Covid-19 Inquiry

Submission by Ealing Reclaim Social Care Action Group
November 2022

Introduction

Ealing Reclaim Social Care Action Group (ERSCAG) is a voluntary group working for improvements in social care generally, and especially in the London Borough of Ealing (see www.erscag.org.uk). We warmly welcome the national inquiry into Covid 19 since we think it is vital that lessons are learnt from the pandemic, locally and nationally. As the pandemic developed, there was extensive learning in our immediate area, and we had several exchanges with Ealing Council about the impact of the pandemic on social care users. We (virtually) attended relevant Council debates, engaged in correspondence with staff and Councillors, and submitted two more detailed documents – a Review of Learning Post-Covid in Ealing (dated August 2020) and an Updated Review of Covid Learning (dated July 2021). The following document therefore derives from our observations and lived experience during the pandemic. Whilst our experience was gained largely in Ealing (and therefore England), we hope that our conclusions will be of use to the national debate and the recommendations of the Inquiry team.

Our submission addresses many of the Covid-19 Inquiry's Terms of Reference,[1] but is solely focused on social care provision and the impact of the pandemic on social care users and workers. It develops a series of lessons learned and recommendations, with (pp 10-11) a short summary of key conclusions.

Lessons learned and recommendations

1. **Discharges from hospital**

One of the early explanations for the high number of deaths in residential and care-homes was that hospitals, in a natural desire (and indeed an 'instruction'[2]) to 'empty' beds, were too precipitate in discharging people from hospital, and infection control was inadequate.[3]

There are at least three lessons to be learnt from this. Firstly, there need to be adequate infection controls and support mechanisms within 'reception' venues and the NHS, to avoid discharging people prematurely or inappropriately.

Secondly, in times of crisis, there need to be a range of step-down measures which allow for a safe transition from hospital to home. It was a great reassurance when Ealing instituted a series of step-down venues to reduce the risks created in this important transition. The extent to which these should be maintained post crisis, or indeed introduced in areas where they do not exist, would be worth exploring, given the assistance they provided to the NHS in moving patients expeditiously onwards after their acute care needs had been addressed.

Thirdly, legislation introduced since the pandemic[4] has made a preferential option of the "discharge to assess" measure. This may be positive in terms of freeing up NHS beds, but

ERSCAG is concerned that this measure might leave people very vulnerable. Once someone has been discharged, they are no longer the responsibility of the NHS, but prior to assessment - can one be sure that the Council has fully taken on their care? People who are returning from hospital, particularly older or disabled people, may find that they 'fall between two stools', and some will not have family or friends to advocate alongside them. ERSCAG understands that there is no easy solution but believes that the transition from hospital to a social care package in the community could allow people to fall through the gaps. Ealing's Health and Well-being Board appears to be addressing the issue,[5] *but the Inquiry may want to reflect on the importance of reliable transition arrangements between the NHS and care arrangements, and make recommendations accordingly.*

2. Primary care learning

Based in London, Ealing residents had the advantage of an array of pharmacies/GP practices that might not exist in other parts of the country. Nevertheless, there are a number of issues which we think would be worth exploring -

a) ERSCAG understands that Ealing is a 'net importer' of nursing home residents and is one of the London Boroughs with the highest number of care home residents, but also has one GP practice dealing with a very large proportion of these nursing home residents [6] This single point of contact was cited by Council officers as a distinct advantage when trying to coordinate medical efforts across a range of privately run residential homes. It is not clear if this should be a recommendation for other Council areas, but at least, given the highly fragmented and privatised nature of care, the Inquiry might want to explore the value, and practicalities, of coordination across a range of homes/GP practices etc.

b) Obviously, GP practices were a key focus when determining priority access to PPE, vaccinations etc, but GP records do not necessarily contain information on a person's work status. This meant that paid carers/Personal Assistants could not easily be identified and prioritised for attention. Some of this information was available in a dispersed way via Council records and, over time, carers were given the necessary support - but improved record-keeping in this regard might help in any future crisis.

