HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Management of the Coronavirus Outbreak, HC 36

Tuesday 19 May 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Amy Callaghan; Rosie Cooper; Dr James Davies; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 446 – 491

Witnesses

I: Adelina Comas-Herrera, Assistant Professorial Research Fellow, Care Policy and Evaluation Centre, London School of Economics and Political Science; Professor Terry Lum, Professor of Social Work and Social Administration, Hong Kong University; and Isabell Halletz, Chief Executive Officer, AGVP (Employers' Association – Care Homes), Germany.

II: James Bullion, President, Association of Directors of Adult Social Services; Professor Martin Green, Chief Executive, Care England; and Vic Rayner, Executive Director, National Care Forum.

Examination of witnesses

Witnesses: Adelina Comas-Herrera, Professor Lum and Isabell Halletz.

Q446 **Chair:** Good morning, and welcome to the House of Commons Health and Social Care Select Committee. Today, we are focusing on the impact of coronavirus on the social care sector, what lessons can be learned from around the world and what long-term changes need to happen to the sector as a result of what we have learned.

We are going to start with half an hour to 45 minutes on lessons that we can learn from abroad. We have an extraordinary panel of witnesses to help us understand it. Adelina Comas-Herrera is from the London School of Economics and Political Science, Frau Isabell Halletz is the chief executive of the German employers' association for care homes, and Terry Lum is the professor of social care policy at Hong Kong University.

You are all extremely welcome, and we are very grateful to you for sparing your time this morning. I will start with some questions for Adelina Comas-Herrera, who wrote a paper for the London School of Economics about what can be learned from other countries around the world about how to protect care home residents during a pandemic. Adelina, in the paper you argue that having large numbers of Covid deaths in care homes is not inevitable, with the right infection, prevention and control measures. Which countries do you think have done that best? What kinds of things are they doing that we have not been doing in the UK?

Adelina Comas-Herrera: The first thing to do is to be able to control the infection outside in the community. Countries that have gone into lockdown very quickly in the full community, and not just in care homes, seem to have had many fewer deaths from Covid-19 in care homes. That is the first measure. If you do not have Covid outside, you do not have Covid inside. The data seems to be bearing that out quite clearly. We will hear about Hong Kong later, of course, which is one of those examples.

Measures in other countries that seem to have worked quite well were very realistic about the ability of care homes to be isolation centres. They were not built to be places of isolation—quite the opposite. They are places of communal living, so we need to be careful about what we assume that, with the best will in the world, care homes can do without additional capacity and resources. By resources, I also mean resources of space; it may be that in some places you need additional buildings and capacity for isolation.

The second thing is to recognise what we know about Covid and update the guidance as quickly as possible to reflect what we know about Covid, which is that it is not like influenza. People can get Covid without showing symptoms. We have plenty of evidence of that from late March from the US, showing that there was asymptomatic transmission of Covid in care homes. It has taken a while for many countries to update their guidance

to reflect that. It also has implications for discharge policies in some hospitals.

If we were thinking of a recipe, we would be looking to have very good awareness of the local levels of Covid, in the community local to the care home. As soon as you have infections locally, you have to make sure that you test the entire care home—residents and staff. You do contact tracing within the care home and ask who has been in touch with the people who potentially have Covid. You make sure that people are isolated, even if they are not showing symptoms, if they have been in contact with somebody. Of course, as I said, you make sure that you can do the isolation properly. We need to think about what that means for the staff—the equipment required and so on.

It is hugely important to have very good co-ordination between all the different levels of government involved in dealing with the outbreak. Many countries have now established national taskforces specifically for care homes, looking at how to reduce infection and make sure that there is good co-ordination at both national and local level with all the different players involved in the long-term care sector.

Q447 **Chair:** We are going to hear about Hong Kong and Germany in a moment. Could you give an example of some other countries that have done this well and some of the specific things they have done?

Adelina Comas-Herrera: Every country is very different in the way they organise long-term care, and even in their traditions of care. For example, in South Korea there has not been a single death of a care home resident in the care home. That is because anybody with suspected Covid was immediately isolated. If they tested positive, they were removed to quarantine centres or hospitals. Not a single person has died with Covid in a South Korean care home. That is an example of how quickly they acted to make sure there was no possibility of transmission within the care home.

Singapore adopted similar measures. They have had some infections, but they acted quickly to make sure that it did not spread within care homes. Of course, those countries had experience of SARS, as did Hong Kong, and we will hear more from Terry about that. Their infection control policies were based not on influenza but on SARS, and perhaps that put them in a slightly better position to deal with this.

Among other measures that have worked was much wider testing in the community. That helped to understand where the local hotspots were and which care homes might be more vulnerable and at risk.

There is one other example in a few countries. I have just read an article from Jordan, but I have also seen examples from China and the UK, where it has been done voluntarily. Members of staff move into the care home, especially when there is a lot of Covid around, and stay there for two or three weeks, and then they are replaced by another team who

have all been tested just before they move into the home for another shift.

Provided that the staff are adequately compensated and there is enough provision to make sure they do not feel forced to do it, that might be quite a good way of maintaining the quality of care that care homes might want to provide. If you can be reasonably certain that you do not have Covid, it means that the residents can continue much more with their normal routines than if you are constantly under suspicion and worried, with staff coming in and out every day.

Q448 **Chair:** Thank you, Adelina. I turn to Frau Isabell Halletz, who represents the employers' organisation for care home providers in Germany. Thank you very much for joining us this morning. Could I ask you about the latest data from Germany about the numbers of infections and deaths in care homes in Germany?

Isabell Halletz: I checked it this morning, because the RKI—the Robert Koch Institute—has a separate evaluation for personnel in healthcare, like healthcare staff, and for residents living in long-term care homes. We have a total of nearly 15,000 infected people living in healthcare homes, compared with 818,000 living in long-term care homes. I would say that is still quite a low number. The total number of deaths is nearly 3,000 people; basically, a tenth died because of the Covid infection.

There is a huge number of recoveries. More than 10,000 old people have recovered. It is a success for the healthcare system that, although so many people were in a very high-risk group, they still recovered.

We also have quite a high number of nurses infected by the Covid virus. We have nearly 1.1 million working in the long-term care sector, and currently 8,560 are infected. Nearly 8,000 have recovered already, which is a good number, and only 42 have died because of the virus. As Adelina said, there are many measurements and many actions taken so that health staff and the vulnerable, high-risk groups do not die because of the virus. We have transferral systems, and quite good pandemic planning about what to do when an infection is discovered, and how to react as quickly as possible to prevent other infections in long-term care homes. We also have very strict rules for health staff.

Q449 **Chair:** The way these numbers are calculated is slightly different in different countries, but 3,000 deaths in care homes is a lot lower than the 12,500 that was the figure for the UK as of a week ago.

There has been a lot of debate in the UK about hospital discharges. What precautions do you take in Germany to make sure that you are not importing coronavirus from a hospital when a patient is discharged?

Isabell Halletz: That was a very hot topic in discussions with the Federal Ministry of Health and the local health authorities. We made it clear, from the experience of healthcare providers for long-term care, that we saw a very big risk for residents living in long-term care from patients coming

from hospitals and from new residents who had not been in the home before. They have either to provide a negative test result or to make sure that people coming from hospitals stay in quarantine for 14 days. They are in separate sections, either in the care home or in separate health facilities like rehab centres. There is a stopover for at least 14 days to make sure that no infected people go into long-term care homes.

Q450 **Chair:** Thank you. I want to bring in Professor Lum from Hong Kong University. Hong Kong is in the extraordinary position of having had no infections and no deaths in care homes, despite being right next door to mainland China.

Your paper talks about what you learned from SARS and MERS, and the 57 care home deaths you had in the SARS epidemic of 2003. Can you tell us what you have learned that has been the key to your success?

Professor Lum: The first and most important thing is to stop the transmission from hospital to nursing home. The first thing is to stop the transmission or the outbreak within hospital. We have been doing quite well in that area. For example, three months, or close to four months, into the epidemic, we do not have a single case of a frontline healthcare professional being infected in Hong Kong. That is an amazing statistic.

Secondly, we do a very good job on isolation. Once a person is infected, we isolate that person in hospital for treatment. At the same time, we isolate all the people who have been in close contact with them in a separate quarantine centre for 14 days for observation. They are regularly tested during those 14 days to make sure they do not have the virus. We have very extensive isolation both for people who are infected and for close contacts. We even use a computer to trace the close contacts of infected people, particularly for cluster outbreaks.

The third thing is co-ordination. After the SARS outbreak, we found that we needed someone in the nursing home to co-ordinate all the infectious disease control. The Government require that all nursing homes have one person, usually a nurse, trained as a professional to handle infection control. That person is the point of contact in all nursing homes to make sure they follow the guidelines issued by the Government or the Department of Health on infection control. That person plays an extremely important role in this outbreak.

