Care England – Written Evidence (LBC0093)

Key Points

1. Are there any positives you would take from this pandemic?

The Covid-19 has brought to light the essential role of adult social care. This impetus for change needs to be harnessed, not forgotten, in order to facilitate a fully integrated health and social care system.

Over the last four months, the Government has allocated an unprecedented amount, approximately £4bn, to local authorities to aid the pandemic response. Although not all this money was allocated to meet the needs of the adult social care sector, this was money unlike the sector had ever seen before.

The pandemic has also shown us it is that the social care workforce is the sector's greatest resource. There is a need to recognise the efforts of health and care professionals as a whole nation. These are the heroes on the frontline leading the fight against Covid-19.

The Covid-19 pandemic has demonstrated the interdependence of the health and social care system and the organisations that operate across the system. The pandemic has acted as a catalyst for change by facilitating new relationships between primary and social care organisations. The CQC must move to promote these new relationships by moving to a system-based approach. I

The pandemic has illustrated in stark terms the importance of data in responding to localised developments in a timely and effective manner. It many ways, Covid-19 has been a catalyst to digitalisation as technology has become an added necessity for social care providers.

2. What are the things that you are most worried about?

A decreasing funding pot has hampered providers' efforts to recruit and retain staff. This has manifest in a number of ways, spanning the overall financial attractiveness of the adult social care sector as an entity in itself, but also providers ability to compete with other sectors. The adult social care workforce needs to be seen for what it is; an exciting, challenging, professional career and we have to ensure that staff are remunerated accordingly.

All funding provided to the sector has thus far been short term in nature. Adult social care providers need the requisite funds which gives them confidence into the medium and longer terms.

Long standing issues for the adult social care sector will persist despite Covid-19 and it is in turn incumbent upon us to adapt to the new realities of society to create solutions for these issues. For example, reprimanding the public perception around the need and attractiveness of care homes, or broader issues around ableism and ageism. Similarly, centrally lead efforts must be enacted to address the historically high staff turnover and vacancy rates.

We must not return to a position where the regulator remains unreceptive to the needs to the very sector it regulates. Clear leadership and direction must be fostered by increasing the transparency of their work, whilst provider relationships need to be improved by offering clear direction and guidance.

Infrastructure is the key challenge in digital adoption and gaining value from technology. There must be some infrastructure investment fund for social care.

A centrally lead data strategy must be receptive to the needs of providers. At its core, providers will ultimately be motivated to input into data systems if they see these systems as being of benefit to their own organisations. However, during the Covid-19 pandemic, care providers have often not been able to see the benefit of those data collection systems which have been created. Instead, there has been a widespread feeling that these systems have merely been created for the benefit of those whom eventually receive the data. In no way is this an effective trend to created trust and collaboration within the system.

3. What do you most hope changes for the better?

Moving beyond Covid-19, we need to craft a new approach, one that ensures that vulnerable people are not abandoned by the NHS. We need a system of support in which health and social care act in a coordinated fashion focused around the person and are financed adequately and appropriately.

Whilst for sectors like the adult social care sector which contribute to protection and wellbeing of society's most vulnerable, the Government needs to create a business environment which makes its financial sustainability feasible for the coming years. This includes for both the independent and charitable sector.

There needs to be greater pay and recognition of the workforce. Such realities mean that social care is not able to compete with the NHS given the lack of parity between their respective financial positions.

The safety and wellbeing of the workforce must also be maintained through an effective supply chain for PPE to social care employers and their workers, providing the same priority as PPE supplied to the NHS, whilst also ensuring regular asymptomatic testing for workers with client-and resident-facing contact, volunteers, and visitors, across all social care settings.

Part of leadership is taking a sector with you which is best done through building trust within the sector. Currently, many providers feel there is a lack of transparency within CQC and its development of key policies. We hope CQC is able to improve its visibility and take account of the voices of providers.

Care England believes that regulation must be geared towards providing incentives to both digital leaders and leaders at large to act creatively.

Evidence from social care providers suggests that they want to see a single source of data collation from a centrally lead body in order to gain a whole

sector representation. The data inputted must also be segmented with a single-entry point. This data needs to be inputted as part of a clear data strategy which ensures benefit to both the Government and providers. This single source should be centrally funded in order to ensure that additional pressures are not placed onto care providers or care organisations.

Professor Martin Green OBE, Chief Executive of Care England, would be happy to give oral evidence to further support this submission.

1. Introduction

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.

Care England welcomes the opportunity to present evidence to The House of Lords Covid-19 Committee which has been established to look at the long-term implications of the pandemic for the UK economy and society. The Covid-19 pandemic has posed an array of unprecedented challenges to the adult social care sector. As we now move into 'the new normal' we must take account of these issues and reflect on what we have learned collectively in order to improve the health and care sector in the future. It is also an opportunity to dwell on the positive and thus recognise the adaptability of the adult social care sector.

In planning for life beyond Covid-19 the Government must set out how it intends to ensure that political actors are no longer unreactive to the needs of the independent adult social care sector. There is much that the sector has changed from within, but given it is funded predominantly by the state and so intrinsically interrelated with the National Health Service (NHS) it is essential that Government manages the overarching direction of travel and facilitates the necessary help and change. The next few months will continue to be difficult for care providers, with situation-specific, person-specific decision-making in a kaleidoscopically changing environment of relative risk. Emerging systems to manage the virus have been put in place as a result of the change Covid-19 has demanded. This impetus for change needs to be harnessed, not forgotten in order to facilitate a fully integrated health and social care system.

