Written evidence submitted by Care England

I. Care England, a registered charity, is the leading representative body for independent care services in England. Membership includes organisations of varying types and sizes, amongst them single care homes, small local groups, national providers and not-for-profit voluntary organisations and associations. Between them they provide a variety of services for older people and those with long term conditions, learning disabilities or mental health problems.

II. For too long, adult social care has been kicked into the long grass by governments of all stripes. This crisis has accentuated the role of the adult social care workforce and adult social care providers in the care for some of society's most vulnerable. We hope that the recognition stimulated by the COVID-19 pandemic for the sector propels forward those reforms necessary in ensuring its long-term sustainability. At its core this includes the creation of a system which means that adult social care providers no longer have to focus upon keeping their heads above water.

III. Care England welcomes the opportunity to submit written evidence to the Public Accounts Committee's inquiry into Readying the NHS and Social Care For the COVID-19 Peak. Professor Martin Green OBE, Chief Executive of Care England, would be willing to give oral evidence at future Committee meetings.

1. Increasing the availability of healthcare professionals and beds to treat COVID-19 patients while maintaining other essential health services

1.1 At the beginning of the pandemic the adult social care sector was abandoned by the NHS for example patients were discharged from hospital into care homes without the necessary COVID-19 tests and care home residents were encouraged to have DNARs. The focus was on the NHS at the expense of the adult social care sector despite the vulnerabilities of those in receipt of adult social care.

1.2 Emptying out hospitals into care homes without COVID-19 testing in place was a flawed policy; yes care homes had the bed capacity and were well positioned to barrier care, as demonstrated by outbreaks of norovirus or flu, but COVID-19 was different unless providers knew what they were dealing with. In the absence of robust testing and inadequate PPE care homes, abandoned by the NHS, were left to the ravages of the virus as made abundantly clear by the number of deaths amongst care home residents and staff.

1.3 Care homes residents, both older people and adults with learning disabilities, were in many instances left to fend for themselves without due attention to their underlying conditions, co-morbidities as well as COVID-19. Care England welcomes the fact that the Enhanced Healthcare in Care Homes was brought forward and this needs to be accompanied with a robust policy about the end to GP retainers, under no circumstances should a care home be told that deregistration of residents, or no access to local GP services might happen, if a retainer is not paid.

1.4 For the first few months of the pandemic the Care Quality Commission's silence was deafening. The regulator could have been a force for good working with the sector to alleviate the challenges.

2. Securing adequate vital supplies, including PPE, testing equipment and ventilators

2.1 It has been well documented that care homes were the last in line for vital supplies including PPE and testing. PPE was requisitioned for the NHS at a time when the adult social care sector needed PPE to the greatest extent. We believe that these practices were part of a broader failure in government strategy which encompassed an overarching focus upon the needs and vulnerabilities of the NHS rather than social care.

2.2 Many adult social care providers have chosen to source PPE from private providers owing to impatience with public provision. The latest tranche of money from DHSC for infection control, £600m, has so many clauses attached to it that it is impossible for providers toutilise it to relieve their very substantial COVID-19 costs, including costs for PPE, they can however use the money to pay for a bike shelter.

2.3 The applicability of Public Health England's (PHE) care home guidance ("COVID-19: How to work safely in care homes") and domiciliary care guidance ("COVID-19: Personal protective equipment (PPE) – resource for care workers delivering homecare (domiciliary care) during sustained COVID-19 transmission in England") to learning disability settings created great concern, particularly around the use of Personal Protective Equipment (PPE). There has not been a sufficient focus on services for learning disabilities demonstrated very clearly by the insufficient ONS data and delay in the testing regime.

2.4 There were enormous challenges in terms of securing sufficient PPE not helped by 40 different versions of PHE guidance on what was deemed to be suitable PPE for providers. Ministerial intervention was sought for securing PPE supply chains which alleviated the problems to some degree.

2.5 Projects Cygnus and Iris have demonstrated the need for significant amounts of PPE and the pivotal role of care homes, but this was not shared with the ASC nor acted upon.

2.6 With regards to testing, the sector is wholly supportive of routine testing. Testing must not be seen as a one off occurrence, but rather a routine procedure for staff, residents and visitors. The system has been fraught with challenges and results seem to show a whole host of anomalies.

3. Protecting and supporting vulnerable groups, including those residential care homes and healthcare professionals

3.1 As stated above, the adult social care sector was not given the recognition it needed in order to thwart the spreading of the virus. Staff had to fight for their status as key workers.

3.2 Looking ahead adult social care must be put on an equal footing with the NHS. There needs to be a seamless transition between the two sectors rather lip service to integration. The response, or lack of, from many statutory bodies has been disappointing and it is questionable as to why the army and management consultants needed to be drafted in to help deliver PPE and testing when vast swathes of civil servants were seemingly incapable to do so.

3.3 Care England carried out its own costing analysis (as part of an ongoing costing exercise that will be built upon over the coming weeks and months) which found that COVID-19 costs had added additional £72,571,189 to older persons care services, along with, £7,340,444 to LD and supported living services. The sector's financial position is precarious.

3.4 Very late in the day the Department of Health (and Social Care) has recognised the symbiotic nature of health AND social care and we welcome Ros Roughton's promotion as an individual with a robust knowledge of the sector; however we have less confidence in many of the other officials in her team who have turned the pandemic into lessons in red tape and bureaucratic spaghetti.

3.5 The Government has had good intentions, but unfortunately because of the way in which it has used the flawed mechanism of local authorities to dispense the vitally needed money, much of the £3.2 billion allocated for adult social care has not reached the front line. This amount of money could have transformed social care, and sustained it through COVID-19 and beyond, but because of the way in which it's been given to local authorities, with no accountability trail, this money has been in part wasted.

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