c) It is particularly important that medical records note when someone is housebound, so that special provision can be easily made for their needs at times of crisis. The priority in vaccinations was, understandably, to deal with large numbers, and vaccination centres were established quickly. However, those requiring attention in their homes were left very frightened that they would be overlooked. ERSCAG understands that other home-based services were suspended or reduced leaving people reliant on community nursing very frightened. We intervened in a couple of individual instances, but it would be good to have systems ensuring that the needs of groups with different access needs are fully considered.

3. Residential care

The Inquiry will be looking carefully at the learning for residential care given the high level of fatalities[7] and the widespread public concern created by 'lockdown' measures.

a) As opposed to health measures (mainly channelled via the NHS) and public health steps (channelled via Local Councils), social care is largely privatised. At a time of emergency, especially when social care users (by virtue of age and/or disability) are amongst the most vulnerable cohorts in the population, this lack of any central organisation could have proved very problematic. It was vital that Councils were given the powers to take effective control of care homes, and that they did so. Ealing Council's ability to coordinate PPE provision, privilege supplies to care-homes, and ensure infection control were all vital measures. In due course, Ealing Council also had to actively monitor market conditions, help care-homes close temporarily or permanently, and provide alternative options. *The Covid-19 Inquiry may not want to engage in proposing changes to social care arrangements,[8] but the pandemic did highlight important gaps in provision.* ERSCAG hopes that local Councils will be commenting in some detail on their experience of having had to 'compensate' for market failings in residential care, and the learning regarding the interplay between 'public' (Council/NHS) and private provision at times of a national emergency.[9]

b) Media reports highlighted a number of specific concerns with regard to care-homes. Early on, for example, low-paid care workers who were employed at more than one home, or were employed on a temporary basis, posed a risk that they might unwittingly be transmitting infection from one workplace to another; some media also suggested that there were different mortality rates as between larger and smaller homes. At a later stage, it was realised that different shift patterns made 100% vaccination coverage of care-home staff slower than ideal.[10] *We expect the National Inquiry will carry out research into such issues, to learn future lessons?*

c) A serious problem that was reported very widely was the difficulty posed to family members who were restricted in their access to loved ones. Clearly care-homes had to protect their residents and staff from infections brought in by visitors. Yet, it is difficult to believe that safeguards do not exist which would protect all involved, whilst allowing some form of physical and emotional contact. ERSCAG supporters suffered directly from being denied access to visit (and reassure) loved ones, but we expect the Inquiry will receive extensive testimony on this issue. *We commend to your attention the recommendations made by the Joint Committee on Human Rights in their inquiry into "Protecting Human Rights in Care Settings"*.[11]

d) At the outset of the pandemic, ERSCAG became aware that some disabled people were in a local residential home merely awaiting the provision of accessible accommodation. The Council moved fairly rapidly to resolve some of these situations, but the experience highlights the importance of Councils ensuring that no-one is 'delayed' in a care-home when this provision is not appropriate for them. This problem in turn highlights the need for Councils to ensure adequate provision of accessible housing, or suitable adaptations, to facilitate social care users living as independently as possible – even, or especially, in times of an emergency.

4. Domiciliary care

The great majority of social care users are receiving care packages in their own homes. ERSCAG is unaware of any calculations that have been done regarding the likelihood of an

increase in demand for care packages as the impact of covid, and long covid, but assumes that there may well be an increase?

a) When the pandemic was declared, social care users dependent on paid carers or Personal Assistants were immediately worried about a possible breakdown in service provision. Ealing Council was able to assure us that their 'duty of care' responsibilities meant that they had an emergency response telephone line which care users could access 24/7 if need be. This 'after-hours' service apparently existed before the pandemic but appeared little known to those who might have benefitted from this reassurance. *Given that this service is presumably provided around the country, and will continue to be maintained post-pandemic, it would benefit from wider publicity, especially to those most likely to require it in an emergency*.

