

Gerry Mitchell

On the Corona Frontline

The Experiences of Care Workers in England

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About this publication

This paper looks at the impact of COVID-19 on care workers and the people they care for in England. It explains why the care sector was so vulnerable to and ill-equipped for the pandemic and charts the delayed government response to it and how that was further impeded by a lack of integration between health and social care. It documents trade union campaigning on the health and safety of workers, the lack of or inadequate personal protective equipment (PPE), sick pay, accommodation and access to testing as well as their fight for longer-term reform, emphasising how the immediate problems in the sector are connected to its longer-term systemic issues. These campaigns have also focused on shifting public opinion about the status and value of care work and the need to address the structural inequalities that impact on care workers.

About the Author

Gerry Mitchell is a social policy researcher, most recently having worked for Compass (London) and TASC (Dublin). Previously, a Research Officer in the Social Policy Department at the London School of Economics, with degrees from Cambridge and LSE, she completed her PhD as an Associate at the LSE's Centre for Analysis of Social Exclusion. Her research interests include inequality, frontline experience of social policies and reform of party-political culture on the Left. Gerry is also involved in local politics as Chair of Woking Constituency Labour Party in Surrey. She stood as its parliamentary candidate in the 2019 General Election. Twitter: @GerryMitchell2

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Responsible for this publication within the FES

Dr Philipp Fink, Director, FES Nordic Countries
Josefin Fürst, Policy Officer, FES Nordic Countries

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1 INTRODUCTION

This paper discusses the impact of the COVID-19 pandemic on the care of older people in the adult care sector in England. It considers care workers and the people they care for, whether in their own homes or in care homes.¹ It reviews the trade union responses to the crisis, their calls for measures that need to be implemented immediately as well as their recommendations for longer-term systemic reform.

Unlike the free-at-point-of-use National Health Service (NHS), social care is means-tested in England. With no single national budget, it is commissioned and purchased through local authorities and delivered through a complex system of private, public and voluntary-sector providers as well as professionals and informal carers, with overlapping accountability. Most services are delivered by for-profit companies and the sector is hugely fragmented and disparate, with 18,500 employers across nearly 40,000 establishments.

The pandemic has highlighted long-standing issues with the sector including long-term underfunding and an undervalued, underpaid, low-status workforce exposed to exploitative employment practices and a lack of career progression. Staffing is in crisis with high vacancy rates and high turnover. The sector suffers from market failure, with providers frequently closing down or handing back their contracts to local authorities.

Adult social care was ill-prepared for the pandemic. Despite being warned of the sector's vulnerability, the government downplayed the importance of social care at the start of the pandemic and funding was not forthcoming. With a delayed central response, providers had to make very difficult decisions about whether to stay open and had to establish supply chains without any help from local authorities or government. The eventual government response was uncoordinated and impeded by the lack of integration between health and social care and the lack of an established social partnership between government, employers, unions and other public sector organisations. This resulted in failures to protect an already vulnerable client group and workforce.

The trade unions were instrumental in negotiating the initial job retention scheme, and its extension into autumn. They fought for the health and safety of workers, exposing the inadequacy or total lack of personal protective equipment (PPE), lack of access to testing—and repeated testing—lack of adequate sick pay and lack of accommodation. At the same time as winning victories on these issues, they also ran public awareness campaigns highlighting the

¹ Care homes may be residential or nursing homes. Care homes without nursing are known as residential homes. Care homes with nursing are known as nursing homes. Nursing homes are care homes where a nurse must be present to provide or supervise medical care alongside basic personal care. Some homes provide both types of provision. "Care home" is used for both types of home in this report, unless discussing something specifically to do with a nursing home. For an explanation of the differences, please refer to: <https://www.trustedcare.co.uk/help-and-advice/difference-care-home-nursing-home>.

role that carers play and shifting public opinion about the status and value of care work.

All through the pandemic, unions have continued to campaign for longer-term reform of the social care system, for the creation of a properly funded National Care Service, in which private sector involvement is limited and there is proper sectoral collective bargaining to ensure a fairer system of productivity, pay, terms and conditions, and working practices.

2 CONTEXT

There is a lack of basic understanding of the adult social care sector in England by the public, the government and the media (Bottery et al. 2018). As outlined in the introduction, unlike the NHS, the social care system is means-tested. People with savings over £23,000 are required to use those (and potentially sell their home) to self-fund their care. Care home places can be funded by local authorities, the NHS or privately.