The fourth thing is that nursing home operators have a kind of annual fire drill for infectious disease control, which is the flu season each year. Hong Kong is a very congested and dense area. Once a flu virus gets into a nursing home, it will spread quickly, so every single year they do a drill to make sure they can contain any possible flu outbreak in hospital. That drill, year after year, has become a kind of practice. It is extremely well practised in nursing homes. When anybody shows a flu-like symptom, they start the process right away. That contributed to the statistics in Hong Kong; so far, after four months, we have zero infections in nursing homes and zero deaths.

Q451 **Amy Callaghan:** Professor Lum, to follow up what you were discussing, I understand that the measures were implemented so quickly because of the previous plan you had done. How critical was the timing of the implementation of your approach to care homes?

Professor Lum: It is extremely important. I spoke with nursing home operators this morning and asked them about the timeline of what they did. They said they heard about the Wuhan virus, before it was even labelled as Covid-19, and they started the whole process right away. It was in mid or late January that they started the process, even though at that time we did not have a single case in Hong Kong.

In Hong Kong, everyone has a high sense of responsibility after the SARS outbreaks. It put people into an extremely alert state once they heard about something uncertain, particularly in China. From late January, even before the first case in Hong Kong, people started to use face masks in Hong Kong.

If you look at the statistics in my paper, in late January more than 70% of people in Hong Kong were already wearing face masks. By mid-February, 97% of people were using face masks. In nursing homes, they required all staff to wear face masks by late January. By early February, they stopped all outside visits, although that was not required by the Government. They stopped all outside visits to the nursing home in early February. Then they pretty much stopped all activities in the months of February and March. They thought the outbreak was under control by early April, so they resumed small-group activities, such as exercise and cognitive stimulation activities, but they required social distancing and that all participants wear face masks.

In the whole process, people have a very strong sense of responsibility. That puts them into high gear in terms of prevention and protection.

Q452 **Amy Callaghan:** Moving on to a more general question—I am happy for anyone on the panel to answer this—what lessons can be learned from international experience of reducing lockdown, where they are beginning to allow visitors into care homes again?

Professor Lum: The Hong Kong situation is very interesting. We do not have total lockdown in the city. We only stopped the schools, and all business pretty much went on as usual until March, when we had a second outbreak. That was mainly imported from overseas countries, when people returned to Hong Kong. At that time, we stopped gyms and exercise activities. We stopped massage places and bars. Those are the only three areas that we stopped, so we pretty much have everything going on as usual. People worked continuously until now.

Isabell Halletz: I can add some information about Germany. We were very strict with the lockdown. We had a lockdown for four weeks, which started in April and ended by the end of April. We locked down every business, school and kindergarten. We prohibited visitors to care homes,

even service personnel or other health personnel who are not employed at those homes. They had to stay out of the homes in order not to bring any kind of virus, or anything else, into the homes. That was very strict.

We have a federal system, where every state has its own rules and regulations. At the beginning, it was quite difficult to co-ordinate all the different states and local authorities. They implemented a risk team in the high federal ministry, at health ministry level. Every day, they had to report new infections to the RKI. We had very close contact. There were phone calls every day with the RKI—the Robert Koch Institute—which is responsible for giving advice on what to do.

As Professor Terry Lum said, we also had regulations that in long-term care homes we had to wear masks and mouth and nose protection, as well as full body cover, by the end of March. It was not only in the hospitals as before. By the end of March, you had to be fully protected in order to work there.

We are now loosening those regulations a little bit. We are starting to have visitors come back to visit residents in long-term care homes, but this is critical because the providers are very anxious about a second wave. Either the first wave of infected people was not as high as expected or we did quite well with locking everything down. The health facilities did not expect such a small number of patients coming in.

We have separate areas in Germany where there are still a lot of infections in long-term care homes, especially in the south. The RKI referred to many people going to Italy and Austria for skiing and winter holidays, and when they came back they brought in the virus. It was detected too late—not too late, but later probably than in Hong Kong—to stop it spreading at a very early stage, so they are still struggling a lot. Those were the first two states in Germany that already had complete lockdown by the middle of March. It helped the hospitals and long-term care homes to flatten the curve of infections in those areas.

Q453 **Barbara Keeley:** This question is for Adelina and Isabell. I understand the point you make about lower levels of transmission in the community, but we cannot change when we did the lockdown. You make an important point about the need to be realistic about making care homes centres of isolation, when they are actually centres of communal living. You made a point about the value of having members of staff moving into the home.

Given what you know about care homes in this country and the situation we are in, as we exit lockdown and start to relax the guidance, what advice would you give the UK about how we can make our care homes safer? We are still in the position of having 40% of our deaths in care homes. That is far too high a level.

Of all the things that you ran through—you said some interesting things—and given that we cannot change the care homes overnight, what would be the most important thing? Is having step-down or isolation centres

more important? Is having the staff move in more important?

Adelina Comas-Herrera: We have not finished with Covid. It will still be around us for a while, so it is important that each care home—a bit like Terry described in Hong Kong—now starts having good technical support for their isolation capabilities. By capabilities, I mean the fabric of the building, the facilities they have and the staff.

What will happen is that a certain percentage of staff become unwell, because maintaining isolation has extra staff capacity requirements. Each care home ideally needs some technical support because this is a new situation for all of us. We have people who have the expertise, and we can learn from countries that have dealt with Ebola, and other infectious diseases of that nature, about what constitutes good isolation in a building like a care home, for example.

From my point of view, each care home should know how many people they can realistically isolate in their building and within their current staffing levels. Where they cannot isolate all of their residents, should they need to, they need to know where to go and what to do. That is where the extra-capacity alternative buildings would come in. There may be some homes that do not need that at all, but there may be some homes that do. Each one is different.

It is vital that we have a very good connection with local information about the spread of the disease in the community. To give an example, if you are on an island and there are no cases at all, what the care home needs to do is very different from what it would be if they were in what is currently still a community hotspot in another part of the country. It is important that there is very good communication of what we know about the local public health situation, the local data on cases, what care homes need to do, and the level of preparedness and alert.

If you can see that it is coming, drastic measures—like staff moving in—may be very suitable. That is why I think some care homes did it. They could see it coming and they voluntarily did that. There are quite a few examples in the UK. Again, as I said, it is about local information and local responses, and each care home itself will need something quite different.

Q454 **Barbara Keeley:** Following on with quite a small point, are you saying that perhaps each local authority area might need an isolation step-down facility so that care homes could manage that isolation?

Adelina Comas-Herrera: Ideally, yes. If I were to design it, I would have a national taskforce and I would make sure that there was resource so that each care home had some technical support and understanding of what they needed. It could be communicated through the local authority, and they could say how much extra capacity they think they would require. That is how I would see it.

Isabell Halletz: From what we experienced, it was very crucial and helpful to have pandemic planning, and information about who was doing what in what situation and who was reporting to whom. It was mandatory for every healthcare home to set up that kind of planning and to know what to do when. It was not only if people were infected but for prevention.

What was also helpful was that other parts of the economy stepped in. For example, rental car companies offered free rental cars for healthcare personnel and staff to drive, in order to reduce the possibility of getting infected when taking trains or buses. That was very helpful for the healthcare personnel.

It was also helpful to have recruited people who had left the area, former nurses now working in other professions. They had quite a broad recruitment strategy to motivate those people to come back and help out.

We had the support of the German army. If there was a shortage of health personnel because of an infection or other causes—sometimes people get sick without catching the virus—we could contact the local health authorities and ask for army medical staff to support and keep up the care in those healthcare homes.

Q455 **Chair:** Isabell, could you confirm that it is the case that German care homes would not accept patients discharged from hospitals unless they had the ability to quarantine them for two weeks? Is that right?

Isabell Halletz: Yes, that is right. At the beginning, in February or March, there was not that strict regulation. There were still referrals from hospitals to long-term care homes, but the experience was that patients coming from hospitals had a very high risk of bringing in the virus, even though they did not show any symptoms. The regulations were that you were only tested if you had symptoms.

We finally changed that last week. We fought for that. We now have tests even if you do not show symptoms. It was very important for health staff and for providers to be able to test people not showing symptoms. That is what we asked for. Either you have a separate section where you isolate people for 14 days, or you do a stopover in rehab centres, or even in hotels that have been reorganised. Sometimes they use huge halls for the stopover, where the local authority has made little hospital areas to make sure people do not bring the virus into residential care homes. If it is in the residential home, as Professor Terry Lum said, it is very hard to stop the virus. When you detect it, it is already too late, so you have to do a lot of prevention to keep it out.

