with my sister, was in February. I suspect deep down she is probably missing physical touch and contact with myself, my sister and other members of the family.

Q2 **Mark Logan:** Was February the time when she went into a new care home? What is the timeline?

Philip Scott: No. She has been in her present care home for five years. She has been in social care for seven years. She was diagnosed with Alzheimer's nine years ago, but she has probably been living with Alzheimer's for the best part of 10, 11 or 12 years.

Q3 **Mark Logan:** Mr Scott, you are based in London—is that right—and your mother is in Lancaster?

Philip Scott: That is correct. I am in London and mum is in Lancaster. Before the pandemic, I went up every month to see her.

Q4 **Mark Logan:** Since the outbreak of the pandemic in February/March, have you not seen her physically in person?

Philip Scott: The care home where she is resident introduced garden visits in the summer, so I was able to see mum in August, but at a 3 metre distance. It was quite hard to communicate with her. The garden visit in September that I had planned to make had to be scrapped because Lancaster went into a local lockdown situation.

Q5 **Mark Logan:** Has that been the case since September? Are you not able to travel up to Lancaster again?

Philip Scott: I cannot at the moment. The whole of Lancashire—in fact, most of the north-west—is in a local lockdown situation. It is difficult to ascertain just when I will be able to go there again.

Q6 **Mark Logan:** I read, Mr Scott, that you said that, although the care home has been very good at putting on Skype calls, it is no substitute for seeing your mum in person. How has that whole experience been in these last few months?

Philip Scott: It is great that the home has been facilitating Skype and, in the summer, introducing garden visits, but it is not the same as actually being able to see her, hug her or hold her hand. During March and April, when the virus was ripping through care homes, it was a time of considerable anxiety for both myself and my sister. My mum is 91 years old. She has severe Alzheimer's. She is in a very high-risk category and I think, if she had acquired the virus, she would have passed away.

Q7 **Mark Logan:** Since the outbreak back in February/March time, do you think that more could have been done, or we could have done things differently?

Philip Scott: My view is that at the beginning of the outbreak care homes were very much sidelined. It is clear that they were considered low risk, but that was not the case at all. The NHS was a main focus. That is right and proper, but I feel that the care home sector should have been much more of a focus. It seems to me that there was lack of liaison between the NHS and the social care sector, which I think is an ongoing issue. It is an ongoing problem.

Q8 **Mark Logan:** Do you think it has improved from the summer and in recent weeks?

Philip Scott: Yes. As the spring progressed and as we got into summer, people realised that care homes needed to be focused on much more. Testing in care homes was ramped up. Testing in care homes was not really happening at the start of the pandemic. I am aware that in my mum's care home the staff were having to make a round trip of 130 miles to get tested. There was a local testing facility, but it was reserved for NHS staff. That situation is much improved.

Mark Logan: Mr Scott, thank you very much for answering my questions this morning. I wish your mum, Sylvia, all the best. I hope you can see her in person very soon.

Philip Scott: Thank you; you're welcome.

Q9 **Chair:** Mr Scott, does your mum recognise you?

Philip Scott: I am afraid that she does not.

Q10 **Chair:** Was that the same at the start of the year, or has it happened during the course of the year?

Philip Scott: She has not recognised me for quite some while, or at least she does not openly recognise me. It is quite possible that deep down she knows who I am, but she is not able to voice it. That has not just happened this year.

Q11 **Chair:** I was wondering whether, if she was able to touch you, that might be something that created a sense of familiarity and intimacy.

Philip Scott: It is quite possible, if I was there in person and able to hold her hand and touch her, that deep down it might trigger some recognition or some memory.

Chair: Thank you very much. We really appreciate you talking to us this morning. It is a very sad story, but we wish you and your mother well.

Philip Scott: Thank you.

Chair: We are now going to move on to Helen Spalding, who cares for her daughter, Maja, who has a genetic condition. Barbara Keeley will ask her a few questions.

Q12 **Barbara Keeley:** Helen, can you talk us through the support that you and Maja normally receive, and how that has changed during the pandemic?

Helen Spalding: Before the pandemic, the support we would normally get is as follows. Maja would usually be at college five days a week. She goes to clubs and activities, run by various different organisations, Monday, Tuesday, Wednesday, Thursday and one Friday a month. On Saturdays, there are two activities. We are Christians and we belong to quite a lively church, a very active church, and on Sundays she is very enthusiastic about the groups and the children's work in the church. Every evening after college, she is active. We had three hours a week of carers' direct payment.

Q13 **Barbara Keeley:** What changed during the pandemic? That is a fairly comprehensive range of support that you were using before. What happened as soon as there was lockdown?

Helen Spalding: As soon as we went into lockdown, obviously the college closed. She was at home every day. All the clubs and activities stopped; everything stopped. For Maja, that was completely dreadful. It sent her into a tailspin.

Q14 **Barbara Keeley:** It just completely changed your world, didn't it? What was the impact on you and your family?

Helen Spalding: There is myself living here with my daughter, and my husband, who is my daughter's stepdad. It impacted all three of us. Maja's mental health deteriorated almost straightaway; she was self-harming. In June, my daughter verbalised that she wanted to die.

I suffer from ME, so for me it was such hard work; it was non-stop. From the moment my daughter was awake in the morning, I was alert and on it, trying to keep her busy and active. We very quickly got together a timetable of online activities for her to do, as well as college work. She enjoyed doing that, and daily exercise and things like that, but it was exhausting.

I am quite a determined person, so I just got on with it, did it and threw myself into it. However, there was no housework done; not at all. That might sound a bit glib—I don't know—but, aside from doing the dishes and the laundry, there was nothing. When my daughter went up to her bedroom to watch TV at about 8 o'clock of an evening, I would flake out on the sofa. That would be it.

My husband suffers from COPD and a couple of other conditions, so he is not exactly an active person. He just looked after himself. We had meals together, but there was an impact on our marriage. It could have been devastating, but I think it is testimony to our strong relationship that we have got through it. Things are not the same. As a marriage, we are currently going through a healing process.

Q15 **Barbara Keeley:** What extra support could there have been? You were catapulted into the situation of providing what sounds like round-the-clock care. What support would have helped you? Is there anything that could have been there for you that would have helped? Clearly, there are a lot of things, but is there anything that strikes you now?

Helen Spalding: The mental health support for my daughter could have been a lot better. On 4 June, she verbalised to me that she wanted to die. Later that day, I got on the phone separately to our GP and to our social worker, but it was not until 4 September that we had some medication in our hands for her. That is three months. I think that is unacceptable.

In many ways, it is a blessing that my daughter lacks capacity, because there is every chance that, if she was ever so slightly higher functioning, she would not be with us; she would have done the deed. That is definitely an area that could be vastly improved. There could have been clearer guidance and information.

At the beginning, when we first went into lockdown, I was getting very contradictory information and advice. I was reading things and hearing professionals saying, from various sources, that people with rare genetic disorders were very vulnerable to coronavirus and that they should shield. However, when the Government—very quickly, I might add—set up their information on GOV.UK there was nothing to back that up. We never received a shielding letter either, so it was very unclear right from the very start just how dangerous this could be and how worried I should be.

The other thing that kept coming my way—again from various sources—was that, should intensive care units reach critical levels, the teams running them would have to make very difficult decisions if equipment became pushed, scarce and limited. I was getting information along the lines that, if push came to shove, teams would have to make very difficult choices, and adults with learning disabilities were, sadly, on a list of people who would not be prioritised. That came to me from several different sources. It was so worrying.

Q16 **Barbara Keeley:** In terms of the support that you, your husband and family have been able to get, what is the situation like now? Has anything improved? You mentioned being able to get medication, but only after three months. What is the situation now? We are clearly facing the second wave.

Helen Spalding: My daughter is now on medication, and it seems to be working, which is great. That is good news. She is back at college five days a week. That is brilliant. Transport for students with special educational needs to and from schools and colleges across Wiltshire, where I live, has been very problematic with regard to social distancing, and even wearing face masks. My daughter travels in a taxi. The first day back, the driver did not have a face mask on. It is simple things like that, so that has been problematic.

She is back at college five days a week. Clubs and activities have not opened up. She is able to do one via a Zoom link online. That is only every two weeks, so in the evenings she misses that. It is still tricky. It is a lot better than it was—don’t get me wrong—and our situation is vastly improved, but it is still hard work.

With the prospect of a second wave, and perhaps another full national lockdown, I feel better equipped for that situation. What worries me now are the local lockdowns that have just been announced. If my daughter was to be at home again, for a long period of time, shielding, there would be, for example, no Joe Wicks exercises every morning because it would just be our area. Does that make sense?

Barbara Keeley: Yes, it does, absolutely.

Helen Spalding: It would not be the national—I can’t think of the word.

Barbara Keeley: The pulling together.

Helen Spalding: Yes. We were plugging into a lot of things online. I am sure that there are things we could do, but she would not necessarily see her friends, whereas before there were things that were online and she would see people she recognised. If it was just a local thing, I would worry that the support from other areas and from other sources would not be there.

Barbara Keeley: I am aware that it has been an incredibly difficult time for you. I really appreciate your giving evidence and talking us through it this morning. I hope you find that support, if and when things change in your local area. I hope they do not, actually. Thank you very much for talking us through that.

Helen Spalding: Thank you very much. Thank you for the opportunity.

Q17 **Chair:** Helen, I found it very shocking that you had heard that, if there was a shortage of bed capacity, Maja might be discriminated against because of her learning disability. Could you tell me how that makes you feel, as a mother?

Helen Spalding: Just horrendous. It is personal. I take it personally. There might as well be somebody in the room ready to give her a lethal injection. It makes me feel that nobody cares. It also makes me feel that it was a drastic situation that the country was thrown into at that time. It is horrendous; awful. It is the most awful feeling.

Q18 **Chair:** Thank you for sharing that with us. I will undertake to write to the Health Secretary to get to the bottom of whether that did actually happen, or, if it didn't, why people like you might have got that impression. Thank you very much for sharing that with us, and thank you for joining us this morning. We really appreciate it.

Helen Spalding: Thank you very much. I would be really interested in the reply that you get to that question.

Chair: We will pass it on to you. Our final person in this panel is a lady who runs a care home in Tunbridge Wells, the Tunbridge Wells Care Centre. Greg Clark is going to ask Theresa Steed some questions.

Q19 **Greg Clark:** Theresa, good morning. Thank you for joining us and sharing your experience. What we are trying to do in this Committee is to look at what you experienced, what you went through, in the first wave, so that we can learn lessons and apply them and, hopefully, avoid some of the things that were not so good first time round. If there were things that were done well, we can make sure that we give advice that they are done again.

Could you give us a summary of how it was for you, as someone running a care home, during the first wave of the pandemic?

Theresa Steed: Thank you for inviting me to talk. During the first wave, the biggest impact was hospitals being asked to empty as many beds as possible for the Covid patients coming in. They were told to get them out to as many care homes as possible. What was not being given to the care homes was information as to whether those people were Covid or not; they were informed by the Government, they said, that they did not need to be tested.

From my point of view, as the manager of a home, I had a person that needed to be assessed, but I also had the residents in the home, the staff and the visitors who were coming in. The impact on all of those from not being given that information was huge. We were putting them at risk, and also the people in the environment they were coming into.

Hospitals did not take that on board. They did not seem to want to listen to that. We turned people down. We turned them down because they could not give me evidence, or even back-up paperwork, of their checks for the last seven days. You are looking at a trend in temperature changes, or if they feel unwell—those kinds of things—but they were not prepared to give us that information. That was crucial to taking a person, both for them and, as I said, for the home they were coming into.

I had a person that I needed to go and assess. I called the ward, because I had already been told that Covid was on the ward. I called them to ask whether the person had Covid. The matron actually called me and said, “Who gave you that information? It’s false. We don’t have Covid on the ward.” Half an hour later, I went in to do an assessment, and when I checked the ward it was closed because of Covid. It is the actual fact that it was being hidden. We all need to be given the information and the facts to be able to deal with it, not hide things. We are working in it together, but the hospital had the information and the community did not. We were being kept blind, which was putting people at risk.

Q20 **Greg Clark:** In those early days, Theresa, when the hospitals were discharging patients, did you come under pressure to take patients or was it more the normal thing that people were being discharged from hospital and you were approached?