Throughout the 1980s, Conservative government policy led to the availability of social security funding for care home placements without a needs assessment. This stimulated massive growth in private sector provision and prompted many local authorities to privatise provision in order to take advantage of favourable funding arrangements. This rapid and large-scale expansion of private provision was largely unmanaged and unchallenged. In 1979, 64 per cent of residential and nursing home beds were still provided by local authorities or the NHS. Today, 84 per cent of beds in care homes for older people are owned by private companies, 13 per cent by the voluntary sector and only three per cent by local authorities (Blakeley/Quilter-Pinner 2019). Similarly, 95 per cent of domiciliary care was directly provided by local authorities in 1993. By 2012 it was just 11 per cent.

FUNDING AND ORGANISING CARE

Local authorities organise (commission) and purchase care (based on cost and not quality) and most recipients will contribute to the costs. Local authorities decide how much they will spend, although some funding comes as central government grants earmarked specifically for social care. The funding dynamics of this means-tested system have led care home providers to increase the fees charged to self-funding residents to subsidise their local authority-funded places (RCN 2018). 41 per cent of care home residents are self-funders. On average, their place costs around 40 per cent more than one paid for by the local authority (Parliament 2020).

The funding dynamics also mean that providers are financially motivated to register as care homes, as opposed to nursing homes, as general care beds cost less to run. However, this increases the overall burden and stress for staff as well as presenting significant care dilemmas. At best, this

causes delays to provision of nursing care for residents and puts pressure on care home residents to perform certain tasks themselves. At worst, specialist nursing care is not available in the care home and dependent on the availability of community district nurses, whose numbers have decreased by more than 40 per cent since 2010 (RCN 2018). This leads to knock-on pressures in other areas of the health system, such as acute emergency services.

The unit cost of providing residential and nursing care for older people is also increasing, driven mainly by workforce costs (Bottery/Babalola 2020). This pressure has led councils to reduce the amount they pay providers to the point where many are failing to pay the minimum amount considered necessary for safe levels of care. They have also tightened eligibility thresholds, so that only those with critical or substantial levels of need are able to receive publicly funded care. With funding not based on individual need, those needing nursing care provision fall between the gap of local authority and continuing healthcare funding and are forced to rely on unregulated “unqualified” social care support. If their health needs are not met satisfactorily at an early stage while still living at home, health crises and nursing home admissions are more likely, both of which are more costly. At the same time, there has been a shift towards more people receiving short-term as opposed to long-term care. Whether this is driven by service availability and funding is unclear (Bottery/Babalola 2020).

FUNDING CUTS AND STILL NO CLEAR POLICY ON SOCIAL CARE

Adult social care in England has to be viewed in the context of a decade of austerity, with local government suffering the brunt of spending cuts. Although relatively protected compared to other services, total spending on adult care is still lower than it was in 2010, despite demand from an ageing population (Harris et al. 2019)—with increasingly complex needs—in a situation where life expectancy is stalling and possibly starting to reverse. 2015 saw the largest rise in mortality since the Second World War (Dorling 2017). Cuts have been largely targeted at the poorest areas of the country, with nine of the ten most deprived councils seeing cuts of almost three times the national average. Many of these have had to scale back their social care services leading to concerns about the estimated 1.5 million older people who have unmet care needs (Age UK 2019).

As spend is matched to budget through a locally driven resource-led process, there is, unsurprisingly, a postcode lottery in social care provision. In 2018/19, the highest-spending ten per cent of councils (adjusted for regional price differences) spent an average of £22,700 (25,189 euro) per service user. The lowest-spending ten per cent spent £12,900 (14,315 euro), a difference of over 70 per cent. And these differences are not random. The highest-spending councils tend to serve more affluent communities, where the social care means test results in 50 per cent fewer service users per head of population (Slasberg/Beresford 2020). While benefits such as attendance allowance and personal independ-

ent payment do provide a degree of support, social care users and their estimated 5.4 million informal carers—the largest source of care—shoulder most of the burden arising from the pressures in the system. In 2015/16, the value of that informal care was almost as much as was spent on the NHS (Thorlby et al. 2019).

