**Written evidence submitted by the National Care Forum (COR0004)**

COVID briefing for Health and Social Care Select Committee – 19 May 2020
**Inquiry - Management of the Coronavirus Outbreak – Oral Evidence Session 19 May 2020**

About NCF
**The National Care Forum (NCF)** represents the interests of not-for-profit health and social care providers in the United Kingdom. Our members include more than 115 not-for-profit social care and support providers across the country. The NCF has been promoting quality care through the not-for-profit care sector for over 25 years and is a leading voice in the sector. We have been regularly engaging with our members to feed this intelligence into the government's COVID response.

Views on the current situation
There are a number of key issues in relation to the government's management of and response to the COVID outbreak that we would like to cover:

1. **Priority testing for social care staff and residents/ users of social care**

The government has been slow to respond to the need for comprehensive and routine COVID testing across care settings. Corvid testing in the UK began in January 2020 and in March, patients in hospital began being tested. Yet in social care, it was not until 15 April, with the arrival of the Social Care Action Plan that testing for all social care staff was promised, and then 28 April when testing of residents in care homes was promised.

Despite all the commitments from ministers, and even with the advent of the national social care testing portal, there is still not a programme in place to enable comprehensive, routine, regular whole home testing for staff and residents in care homes. And other care settings such as supported living and housing with care are not able to access the social care portal.

Given the robust evidence emerging about the prevalence of COVID amongst people who show no symptoms, comprehensive, routine regular testing is essential for care providers to be able to protect both staff and residents effectively and to continue to provide good care and keep on top of the COVID risk.

The various responses on testing have been very confusing, with shifting approaches – there was the first centralised approach via the CQC, then the Getting Tested portal which diluted the prioritisation of social care and shut the CQC system down without notice and the hugely variable local responses by LAs and PH Teams. The dedicated social care portal will help but only has 30,000 tests per day which will cover approximately 300 care homes per day, so will take until June to cover all 15,000 and that does not help other care settings.

**NCF ask: we need 200,000 social care tests per day to enable comprehensive, routing weekly testing for care homes – and more to cover other settings**.

2. **Better, faster access to PPE now and for the months ahead**

There is still a problem with the supply of personal protective equipment for care staff – this includes things like face masks, gloves, aprons and eye protection. Given that the UK is in sustained COVID transmission and the updates to PPE guidance to take account of this, providers are facing an uphill battle to obtain enough PPE to equip their staff properly.

The government was late to respond to the huge PPE issues facing social care, which felt that the NHS was given priority in terms of access to PPE in February and March. As we moved into April, the government did start with efforts to help, such as emergency drops of PPE to Local Resilience Forums to give to providers who were in extremis, working with wholesalers to release flu pandemic stock to them and the ongoing development of the PPE portal (Clipper). However, we are still weeks away from a robust, smooth, reliable supply of PPE for the sector.

Providers have responded by having to source their own PPE individually, facing hugely inflated prices for PPE, which is costing hundreds of thousands of ponds, sometime millions of pounds and this looks set to continue for months ahead.

**Ask: free PPE to social care providers and ramped up to increase the supply of PPE**

3. **Increased funding to enable care providers to continue to operate in the face of catastrophic COVID costs**

Care providers have dramatic increases in their current operating costs – in the region of 35% increases in costs just to keep going with their current service provisions. These increases are the result of huge increases in staffing costs as staff absence (for a range of reasons) and providers need to backfill staff, dramatic increases in the cost of PPE (1000% is not uncommon) and the volume of PPE now needed; big increases in the costs of cleaning and infection control for managing suspected COVID and increases in other supply costs such as food.

The Government has given £3.2bn to support social care, via LAs. The LGA and ADASS have issued guidance to LAs to give a 5% uplift to care providers – comprised of 5% to cover the increase in the National Living wage, which is NOT COVID related and a further temporary 10% to cover the increased costs of COVID for Aril initially, to be reviewed after that. There is no requirement for LAs to follow this guidance, the Government seems unable to mandate it and consequently, very few LAs are passing any of this to the frontline. Where LAs are passing on the funding, many are not prepared to cover the additional COVID costs for self-funders and many are requiring very detailed evidence of the costs providers have incurred, which is becoming a big administrative burden.

We are now in May and providers are facing very serious cash flow problems as their costs have escalated hugely and their income has fallen due to issue relating to occupancy and demand.

**Ask: proper access NOW to the £3.2bn allocated to LAs to support social care and a direct payment mechanism to providers to keep them afloat in the face of catastrophic COVID costs**

4. **Better use of data and evidence to inform the national and local COVID response planning and implementation**

It has become evident as we have moved through the COVID crisis that the government has be very late to the use of data to inform and shape its response to support and action for social care. Examples include the delay in the CQC amending their notification data collection to include details on deaths relating to COVID (16 April) , the government's single minded focus within its pandemic response planning on the number of deaths in hospital to the total exclusion of deaths in the wider community, including care homes (this data was only included in the briefings from late April) and the absence of data from Public Health England on recorded out breaks in care homes which only started to be published (29 April).

This has no doubt hindered the planning response across both central and local systems. Without an accurate, timely picture of data across the social care landscape, it is difficult both to ensure that support and resources are targeted where they are needed most and to plan for a strategy to move out of lock down. It is also not clear that key partners understood the value and importance of the data that they held and how it needed to be used to shape strategic and implementation responses.

Providers were asked to complete the NHS Capacity Tracker (from 1 April) and/ or the CQC Update (later in April) to enable a daily data feed into both the local and national system and it is only now that we are starting to see that some use is being made of that data to actively support care providers.