Theresa Steed: No, there was definitely pressure. It was not just pressure from our local hospitals either. We had areas outside Tunbridge Wells, going into Maidstone and Gravesend, all calling for vacant beds. But we still hit against the same thing; they were not prepared to give us the information that we needed to make a judgment that we could keep them safe, as well as the residents that were in the home.

Q21 **Greg Clark:** And the information you needed was whether the patient was Covid positive or not.

Theresa Steed: Yes.

Q22 **Greg Clark:** Clearly, there was a shortage of tests. One of the things that this joint Committee is going to look into is why that was and how we can make sure that it does not happen again. Presumably, for your existing residents, as well as new admissions, testing was important. Tell me a bit about your experience of being able to test your residents, and perhaps your staff colleagues.

Theresa Steed: At the beginning, it was non-existent. We could not get swabs. Staff had to travel around to get their swabs, some to Gatwick and some further afield. The residents did not have the ability to go around, so we called on local hospitals to support us with swabs. We were told no by them. We got some from Maidstone hospital, and apparently en route back to the hospital they got destroyed, so they could not be read either.

There was always another reason why we couldn't have them: the stock was not there, or it needed to be elsewhere. I asked if we could have the community team come out and support us, to give us swabs. They said no, and that, because at the time we did not have it in the home, we would not be able to tap into those resources. That is wrong. We did not want it in the home, and we wanted swabs and the ability to swab, as we can now. That is where we were. From the beginning, we kept it out of the home, but we got it in the home in June and it impacted on one floor completely.

Q23 **Greg Clark:** Is it possible for you to tell whether the problem was that there weren't enough tests available, so you could not get them, or was it the system of organisation that was not working, so that you had to go to lots of different places to beg, borrow and steal the tests?

Theresa Steed: I think the system was not working. It was not the case that they were not available. They looked at other areas as being a priority. As far as they were concerned, care homes were not a priority, although we had high-risk people in the homes.

We are a nursing home, so from our point of view it is about keeping them as comfortable as possible. The impact of having somebody pass away with Covid, whether a direct link or linked to Covid, has a massive impact on families. We were not able to give them the resources, and we had people who were tested positive towards the end of their life and they died. It is not being able to give the family the peace of mind that they died from the condition they were ill with at the end of their life, or whether Covid made their life shorter. It is hard as a manager to support staff and the families sitting with their loved ones, not knowing whether they can take their masks off and give their mum or dad a kiss and a hug at the end. It is really hard.

Q24 **Greg Clark:** On the question of visitors, you probably heard that we discussed the difficulties and strain it can put on loved ones who cannot see someone who is in a care home. How have you managed to cope with and manage the restrictions on visiting?

Theresa Steed: We have a system in place for anybody who comes in. We have a scanner thing at the front door, so we can scan anybody who comes in. It is about supporting the families. When anybody comes in who is end of life, we support the families visiting, because it is crucial to keep that link and for them to be able to say goodbye.

In September, we opened again to in-house visits or in the garden, weather permitting. There was a half-hour slot and booked appointments. That gave us time to sanitise the area where somebody was sitting and had been. It was not on the units; it was purely in two areas to minimise the impact on the floor. We go through the questions. We take the temperature of the visitors, because that is important to make sure that they are safe and so are the residents that are with us.

Q25 **Greg Clark:** Going back to testing, could you say a bit about how it is now? We talked about the beginning of the pandemic. Have they now got the system right? Related to that, are your staff now getting tested weekly and your residents monthly?

Theresa Steed: Yes. We get tests now every month. We order them in the quantity that we need. That covers us for a month. Every member of staff gets a test every week and the residents every 28 days. We have had two cases where a staff member and a resident both tested positive. We had a member of staff test positive about a month ago; that person was also positive in June.

It is about the turnaround of getting the results back. With our first gentleman who tested positive, and was already positive in June and has antibodies, it took nine days to get his results. In those nine days, he was still working with us because he was asymptomatic. We got a phone call from track and trace to say, "This person has tested positive. He has to isolate for 10 days." He had already worked for nine of those days, so they said, "Tomorrow, he can come back to work." That does not make sense. If he had been unwell, hopefully, he would not have come in, but we had a nine-day delay on getting the test result back.

Q26 **Greg Clark:** That was in June, was it?

Theresa Steed: In June, he was positive originally, and this one was September.

Q27 **Greg Clark:** This is a more recent one.

Theresa Steed: Very recent.

Q28 **Greg Clark:** In terms of the tests that you have been carrying out in recent days, has there been any change in the time taken to get them back? Have you detected any worsening of the times, or do you think it has maintained its standards?

Theresa Steed: We have had time delays. We have a lady and a gentleman who both tested positive, and we have not been contacted by track and trace. Again, it is only because the results come to us and the staff that we were able to find that out. The communication from when the swabs are being done back to the person or their place of employment is still putting people at risk.

Q29 **Greg Clark:** So you had the result, but no contact from track and trace. Have I understood that correctly?

Theresa Steed: Yes.

Greg Clark: Theresa, thank you very much indeed. Perhaps I could say to you, your colleagues and your equivalents right across the country, as well as the people you care for, that we all recognise that the last few months have been a time of great stress and commitment. You have done an amazing job for many of the most vulnerable people in our communities. Thank you.

Q30 **Laura Trott:** Theresa, I want to ask two quick follow-up questions around visiting. First, do you think the balance is currently right between protecting patients and staff by limiting visits, and the impact that that has on your residents?

Theresa Steed: Yes, I think it is. We have quite a lot of family members who will not visit, purely because they do not want to put their loved ones at risk. As a manager, I find that sad; they are thinking about it overall, but there is the impact it has on their loved one by not seeing them. We do Zoom and WhatsApp, but for somebody with dementia looking at a WhatsApp tablet is like looking at a picture that is moving. It is not like seeing their loved ones, and it is not like getting a hug or giving them a kiss. It impacted on families when we opened up and gave them time slots. They try to book a whole week's worth of visits, and we have to limit that, because we have other people. Trying to fit people in is really hard. It is hard to say to somebody, "I'm sorry, but you can't have that one because you have had this, this and this."

Q31 **Laura Trott:** Is there more that you think the Government could do to support visits? One suggestion would be that a named relative could be treated as a key worker and regularly tested so that they can visit. Is that something you would support?

Theresa Steed: Yes, that is something I would support, but your test is only as good as the day it gets issued. I had Covid at the beginning, and there was a five-day window from me getting it before I actually developed symptoms, but there was a four-day window from when I had my test to when I tested positive. You have quite a big area in between. Staff who come and work with us like our volunteers, hairdressers and chiropodists get tested under our swabbing so that we know they are safe. I would support anything that would allow a family member to be able to visit.

Laura Trott: Thank you so much.

Chair: Thank you very much indeed, Theresa. Thank you also to Philip and Helen for your testimony. It is a very good curtain-raiser for the questions that we now want to ask some experts and then the Government Minister responsible, Helen Whately. We really appreciate you joining us this morning.

Examination of witnesses

Witnesses: Jane Townson, Kathy Roberts and Professor Oliver.

Q32 **Chair:** We are now going to hear from some of the experts. I am delighted to welcome Kathy Roberts from the Care Providers Alliance; Jane Townson from the UK Homecare Association, who has spoken to the Health and Social Care Select Committee before; and Professor David Oliver, who is a practising geriatrician at the Royal Berkshire NHS Foundation Trust, as well as being a trustee of the Nuffield Trust and a visiting Fellow at the King's Fund. Thank you for joining us this morning.

Kathy Roberts, what is your reaction to the stories we have just heard?

Kathy Roberts: The experiences of Philip, Helen and Theresa put into stark reality the impact of the pandemic on individuals, families and providers. A common thread throughout is the lack of clarity, particularly very early on, with social care and health, as well as lack of understanding about the important role that social care has.

I thank Helen for coming forward and talking a lot about being a carer and a mother during this time. Social care has an impact and responds to the needs of all adults who have permanent substantial needs within the community setting. Very early on, particular issues were raised around testing. It has improved on discharge at the moment, although, as Theresa was rightly saying, we still find that it is not as good as we would want at this moment in time. It is probably between two and three or four days to get results back in a care home setting, and that is very much based on locality and region. There is a lot of variation.

What Philip was saying, particularly around access to care homes, human rights and individuals being isolated, is something that providers are very aware of and are working towards. We have visiting protocols that the CPA put together. That has had 30,000 downloads from providers, who are looking at ways in which they can support people to access their family, and their family of choice. Unfortunately, what was said by Philip, Helen and Theresa is not unique.

Q33 **Chair:** To follow up on the question that Laura Trott asked Theresa Steed, would your members support a system where someone like Philip's mother, who was very vulnerable, would be allowed to have a named relative who was treated as a key worker and tested on a weekly basis, so that she was able to continue to get visits from a loved one on a regular basis? Is that something your members would be supportive of?

Kathy Roberts: Many of our members have said that they would be very supportive of that, alongside them carrying out dynamic risk assessments on a daily basis; so, yes, they would be.

Q34 **Chair:** Can I ask you about the bigger picture, Kathy? There were about 16,000 deaths in care homes between March and September, about 40% of all the Covid deaths. Many of them, in different ways, were linked to infection prevention and control issues, whether lack of PPE, agency staff working in multiple care homes, not stopping visitors early enough or lack of testing. Going forward, how do we make sure that the care sector learns the lessons that it needs to learn for future pandemics?

Kathy Roberts: There are multi-layers to that question. In the care home setting—I am talking about care homes, although we obviously have to look at the whole of social care—we can look at the infection prevention controls that are in place. They cannot be generic; they need to be very specific and based around the pandemic. We need those. We are working very closely with the CQC and others, and the CQC will need a more prominent role in moving forward with that.

Q35 **Chair:** Do you think pandemic preparedness should be something that the CQC looks at in its inspections in the future, to make sure that we are ready not just for coronavirus but for any pandemic that might happen?

Kathy Roberts: Yes. I would say that a lot of lessons have been learnt, and that needs to be integrated into the inspection process.

Q36 **Chair:** I have a final general comment, because you are an umbrella body that represents lots of different organisations. We got a very strong sense from comments made by Philip Scott and by Theresa Steed that the care sector felt that it was treated as second fiddle during this pandemic.

The NHS has a long-term funding settlement, a 10-year plan and so on. If we are to do right by the care sector after the enormous sacrifices made by the people working in that sector, and also do justice to the people who sadly passed away as a result of mistakes that were made, what are the big lessons that the Government need to take away from that?

Kathy Roberts: First and foremost, social care needs a 10-year plan. Part of that needs to be a people plan. We need to look at the workforce very much within that. It is a very low-paid workforce, yet it is comparable to that of the NHS. We need to look at them together.

The whole person and the whole systems need to come together, but not necessarily in an integrated system. We need to be able to use things like data more effectively. We need to be able to use processes whereby they interlink. In mental health, for instance, there is a lot of interlinkage between the NHS and social care. There need to be better inspection processes, and we need to look at that within the local authority and CCG setting. We need parity on things like PPE in the future. There need to be some sort of funding arrangements and agreements within that, so that we are not in a bidding war to get hold of protective clothing and protective gear.

In the 10-year plan for the sector, it is absolutely essential that we use data more effectively. We need better inspection processes. We need to listen more to the providers who are providing services and understand that it is not the same as the NHS. There are risks, and the risks can be mitigated. People can live within community settings more safely.

Chair: My colleague Greg Clark has some questions for Jane Townson and Professor Oliver.

Q37 **Greg Clark:** Thank you, Jane, for joining us. We have talked about care homes, and we have talked a lot about the NHS, but people who work and look after people in their homes have made a huge contribution over recent months. Would you share your reflections on the most pressing lessons that need to be learnt for the home care sector?

Jane Townson: First of all, I start by paying tribute again to the home care workforce. Unlike many other professionals, they were doing face-to-face visits with courage, compassion and care throughout. We are very grateful to them.

