

Adult social care in England: COVID-19

A review of the 2020 to 2021 winter plan and subsequent actions – what more should be done?

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Foreword by Sir David Pearson (September 2021)

"I was asked to conduct a review with stakeholders of the implementation of the 2020 to 2021 winter plan earlier this year. The stakeholders were of the view that the winter plan had been a helpful and important tool to guide the government and the sector in navigating the pandemic over the winter and wished to see a further plan for 2021 to 2022. I am therefore very pleased that the government have produced a further plan.

"The review was conducted from the end of March through to early May. Much progress has been made since then to reduce the restrictions for all of us and enable us to get on with our lives. Many of the assumptions we made about the progress of the pandemic and its continued impact on the sector have proved to be the case.

"In terms of reducing the risk of the virus to people who are in receipt of social care services, and the 1.5 million people who work in it, the vaccination programme has been critical and will continue to be so. We also know that with continued sustained community transmission of the virus, and the further risk of flu and other respiratory diseases over the winter, we all need to continue to be vigilant. This will be whilst enabling people to live the best lives they can; including being connected with close families and friends and other networks and activities which enhance our wellbeing. This new plan reflects many of the recommendations of my review with stakeholders as well as learning and reflection since.

"Social care has been the subject of increased focus over the intervening period with the announcement of funding reform the development of a white paper over the coming months. There is a recognition of the importance of social care and the need for investment and development in the future.

"In the meantime, the 2021 to 2022 winter plan and the resources announced in it will be critical in ensuring that the services are able to continue to respond effectively to meeting the needs of and providing care and support to the people of this country in the face of the continued threat of the virus."

1. Context

Significant numbers of people receive care and support in order to stay safe and to be as independent and active as possible. The sector is very diverse and distributed in terms of leadership and responsibility with 152 local authorities, 18,200 providers who provide care and support in 38,000 settings, and 1.5 million staff.

In the [adult social care \(COVID-19\) winter plan](#), it was stated that vital lessons had been learnt about the virus and how best to fight it. There was no doubt that there would be many more lessons to learn. That statement is still true today and will continue to be so in the months ahead, as our knowledge about the virus continues to change and evolve.

What effect has COVID-19 had on adult social care?

COVID-19 has had profound effects on the population of this country, and the adult social care sector has felt those effects particularly so. There has been a high cumulative excess mortality rate, as the data below sets out, as well as a detrimental impact on the health and wellbeing of the population.

As recognised in the April 2020 [report from Adelina Comas-Herrera and others on mortality associated with COVID-19 in care homes](#), “many older people receive care in the community” and “currently, there is limited evidence from anywhere in the world on how those individuals have been directly or indirectly affected by COVID-19”. Of course, this also applies to those working age adults who receive adult social care services. The impact of COVID-19 is a result of the interface between the virus, the people who use social care services, and the environment in which they receive those services. The more communal and intimate the environment – the greater risk. This is why a considerable focus has been on care homes. However, the data that does exist indicates that there is greater risk for people who receive social care services outside of care homes, and the people who provide those services, than for the general population.

Aside from the direct impact of the virus, one of the main consequences of the non-pharmaceutical interventions (NPIs) has been to isolate sections of the population, which was necessary to control the virus and its impact. For people who use social care services, this has been felt acutely, emphasising the importance not just of considering the direct impact of infection from the virus, but also of mitigating the indirect impacts through the measures to protect people’s physical wellbeing.

As people from Black, Asian and Minority Ethnic (BAME) communities have experienced disproportionate levels of ill-health and have come forward in lower numbers for vaccination, all elements of the adult social sector are required to

redouble their efforts to enable and support our BAME workforce and care recipients to access support, information, and services that best meet their needs.

What does the data show?

There is a strong link between levels of transmission and mortality in the community and those in care homes, and as Figure 1 below shows, this is a consistent pattern across the world. The measures that countries have taken can reduce, but not eliminate, this risk where there are high rates of community transmission.

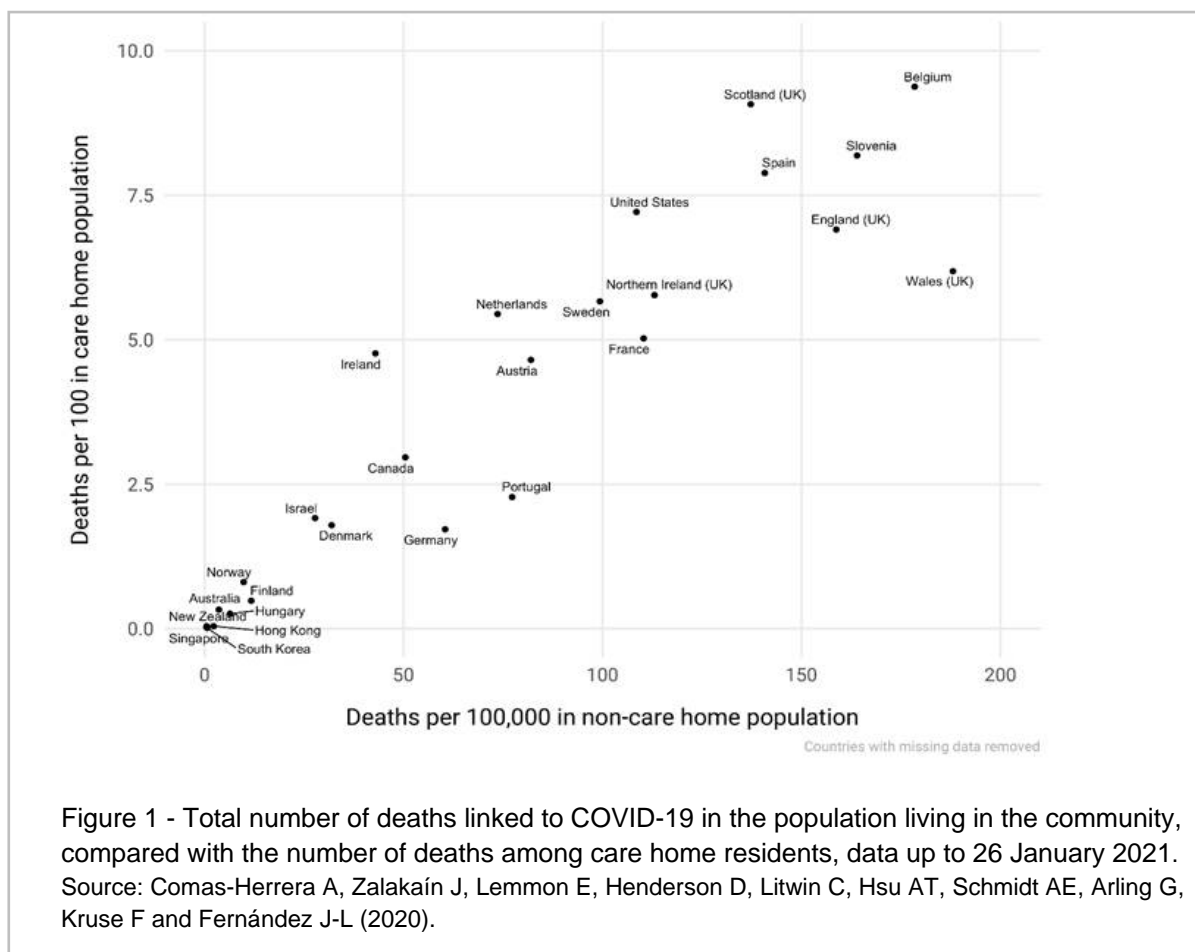


Figure 1 - Total number of deaths linked to COVID-19 in the population living in the community, compared with the number of deaths among care home residents, data up to 26 January 2021. Source: Comas-Herrera A, Zalakaín J, Lemmon E, Henderson D, Litwin C, Hsu AT, Schmidt AE, Arling G, Kruse F and Fernández J-L (2020).

There were large increases in mortality experienced by care homes at the peak of the pandemic, likely reflecting increases in both COVID-19 and non-COVID-19 deaths. Week 17 (20 to 26 April 2021) saw a 251% increase in deaths in care homes compared with the average of the previous 5 years in England and Wales (an excess of 5,656 deaths) based on the data published by the [Office for National Statistics – deaths registered weekly in England and Wales](#).

When comparing care home deaths in various stages of the pandemic with the average of the previous 5 years in England and Wales (2015 to 2019):

- in the first wave (March to June 2020), deaths were 78% higher

- in the summer (July to September 2020) when the winter plan was developed, deaths were 5% lower
- in the second wave (November 2020 to February 2021), deaths were 12% higher

Deaths of care home residents in England, by week reported

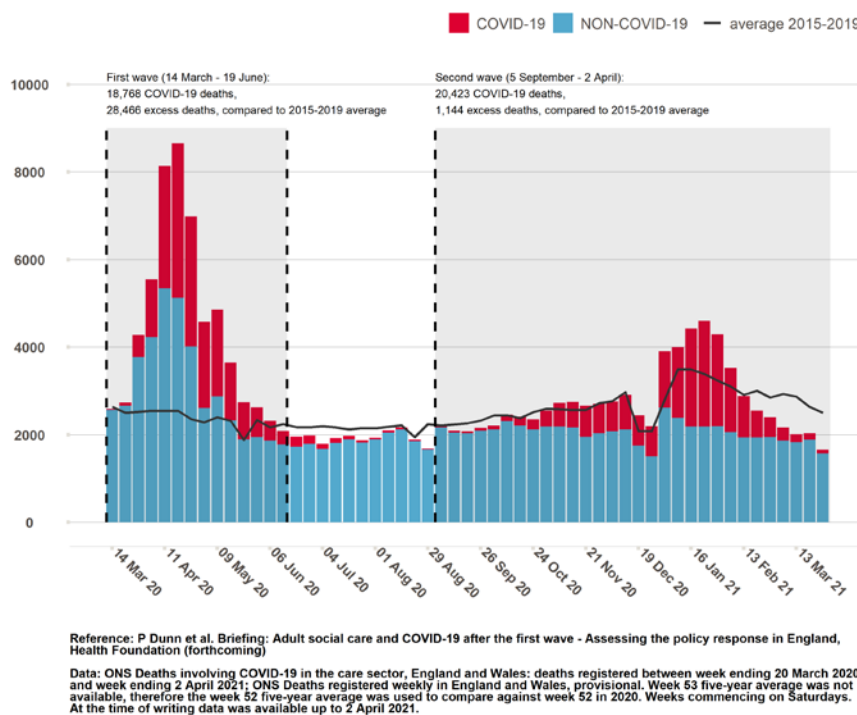


Figure 2 – Deaths of care home residents in England, 7 March 2020 to 2 April 2021.

Source: The Health Foundation, 11 May 2021.

The above 3 figures are not directly comparable as care home occupancy rates are known to have fallen over the course of the pandemic. But they nevertheless tell the story that the care home sector has seen a much lesser impact from the second wave, which is backed up by accounts from the larger care home groups.

Overall, in England and Wales there were 26% more deaths in care homes, from all causes, in the 12 months March 2020 to February 2021 than the average for the previous 5 years (2015 to 2019).

But while COVID-19 accounted for around 40% of all deaths of care home residents between April and June 2020 in the first wave of the pandemic, it accounted for only a quarter (26%) of all care home resident deaths between September 2020 and February 2021 in the second wave. This compares with a global average of 41% between March 2020 and January 2021 (This is based on 22 countries, from the start of the pandemic, updated to various different dates the latest of which is the 25 January 2021, from [the International Long Term Care Policy Network report](#)). Whilst cause and effect is difficult to unpick, the evidence strongly suggests that the actions

taken since the beginning of the pandemic, including those outlined in the winter plan, have had a significant impact in reducing risk.

There were 25,100 deaths notified to the Care Quality Commission (CQC) in home care (domiciliary care) service users (wherever the death occurred) in England, registered from 11 April 2020 to 2 April 2021. Of these, according to the [Office of National Statistics](#), 2,226 involved COVID-19 (9%).

The pandemic has shone a national spotlight on social care; its frailties and fragmentation, but also its strengths and importance for those who receive it, their unpaid carers, relatives and friends. COVID-19 has also highlighted the remarkable contribution from the social care workforce and the millions of unpaid carers. The stakeholder group suggest that it is important that this focus is maintained and enhanced through the next phases of the pandemic and beyond.

Assumptions

Our understanding of the virus, its impact and future risk is growing all the time. But the future remains uncertain, with the precise course of events, such as what level of community infection, hospitalisation and deaths there may be in the months to come, all remaining unclear.