5. **Social care workforce – recognition, reward and protection**

The COVID crisis has highlighted what we in social care already knew about our workforce – their levels of skill, compassion and resilience have shone through in this pandemic and they really have been on the frontline of the COVID response. Despite the pressures of workforce shortages as their colleagues, the difficulty of working in PPE, the anxieties about PPE and COVID, the pain and grief of losing those their cared for to COVID, they have battled on.

Our care workforce needs the appropriate recognition for the work that they do, an acknowledgment that they are highly skilled and a tangible increase in their pay. This can only happen if the long term funding of social care is resolved.

There are also emerging concerns about the risks to the BAME workforce in social are, as the evidence builds about the potentially disproportionate impacts on those communities when exposed to COVID 19. Social care providers are asking for more guidance from the government on this issue to help them protect their BAME workforce (and residents/ people using services) effectively

**Ask: more funding into social care to enable better pay for our workforce; a recognition of their skills and qualities, with a focus on capabilities and values, not just qualifications;**

**Ask: more guidance on protecting BAME staff and residents/ people using services) effectively**

6. **Withdrawal of primary care/ community health support**

In early March as the emphasis was placed on the importance of protecting the NHS and freeing up bed space capacity in hospital began, we saw a redirection of effort and support within both primary care and community health services towards this mission. This had an immediate and very direct consequence for social care – it meant that primary care and community health services actively withdrew form support their care homes and care providers as they were asked to focus on the support of those being discharge from hospital back into the community. In many areas. care staff were asked to pick up the medical and clinical task previously done by District Nurses and GPs support reduced significantly.

NCF were able to ask for the Community Services Prioritisation Framework to be amended to ensure support for care homes remained a priority but even so, the support from the health services was being withdrawn at the time it was needed most.

**Ask: part of our NCF 'ring of steel' ask was for better support from primary care/ community health services, which we are now starting to see with the acceleration of Enhanced Health in Care**

**Homes; additional clinical support is essential, as is very specialist infection prevention and control support – COVID is the equivalent of Ebola not Norovirus – we need that level of specialist IPC support**

**7. Recognising the expertise within the care sector**

As the pandemic has moved into care homes, it has become clear that much of the advice about symptoms and early detection has not necessarily been correct. Care staff have reported that symptoms in older people rarely manifest as a cough and a temperature, but are much more often likely to be sickness, UTIs, diarrhoea or other signs of being unwell. In the absence of testing, an early recognition of this and an early amend to the guidance on symptoms for care home staff and GPs and community health services would have been helpful, as would work to research the nature and trajectory of the virus within care settings as opposed to acute settings.

**Ask: recognition of the expertise within the care sector in informing the advice and symptoms guidance on COVID**

**8. Indemnity and insurance**

The issue of insurance in a COVID world is beginning to emerge as a key challenge for social care providers. Insurers and underwriters are increasing concerned about the potential liabilities brought about by COVID and are starting to limit the cover offered by their policies to exclude COVID liabilities (especially in relation to public liability cover). They are also repricing policies with significant increases in premiums for policies which are offering less/ no COVID cover. The government has provided indemnity ot he MHS, but not yet managed a similar response for social care.

**Ask: that the DHSC set up an indemnity scheme for the social care sector equivalent to that provided by section 11 of the Coronavirus Act 2020 in combination with other NHS indemnities, for health service providers.**

Lessons learned for the second wave of COVID

**Parity of social care with health – a true whole system response**

A number of the issues raised in section one about current issues come back to one key single issue – the fact that social care has not been seen as the equal partner to health from very start of the pandemic. Effort, planning and resources were all devoted to protecting the NHS without an understanding and recognition of the key role that social care plans within the system , out in communities. This is a health pandemic and yet the support for social care in managing this health pandemic has not been there, consistently, woven though the response planning.

Key lessons include:

- **Better use of data immediately to prepare for and respond to wave 2** – the DHSC, NHSE/I, PHE, LAs, CCGs and the CQC all have a key role to play in making sure that the data they gather is used at both a national and local level to respond to a second wave of COVID. It is essential that these key partners understand the value and importance of the data that they hold and share it to the strategic and implementation responses in wave 2.

- **Ensuring sufficient capacity for comprehensive, routine, regular priority testing for social care staff and residents/ users of social care -** it's clear that the government did not have and still do not have sufficient COVID testing capacity to ensure comprehensive, routine, regular, priority COVID testing for social care. This must include not only care homes but other wider care settings, such as supported living, housing with care and other congregate care settings. Given all that we know about the importance of testing and the prevalence of COVID positive people who are not exhibiting any symptoms, then proactive, pre-emptive testing is imperative in wave 2.

- **Reliable, affordable PPE for the foreseeable future** – the difficulties in accessing affordable, reliable PPE have been enormous. We simply cannot repeat those for wave 2. The government must find a solution to ensuring reliable affordable PPE for the foreseeable future – and will need to replenish the emergency flu pandemic sti=ock as well.

- **Production of guidance –** much of the guidance produced for the social care sector has not been done in a collaborative way and has therefore been very confusing for care providers, as it has general y had a medical/ clinical/ acute hospital focus. This has made it ineffective and time consuming at a time when care providers and managers do not have the spare time to distil and interpret it. PHE need to consider what they have learned from this process and set up pre-emptive arrangements to avoid the same thing happening again in wave 2, especially if the virus evolves

- **Social care workforce –** better pay – as set out in section 1, the importance of recognising and rewarding our care staff is essential. The government must find a way to put enough funding into social care to ensure we can pay our staff at a rate that recognises their skills, commitment and contribution to society.

*May 2020*