b) In Ealing, a range of support networks were mobilised by the Council (Ealing Together, Ealing Covid 19 Mutual Aid group etc) as well as a range of support mechanisms (extended 'Taxicard' and Dial-a-Ride systems; identification systems to privilege Personal Assistants/carers to help with shopping; Foodbank home deliveries; supermarket priority delivery slots etc). The mobilisation of a large number of volunteer helpers, with the support of local charities, community organisations, and faith groups was greatly appreciated by carers and care-users. Similarly useful were the self-help schemes established by way of What's App and Facebook groups encouraging people to be alert to the needs of neighbours. *ERSCAG suggested that the Council formally evaluate how these systems worked in practice and, where appropriate, consider which, if any, should be maintained beyond the original 'emergency' – this may be something for other Councils to consider also?*

c) *Some measures introduced to respond to covid need to be considered as potentially longer-term measures.* For example, PPE and other infection controls were necessitated by Covid, but those with particularly vulnerable health conditions might benefit from these measures more permanently? Could Disability Related Expenditures (which are discounted from one's income when means-testing social care users) be interpreted more generously to include heightened infection control measures for those who would benefit?[12] The Council maintained close contact with domiciliary care agencies (as well as care-homes) to monitor their operational methods, their financial resilience and their sustainability. The institutional relationships may be difficult to maintain long-term - especially given the problems of funding cuts to Councils[13]- but it would be unfortunate to lose them once they have (hopefully) been strengthened as a result of the emergency. There were some administrative hiccoughs at the outset about outreach to Direct Payment Users (eg individualised rather than easily accessible centralised records; out-of-date records on 'preferred means of communication'[14]) and these need to be remedied.

5. Provision of daycare opportunities

The pandemic created great problems for the users and providers of day-care services. Certainly at the outset, and for some time after lockdown was formally ended, face-to-face provision had to be suspended entirely or seriously limited. Staff and volunteers maintained 'welfare checks' with service users and their families and carers by way of regular phone

calls and other 'virtual' options where this was possible, but this took some time to organise. Indeed, the transition highlighted the problem of 'digital inequality' amongst both users and staff. Then, gradually, as users became more confident about infection control measures at day-care centres, college & apprenticeship courses, and in the transportation arrangements they relied upon, more 'normal' service resumed. A major hit was the loss of internships in the hotel, catering and café sectors (all themselves badly hit by lockdowns) and those have not yet been fully re-instituted, and may never be? Another challenge was the almost complete reduction in residential 'short break' options.

Our experience in Ealing suggests that these problems will have important long-term consequences. Large day-care centres owned or rented with a view to working with many people at the same time may no longer be seen as ideal; experienced staff have left in large numbers; and new services have to be designed, including the recruitment of local employers willing to provide new internships and employment opportunities.

The Inquiry may want to consider issues such as:

a) Day-care provision is largely geared to people with learning difficulties or autism and ERSCAG was made aware relatively early of cuts in their social care provision.[15] We do not have any information to hand about what was happening to services for people with dementia? *The National Inquiry will presumably be commissioning a range of research and it would be useful to determine, by way of quantitative and qualitative research, who was impacted and how by the pandemic?* Were people with disabilities particularly disadvantaged in terms of their care packages; in services provided; in hospital treatment; in decisions about 'DNR' notices; or in vaccination planning?[16]

b) In Ealing (and presumably elsewhere), day-care opportunities are largely provided by charities commissioned to provide services, albeit funded by the Council. Locally an All-Age Learning Disability Strategy has been commissioned by the Council to look at this work over the longer term. Amongst other things, the Strategy will look at the myriad support projects provided by the voluntary sector and any changes required. If service providers are to re-purpose their venues and increase their staff-user ratio, this will require them changing their business model. If this puts their financial viability at risk, this would lead to an unacceptable diminution in service or even closure of many centres*. The Inquiry should commission some specific research into the long term consequences of covid-19 on this sector and recommendations to be made?*