The independent adult social care sector is a key part of our heath and care system and one that can help lead us into a new integrated and stronger future with services centred around individuals and free of much of the excessive bureaucracy and neglect within government that has characterised the attitude to this sector for too long. What is required now is a different culture, one where success is measured in outcomes.

In this written submission Care England seeks to outline the policy areas which are fundamental to the future sustainability of the adult health and social care sector. These policy areas have been brought to light and exacerbated by Covid-

19 and must be addressed in order to improve the sector in the future, especially in light of the systemic inequalities that the pandemic has highlighted.

2. Funding

The Covid-19 pandemic has increased both the political and public saliency of the adult social care sector due to the pressures and challenges that the pandemic has presented. Despite this, the financial rescue packages from Government have not, in the main, reached the front line in a timely and effective manner. The NHS has received major financial boosts directly, such as the cancelling of over £13bn debt overnight, whilst the money allocated for social care has been routed through Local Authorities and has been slow to materialise or has not reached the front line at all. This is despite the fact that over the last four months the Government has allocated an unprecedented amount, approximately £4bn, to Local Authorities to aid the pandemic response. The failure of this money to reach the frontline was evidenced in the House of Commons Public Accounts Committee on 22 June. Local Authorities are a failed mechanism for delivery.

We believe that this was not the Government's intention for the money, or the spirit in which the funds were intended. Rather additional bureaucracy has made it hard for providers to access the intended funds and seemingly undermines the Ministerial pledge to create a protective ring around care homes. Now is the time for delivery; part of this can be
through a cultural reorganisation. We can't use financial starvation to change the market without working with all providers and those that need services.

2.1. The issues which Covid-19 has highlighted

The adult social care sector has been allocated an unprecedented amount of money over the course of the pandemic, however the delivery of the money to thoise providing the care through the failed mechanism of Local Authorities has been an obstacle to its timely and effective delivery.

Although we recognise the steps that many Local Authorities have taken to support their local health and care systems, the evidence we have received from members is suggestive that the money allocated to local councils was not being passed in a timely and efficient manner to care providers who were subjected to varying localised approaches and bureaucratic hoops which created a barrier to accessing the vital funds required.

We have highlighted such issues in previous consultation responses, written and oral submissions including the Health & Social Care Select Committee's inquiry into Funding and Workforce. However, it is worth re-emphasising such evidence briefly here. Care England has collected data from its members over the course of the Covid-19 pandemic which elucidates the notion that care providers have been subjected to barriers in relation to funding and the sector was of course in a very precarious state before the pandemic. This has been evidenced across a multitude of service providers within the adult social care sector.

- For example, a Care England member who provides learning disability care operates in over 150 Local Authorities had only received extra funding of 10% or above from just 2.5% of those commissioners they were engaged with in late April which represents the peak of the pandemic.

While in terms of older person services, we received the following evidence of fee uplifts which do not sufficiently meet the increasing costs of COVID-19:

- Again in late April, one older person's provider who operates in over 100 Local Authorities across the United Kingdom had received the commensurate 10% fee uplift (as stated by ADASS/ Local Government Association (LGA) guidance) in just 7.5% of authorities.
- The imposition of conditions and administrative processes (in order to gain funding) which, in fact, increase the overall cost for providers in terms of financial, administrative and health risks arising from Covid-19.

Whilst we appreciate that the funding situation has continued to progress over the past months and therefore many of the statements we made in the above briefings are time contingent, the reality has continued to be unacceptable for many adult social care providers. Below we further detail some of the existing realities for adult social care providers:

- We continue to hear from providers that they have not received Covid-19 financial support from some Local Authorities, for example, one older person's provider whom commissions with over 70 Local Authorities said that they were "awaiting details or had no offer" in 13% of those Local Authorities' they commission with (data received on 27/05/2020).
- Whilst in the context of Learning Disability services we believe that the situation continues to be even more stark. For example, an Learning Disability provider whom commissions with over 100 Local Authorities had not received a response from 40% of those Local Authorities with whom they commission (data received on 28/05/2020).
- Another Learning Disability provider has stated (received on 28/05/2020) that 50 Local Authorities have not communicated any offer of financial support. We believe that given that it is now two months since the start of lockdown, that all care providers should have at the very least received a comprehensive offer of support.
- We have collated evidence from our members which indicates that more than 70% of Clinical Commissioning Groups (CCGs) have not contacted or agreed to fund the Covid-19 extra costs of current Continuing Healthcare (CHC) funded residents themselves or via their respective Local Authorities.
- Of those CCGs who have agreed to meet the extra Covid-19 costs there are still huge difficulties encountered by providers: some CCGS have said they will look at provider costs after they complete a proforma but have not promised to pay; some CCGs have paid something but a low percentage figure; and others have paid some providers but refused to pay others.