Overall, home care has proved itself remarkably resilient to Covid-19. The workforce have managed to keep people safe. A small study by Public Health England showed that home care workers had similar prevalence of Covid-19 to the general population. They have been very careful not to transmit that to the people they are looking after, even though testing has been very difficult to get hold of. Deaths overall in home care, while higher than in previous years, have been substantially lower than in care homes. Of course, we do not have the congregate settings and there is less opportunity for transmission. Overall, we are proud of the home care sector and what it has managed to achieve.

I was talking to my colleague in Scotland, Donald Macaskill, recently. He reflected that social care feels as though it is treated like a Victorian child. Certainly, the home care sector often feels as though it is thrown scraps from under the table of the NHS and care homes, and ends up with metaphorical rickets due to malnutrition. Unlike home care, Victorian children were at least seen, if not heard, and when they were sent out to work on the minimum wage in Victorian factories they were at least paid for shifts rather than by the minute. We still have a long way to go to ensure that social care workers are seen as an integral part of the system.

I was listening to Helen, Theresa and Philip. They will testify that it is so important to have additional support. Many people do not. Carers UK estimates that an additional 4.5 million people have become informal carers in Covid-19, taking the total to about 13.5 million. We have just under 1 million—850,000—people being supported by formal home care. The balance between formal and informal needs to be looked at, to ensure that everyone can keep going. As Helen explained, it puts pressure on the whole family.

Our concern is that home care came into the pandemic with low status and in a weakened condition. Knowledge of home care and social care more widely in the Department of Health is quite weak. There is not a fully collegiate approach to, for example, developing guidelines. There is lack of clarity and accountability, so it was often very difficult when we had queries to find out who was actually ultimately responsible for making decisions on guidelines on PPE, for instance. It is split between the Department of Health and Social Care, Public Health England, the Health and Safety Executive, the medical devices regulator and so on.

We have a lack of vision. All we ever hear about is care homes and talk about people not having to sell their houses to pay for care homes, but altogether there are over 15 million people supporting people at home and only half a million people in the combination of care homes and hospital. The balance of the conversation is in completely the wrong place. We need vision to take us forward.

Q38 **Greg Clark:** That is very clear and very helpful. Your analysis is that the NHS, quite rightly, gets a lot of attention. There are then care homes, but you think domiciliary care settings get less because they are less visible. I do not want to put words into your mouth, but is that a fair characterisation of your testimony?

Jane Townson: Visibility is an issue, and general lack of understanding of the social care sector. Domiciliary care is only a part. Kathy will tell you that there are all sorts of other parts of it too. There is mental health, shared lives and other kinds of provision that have not been focused on sufficiently.

Q39 **Greg Clark:** In a long-term plan—perhaps a 10-year plan—for social care, do you think there needs to be a specific plan for the home care dimension?

Jane Townson: We need a vision and a strategy overall. For example, I have mentioned Norway before; they have made a decision to enable as many people as possible to live well and safely at home. Let's start with having a policy vision. We need a nationally mandated minimum fee rate for home care so that, as an absolute minimum, providers can pay the national legal minimum wage. We should not even have to ask for that.

As Kathy said, we need a workforce strategy. One and a half million people work in the social care workforce. That is more than in the NHS. The NHS has a people plan. We have nothing so far for social care. The tasks, the skills and the competencies that they have to perform are complex. As was mentioned, digital is now being thrown into the mix as well, and people's needs are more complex. We need to understand what skills, competencies, training and standards we need, and then make it possible to deliver them.

Q40 **Greg Clark:** Thank you. Specifically on testing during the first part of the pandemic, can you say something about the ways in which your members managed, or perhaps did not manage, to get their hands on testing? Perhaps you could say how it is now, and whether your members and people in the domiciliary sector are getting the tests that they need?

Jane Townson: Home care was never on the priority list. The justification for that was the small Public Health England study, which, while it may be true that the prevalence of Covid-19 in the home care workforce is similar to that in the general population, ignores the fact that home care supports people on the high-risk list by definition. We also have live-in care where care workers live 24/7 with clients. Understandably, those people want to be sure that the people coming in are not infected. We wanted asymptomatic testing.

In the very beginning, for people with symptoms, finding tests was not too difficult, but now it has become really difficult because more and more people have been promised tests. Once schools and universities went back, it was very difficult even for people with symptoms to get tests quickly. We still have not made any progress on getting asymptomatic testing for live-in care workers. We would argue that in areas of local lockdown, where transmission rates are higher, home care workers ought to be on the routine testing list as well.

Q41 **Greg Clark:** Would you extend that to people who are unpaid home carers? There are many millions across the country who do, in many ways, similar tasks, but are perhaps even less connected to the support systems.

Jane Townson: Yes. As Helen explained, all of that has been quite difficult. The confusion about guidance has been difficult for everybody, whether informal or formal carers, to work out what they are supposed to be doing.

Q42 **Greg Clark:** Professor Oliver, you are a hospital consultant. We can see that, as you are in a hospital by the looks of it. Thank you for taking time out to join us. Looking back to try to learn lessons from some of the early policies, it was the case that in the guidance that was issued on 19 March, in preparation for the first wave of the coronavirus, the Government and the NHS said: "Unless required to be in hospital, patients must not remain in an NHS bed…acute and community hospitals must discharge all patients as soon as they are clinically safe to do so."

That was clarified through guidance issued to care homes on 2 April that said, very baldly: "Negative tests are not required prior to transfers/ admissions into the care home" sector. As a consultant, were you aware of that guidance and did you have a view of it at the time?

Professor Oliver: Because I have an interest in health policy as well, I was quite aware of the guidance. I think we have to look at the context back in March and April. The context then was that we had been watching Italy, New York City and certain cities in Spain. We had modelling suggesting, quite accurately, that there would be a big surge and pressure on acute beds. Even before there was any guidance, there would have been a major imperative to get people out to community sectors quickly. There was operational guidance and the Coronavirus Act, so there was a big push from the centre.

As you say, the guidance on 2 April was signed off by all the key agencies saying that you do not need to wait for tests. Interestingly, in Scotland they said, "Don't send people if they have symptoms." Members of the

Committee could usefully look at the Health Foundation report from September on the timeline of testing. There was very limited testing available, even for sick people in hospital at the time. Even for people that we pretty much knew had coronavirus through March and early April, it was hard to get tests and they took days to turn around. People should also be aware that first tests are often negative in people who then go on to have a positive test several days later. In that context, the counterfactual would have involved keeping many people in hospital for tests that were not available, and a first test would not even rule out coronavirus.

However, taking a balanced view, people from the care home and social care sector were saying loud and clear at the time: "We are not hospital wards. We are not geared up for infection control, isolation, cohorting and zoning. We do not have PPE." They were not being listened to, and then basically the NHS comms apparatus were saying that it was not a big problem. It took good investigative journalism from people like Billy Kenber in *The Times* and from the *Birmingham Post and Mail* to show that very clearly people were being discharged. It took until 14 April for the guidance to change.

There was not enough testing. There was not enough PPE in care homes or outside the PPE supply chain. Acute healthcare did not fully appreciate the limitations of trying to do infection control in care homes. Let's face it, if we had a norovirus outbreak, a clostridium outbreak or a flu outbreak on a hospital ward that we can test for, we would not decant all of those people into care homes.

What is important is what we do now. There has been a whole load of developments since then. We do at least now have the capacity to test hospital patients before they leave. There is guidance that care homes can take people with a positive test, and they can take people who are not yet tested, as long as they know—one of your previous witnesses talked about honesty—and as long as they can provide the isolation and the PPE required.

It is also clear in the guidance that, if they do not feel able to do that, with the infection control fund and the additional moneys for social care, the local authority has to consider an alternative place where people can be quarantined. There were mistakes made, but we have a lot more testing capacity now, notwithstanding the fact that, despite all the fine words, care homes themselves are still reporting problems with testing. The Republic of Ireland was testing all residents and staff every two weeks several months ago.

The final thing I will say about this is that we know from various bits of research from the LSE, the ONS and so forth that there is a lot of asymptomatic carriage by care home residents and by staff. Some of the infection was brought by agency staff working in multiple sites. The bigger the care home, the bigger the risk of cross-infection. There were links to care homes that did not pay sick pay for people self-isolating. The narrative that all the outbreaks were seeded by hospital transfers is not true. If right from the outset we had had a strong social care and care home sector voice in national planning and in local agreements, some of the problems would not have happened. "Protect the NHS" essentially meant protect the acute hospital bed base, with everything else a bit of an afterthought. That was a mistake.

Q43 **Greg Clark:** That is very clear, and rich in recommendations for us. Our purpose is very much to recognise that decisions were taken in haste without much information. What you have said about the fact that the testing capacity was not there, and about the requirement to vacate beds, because it was not possible to know the result, is an important piece of context.

Now we have greater capacity, and it is important that we should learn the lessons for the future. I was struck when you said that, if there was an outbreak of C. difficile, there would not be a response to discharge people. How was it that, although there would have been other protocols, or certainly the tacit knowledge in place not to do that, that did not seem to transmit itself to this new pandemic? Why was that?

Professor Oliver: It is only one doctor's impression of the system. At the time, we were absolutely concerned about complete overwhelm. We had seen it happen in other nations, and the modelling suggested overwhelm. In general, in peacetime and before the pandemic, you do not want people marooned in hospital beds who are fit to leave hospital. We have had far too many delayed transfers of care, so in some respects having emergency legislation and funding to say that if people do not need to be there we should move them on was a good thing. By the way, care home residents and other people can contract coronavirus in hospital while they are waiting for testing, so you have to factor that in.

In the absence of adequate testing capacity, and the fact that first tests can have a false negative as high as 30%, and the air cover and push from Government agencies, that was the mindset. I come back to what I said. With a known entity that we have tests for, I do not think anybody would decant norovirus patients into care homes. I also have to ask, where was the full involvement of local health protection teams and infection control teams around the country, and local directors of public health, and where was the social care voice at national level on SAGE and within the Government? That is not a wise after the event thing. People from the sector were saying at the time that it was unwise.

I look after several people from care homes in any given week. Now, we are very conscious that we are not to transfer anybody there without testing. Care homes, because of what happened, have become more assertive. They also feel protected now by the policies. What happened in March and April was in a particular context, at a particular time. Across Europe, we are not by any means the only nation that has had a high number of deaths among care home residents from coronavirus, and sometimes for similar reasons.

Q44 **Greg Clark:** As you said at the beginning, you are involved in policy discussions as well as in practice. From what you have said, the integration of health and social care, or at least the recognition that they need to mesh together, is obviously reflected in the creation of a new Department of Health and Social Care, but the implication is that, at least in the early stage of the pandemic, there was a disparity of power, or at least influence, between health and social care.

Professor Oliver: There was a dominant voice in policy. I was the national clinical director for older people and I worked in the social care division. Even at that time you could see, just as Jane Townson said—I agree with everything she said—it was a poor relation.

There is something we have not touched on. We are focusing on transfers to care homes, but there is the whole issue of adequate input from local health services to care home residents, especially care homes without registered nurses, because they have very complex health and care needs. Things like adequate supplies of oxygen, palliative care medicate, adequate in-reach from local primary care, geriatric medicine and advanced care planning are things we should be doing whether there is a pandemic or not. They were part of the enhanced support for care homes part of the NHS 10-year plan. We must not lose sight of that.

People in care homes get sick. It is not always the best thing for them to be conveyed to hospital. If you wanted a low death rate in care homes, you would admit them all to hospital. We do not want to do that. We want to support people in situ. There were too many reports of care homes struggling to access consistently the right kind of input from local health services, even though there are some great pockets.

As Jane alluded to, people having home care or relying on informal carers also need access to healthcare support within their own home. Next time around, we cannot predicate everything on intensive care units and acute beds not being overwhelmed.

Greg Clark: Thank you. That is very clear, and it is the purpose of the inquiry to be able to make those recommendations. I take this opportunity, Professor Oliver and Jane, to thank you and all your colleagues, both in hospitals and, in the case of Jane, in home care for the extraordinary commitment, dedication and hard work that has resulted in many lives being saved and the experience being much better than it might have been.

Chair: We are not letting you off the hook yet, Professor Oliver. Some colleagues want to ask you some questions.