6. Paid care workers

One of the very few 'advantages' of covid was that it increased the public awareness of the existence and needs of social care users. Care workers were also seen, perhaps by many members of the public for the first time, as 'essential workers'.

a) Pay and conditions: The absolutely essential nature of the work carried out by Personal Assistants and care workers was publicly recognised during Covid (alongside their NHS colleagues), but their pay and conditions rarely reflect the importance of the work they do. Ealing Council has committed to ensure at least the

Real (London) Living Wage to all carers employed in the Borough, and this should be made a commitment by all Councils. It also became apparent that care workers were moving between different private homes and not having their travel time and/or expenses covered, thereby further decreasing their wages. It will be impossible to recruit people to these vital jobs if society does not recognise their importance and ensure that they are paid decent wages commensurate with their skills, and that their conditions of work also reflect their 'essential worker' status.

b) Work status: The impact of losing many EU nationals from the NHS and care workforce after the Brexit vote, as well as the pandemic, has meant that workforce shortages are very grave.[17] Many care users have found and still find it difficult to recruit staff. We understand that Ealing Council is engaged in various national recruitment efforts, but the answer is not an easy one. Proposals from others have argued for (a) more investment in training for care-workers (see on); (b) including care-workers on the list of 'shortage occupation list" to facilitate access to visas; and (c) a more long-term workforce strategy. 0o These and other measures should be recommended by the Inquiry since they are all *<u>relevant to ensuring that we prepare "for future pandemics across the UK"</u>* (item 2 of the Inquiry's Terms of Reference).

c) Qualifications, training etc: By arguing for a wider pool of possible recruits (via the easing of visa restrictions), ERSCAG is not suggesting that British-born workers would not be very welcome to take up this work. However, if the profession is to be sufficiently attractive to young school and college leavers, caring must be seen as the *profession* it is. Staff must be adequately paid, trained in a range of skills, and caring should be treated as on a par with the status offered health workers. As we know from many of the media interviews with young care workers during Covid-19, it can be a very fulfilling career – we must ensure that one of the lessons from the pandemic is to make it one for more people.

d) The 'threat' of mandatory vaccinations to care workers raised in earlier phases of the national response to Covid appears to have been largely counter-productive, with media reports of care staff feeling discriminated against and resigning. Like with vaccine hesitancy, it seems that targeted campaigns - carried out respectfully and in consultation with the individuals and groups involved - worked more effectively.

7. <u>Carers</u>

Reference is made at several points in this submission to the rights of carers which were not respected during covid-19 – for example, the importance of a designated person being permitted to visit their loved ones when in hospital or a residential home. However, there are other issues that would be worth addressing as well:

a) Do medical records routinely record that someone is in receipt of care and/or that they are the primary carer for someone? This would facilitate tracing people who should be treated together? For example, in Ealing, some couples attended together for vaccinations, but the non-disabled partner was denied treatment which rather undermined the decision to prioritise the most vulnerable.

b) Ealing Council has a system of providing primary carers with an emergency card to be carried with a contact number for use if they are involved in an accident or otherwise detained and have someone vulnerable at home requiring help. The 'emergency card' system provides great reassurance to carers who know that there is a 'safety net' for those dependent upon them should anything happen. Is this common to other Councils or should it be recommended more generally?

c) The Inquiry might find it useful to seek input about the impact of covid 19 on carers, or care provision more generally, in an analysis of complaints made via the Local Government and Social Care Ombudsman (www.lgo.org.uk)?