Q456 **Dean Russell:** In the UK, we are now in the process of starting to ease lockdown measures. I want to understand what can be learned from the international experience, where other countries such as Germany and Australia have started to reduce their lockdown, in particular around care homes. Where are they beginning to let visitors back in? What is the

process for that? What can we pick up now that we can implement, moving forward, to protect people in care homes, and to learn more broadly around the lockdown measures?

Professor Lum: In Hong Kong, nursing homes started to take away lockdown on Mother's Day, to allow people to visit their mothers. They designate an area in the nursing home as a visitation area. They allow a family and a resident to meet there. Before they can get into the nursing home, they have their body temperature checked and they need to follow strict protocol for hand sanitiser. They need to wear face masks when meeting each other. The nursing homes are starting to go back to normal as of today. Since Mother's Day, they have been getting back to normal. So far there is no infection, touch wood. Another one for society is that our high schools will soon have face-to-face classes—next week—which is big news for Hong Kong.

We have become very accustomed to wearing face masks. I would say that 98% of people in Hong Kong wear face masks. Hand sanitiser is a must. We have a protocol for when you have been outside. In my family, for example, once I get into my house, I take off all my clothes, wash my hands, throw away my face mask and then take a shower before I touch my family or do anything else.

As I said, there was a sense of responsibility after SARS. We know that, if you get infected, it is not only you; it is the whole family and then the whole extended family. People are extra sensitive and careful about not bringing the virus into their home or into their workplace. As long as we keep that kind of attitude, Hong Kong should be okay.

Another thing I want to share is that transparent and reliable scientific information is extremely important. For example, in Hong Kong we have several people who led the fight against SARS in 2003. They are still around and still active professionally. They have become authoritative figures who tell people what to do. Sometimes, they even advise against the Government. For example, early on, the Hong Kong Government said that you should not wear face masks. The medical doctor who led the fight against SARS said, "You need to wear face masks." He said that everyone needed to wear face masks, going against the Government. Later, in mid-March, the Government changed their stance and said, "You need to wear face masks even though you do not have symptoms."

We have several people who take that authoritative position in the Government, but most of them are professors or medical doctors. They use scientific information and explain it in a way that most people can understand. That is extremely important in bringing Hong Kong people together to fight this battle.

Q457 **Chair:** Adelina, do you want to come in on the things to look out for when lifting the lockdown?

Adelina Comas-Herrera: We had a webinar yesterday when somebody from Australia gave a presentation about how they are now starting to relax the restrictions on family visits, particularly in care homes. She shared some resources. I am waiting for the final version of the slides and the video, but I would be very happy to share that. She went into quite a lot of detail and shared some of the policies that care homes are putting in place to ensure that family visiting is safe.

I stress that there is a difference between visitors and what I would call family carers. Quite often people in care homes still receive care from relatives, who probably visit daily. It is disruptive for people in care homes, particularly if they have dementia and they do not understand why their relatives are no longer coming to see them and why they have to see them, at best, through the window. It is very important to appreciate the huge emotional wellbeing cost that has on people in care homes. It is especially important that we make sure family visits are safe. In the same way that we can make care home staff safer, we should also be thinking about how that applies, as Terry illustrated, to family visits.

Q458 **Dean Russell:** Isabell, every country seems to be dealing with this slightly differently, especially when coming out of lockdown. Do you get a sense that globally there is a dialogue and that different countries are sharing best practice, or is everyone trying to go it alone?

Isabell Halletz: There is at least a sharing of experience within the EU Commission. There is a separate committee in the EU reporting on who is doing what. They have regular telephone calls and conferences to share who is doing what and when, and how to learn from each other.

Globally, I am not sure whether the WHO is somehow co-ordinating a form of communication. I have not joined that kind of meeting yet. I like sharing experiences, as in this session, because it is something we can all learn from. We all have different experiences, and it is very helpful to exchange.

Q459 **Dean Russell:** From your perspective, I suppose those learnings are quite public. Would you say that scientists are broadly sharing what they find?

Isabell Halletz: That is what they do, yes.

Q460 **Dr Evans:** My question is for Adelina. It is a gut feeling. We are learning a lot from all the different types of care homes. Every country is in a different position. The temptation is to want to compare. Which care system broadly represents the UK as a best comparison? Is there a way in which, looking wider across the world, private care homes with a certain insurance-based system do better than those with a national base? Do you have a gut instinct of where that seems to be?

Adelina Comas-Herrera: I think countries that have public financing involvement for every care home resident—Germany, South Korea or Hong Kong—know how many care home residents they have, their age

and probably their health status. They have regular assessments because of the insurance system. They understand their levels of need and how much funding needs to follow from that.

In the UK, we are a bit more like the US, in the sense that many people are paying entirely. About 40% of care home residents are self-funders, so there is no public data on them individually. We do not have that information. We also do not have anything like a care home minimum dataset in the UK yet; I think there is in Scotland, but not in England and Wales. We do not know about those people. We do not have numbers for them. I am trying to work out what share of care home residents have died in England, and I am struggling to find out the number of care home residents in England now and their age. Because of that, we cannot put the numbers into a model. When we have a model, for example, for the whole population, we will have a whole set of people for whom we actually do not know very much at all.

In terms of planning, information systems are crucial. If you already have an information system in place, it is much easier to track what is happening when there is something like this pandemic. I emphasise the fact that, if there is no public money going in for quite a big section of care home residents, it is very hard to have systems in place to make sure that the public sector and the health sector know how best to support them.

Q461 **Dr Evans:** Do you perceive that there is a difference in the way in which, broadly, private versus public or different countries can group together? Although there are individual circumstances, apples and pears—if I use fruit and veg—when grouped broadly is there a different approach and different success rates? I know it is hard without the data, but what is your gut feeling, as it is your specialty?

Adelina Comas-Herrera: At the moment, it is very difficult to make that sort of judgment. The things that are clear with the current level of evidence are more to do with the level of infections in the community and then in care homes. We have a lot of issues with the data in terms of knowing how the numbers of deaths or infections in care homes are counted in different countries. Then we have an issue of knowing what to compare that with. At this stage, I could not firmly say that the way we finance care is affecting success in fighting Covid, but I would say that it is definitely affecting our ability to keep track of what is happening.

Q462 **Dr Davies:** If you want to tackle a problem, you need to know how bad it is. Adelina made the important comment earlier about the number of asymptomatic individuals among the elderly population. I have seen evidence of testing locally, where large numbers of individuals in care homes who were not thought to be carrying Covid were in fact carrying it.

Do you think there needs to be much more awareness of the fact that the signs and symptoms of Covid in the elderly are not necessarily limited to a cough or a temperature?

Adelina Comas-Herrera: It is very important to update the guidance for England to make sure that is fully reflected and communicated to all care homes and that it is influencing how we prioritise testing. If I may say so, the change in guidance has been quite slow in recognising asymptomatic transmission, particularly in England.

Q463 **Chair:** Professor Lum, as my final question in this section, could you answer this? You said something very striking in your earlier comments that I have never heard before, which is that there has not been a single infection of frontline healthcare workers in Hong Kong. We have been talking about care homes, but are there any broader lessons that you learned from SARS and MERS about frontline healthcare workers that you could briefly share with us, because that is extraordinarily impressive?

Professor Lum: First, we know that older persons are more vulnerable to the virus. Even worse, once they get infected, a lot of them will need intensive care and eventually a mechanical ventilator. The first way to protect frontline healthcare workers is not to overwhelm the system. It is extremely important not to get the virus in care homes.

It is an interesting phenomenon. You want to protect frontline healthcare workers, but in order to do so you do not want the virus to get into the care home. Once it gets into the care home, it will spread among older people really fast. A lot of older people get into the care system and then go into intensive care, and the intensive care room is overwhelmed. Then they need to use negative air pressure, or to deal with the infection at an isolation or treatment centre. Once they get into that situation, the virus will spread within the hospital. That is exactly what happened in the SARS outbreak.

The second thing is to trace all close contact people so that we know, when people come in, whether he or she has had close contact with someone who has had the virus before. In the Covid-19 pathway of infection, the virus load is highest on the second day after infection. At that time, the symptoms have not been showing up yet. It is not as simple as the contaminated patient. People who get infected are highly infectious even before they have symptoms, so, if we did not know whether a person had had contact with a person or patient before, we should not admit that person into a regular ward. That would eventually lead to an outbreak. The second thing is to make sure that does not happen.

We learned a lot about the potential spread of the virus. They make sure they have enough personal protective gear in the hospital. The good thing is that in Hong Kong, because of SARS, we have enough stock in hospitals as well as in nursing homes. For example, in nursing homes they usually have about one to three months' stock of face masks or other personal protective equipment. That is important. It allows them about three months to prepare for the worst. That three months gives us the opportunity to manufacture masks in Hong Kong, as well as purchasing high-quality equipment. Those are essential things.