We¹ are assuming that the following things are likely throughout 2021 to 2022:

- the vaccination roll-out will continue at pace, but there will continue to be some uptake issues in some demographic groups (for example, younger people, BAME communities) and some localities (such as deprived areas)
- whilst new variants of concern may impact on vaccine effectiveness, the overall effectiveness against both disease and transmission will remain high
- further vaccination for at-risk groups will be required in the coming autumn/winter, so called 'booster doses'
- community prevalence of COVID-19 will remain with regional variations, and the 'R rate' will rise above 1 at times, but these will be 'managed' during the summer and the impact on hospitalisations will be less acute than seen previously
- cases will likely rise in the autumn resulting in a 'third wave', but it is not clear currently exactly when that wave will arrive, or how large it will be. That wave will put pressure on the NHS and adult social care (ASC), to an extent which is still unknown

¹ All references to 'we' throughout this document refer to David Pearson and the Social Care COVID-19 Stakeholder Group collectively. It does not refer to the Department of Health and Social Care.

Our emphasis, therefore, is on vigilance and preparing for multiple eventualities, as the government's [spring 2021 roadmap](#) does with its step-at-a-time approach, and as too does the Care Provider Alliance's three-scenario planning model.

Irrespective of which scenario plays out, the objectives of everyone in the adult social care sector are clear. They are to:

- prevent COVID-19 infection
- recover from COVID-19 outbreaks
- enable people who use social care services to live well
- support carers and those who employ personal assistants
- ensure the health and safety of the workforce
- address the cumulative impacts of up to 13 months of isolation

Alongside taking considered steps as part of the roadmap, the emphasis must shift towards addressing the impact of the infection, prevention and control (IPC) measures. This means better connecting the people who use social care services with both their loved ones, and other health and support services, recognising the impact of isolation and distance from essential services can and does have on people's lives and wellbeing, and addressing that impact.

The essential IPC measures that have been painstakingly developed and implemented during the last 13 months to protect those people who receive social care services and those who work in it, must remain in place. It is essential that all parts of the sector remain vigilant and resilience is strengthened.

2. Scope of this review

This review has evaluated the policies and initiatives put in place to support the adult social care sector this winter, both those in the adult social care (COVID-19) winter plan (published in September 2020) and those introduced later.

This work is being produced in 2 stages:

- stage one: this report, providing an overview of things that went well, less well, and where further action is needed
- stage two: policy development in the areas identified as needing further action in stage one, done in conjunction with stakeholders

This process draws upon the expertise of policy teams; the outputs of scenario planning work; sector views through the Social Care COVID-19 Stakeholder Group ([Social Care COVID-19 Stakeholder Group terms of reference](#)); the recipients of adult social care and their families, and unpaid carers through the Minister's Lived Experience Group. These groups have considered:

- what in the winter plan went well? What went less well?
- what actions should continue/stop? What further actions should be taken?
- consideration of potential future scenarios that may change the nature of our future planning
- consideration of the need to 'protect and connect'; a balance between the focus on IPC measures, whilst also considering wellbeing. Examination of the effects of isolation and associated risks
- consideration of the need to 'protect and connect'; examining the balance between the necessary IPC measures; and the effect that these have on wellbeing as a result of increased isolation
- consideration of future policies and actions, including mechanisms for escalation where needed, and looking forward to next winter and the preparations that need to be in place

Data analysis and ongoing clinical work have informed our understanding of the effectiveness of our interventions and what, if any, changes should be made to these interventions in the short to medium term.

Some of the best solutions to the short-term problems lie in reform. Whilst this review does flag some examples where this is the case; reform is outside of the scope of this review and recommendations have not been made on the reform agenda. However, we advise that the comments and findings of this report be considered as part of the work on reform. The stakeholder group were clear that many of the

challenges highlighted by the pandemic were pre-existing, and the best solutions (such as regarding the workforce) lie in more far-reaching measures than can be put in place as a short-term measure. There was a view from some that there were also insufficient national levers in a fragmented system.

3. The 2020 to 2021 winter plan

Stakeholders widely welcomed the publication of the ASC winter plan. The Association of Directors of Adult Social Services (ADASS) commented that having a winter plan was an important first step, and alongside the local area management plan and the wider clinical commissioning group (CCG) winter plan, it provided the sector with national expectations, backed up with financial and practical support.

They felt that by assigning actions to organisations right across the social care sector, the winter plan gave adult social care more of an equitably high status of importance with the NHS, which was a powerful signal. However, ADASS were of the view that whilst the [Infection Control Fund](#) (ICF) was welcome, the overall winter plan was underfunded.

The Local Government Association (LGA) felt that the winter plan was helpful in that it was built from sector views as well as government's, was not just a plan to support the NHS, and set some objectives and brought in targeted investment.

They also stressed the importance of the winter plan having some degree of national consistency (whilst recognising that local sensitivity might require some justified variation) that enables and supports local implementation, and that this approach could be used by the department more widely.

The winter plan set out the key elements of national support available for the social care sector for winter 2020 to 2021, as well as the main actions to take for local authorities, NHS organisations, social care providers and the CQC, including in the voluntary and community sector. [Annex II](#) sets out the commitments made in the winter plan.

The winter plan is delivered in the context of a distributed system where the legal responsibilities for delivery rest with 152 local authorities and over 18,000 provider organisations. In normal times, national action is focussed on policy, legislation, the overall funding envelope and regulation (through the CQC).

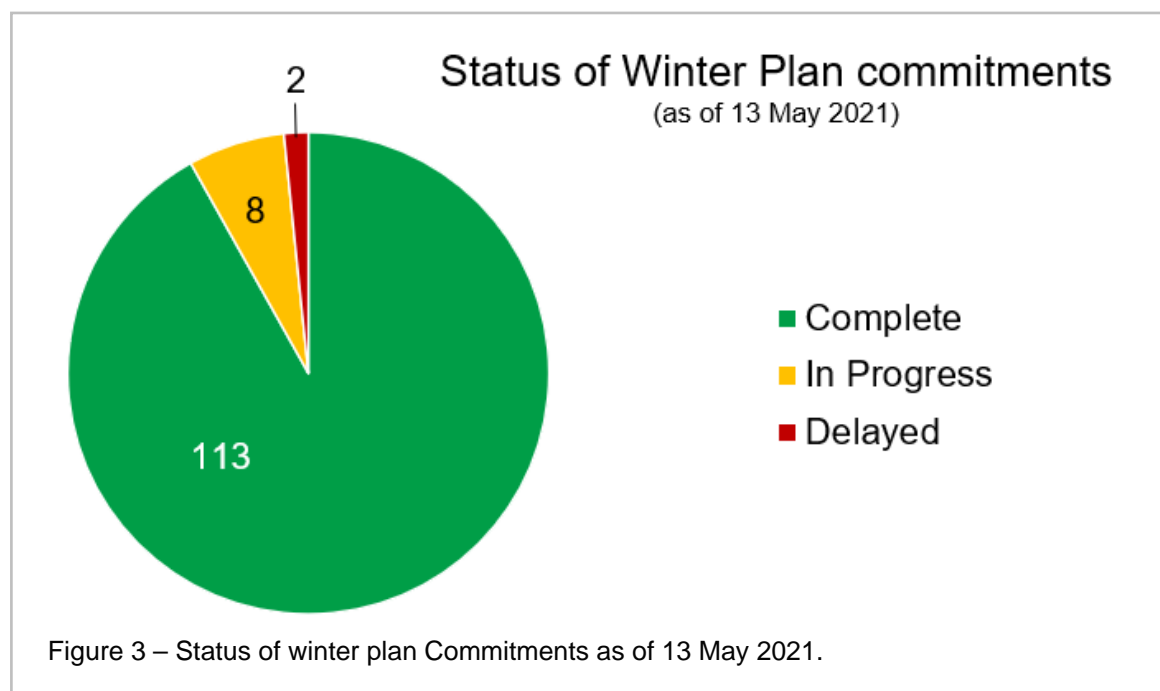
It is important that there is a debate about the balance of responsibility, and it is important that the right balance of levers between national and local is achieved. For now, it is important to recognise and appreciate the enormous efforts of all the constituent parts in the response to COVID-19, and the good regional and local partnership working that was demonstrated by the delivery of this wide-ranging winter plan.

Stakeholders were keen to flag that, although locally systems sought to align the ASC winter plan with the NHS winter plan, there could in future be more alignment.

The Social Care COVID-19 Stakeholder Group has reviewed both the winter plan, and [the Social Care Sector COVID-19 Support Taskforce: final report, advice and recommendations](#) (published in September 2020).

The taskforce report contained 52 recommendations; the majority of these (39 or 75%) were either included in the winter plan or implemented subsequently.

The winter plan contained 123 commitments; the majority of these (113 or 92%) were implemented in full. Figure 3 below shows the degree to which the plan has been implemented in more detail.



Only two have not been implemented:

- to restrict movement of staff between care settings via amendment to Regulation 18 of the CQC Regulated Activities Regulations

Following consultation on proposals to regulate, respondents were largely opposed to regulation and told the department it would be difficult to implement particularly at a time of increasing levels of COVID-19-related staff absence during winter. Restricting the movement of staff between care settings remains essential to minimise the risk of COVID-19 outbreaks and infection in care homes, so instead the government has:

- published clear, strong updated [guidance to care home providers of the need to restrict staff movement between care homes](#), unless in exceptional circumstances
- announced a £120 million ring-fenced fund for local authorities to increase workforce capacity, which could be used to support providers to restrict

staff movement by, for example, supporting providers to access additional staffing resource to minimise deployment of those who work in multiple settings

The decision was taken not to publish a joint operating procedure; instead the ASC regional assurance team are working effectively with colleagues from the [COVID-19 contain framework](#), [Better Care Fund](#), ADASS and LGA to support and be the conduit for information between local and national government on a range of issues relevant to the adult social care sector, currently specific to COVID-19. There is a communications plan in place to cascade lessons learned from previous COVID-19 outbreaks and in particular to ensure continued focus on personal protective equipment (PPE), adherence to the testing regime and the importance of supporting staff.

Supporting the workforce

Background

The sector approached the pandemic with 112,000 vacancies (from a workforce base of 1.54 million) and turnover rates of between 30 and 40% (in care homes the turnover rates of care staff were 39.5%). There also were limited mandatory requirements for training and widespread use of zero hours contracts – from 9% in care homes to 42% in home care, according to the [Skills for Care website](#).

During the winter months, there were significant pressures caused by large numbers of staff in some services being absent due to sickness

Insufficient staffing can lead to poor quality or inadequate care, and an inability to support and orchestrate essential functions (such as care home visiting). Whilst this review provides some analysis of the issues below, our advice is that the department should do further work over the next period to clarify the risks and the measures and options that can or should be adopted. We are of the view that this is the most significant and high-priority issue facing the sector.

What support measures were put in place?

Updated guidance was issued advising the continued importance of limiting the movement of staff between care settings to help minimise the risk of outbreaks and infections. The updated guidance confirms that the only exceptions to this are where staff movement is unavoidable to meet the needs of people using the service and keep them safe at all times, and provides more detail on these exceptional circumstances.

Funding was provided to pay staff when isolating due to confirmed or suspected COVID-19 cases, and to help limit staff movement.

Providers were supported with the increased cost and logistics required to administer the expanded testing programme of staff and visitors.

A £120 million [Workforce Capacity Fund](#) was provided to supplement and strengthen workforce capacity in the sector.

A national ‘call to action’ was launched in February inviting new applicants interested in short-term work, which has received over 3,000 applicants, alongside a national recruitment campaign promoting careers in social care.

Deborah Sturdy was appointed as Chief Nurse for social care to provide the professional leadership to and support the wellbeing of the ASC nursing workforce.

Guidance and tools to staff and employers on how staff can manage their personal mental health and wellbeing was issued.

Care staff were provided with free access to a number of mobile applications to support their mental health and wellbeing.

What do stakeholders think?

Whilst stakeholders welcomed the Workforce Capacity Fund being provided to mitigate these workforce capacity issues, it came late; the guidance and grant conditions being announced on 29 January 2021, and the first tranche of funding not being paid until February 2021. Stakeholders believe that if funding had been provided as part of the winter plan in September it would have reduced the risk of the small number of cases of COVID-19-positive staff continuing to work in care homes

The additional ICF funding, which ensures that providers can afford to pay staff who are isolating in line with government guidance their normal wages while doing so, is greatly appreciated by the sector. As of 26 April 2021, Capacity Tracker data reported by care providers suggests that 83.6% of care homes with staff self-isolating were paying them their full wages to do so, meaning some were not, and there are reports that some of those providers are not paying anything above statutory sick pay (SSP). The decision to not pay self-isolating staff full wages is taken by each individual employer, and whilst government can provide the funding to enable them to do so if they wish, it does not currently have the levers to ensure that they do.

Stakeholders note that the streamlining of recruitment processes and onboarding, and the addition of staff banks, have had a very positive impact on their staff capacity and vacancy rates, and as a result are seeing cost savings through reduced agency costs.

However, it is felt that these interventions should go further to address recruitment difficulties, which are greater than those in the NHS. As an example, following the

introduction of ‘designated settings’, those provided in NHS settings were able to recruit at pace, whereas private ASC provider-run settings recruiting for identical roles faced significant difficulties. It is believed the link to pay levels and lack of perceived parity between NHS and social care are significant reasons for this.