Q45 **Zarah Sultana:** My first question is addressed to Kathy and Jane. Picking up on the comments you made about there being lack of understanding about the care sector, lack of parity and lack of vision, what are your thoughts on the announcements made by the Government of around £1.1 billion in funding for infection control in care homes in England? It was £600 million in May, and another £546 million more recently to address transmission during the winter. Have the providers that you represent been able so far to access that money? Do you believe it is enough after a decade of underfunding for the sector?

Kathy Roberts: Any resourcing to social care is very welcome. It will absolutely help; yes. We do not totally understand, with the infection control fund at this moment in time, whether that will be enough. We know that social care has been under-resourced for many years. We know that—*[Inaudible]*

Q46 **Zarah Sultana:** Kathy, could you repeat what you said? There was typing, so I am not sure if others were able to hear what you were saying.

Kathy Roberts: Yes; 99% of care homes are completing their capacity trackers at the moment. There is a tremendous amount of data coming from care homes. Care homes are incredibly compliant in trying to look for ways forward and supporting the people in their care homes. They will utilise the funding where they can. There are obviously caveats against any funding, and we need to be able to look into that and understand that.

I do not believe there is enough funding going into social care. As you rightly said, it has been underfunded for many years. I will pass to Jane to give a little bit more information.

Jane Townson: As I mentioned earlier, home care entered the pandemic in a weakened position. It has been grossly underfunded for many years, with only one in seven councils coming anywhere near the United Kingdom Home Care Association's minimum price for home care. To give you an example, the increase in the national minimum wage of 6.25% was announced on 1 January 2020. By April, when it kicked in, very few councils had made any adjustments to their base fee rates to accommodate the extra costs of that.

In the first round of the infection control fund, 75% of it was dedicated to care homes, with 25% for other uses to be dispersed at councils' discretion. Only 52% of the 25%—about 13% in total—made it to any home care providers. We lobbied for that to be changed. In the second tranche of ICF, home care is included in the core grant, in the 80%, but of course now that is split between home care and care homes. The amount that has been given is lower than previously, and it has to last longer. We are not optimistic—all of us in the care sector—that that will be enough.

The biggest cost is PPE, which is dealt with separately. We very much welcome the PPE strategy that the Government have laid out, and the aspirations to provide free PPE. The press releases were all about free

PPE. At the moment though, providers are unable to access the quantities that we are told they should be able to order through the portal because there are not enough supplies behind the scenes. That needs to be addressed; at the moment, PPE is the major additional cost, apart from staffing.

Q47 **Zarah Sultana:** Linking to some of the comments made earlier around lack of PPE, which you have just touched on, Jane, as well as the lack of testing, which has impacted the transfers from hospitals, do you both have confidence in the Government's test and trace strategy at the moment?

Jane Townson: Unfortunately not.

Kathy Roberts: No. I think testing still has quite a way to go. The percentage of returns is still too low. It has improved for people on discharge, but not for the workforce. PPE has improved, I have to say, and it is positive news that under-50-bed units are receiving free PPE. As Jane said, we do not know what that means in the longer term. In the next six months, it is critical to have the stocks in place.

Q48 **Zarah Sultana:** I have two more questions. One is about the future of care homes. An analysis by Knight Frank estimates that occupancy levels across the UK slumped to an average of 80% in mid-August. Are you concerned about what that looks like in terms of care homes potentially having to close in the near future? What does the sector need in support going forward after coronavirus?

Kathy Roberts: More work needs to be done on vacancy levels in care homes. Obviously, they are looking at infection control measures at the same time. More analysis needs to be done of that data.

My understanding is that there has not been an annual increase in the closures of care homes, but we are very mindful of the impact on care homes and the ability to see through the next few months. The workforce comes into that as well. There has been a tremendous impact on the workforce and the resilience of the workforce. The social care workforce was running at around 40% vacancy before the pandemic. There are some real risks around service continuity in the workforce.

Q49 **Zarah Sultana:** Thank you. Professor Oliver, you talked about looking at—*[Inaudible]*—and how the narrative or discourse nationally was perhaps blaming hospital transfers for outbreaks in care homes. What do NHS professionals feel about potentially being scapegoated for such issues?

Professor Oliver: I cannot speak for everybody in the NHS. I am a doctor who works across boundaries, and I have done care home work as well as acute work. In the acute sector at the time, we would have been thinking, "Well, what do you expect us to do, having watched other nations being completely overwhelmed and having modelling showing that acute services will be overwhelmed, with lack of access to testing, even for our own staff and even for sick people in our own facilities?" The narrative in the mainstream media was simplistic. It was all emotive language like people being abandoned to die and condemned to death.

People need to remember that about a third of all care home residents die each year anyway, because they are a very frail cohort. People on average only last about 18 months from admission. With any seasonal pandemic, people will die. Putting it all on to cruel, acute hospitals being pushed by mean officials in the centre to discharge everybody untested was a simplification.

We should have listened more to the sector, because it is not realistic to expect people without PPE and without testing for their own staff, and with their own workforce issues, to do isolation and infection control as a hospital ward would, especially when in half of the cases they have not even been told that a person has suspected coronavirus. Everybody has been scapegoated a bit. More recently, care homes have been scapegoated around visiting, but they have to have a clear dynamic risk assessment about allowing visitors in because of risks to visitors and other residents.

You should always imagine the counterfactual. What would have happened if we had kept everybody in until they had had two investigations to clear them of Covid? What would have happened if they had had unlimited visiting in care homes? That would have provided some poor headlines as well.

I think everybody has felt a bit got at, but fundamentally you should hang on to what Jane Townson said. There were underlying structural problems in the funding and staffing of social care, both in care homes and in people's own homes, before the pandemic. But, before, they were invisible. Even the care homes were invisible. Now at least we have them in the spotlight.

I would like to see the Prime Minister making good on his Queen's Speech promise to have a workable and sustainable cross-party solution to social care funding and provision by next year. It should not exclude unpaid carers, who are often short of support. Certainly, we need more joined-up working between health and social care. I will be holding the Government to account for delivery of the enhanced support for care homes component of the NHS 10-year plan, which is clearly there as a commitment.

Chair: The Minister has arrived, but we still have some very important questions, so I ask Paul Bristow and Barbara Keeley to be brief, to make sure that we have enough time to ask questions of Helen Whately.

Q50 **Sarah Owen:** I will be very quick. The Health and Social Care Select Committee has looked at staff burnout. It is something that Kathy touched on just now when she talked about the vacancies for carers. At the beginning of the year, it was about 122,000. I want to hear from

Kathy and from Jane about the impact that that shortage of care is having on the sector and on the people who are cared for. I also want to know if there is an impact from the Government's Brexit and immigration policies, and the rhetoric around it not being a skilled job. Anyone who has been a carer knows that it is a very skilled job.

Jane Townson: In home care, interestingly, at the beginning of the pandemic, hours of delivery were reduced by between 6% and 10%, for a couple of reasons. First of all, citizens themselves cancelled care visits because they were afraid of infection, and there were perceptions about inadequate PPE for care workers. In some cases, councils cancelled care visits to create capacity for hospital discharge that did not happen at scale.

Ironically, many of our members had to scale back recruitment because there was not enough work. The volumes have now recovered and are increasing. Demand for home care is increasing. That may partly be a reflection of people holding back before going into care homes, and also realising that home care exists.

Because there have been risks to jobs in other sectors like hospitality and retail, at the moment recruitment is quite buoyant, but we are concerned about how long it will last. Care is not for everybody. You have to have a particular empathy and set of values. It is hard and tough work. It is emotionally tough and physically tough.

We are concerned about migration policy. Senior care workers have been put on the shortage occupation list, but it will not make much of an impact. We think that the Government need to make an exception for health and social care workers with regard to immigration, particularly in the short term.

Kathy Roberts: Service continuity has always been the priority for providers. They have looked at how to manage that with overtime and additional hours. Obviously, that adds to staff resilience. The workforce have been absolutely exceptional. They have also been a point of contact for people who have been isolated in the community. The provider sector has really stepped up over the last few months.

The other thing that will potentially have an impact is staff movement. Staff often work in more than one facility, particularly care homes. That could have an impact if it is restricted further. It is something to be very aware of.

Q51 **Sarah Owen:** Coming back to my point on staff burnout throughout the pandemic, has it had an impact, and how can that be best addressed? The problem is not just recruiting carers; it is retaining them, as Jane has just mentioned.

Kathy Roberts: Yes, it has an impact. A lot of organisations are putting a lot of time into their staff and staff welfare. They are looking at what support is available for their staff. It is a difficult one, and I do not have a direct answer. I do not know whether Jane can answer it better than me.

There is a lot of investment going in from organisations to try to support their staff, who have continued to work very hard. Many have made massive sacrifices. Staff in care homes have actually moved into the care home to support their residents. There need to be certain incentives for the workforce. There needs to be better pay for the workforce, as Jane has said. We need to look at moving forward with a workforce strategy over the next five to 10 years. It is a crucial workforce that represents as much care and support as there is in the NHS.

Jane Townson: There are particular pressures on registered managers, particularly in care homes. It comes back to what David said about people being scapegoated. There are huge pressures of being accused of all kinds of things. Providers are worried about litigation. They are worried about their residents and about families either being able to see their loved ones, or not seeing them as much as they would like to. A lot of it will depend on how we, as a system and as politicians and officials, treat the investigations into all of this. Certainly in Scotland, it seems to be quite harsh. We are hearing about a lot of resignations of registered managers. We do not want that to happen. It has to be done with an attitude of learning, and, as David said, putting things into context and considering what the alternative was at the time for people. We can support our workforce by being understanding and by being gentle in how we investigate some of these issues.

Q52 **Paul Bristow:** I declare an interest. My wife owns a communications consultancy, with clients in the social care sector.

My father died during lockdown. The care he received from domiciliary care workers was absolutely excellent. I want to place that on record and say thank you very much to the workers who looked after him, and the sector as a whole.

My questions are to Jane. How would you rate the morale of domiciliary care workers at present?

Jane Townson: Overall, I think it is not too bad. There is a real sense of esprit de corps. They pulled together; they kept going and they have carried on. It was very positive for them to be designated key workers. Our colleagues in the Department of Health and Social Care had to fight quite hard for that to happen, so we really appreciate that. They received more recognition, and we have to make sure that that does not vanish.

They were given more opportunities as well, to perform tasks that normally other professionals like district nurses or even GPs might do. What we do not want, when it suits those professionals, is for them to take it all back again. We discussed that in a previous hearing. My sense is that they are tired—everyone is tired, actually—but they are still feeling positive and able to support people at home. They are pleased that demand is increasing for that.

Q53 **Paul Bristow:** That positivity is incredibly welcome. To what extent do you feel that a payments system that pays on periods of activity rather than on something like outcomes affects the ability of domiciliary care workers to do their job?

Jane Townson: It really upsets them because they want to meet the needs of the people they are supporting. It is very difficult to do that if the focus is on how many minutes you are there, as I discussed last time. To use the analogy that I used previously, if an NHS trust said to a nurse, "We are not interested in whether your patient lives or dies or what happens to them. We are only interested in how many minutes you spend by the bedside," there would be a collective tut-tutting.

Unfortunately, that is what happens in the way home care is purchased. That is because there is not enough funding in the system, and councils have had to come up with ways to try to make the money spread across as many people as possible. We need to address the underlying fundamental issue that the costs of delivering home care need to be properly covered.

Q54 **Barbara Keeley:** I have a couple of questions for Professor Oliver. I am interested in looking back at what you said about the lessons learnt from what went wrong with rapid discharge to care homes. We are clearly back in a situation where we keep hearing about pressure on beds, which will undoubtedly only escalate over the coming weeks, so what structural changes do we have to make to avoid that situation? I think you touched on the social care voice on SAGE; where was the social care voice in national Government? Certainly, as a Committee we have heard that again and again, so the first part of my question is: what can we do to avoid that happening again? What structural changes can we make?

You talked about enhanced support for care homes and about things like oxygen, palliative care and medicine. What we have heard from care home staff is that they did not even have GPs visiting. GPs were just using video links. It would be difficult to try to bring the overstretched and tired workforce that we have just heard about in care homes up to speed on the need for oxygen and palliative care medicine. Those are interesting things that you said, but how can we make those changes now? We look back and they were not there before, but how can we make them now?