- Further, only a very small percentage of CCGs have contacted providers to inform them as to what increase will be applied to their standard CHC fee rates for the financial year 2020/21. This is unacceptable as we are fast moving to the end of June 2020 and these fees should have been increased from the 1 April 2020. Accordingly, we would recommend that the NHS issue a letter of instruction to CCGs clarifying the need to help meet the extra Covid-19 costs.
- At the end of May, councils had been allocated two central government grants to aid the social care sector: the £3.2bn grant to local authorities (for all Covid-related council costs, with no ring fencing for social care); and the £600m ring-fenced infection control grant. Older person care services who responded to Care England's cost collection survey for May reported that they had to date received a cumulative £3.7m from the £3.2bn grant and £2.2m from the £600m grant. In total this only represents £5.9m of centrally funded aid. If these figures are scaled up to all independent sector care homes for older people in England, this indicates national payments of £26.1m and £15.5m respectively (total £41.6m).

Whilst a greater proportion of providers have received an "offer" of support, the picture is much more complex when a Local Authority has merely stated its intention to support a care provider or not. Instead, timely and effective measures are what is needed at this time of crisis. This differs from offers which on paper may give a semblance of support, however, do not really deliver in practical terms. Care England hears from its members on a daily basis that they are encountering such offers.

This is cast against a backdrop of bureaucracy imposed by Local Authorities where a lack of uniformity in the approaches of Local Authorities was imbued which would create additional administrative burdens upon already stressed care providers who provide care for some of society's most vulnerable. At a time of crisis, these are the very opposite of the sorts of processes which already stretched social care providers wish to be dealing with. The dynamism demonstrated by care providers has not been mirrored in the commissioners and Local Authorities.

2.2. The implications of Covid-19

Rising costs as a result of Covid-19 are inexorably intertwined with the funding reality of the sector in the short, medium and longer term. All funding provided to the sector has thus far been short term in nature. Adult social care providers also need the requisite funds which gives them confidence into the medium and longer terms. Successive Governments have fudged the issues of adult social care and the Covid-19 crisis has brought to the fore the inter and intra relationship between health and social care which needs to be addressed in any future policies.

The latest data collected by Care England through our monthly surveys which included response from 54,100 registered beds for older people which represents 14.2% of all (380,690) registered beds in England for older people and 11.8% of

all (456,752) registered beds in the UK, evidenced that the total additional Covid-19 costs among all English independent sector care homes for older people were estimated at £247 million in May, representing an annual run rate (if elevated costs were to continue at the same level) of £2.9 billion.

Further, lost income from reduced occupancy emerged as by far the largest component of additional cost in May as deaths continue to exceed normal rates in care homes and as referrals and new admissions of permanent and respite residents remain at unusually low levels, reflecting public fears that care homes may not be safe. The weighted average occupancy rate among homes for older people, as reported by Care England survey respondents, fell from 83% at the end of April 2020 to 77% at the end of May, a drop of 6 percentage points. It is likely to have dropped further in June and may fall yet further in coming months – which would lead to further increases in lost income costs – depending on how long it takes for public confidence to return.

Although some costs may decrease over the coming weeks and months, for example, as occupancy levels continue to fall, this will mean that agency costs will too go down. However, at the same time, the likely progression of staffing costs is much more complicated than this, and other factors will likely be a barrier to providers' ability to decrease staffing costs in reaction to the changing context. For example, it is also necessary to acknowledge the existing and continued measures which care services have made in relation to providing additional support to their service users, including:

- Widespread testing might also result in finding more staff having the virus who are asymptomatic and therefore need to self-isolate.
- Test and trace system may mean that staff are more likely to have to isolate in the coming weeks and months.
- Supporting the mental wellbeing of residents in light of their decreased interactions with family members and challenging work that they are undertaking
- Increasing support for individuals with particularly complex needs through these most challenging of times, for examples, individuals with advanced dementia.
- Similarly, the range of activities provided by charities and communities groups has also significantly fallen, and in turn, care staff have and will continue to step up to the mark in providing such activities to their residents.
- While community nursing provisions have also declined sharply and again care services have taken measures to counterbalance this – in turn increasing staffing costs.
- Infection, prevention and control measures, including cohorting, zoning and isolation practices, will mean extra staff, equipment, capital and cleaning costs will need to be part of business as usual going forward.

2.3. Recommendations

Whilst for sectors like the adult social care sector which contribute to protection and wellbeing of society's most vulnerable, the Government needs to create a

business environment which makes its financial sustainability feasible for the coming years. This includes for both the independent and charitable sector. Some measures to do so may include the following:

- Direct action by the Government to take steps to alleviate the tax, VAT and national insurance framework within which care services operate.
- Extending Statutory Sick Pay support to companies employing over 250 people.
- Freezing Care Quality Commission (CQC) fees.
- Reshaping the apprenticeship scheme.
- The Government should review the current VAT regime for nursing and residential care services to change their status from exempted from VAT to zero-rated.
- The ongoing Supreme Court sleep in case represents a potential threat to the financial sustainability of the sector. Government must take the necessary steps to support the adult social care sector in the case that back pay is mandated by the courts.
- Extending the Infection Control Fund (ICF) with a reformed framework.If the Government decides to again pursue the delivery of money through the failed mechanism of the Local Authority by extending the ICF the extension must not only be granted swiftly in order to allow providers to build comprehensive contingency plans, but must be caveated with a reduction in bureaucracy and extension in remit. This would be best achieved through clear guidance issued to Local Authorities in order to clarify what Local Authorities should be using the money to fund, for example: out of county placements; Personal Protective Equiptment (PPE); and additional pay for extra shifts. This would help reprimand the evidenced situation of learning disability providers being treated differently in terms of the support granted to them by Local Authorities relative to older persons organisations. This is despite the fact that many of the costs incurred have been largely similar. This is elucidated through Local Authorities largely failing to help meet the Covid-19 costs of out of county placements, which are far more prominent within learning disability and autism care than older person care. This must be managed through better centralised direction.
- Free PPE and extension of VAT relief on it.
- Greater central direction on ensuring monies from central government for adult social care providers which is allocated through Local Authorities and the NHS gets through to providers.
- The extra funding for the social care sector must not end this summer but continue into the coming winter, and covers the extra costs of Covid-19 of self funders as well as those people who are state funded via Local Authorities and CCGs.
- Consider how the adult social care workforce can be properly recognised and rewarded for their efforts during this crisis both in the short term and in the longer term.