Stakeholders question if greater NHS-ASC cooperation on recruitment and putting NHS and ASC reward and conditions on a more level footing, would solve some of the issues the sector faces, and reduce instances of the loss of some of ASC’s most able staff to the NHS. A common concern is that the overall lack of recognition and reward may lead to those working in care to leave after the pandemic.

The appointment of the Chief Nurse has been very welcomed by stakeholders, complementing the work of the Chief Social Workers. The increased support provided by regional hubs has also been welcomed, especially by smaller providers who lack central support functions of larger organisation.

The sector feels that the mental health and wellbeing support on offer for staff is insufficient. Where it does exist, it is of varying quality.

Stakeholders believe that the challenges affecting the sector can only partially be addressed by short-term measures and UNISON in particular advocated for a longer-term workforce strategy.

Action is needed to address risks in the short-term pending any decisions about longer-term reform. Failure to address risks to staff capacity could lead to insufficient staff at very short-notice to run essential services, or – as happened in a small but very serious number of cases this winter – staff being asked to work whilst COVID-19 positive.

What are our recommendations?

Recommendation 1:

As a part of the stage two, the efficacy of the workforce measures put in place should be further reviewed to more clearly identify which individual interventions were effective. This is to inform the decisions about what measures should be continued or introduced, and the resources that would need to be available for the forthcoming winter.

Action for: Department of Health and Social Care (DHSC)

Timescale: By end of August 2021

Recommendation 2:

Identify the specific risks to workforce capacity, supply and quality over the coming year, and develop and implement workforce contingency arrangements to reduce the risks and help to ensure workforce supply and safe working practices. The findings of this process should be further considered in the broader work on reform.

Action for: DHSC, local authorities, ASC providers

Timescale: By end of August 2021

Recommendation 3:

Undertake further investigation to provide more information on why some people who were COVID-19-positive were working during the winter period and address those issues prior to autumn 2021.

Action for: DHSC

Timescale: By end of August 2021

Recommendation 4:

Extend the time-limited workforce wellbeing support put in place during the pandemic.

Action for: DHSC

Timescale: Immediately

Recommendation 5:

Providers to place a greater focus on well-being and mental health support, including investigating the provision of a dedicated occupational health service to all staff.

Action for: DHSC, ASC providers

Timescale: By end of September 2021

Infection, prevention and control (IPC)

Background

IPC measures were standard in adult social care settings prior to March 2020, as outlined in statutory guidance (such as the [Secretary of State's Code of Practice on infection prevention and control](#), issued under section 21 of the [Health and Social Care Act 2008](#)). Enhanced IPC measures are a standard defence for an outbreak of any infectious disease, so were already in place long before the first outbreaks of COVID-19.

When the first COVID-19 outbreaks began in adult social care settings, the main tools to combat the risk from the virus were PPE, testing and minimising risks of patterns of behaviour that increase the risk of the virus; the winter plan sought to strengthen those tools further.

Through the winter plan, the Infection Control Fund, which was first implemented in May 2020, was extended until March 2021, providing a further £546 million for the care sector, this has since been extended by a further £203 million, bringing the total government-provided funding to social care specifically for IPC to £1.349 billion.

Given that several IPC measures were implemented simultaneously, it is difficult to analyse, or draw conclusions about the effectiveness of any of them in isolation. However, SAGE are looking into this question, and there will be advice on this point in the near future.

To allow for reasonable adjustments where needed, guidance has been published for care staff supporting adults with learning disabilities and autistic adults. A comprehensive risk assessment should be undertaken for each resident to identify their specific risks. In a pilot last year, 250,000 transparent face masks were procured and piloted with the health and social care sector, these were confirmed as a valuable aid to communication and an innovation stage is now running to accelerate the activity of producing a transparent mask that is clinically safe.

What do stakeholders think?

Stakeholders note an improvement in both the IPC measures in place, and the standard to which they were enforced, right across the sector; and recognise the value of the IPC training provided. The vast majority of homes reported that all staff have now received IPC training, including COVID-19-specific IPC training. But some report that measures were less well-implemented, and this suggests that improved follow-ups and refresher sessions after the delivery of initial IPC training might help resolve such issues.

Stakeholders feel that IPC guidance could be made even clearer and more accessible for frontline staff to follow, such as by more widespread use of infographics. An illustrated guide on the use of PPE in social care settings was developed and published last year, to assist in the ease of understanding of guidance which is at times complex and often changing. They stressed the need to understand the audience better and consider more co-production with end users.

Lessons have been learnt from the first wave and the winter plan, and there should be development of a longer-term strategy for IPC. As infection rates decrease and restrictions ease, an effort will be needed to maintain momentum and ensure that the progress which has been achieved, in the form of high IPC standards, is not lost. At this point the advice we have received is that for planning purposes existing IPC

measures (as well as measures that may need to be added as evidence dictates) will need to be in place during 2021 to 2022.

The advice is that there should be a refresh of the IPC strategy for all ASC settings, ensuring it is as wide-ranging and standardised as can be, with an appropriate level of oversight.

There needs to be a balance between implementing IPC and the burden of it. There has been some indication that complacency and fatigue has begun to set in within the sector; and that some IPC measures such as social distancing, lack of physical contact, and the wearing of PPE, can all have a negative impact on mental health and be challenging for people with learning disabilities. IPC also results in an additional cost to delivering care that needs to be paid for. The cost to providers is being mitigated by government through the ICF currently, and the transition to any future reduction in this support needs to be managed carefully so that providers and local authorities can understand how any remaining additional costs can be met in good time. Ongoing clinical work on the impact of individual IPC measures and this review will help inform what measures are able to be stepped down in the future to find the correct balance of IPC and wellbeing.

During the pandemic it has also become clear that some local authorities have taken a more pro-active role in enforcing infection control measures than others.

Given the risks identified in the planning scenario it is anticipated that all the key elements of infection control will be needed. Indeed, in order to reduce restrictions on services opening up or people who use social care services having more essential contact with services, families and friends, the IPC measures and surveillance (e.g. through testing) will remain critically important in order to identify any changes and reduce risk.

What are our recommendations?

Recommendation 6:

Given the uncertainty around future risks in light of vaccine efficacy and variants of concern, all key elements of infection prevention and control should remain in place until such time as the clinical advice is that they can be removed. The associated financial support from government should continue until it is safe to reduce the measures and the cost.

Action for: DHSC

Timescale: Until March 2022

Recommendation 7:

Publication of an IPC strategy for all social care settings, which should:

- include clear, easy to understand IPC guidance, training and best practice for the frontline
- be inclusive of reasonable adjustments in exceptional circumstances
- be supported with a comprehensive training programme championed by the Chief Nurse for social care
- be aligned with all relevant equivalent NHS guidance

Action for: DHSC

Timescale: 21st June 2021 (Step 4 of the [Spring Roadmap](#))

Recommendation 8:

IPC measures are required beyond the current funded period (June 2021; PPE until March 2022). IPC funding should be extended appropriately and made available at the same time as the release of guidance to provide certainty and security to providers, and allow them to continue to implement IPC measures.

Action for: DHSC, HM Treasury

Timescale: June 2021 (when current funding ends)

Personal protective equipment (PPE)

What support measures were put in place?

The winter plan committed to providing free PPE for the COVID-19 needs of:

- care home and domiciliary care providers, through the PPE portal until March 2021 - this has subsequently been extended to March 2022
- social care providers ineligible for supply through the PPE portal, through local resilience forums (LRFs) and local authorities (LAs) until March 2021 – this has also subsequently been extended to March 2022

On 9 February 2021, free PPE for unpaid carers (who do not live with the person they care for) for COVID-19 needs was also announced.

As of 9 May 2021, around 2.2 billion items of free PPE have been provided through the portal for ASC providers' COVID-19 needs.

Since April 2020, around 439 million items of free PPE for COVID-19 needs have been distributed via LRFs. This number includes items of PPE delivered since 14 September 2020 to LAs where LRFs have stood down regular PPE distribution

What do stakeholders think?

There were concerns at the beginning of pandemic around the lack of supply, logistical ordering and delivery, and the cost of PPE. Stakeholders are unanimous in praising the improvements made in this area, and report that the current arrangements of the national portal, and supporting local arrangements to cover gaps, works well. This has been a fantastic effort with barely any providers now reporting shortages. They also welcome each of the successive extensions of free PPE provision for COVID-19 needs. The early notification of the extension to the extension to the end of March 2022 is particularly welcome in giving greater certainty for this financial year.

Despite the costs being brought down by the access to free PPE, there is a worry that costs will increase as time goes on and that providers have to meet the costs of storage. Providers continue to suggest that raising VAT from the procurement of PPE for the sector should be reconsidered, given the essential nature of this equipment in protecting the people who use services and the staff of an essential service. Some felt that ordering and receiving could still be quite a slow process and some users (particularly those in receipt of direct payments who employ their own staff) report that they are still struggling to get what they need. In some cases, they have had to purchase their own PPE utilising their direct payments. Whilst these issues should continue to be monitored and addressed, overall this has been a highly successful policy initiative by the government.

There should be a review of the longer-term policy on PPE, and any changes in provision should be very gradual and handled with care. This policy has been a significant success; in the early stages of the pandemic PPE was a major challenge, partly as a result of the international difficulties in supply, partly related to the considerable cost and the efficacy of 18,200 separate social care organisations all trying to purchase PPE on an independent basis.

What are our recommendations?

Recommendation 9:

There should be further consideration to making PPE for the ASC sector exempt from VAT, in line with the tax status of the NHS.

Action for: DHSC

Timescale: August 2021

Recommendation 10:

Review future PPE policy in light of ensuring that social care staff and recipients of care are better protected against other viruses, as part of the IPC strategy.

Action for: DHSC

Timescale: By end of July 2021

Testing

What support measures were put in place?

Testing across adult social care settings was expanded.

In light of the new variant and rising prevalence, testing of staff was enhanced in December 2020 (both routine and after any positive test), adding lateral flow device (LFD) tests for staff, visiting professionals, and visitors when permitted by national restrictions. This was supported by the £149 million [Rapid Testing Fund](#) announced in December, and the roll-out of self-test LFDs for staff in January to allow staff flexibility to test at home.

Testing to the wider sector was expanded and overall testing capacity increased:

- in November 2020, weekly polymerase chain reaction (PCR) testing for homecare workers was rolled out
- in February 2021, weekly PCR testing for all staff in eligible day care centres began, as well as weekly PCR testing for personal assistants
- testing was also expanded further in extra care and supported living settings with weekly PCR tests and twice-weekly LFD tests for staff, monthly PCR tests for residents in high-risk settings, and weekly PCR tests for staff in wider settings

As part of new discharge requirements, every hospital patient being discharged into a care home was required to have a COVID-19 PCR test within the 48 hours preceding their discharge, and receive the result prior to discharge (except where that person had previously tested positive within the preceding 90 days, in which case a clinical assessment of their likely infectiousness is made instead)².

What do stakeholders think?

The speed at which testing was rolled out, and the strain on the resources in both the DHSC and NHS Test and Trace teams, meant that testing guidance was often not as well co-ordinated as it could have been.

Overall, stakeholders have welcomed the improvements to testing over the winter period. The extension of regular asymptomatic testing beyond care homes to include high-risk extra care and supported living settings, domiciliary care, personal assistants and day centres was widely welcomed, and whilst they felt that increased

² This requirement was communicated in a [letter to the system on 13 October 2020](#), and further articulated in [subsequently published guidance](#). These arrangements built on the previous requirement that had been in place since 15 April 2020: that every hospital patient being discharged into a care home was required to have a COVID-19 PCR test.

testing was initially difficult to implement, the addition of the Rapid Testing Fund has helped to ensure that staff are able to get the tests they need.

Regarding LFD tests, initial concerns about their take-up were largely overcome thanks to the increased robustness of the tests, combined with acceptance that the tests still have a part to play in preventing the spread of COVID-19.

Delays in receiving test results were experienced at certain times in the winter which exacerbated existing staff capacity pressures. Stakeholders also raised that if a staff member undergoes a COVID-19 test at a public test centre, the result may not be recorded with their employer, and therefore not included in total rates of community staff testing that is reported, leading to under-reporting and a possible risk to follow-up action.

Looking ahead, if and when clinically appropriate to scale back the ASC testing regime, it should be done gradually with the capability to ramp back up immediately, in case this is necessary.

The maintenance of a full testing programme may help to balance the possible reduction in other constraints such as visits into care homes and visits out as well as the potential for relaxing some aspects of PPE use (at the appropriate time).

The testing strategy as it has been rolled out has been a major tool in managing the risk of infections and outbreaks in social care, and helping to keep the virus at the front door of homes and gradually providing the same opportunity for the wider sector.