Lastly, as I said, there is a very high sense of responsibility in Hong Kong. About 20% to 30% of patients infected by SARS were medical doctors, nurses or frontline workers. Several doctors passed away because of that. It was a very painful experience, so we try everything possible to stop infection within hospitals. By doing so, we are able to shut down the chain of transmission from hospital to nursing home, and we are able to protect a large number of older people in nursing homes from getting infected. As a result, we do not overwhelm the care system.

Chair: Thank you very much indeed. We are now going to say thank you and good bye to Professor Lum from Hong Kong and Frau Halletz from Germany. Thank you for joining us, despite how busy we know everyone is at the moment. Adelina is going to join us for the next session, as we welcome more witnesses and move on to a detailed examination of the situation in the UK at the moment.

Examination of witnesses

Witnesses: Adelina Comas-Herrera, Professor Green, Vic Rayner and James Bullion.

Q464 **Chair:** I welcome Professor Martin Green from Care England, which represents the largest care home providers, Vic Rayner of the National Care Forum, representing not-for-profit care homes and domiciliary care providers, and James Bullion from the Association of Directors of Adult Social Services—he represents all the people in local authorities who are responsible for the delivery of social care.

For the first question I will stay with Adelina, because we want to do a little bit of a stock-take as to where we are right now in the social care sector, particularly in care homes. Adelina, the official figures so far are that we have had 12,500 Covid deaths in care homes, but some of your colleagues at the London School of Economics say that it is more likely to be 22,000 deaths in care homes, which would mean that one in 20 of all care home residents in this country has died from coronavirus—a very shocking figure if it were true. Could you tell us why you and your colleagues think it might be that high?

Adelina Comas-Herrera: We looked at the ONS data for excess deaths in care homes; when I say excess, it was compared with 2019, using data that the ONS published last week. We started with an initial set of figures earlier in the week and then they published new figures on Friday, so this weekend we updated our estimates based on their results. The number of care home residents who died up to 1 May, and registered by 9 May, would be 22,231. That is for England. Yesterday, some colleagues published data for Scotland, and the report is now on the web, but I am not as familiar with it as I am with the England one.

My colleagues at LSE and I are focusing on excess deaths because we are aware that while it is very important to know the number of people who died with suspected Covid, or where Covid is assumed by the doctor to be

the cause of death—or maybe there has been a test—it is also very important to be aware that it may not always be as apparent, especially from the symptoms of people living in care homes, that they do indeed have Covid. There may be some under-reporting when we consider the official figures where Covid is mentioned in the death register.

There may be other deaths that are to do with the fact that care homes may not be accessing healthcare in the way they would normally, so people are not being transferred as much as they used to be. They may not be getting more routine healthcare to monitor people who have all sorts of other health conditions, which is probably why they are in the care home in the first place. There may be less access to what I would call the usual healthcare that people get, and there may be other deaths that are related to the lockdown measures. We do not know. It may be that people who no longer see their relatives decide to stop eating, for example, because they are depressed. That might happen in people with dementia, for example.

We know that many more people have died this year than the same time last year and that the difference is about 22,231, which is about 55% of all the excess mortality we have seen in this period in England. That would mean that, if we used the metric of excess deaths to look at the whole impact of Covid, direct or indirect, we would say that more than half the deaths in England have been among care home residents.

Q465 **Chair:** Are you saying that the 22,000 figure is the excess deaths you think might be linked back to Covid but that it could be higher than that—that the total number of excess deaths is more like 40,000? Is that right?

Adelina Comas-Herrera: No. It would be how much more mortality we have had in this period than usual. That would be, I think, the higher range, the highest number we would probably see. There is always some uncertainty and we will see what happens when we get more up-to-date information. Even today, there may already be some new data coming out.

Q466 **Chair:** The ONS numbers also say that just under 40% of all Covid deaths have been in care homes, and that—

Adelina Comas-Herrera: May I clarify? There is a difference. If we look at deaths in care homes, which is different from deaths of care home residents, we get a different figure. The ONS figure was deaths in care homes and the one I gave you was deaths of care home residents, which includes care home residents who died in hospital. That is why there is a slight difference.

Q467 **Chair:** Thank you very much. Could I bring in Professor Green? First, in terms of the situation that we are in now, do you think the R rate in care homes that have the virus is above 1? Is it still growing exponentially, or are we on a downward curve?

Professor Green: We are probably at the top of the curve and, hopefully, heading downwards. Part of our challenge has been that we have not had appropriate real-time data, so it has been very difficult to keep a handle on some of the things that have been going on in real time, and we are often a bit behind the curve when we get our data. Then we have to second-guess where the data is going to go next.

Q468 **Chair:** On the situation now—we will come to broader questions in a moment—the Government commitment on 28 April, several weeks ago, was that testing would be available to all staff and residents in care homes. What are your members telling you now about the availability of testing, as of today?

Professor Green: Our testing is improving, and there is certainly more testing around, but there are some logistical issues. For example, people often find that their tests do not arrive on time or, indeed, are not taken away on time. There have also been some significant time delays before people get results; we are looking sometimes at eight or 10 days before people get results.

Testing is not a one-time occupation. We need to have regular testing. It has to be done two or three times a week if possible, so that we can really get on top of this. The evidence from some of our international colleagues shows us that we need a clear approach to testing; it needs to be very swift and regular.

Q469 **Chair:** The Health Secretary has said that he wants to move to routine testing of frontline care staff and NHS staff, but have you had any indication or sense that that is going to start any time soon?

Professor Green: We have had the announcements, but so often with the announcements there is a time delay before delivery. I think the intention is there, but it would be very helpful to have both testing and track and trace in place because that could be a game changer. The short answer is that we have had the announcement. What we have not had is the delivery, and we are not really clear when that is going to arrive.

Q470 **Chair:** Presumably, you were listening to what Professor Lum was saying in Hong Kong, Frau Halletz was saying about Germany and Adelina's general analysis. What are the things that strike you most as things we should have done here and, if we are not already doing them, that we need to start doing as soon as possible?

Professor Green: The first thing that came out from the evidence we just heard is that we should have been focusing on care homes from the start of the pandemic. What we saw at the start was a focus on the NHS, and that meant that care homes often had their medical support from the NHS withdrawn. We also had disruption of our supply chains for PPE.

Another interesting thing about the statistics was that we did not see anybody who might have required a hospital intervention going to hospital. That was not only about Covid; it was about other conditions as

well. I think that is why we see from Adelina's figures that the numbers might be much higher of people who had things that were not Covid-related but who would normally have had a hospital intervention, and that did not happen. We also saw people being discharged from hospital when we had not got the testing regime up and running.

Despite what has been said, there were cases, I think, of people who either did not have Covid-19 status or were symptomatic and were discharged to care homes. Given that the care homes are full of people with underlying health conditions, we should have looked at focusing on where the people at most risk were, rather than thinking about particular organisations, when we were prioritising where we put our energies.

Q471 **Chair:** Vic Rayner, you represent not-for-profit social care organisations. What were the things that struck you most about the evidence that we heard from Germany, Hong Kong and around the world?

Vic Rayner: It was very interesting to hear their experience. Obviously, we have been connecting up with international colleagues as well, to try to make sure that we are learning from across the globe.

A number of things struck me. In Isabell's evidence, there was very clear recognition of the need for a partnership approach at both national and local level with those providing care. I was struck by her comments when she talked very clearly about how providers of long-term services had been able to have a very important impact by being able to negotiate and discuss some of those conditions, around discharge particularly.

Those were areas that we had been raising very strongly with Government and colleagues across NHS England from an early stage—the need for testing and the need for adequate PPE, et cetera. There is something very important about partnership that we need to learn as we move forward. Lots of the things that Adelina and other colleagues are talking about in terms of the approaches that people have taken globally are in place across the UK, but in individual care homes.

There are lots of examples from our membership where people have tried to remodel services—for example, where they have tried to set up particular isolation areas or utilised different floors in homes to enable the separation of people who are Covid positive and those who are not. People have tried to develop specific teams who might work with those who are Covid positive and those who are not. People have taken a variety of different approaches to the way they work, to ensure the safety and support of those they are looking after and those who are working in those environments, but those have not been picked up on a national basis. Indeed, the resource that Adelina talked about has not flowed with that understanding.

The majority of our care home stock is 20 to 30 years old, if not older in some cases. They are buildings that were set up for people to come together and share space, which means that, if you are to isolate people

meaningfully in those settings, you probably have to do it at below your current capacity; you have to take some of your capacity out of usage to enable that to happen. Of course, to do that as an independent organisation, whether you are not for profit or for profit, there will be an impact on your resource level, on your funding level and on the funding and the resource needed to flow to enable organisations to do that. Many of the workforce restrictions that Adelina talked about have been included in the care home intensive support plan.