3. Workforce

Broadly, Covid-19 has exacerbated the existing workforce pressures which were an issue within adult social care prior to the pandemic. Future government policy must take account of the increasing burden which Covid-19 has placed upon the adult social care workforce and the sector as a whole.

Short term measures and building upon those systems which have arisen as a result of Covid-19 are of particular pertinence in increasing the attractiveness of the adult social care sector in the short to medium terms, including testing and PPE. The adult social care sector has inevitably experienced extremely high levels of sickness and absenteeism as a result of Covid-19. In the absence of reliable testing this remains a concern.

Long standing issues for the adult social care sector will persist despite Covid-19 and it is in turn incumbent upon us to adapt to the new realities of society to create solutions for these issues. For example, reprimanding the public perception around the need and attractiveness of care homes, or broader issues around ableism and ageism. Similarly, centrally lead efforts must be enacted to address the historically high staff turnover and vacancy rates.

3.1. The implications of Covid-19

On 27 April at the daily press briefing on the government's response to the Covid-19 pandemic Rt Hon Matt Hancock, the Secretary of State for Health and Social Care, announced that that the pandemic "*has shown that this country values our health and care workers so much.*" However, the measures introduced by the government as part of the response to the Covid-19 pandemic demonstrates that the social care workforce has not been given the precedence it either deserves nor it was depicted to receive.

The primary issue was that the social care workforce consistently remained an afterthought to the NHS. Perhaps the most damning evidence of this was at the onset of the pandemic when the NHS aimed to free up 30,000 beds in order to have capacity. All resources were diverted into the NHS with social care ignored despite the fact that care homes were at risk given the demographics and co-morbidities of their residents albeit care homes for older people or people with learning disabilities and/or autism.

Further, in a survey launched by Skills for Care in late March it was reported that 25% of the adult social care workforce, which is comprised of approximately 1.5 million people, were unable to work due to Covid-19 related issues. As means of reprimanding such issues, the government launched the Social Care Action Plan on 15 April wherein several measures were announced aimed at improving recruitment and retention in the adult social care workforce including: the creation of a new Care Workforce app; a national recruitment campaign aimed at recruiting 20,000 people in 3 months; and priority access and benefits for care workers for supermarkets and other businesses.

However, evidence suggests that organisations, including Care England, were required to fill the policy vacuum left by the government as the social care workforce did not receive the support it deserved. For example, the recruitment campaign detailed within the Adult Social Care Action Plan began on 24 April, whilst the NHS recruitment campaign had begun on 19 March. In response, Care England promoted the campaign "Social Care Needs You Too" in order to encourage the support of the nation to care for some of society's most vulnerable during these unprecedented times. Care England also worked with the National Care Force to help sign up 20,000 volunteers and 2,000 providers to support the care workforce in this challenging time.

Further, the Adult Social Care Action Plan and subsequent guidance did not take decisive steps to improve the current conditions for care workers. For example, it was not until the 15 May when the 'Coronavirus (Covid-19): Care Home Support Package' was introduced that financial aid was lent to specifically tackling infection prevention and control measures. The package was intended to form part of wider support for care home residents and staff, including by limiting staff movement, protecting wages and giving access to NHS personal protective equipment (PPE) training. However, as evidenced by Skills for Care across the adult social care workforce, around 3.4 million additional days were lost to sickness in March, April and May than would be expected looking at the pre-pandemic period. Whilst, between mid-April and mid-May, absence rates among staff in care homes were around 10% on average. This meant that prior to the additional £600m allocation, providers were required to support their workforce in silo.

This is demonstrative of the inequalities which continue to persist between the NHS and adult social care, despite being two sides of the same coin. Such inequalities are counterintuitive when one considers the co-dependency and intertwined nature of both sectors. In addition, Care England disputes whether you we can have a truly balanced system for as long as such inequalities continue to persist. Providers were damned if they helped free up NHS capacity and damned if they didn't.

3.2. Recommendations

The greatest priority needs to be better pay and recognition of the workforce. One example being that social care providers are unable to compete for staff with the NHS. This is a key issue given that both sectors often compete for the same workforce pool, given the similar skills and values which are required across both fields. Despite this the NHS' funding has outstripped adult social care funding by an exorbitant amount. Such realities mean that social care is not able to compete with the NHS given the lack of parity between their respective financial positions. These arguments have been echoed in Hft's 2018 Sector Pulse Check which heard how 61% of those providers surveyed 'also indicated that a career in social care is not valued the same as a career in the NHS, and that this is contributing to the difficulty in recruiting staff'.