8. Health Inequalities

ERSCAG appreciates that the Inquiry's Terms of Reference has as its first aim to "*consider any disparities evident in the impact of the pandemic on different categories of people, including, but not limited to, those relating to protected characteristics under the Equality Act 2010".* We assume that the Inquiry will commission research on the following:

a) Disaggregated statistics on the basis of all the protected characteristics would be helpful in determining the impact of pandemic on specific groups according to levels of infection, hospitalisation, fatalities, long covid, vaccination take-up levels etc.[18] *The Inquiry may also want to make recommendations about the importance of gathering such data on an ongoing basis?*

b) *Socio-economic status is not one of the listed protected characteristics, but ERSCAG believes that the Inquiry should research the impact of Covid-19 on this basis also.* Several media and other reports suggested that poverty levels, size of households, employment status, all appear to have had an impact on the experiences of covid, and the take up of, or failure to take up, the vaccination programme. Certainly, the widespread provision of free supplies of PPE (Personal Protective Equipment) and Lateral Flow Tests (LFTs) were crucial in the earlier stages of combatting the pandemic. Once these basic safeguards had to be paid for, it was obviously problematic for people on low incomes or benefits to cope, even though they (care-workers and those employed in public transport and retail) were often the most exposed to later waves of Covid.

c) Presumably trade unions and businesses will be making submissions to the Inquiry about the impact of covid-19 on working practices, re-integration of workers back into the workforce, and their assessment of the socio-economic inequalities created or exacerbated by Covid?

d) More generally, essential workers - including care workers - are often poorly-paid and/or have an insecure employment status. In many instances, as noted earlier, care workers were required to move between different residential homes, or different private homes and were (because of shift work) not always easily available for vaccination programmes. Statistics about the impact of Covid 19 generally on such workers would be very valuable.

e) ERSCAG understands that emergency legislation suspended the requirement on public authorities to undertake Equality Impact Assessments and believe this is worth re-visiting. *The Inquiry should explore if this was a necessary measure, if it has been appropriately time-limited and/or, did it undermine efforts to ensure that the response to Covid did bear in mind the equality impact of any measures taken*?

f) The passage of emergency legislation also suspended on-site inspections by the Care Quality Commission for much of the pandemic, but this then perhaps left people without confidence about what was happening to their loved ones. Is there any learning from this? Did the Council have access to the kinds of disaggregated statistics that they needed to carry out their increased oversight function?

g) Ealing Council has carried out some very interesting recent work on health inequalities – both by way of carrying out an Integrated Equality Impact Assessment, and the establishment of an Ealing Race Equality Commission. Both efforts, and perhaps others also, highlighted the equality learning in the wake of the pandemic, and may be something for other Councils to consider? *At least, the Inquiry should recommend that public health staff and care-workers must have equality training.*

h) A local hospital appointed a specialist nurse to assist with the needs of patients with Learning Disabilities. We presume this was in response to an increased intake of such patients during covid, when the NHS was already under great pressure. However, having a staff member who can better understand and communicate the needs of people with Learning Disabilities to other staff was very helpful at the time, especially when family members/support workers were unable to visit. Specialists can brief themselves on the dietary, medication and communication needs of Learning Disability patients. *This kind of improvement in NHS services bears being replicated in other hospitals, and extended to GP practices, beyond any emergency.*

9. Communications generally

Good communications – whether between national and local bodies, between Councils and the NHS, or between all of these institutions and the general public – is extremely important. Our experience in Ealing was that it was not always 100% successful - but there were several communication lessons learned during covid-19:

a) Regular national broadcasts were vital to keeping people informed of the seriousness of the pandemic, and the actions to be taken - though why, in England, they were made without basic BSL interpretation is inexplicable.

b) National messaging was insufficient of course, and much more targeted information was produced at the Ealing level. Ealing Council reported that they reached out with information to social care users, to local voluntary and other groups, set up a Care Homes Cell to work on care home resilience, had regular meetings with relevant local NHS staff, and engaged in learning on a pan-London basis. Communicating these efforts via Council Scrutiny Panel meetings helped reassure the public.