What are our recommendations?

Recommendation 11:

A regular testing regime should continue for 2021 to 2022, whilst developing a strategy for being able to step down and step back up testing intensity (as the level of transmission allows) as driven by emerging evidence, infection prevalence and variants of concern. Work should continue to develop a clear strategy to achieve this.

Action for: DHSC

Timescale: Until end March 2022

Vaccination

Background

The UK has seen one of the fastest roll-outs of vaccination in the world. Care home residents and staff in homes for older people were in the [first priority cohort as defined by the Joint Committee on Vaccination and Immunisation \(JCVI\)](#), and the

rest of the social care workforce were in priority group 2 and unpaid carers in priority group 6.

From November 2020, all adults with Down’s syndrome were considered to be clinically extremely vulnerable (CEV), on the basis of new analysis, and were put into priority group 4. The JCVI initial advice put people with a ‘severe or profound learning disability’ in priority group 6. However, there is a lack of consistency in the way that people with a ‘severe or profound learning disability’ are identified, and in how this is reported in GP records.

JCVI subsequently issued [updated advice \(in February 2021\)](#) which stated that anyone who was on a GP learning disability register could be prioritised within priority group 6 because of heightened risks facing those on the register. Their updated advice set out their assessment that risks facing adults with a learning disability (except Down’s syndrome), once other risk variables were accounted for, were similar to those of the general population.

The vaccination programme in social care has also been relatively successful. As of 9 May 2021, in care homes serving older adults, 95% of eligible residents and 82% of eligible staff have received their first dose. Vaccination roll-out to cohort 2 staff began later, and first dose take-up across settings as of 9 May 2021 is:

- 75% for staff working for CQC-registered providers (domiciliary care providers and younger adult care homes)
- 73% for staff working in other settings (including non-registered providers and local authority employed)

We acknowledge that there are some limitations in this self-reported Capacity Tracker data, especially for those in settings other than older people care homes (cohort 2).

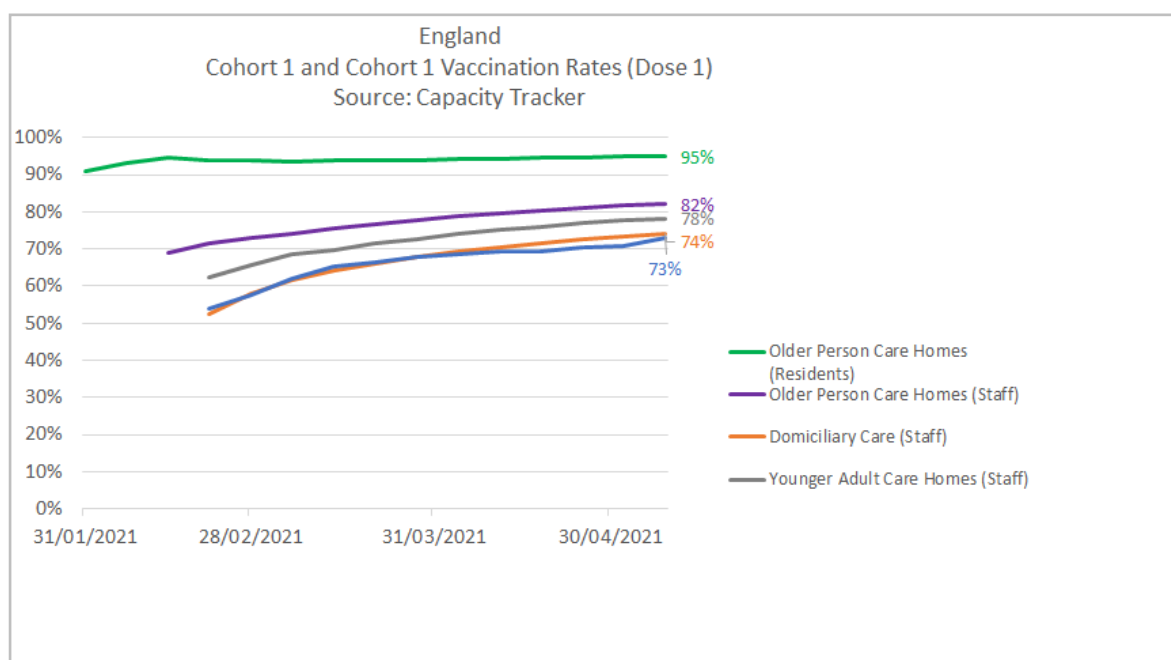


Figure 4 – ASC vaccination rates, as of 9 May 2021. Graph showing the rates of vaccination within ASC as outlined in the paragraph above.

Experts on the social care working group of SAGE advise that the threshold to provide a minimum level of protection against outbreaks of COVID-19 in each individual care home is that 80% of staff and 90% of residents in the care home be vaccinated. There are no equivalent thresholds for other social care settings.

In early December 2020, it was agreed between the department and the NHS vaccination programme that support and advice would be provided to the programme on the deployment of vaccination to those cohorts that were specified in the priority lists provided by the JCVI. A small team of civil servants and experts from the sector, led by the Chair of the social care taskforce and the Director of Social Care Delivery in the department, worked with the NHS vaccination programme and the sector to contribute to the processes and procedures for care homes for older people, and developed the standard operating procedures for social care workers and unpaid carers.

The work has been designed to ensure, as far as possible, that vaccinations are deployed in the way that is most appropriate for the social care sector and to inform, enable, encourage and support those social care workers or those receiving services in priority groups to be vaccinated. This work will need to continue in the next phase of vaccinations ensuring that this programme is aligned with flu vaccination next winter.

Consultation is underway with a proposal requiring care home providers caring for older adults to deploy only those workers who have received their COVID-19 vaccination. A [5-week consultation](#) has been launched to look into this.

What do stakeholders think?

Stakeholders noted that the vaccine programme has been a success, and has been especially appreciated by unpaid carers and personal assistants. They also note that the programme has had the unintended positive effect of better identifying carers within the community and ensuring that records are up to date.

Some have reported that there have been cases of unpaid carers being asked by vaccination staff to prove that they are a carer, despite this not being a requirement, and being turned away when they are unable to provide said proof.

UNISON believed the government was right to focus on boosting trust and confidence in vaccination through communications with the workforce. However, they argue that communications work could have been significantly scaled up as areas of low vaccination rates emerged.

What are our recommendations?

Recommendation 12:

Operational arrangements are reviewed to ensure effective implementation in the next phase of vaccinations, including alignment between the vaccination for COVID-19 and flu.

Action for: NHS England and NHS Improvement (NHSE/I), DHSC
Timescale: By the end of June 2021

Recommendation 13:

Continue work on improving vaccine take-up through access and reducing vaccine hesitancy across the ASC workforce. Continue to monitor and review progress of this work, its focus and its success .

Action for: DHSC, NHS
Timescale: Immediately

Recommendation 14:

That the NHS ensures that there is point-of-care data for social care cohorts in time for the next phase of vaccination and launch of the 2021 to 2022 flu vaccination programme, and that there is local/national access to the data in appropriate form.

Action for: NHS
Timescale: By September 2021

Recommendation 15:

That detailed planning takes place with the NHS vaccination programme for the next phase of vaccinations for COVID-19 and flu, taking account of the successes and challenges in the vaccination of care workers and unpaid carers.

Action for: DHSC, NHS
Timescale: By June 2021

Resources

Funding

What support measures were put in place?

The government has provided almost £1.8 billion in specific funding for adult social care. This includes 3 specific funds:

- the over £1.3 billion Infection Control Fund. This fund is intended to reduce the rate of COVID-19 transmission within and between care settings through effective infection prevention and control practices. Initially set up in May 2020 and worth £600 million, this was extended with a further £546 million in September 2020 and again in March 2021 with a further £203 million, taking total ICF funding to over £1.3 billion
- the £120 million [Workforce Capacity Fund](#) (WCF) (announced 16 January 2021) to support local authorities to put in place measures to strengthen staff capacity across the sector
- the £288 million Rapid Testing Fund to support the care sector to implement additional LFD testing of care home staff and visiting professionals, and facilitate indoor/close contact visiting where possible. This was launched in December with an initial £149 million and extended in March with a further £139 million

The government also provided access to £4.6 billion in un-ringfenced funding for local authorities to address pressures on public services in 2020 to 2021. A further £1.5 billion is being provided in 2021 to 2022.

What do stakeholders think?

Stakeholders offered broad support for all of the additional funding packages announced, noting it was crucial in allowing them to overcome the additional burdens placed on them by the pandemic. ADASS state that the ICF in particular was a key mitigating factor in the avoidance of provider failure.

Think Local Act Personal felt that linking provider data provision requirements to their ability to access to COVID-19 funding has been largely effective; however, they feel that this is not something which could, or should, be replicated for direct payment holders.

Stakeholders felt that the funding received was insufficient, and that funding announcements came too late, especially so in regard to the WCF, and was often too short term with no certainty of the amount that would be received, limiting the amount of proper planning to optimise usage, and causing a rush to spend by deadlines. There has not been the level of certainty around future funding that providers would have liked, because of the need for funding to be secured on the basis of sector need and evolving public health advice; there is not the level of certainty around the future course of the pandemic that would be needed to facilitate this.

Some stakeholders feel that grant conditions were complex and over-prescriptive, which meant that possible usage was limited and some ‘better uses’ were ruled out, and added significant admin burdens on grant recipients. Although the department has worked with the sector when designing each fund to reflect their concerns as far as possible, the process is ultimately a difficult balancing act between the needs of stakeholders, and the need to ensure the fund achieves its aims in a successful and compliant manner.

Some stakeholders suggest that there should have been more targeted funding to support provision of carers’ respite services. Although the ICF was able to be used by local authorities for these services, whose importance was underlined in the grant guidance.

Stakeholders also comment that direct payment holders could benefit from being able to more easily access COVID-19-related funding and support, as compared with regulated providers, this area requires further thinking and work.

Market indemnity

What support measures were put in place?

The [Designated Settings Indemnity Support](#) (DSIS) was introduced by the government to provide temporary, state-backed indemnity cover for those care homes already assured by the CQC, or intending to be assured, as designated settings, which are unable to obtain sufficient insurance.

DSIS has provided, where needed, cover for clinical negligence, public liability and employer’s liability. It does not replace existing insurance for designated settings, but has acted as a ‘gap-filler’ to bring cover up to a sufficient level. This will run until 30 June 2021. The indemnity support arrangements will continue to apply to any patients discharged into designated settings until 30 June 2021 for a further 14 days after this date, but admissions from 1 July 2021 would not be covered under these arrangements.

What do stakeholders think?

Prior to the introduction of the DSIS, a number of care providers found it difficult or impossible to obtain sufficient cover to operate as CQC-assured designated settings for discharge.

Some care providers have encountered difficulties as their policies have come up for renewal, including around the affordability and availability of adequate COVID-19 cover. The department has been carefully monitoring the state of ASC insurance market throughout the pandemic and has been working closely across government, with care providers and insurance representatives to understand the breadth and

severity of the issues experienced, and whether there is any further action that should be taken.

It is suggested that the government needs to continue to give serious consideration as to how best it can support the care sector in the face of a hardening insurance market, and whether there is any further action the government should take.

What are our recommendations?

Recommendation 16:

As it will be necessary for critical infection control measures to be in place for the course of this financial year, government should continue to ensure that these measures are financially supported and incentivised. It is also advised that decisions are made as soon as possible and in advance of winter.

Action for: DHSC, HM Treasury

Timescale: By end of July 2021

Recommendation 17:

Government should continue to review the state of the adult social care insurance market, including the impact of COVID-19 restrictions on providers, and consider whether further action should be taken.

Action for: DHSC, HM Treasury

Timescale: By end of June 2021

CQC support

What support measures were put in place?

The CQC:

- prioritised IPC inspections, reallocated resources to increase their capacity to monitor infection control and increased the number of inspections conducted over the winter months
- developed an [IPC tool](#) and prioritised IPC inspections, utilising resources from across CQC to meet the increased inspection demand over the winter period. Since October 2020, CQC has carried out over 1,400 IPC-specific inspections, as well as using its IPC tool in 4,000 additional risk-based inspections
- designed and delivered an assurance programme for designated settings in line with the ASC winter plan. As of April 2021, over 140 settings have been approved, totalling over 2,200 approved beds, with over 900 alternative beds provided in alternative settings such as community hospitals

- also monitored incidents of blanket visiting bans and issued a [statement making clear to the sector that blanket bans are unacceptable](#) and that providers should follow government guidelines
- continued its routine monitoring activity, using whistleblowing and safeguarding alerts, as well as concerns raised through their [Give feedback on care platform](#), to direct regulatory activity in response to risk of harm to people using services. Where CQC received credible COVID-19 related concerns (such as in regard to staff movement or poor IPC practice), its default position was to trigger an inspection. Where relevant, CQC shared intelligence with local stakeholders (including local authorities and local resilience forums) to inform and support their work

What do stakeholders think?