Meanwhile, a colossal funding gap remains in the sector. Around one in ten people aged 65 face future lifetime care costs of over £100,000 (€110,967) (Alderwick et al. 2019). Addressing this scale of need at the same level of services as in 2009/10 would cost £7.98 billion. Setting a cap of £48,000 on the amount people can expect to pay for care over their lifetime, as recommended by the Dilnot Commission, would cost £3 billion in today’s money (Idriss et al. 2020).

Decisive political action and an appropriate funding settlement are required for the transformation needed. Despite 12 green and white papers and five independent commissions over the last twenty years, a succession of governments has “ducked the challenge of social care reform” (Thorlby et al. 2019). Existing piecemeal responses are unlikely to meet rising demand and are nowhere near enough to widen access to publicly funded care. The government pledged one billion extra funding (split between adult and children’s social care) in the 2019 spending round² for 2020/21 to be replicated in each year of Parliament. The Better Care Fund has transferred some funding from the NHS to social care and councils have been allowed to raise council tax for social care through a council tax precept that has injected over £2 billion into their services. However, since re-election in 2019, the Conservatives have provided no clear policy on social care, promising to seek cross-party consensus on reform, but providing little detail on what they want to achieve through it—aside from a single commitment that no one should have to sell their home to pay for care. The awaited green paper has still not been published.

3 THE STRUCTURE OF THE ADULT SOCIAL CARE SECTOR

While the Department of Health and Social Care (DHSC) has ultimate responsibility for and oversight of the NHS, NHS England and local authority clinical commissioning groups are responsible for the planning, commissioning and delivery of social care. Public Health England is responsible for responding to public health emergencies, working locally through health protection teams; it is to be dissolved in a restructuring in spring 2021. Councils operate in conjunction with other local structures to plan and commission health and care services. The Ministry of Housing, Communities and Local Government has responsibility for local

² The Spending Round is a Whitehall-led process to allocate resources across all government departments, according to the government’s priorities. Spending reviews set departmental budgets for current and capital spending over several years. It is then up to departments to decide how best to manage and distribute this spending within their areas of responsibility. This Spending Round is very similar to a Spending Review but allocates spending for just one year rather than for multiple years. <https://www.gov.uk/government/news/what-is-the-spending-round>

government finance, which includes certain social care services. Care homes sit within this structure. The Care Quality Commission (CQC) is responsible for monitoring, inspecting and regulating homes, and other bodies possess powers to investigate individual complaints and provide guidance on good practice. Skills for Care is an independent charity tasked with adult social care workforce development, in partnership with the DHSC. However, although there are 1.62 million people working in social care, there is no one obvious representative of care employers.

Despite the existence of these bodies and new emerging models of care, lack of integration between health and social care has been a fundamental problem in England for decades. In terms of the significance of this to the impact of coronavirus on the adult social care sector, back in 2017, Exercise Cygnus, a government pandemic simulation modelling exercise (Public Health England 2016), found that “it was extremely difficult for the centre [central government] to locate capacity in the care sector, due in part to the fact that care homes are almost entirely privately run and at greater arm’s length from government than NHS hospitals” (Pegg 2020). This “raised concerns about the expectation that the social care system would be able to provide the level of support needed if the NHS implemented its proposed reverse triage plans, which would entail the movement of patients from hospitals into social care facilities” (Pegg 2020). Local responders reported that a multi-agency response was essential but that the current operation did not provide the framework for them to achieve this.³

The COVID-19 crisis has shown that central government can influence change in the NHS and other healthcare settings particularly effectively through the well-established social partnership forum between government, employers, unions and arms-length bodies. However, replicating such partnerships and equivalent mechanisms in social care’s hugely fragmented and disparate provision—with 18,500 employers across nearly 40,000 establishments—is much harder. Within one local authority, as many as 800 different care businesses can be delivering care services at any one time. The transfer of patients from hospitals to care homes without first being tested for COVID-19 was the most obvious example of the problems this can cause.