Professor Oliver: First, on structural changes, most people who are delayed transfers from acute beds are not waiting for care homes. They are waiting for home care packages or intermediate care—out-of-hospital rehabilitation and support in their own home, led by health teams.

In the early pandemic, because of the funding and the rules, we were able to get people out to those services more quickly. The worry would be that, if there is no sustainable funding, they are saturated, so it would be a very good thing to have more capacity in post-acute or admission prevention rehab services in their own homes, which again is part of the

10-year plan. In some cases, doing that properly will stop people needing long-term social care.

Yes, it is important to have general practitioners in care homes. I know there has been something in the GP contract about named accountable GPs, but whether there is a pandemic or not they need access to the full range of healthcare inputs, whether it is physios, dieticians or speech therapists. They need palliative care, so that people who are dying can die in situ. In some parts of the country, there are really good teams that go in and give people, short term, fluids and antibiotics.

I do not want to criticise all GPs because there are some great examples where GPs spend a lot of their working week supporting care homes. The models for all of those things are there, but they are patchy. They need to be the norm, whether there is a pandemic or not; otherwise you end up with people defaulting to acute hospital beds avoidably, or being discharged without the right levels of support. That has to be allied to proper, advanced care planning. Anyone going into a care home needs a plan about what happens if they get sick and whether they get conveyed to hospital. Something we have not touched on is resuscitation. If those plans are already in place, you will not end up with the kind of scandals we have had about imposition of DNACPR.

The bigger structural issue is who is involved in decision making at national level, on SAGE for instance. My perception is that we do not have a strong social care and care sector voice at national level—I know we brought David Pearson in after the event and there is a plan to have a director of nursing and a chief nursing officer for care homes—but if it had been there and listened to, it would be an improvement. Can you remind me of the second question, Barbara?

Q55 **Barbara Keeley:** How can we bring the enhanced support that was missing into care homes? We heard from care staff that they were not getting much support at all. When we get back into a situation, how can we make sure it happens?

Professor Oliver: There is some logistical stuff about keeping them in the PPE supply chain and about the change in legislation that allowed them to keep palliative meds. It is about logistics and supplies.

Fundamentally, the community healthcare and primary healthcare staff going in to support care homes need to be adequately resourced for the role. At the moment, they are already struggling with workforce gaps; there has been a decimation of the district nursing workforce service, for instance. We only have about half the capacity we need in intermediate care. It is no good just saying, “Put it in the GP contract for one named GP to be accountable for a care home,” because they also need people like community pharmacists, other professionals and nurse practitioners. That is especially the case for residential homes that do not have registered nursing.

Something we have not touched on is whether, for the homes that employ registered nursing, we are doing enough to support them with training, personal development and career opportunities. For the 20% of homes that are owned by big chains with private equity backing, those big companies have a clear responsibility, but most care homes are small operations that own one or two homes. It is not realistic to expect them to do all of that development and training on their own. The bottom line is that it has to be prioritised, valued and adequately resourced. If one good thing comes out of this, it will be that at least they are on the radar now and people think about getting those aspects of care right.

Q56 **Barbara Keeley:** Do you think we are still missing that voice on SAGE and in national Government?

Professor Oliver: I am no longer inside the Government machine. Obviously, there are some strong lobbying voices like the National Care Forum, ADASS or the Local Government Association. They do good work. We have one Minister of State for care services alongside three or four other junior Ministers and the Health Secretary. I do not believe we have anyone from primary care or social care on SAGE, or necessarily on any of the other pandemic preparedness groups.

For instance, at the Downing Street press conferences, until right towards the end, when David Pearson appeared a couple of times, there was no social care voice. That needs to be rebalanced. As Jane rightly says, most care is delivered outside institutional settings, and most of it is delivered by unpaid carers who often do not get much support. It is not strong enough. At least in my time in the DH we had David Behan, who was social care through and through, as the director general for social care. I am not sure that we have anybody with equivalent clout and seniority at the moment.

Chair: Thank you very much indeed. On that very note, David Pearson has arrived to give evidence alongside Helen Whately. A very big thank you to Professor Oliver, Jane Townson and Kathy Roberts for your very helpful evidence.

Examination of witnesses

Witnesses: Professor Cummings, Michelle Dyson, David Pearson and Helen Whately.

Q57 **Chair:** That was a perfect curtain-raiser for the Minister for social care, Helen Whately, who has now joined us, alongside David Pearson, who is chair of the Government's social care support taskforce, and past president of ADASS. Remotely, we have Professor Jane Cummings, former chief nursing officer for England, and now testing director for adult social care, and Michelle Dyson, who is the director general for adult social care at the Department of Health and Social Care. Thank you all very much for joining us.

Let me start by saying thank you very much to your team at DHSC, Helen Whately. Civil servants do not often get thanked. Typically, people thank those on the frontline, but it has been incredibly hard work for everyone at DHSC, and we want to recognise that as a Committee.

SAGE talked about asymptomatic transmission from the beginning of February, so we had a pretty good idea that this was a disease where a lot of transmission was happening between people who did not have any symptoms. In Germany, they had a shortage of tests at the start, but they had a rule, right from the outset, that if you were taking a patient from hospital into a care home who was not tested, that patient either had to be quarantined in the care home for two weeks or you were not allowed to take the patient at all. I know it is very easy to say these things with the benefit of hindsight, but, looking back, we should have done that here, shouldn't we?

Helen Whately: I welcome this inquiry and the spirit of the inquiry, which is clearly to learn lessons and rapidly apply them, as we are still very much in this pandemic. It is very much the approach that I and colleagues at the Department of Health and Social Care have been taking the whole way through the last few months.

On your question about discharges and whether people should have been quarantined, from very early on, it absolutely was the guidance to the social care sector that anyone being discharged from hospital should indeed be isolated for a period of 14 days. I recognise that early on we did not have a large volume of tests available and, therefore, it is true to say that people were being tested in hospital if they had symptoms but there was no blanket testing of everybody brought in initially. At that time, and it continues to be the case, anyone who is discharged from hospital to a care home should be quarantined for 14 days.

What has happened over the period, as we built up both our understanding and the volume of tests that we had, is that the point at which we published our adult social care action plan, on 15 April, was when we said that everybody should be tested prior to discharge, and that someone should only be discharged to a care home if the care home felt that they had the facilities, effectively, to quarantine someone. If they felt that they did not have those facilities, the local authority should step forward and provide alternative facilities, using the funding that was available to support discharges, until the isolation period had been concluded.

We have continued to strengthen the protections and support around discharge, and going further—

Q58 **Chair:** I am sorry to interrupt, but there is a difference between guidance and what happened in Germany where they said that, if you cannot quarantine someone, you must not take them from hospital. In the interests of looking forward, I want to be clear. On 2 April, as Greg Clark referred to earlier, NHS England sent out guidance to care homes, in which they explicitly said that some of the discharged patients might have Covid-19, they might be asymptomatic and no tests were required. I want to check that we would not now do that, and that it would not just be guidance but would be absolutely clear that the hospital would be told not to do it, and the care home would be told not to accept anyone unless they could guarantee that they could properly quarantine.

Helen Whately: Correct. That is absolutely the case. In the winter plan, there is a specific requirement to involve the local authority in the event that someone is being discharged to a care home, particularly because we have heard—this should not have happened—and as previous witnesses have mentioned today, some care homes felt under pressure to accept people who had been discharged. That should not be the case. The local authority must be involved.

We are also working with the CQC on actively inspecting and designating specific facilities that have the highest standard of infection prevention and control for people to be discharged from hospital.

Q59 **Chair:** Can I ask you about another bit of guidance? In Canada and Israel, for example, care homes were banned from using agency workers who were working in more than one care home. What happened here was that we, again, advised care homes on 2 April, but we have not banned it. The word in the sector is that there are still lots of agency workers working at more than one care home. Should we not just ban it here?

Helen Whately: It is a very important question. I have spoken to my counterparts in Canada and other countries to learn from their experiences. In April, and in the run-up to the publication of the adult social care action plan and then the care home support plan that followed that in May, we had very active conversations with stakeholders about how far we could go on that; David Pearson may well be able to add to this.

We were beginning to see evidence internationally and in the UK that there was greater risk of a care home having an outbreak if staff were working in more than one setting; for instance, an agency staff member might be working in multiple care homes. We saw that there was an increased risk. As a result, we looked at whether we could, at that point, ban that and say that staff could only work in one setting. Working with the sector and talking to providers, there was great concern that with an outright and immediate ban we might have some care homes that simply did not have enough staff to look after their residents.

Earlier in the pandemic, I remember looking at other countries and saw that Spain was ahead of the curve on the rates and that people were, very sadly, dying in care homes because staff had just walked away. The military were going in and finding abandoned care homes. We did not want to see anybody suffer from neglect in that way, so we had to make sure that there were sufficient staff to look after people. That is why the position in April and May was guidance that, as far as possible, care homes should make sure that they were using staff who only worked in one setting. We supported that with the infection control fund of £600 million to provide extra funding, because providers I spoke to said, "That will cost us extra. We may have to pay a premium for staff to work only in our setting," so we provided that extra funding.

In the winter plan, published in September, we said that now it is mandated. As of now, staff must only work in one setting. We have gone from the guidance position to saying, "This must be the case." That is, again, supported, with the second round of the infection control fund recognising the extra costs.

Q60 **Chair:** The concern that people have, as we have heard this morning on a number of occasions, is that the social care sector was a bit behind the curve in terms of the priority it was given. With some of these measures, we got to the right place eventually, but it took us too long. The Health and Social Care Committee heard, for example, that in Hong Kong external visitors were banned right at the start of coronavirus, at great human cost to the residents, but they have not had a single infection or a single death in any care home in Hong Kong. In our case, we did not do cohort isolation until two weeks after the lockdown.

I want to ask about the timeliness of the measures that we introduced. This morning, we heard that the Government have rejected the advice of SAGE to have a two-week circuit breaker in September and have opted for less draconian measures. Do you think there is a risk that we could again be making the same mistake and not acting fast enough or decisively enough to control the spread of the virus?

Helen Whately: On the Hong Kong example, I have spent some time looking internationally to learn the lessons as best we can. From what I can see internationally, many countries are like the UK. In England, we have had a really difficult pandemic for care homes and, very sadly, many lives lost. The most common factor when there have been many deaths in care homes has been the extent of community transmission. We generally see that, when there is widespread transmission of Covid in the community, it is hard to keep it out of care homes. That is a really important point and timely right now, when there has been some debate about the level of restrictions that should be in place and suggestions that you could, essentially, mothball those who are more vulnerable. What we know, and what other countries have seen, is that care homes are, in essence, part of the community.

Coming specifically to the point about visiting, countries have had quite differing visiting policies. It is not clear that where countries have been very strict on banning visitors they have necessarily had fewer deaths in care homes. For instance, Spain introduced a very early ban on visitors but had a huge problem in their care homes.

On the timing of guidance, I would argue that we moved pretty quickly. For instance, guidance was sent out to residential care on 25 February in the first phase. There was guidance again on 13 March, the day after we went from the delay phase into the contain phase. There was further guidance on 2 April. Then we had the adult social care action plan on 15 April, which brought it all together.

In all of those periods, we were working with the sector, drawing on the clinical advice, while recognising, of course, that we are talking about a hugely diverse sector, which does not have the type of infrastructure that we have for the NHS. For the NHS, we have NHS England. As you know, Chair, in the Department we have a social care team that, initially, was purposed to look primarily at social care reform. We have built up those resources. We have built up the infrastructure that we have. All the time, we have been doing a balance in wanting to get guidance and support out quickly to the sector while wanting to engage with the wide range of forms of care that we have.

Q61 **Chair:** Sir Robert Francis says that it is a human rights issue that you should be able to see visitors as a resident in a care home, and whether you want to take the risk should be decided by the resident. You said in the House of Commons last week that you were very sympathetic to the idea of a named relative being treated as a key worker and being tested on a regular basis so that they could carry on visiting a loved one. Do you have a date when that might be possible?

Helen Whately: On the human rights point about visiting, as I said in the Chamber last week and have said on other occasions, visiting is incredibly important for residents and their families in care homes. I really want us to enable visiting, but it must be safe. You have to recognise that, should a visitor take Covid in, they are not just endangering the individual they are visiting. It is very hard to control Covid within a residential setting, so it is not as simple as just an agreement between resident and visitor.