ADASS commented that inspections ceased early in the pandemic and therefore there were concerns about homes becoming ‘closed institutions’. CQC did encourage whistleblowing in relation to quality and safeguarding issues, strengthened their response to these concerns, and also launched a joint national campaign with Healthwatch England and other partners called ‘Because We All Care’ to increase feedback from people who access health and social care.

Regional support and oversight

What support measures were put in place?

DHSC set up a Regional Insight and Assurance team, comprised of sector experts, to support all care settings in gathering and disseminating examples of best practice and providing rapid insight with a regional footprint to key policy areas – PPE, funding, vaccines, workforce capacity and other IPC measures – and acting as a key enabler for effective policy implementation.

What do stakeholders think?

The regional assurance team is relatively new, and stakeholders were keen to understand more about their emerging role, future priorities and to further engage with them. Stakeholders feel that the team has established positive engagement with sector partners, are feeding into policy decisions well, and their efforts to filter requests from government to the sector are appreciated by ensuring they strike the right balance of quantity and quality.

What are our recommendations?

Recommendation 18:

The regional assurance team to provide further information to the sector on their current role and future priorities.

Action for: DHSC

Timescale: By end of June 2021

Supporting people who receive social care and their carers

People who receive social care

What support measures were put in place?

[Direct payments guidance](#) was updated, reiterating the requirement of commissioners to be flexible to ensure people get the care and support they need.

DHSC worked with the sector to develop policies and [guidance relating to care home visiting](#), and this was updated as the quickly evolving situation developed, most recently as part of the [Spring Roadmap](#).

Care home visiting is a contentious and emotive area, and one in which the balance between protecting people from the virus but not leaving residents and families or friends with intolerable long-term physical separation has been difficult to achieve. The policies developed before Christmas 2020 and over recent weeks have been successful where adopted by care homes. Further work is taking place, and is needed, to ensure that progress is sustained, and that all care homes are in position to enable visiting into care homes and visits out.

What do stakeholders think?

Stakeholders are struck by the importance of the government and the sector doing whatever is necessary to ensure that care home visiting, both inward and outward, is made available to all residents in care homes with measures to mitigate the risk.

The process of isolation and distancing has meant that there has been less interaction with service users and many social care settings. In normal times, this interaction highlights issues of risk and concern, including safeguarding. As we progress through the roadmap and facilitate more interactions between different services, particular attention should be given by adult safeguarding boards, regional and national assurance, and regulation that sufficient measures are in place to deal with situations of potential concern, including safeguarding.

An area that has remained one of concern is the degree to which day services and related support is available. This is particularly so, in relation to smaller providers (typically in the voluntary and community sector). The suggestion is that further work takes place as part of the second phase to understand that degree to which these

issues are being resolved and what, if any, further national and local support might be needed.

What are our recommendations?

Recommendation 19:

Further work is undertaken to extend the level of care home visiting and residents going out across the country with the appropriate IPC measures to mitigate the risk of infection.

Action for: DHSC, UK Health Security Agency (UKHSA)

Timescale: As soon as possible or in line with the Spring Roadmap steps (17 May, 21 June 2021).

Recommendation 20:

That further work takes place to understand the degree to which day services and related support services have reopened or have been replaced and what further actions are necessary, nationally or locally.

Action for DHSC

Timescale: By end June 2021

Unpaid carers

What support measures were put in place?

[Guidance was produced for those who provide care unpaid](#), including young carers and young adult carers, which received c.480,000 views on gov.uk.

[Guidance was produced by Social Care Institute for Excellence \(SCIE\)](#), in collaboration with others, to support providers of day care centres in safely reopening and continuing to provide quality care.

Some of the money provided to local authorities through the ICF was made available to be used to help services reopen safely or be reconfigured to work in a COVID-19-secure way.

Regular testing and free PPE were expanded to cover staff and volunteers of day centres to support them to operate safely.

Funding for the Carers UK support line was extended to cover the whole of winter and has since been further extended to the end of June 2021.

£500,000 of funding was provided to Carers Trust, from the government's COVID-19 support package to charities, to support unpaid carers experiencing loneliness during the pandemic.

Support for access to free flu vaccinations for unpaid carers was reinforced.

Unpaid carers were classed as essential workers to ensure priority access for testing.

Free PPE was provided to unpaid carers who do not live with the person they care for until March 2022. Local authorities were permitted to provide free PPE to other unpaid carers at their discretion.

COVID-19 vaccinations were made available to all unpaid carers through their inclusion in JCVI priority group 6.

Carers allowance rules on breaks-in-care were relaxed to ensure that that essential respite and emotional support does not inadvertently cause a drop in income, originally until end of winter but now extended to end of August 2021.

[A leaflet on looking after friends or family when they leave hospital](#) was produced containing helpful information for unpaid carers to receive when those they are caring for leave hospital.

Exemptions from national lockdown restrictions were provided to unpaid carers, allowing carers to arrange for another family member or friend to provide respite care so that they can take a break, where this is reasonably necessary, and so certain households can also form a support bubble with another household.

What do stakeholders think?

Stakeholders note that the needs of unpaid carers have increased during the pandemic, yet the support offered to them by both state and voluntary providers has been curtailed. The suspension or reduction of respite services has resulted in burnout, reduced social contact, and feelings of isolation and loneliness – all of which have been felt even more acutely by those who have needed to shield.

Stakeholders report that the [hospital discharge to assess guidance](#) did not refer to any carers' rights. This is now being reviewed.

Unpaid carers have particular needs and these are not always well understood. Work has taken place with NHSE/I on guidance and a letter enabling unpaid carers to identify themselves and their needs, so these can be more easily met.

As we unlock, carers will require greater support so that they are able to have breaks from providing care, and feel safe to leave the house and use services once more. They also note that impacts have been felt particularly by those with low levels of need, as the much-appreciated limited support offered during this winter was primarily focussed on those with the greatest need. 12 months of accumulated low-level need has resulted in a high level of need for those services to resume.

Stakeholders note positive examples of innovation in trying to support people with day opportunities while usual building-based services were closed. They also commented that small day service providers in their local areas have concerns about their viability and ability to resume service provision, as and when doing so is permitted and feasible, especially those who do not have their own premises and thus operate out of those of a third party.

User groups noted that direct payments guidance, and the reiteration of flexibility, went down particularly well and should continue into the future.

What are our recommendations?

Recommendation 21:

Communication and contact with carers and those who draw on care and support is strengthened, such as regular/frequent contact/calls made to carers to check-in with how people are coping as we progress through the roadmap.

Action for: DHSC, LAs, NHS primary care networks (PCNs), carers' organisations networks

Timescale: By end of June 2021

Recommendation 22:

Local authorities to strengthen local support provided to carers, including accessing day care service opportunities and respite services, to ensure they are better able to remain open and continue to operate.

Action for: Local authorities

Timescale: By end of June 2021

Guidance

What support measures were put in place?

From the start of the pandemic, a wide range of guidance was provided in the adult social care sector, and reviewed and updated frequently. The challenge has been the:

- rapidly evolving evidence, which has led to the need for frequent changes in guidance
- need to provide this in a way that is accessible to a wide range of organisations and the workforce

What do stakeholders think?

The increased amount of co-production of DHSC policy, communications and guidance that has taken place is strongly welcomed by stakeholders, with the letters to recipients of direct payments noted as a particularly successful example of this; the personalisation and tone were very well received.

Stakeholders said that there needs to be a greater focus on co-producing guidance, not only with the sector and arm's length bodies but with end users as well.

They also noted that co-production with end users in mind would be helpful, as users often do not have the time to read the larger guidance and need something tailored towards them that is clear and easy to read. One suggestion from stakeholders was that clear infographics could be produced to be easily digested by users and the larger guidance read by managers to answer any queries they may have.

Stakeholders realised the need for frequent updates of guidance, and appreciated the challenges that this posed, but felt that often the guidance was needed more quickly and that the amount of guidance meant that sometimes messages were not as clear as they perhaps could have been. The importance of guidance that is easy to read and accessible was stressed.

What are our recommendations?

Recommendation 23:

Guidance should be clear, easy to understand and aligned.

All guidance should be co-produced and tested with end users to ensure its comprehensibility and accessibility. It should also align with equivalent NHS, Public Health England (PHE) or UKHSA guidance and, where possible, be published at the same time. These tests should be built into the process before publishing. Where guidance is updated, it should identify what iteration is the most up-to-date version, and what has changed compared to the version it has replaced.

Action for: DHSC

Timescale: Immediately

Recommendation 24:

In the longer-term, that a project is undertaken to determine the most appropriate structure for co-production at national level, and how this links with local arrangements.

Action for: DHSC

Timescale: By October 2021

Recommendation 25:

Guidance should be sent to all statutory and regulated organisations (providers, commissioners, local authorities) immediately and directly.

In order to do this, ways should be developed to compile and maintain up to date lists of all the organisations in the sector.

Action for: DHSC, NHS, UKHSA (all bodies which publish guidance)

Timescale: Immediately

Recommendation 26:

Clarify and confirm the arrangements for disseminating of guidance to non-regulated settings (including personal assistants and unpaid carers).

Action for: DHSC, LGA, ADASS

Timescale: Immediately

Digital support

What support measures were put in place?

NHSmail, Microsoft Teams, and discounted broadband deals were made available to all care home providers.

10,970 free iPads were delivered to care homes in the weeks before Christmas 2020, all of them including a 12-month data SIM package so that poor wifi connectivity would not hinder their usage.

These measures allowed for residents to have video consultations with medical professionals and virtual visits with loved ones, as well as supporting staff to access medical records and order medication.

There are currently 14,162 social care sites using NHS mail which is 3 times higher than before the pandemic and more than half of the social care market. There are also almost a thousand other sites using their own form of secure e-mail.

Research on the iPad usage shows that (as of 6 May 2021):

- 96% of iPads have been activated

As of 19 February 2021:

- 95% of the 1,813 surveyed said they are using the iPad very frequently (every day or every other day)
- 91% stated that it has had a positive impact on care home staff

Top 3 uses for the iPads:

1. calls between residents and loved ones (81% of those surveyed)
2. calls to other health professionals (49% of those surveyed)
3. calls to GPs (48% of those surveyed)

What do stakeholders think?

Stakeholders note the success of the innovation and speed of adoption of new digital technology, which is ensuring that people who receive care and their carers are able to continue to connect with their loved ones and medical professionals, but recognise that this is, however, rarely a substitute for face-to-face contact.

Those with lived experience noted that some users have not had access to digital support and so have been more isolated than ever before. This has highlighted the impact that volunteers have had, whether it be providing that digital support for those who don't have access or organising film nights for those with learning disabilities. There needs to be support for these volunteers going forward.

What are our recommendations?

Recommendation 27:

Increase digital inclusion support for ASC providers and people who use services, so that those without access are supported to get online, and to ensure that the digital aims of the winter plan are achieved in every setting.

Action for: NHSX, local authorities

Timescale: By September 2021

Addressing inequalities

What do stakeholders think?

Stakeholders suggested that – insofar as the groups that evidence suggests may have been disproportionately impacted by the virus – more needs to be done to ensure that their needs are better recognised and better met. Those members of our

communities with protected characteristics are significantly represented in the social care sector as users of services or in the workforce.

It is also the case that various studies have evidenced the disproportionate impact of COVID-19 on BAME people and those with learning disabilities, including higher levels of mortality than the overall population. The reasons for this are likely to be multi-faceted, including relative deprivation. There needs to be continued engagement with those groups to better understand the issues faced and the solutions. This has long been the case, but it has been reinforced by the experience of COVID-19 as an essential prerequisite of effectively addressing the need and risk, including the concerns of unjustified differential treatment. It is with this perspective and through this lens that social care policy makers, commissioners and providers need to consider every policy, action and service.

What are our recommendations?

Recommendation 28:

Local authorities and NHS organisations should ensure they take steps, in line with the public sector equality duty of the [Equality Act 2010](#), to ensure they evidence and address the inequality of outcomes for people affected by COVID-19. DHSC should make available further specific advice for the sector in addressing inequalities, and there should be appropriate oversight to ensure these steps are taken.

Action for: DHSC, local authorities, NHS organisations

Timescale: By July 2021

Data and research evidence

Background

Prior to COVID-19, NHS Digital publications formed the main source of data on adult social care. These were primarily annual data, reporting 6 months after year-end, on expenditure (ASC-FR), activity (SALT), the user and carer surveys, and [the Adult Social Care Outcomes Framework](#) (ASCOF). DHSC did not collect any data directly – this was done on its behalf by NHS Digital (previously the Health and Social Care Information Centre). Data was generally only available at the local authority level.