Q472 **Chair:** We will come back to funding shortly, but first I want to ask James Bullion a couple of things. You came to speak to us at the end of March, so welcome back.

First, what struck you, listening to what is happening in other countries, as things we are doing and things we need to be doing? Secondly, we had quite a long discussion when you came at the end of March about the issues with PPE in the social care sector. Do you think they have been resolved or are you still worried about them?

James Bullion: What struck me about the contributions earlier was the degree to which data testing and the integrated approach that systems are taking was not able to be replicated here in the UK. Partly, as Vic Rayner says, it is sometimes about the local nature of the way care markets and social care are operated in this country, but we lack an infrastructure for social care that would have benefited us in implementing things like testing or distribution of PPE, for example.

A second thing that struck me was how we did not quickly enough take into account the risk of symptomatic or asymptomatic transmission, both from people coming out of health settings into care settings and among the staff working in our care sector. Some of that is to do with the knowledge that we had of Covid-19, but some of it could have been anticipated by the previous planning on pandemic flu.

In relation to PPE, I was very concerned when I came in March—I am still concerned actually—that PPE is the single biggest and most expensive factor in the cost of dealing with Covid in adult social care, both for providers and local authorities. We still do not have an effective supply chain, although the situation has improved since March.

I can track from when I was here before an initial perspective from local government stepping out of the way and suppliers sourcing their own, through to local government and local resilience forums being the supplier of last resort, and now through to local government being a sourcer of supply. For example, in London there is now a consortium of councils and providers sourcing PPE. If we had had a national position on PPE that had even made it free, with local government sourcing it, or had made it paid-for and local government sourcing it, we would have been far ahead of where we are now. Some of our problems around transmission no doubt relate to PPE and, very sadly, some of the deaths too.

Q473 **Dean Russell:** Obviously, care homes are an essential part of this, but there is also the wider home care sector. I want to know the situation regarding PPE testing and managing Covid-19 in the home care sector more broadly, because that affects an awful lot of people and staff, too.

James Bullion: I am pleased you have made that point because it was one of my points to make to you as a Committee.

Actually, when we look at the figures, both for deaths, very sadly, in the community and for transmission and outbreaks, we have a significant problem in home support. If I have a gentle criticism of the recent funding for infection control, it is that we are almost tagging on home support in that recent plan to say, "Oh, by the way, councils, try to do something with some of this money for home support." The response so far is completely inadequate. We need a separate plan for home care to protect the staff and to protect people, as we are not finished with waves of Covid in the social care sector, in my view.

Chair: Home care is obviously a very important issue.

Q474 **Paul Bristow:** I want to explore access to testing among personal care assistants and domiciliary care workers who visit clients in their own homes. Before I do, I declare an interest in that my wife owns a communications consultancy that has clients in the social care sector.

I am hearing anecdotal evidence about clients who receive care at home refusing to allow personal care assistants and care workers to visit them. Obviously, they are scared of infection. On a personal basis, I have experience of that with my father who died relatively recently. He was very ill and received personal care.

I want to understand whether you are hearing the same. Are personal care assistants and care workers who visit clients in their own homes getting timely access to testing, and will communicating that more widely reassure clients who receive care at home?

James Bullion: There is a huge part for testing to play in reassuring both staff and people in receipt of care that the person coming into their home has had a recent test and a result that says they are negative. There is not widespread testing; it is growing, but the care workforce is 1.6 million in this country, so we are nowhere near the level of testing required.

In relation to the first point you raised, in our quick survey of ADASS members we have seen about a 10% incidence of people switching off their personal care, either home care or personal assistance, and almost furloughing it while they protect themselves because of those worries. There is a kind of mirror potentially going on in home care of the deaths in care homes. They may be being caused by people taking action to protect themselves from infection but not necessarily taking care of their health and wellbeing in the intervening period. We need to look at that as we look into Covid in the future.

Q475 **Barbara Keeley:** On sourcing PPE, the existence of the combined authority in Greater Manchester actually allowed joint procurement and mutual aid, so that is a good example of how it worked, which is the point James was just making.

What do we know, given what we have learned so far in this session, about how outbreaks in care homes have begun in England? Today, there is an article *The Guardian* pointing to the use of agency staff as a definite factor in spreading Covid-19 in some care homes. How important a factor is that versus the other risks we have talked about, such as the admission of residents discharged from hospital without testing? Perhaps bearing in mind that in an ideal world we would not want to use agency staff—we have 122,000 vacancies across the care sector—but if we have to use agency staff, how can what is reported in *The Guardian* today be avoided? How can agency staff causing that problem be avoided?

Professor Green: The short answer is that we are not really clear which were the biggest routes of transmission. At the start, we did not have comprehensive testing, so we did not know who was Covid-19 positive. Obviously, though, if people had come out of hospital and they did not have a test, that was a great danger.

Similarly, agency staff moving between care homes is another danger. If we are to make sure that that does not happen, we might have to make sure that agency staff are restricted to one or two sessions in a particular care home rather than moving between care homes. There are obviously financial implications of that.

The point you made, Barbara, is a really important one: before this pandemic we had staff issues, so, if we are going to reduce our capacity to use agency staff in the way we have done in the past, we have to upscale our approach to filling gaps in the system. The Department of Health and Social Care has developed a new approach to the recruitment of care sector staff, so, hopefully, that should be able to plug some gaps, but it is going to be extremely difficult, given the numbers of staff who are having to self-isolate, and that might only get worse when we have both comprehensive testing and track and trace. We have to apply ourselves to how we deal with staff issues in care settings because it will become an increasing problem.

Vic Rayner: To add to Martin's points, we know that we are in a position of sustained transmission; there is clearly Covid across a wide range of communities. It goes back to the point about having the right level of focus on data and the information points at a much earlier stage so that we could have pinpointed it.

Martin mentioned the testing of symptomatic and asymptomatic residents, which started last Monday. We know there are only 30,000 tests a day. Even in the Government's reckoning, that will enable us to test all those care homes by early June, but that is only one lot of testing, not repeat testing. That means you do not have all the right tools and

resources to manage outbreaks in homes or to identify where and when infections might have come into those homes. It is incredibly challenging for providers to operate in that climate.

I know the Committee is interested in thinking about how we address a second wave in care homes. It is absolutely critical that we get repeat testing and are really clear that all staff members, whether they are agency staff or directly employed by the homes, have regular, frequent testing, and that the results come through in a timely fashion so that homes can make proper decisions about who can be there and who supports them.

The challenge in all the discussion, with or without that data, is that we end up in a position where staff who have done a most extraordinary and incredible job of supporting people in this very difficult climate end up feeling like they are the people who are responsible for the spread, which is the last possible thing they would want to do, whether they are agency or employed. It is really important that we do not get into that narrative.

Chair: We are going to come on to workforce issues in a moment.

Adelina Comas-Herrera: There are quite a few countries where staff have been banned from working across more than one care home. In Ireland it is a recommendation. In Israel, Canada and Singapore it is banned. As was said before, that has huge implications for regular staffing in care homes. Quite a few countries keep staff ready to go into care homes when the staffing levels are reduced, and that of course requires quite a lot of co-ordination and an understanding of who is going to fund those rapid responses.

I emphasise the importance of contact tracing for staff. So it is not only testing; the testing needs to be linked to contact tracing both for home care staff and staff in care homes.

Barbara Keeley: On Vic's point, it is very important that we say, and I certainly want to say, that I am very grateful to the care staff in my local authority area. In the homes that have had deaths and outbreaks, they are doing a remarkable job and we should all keep saying that as much as we can.

Chair: Absolutely.

Q476 **Dr Davies:** We have heard about the importance of isolating cases in care homes. One difficulty that strikes me is that many care homes in the country are converted older buildings; they are not purpose-built. To what extent is that the case percentage-wise, and is there an argument that, going into the future, there should be planning regulations in place, with an arrangement to provide en suite facilities and so forth, so that we can provide isolation more easily in future circumstances?

Professor Green: We should acknowledge that there are lots of care homes, as you say, that are, in effect, at the end of their shelf life, and

there needs to be a big investment strategy. We have to look at that in terms of the future, but it would have been great to have had some kind of database that identified the care homes that had the capacity to do more isolation and the ones that did not.

The other thing that came out of the previous evidence session is that we had a policy of emptying hospitals and filling care homes, but in some countries, when people were symptomatic, they were taken out of care homes into isolation facilities. Given the nature of the stock we have, we should probably have looked at that as an option as well, so that we could have made sure that, if there were people who had the virus, they did not stay in their care home if that care home had difficulty isolating them.