A 2019 Health Foundation briefing found that if social care pay were to grow at the same rate as the NHS pay deal for Agenda for Change staff, in order to improve recruitment and retention, this additional cost pressure would bring the funding gap to £4.4bn in 2023/24.[1] However, the ability of the adult social care sector's ability to come anywhere near such pay scales is impinged by the continued underfunding of the adult social care sector. More specifically this has manifested itself when one juxtaposes the respective pay rates seen in each sector. There is a 7% gap between the pay rates for adult social care nurses, and the rates available for nurses in the NHS. Care workers in the adult social care sector receive an average full-time equivalent pay which is one-fifth lower than a similar role working to provide support to doctors and nurses in the NHS. In order to equivalate current social care staff and NHS staff pay rates, the government would need to increase funding by around £1.8bn.[2]

Further, Care England recognises that good and fair wages remain a lynchpin in the future sustainability of the adult social care sector. So too does the delivery of quality care to some of society's most in need. However, the introduction of the living wage has in fact impinged upon social care providers' ability to reward their most experienced staff through their inability to maintain pay differentials. Thus, the unnuanced nature of the National Living Wage's delivery has exacerbated the inability of employers to reward their most loyal staff members.

We implore this government to listen to the guidance of the independent Low Pay Commission and recognise its role 'in the sectors which Government itself funds – social care and childcare – sufficient funding is necessary to meet the cost of the rising NLW'.[3]

The government must work to maintain the safety and wellbeing of our workforce. Throughout the pandemic the adult social care sector has been subjected to guidance which does not recognise the nuances within the sector. The lack of bespoke guidance for each care setting and service user has meant that although the guidance produced over the course of the pandemic might be suitable for older person centred care settings, where the majority of residents are aged 65 and above, this is not the case for specialist care settings, such as those supporting adults with a learning disability or dementia. The implications of such a blanket approach being adopted manifested itself in the very real situation
of care providers being hindered in delivering the physical and psychological care and support that they are obligated and commissioned to provide.

The safety and wellbeing of the workforce must also be maintained through an effective supply chain for PPE to social care employers and their workers, providing the same priority as PPE supplied to the NHS, whilst also ensuring

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[1] https://www.health.org.uk/sites/default/files/upload/publications/2019/S08_Investing%20in%20The%20NHS%20long%20term%20plan_WEB_0.pdf

[2] The Health Foundation (2019). The real cost of a fair adult social care system. https://www.health.org.uk/news-and-comment/blogs/the-real-cost-of-a-fair-adult-social-care-system

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/844178/The_National_Living_Wage_Beyond_2020__1_.pdf

regular asymptomatic testing for workers with client-and resident-facing contact, volunteers, and visitors, across all social care settings.

Finally, measures must be put in place to support care workers' mental and physical health. Care workers are the front line, they need and deserve a centralised support service where they can glean emotional support. Covid-19 has put even more emotional pressures on adult social care workers and it is of paramount importance that we support them. Our staff are our biggest and best resource and need to be treated accordingly. This could be facilitated through the notion raised by Dr Rosena Allin-Khan MP, Shadow Minister for Mental Health, on 29 June of a national support service with a centralised number that care workers can ring if and when they need emotional support; Care England supports this initiative.

4. Regulation

This Section seeks to reflect on the most pertinent issues which Care England has identified in relation to the regulation of adult social care services, namely the role of the Care Quality Commission (CQC), whilst also presenting some tangible solutions in order to better ensure safe, quality and sustainable Covid-19 proof care in the future. Many of the issues emanating from Covid-19 in the adult social care sector have merely been symptoms of deeper-rooted issues within the sector.

4.1. Leadership

Covid-19 compounded longer-term trends where the NHS was perceived as the long-term project whilst neglecting adult social care, in the same way that it's been neglected over the last 20 years by Governments of all colours. Issues which have occurred in care homes are symptoms of long-standing trends intertwined with the Covid-19 pandemic. The most important factor has been the ability to exercise central control. For example, change in the NHS has been achieved due to a clear command chain. Even where new roles have had to be created, they have fitted into an existing structure with a wide reach. In care there has been too much diffraction of leadership between NHS, DHSC, CQC, MHCL (local government via LGA and ADASS), and so clear leadership has been lacking.

Care England has heard on a consistent basis from our membership that over the course of the Covid-19 pandemic that they have not felt sufficiently supported especially in the early months by the regulator. The opinions of providers are a fundamental indication of the extent to which the system is not fit for purpose. CQC was in a unique position to help navigate the Covid-19 pandemic through clear messaging and oversight. As a result, Care England would have expected the CQC to have been much more proactive in contacting adult social care providers at the height of the pandemic. For example, Care England has collated evidence from providers indicating that they were contacted by the CQC at the end of the lockdown rather than during the most difficult period for providers.

The inaction from governmental quangos and CQC were highlighted twofold. First, the use of external bodies, such as Deloitte, were required to organise the testing regime when well-staffed bodies such as CQC, were not doing their usual regulatory activity and should in theory have had the capacity to run such schemes. Second, trade bodies such as Care England had to fight to address the issues felt in the sector. For example, we felt the need to issue our own guidance through FAQs and for Learning Disability providers, specifically advice regarding the use of masks and what to do if PPE could not be sourced. Care England has also just issued guidance for Learning Disability services around visitors. This combined with the Government's own failure to deliver guidance in a timely way has, in some instances, lead to a perfect storm of uncertainty amongst providers in terms of the practice surrounding the management of Covid-19. The issues partially stemmed from the inability of public sector bodies mobilising to take swift and decisive action, but also, their organisational capacity to be agile in terms of the functions they fulfil.