Outside NHS Digital, the quarterly Skills for Care survey, and Capacity Tracker (CT) provided data on the adult social care workforce and on occupancy and vacancies in care homes respectively. CT was originally set up in 2017 to help discharge teams to find care home vacancies to optimise patient flow out of hospital and to support movement between health and care systems.

What support measures were put in place?

The main response to the pandemic was to significantly increase the scale, scope, frequency and timeliness of the data collected from the sector.

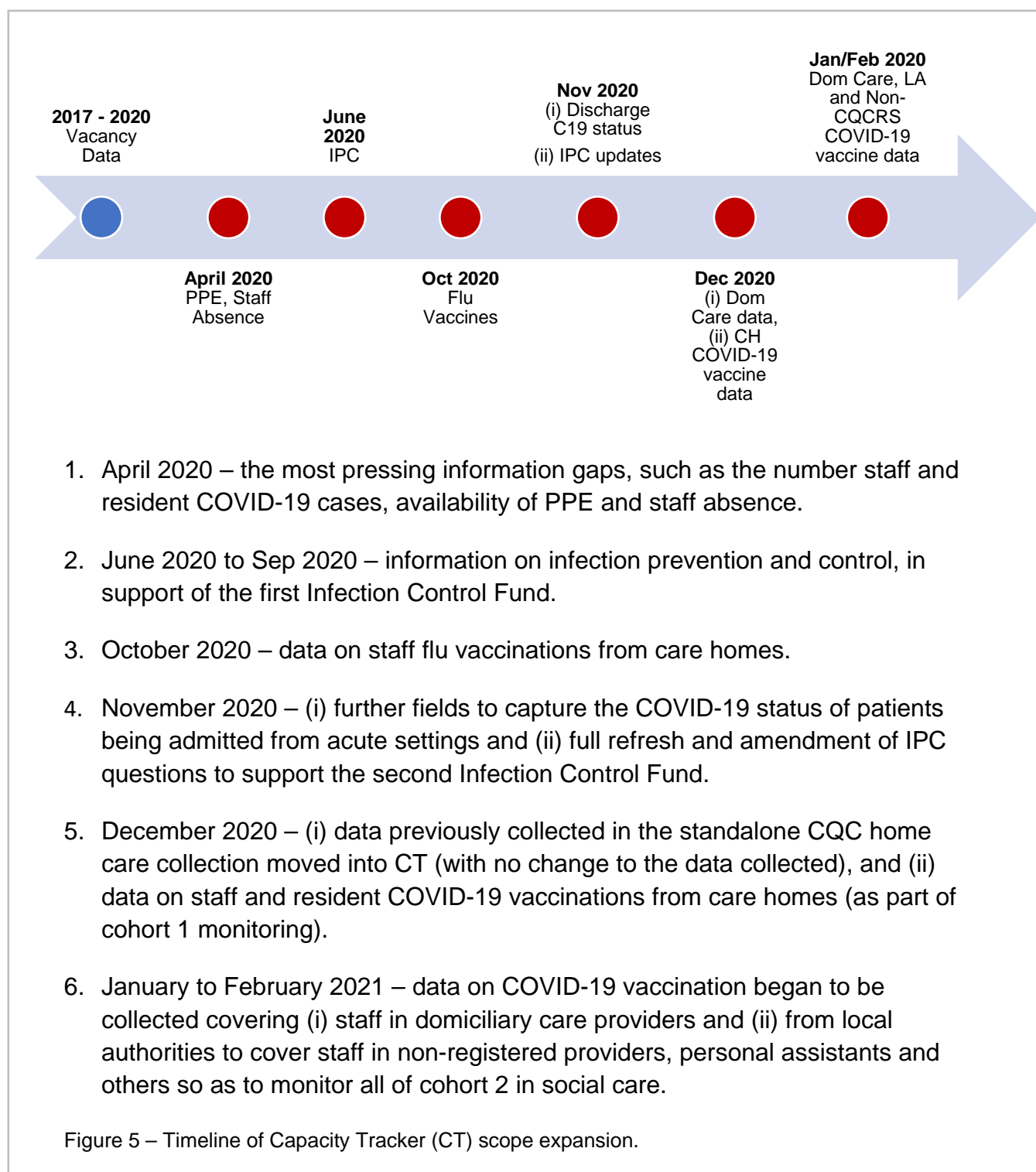
In particular, the role of CT was expanded to make it a national COVID-19 information tool. In the absence of other reliable data sources, it became the main source of data for monitoring and assuring infection prevention and control activity by care home and home care providers.

This expansion began in April 2020, with more COVID-19-related data being added to the scope of the collection over the last 12 months (as detailed below in Figure 5). The 3 ICFs have relied on the CT to monitor provider spend and IPC activity, while DHSC's ability to rapidly stand up data collection to monitor the vaccination of JCVI cohorts 1 and 2 used the existing CT infrastructure in the absence of reliable point-of-care data.

User feedback confirms a high level of acceptance of CT as a data source and collection tool among stakeholders, including care providers, CCGs, local authorities and acute trusts. The ability to access the ICF has acted as the biggest incentive to providers to submit data into CT. Prior to the pandemic, only around half of CQC-registered care homes used the CT to report their vacancies. This has now increased to over 95% of registered care homes.

However, as CT data are supplied directly by providers, the benefits of the availability of timely and granular data need to be set against the need for organisations that use the data for operational purposes, such as DHSC, local authorities, NHS England, to check the data and assure its quality and accuracy.

CT has been able to respond swiftly to monitor and record some notable successes in managing the pandemic in adult social care. For example, in November 2020, data capture fields were added to track the COVID-19 testing status of patients discharged from acute settings to care homes. It offers a fast and reliable way for care homes to flag risks such as shortfalls to PPE stocks or workforce, so that DHSC, or commissioners and suppliers, can respond appropriately.



The CT has also served to monitor vaccination of JCVI cohorts 1 and 2, in the absence of appropriate NHS point-of-care data collections for these cohorts. It has flagged up the rapid progress in vaccinating residents of older peoples' care homes

against the slower progress in vaccinating staff, and provided useful intelligence, for example, to identify local authorities with low vaccination rates.

However, providers and their representatives have highlighted the volume and frequency of CT data collection requirements as a burden. Though accepting of the need to provide the data in the early stages of the pandemic, they now question the continued daily requirement, more than a year later, to keep providing significant amounts of data.

Currently, CT is the only source of data that provides an overview across adult social care providers in England, including the social care workforce and residents. Given the increasing importance of the need for data that are consistent and comparable across the country, and which can link to, and compare across, data sources and with specific settings/organisations, it is likely that the CT will continue to be needed for this purpose.

DHSC has also developed the adult social care dashboard, which brings together relevant data from Test and Trace, CT, the CQC and other sources to allow the most up-to-date data to be viewed at national, regional and local levels. The dashboard provides detailed information on current levels and trends of COVID-19 infection in care homes, including testing numbers, test positivity rates and outbreaks among staff and residents, as well as vaccination uptake data.

The dashboard is increasingly relied on within DHSC as a single source of adult social care data for policy and operational use. Authorised users can access data on individual care homes, to help investigate and manage large or unusual outbreaks e.g. within a highly vaccinated population. It has also been made available to local authorities as a source of data for operational purposes, and over 85% of them have at least one registered user.

Policy and practice has been supported by research from a number of sources including work funded by the government. The Vivaldi research and analysis from the International Long-Term Care Policy Network have both been ground-breaking. It has included some research and analysis that is the forefront of the international understanding of the issues and risks in the social care sector. The advice is that this should continue and be built upon in order to understand the issues and risks better, not only in care homes, but also in the wider social care sector.

What do stakeholders think?

The development of testing data demonstrates that it is possible to link NHS point-of-care data with specific ASC settings. This has the potential to be of great value in understanding the health and care needs of the sector in the round. We need to improve sector coverage in point-of-care data as well as data quality to allow this potential to be tapped more effectively than is currently feasible.

Stakeholders feel that the improvement in the quantity and quality of sector data now gathered is a good thing, and should be maintained post-COVID-19, but some feel that the data is still not sufficient, and that what is needed is comprehensive site-level, system-wide data.

Stakeholders also noted that the greater use of data and communications has resulted in greater consistency in terms of provider management of IPC. However, it is harder to secure that same standardisation in the commissioning, market stewardship, and leadership roles of local authorities; particularly given that many care services do have a direct commissioning relationship with their local authority or the NHS.

Some stakeholders have concerns that the CT has replaced previously existing local data collection systems, some of which were more comprehensive or had greater locally specific value. A particular issue of concern is the reliance on CT to monitor vaccination uptake across the sector, reflecting perceptions of the reliability of self-reported CT data. Stakeholders have also called for a review of the CT; it should be noted that this is currently underway and is due to report in May 2021.

It is clear that one of the challenges for the government and for the sector is having enough data and information in a timely manner which can be shared at a national, regional, local and provider level. While it is recognised that there is a balance to be achieved between the burden in collecting data and the availability of timely data. The conclusion is that there needs to be continued collective effort to collect data and use it to inform national policy and enable operational responses to rapidly changing circumstances.

What are our recommendations?

Recommendation 29:

To continue work with the sector to review data needs and data burdens and to progress increased data transparency over 2021 and 2022. To progress the development of an ASC data framework that provides timely, comprehensive and robust data for the longer term.

Action for: DHSC, NHS

Timescale: review progress by end of July (in time for a potential roll-out of 'booster' doses) and again in December.

Recommendation 30:

That the contribution of research is reviewed, and further plans made for the extension of research and evaluation for the coming year, including extending to the wider social care sector

Action for: DHSC

Timescale: End of June 2021

Collaboration across health and care services

What support measures were put in place?

From 1 October 2020, PCNs became responsible for the full Enhanced Health in Care Homes (EHCH) clinical service set out in the GP contract and all care homes were assigned a named clinical lead within their PCN as part of this programme. Some PCNs had in fact started rolling out elements of the EHCH in advance of this requirement as early as May 2020.

As part of the [NHS @home programme](#):

- remote oxygen saturation level monitoring (using pulse oximeters) was further rolled out across care homes, providing 34,600 pulse oximeters. This is being expanded to cover every CCG footprint in England
- COVID-19 virtual ward services, which support safe and early discharge for COVID-19 patients with an improving clinical trajectory including those in social care settings, were further expanded across 96% of integrated care systems (ICSs) and are being set up by 19 March 2021 to all patients
- Which was expanded to cover non-COVID-19 patients – including monitoring blood pressure and glucose levels at home

Designated settings that are safe for people leaving hospital who have tested positive for COVID-19, or are awaiting a test result, who require care home care, were established across England.

The requirement for PCNs to provide the necessary rehabilitation for those recovering from COVID-19 was reiterated.

Care homes were supported with end-of-life planning via training, support with advanced care plans and joined-up working with community palliative care teams and hospices.

What do stakeholders think?

Stakeholders welcomed the additional support, especially the designation of a named clinical lead for each care home. They also noted the increased collaboration taking place across the sector, with local authorities, NHS partners, Health Protection England and providers now working together much more closely, and this is something all are keen to see become a permanent feature post-pandemic. There is a desire to see this happen to an even greater extent, with all policies being co-

developed not just with the providers and user groups, but also with individual people who use services and their carers.

Stakeholders viewed the discharge to assess scheme as being helpful in ensuring that people are able to be discharged in a timely way, without impact on the ability to identify their longer-term needs. Some stakeholders urged that the discharge to assess scheme needs to be subject to continuous review, taking into account the experience of those leaving hospital, relatives and other people acting in a supporting role.

Stakeholders have mixed views on whether the CQC-assured designated discharge settings scheme has been a success or not, with some questioning if the scheme has achieved its aim of reducing incidence of COVID-19 into care homes, given the lack of evidence to date, and others noting the difficulty experienced in implementing and operationalising the scheme. There is a need to assess whether the scheme is the best option for the future.

The additional funding provided for the enhanced discharge measures, and the general speed of collaboration between the NHS and ASC in removing barriers to safe and timely discharge (for those who are clinically fit to be discharged) is generally viewed as being a success.

Whilst it is recognised that the EHCH model has worked well in some areas, this is not the universal experience, with many reports of there being significant geographical variation, and those providers in areas which have less-generous offers feeling frustrated at the perceived inequity. Stakeholders agreed the EHCH model needs to be continued throughout 2021 to 2022, so that all – but especially those recovering from COVID-19 – who need care and treatment at home can get it. EHCH also needs to be standardised across England, so that all areas can benefit from the fantastic results that have been demonstrated in certain areas.

For the future, stakeholders felt that:

- anticipatory care needs to be strengthened
- crisis response and recovery and reablement at home services need to be increased
- if residential care is absolutely necessary after a spell in hospital, time for people to recover, rehabilitate and have their needs assessed should be built into their care programme
- if longer-term care is needed, the options and implications for them should be considered by social care staff and clinicians alike

- local systems must also ensure that there is widespread sharing of, and subsequent acting upon, best practice and learning

What are our recommendations?