On the point about treating a care worker as a key worker and, therefore, them being trained to wear PPE and be tested, I am planning for us to launch a pilot on that shortly. I cannot give you a date, but I can say that we are moving forward with it and we are going to pilot it.

Q62 **Chair:** Thank you. Just before you came, we heard from Professor David Oliver, who advises the King’s Fund and the Nuffield Trust and is also a geriatrician at the Royal Berkshire Hospital. He said that the phrase “Protect the NHS” meant that everything else became an afterthought, and that was a mistake. We have a 10-year plan for the NHS and we have a people plan for the NHS. Will you, as the Minister for social care, commit to a 10-year plan for the social care sector and a people plan for the social care sector as well, so that it is not an afterthought?

Helen Whately: Even in the grip of the pandemic we are in, we have been working, and are working, on social care reform. The Prime Minister has, several times, repeated his commitment to that. I am absolutely determined as well that we should take it forward.

Some of the earlier witnesses who spoke so compellingly, especially Jane Townson, talked about the need for a vision for social care. I absolutely want to make sure that we set that out. We set out our vision for social care to have greater esteem in our society and in our health and care system, and our ambition for people to live independently for longer and to live behind their own front door for longer. We have set out our ambition for the workforce, and I know it has been really tough for care workers at the frontline during this time.

There has been more recognition of social care and more recognition of what care workers do, which is right and good, but I want us to go further on that. I want to make working in social care a rewarding career that people step up to and really want to do, and see as an opportunity. I want us to go forward with a substantial plan for social care.

Q63 **Greg Clark:** I reiterate the thanks of the Chair for all the work of the Department, and your team and officials at this time.

Obviously, the role of scientific advice, as we go forward, is going to be as important as it has been looking backwards. We had the minutes of SAGE published yesterday, in which it became clear that, on 21 September, SAGE was advocating a more restrictive and aggressive set of measures than those that were adopted. How is the decision being taken now as to what measures to follow?

Helen Whately: It is probably helpful for me to answer for social care, where the decisions that are taken—for instance, on the policies in the winter plan—are generally informed by a combination of guidance from SAGE, from the chief medical officer and deputy chief medical officers, from Public Health England and from scrutiny of the increased amount of data that we have for social care. One of the big changes over the last few months has been from a situation where we had very little data, including, for instance, the fact that we did not have reporting about deaths from Covid in care homes in the earlier period, to a position where we have much better data, which feeds into the policies that we now have for social care.

Q64 **Greg Clark:** Social care is part of the wider restrictions that are being adopted. We now have the Joint Biosecurity Centre. Did it play a role in advising on or determining the package that was announced yesterday?

Helen Whately: Yes. The Joint Biosecurity Centre is very closely involved in decisions about what restrictions should be in place, and pulls together a huge amount of information about the rates of Covid in different parts of the country and about transmission patterns.

Q65 **Greg Clark:** Did they advise on the package of measures that was proposed yesterday?

Helen Whately: I am pausing because, in the context of lessons learnt on social care, I am not in a position to go through the process that resulted in the package that was announced yesterday.

Q66 **Greg Clark:** It is relevant in this sense. A lot of the decisions that have been taken on social care and in other institutions in the health economy have been advised by scientific papers. For example, a working group on social care is part of SAGE. I was looking at its minutes, which were published yesterday. It is very germane to the point about visitors. It says that "modelling studies show that allowing visiting has only a marginal impact on the case load in a home." That is the social care working group of SAGE. SAGE has had an important role to play. I am trying to understand whether the creation of the Joint Biosecurity Centre changed the role of SAGE in determining policy.

Helen Whately: I am not in all of the meetings of the Joint Biosecurity Centre and on the determination of, for instance, the restrictions—the three levels—that were announced yesterday. Therefore, I do not feel in a position to give you the perfect answer to that question.

David Pearson: Perhaps I could help.

Greg Clark: Please.

David Pearson: I have sat on Joint Biosecurity gold since the middle of June when I took up the appointment as chair of the taskforce. Professor Jane Cummings has been sitting on the silver, which is chaired by Chris Whitty. Through those discussions, at every meeting where there have been concerns about what measures should be taken in a local area, whether it be Leicester, Bradford or other areas of the country, the social care element has been taken into account.

The Minister is absolutely right about the nature of the involvement in that setting, but the learning from those experiences, and the development of the intelligence and information that has come from local areas and the dialogue that has taken place with local systems, has informed the sorts of measures that need to be taken. It is in the round of joint biosecurity.

You mentioned the SAGE sub-group. We have had a great deal of contact with the SAGE sub-group and regular contact with Jenny Harries, the deputy chief medical officer, who has been chairing it. It was part of the intelligence and the learning that informed the tiering. It is in that context.

Q67 **Greg Clark:** Specifically on policy measures, is the Joint Biosecurity Centre advising on what policy measures should be adopted now and in the future?

Helen Whately: Yes. To the extent that, like David, I sit on a number but not all of the JBC meetings, yes, absolutely, it advises on policy measures to be adopted.

Q68 **Greg Clark:** Given that we know that SAGE had a particular perspective on measures to be taken on 21 September, do we know what the view of the Joint Biosecurity Centre was on the measures to be taken?

Helen Whately: I do not have that information with me today. My understanding is that we are talking about lessons learnt for social care over the last few months, so I cannot set out the full answer to that question today.

Q69 **Greg Clark:** One of the things that we have done is to set up a Joint Biosecurity Centre. What are the objectives of the Joint Biosecurity Centre?

Helen Whately: From what I know, the Joint Biosecurity Centre brings together a huge amount of information—for instance, from testing, test and trace, other data sources, and drawing on conversations with regional directors of public health, to enable more informed decisions to be made about local restrictions when you get higher rates of Covid in particular areas of the country.

Q70 **Greg Clark:** Do we know who the members of the JBC are?

Helen Whately: You will know that Baroness Harding is the chair, and there are several other members.

Q71 **Greg Clark:** How often does it meet?

Helen Whately: I usually join a weekly meeting, which is now on a Wednesday, called the JBC gold meeting. The JBC silver meeting is usually the day before that to prepare for it, and there are other meetings during the week.

Q72 **Greg Clark:** Did it need to consider the measures that were proposed and have been adopted in the last few weeks? Did it provide advice on the SAGE advice?

Helen Whately: There have been many discussions involving the JBC about what measures should be adopted.

Q73 **Greg Clark:** According to its own website, the JBC is accountable to Parliament through you as the Minister for Care. Given that route of accountability to Parliament, I am quite keen to understand the role that the JBC is now playing on taking the advice of SAGE, which is now published, and then determining how that should be translated into policy.

Helen Whately: For instance, the chief medical officer is in the Wednesday JBC gold meeting and in the silver one the day before. The chief medical officer is in those meetings and draws on the advice from SAGE.

Q74 **Graham Stringer:** Are you happy for the minutes of the Joint Biosecurity Centre meetings to be published?

Helen Whately: That is not a decision that is mine to take, but I absolutely support it.

Q75 **Graham Stringer:** Whose hands is it in? Who takes the decision whether or not to publish the minutes?

Helen Whately: I think that would be with the Secretary of State for Health and Social Care. Transparency is an important part of what the Government should be and are doing during this pandemic. We have been increasingly sharing more data week by week, as we are able to do so.

Q76 **Graham Stringer:** Has the Secretary of State taken a conscious decision to keep the minutes of those meetings private?

Helen Whately: I cannot answer for a decision by the Secretary of State.

Q77 **Graham Stringer:** But you are attending the meetings, so I would have thought that you would know.

Helen Whately: That is not something I can answer.

Q78 **Graham Stringer:** Thank you. You, very generously, described how you had got international information to help you make decisions. At the start of this process, did you get information from other countries about what happened when the virus got into care homes and what were likely to be the fatalities if it did?

Helen Whately: We were seeking information in multiple ways. For instance, one thing I did during the pandemic was to arrange calls with my counterparts in a number of other countries to speak directly to them about their experience of the pandemic. I was also looking to Public Health England and to the deputy chief medical officer, who was particularly supporting us with clinical guidance for social care, to find out what we could learn from other countries and what research existed. For instance, early on we started hearing that there was evidence, some of which came from the US, that you had higher risks of outbreaks if you had staff moving between one care home and another, and that was one of the things that fed into our policy decision on restricting movement between care homes.

Q79 **Graham Stringer:** We were told in private on the Science and Technology Committee that, if the virus got into care homes, you were likely to get 40% fatalities. Were you aware of that figure?

Helen Whately: That is not a figure that I am familiar with, no.

Q80 **Graham Stringer:** Were you aware of any figures in care homes around the world, if the virus got loose in them, about fatality rates?

Helen Whately: I did not see a forecast of fatality rates.

Q81 **Graham Stringer:** You must have asked when you had those discussions.

Helen Whately: Yes, I absolutely asked what we could possibly learn from countries overseas. As I mentioned earlier, at the beginning the greatest worry was that we would see residents in care homes neglected. One of the worries at that time—indeed, it was a concern for the NHS as well as for social care—was that we would see a large proportion of the workforce off sick with Covid. If we had a large proportion of the workforce off sick with Covid, how would we make sure that people had the basic care that they needed to survive?

Quite a lot of the work that we did in the early days was to establish data tracking, so that we could find out whether care homes were coping and whether they had the workforce they needed. That began to come through in mid-April on something called a capacity tracker, which was a data collection system that we developed to provide more information, in essence.

We were working with the sector to try to make sure that, in the event that a care home had a crisis and did not have enough staff, the local system would come round and support it, and we were also working to support the recruitment of care workers. In fact, at the time there was an increase in interest in working in health and social care. We set up a service to enable people to do remote video interviews and online induction training to support the sector in recruiting more staff.

Q82 **Graham Stringer:** There are no good and easy answers to the problem. People were going to die either because health services were withdrawn as hospitals focused on Covid or people went back into care homes infected. People would die of Covid. They might die of poverty as well if they lost their job. There were obviously risks all the way around the clock. Who was giving you risk advice? How were you judging the possible different outcomes?

Helen Whately: In this, as in all areas of policy, we took advice from Public Health England, the chief medical officer and the deputy chief medical officer on, for instance, guidance to the sector on use of PPE, infection prevention control and things like that.

Q83 **Graham Stringer:** Did you actually take advice on the risks of the consequences in different sectors, between care homes and hospitals, or between Covid and suicide because of loss of employment or isolation?

Helen Whately: I am thinking back to the period of the peak. There was pressure and a need to act quickly. I was certainly hearing from social care providers I was talking to that they wanted more guidance, support with accessing PPE, and more access to testing, and that they were struggling financially and wanted more financial support.

We were working rapidly to take action on those multiple fronts, hand in hand with taking advice from our clinical adviser, Public Health England, and engaging with the sector to see what would be most helpful, bearing in mind that we had care homes, domiciliary care, unpaid carers and supported living settings—a huge range of settings—and to come out with policies that would support that range of settings. Indeed, we were weighing up the balance in visiting policy, trying to work out the right balance to strike between restricting visitors and recognising the importance of people's wellbeing of having access to visitors, particularly for those with dementia. There was a huge amount of weighing up of the options in order to come up with what we felt was a helpful policy.

Graham Stringer: You did not quite answer my question about risk advice, but thank you.

Q84 **Dr Evans:** In the context of lessons learnt, Minister, can you talk about the images and the information about what was going on in Italy and Spain at the height of the pandemic and the assessment about discharging patients? Clearly, there was pressure on acute hospitals, so the argument was to discharge. What assessment was made at that time to understand the balance and the risk posed to the care sector.

Helen Whately: What I think will probably be helpful is to talk through the stages and what happened, as I recall it. As you say, we had the context of Italy particularly, where we were seeing patients being turned away. I spoke to doctors in England who were incredibly worried that they might have to make some of those, essentially, rationing decisions. There was huge concern that the NHS was going to be overwhelmed. We had the development of the Nightingales, and production of ventilators and things, to try to help the NHS cope.