Q477 **Rosie Cooper:** Professor Green, you recently argued that key social care recommendations following Exercise Cygnus were not implemented. The core question is whether enough pandemic planning was done within the social care sector. Perhaps I could tack this on. Earlier in one of your answers you mentioned the delay in testing. Are you aware of a critical number of test results that come back unclear, which people take to mean that the tests were lost?

Professor Green: In terms of the test results coming back, one of the challenges has been that people have had situations where their test results have been lost; they have also waited a long time for those test results. Then, of course, we are unclear whether or not the test results are current, so they might have to go back for other testing. That is a real challenge.

In terms of where the pandemic planning was, one challenge was that the pandemic planning did not comprehensively overview social care and did not understand that social care was a very diverse bit of the system, and the pandemic planning that was focused on the NHS clearly worked better than the elements that have been rolled into social care. One of the challenges has been that our focus in previous pandemic planning was much more around the NHS.

Our focus at the start of this pandemic was clearly the NHS, and there was no recognition in either the planning process that happened in 2016 or, indeed, at the very start of the current pandemic that the most vulnerable people were in care homes, so we should have prioritised care homes both in the planning that went on for 2016 and in the planning that went on at the very start of this pandemic. We saw in the examples from Germany, Hong Kong and Singapore that when you focus on the central area of care homes, because there are so many people in the high-risk group, you can retard development of this virus.

Q478 **Rosie Cooper:** What changes do you think need to be made to ensure that social care is better able to stand a second wave of Covid-19, should that happen, as we expect?

Professor Green: The first thing is that there has to be a significant upscaling of support from the NHS. The NHS must not withdraw, which it did at the start of the pandemic. We saw lots of community services and community nurses being taken out of care homes, and some GPs said, for example, "We're not going to come to a care home and we're not going to even consider taking anybody who is in a care home to hospital." There has to be some clear focus in that context.

We also have to get the PPE issue sorted out. At the moment, even now, we are still in a position where people are not getting enough PPE. First, we need to have the commodities of PPE. Secondly, we need much clearer guidance delivered by Public Health England and others. The third thing we need is a national strategy on this.

The idea of localism is all very well in the best of times, but what we have seen in this pandemic is that it is not fit for purpose when we are in a crisis. We need clear central direction and some clarity about how care homes will be supported by the NHS, how they are going to get their PPE, and how track and trace can be linked to a testing regime, which needs to be focused on care homes. We also need real clarity about how we sustain those organisations so that they will be able to come out of this and still provide services in their locality.

One of the things we saw, and the data that Adelina gave clearly showed, is that we will have severe problems around the numbers of people in care homes, which will translate into significantly less income, so some of those services might find themselves going under. We must have a strategy, and it needs to be a national strategy, to get the money directly to the frontline. When all that has been achieved and we have moved out of this, we can have a forensic examination of what we need to do in the future to make sure it does not happen again. We can also have an examination of what needs to be local and what needs to be national.

Chair: That leads very nicely on to the other area we wanted to talk about in this section, which is the funding issue, not the long-term funding issue in the social sector, which we may come on to, but the short-term crisis. We heard a story this morning about a care home that says it is going to close down because of coronavirus and financial pressures. We should ask you about that, Professor Green, and James Bullion from the local authority side.

Q479 **Sarah Owen:** Yes, this question is for James Bullion and Professor Green. As well as coping with Covid-19, councils across the country are facing another year of cuts. My council, Luton, is no exception; it is currently facing a devastating financial impact of £49 million due to the pandemic and loss of revenue. Do you think local authorities and the care sector have the funding they need to cope with the immediate pandemic, a possible second wave and the shortage of carers?

Professor Green: The short answer is no, but part of the other issue for me is that when the £3.2 billion was allocated there were clear messages

that it should be going to the frontline of care. That was what we as care providers heard. Our colleagues in local government, because of the pressures on their budgets, saw the money in a much broader sense around some of the other things they had to do.

One of the challenges has been that the Government have not been nearly specific enough about where the money needs to go. There seems to be no clear audit trail. In my organisation, some of my larger providers might deal with a hundred different localities, and 60% of those localities have not come to talk to them, never mind given them money. I can supply the Committee with an extensive list of where those areas are.

One of our challenges is about local authorities. I really feel for them, in that they have so many different requirements and pressures, but care providers, particularly in the midst of a pandemic, need the money to make sure that the safety of their residents and staff is the top priority. They need the money so they can cope with things like enormous increases in the PPE bill. They also need the support of the NHS, as I have said. Even if you have not had that money, you should have an expectation that you will get it. I think the LGA and ADASS said there should be an expectation that you will get 5% for normal cost increases, although of course the living wage went up in April by 6%, and then 10% more for Covid-related costs. In many areas that has not happened.

James Bullion: First, on the broader question about whether it is enough, we have calculated, in the Local Government Association and the Society of County Treasurers, for example, that in the broad picture for local government, it may be as little as a quarter of what is needed because of the impact on wider services for local government, which includes loss of income, children's social care and so on. Specifically in relation to adult social care, I do not think the amounts within the £3.2 billion allocated to adult social care have been enough.

On the money getting to the frontline, there is of course an issue of timing. We got the money in April and here we are on 19 May. You would expect some delay in some areas sometimes in getting the money through, and I acknowledge that that has happened in some areas. Our recent survey of our members shows that actually the money is earmarked for adult social care providers, but the pattern in which local government operates has differed across the country. About a third of councils, instead of allocating money straight out to providers, have said, "Come and have a conversation with us and we will meet all of your costs." There are examples of that taking place. Other councils have given a 6% increase and held back money to have a further conversation about costs, and some councils have gone for a straightforward 10% increase in costs.

There is firm evidence, though, that councils are paying on account; they are paying whether the care is received or not, and they are paying in advance. The indication from our members is that about 10% of money

will have been paid out to providers, in addition to normal payments, in April. Because of the distributive nature of local government, as Professor Green explained, it is not easy to aggregate the evidence, but if you look at the national capacity tracker data for occupancy levels in care, which were relatively stable until last week, there have been a few instances of providers who have come forward to express worries about business, but we have not seen collapse. We are working very hard to make sure that that does not happen. I think local government has stood up well; it has provided PPE and it is providing co-ordination on testing.

The one area of perhaps sharper disagreement between myself and Professor Green is that I think what works is local, not national. Nationally, approaches to testing and PPE have been very challenging. Where it has worked well, it is local government and the local NHS coming together to protect social care, and that is the model I encourage the Committee to look at.

Chair: We want to leave some time to talk about longer-term lessons for the social care sector but, before we move on to that, it is very important that we spend a bit of time on the social care workforce and the extreme pressure that they have been under.

Q480 **Taiwo Owatemi:** Given that the social care workforce is under a lot of pressure, what are the main issues currently affecting the workforce at the moment?

Professor Green: I think the issues are the enormous pressure that people are under. Lots of people are self-isolating, so the staff who are in have significant pressures. There are also big issues about, for example, transport; people do not want to use public transport. In fact, there was a point made in the previous evidence session about some organisations outside the care sector who have stepped up. Six car rentals spoke to me many weeks ago and have provided cars for some care homes so that they can transport their staff. There was also an offer from some hoteliers of accommodation if staff did not want to go home. I think staff are worried about, first, bringing Covid-19 into care homes and, secondly, the potential to take Covid-19 back to their families.

There is also the worry that they have around PPE. In some areas, that has been extremely problematic and still continues to be. It is a really big issue; people are concerned about that. They are also concerned in the workforce about the fact that they have had endless guidance from various different agencies, much of which has been changing by the day, and, frankly, I do not understand why. We need clear guidance from Public Health England. What has come out of this for me is that Public Health England understands the NHS but does not understand the social care workforce and what our needs are. There are some issues there.

Going back to something James said, care providers are desperate to pay their staff more, particularly the ones who are able to work and have shown the most amazing commitment. The reality is that we need the

money in our bank accounts now so that we can pay people appropriately, and there are some issues there.

There have been long-term issues around training and development, but obviously we now need much clearer easy-to-access training on things like infection control and some of the issues around isolation. That again is something that staff are telling me. They have done an amazing job, sometimes in the most difficult of circumstances, and the support they have been offered has sometimes been less than helpful.

Vic Rayner: To add to some of the points that have been made in relation to the staff, it has been very difficult for staff. They have had to take on a whole new range of skills, and they are working in a completely different environment, many of them, from the one they joined. Martin mentioned some of the challenges around how health services have changed; staff have had to take on additional responsibilities in relation to providing some of the health functions that district nurses and others would have been offering in homes. They are taking on new skills and challenges.

Also, particularly for many of them who are working in homes where there have been large numbers of deaths, staff are trying to cope with a lot of loss—people they have worked with for many years sometimes. They are trying to deal with that grief and bereavement, and to be there for people at end-of-life care in numbers that they would not necessarily have had before. They are giving a lot of themselves to support that.