In the future, CQC must encourage and enable the re-establishment and improvement of person-centred and creative services. For providers to do this in the uncertainty of local lockdowns and sustained financial pressures, Government, and CQC in particular, need to give a firm commitment to support human rights-based practice, by offering clear guidance and good examples. Risk-aversion is almost inevitable unless government guidance clarifies as soon as possible, in practical terms (including indemnity and insurance, currently a very confused picture) how providers will be protected if harm should occur when users of services are being supported to take known, but unlikely and reasonably mitigated risks, for example, going to shops or places of worship, or meeting with relatives.

Part of leadership is taking a sector with you which is best done through building trust within the sector. Currently, many providers feel there is a lack of transparency within CQC and its development of key policies. For example, the current system lacks rigor in the oversight of commissioning- this was referenced by the CMA in their recommendations for an independent body to monitor and review commissioners and further developed by the Care Quality Commission in their recent report, Beyond Barriers, which called for an extension of CQC's role to regulate commissioners. Care England has long supported such an extension as a critical mechanism to ensure greater transparency and consistency in how markets are supported to be more sustainable across the whole country.

The creation of trust within the sector is also reliant on joint working and consultation. Again, members have conveyed the notion that these principles have not been applied in the development of policy. One manifestation of this has been in relation to data and the lack of consultation with the sector regarding what KPIs would be most beneficial for the sector itself to collate. Instead, much of the data collation has been led by the CQC's own interest, in turn, disincentivising the engagement of providers in many cases. At its core, meaningful data collection is reliant upon all parties feel that it is beneficial for both them and the broader good.

4.2. Integration

The Covid-19 pandemic has demonstrated the interdependence of the health and social are system and the organisations that operate across the system. Thus, going forward, CQC needs to look to not only promote this interdependence, but also look at system performance through more effective whole systems pathways.

In terms of integrated working, Care England proposes that in line with joint budgets and plans, refreshed governance rules need to be in place to enable commissioners and providers to work better together. Under current systems, providers are often marginal contributors (a consistent theme in many of the CQC Local System Reviews) and Care England is calling for independent community care providers to be sitting members in local integration arrangements.

With a fully integrated regulator we would have expected the CQC to be much more vocal about some of the challenges around primary care with regards to its withdrawal from care homes as well as some of the challenges around discharges from hospital at the start of this pandemic. At a recent Public Accounts Committee meeting, Sir Geoffrey Clifton Brown stated that the national policy was driven to stop the NHS being overwhelmed and that there was not the same degree of care given to adult social care settings.

Further, as a fully integrated regulator CQC could have also played a much stronger role in the pandemic in facilitating joint working across the health and social care continuum. Although we are pleased to note the introduction of the new CQC initiative of Provider Collaboration Reviews wherein CQC is carrying out rapid reviews of how providers are working collaboratively in local areas, we feel that this initiative could have been facilitated sooner.

Such evidence elucidates the chasm between the support social care receives from central Government and public bodies, relative to health care. However, Covid-19 has acted has a catalyst for change by facilitating new relationships between primary and social care organisations. The CQC must move to promote these new relationships by moving to a system-based approach. For example, never again must some of society's most vulneravle be subjected to the blanket use of DNA CPR which was evidenced at the outset of the pandemic. A DNA CPR should only be applied on an individual basis not applied to groups of people. It is so important to make sure that, even where a DNACPR might be appropriate in a particular context, that it is reviewed with the person and their family/carers at a point of transfer. In this vein, the future of regulation needs a capacity to support and look at whole systems.

4.3. Funding

It is well known that adult social care has for many years been afflicted by a multi-billion-pound funding gap. Whilst the Covid-19 pandemic has merely exacerbated this as an issue. Care England has itself been engaging in its own

cost collection exercises which have shown the financial cost of Covid-19 to be unprecedented to the sector.

As noted earlier, over the Covid-19 pandemic the Government allocated an unparalleled amount of money, almost £4bn in 20 weeks. Yet, due to the allocation of money through the failed mechanism of the Local Authorities, this money has not reached the frontline. The lack of uniformity in the approaches of Local Authorities is a symptom of the lack of oversight of Local Authorities. Again, this is indicative of the need for greater oversight to be placed upon commissioners and this remains a blind spot within the adult social care system and how it is regulated. At the very least, there needs to be a review of the role which the provider should play in the commissioning of care. Fee levels and the nature of commissioning are fundamental in the outcomes relating to care. Often, we find that providers are receiving such low fee levels that it means they are merely swimming to keep their heads above water. This means that some providers often don't have the capacity to act in a strategic manner in the delivery of care. This is despite the best efforts of the social care sector, however after years of neglect by Government of all stripes providers are really feeling the pressure in many years.

The social care sector is subject to public sector commissioner delays to health and Local Authority assessments, delays to payments and fee announcements , complex system requirements across contracting and payment arrangements, and LA/CCG disputes over who pays. Such commissioning has the capacity to impact on cash flow and sustainability. Care England believes that the CQC should monitor and rate LA and CCG commissioning practices, whilst the Department of Health and Social Care should review the guidance on commissioning which accompanies the Care Act 2014.