Recommendation 31:

To review if the CQC-assured designated settings for discharge scheme is the best option for the future or if there are alternative options that are as safe.

Action for: DHSC

Timescale: End of June 2021

Recommendation 32:

Further work to take place with the NHS to ensure consistent application of the EHCH model across the country.

Action for: DHSC, NHS

Timescale: End of September 2021

Supporting mental health

For workforce wellbeing, please see the section on [Supporting the workforce](#).

What support measures were put in place?

A [national mental health support winter plan](#) and a [COVID-19 mental health and wellbeing recovery action plan](#) were published.

What do stakeholders think?

Stakeholders commented that those experiencing mental health problems and their friends, family and carers have been significantly affected by the pandemic. It is thought that, as a result, there is now an acute build-up of need for greater support .

Two key issues were highlighted by work with the approved mental health practitioner (AMHP) leads' group on the impact of the pandemic on AMHP practice:

1. It suggested that situations had escalated to Mental Health Act assessments because, in some areas, they were the only people undertaking direct face-to-face work in the community. Therefore, maintaining direct support to people with mental health issues is very important in maintaining people in the community and reducing risk. This may range from keeping some support

groups running to professionals maintaining contact face to face with those at significant risk.

2. When people do present in crisis, it should be ensured that there is a way of diverting people from accident and emergency to a safer place for assessment, as in the first wave some people ended up waiting in ‘red’ zones for many hours whilst beds were located.

Adult social care has an essential role in assessing, meeting and reviewing mental health needs (including through commissioned voluntary, community and social enterprise (VCSE) mental health and wellbeing services). The Mental Health and Wellbeing Policy and Oversight Group (the successor to the Mental Health and Wellbeing Advisory Group of the [Social Care Sector COVID-19 Support Taskforce](#)), convened by the Association of Mental Health Providers, was now a key vehicle for DHSC, NHSE/I, UKHSA, social care in local government and the mental health provider sector in facilitating ongoing collaboration on the strategic and best practice priorities for social care for mental health.

Stakeholders would like to see mental health feature more prominently in any future winter plan, and have recommended several areas to focus on, including greater access to primary mental health and community support for those impacted by isolation and trauma, those with substance misuse issues, and the homeless. They would also like to see wider provision of greater anticipatory care, assertive outreach and crisis resolution.

There is a crucial interface with the NHS and wider health policy in mental health. We, therefore, recommend that a standalone piece of work is undertaken to review the mental health support provision in the adult social care sector that was in place this winter, informed by recommendations of the Mental Health and Wellbeing Advisory Group to the Social Care Sector COVID-19 Support Taskforce.

What are our recommendations?

Recommendation 33:

Undertake a standalone review of the support that adult social care provided for people experiencing mental ill-health this past winter, with a view to strengthening the support offered in winter 2021 to 2022.

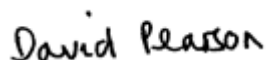
Action for DHSC, NHS organisations
Timescale: By end of July 2021

4. Next steps

This report has been considered by the Minister of State for Social Care and the Secretary of State for Health and Social Care. All the recommendations are accepted.

As part of stage two of this process, we will help those teams to work on the areas that have been identified in the recommendations of this report as requiring amendments or development of policy, or changes in practice, as part of the ongoing response to the COVID-19 pandemic, in both the immediate term but also in the medium term as part of planning for winter 2021 to 2022.

This will ensure that the government's COVID-19 response is as robust and supportive as can be, and that the lessons learned from this winter inform future policy and practice.

A handwritten signature in black ink that reads "David Pearson". The signature is written in a cursive style and is contained within a thin black rectangular border.

Sir David Pearson
Chair of Social Care Sector COVID-19 Support Taskforce

Annex I – Summary of all recommendations

Recommendation 1:

As part of the stage two, the efficacy of the workforce measures put in place should be further reviewed to more clearly identify which individual interventions were effective. This is to inform the decisions about what measures should be continued or introduced, and the resources that would need to be available for the forthcoming winter.

Action for: DHSC

Timescale: By end of August 2021

Recommendation 2:

Identify the specific risks to workforce capacity, supply and quality over the coming year, and develop and implement workforce contingency arrangements to reduce the risks and help to ensure workforce supply and safe working practices. The findings of this process should be further considered in the broader work on reform.

Action for: DHSC, local authorities, ASC providers

Timescale: By end of August 2021

Recommendation 3:

Undertake further investigation to provide more information on why some people who were COVID-19 positive were working during the winter period and address those issues prior to autumn 2021.

Action for: DHSC

Timescale: By end of August 2021

Recommendation 4:

Extend the time-limited workforce wellbeing support put in place during the pandemic.

Action for: DHSC

Timescale: Immediately

Recommendation 5:

Providers to place a greater focus on wellbeing and mental health support, including investigating the provision of a dedicated occupational health service to all staff.

Action for: DHSC, ASC providers
Timescale: By end of September 2021

Recommendation 6:

Given the uncertainty around future risks in light of vaccine efficacy and variants of concern, all key elements of IPC should remain in place until such time as the clinical advice is that they can be removed. The associated financial support from government should continue until it is safe to reduce the measures and the cost.

Action for: DHSC
Timescale: Until March 2022

Recommendation 7:

Publication of an IPC strategy for all social care settings, which should:

- include clear, easy to understand IPC guidance, training and best practice for the frontline
- be inclusive of reasonable adjustments in exceptional circumstances
- be supported with a comprehensive training programme championed by the Chief Nurse for social care
- be aligned with all relevant equivalent NHS guidance

Action for: DHSC
Timescale: 21 June 2021 (Step 4 of the Spring Roadmap)

Recommendation 8:

IPC measures are required beyond the current funded period (June 2021; PPE until March 2022). IPC funding should be extended appropriately, and made available at the same time as the release of guidance to provide certainty and security to providers, and allow them to continue to implement IPC measures.

Action for: DHSC, HM Treasury
Timescale: June 2021 (when current funding ends)

Recommendation 9:

There should be further consideration to making PPE for the ASC sector exempt from VAT in line with the tax status of the NHS.

Action for: DHSC

Timescale: By August 2021

Recommendation 10:

Review future PPE policy in light of ensuring that social care staff and recipients of care are better protected against other viruses, as part of the IPC strategy.

Action for: DHSC

Timescale: By end of July 2021

Recommendation 11:

A regular testing regime should continue for 2021 to 2022, whilst developing a strategy for being able to step down and step back up testing intensity (as the level of transmission allows), as driven by emerging evidence, infection prevalence and variants of concern. Work should continue to develop a clear strategy to achieve this.

Action for: DHSC

Timescale: Until end March 2022

Recommendation 12:

Operational arrangements are reviewed to ensure effective implementation in the next phase of vaccinations, including alignment between the vaccination for COVID-19 and flu.

Action for: NHSE/I, DHSC

Timescale: By the end of June 2021

Recommendation 13:

Continue work on improving vaccine take-up through access and reducing vaccine hesitancy across the ASC workforce. Continue to monitor and review progress of this work, its focus and its success.

Action for: DHSC, NHS

Timescale: Immediately

Recommendation 14:

That the NHS ensures that there is point-of-care data for social care cohorts in time for the next phase of vaccination and launch of the 2021 to 2022 flu vaccination programme, and that there is local/national access to the data in appropriate form.

Action for: NHS

Timescale: By September 2021

Recommendation 15:

That detailed planning takes place with the NHS vaccination programme for the next phase of vaccinations for COVID-19 and flu, taking account of the successes and challenges in the vaccination of care workers and unpaid carers.

Action for: DHSC, NHS

Timescale: By June 2021

Recommendation 16:

As it will be necessary for critical infection control measures to be in place for the course of this financial year, government should continue to ensure that these measures are financially supported and incentivised. It is also advised that decisions are made as soon as possible and in advance of winter.

Action for: DHSC, HM Treasury

Timescale: By end of July 2021

Recommendation 17:

Government should continue to review the state of the adult social care insurance market, including the impact of COVID-19 restrictions on providers, and consider whether further action should be taken.

Action for: DHSC, HM Treasury

Timescale: By end of June 2021

Recommendation 18:

The regional assurance team to provide further information to the sector on their current role and future priorities.

Action for: DHSC

Timescale: By end of June 2021

Recommendation 19:

Further work is undertaken to extend the level of care home visiting and residents going out across the country with the appropriate IPC measures to mitigate the risk of infection.

Action for: DHSC, UKHSA

Timescale: As soon as possible or in line with the Spring Roadmap steps (17 May, 21 June 2021).

Recommendation 20:

That further work takes place to understand the degree to which day services and related support services have reopened or have been replaced, and what further actions are necessary, nationally or locally.

Action for DHSC

Timescale: By end of June 2021

Recommendation 21:

Communication and contact with carers and those who draw on care and support is strengthened, such as regular/frequent contact/calls made to carers to check in with how people are coping as we progress through the roadmap.

Action for: DHSC, LAs, NHS (PCNs), carers' organisations networks

Timescale: By end of June 2021

Recommendation 22:

Local authorities to strengthen local support provided to carers, including accessing day care service opportunities and respite services, to ensure they are better able to remain open and continue to operate.

Action for: Local authorities

Timescale: By end of June 2021

Recommendation 23:

Guidance should be clear, easy to understand and aligned. All guidance should be co-produced and tested with end users to ensure its comprehensibility and accessibility. It should also align across government, so that DHSC ASC guidance is aligned with equivalent NHS, PHE or UKHSA guidance. Where possible, equivalent guidance should be published at the same time to ensure alignment. These tests should be built into the process before publishing. Where guidance is updated, it should identify what iteration is the most up-to-date version, and what has changed compared with the version it has replaced.

Action for: DHSC

Timescale: Immediately

Recommendation 24:

In the longer term, that a project is undertaken to determine the most appropriate structure for co-production at a national level and how this links with local arrangements.

Action for: DHSC

Timescale: By October 2021

Recommendation 25:

Guidance should be sent to all statutory and regulated organisations (providers, commissioners and local authorities) immediately and directly. In order to do this, ways should be developed to compile and maintain up-to-date lists of all the organisations in the sector.

Action for: DHSC, NHS, UKHSA (all bodies that publish guidance)

Timescale: Immediately

Recommendation 26:

Clarify and confirm the arrangements for dissemination of guidance to non-regulated settings (including personal assistants and unpaid carers).

Action for: DHSC, LGA, ADASS

Timescale: Immediately

Recommendation 27:

Increase digital inclusion support for ASC providers and people who use services so that those without access are supported to get online, and to ensure that the digital aims of the winter plan are achieved in every setting.

Action for: NHSX, local authorities

Timescale: By September 2021

Recommendation 28:

Local authorities and NHS organisations should ensure they take steps, in line with the public sector equality duty of the Equality Act 2010, to ensure they evidence and address the inequality of outcomes for people affected by COVID-19. DHSC should make available further specific advice for the sector in addressing inequalities and there should be appropriate oversight to ensure these steps are taken.

Action for: DHSC, local authorities, NHS organisations

Timescale: By July 2021

Recommendation 29:

To continue work with the sector to review data needs and data burdens, and to progress increased data transparency over 2021 to 2022. To progress the development of an ASC data framework that provides timely, comprehensive and robust data for the longer term.

Action for: DHSC, NHS

Timescale: Review progress by end of July 2021 (in time for a potential roll-out of 'booster' doses) and again in December 2021

Recommendation 30:

That the contribution of research is reviewed, and further plans made for the extension of research and evaluation for the coming year, including extension to the wider social care sector.

Action for: DHSC

Timescale: End of June 2021

Recommendation 31:

To review if the CQC-assured designated settings for discharge scheme is the best option for the future or if there are alternative options that are as safe.

Action for: DHSC

Timescale: End of June 2021

Recommendation 32:

Further work to take place with the NHS to ensure consistent application of the EHCH model across the country.

Action for: DHSC, NHS

Timescale: End of September 2021

Recommendation 33:

Undertake a standalone review of the support that adult social care provided for people experiencing mental ill-health this past winter, with a view to strengthening the support offered in winter 2021 to 2022.

Action for DHSC, NHS organisations

Timescale: By end of July 2021

Annex II – List of winter plan commitments

List of actions committed to in the DHSC ASC COVID-19 winter plan (published 18 September 2020).

Note, where a number appears multiple times, this is where what was originally one single commitment in the published plan has been broken down into multiple deliverables.