THE EFFECTS OF PRIVATISATION

Privatisation has been highly damaging for the stability, resilience and cost-effectiveness of the sector, with market failure now a prominent feature. Nearly one-fifth of the sector is accounted for by five providers, three of which are private equity-funded. High levels of borrowing, complicated corporate structures and cost-cutting measures, including tax avoidance and low staff pay, are associated with such providers. The high expected rates of return imply a level of

risk that is unjustifiable in a sector backed by the state in which demand is stable and increasing. There are also hidden leakages in the system, which increasing funding to the sector will not address. For example, companies within the same umbrella group loan and borrow money or sell and lease beds to each other, and any associated costs are paid either out of public funds or by those funding their own care. Potential collapse of these large firms, and constant changes in ownership of the remaining care homes and provider companies creates huge uncertainty and upheaval for service users, staff and local authority commissioners (Blakeley/Quilter-Pinner 2019, Rowland, 2019). Some providers have retrenched from areas such as domiciliary care, in order to focus on more profitable areas (Unison 2020b). Before the crisis, 75 percent of councils were reporting providers closing down or handing back contracts due to “dwindling fees” with little slack in the system to respond to increased pressure (Edwards/Curry 2020).

4 EMPLOYMENT STANDARDS AND CONDITIONS

Care workers (with nurses) represent one of the largest key worker occupations, while care work in the private sector is particularly affected by low wages and precarious employment forms. While a majority of the workforce are employed on permanent contracts, of which half work full-time and half part-time; around a quarter are on zero-hour contracts (375,000 jobs). Domiciliary care services have the highest proportion of workers employed on zero-hours contracts (42%) especially among care workers (56%) (Skills for Care 2020). Domiciliary care jobs, including personal assistants (PAs) (43%), now account for more jobs in the sector than residential care (41%).

One quarter of the sector’s workforce are aged 55 and over and so could be expected to retire within the next ten years. At the same time, based on the growth of the population aged 65 years and above, the sector will need to grow by 32 per cent (or 520,000 jobs) by 2035 (Skills for Care 2020). Over 80 per cent of the care workforce are women, with the sector’s low pay likely to be a significant driver of the national gender pay gap. Around 21 per cent of the care workforce identify as Black, Asian or minority ethnic (BAME). Around 12 per cent of adult social care workers identify as black, compared to 3 per cent of the total population (Skills for Care 2020).

Social care workers are among the lowest paid in society, with average pay just £9.14 (€10.17) per hour in 2018 (IPPR 2018), below the basic rate paid in most UK supermarkets (Ward 2019). Seven in ten care workers earn less than £10 (11 euro) per hour (Skills for Care 2020). The hours of work and total pay for those on zero-hour contracts can vary significantly from one week to the next. They are vulnerable to workplace exploitation, such as failure of employers to pay for travel time in domiciliary care, and sleep-in shifts in care homes. 54 per cent of councils do not require domiciliary care agencies to pay workers for the time spent travelling between visits (TUC 2020h). When domiciliary care workers

³ Local responders are police, fire and rescue services, health bodies, HM coroner services, local councils, government agencies and other non-departmental public bodies, the armed forces, the private and voluntary sectors, and community organisations.

do not receive the full and entitled hourly rate of pay over the working day, their pay can fall below the legal minimum wage. (TUC 2020h) Progression, training and bargaining power are also poor and this underpins the profession's huge turnover. One in five health professionals say COVID-19 has made them more likely to leave the profession. With no formal pay and grading structure in the sector, skills and experience often go unrecognised and promotion often means more responsibility without corresponding reward (TUC 2020h). The pay differential between care workers with less than one year of experience and those with more than 20 years of experience has now reduced to just 15 pence an hour, halved since 2016 (TUC 2020h).

Care workers make up 53 per cent of the sector's workforce, while those directly involved in providing care (care workers, senior care workers, support workers, those working for direct payment recipients and others providing direct care and support) constitute 76 per cent of the sector. By contrast, managerial and supervisory roles make up only 7 per cent and regulated professions (including registered nurses) just 5 per cent. 12 per cent of jobs do not directly involve providing care, such as administration, catering and cleaning (Skills for Care 2020a). Care workers have an average of three years' experience working in the sector. In comparison, registered nurses have an average 13.3 years' experience. Just under half of the workforce have a relevant social care qualification. 69 per cent of care workers who had started after 2015 had completed some, if not all, of the Care Certificate.⁴ Four in five senior care workers have a social care qualification at level 2 or above, as do 45 per cent of care workers (Skills for Care 2020a).