The impact of low fee levels is being felt not just by the independent community care sector providing services for Older People, but also by those providing services for working aged adults with a Learning Disability. Low or nil fee increases for 2018/19, combined with unhelpful regulation requirements (under the policy of Registering the Right Support) and potential pay liabilities arising from sleep-in pay are putting many independent community care providers in the Learning Disability sector at risk, as well as compromising the Government's Transforming Care Programme plans to support adults with Learning Disability to have independent lives, as providers lack incentives to invest in community facilities. The Government must work with CQC to put mechanisms in place to ensure that commissioners and providers work better to increase capacity, especially for people in ATUs to enable them to be discharged into community settings more promptly.

5. Data

The Covid-19 pandemic has illustrated in stark terms the importance of data in responding to localised developments in a timely and effective manner. One only has to look at the feedback from the Local Authority and care providers in Leicester and how their capacity to respond quickly was undermined slow-moving data flows. Similarly, recent controversy around the definitions used

Public Health England for Covid-19 deaths in England illustrate the need for sound methodology. Whilst Care England's members have noted the non-specific nature of the guidance published by the Government surrounding social care, in turn, failing to recognise the nuanced nature of the sector.

In particular, the adult social care sector has been adversely affected by a lack of comprehensive data collation. This is somewhat reflective of the difficulties which proceed from the innate complexity, vast and disparate nature of the sector as a whole. However, despite such difficulties it is imperative that the Department for Health and Social Care itself develops a comprehensive data strategy for the adult social care sector. At present, the collation of data within the adult social care system is patchy and piecemeal in nature.

Moreover, some of the data collation practices by the CQC and Local Authorities have alienated adult social care providers. In particular, many Care England members have stated that during the Covid-19 pandemic data collation has undermined, rather than assisted their efforts to respond to the Covid-19 pandemic. Therefore, going forward any future data collection exercises led by government with the care sector need to be underlined by key principles. In addition, adult social care providers need to see the value of the data collection processes which are being devised by central and local government. These principles should be co-produced with the adult social care sector. Only through such engagement will the mistakes of the past not be repeated.

Effective data collection is in the interests of both the adult social care sector at large, but also, to allow government actors to make sound policy decisions. During the Covid-19 pandemic we have heard frustration in equal measure from key government officials whom have commented upon the insufficient levels of data in the sector. Therefore, we invite the Government to collaborate with the sector over where we are going forward from here. It is important to note that future policy development must be viewed through two prisms, including, short term Covid-19 data considerations, as well as, the longer term architecture of the system at large. However, it is equally important to not lose

Lastly, it is worth noting that if government and the adult social care sector were to collaborate in the creation of effective data systems, this would be a key step in the adult social care sector being seen as the national resource which it should be. When the Prime Minister talks about no longer kicking adult social care into the long grass – this is a fundamental piece of the puzzle. Thus, we implore the Government to engage with Care England and the sector at large to build a more comprehensive data future for adult social care.

5.1. The data experience and the Covid-19 pandemic

At the start of the Covid-19 pandemic, data collation by the government in regard to adult social care was non-existent in many cases. This was one manifestation of the long running neglect of the sector by the Government and the lack of attention paid to it. This meant that when the pandemic struck, that this was met by a disorientated approach to engage in a sector that had not been sufficiently considered before. In the proceeding weeks this led to the

creation of a number of systems aimed at data collation, however there was never any clear direction from central Government which presented the following issues:

5.1.1. Slow data flow to the frontline

The experiences of care providers within Leicester have been a clear manifestation of the untimely nature in which data has been passed on to care providers. This needs to change in the coming weeks and months, in particular, as we enter the "new normal." In our discussions with members we heard how they were kept up to date with the growing number of cases in the city by their local paper, rather than the flow of data being passed to them by organisations like Public Health England and their Local Authority. This is surely a worrying indication of the lack of data flow to the frontline.

5.1.2. Capacity tracker issues and their broader connotations

The experiences of many adult social care providers and their interactions with the Capacity Tracker system have been broadly negative in nature. The implementation of the Capacity Tracker during the Covid-19 pandemic was carried out in a non-collaborative manner. Despite all the talk of coproduction in the sector its implementation was instead hierarchical in nature. Below we lay out some key examples and key evidence pertaining to the nature of capacity tracker and what broader trends it is indicative of:

- Capacity Tracker involves providers filling out a plethora of questions. However, providers have often stated the difficulties of answering many of the questions. Care services have suggested that this has been a manifestation of the lack of engagement which they received in the actual crafting of the questions involved.
- Burdensome requests – at a number of points during the pandemic, Capacity Tracker has imposed burdensome deadlines upon the adult social care sector at a time of greatest pressure. Such actions lead to providers having a particular perception of the Covid-19 pandemic.
- Also, the nature of the data being collated by Capacity Tracker has been seen by many as not being useful for the care sector itself. Again, this was a manifestation of the failure of those whom crafted the system to actually engage with the sector in the creation of the system.
- Capacity Tracker has also been seen by many as not actually having a tangible impact upon the real world. The system was initially set up with the intention of responding to the immediate needs and pressures of providers. For example, if a provider was to cite that it had PPE needs this would in turn translate to sufficient amounts of PPE being delivered to the care service. However, what we have seen is that this has largely not been the case. Instead, local systems have been seen as being unreactive to the pleas which providers have made in their submissions to capacity tracker. In turn, this has created a system which is in the eyes of providers not reactive to their needs.
- Data inputted manually creating administrative burdens

5.1.3. Data duplication

There has been a significant issue around duplicate data. Local Authorities are still asking for the same data via direct request to their local providers. CCGs are also asking for data and on top of this the introduction of the Infection Control Fund, has resulted in a huge amount of extra reporting data being required via new routes as well as extra questions in the Capacity Tracker.