c) Council efforts to produce material in a variety of 'local' languages were similarly important, not least because it also meant staff having to engage with local community groups to 'spread the word'. Perhaps more use could have been made of social media and supermarket notice-boards etc. But generally, this community outreach quickly alerted the Council to demographic/cultural issues about multi-generational households, the needs of people in hostels (homeless, mental health hostels, domestic violence refuges), and the causes of vaccine hesitancy. Council public health staff were well placed to address these different issues, but had to learn quickly about opening up new dissemination channels & communicating well with the different target groups.

d) Elected councillors in Ealing asked staff for regular up-dated Q-and-A sheets, to allow them to answer directly any issues arising in their wards. This was both a useful way of disseminating reliable information as widely as possible, but it also took some of the communication burden off hard-pressed Council staff.

e) Media scrutiny (national and local) was vital for alerting people to many of the problems caused by the pandemic. This submission refers to many media reports and Freedom of Information requests – information which might not have been available otherwise. Whilst the authorities have a natural interest in reassuring the general public as to the risks, it is also vital that they are scrutinised closely by the media and an active civil society, so that really serious problems (like precipitate hospital discharges to care homes) are spotted quickly and remedied.

10. <u>Council responsibilities in an emergency</u>

As is apparent from much of this submission, a key learning from Ealing was the importance of 'decentralising' authority from central (or NHS) authorities to local Councils working closely with their local NHS partners. This necessary decentralisation of authority also obliged the Council to improve its internal operations, and it seems that some of the early uncertainties about the respective roles of public health staff and social services were ironed out fairly quickly. A couple of examples might be of particular interest.

a) Infection control – in the early stages when the national instruction was 'to stay at home', Councils had the know-how to reach out to particularly vulnerable groups – the homeless and domestic violence shelters etc. – and the mechanisms to reach them. The Contact Tracing option established nationally was much more effective once it was 'delegated' to Council staff who knew their demography best.

b) Vaccinations - Ealing Council produced extensive material in languages other than English; they had trustworthy intermediaries amongst community groups and faith organisations; they appointed Community Vaccine Champions. It is difficult to imagine that serious problems of vaccine hesitancy could have been effectively addressed without this local know-how.

c) Emergency powers: ERSCAG welcomed the fact that the Council did not exercise its right under the emergency legislation to seek easements from the Care Act to

reduce social care assessments but what did other Councils do? We also welcomed the decision of parliament to require six monthly renewals (rather than accord indefinite powers to government). However, we were concerned that the requirement to carry out equality assessments was suspended. *The Inquiry might want to request local Councils to review their powers in the wake of the pandemic and make recommendations accordingly.*

d) ERSCAG cannot comment with any expertise on the financial consequences of the pandemic on Councils, but we assume that this is an issue that the Inquiry will pursue in depth with local government representatives, trade unions and others?

Summary of key learning

ERSCAG outlines in the submission above a whole series of comments/recommendations, but we think that the most important learning can be summarised as follows:

a) While the pandemic required a national (indeed an international) response, it was the efforts at local level to educate, inform and engage people in a common struggle which were vital. Uncertainty and confused messaging were national problems, but there was a sense at the local level that once the Council was more firmly in the 'driving seat' (alongside their colleagues in the NHS) things began to improve. We think it would be helpful for the Inquiry to emphasise the importance of decision-making taking place as near as possible to those affected by those decisions, albeit within a clear national/international framework. Indeed, the Inquiry may want to comment on the role of local government generally in handling the crisis.

b) Effective communication is an important part of any public health campaign. Daily press conferences by the Prime Minister and senior scientists were important, but communications improved once major efforts were 'delegated' to Councils. Councils know the geography and demographics of their local areas; can produce material in appropriate languages (in addition to English); conduct more knowledgeable contact tracing efforts; and can use levers unavailable to others (faith groups, community associations etc) to develop trust and tackle vaccine hesitancy. Centralised public health messages are important but need to be complemented as much as possible with localised targeted efforts.