Homes are bringing in new members of staff. You mentioned the kind of staffing shortfalls in the care sector before this. Now, when people are off and absent, they have to bring in new members of staff in such a way that they can offer effective care and support without necessarily knowing people well and working in a very different environment.

You have to remember that care is a hugely compassionate and personal job. They are trying to deliver that with a whole host of PPE on for people who want to continue and sustain their family connections and family relationships, and trying to be all of those people in providing support to that resident is enormously difficult. I think the overall plea from staff is that they want to be able to get on with caring and providing great person-centred care.

One of our biggest challenges is how we move to the situation that some of our international colleagues described, where we are enabling a care environment to become one that is not just about safety but about quality of life. Those staff are absolutely key to that, and they must be properly recognised. We must come out of this with a much better understanding that staff are hugely skilled, and they need proper recognition and reward for that.

Q481 **Taiwo Owatemi:** Regarding the fact that staff need to be recognised as highly skilled, and the Government's new law that anyone earning less

than £25,600 is classed as a low-skilled worker, how much impact do you think that will have on the care sector, and how do we ensure that we reskill our workers living in the UK to ensure that we meet the needs we might have in the future?

Vic Rayner: There is huge frustration about the continued lack of recognition of the skills of care workers, and very significant concerns about what impact that will have on an already incredibly stretched workforce. I am very disappointed that we have not seen a change in understanding of just how essential and vital a role EU nationals and others from across the world play in delivering care. They have been a fantastic and critical component of the delivery of care in the Covid-19 crisis.

Chair: Thank you. I am sure that Martin and James will want to talk about that, but let me bring in Laura next and then Paul. Perhaps you could be rather brief, because I want to make sure that we leave time for our final set of questions.

Q482 **Laura Trott:** I will be as quick as I can. I have some questions about temporary workers, following on from Barbara's questions earlier, and about the application of current guidance around pandemic planning and whether the workforce is able to pick that up.

We were talking earlier about the fact that there is a high reliance on agency staff within our current workforce. My understanding is that it was about 10% before the crisis. Obviously, we are now operating at far higher rates of absence. Adelina was talking earlier about the fact that other countries have minimised their use of agency staff, and, Professor Green, you said that would be quite difficult in our current circumstances without huge investment.

Can you expand on that a little? What would be required over here to reduce our reliance on agency staff to a level at which we think it would be manageable for people to work in only one home?

Professor Green: The short answer is that in the longer term we have to completely redefine social care work. We have to have clear competencies and a skills framework. We need a proper qualifications ladder. We need alignment with the NHS. Everybody talks endlessly about integration, but they never talk about it in terms of training, development, resources and the money we pay staff.

In the short term, though, what we would have to do is this. If we were, for example, restricting staff to one care home, we might have to put more money into that member of staff, because low-paid workers, in particular, often find that the only way they can make ends meet is by doing a bit of agency work to supplement their current pay. If we are going to stop that, we might have to look at compensating them to make sure it is advantageous for them as well as for the system. In the short term there are those issues, and in the longer term we have to address the whole issue of the workforce in social care.

Vic Rayner: In the short term, it is very challenging because of the vacancies there. Some of the longer-term solutions are about how we make social care better recognised and how we make it a career of choice so that we attract people with the right values and attitudes to work in the sector long term.

It is important to remember that employers do not choose that as a model of employment. They want to employ people permanently; they want a fixed set of staff. Whether you are talking about home care or residential, it works much better when people know the residents or the people they are working with and work with them on a regular basis. That is the way to deliver the best-quality care. We need to learn from this and make sure that we have the right set of rewards and recognition and a career progression structure in place so that people look at care as something where they can give a fantastic contribution.

Q483 **Laura Trott:** There is currently a huge amount of pandemic guidance for care homes—I have waded through some documents from 2013 and 2018—and care quality outlines for infection control as well. Do you feel confident that that is being followed by care homes at the moment, given the high reliance on agency staff?

One of the specifications is that everyone has to be trained in infection control. Are you confident that that is in place at the moment? I ask that not to put blame on any individual but to understand, for guidance going forward, what is realistic and what is not.

Vic Rayner: In relation to infection control, I am confident that the training procedures will be in place for the agency staff using it. What Adelina and other colleagues internationally have made very clear, though, is that our understanding of pandemic infection control for norovirus and for flu is different from what we need to understand in relation to Covid-19. That is a really important distinction, and a number of colleagues mentioned bringing in expert advice, whether it is to understand about buildings or whether it is to understand about staff. We have to be clear that, whatever procedures are currently within homes, we are asking people to do much more than that, and that not only has training requirements that sit beside it but very high resource costs.

We talked a little bit about funding. In work that we have done in partnership with the LGA and ADASS on, for example, the sector's overall PPE costs over a six-month period, we are looking at something like a £4 billion additional cost to provider organisations for ensuring that they have the right PPE in place. Infection control is at another level, and we need to acknowledge that and make sure that we have recognition for the funding for training and resourcing.

Q484 **Laura Trott:** The current CQC guidance says that every home should have isolation facilities, and it says what every home should have. I am worried that there is guidance in place at the moment that, realistically, is not being followed by every care home, so to put extra guidance on top

of that feels slightly ridiculous when we cannot meet the current basis.

Professor Green: It is a really good point. For example, it shows me that we have a regulator that is not really connected to the reality of lots of care homes. My view is that it would be much better if they could identify care homes where it is much easier to do infection control and isolation and those sorts of things. Instead of issuing guidance for the perfect world, they should recognise that you need guidance for the world we are living in and that they might have a role in identifying where services that could be used for isolation are in place, so that we can get a regional picture of where the capacity is and how we could use it more effectively.

James Bullion: I echo Professor Green's last point. There are plenty of examples now of CCGs and councils creating intermediate care space so that care homes do not have to face the choice of taking somebody who is Covid positive and isolating them. I think that is unrealistic and has been unrealistic since the middle of April.

Like everybody else, I pay tribute to the work of care staff. I think there has been a cultural moment during Covid-19 when social care and its staff have been acknowledged in a way that they have not been in the past, but we have been sleepwalking without a workforce strategy for adult social care for five years. It is not only the 10% vacancy factors that Vic Rayner was describing earlier; we have a 35% turnover rate and social care staff without a career grade structure.

The fact that we have agency staff moving between three or four different establishments is a consequence of the structural model we have. We need to look at a salaried model based on outcomes and higher levels of wages. I recognise that is going to be a tough ask for the Government, who have paid out a lot of wages over the past few months, but we are without a dedicated workforce strategy that tries to address both capacity and quality.

We have to acknowledge that we have a 20% quality problem in our care services in this country of either "inadequate" or "requires improvement", and a lot of that goes back to our ability to train and recruit good staff. It is not just about money; it is a whole-workforce problem that we must wake up to and prepare quickly for, not just for future Covid but for future winter pressures and other pandemics that might come at us.

Q485 **Paul Bristow:** Both Vic and Professor Green have touched on this, but I want to ask these questions directly. It is Mental Health Awareness Week. To what extent do you feel that the high death rate in care homes impacts on the mental health of care home staff, and at what level would you put the morale of social care staff at the moment?

Secondly, perhaps for Professor Green, just this morning I was emailed by a constituent who told me that his granddaughter works in a care home. On a recent shift, 14 of her colleagues were off ill, which meant

that she had to deal with every situation, including administering medicine. That level of absence is going to have a huge impact on training, which we talked about earlier. What has been the impact of the Covid-19 emergency on the training of social care staff?

Professor Green: Your point is well made. We have seen high levels of absence in a system that was already pressurised for staff, and obviously that means people have had to do things that they would not normally do. Interestingly—this point was made earlier, I think by Vic Rayner—when the NHS withdrew many of its services from care homes, suddenly things that care home staff were told for years they could not do, they were then being asked to do. We had people really stepping up.

In terms of where we need to go with this, we need some mechanism to identify where there are staff shortages. Then we need some mechanism to try to find ways to plug that gap while recognising the challenges in doing that because of people coming from outside and the risks of Covid.

Interestingly, on the point about morale, it is important to recognise the enormous pressure on care home staff. They go through tremendous challenges when people they really like and have known for a long time are dying, and that, as Vic Rayner said, has been accelerated in this pandemic.

I have noticed how good staff are at self-support, but I do not think we should leave it to self-support. We have to get some mechanisms for mental health services to go into care homes, and some care homes, particularly the larger groups, have identified how to do that. They are offering support to their staff, but it is a massive task when you see the numbers of people in the social care workforce and the numbers of people going through the huge pressure of doing a range of things, but not having the support they normally have because there are not as many staff around, and then going through what might be described as a constant cycle of bereavement.