Number	Theme	Detail	Status
1	IPC	Mobilise intensive multidisciplinary response team to take immediate action when outbreaks occur, support LAs/providers to prevent outbreaks, and learn lessons about the cause of outbreaks.	Complete
1	IPC	Work with Better Care Fund to roll out a series of webinars on care home risks (including IPC, vaccines and testing).	Complete
1	IPC	Implement the comms plan to cascade lessons learned from previous COVID-19 outbreaks.	Complete
1	Assurance	Publish a joint operating procedure to set out best practice for managing increased transmission in the community.	Not Implemented
2	Workforce	Commission digital induction training for new starters, returners, and so on.	Complete
3	Funding	Funding templates for first tranche of ICF returned by LAs.	Complete
3	Funding	Second tranche of ICF released to LAs.	Complete
3	Funding	Evaluation report for ICF1 produced.	Complete
3	Funding	Release the second tranche of ICF2 funding to LAs.	Complete
3	Funding	Validate returns on spending for first month of ICF2 funding received from LAs.	Complete
3	Funding	Validate the returns for the first two months of ICF2 funding.	Complete

3	Funding	Review and reach an agreed position on the sufficiency of the ICF and generate proposals for post-March funding.	Complete
3	Funding	Validate the returns on spend for the first 3 months of ICF2 funding	Complete
3	Funding	Recommendations on the continuation of the ICF.	Complete
3	Funding	Release the first tranche of ICF2 funding to LAs, for providers to use in implementing measures to limit staff movement and paying staff wages when self-isolating.	Complete
3	Funding	Announce ICF2 grant conditions to support infection control.	Complete
3	Funding	Recoup the underspend of ICF1 from LAs.	In Progress
3	Funding	Conduct a more detailed assurance assessment of ICF1 with a sample of local authorities	In Progress
4	Managing Staff Movement	Distribute £120 million fund to support ASC workforce capacity.	Complete
4	Managing Staff Movement	Update guidance on staff movement between care settings.	Complete
4	Workforce	Consider initiatives to further restrict staff movement.	Complete
4	Workforce	Restrict movement of staff between care settings via amendment to Regulation 18 of the CQC Regulated Activities Regulations.	Not Implemented
5	PPE/Visiting	Provide care homes with sufficient PPE for visitors.	Complete
5	PPE	Invite all eligible care homes and domiciliary care providers to access to the PPE portal.	Complete
5	PPE	Further phased roll out of the PPE portal for ASC, increasing order limits to meet 100% of COVID-19 needs for care home and home care providers.	Complete

6	PPE	Provide LRFs or local authorities with 28 days of PPE stock to distribute as 'emergency' supplies in the case of a local outbreak.	Complete
7	PPE	Work with SAGE on how to provide unpaid carers with PPE.	Complete
7	PPE	Begin pilot of providing free PPE to extra-resident unpaid carers.	Complete
7	PPE	Rollout PPE for unpaid carers nationally.	Complete
7	PPE	Agree supply routes via LRFs or LAs and commence regular supply of free PPE for ASC services/providers that are not eligible to use the PPE portal.	Complete
8	PPE	Publish a PPE strategy to set out plans for winter preparedness and longer-term strategic objectives for building resilience in the PPE supply chain.	Complete
9	Testing	Increase our overall testing capacity and have set a target of 500,000-a-day UK antigen testing capacity by the end of October 2020.	Complete
10	Testing	Pilot a programme of testing visitors to care homes.	Complete
10	Testing	Begin rollout weekly testing for domiciliary care workers.	Complete
10	Testing/Visiting	Complete rollout of testing visitor strategy to care homes across England.	Complete
10	Testing	Identify testing options for personal assistants and roll-out to the sector.	Complete
10	Testing	Share draft testing strategy for care homes with latest advice from SAGE on repeat testing and risk-targeting, including the operational plan and capacity requirement to deliver it.	Complete
10	Testing	Distribute £149 million grant for LFD testing in care homes.	Complete
10	Testing	Roll out testing in day care centres.	Complete

10	Testing	Implement self-testing LFD kits for care home staff in England.	Complete
10	Testing	Commence roll out of ASC testing strategy.	Complete
10	Testing	Start rolling out an initial round of testing in the highest risk extra care and supported living settings (testing capacity dependent).	Complete
10	Testing	Begin review of the ASC testing strategy, including retesting strategy; plans for meeting demand during winter; and testing of those discharged from hospital into extra care, supported living and retirement housing.	Complete
10	Testing	Roll out testing strategy for extra care and supported living settings.	Complete
10	Testing	Roll out testing for visiting professionals who are not covered by the regular asymptomatic testing of NHS patient-facing staff.	Complete
10	Testing	Roll out at-home antibody testing for all paid ASC staff.	Complete
11	Testing	Integrate Pillar 1 and Sitrep data into the dashboard.	Complete
12	Vaccines	Publish guidance on how personal assistants can access the winter flu vaccination free of charge.	Complete
13	Discharge	Provide funding to support urgent community response services for people who would otherwise be admitted into hospital.	Complete
14	Discharge	Provide funding for new or extended health and care support for the first 6 weeks following discharge from hospital.	Complete
15	Clinical Care	Resume continuing healthcare assessments.	Complete
16	Discharge	Publish guidance on CQC designation scheme.	Complete
16	Assurance	Publish FAQs on CQC designation scheme.	Complete
17	Clinical Care	Rollout of the Enhanced Health in Care Homes framework.	Complete

18	Clinical Care	Make available loans of pulse oximeters to care homes that do not have the recommended number of devices (1 per 25 beds).	Complete
19	Technology	Deploy NHSmail and Microsoft Teams for all care providers.	In Progress
20	Technology	NHS to work on a fast discovery to better understand current barriers to the adoption of broadband deals for care home providers.	Complete
21	Technology	Offer discounted broadband deals and deliver connectivity guidance for care home providers, allowing care homes to improve their internet connections and access video consultations for residents.	Complete
22	Technology	Publish materials on the Digital Social Care website to support providers to introduce new technologies.	Complete
24	Technology	Accelerate safe adoption of products that enable care providers to access GP record information for people within their care, including the ability to reorder medications online on behalf of their residents.	In Progress
25	Technology	Publish a new version of the data security and protection toolkit for the care sector, including guidance and support to enable safe use of technologies.	Complete
26	Social Prescribing	NHS England and Improvement to offer funding on a time-limited COVID-19 related support offer to support primary care networks to recruit at least one social prescribing link worker.	In Progress
27	Social Prescribing	Ensure that individuals in each PCN have access to a social prescribing service.	In Progress
28	Direct Payments	Update guidance on direct payments for recipients and personal assistants.	Complete
29	Unpaid Carers	Provide and update guidance for those who provide unpaid care to family and friends.	Complete
30	Workforce - Wellbeing	Extend funding to the carers support phone line.	Complete

31	Unpaid Carers/Vaccines	Extend access to the complementary flu vaccination scheme to unpaid carers.	Complete
32	Unpaid Carers	Work with the Department for Education (DfE) to scope initial policy options to support young carers in the medium to longer-term.	In Progress
33	Workforce	Develop support to help carers delivering delegated health tasks.	Complete
34	Workforce - Wellbeing	Issue guidance and tools to staff and employers on how staff can manage their personal mental health and wellbeing.	Complete
35	Adult Social Work	Issue guidance for the support and wellbeing of adult social workers and social care professionals.	Complete
36	Workforce - Wellbeing	Provide care staff with free access to a number of mobile apps to support their mental health and wellbeing.	Complete
36	Workforce - Wellbeing	Review the provision of care staff with free access to a number of mobile apps to support their mental health and wellbeing.	Complete
37	Workforce - Wellbeing	Provide a package of support for registered managers.	Complete
38	Workforce - Wellbeing	Provide the CARE workforce app to signpost to all resources relating to wellbeing.	Complete
38	Workforce - Wellbeing	Review the CARE workforce app.	Complete
38	Workforce Wellbeing	Extend the CARE app until the end of March 2021.	Complete
39	Workforce	Work with LAs to assess access to occupational health provision and other wellbeing support available to social care staff.	Complete
40	Workforce	Work with the Department for Work and Pensions (DWP) to promote joining the social care workforce from hard hit sectors.	Complete
41	Workforce	Begin second round of national recruitment campaign.	Complete

41	Workforce Capacity	Prime Minister-led call to action to encourage people to join the social care workforce.	Complete
42	Workforce	Review the impact of the national recruitment campaign, with a view to a possible further round over autumn.	Complete
42	Workforce	Set up a short-term workforce planning group to identify and implement further ways to help address workforce capacity issues.	Complete
43	Workforce	Review the legislative, vetting, regulatory, and pay and conditions frameworks that have been put in place to enable temporary registration of returning staff and students as part of Secretary of State reporting on Coronavirus Act measures every two months.	In Progress
44	Shielding	Publish shielding guidance for clinically extremely vulnerable people.	Complete
44	Shielding	Update shielding guidance for CEV people.	Complete
45	Adult Social Work	Support principal social workers to lead social work teams through holding regular national webinars to address issues and risks as they arise.	Complete
46	Admin	Appoint interim Chief Nurse for ASC.	Complete
47	Adult Social Work	Support Skills for Care to deliver development programmes for public sector workers.	Complete
48	Assurance	Conduct a series of deep dive reviews of the effectiveness of guidance and support for preventing and managing COVID-19 outbreaks in care settings.	Complete
48	IPC	With support of military social researchers, conduct a discovery on best practice from care homes with no/minimal COVID-19 outbreaks.	Complete
48	IPC	Collation of the existing insight and additional advanced analytics to generate high-risk factors for care home outbreaks to steer regional support teams.	Complete

49	Adult Social Work	Chief Social Workers will continue to engage with key stakeholders and professional bodies to ensure the continuance of opportunities for professional leads to amplify social work and social care's voice.	Complete
50	Clinical Care	Continue to work with stakeholders to understand what more we can do nationally to prevent inappropriate do not attempt cardiopulmonary resuscitation (DNACPR) decisions being made for individuals.	Complete
51	Clinical Care	Publish guidance on for the public on DNACPR decisions.	Complete
52	Admin	Publication of 2-monthly review on Care Act easements.	Complete
52	Care Act Easements	Sixth 2-monthly review on Care Act easements for inclusion in the Coronavirus Act 2-monthly review and contributing briefing for the next 6 monthly debate	Complete
52	Assurance	Bring the Care Act easements to Parliament for review.	Complete
52	Assurance	Issue revised guidance on easements for LAs, building on lessons learned from the first wave of the pandemic.	Complete
53	Assurance	Publication of TLAP report on impact of Care Act easements on service users.	Complete
53	Assurance	Publication of second 2-monthly review on Care Act easements	Complete
54	Admin	Revise and update DHSC contingency plan with learning from Exercise Swift.	Complete
54	Assurance	Work with national partners to run an exercise testing joint contingency plans (Exercise Swift).	Complete
55	Market and Provider Sustainability	Carry out a service continuity and care market review to understand the robustness of the plans local authorities have in place to ensure sufficient capacity over winter.	Complete

55	Market and Provider Sustainability	Following the service continuity and care market review, between November 2020 and March 2021, provide targeted follow-on support to those LAs identified as requiring it through the review.	Complete
56	Market and Provider Sustainability	Develop a Designated Settings Indemnity Support offer and make available to care homes operating as designated settings.	Complete
56	Market and Provider Sustainability	Work closely across government, with care providers and insurance representatives, to understand the breadth and severity of issues relating to insurance renewals in the care sector to understand whether action should be taken.	In Progress
57	Assurance	CQC will introduce a transitional regulatory approach to inspections, bringing together existing methodologies with learning from the COVID-19 response.	Complete
58	Assurance	CQC will develop a new approach to monitoring, which will capture a much broader range of topics, as part of the monitoring process, to present a clearer view of risk and quality.	Complete
59	CQC Support	CQC will undertake 600 inspections a month until the end of March 21.	Complete
61	Assurance	CQC will carry out 500 additional IPC inspections.	Complete
62	Assurance	CQC to begin publishing monthly insight reports to share lessons learnt across the health and social care sector, and help health and care systems prepare better in the future.	Complete
62	Assurance	CQC to attend monthly meetings with MSC.	Complete
63	Assurance	Seek confirmation from all LAs that winter plans are in place, as a condition of ICF2.	Complete
63	Assurance	Care home resilience plans returned by LAs.	Complete
64	Assurance	Mobilise regional assurance and support team to assess and anticipate risks to delivery of the winter plan and provide support to local areas.	Complete

65	Data	Rollout ASC dashboard/one-stop digital data solution to all LAs.	Complete
66	Data	Publication of Capacity Tracker data on GOV.UK.	Complete
67	Assurance	The CQC will identify whether winter plans exist for providers in the Market Oversight scheme and provide a high-level view on their suitability.	Complete
11 and 65	Assurance	Roll out ASC COVID-19 dashboard to all LAs.	Complete
21 and 23	Technology	Begin distribution of tablet devices for remote health consultations to care homes that are in greatest need.	Complete
5 and 7	PPE	Review continuation of customer PPE demand panels for adult social care.	Complete
59 and 60	Assurance	CQC will undertake 300 risk-based inspections per month between October and November.	Complete
59 and 60	Assurance	CQC will undertake 1,200 risk-based inspections between 1 December and 31 January.	Complete