5.1.4. Data transparency

Over the Covid-19 pandemic, one of the primary issues conveyed by the Care England membership has been the transparency of data. This is best elucidated by the availability of deaths as a result of Covid-19 in learning disability and/or autism care settings remained a significant issue until early June. From late April, the Office of National Statistics (ONS) began to publish their weekly report on deaths alongside data provided by the CQC. The information provided by CQC by care homes via death notifications as part of the ONS's weekly reporting on deaths was intended to ensure a more real time picture of Covid-19 induced deaths is captured. However, the data collected did not reveal the number of deaths of those with a learning disability and/or autism, and in which care setting these deaths have occurred. Greater national data transparency at an earlier stage would have not only allowed providers to allay families concerns who have loved ones in specialist care, but it would have also allowed providers to make better informed decisions around contingency planning.

This issue is particularly important in the context of Supported Living services, which at present are not included as part of official statistics. This will again replicate many of the same issues that Supported Living services have been subjected to such as being left behind in terms of support and guidance and be under additional burden in terms of reporting. In the future a solution needs to be reached whereby Supported Living can be included either the care home information or domiciliary care statistics via CQC. This data must be part of a broader data strategy whereby there is a single centralised national platform with clear data governance.

5.2. Recommendations

5.2.1. Creation of systems which benefit both government and providers

At its core, providers will ultimately be motivated to input into data systems if they see these systems as being of benefit to their own organisations. However, during the Covid-19 pandemic, care providers have often not been able to see the benefit of those data collection systems which have been created. Instead, there has been a widespread feeling that these systems have merely been created for the benefit of those whom eventually receive the data. In no way is this an effective trend to created trust and collaboration within the system.

In order to remedy the lack of data reaching the frontline, instead, priority needs to be given to adult social care providers receiving such information. Part of this

is also ensuring that local systems are kept informed and, in turn, care homes are intertwined with local systems. This would also help ensure that real-time data reaches the frontline which can lend to providers being able to create more comprehensive contingency plans.

5.2.2. Trust within the system

Those responsible for the collation of data have often been held in hostile terms by the very care providers passing over the data. Despite Local Authorities' being responsible for the collation of data – they are often viewed through a prism of suspicion by the organisations involved. This is the manifestation of many years of interactions and the often-zero-sum nature of how many commissioning processes are conducted. Going forward, it is therefore important that those whom are tasked with the collation of data in future should be those who will be seen in a much more neutral light.

5.2.3. The need for data collation to recognise the nuances of the system

Many of Care England's learning disability members have voiced their issues surrounding the development of data policy. In many cases, they suggest that not enough dues has been paid to the diversity of the sector itself and the nuanced needs of its many different segments.

5.2.4. Government's data definitions for adult social care

What has not been clear is how the social care sector and the Government have been defining and recording data. There was confusion around, for example, the number of people who had Covid-19 and whether that was because they were suspected or tested. It took a long time to compare data meaningfully across the sector and challenge the Government who were pumping out a set of data for people who had been tested. The sector collates data in different ways. There needs to be clarity around what data social care providers think needs to be collected and how we work to that same agenda with the Government.

5.2.5. Single source of data collation

Evidence from social care providers suggests that they want to see a single source of data collation from a centrally lead body in order to gain a whole sector representation. The data inputted must also be segmented with a single-entry point. This data needed to be inputted as part of a clear data strategy which ensures benefit to both the Government and providers. This single source should be centrally funded in order to ensure that additional pressures are not placed onto care providers or care organisations.

5.2.6. The role of the regulator

Care England is of the view that the capacity of leaders to enact effective change is sometimes limited by the process driven nature of the CQC's regulations. Our feedback from members has suggested that this has at times led to leaders being dissuaded from acting creatively. Instead, we suggest that future

assessments should be outcomes focused. For example, this has been seen by the CQC's behaviour towards innovation and how at times it has not been outcomes focused. This is due to a plethora of reasons, including at times a lack of technical proficiency. Care England received the following feedback from it Digital Special Interest Group:

- CQC seem to endorse electronic care planning (as suggested by Kate Terroni) but this needs to be a universal endorsement across CQC with ground level training
- CQC inspectors often look for hard copy paper records when inspecting as opposed to digital care records when inspecting services
- Limited expertise in how to analyse electronic care records needs to spread across the inspectorate. There are gross inconsistencies in the expertise across the inspectorate which in turn produces inconsistencies in inspection results.
- In this vein, services are being marked down unfairly for the inexperience of the inspectors.
- As services go through the transition period of digitalisation, services are particularly vulnerable as they might be made conscious of new data trends, such as a documented increase in falls, however in reality there has not been an actual increase in falls, only an improvement in recording. Accordingly, the CQC need to make allowances.
- CQC should ask which care planning software systems the services use prior to an inspection. This way inspectors are sent who are familiar with the electronic system and can therefore provide a fair inspection.
- Therefore, Care England believes that regulation most be geared towards providing incentives to both digital leaders and leaders at large to act creatively.

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