c) Similarly, effective coordination is crucial in a time of pandemic. The emergency legislation was probably important in giving Councils and others the necessary powers to require such coordination across public and private sectors, though it would be interesting to both evaluate the usage of emergency powers, and the learning from that. ERSCAG believes that coordination of efforts across different Council departments, between the Council and their NHS colleagues, and between the Council and private sector and charities engaged in the provision of care was largely effective. It also seems to have created some important long-term relationships that will serve the community well. The positive learning from these experiences – both for future pandemics, and indeed for the general health and well-being of residents – is worth recording, sharing and emulating across the country.

d) ERSCAG has no expertise in local government financing, but it is clear that Councils took on extensive financial responsibilities when responding to the pandemic, and that their involvement was crucial to the response. They will have received enormous taxpayers' support from central government, but was it sufficient? In particular, was central government support adequate in light of the long-running cuts to local government budgets? And what of the covid experience will have a long term impact on Council services ? If we are to build in financial resilience for future emergencies, how should the desire to make decisions as close to possible to the people affected influence future local government funding arrangements? Has the immediate response to the pandemic drawn Councils even further into compensating for market failures in the largely privatised care system – and, if so, what impact will this have on local government finances as the pressure for social care provision increases (with an ageing population, and indeed long-covid)?

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Selected short bibliography

ADASS – Association of Directors of Adult Social Services – see *inter alia* report on the pandemic on people with learning disabilities and autism https://www.adass.org.uk/media/8647/adass-rapid-learning-review_ld-autism_may-2021_recs_v9.pdf

Age UK – www.ageuk.org.uk – issued several reports/campaigns throughout the pandemic

Ealing Reclaim Social Care Action Group (ERSCAG) – for additional research resources and its report for the consideration of Ealing Council "Updated Review of Covid Learning" (July 2021)

Equality & Human Rights Commission: https://www.equalityhumanrights.com/en/publication-download/how-coronavirus-has-affected-equality-and-human-rights (October 2020)

Health Foundation Research in July 2020 https://www.health.org.uk/news-and-comment/news/new-analysis-lays-bare-governments-failure-to-protect-social-care-from-covid19

Local Government and Social Care Ombudsman – reports annually on complaints relating to social care received and investigated - see www.lgo.org.uk

Inclusion London: www.inclusionlondon.org.uk – February 2021 - Locked Down and Abandoned: Disabled People's Experiences of Covid-19 (PDF)

Parliamentary Committees:

- Health & Social Care and Science & Technology -Coronavirus: lessons learned to date report published - Committees - UK Parliament.
- Joint Committee of Human Rights Inquiry: Protecting Human Rights in care settings (HC216; HL Paper 51, published 22 July 2022)
- Women and Equalities Committee: several reports on equality and covid 19 - with reference respectively to disability, gender, and race (see September/December 2020, and January, February and March 2021)

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END NOTES

[1] This submission addresses issues of health inequalities; the public health response (aims 1a.i-1a.xii); the response of the health and care sector (aims 1b.i-I.b.xi); and some elements of the economic response to the pandemic (aims 1.c.ii-c.iv). Throughout, we have tried to draw out the 'lessons learned' (aim 2).

[2] Letter from HMG dated 19 March 2020 addressed to Accountable Officers of NHS/Foundation Trusts/CCGs, and Directors of Adult Social Care indicates new Covid-19 Hospital Discharge Service Requirements "*The new default will be discharge home today".* The Guardian reported (29 May 2020) that the Department of Health & Social Care guidelines on discharge from hospital dated 2 April said "*Negative tests are not required prior to transfers/admissions into the care home*".