Vic Rayner: It is Mental Health Awareness Week, and we have to get that support right. In hospitals, there has been a very important focus on supporting people in loss and bereavement but also in the context of trauma. A lot of people who are working in care homes will be going through that, and they will need additional support.

On staff shortages, there have been a number of calls related to the NHS, primarily around nurse returners, for example, and indeed the three quarters of a million people who volunteered their time to the NHS. We have been asking for many months for some of those resources to come into social care, and the fact that, as far as I am aware, we have had a very small number—if any—of those nurse returners coming into the social care environment to date is really problematic. Exactly that kind of expert additional resource at this time of need would provide support for staff, and would provide some additional resource and clinical skills that are desperately needed.

That range of volunteers could be very usefully utilised. We have provided lots of examples of how that could happen in order to provide not necessarily direct personal care but some of the ancillary services that go into the running of both care homes and supported living settings. We have had some additional possibilities of bringing in supportive resources and we have not grasped them yet. We must do that going forward.

Q486 **Chair:** We have just 12 minutes left in the session, and I would like to use the last few moments to ask people about the long-term lessons that we need to learn for the social care sector, having been through the coronavirus crisis. We heard some comments from James Bullion about a workforce plan, which sounds very important. Briefly, first, Professor Green, what would you say are the big, long-term lessons we need to learn?

Professor Green: There are some lessons about the integration of health and social care, how social care accesses health services and how we make sure there is a proper approach, so that every single resident of the care service is regarded as somebody who might have access to the NHS. On James's point about a workforce plan, we have to identify that and get real clarity about having a workforce plan that aligns itself to an NHS one. If we are to have interdependent systems, we need people to move across the systems in their career in the same way as they do as citizens accessing different services.

We have to do something about a long-term funding solution: it has to be long term, sustainable, clear and fair. It also needs a clear examination of what needs to be national and what needs to be local, and every citizen, every care provider and every local authority needs to be clear about what the expectations of them are in the long-term care agenda.

There are some big issues. We also need to think about how we have very clear access to some of the skills areas that we have traditionally not had support from—some of the allied professions around medicine, as well as the NHS and doctors. Those are some of the issues that would be big in my long-term plan.

Q487 **Chair:** James, is there anything you would add to your workforce planning point?

James Bullion: It would be helpful to have a long-term social care plan that can sit alongside the NHS plan so that the integration point that Martin alluded to can be articulated.

It is worth us looking at the social care market and its regulation, and at the levers that we have between us for improving both the working conditions of staff and the rights of service users. We are talking a lot today about moving people around homes, discharging them here and there. What about people's housing rights and their right either to live at home or to have the right of access to housing that might better suit their

needs? I think the homes and how we operate in the market need looking at if we are to improve our quality.

In terms of the long-term funding, we need a solution not just to the question of how much local authorities are funded to fund social care but to the question about how we pay as a society and the breadth of social care. One of the big lessons of Covid-19 has been the work that local authorities have done with vulnerable people, with shielded people. It is not what we have been talking about this morning, but there is a bunch of people on the edge of social care who we could be working with preventively on their future healthcare and social care needs, if we had the resources for it. A prevention plan, a workforce plan, a long-term plan alongside the NHS and better market regulation would be my recipe.

Q488 **Chair:** Vic, what would your long-term recipe be?

Vic Rayner: I will add a few more ingredients. Adelina talked about a national minimum dataset. The fact that we are where we are, I think, is partly because we have not had access to the right data at the right time. Martin mentioned real-time data. It is not possible for homes, local authorities and national Government to plan without that data, and as we come away from this we must understand the importance of data, because it saves lives. We need to measure the things that are important to us.

I echo the points about health intervention. This has been a health pandemic, and in the care sector we have not felt that we have had a health response in the concrete and overarching way that the people who are living in care needed and will continue to need. We absolutely must make sure that we have a care sector that is fit for the future, and that includes long-term reform, but also some short-term changes that might need to happen to ensure that we are ready for the second wave—some of the things about PPE, testing, and so on. We need to get those things right.

Just as an observation, we have talked a lot today about processes, how different bits of the system are fitted together, PPE, testing, hospitals and care homes, but we have not talked a lot about people, and people are at the heart of all this. What we have to do going forward is make sure that the responses we have around social care and the pandemic are focused on those people. I would explicitly say in the context of those in social care that, from a health point of view, it is around intent to treat, and that people feel they absolutely have as much right to all those health services as everybody else in the community. It is also about making sure that we look beyond those processes, and our checkpoint is making sure that people are all right.

The final point is that we have talked a lot about care homes. The care sector is obviously much bigger than just care homes: it is home care, supported living and extra care housing. It is all the different components that people need at different points in the journey of their life. We have

an overall responsibility to make sure that all those bits are there for people when they need them, and that they are safe in all those bits, so, not only in the longer term but in the very short term, we must get things like the testing and the PPE right not just for care homes but for all those component parts of the sector.

Chair: We have time for a few final brief questions.

Q489 **Dr Evans:** My question is to Vic. We have been on for almost two hours, and one thing I am concerned about is how your residents are doing. That is one of the biggest things. We are looking after people who are scared and vulnerable. In my role as a GP, one of the biggest things was touch—touching people on the hand, looking after them. That is all very difficult now. I wondered if you had any feeling about how the people who are actually being cared for are dealing with it. They are the silent voice we never hear from. I would welcome your comments, because compassion is so important in this situation, especially when these are the people who are watching the 24-hour news cycles on TV. That is often what they do. They must be petrified. I would like your comments on that.

Vic Rayner: It is really important. As I said before, care is about compassion; care is about keeping connected with those people. I am very worried, so I think all the things you say are right. People are fearful, anxious, and the routines they have had, whether they are in supported living environments or care homes, have been significantly disrupted; their connections have been taken away.

A lot of people living with dementia will not necessarily be able to understand why family and friends are not appearing on a regular basis. That has been an enormous part of what has helped them to remain independent and to do the things they want to do. There are a lot of very lonely people, I suspect, and we need to understand the physical and mental health impacts of this lockdown on them. I think care staff are doing what they can in that context. People are keeping in touch via digital and all sorts of things, and that works for some but not for everybody.

When we are now thinking as a country, generally, about easing the lockdown, we have to be careful that what we do not leap to a solution that is about locking up and basically keeping those people cut off. We have to find a way, safely but quite quickly, to move back to a situation where people can have the visitors they want and the contact and connection they need to keep them safe. This is not just about keeping people physically safe; it is about quality of life. We have to make sure that our solutions are not oriented around shutting off certain parts of the community, because that brings its own problems.

Q490 **Dr Evans:** Lockdown is tough enough for most of us who are able to get out, go for a walk and use the internet—those kinds of things. Is there any consensus about practical or good ways of taking this forward and

trying to help those stuck in residential and care homes? After all, the key is in the term: it is a home. Imagine having your family in PPE the entire time in your own home; it would be very difficult. Are there any good examples that we can take forward as a Government that might make a difference?

Vic Rayner: There are some examples. Again, we need to look at the international community for some of that, where people have been thinking about safely reintroducing visitors. Definitely, there are some ways of doing that. There is a wider message that care homes are doing their absolute best to keep some of those things going. You will see some wonderful images on social media of people having parties and all sorts of things, while keeping social distancing and keeping PPE. Fundamentally, yes, we want to get back to a place where people can have the people they want around them.

For lots of people, Covid or otherwise, this is end-of-life care, and we need to make sure that end of life is something that has real quality to it. We have to do it safely, but, as I said at the beginning, care homes have had to find out what works for themselves. It is absolutely critical that we share that information and that we resource homes properly to do the things that mean they can safely reintroduce families and others. This is not a sort of nice-to-have element. It is absolutely critical to people's care.

Chair: For our final question this morning, Rosie Cooper.

Q491 **Rosie Cooper:** I would like to ask about payments made to care home staff who have died. Are you finding any great resistance to compensation for them like, for example, the £60,000 that was made available to NHS staff?

Professor Green: I am really pleased that you raised that, because at the moment there is a bit of ambiguity. People are saying that if you have publicly funded residents, you could have access to the £60,000. But if you are a completely independent care home, a private sector care home or, indeed, a charity that does not have any publicly funded residents, there seems to be a question as to whether or not that money would be allocated.

I urge the Government, as a matter of urgency, to clarify that and to make sure that it is available to everybody. We have sadly seen many staff in the care sector who have died during this pandemic. They have given their lives for other people, and we should be supporting their families and making sure they have access to this money.

Chair: I am afraid that is all we have time for this morning. We have had an extremely useful and detailed session with some very interesting panellists from other parts of the world. I particularly thank the panellists who are with us at the moment—Professor Martin Green, Vic Rayner, James Bullion and Adelina from LSE—for their time this morning and for

their excellent answers to our questions. That concludes this morning's session.