At that point, there were also steps to discharge people who were clinically fit to discharge, and that included people who were clinically fit to discharge to social care and care homes. Around that time, I began to hear directly from some care homes that they were worried that people were being discharged to them, who a few days later began to show symptoms of Covid. They did not feel necessarily that that was the right thing to be happening. They wanted patients to be consistently tested so that they would know whether someone was Covid positive or not. That led to our policy, which was announced on 15 April, that everybody being discharged from hospital should be tested, so that care homes would have that information. It is worth repeating that, irrespective of the test result, someone being discharged from hospital should be quarantined for 14 days, because we know there is an incubation period and it may turn out that they are Covid positive a little while later.

Q85 **Dr Evans:** Moving that on, given what Professor Van-Tam said about transmission during the next couple of weeks, there is a threat that the NHS, potentially, will be in a similar situation again. What have you put in place this time to make sure that we are not in the situation where we found ourselves in March and April? If you would be happy to answer that question, can I put the same question to David Pearson? The key bit about lessons learnt is that we can do something now.

Helen Whately: You are absolutely right. What we introduced following the adult social care action plan in mid-April was that somebody should only be discharged to a care home if that care home had appropriate isolation facilities. If not, the local authority should make sure that they had alternative facilities for that. We know that many local authorities have, indeed, set up those kinds of facilities.

Following the work of the adult social care taskforce, which David led over the summer, we are now going through a process of accrediting in every area a specific facility that is accredited by the CQC as absolutely definitely having the gold standard of infection prevention control, so that people can be discharged to that location from hospital.

Q86 **Dr Evans:** Do you see a call coming from the NHS saying, as we had before: "We need the space. Discharge everyone," but you now have protection in place, or are you doing something different about going to one of those accredited sites? If so, when is that likely to happen, given that we have two weeks of what is going on in Liverpool?

Helen Whately: We are now making sure that we have a sufficient number of accredited beds to support that, and prioritising that process in areas where transmission rates are higher. Of course, as we know from the discussions over recent days and weeks, the best way we can enable the NHS to look after people and keep people Covid-free in care homes is, as a society, to control the rates of Covid and keep infection rates as low as we possibly can in our communities.

Q87 **Dr Evans:** Mr Pearson, would you answer the same question?

David Pearson: Certainly. I would like to start by reinforcing the last point the Minister made. The evidence across the world is that every country with sustained community transmission has struggled to keep it out of care homes. This country is in a much stronger position now to keep the virus, as much as possible, at the front door, through the testing regime, whole care home testing and weekly testing of staff in particular, where we know that there is something like a 75% to 25% staff to residents ratio of positive tests. That is absolutely critical as part of our strategy.

Going to your point about hospital discharge and care homes, there are four essential ingredients. The first is that everybody has a clear outcome to a test on leaving hospital, within a specified and reasonable period of time, which has obviously been extant since the 15 April social care action plan, but is reinforced.

The second thing is that there is good information. You heard earlier from the care home owner from Tunbridge Wells who said that she did not have quite enough information. Clearly, as we have known for a long time, speed in helping people to leave hospital, when they are well enough, is in their interest. Staying in hospital you can pick up infections, as Professor Oliver said, and it is terribly important that people are able to move on in their lives and get out of hospital when it is safe to do so. Good information would help with their care.

Thirdly, through the task force and subsequently, we have done a fair bit of work on cohorting and zoning. As the Minister said, it is the gold standard for safe care in particular settings. That is where the CQC assurance process will help us to be clearer and even more confident. We learn something about this virus every day, don't we? Therefore, our plans need to be agile. What we have learnt is just how pernicious the virus is, beyond the scientific modelling back in the time you were referring to earlier. That makes that work even more important.

My final point is, as set out in the taskforce's recommendations and in the winter plan, absolute clarity about enhanced health in care homes—clinical support. Another part of my portfolio is that I have been the long-term chair of the integrated care system in Nottinghamshire. I know how fantastic the outcomes can be when health and care can work together and provide collective support.

Q88 **Dr Evans:** What are we going to look back at in hindsight in this Committee next time? This time, it was acute beds into social care. Another could be the welfare of residents, having been locked down potentially for almost a year without contact. That is an obvious one. Are there any other obvious hindsight points that we could acknowledge now that could be looked at to stop them becoming a problem?

David Pearson: Are you talking about hospital discharge or the wider issues? Do you mean more generally?

Q89 **Dr Evans:** Discharge from hospital becomes very obvious looking back, doesn't it?

David Pearson: Yes, it does.

Q90 **Dr Evans:** One of the big problems that is not talked about is the welfare of people there for nearly a year during lockdown.

David Pearson: Indeed. In the taskforce, we were very careful to make sure that we balanced, as is written in the report, the process of protecting, but protecting cannot be at the expense of social distancing from the people who love you and who are important to your welfare, including other public services such as the NHS. That is something we say very clearly in the report.

There are lots of things the Government have put in place as a result of the taskforce. I originally thought it would produce a pithy document with a few recommendations. It turned out to be 56 pages with 52 recommendations. Credit to the Government, they published their response within three weeks with a very significant winter plan that brought in all the recommendations from the taskforce.

My answer is that the collective implementation of all those recommendations will be absolutely critical. There are some clear national things around testing, PPE, resources to deal with some of the extra costs through the ICF and free PPE, and the whole process of infection prevention control analysis and support in local areas. Those are critical.

We made a number of recommendations for local authorities and providers because this is, clearly, a collective effort. Government must do what Government need to do, but it is also dependent on local authorities and providers being able to follow best practice consistently. They have done some fantastic work. There are some marvellous examples out there to build on.

Q91 **Neale Hanvey:** Before I get into my questions, I thank all of those who have given us such powerful testimony this morning.

Prior to the pandemic, there was an appetite for social care reform across the sector. The Government had a vision for a cross-party supported strategy. That then became a possible Green Paper, and many viewed that as equivocation or kicking the can down the road. The Minister has spoken this morning about the need to implement social care reform. Can she give the Committee a bit more detail about the timeline in which she expects that to happen, given that that commitment has not been reflected in the winter plan?

Helen Whately: Absolutely. The winter plan is specifically focused on support on Covid and sets out to be a useful document, rather than to include additional content to do with social care reform and broader policy. Clearly, the Department has been dealing with a pandemic. In the early period of the pandemic, social care resources in the Department were all repurposed to support our response to Covid. We then went through a period in the summer when we were building up the scale of the team in the Department, although actually we have been building it up the whole way through. While the work was going on with the taskforce and to develop the winter plan as a wave 2 plan and build up capacity to support the sector during the winter, we were also able to restart work looking at social care reform.

We are still absolutely committed to carrying out social care reform. We still want to achieve cross-party consensus on that. As has been said many times by many people, the social care system needs fixing. For us to have a sustainable answer, we need broad consensus around that answer. I want to achieve that consensus. I am committed to reform but I cannot give any further information on the timeline.

Q92 **Neale Hanvey:** When do you expect those conversations to begin?

Helen Whately: Before we got into the peak of the pandemic, contributions were sought from Members of Parliament across party for views on social care reform. We were then in the period of particularly focusing on the pandemic, but what I can say is that we will be coming forward with reform and will be seeking a consensus.

Q93 **Neale Hanvey:** This inquiry has been welcomed quite widely as a swift means to identify lessons to be learnt and has been characterised thus in the press. One of the obvious lessons that has come out of it, and is the focus of today's conversation, is the fragmented nature of social care and the under-resourcing of social care. Given that that is such a clear message, I will continue to persist with the question. Do you expect social care reform to commence next year, the following year or in 2023? When can we expect action on reform in social care?

Helen Whately: My answer is not going to be any different from the previous one, which is that I am absolutely committed to us carrying out social care reform, but I cannot give you further information on the timeline.

Q94 **Neale Hanvey:** At the moment, the Government are providing piecemeal funding for certain parts of the delivery of social care. We have had very powerful commentary this morning, particularly from Professor Oliver, who highlighted the need for social care reform to happen as quickly as possible. There are obvious benefits from that, in that any extant pressures on the NHS would be relieved by placing people in an appropriate setting, rather than in the delayed position with their discharge.

I am sorry to say that I find the Government's response a bit vague. It seems to be one of the most crucial lessons that has come out of the Covid pandemic. We have heard about the consequences of that from our witnesses today. I gently suggest that we need something more than vague commitments.

Helen Whately: While work is ongoing on the broader social care reform agenda, that is not stopping us making progress and drawing on things that we have learnt during the pandemic. For instance, one area where we have made great progress is on data and oversight of the system.

One of the big challenges with a highly fragmented social care system is a lack of comprehensive data about who is receiving social care and, in essence, what is going on at the frontline. What we have developed by using the tool known as the capacity tracker at the moment is a much greater dataset. We now have a dashboard specifically for Covid metrics, which I am able to look at every day; it gives me information about what infection prevention control measures care homes report that they have in place. Are they reporting, for instance, that they are paying their staff sick pay for isolating?

We have a much greater set of data than we had before, and we are continuing to build it up. We are building up our ability to take action and work with local authorities where there are concerns about the compliance or performance of a care provider. That sort of stuff is happening. We are not waiting for a formal announcement of reform to make progress on how the system works.

Another example would be enhanced health in care homes. Professor Oliver spoke very powerfully about the importance of clinical support for care homes. I certainly heard that myself during the pandemic. I heard from a range of providers. Some said that their local GP, for instance, was enormously helpful and doing remote consultations when it did not seem right to come in person. They were doing that really well and supporting the care home, but others said they had not seen so much local clinical support.

That was why one of the policies in the summer was for a named clinical lead for every single care home. As of October, enhanced health in care homes is being implemented across the whole country so that every care home is assigned a primary care network to support it. I am working with my colleague, the Minister for primary care, to make sure that we have the best possible insight and reporting of the effectiveness of that. Improvements are taking place all the time.

Q95 **Neale Hanvey:** I noticed the dashboard and the performance assessment in the winter plan. While metrics are useful in healthcare and they assist in some respects to look at performance, I have been having conversations with commissioners and providers who say that in many respects the key performance indicators do not help them to deliver or manage the pressures that exist. I will use one example.

Care home staff, carers, unpaid carers and community carers are all suffering from the stress of dealing with the pandemic. That was recognised by the nation clapping on Thursday evenings during the pandemic, but there is a fundamental principle about recognising and valuing those staff and giving them decent pay. Those are the kinds of actions that will address the structural problems. Is there any action on valuing staff?

Chair: Can I ask you to be brief in your answer, Minister? I have a number of people I am trying to squeeze in.

Helen Whately: I will do my best. I reiterate the importance, and my appreciation, of all the work that has been done by frontline care workers through the pandemic who have faced incredibly tough times. I have spoken to many directly about how hard it has been, and how they have appreciated, for instance, the clap for carers. That included social care workers. It was not just about the NHS.

I have certainly worked hard, as have others, to make sure that, when we talk about the NHS, we talk about social care at the same time. We should talk about health and social care in the same breath and give parity of esteem to those who work in social care, along with those who work in the NHS, for the important work they do. I have also worked to make sure that where we have, for instance, support for NHS workers on wellbeing, the same support package, as far as possible, should be available to social care workers, recognising that they are generally employed by private providers, many of whom are themselves doing a good and important job in supporting their workforce through this difficult time. We need to do more and make sure that there is a consistent level of support to the sector.

Q96 **Dean Russell:** Can I also share my thanks to the social care workers through yourself, Minister? I was speaking recently to Camille from Abbots Care in my constituency. She said that one of the big concerns coming through from care homes and home care workers is the rise in insurance premiums. They are really worried that they are getting out-priced and are not going to be able to take in patients who, perhaps, had coronavirus previously. Potentially, especially with the rise that we are going through at the moment, that is going to cause a massive backlog of providers not being able to take patients from hospitals because they cannot afford the risk of doing it. Is that something that is being looked at, because it is going to be a really big issue over the coming months?

Helen Whately: Yes, absolutely, it is something that is being looked at, along with the broader question of the financial viability of the sector and the extra costs that the sector is bearing, recognising the extra costs in social care. That is one reason why we are now distributing free PPE to meet the needs of adult social care during the winter. The infection control fund is in place specifically to fund extra costs associated with Covid, such as the extra workforce costs and sick pay for staff, which is really important. We are indeed also looking at the rising insurance costs.