[3] An Ealing journalist learnt from FoI requests that, of the 119 people discharged to care homes in the North-West London area between 1 March and 15 April (2020), only 32 had been tested. An email by a cardiologist, as reported by the Daily Telegraph's Business Editor (12 May 2020), read: "*we discharged known, suspected and unknown cases into care homes which were unprepared, with no formal warning that the patients were infected, no testing available and no PPE to prevent transmission........The official policy was not to visit care homes ....so after infecting them with a disease that causes an unpleasant ending, we denied our elders access to a doctor – denied GP visits – and denied admission to hospital..."*

[4] The Health and Care Act, 2022

[5] The Ealing Health and Well-Being Board meeting on 7 September 2022 discussed 'Discharge Action Plans", a named "Head of Discharge", and 'Discharge Hubs'. Reference was also explicitly made to the need for special consideration of particularly vulnerable categories eg homeless people.

[6] **https://www.theguardian.com/world/2020/apr/22/without-a-plan-its-not-going-to-stop-care-homes-fear-worst-yet-to-come-covid-19** includes an interview with Dr Anna Down, a doctor with the Argyle practice in Ealing working with 1000 nursing home residents.

[7] In July 2020, ERSCAG was in correspondence with the Director of Adult Social Care about the contradictory statistics available regarding the number of covid 19 deaths in Ealing care-homes (and whether it was 25% or 42% of total covid deaths). Either of these statistics were of course worrying. The Director agreed "*to check again with public health about the correct figure and whether this can be disclosed";* ERSCAG has no updated figures.

[8] ERSCAG campaigns for a National Care Support and Independent Living Service (www.nacsils.co.uk) which should be publicly funded, free at the point of use, nationally mandated, but designed and delivered co-productively.

[9] The parliamentary Joint Committee on Human Rights in its report entitled "Protecting Human Rights in Care Settings" concluded explicitly: *"A public authority cannot abdicate its duty to protect the human rights of the people it serves when it outsources services to third-party providers*" (para 65, HC 216, HL Paper 51, published 22 July 2022).

[10] See, for example, ONS data (cited in ERSCAG's August 2020 document) which reported that there were more covid-19 cases in care homes that hired temporary staff; higher rates of infection in care homes that did not offer staff sick pay; and the movement of staff between homes was seen as a potential vector for infection. Indeed, these findings, encouraged some Councils (eg Liverpool) to consider more in-sourcing of social care.

[11] The JCHR's July 2022 report (HC 216, HL Paper 51) made recommendations about Liberty Protection Safeguards, human rights training for frontline staff, and specifically on access: "*The government must introduce legislation to secure to care users the right to nominate one or more individuals to visit and to provide support or care in all circumstances, subject to the same infection prevention and control rules as care staff" (*para 83).

[12] Care users are facing additional costs funding Lateral Flow Tests for staff working with them, now that testing is no longer provided free. Cost-of-living pressures are increasing also with – for example – much greater energy expenditures necessitated by a person's disability (eg utility charges for specialist equipment, heating, etc).

[13] Councils will also be understandably wary of financially or administratively 'subsidising' the work of domiciliary care agencies and residential homes which are commercial enterprises.

[14] Some ERSCAG supporters had several early communication problems because they were unable to communicate by phone with decision makers, or the fact that they were Deaf Blind had not been registered in their records.

[15] MENCAP press releases of 10 and 20 August 2020 (www.mencap.org.uk)

[16] A number of reports cited in the bibliography here are relevant to any such research.

[17] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx (published October 2022)

[18] See, for example, the Guardian (5 June 2021) reporting on the successful efforts to address vaccine hesitancy and noted that "*vaccine uptake more than tripled among black British and Asian communities between February and April*" and that improved take-up "*is a direct result of the work NHS teams have done with local communities and …previously hesitant groups, increasingly convinced that the vaccine is the right decision.*" Lessons can also be drawn from an article (15 July 2021) in the British Medical Journal, finding that people with learning disabilities were five times more likely to be hospitalised, and eight times more likely to die of covid.