Q97 **Dean Russell:** How quickly will that be prioritised in terms of helping care homes right now?

Helen Whately: We absolutely are looking at it and keeping a very close eye on it, along with working with local authorities, ADASS and the LGA, where local authorities have the statutory responsibility for the local care market, and making sure that there is provision of care for those who need it. We are working closely with local authorities for that reason.

Q98 **Dr Davies:** I have a query for Professor Jane Cummings in relation to surveillance testing in care homes. What percentage of care homes currently meet the weekly testing that is being sought? What is the reason why that is not 100%, if it isn’t? Allied to that, in relation to the performance of that system, are you happy that the increased pressures that winter may bring will allow performance to continue to improve and not worsen?

Professor Cummings: Thank you for the question. I cannot give you the exact number. More than 15,400 care homes are currently doing testing. Obviously, the number of people who are tested every week varies. To be absolutely accurate, I would have to go and look in detail.

We have had some issues where not all care homes have tested all staff every week. Part of that is because testing is quite uncomfortable, and some people do not like it. They have been influenced by the longer turnaround times that we heard Theresa talk about earlier. However, that is improving and we have seen a reduction in the median time for testing results, which is absolutely vital because we do not want people who are positive to carry on working, or for us not to know about that. I am pleased that those have reduced significantly.

We have written to reinforce the importance of weekly testing. It is very clear advice and guidance from SAGE. We know that it is one of the best ways of responding accurately when people have Covid.

We have been working with the national testing programme to make testing as easy as possible, to allow them to book couriers when it suits them, to get access to training and support and to be able to flag any concerns with us. The national testing programme runs a helpline, with more than 100 people available to take queries. We respond on an individual basis when things are flagged. I often get issues flagged with me as the director who sits in the adult social care team. It is absolutely vital, and something that I spend a lot of my time concentrating on.

Q99 **Greg Clark:** Professor Cummings, on weekly testing in care homes, we understand that there are a lot of care homes across the country, but that is a key target that has been committed to. Surely, you must have a way of monitoring it. Is that not a daily piece of information that you have?

Professor Cummings: We do look at it. As you will have seen from the winter plan, we are developing a dashboard and that is now available. We look at it daily. The Minister, myself and our director general look at it every day. We get results, but we cannot always match a test to an individual care home.

Q100 **Greg Clark:** What is the current performance?

Professor Cummings: I will have to come back to you on that. I do not have it with me. I do not have it at the tip of my fingertips. I would rather give you accurate information. It varies across care homes. I will look at it. We know it is improving. I will come back to you very quickly with an absolute figure so that you have that result.

Q101 **Greg Clark:** You have just told the Committee that you look at it every day. It is a very important figure. It is the key figure, given that that commitment has been given. What is your last recollection of what that figure of attainment is?

Professor Cummings: Let me have a look and see if I can tell you. The best way I can tell you is to look. The last figure I have is that 48% are testing 80% of their residents; 68% of care homes for over-65s are testing at least those. The staff ones I need to try to find—I am looking. I am really sorry. It is quite difficult to manipulate this while I am on Zoom. I will come back to you. We look at it. We insist on that.

Q102 **Greg Clark:** In terms of staff, given that you look at it every day, are you almost there? Is it 90%? Is it half? Is it less than that? What is your feel for where it is?

Professor Cummings: It is well over half and less than 90%.

Greg Clark: Thank you.

Professor Cummings: As I said, there are a variety of reasons for that. One is that staff are on holiday. They might be off sick. They may not be available. We are using the infection prevention control fund to enable staff to come in on days off or to arrange couriers on other days, so that they can access testing. Those staff, as you all know, work incredibly hard and we want to make it as easy as possible for them to access the testing. We are also looking at other technologies so that we can make it easier for them. That, for me, is the absolute priority: do it frequently, make it as easy as possible and make sure that we act on the results.

Chair: Thank you. Last but not least, if the Minister is happy to take a couple more questions, Barbara Keeley and Rosie Cooper have questions to ask.

Q103 **Barbara Keeley:** Helen Spalding, one of our earlier witnesses, talked about the impact on her and her family of taking on the care of her daughter who has a learning disability and physical conditions due to a rare genetic disorder. We heard that all care and support effectively disappeared during the lockdown, there was no guidance about shielding for the genetic disorder, and there was no support for her daughter's mental health; it took three months to get medication. Worst of all, and most hurtful, was reporting that her daughter would not be a priority for an intensive care bed if she contracted Covid.

I know that many thousands of family carers feel the same way. Could you tell us, Minister, what can be done to make sure that families of people with learning disabilities and genetic disorders of the type I have described do not feel so abandoned, and get better support in the second and later waves of the pandemic, because they clearly feel that the NHS abandoned them?

Helen Whately: Thank you, Barbara. I heard Helen Spalding's testimony earlier. I was shocked to hear what she said, particularly the awful thing where she felt that her daughter would not be treated as a priority if she needed to be admitted to hospital and into intensive care. That, clearly, is not how it should be; everybody should be given the care they need as an individual.

Having talked to quite a number of people, particularly carers and unpaid carers, during the course of the pandemic, I know that it has been really tough for that group of people. As Helen and others have said, they found that services were withdrawn, for instance for respite care or day care, because of concern about whether it would be safe for people to go to them, and that it was felt that those services should not continue, particularly as they look after people who are more vulnerable, with health conditions that would put them at risk of complications if they caught Covid.

It has been hard to work out how to support those who are unpaid carers, and those they care for, during the pandemic. We have worked with charitable organisations that support them and helped to fund helplines. We have advised local authorities to contact everybody who receives care, and is supported by an unpaid carer, in their community to see whether they have the support they need.

Q104 **Barbara Keeley:** Minister, could I stop you for a moment? You do not have a national carers strategy and your carers action plan is about to run out. Are you saying that the burden that has been loaded on to families like Helen Spalding's, with the lack of support and the abandonment they feel, is not something that can be addressed in a better way? We did not have good support for carers before, but it has been shown to be completely unacceptable during this pandemic.

Helen Whately: I am not saying that at all. I thought it was helpful to say some of the things we have done to support those in that situation.

Q105 **Barbara Keeley:** You are saying that local authorities have to contact them. That is just moving the issue on to local authorities. Local authorities are stretched as it is, with all the support that they are having to put into the care sector. Perhaps that is something you could take away, Minister; it does not sound as if you have anything to offer the Committee today.

Helen Whately: That particular thing was in response to me talking to people who said that they did not feel that anyone was looking out for them. It was that people could receive support closer to home. A communication from national Government is not necessarily going to help people when what they need and are looking for is support in their local community.

One of the things I have been very actively working on is to support local authorities on the reopening of day services and respite services. What has been particularly mentioned by those I have spoken to who are carers is the loss of those extra support services, which has made life much harder, so we have been supporting local authorities to reopen them, including saying that one of the areas of discretionary spending in the infection control fund could be for some of the extra costs to enable the reopening of those services. Of course, they need to be reopened in a Covid-secure way.

Coming to you, David, I know that the taskforce had a particular workstream looking at support for those who are providing unpaid care.

Q106 **Barbara Keeley:** Before we leave it, Minister, you need a strategy for carers. Can I leave that with you? You need a strategy and a better plan for carers. You cannot just leave support for them like this. I will leave it there, but I am very disappointed in your answer.

David Pearson: We have eight advisory groups supporting the taskforce, looking at particular constituencies, including one for carers, which was chaired by Emily Holzhausen from Carers UK and Philippa Russell, a carer herself. They made a number of recommendations that we incorporated in the plan.

The Minister mentioned day services and the review of carers who are shielding in particular circumstances to make sure that additional support is available. I understand your point about local authorities, but I know that directors of adult social services across the country were extremely concerned, and made a contribution to the effect that there needs to be a further review of people's circumstances in those isolated situations. There is a particular section in the winter plan covering carers, which is built on the work of the taskforce. You are absolutely right that there is lots to do, but there is also quite a bit in the plan for the short term.

Q107 **Rosie Cooper:** Minister, shielding was a fiasco in wave one, with seriously confused messages, resulting in incorrect lists, which left many people very scared, not knowing where to turn. Can you, please, describe the shielding process as you see it now, bearing in mind your comments earlier on the spirit of learning lessons and rapidly applying them? What is the shielding process in each of the tiers, especially tier three? Who is responsible for the messaging? Are local directors of public health involved? Are enough resources going to be given to councils to deal with it?

I have been trying to get that information for days. I have just been told by a journalist that the information is now starting to come through. They said that the information is remarkably vague, it is not specific and it actually says, "Formal shielding rates may be put in place at a later date." This is happening today. For example, 40,000 people in Liverpool have shielded. What is your advice for them? Where are we up to? What lessons have you learnt? What are you putting in place? I would be grateful for a really strong message from you as the Minister for Care to people who, under the current rules, if they cannot work from home, will be forced to go to work and endanger their lives?

Helen Whately: I can start by looking back at the original shielding policy where, as I expect you know, people were identified based on conditions they had which meant that they were expected to be at greater risk if they caught Covid. Those records produced the initial shielding list. In addition, if people were concerned that they ought to be on that list, they were advised to speak to their GP or a hospital doctor, who was then able to advise them and, where appropriate, add them to the list to enable them and help them to get access to the additional support that was available for people who were shielding.

As Covid rates came down, shielding was, in essence, stopped, in the sense that people were advised that, in general, they did not need to continue to shield. Future advice about shielding or a successor to it would be based on a much greater understanding of who is at risk. There were people who were thought to have been at risk earlier on, but now we know much more about the risk factors; for instance, age, obesity, diabetes and things like that are greater risk factors. My understanding is that in future, should there be guidance that people ought to take steps different from the overall social distancing guidance, it will be much more tailored to an individual's health condition.

Q108 **Rosie Cooper:** Minister, you have not answered the question at all. This is happening today, not in the future. You have declared Liverpool as tier three. My constituency is in tier two, on the edge of it. Are you identifying people who are shielding? Have you identified them? Your answer just then talked about the future. I am talking about today. Your Government declared this situation yesterday. What is your message today to people who have serious health conditions? If they cannot work at home, should they be going to work? Who should they talk to? Have you involved the directors of public health? Have you ensured that local councils have the resources? Minister, please answer some of those questions.

Helen Whately: What I can say is that it is incumbent on all of us to follow the guidance that is given to us about the way to behave, including social distancing and the restrictions in each area. As I said, to the extent that the clinical guidance from the chief medical officer and others is that some people should take additional steps to protect themselves, that would be based more, compared with the past, on their personal circumstances and health conditions.

Q109 **Rosie Cooper:** Who should they talk to today? Have you supplied local authorities with enough money and resources so that they can talk to the people in their area? I am using Liverpool because that is the only tier three, but it could be any of our constituencies tomorrow. What are you doing to help the people responsible for those who fear for their lives if they catch Covid? Just saying "Obey the rules" is not enough. Either you have a shielding programme or you haven't. You care or you don't. You said before that you were appalled because everybody should get the care that they need. This is the starting point. How do you keep people safe? It is all right having lockdowns, but what are you doing about people who, in tier three areas, unless you provide some support, will need to go to work because they cannot work from home? Are they expendable to you?

Helen Whately: Rosie, not at all. I cannot provide different advice in this Committee from the advice that is generally available at the moment.

Rosie Cooper: I surrender. We need some decent answers.

Chair: We have to leave it there, because we have run out of time.

This has been the opening session of a big inquiry and it has taken on a very significant issue of social care. We have surfaced some big issues around infection prevention and control, as well as clarity of messaging. The general clear message is the sense in the social care sector that they have been a poor relation to the NHS throughout the pandemic, and a very strong desire from witnesses and, indeed, from Committee members to see that put right soon.

I know you did not give a commitment to a date, Minister, or, indeed, to us having a 10-year plan, but you gave a commitment that you, personally, want to see something like that happen as soon as possible. We will certainly hold you to account on that. We are very grateful to you for your time this morning.

Thank you, David Pearson and Professor Jane Cummings, and we thank Michelle Dyson, who I am afraid we did not hear from today but who has been patiently sitting through the last panel. That concludes this morning's session.