STAFF SHORTAGES AND CHALLENGES RECRUITING

The adult social care sector has "a self-perpetuating cycle of workforce shortage causing huge strain and leading to further workforce shortage in turn" (Thomas/Quilter-Pinner 2020: 7). In 2018, it suffered a shortage of 110,000 people (The King's Fund 2018). Adult social care turnover rates are among the highest of all sectors. In 2018/19, one third of directly employed staff left their jobs, with approximately 122,000 vacancies at any one time—nearly one in every ten roles (Age UK 2020b; TUC 2020h; Skills for Care 2019). These shortages have been accentuated by the pandemic. In a survey of 211 providers in March 2020, over half reported considering or having taken on staff on a temporary or short-term contract that they would not have done previously (Eastwood 2020).

The widespread use of agency staff across multiple homes has been identified as a key factor in the rapid spread of COVID-19 between homes in the United States, and this may also have played a part in the UK. Unison has prepared a joint union response to the government's intention to bring

in new regulations restricting care workers to a single place of work without providing any financial support to enable them to do so (Barnes/Donnelly 2020; DHSC 2020b). The government's new immigration proposals preventing migrant workers being recruited to roles paying below £25,600 (€28,407) will have damaging effects on a sector that is vulnerable to sudden shifts in immigration patterns, with 17 per cent of the overall workforce composed of non-British nationals (Unison 2020c); 16.5 per cent of registered nurses working in social care come from the European Union and 19.7 per cent from non-EU countries (RCN 2018).

Care work is perceived as unskilled. Yet much of the work that care staff carry out requires considerable technical skills and interpersonal abilities that are often overlooked. There is also a frustrated desire for greater training and development opportunities, which are "virtually non-existent for large swathes of the workforce" (Unison 2020b: 4). This applies at all levels with care managers, for example, taking on their jobs without any training (Unison 2020b: 4). The Care Certificate only covers a basic induction into care rather than more specialised training and is not a mandatory requirement for employers. While there is professional registration for nurses, no such registration exists for care workers, which would be one way of ensuring a more consistent approach to standards and boosting the prestige of care work (Unison 2020b: 5).

A Royal College of Nursing (RCN) response to the House of Lords Economic Affairs Committee 2018 inquiry into social care funding in England pointed out that there were not enough registered nurses and healthcare support workers to deliver safe and effective care in adult social care settings and that while the number of registered nurses was declining (down 20 per cent since 2012/13; Skills for Care 2020: 8), the number of care workers was increasing. It raised concerns about inappropriate substitution of skills leading to poorer outcomes for people using these services (RCN 2018; see also RCN 2017) and called for funding to include ring-fenced provision to address gaps in the workforce and to expand it to meet population needs. It also called for comprehensive population-need and workforce data in order to make decisions about provision and resource in the sector. Based on this assessment, the government should produce a fully-funded national workforce strategy for health and social care and then take steps to ensure that adequate numbers of staff are recruited and trained. This could include a national recruitment campaign specifically for social care and incentives to increase supply of nursing staff (RCN 2018).

5 ADULT SOCIAL CARE AND CORONAVIRUS

Government policy on COVID-19 during the pandemic

The first confirmed COVID-19 case in the UK was on 31 January 2020. On 25 February, Public Health England issued COVID-19 guidance for social care settings advising that "it is ... very unlikely that anyone receiving care in a care home or the community will become infected" and "there is no need to do anything differently in any care setting at pres-

⁴ For an explanation of the Care Certificate, see: <https://www.skillsfor-care.org.uk/Learning-development/inducting-staff/care-certificate/Care-Certificate.aspx>.

ent.” (Dunn et al. 2020a). The government published a Coronavirus Action Plan on 3 March, and the first UK COVID-19 death was reported two days later. From an initial £5 billion emergency response fund for the NHS, local authorities and other public services, £1.6 billion was allocated to local authorities but not ring-fenced for any one service. NHS England asked hospitals to urgently discharge patients who were medically fit back into social care settings—after which 25,000 patients were discharged (Dunn et al. 2020b).

On 13 March, the original guidance for care homes was superseded. Residential providers were asked to review their visiting policy, prevent visits by anyone suspected of having COVID-19, follow good hand hygiene and advise staff to wear PPE when caring for those with COVID-19 symptoms. The first lockdown was introduced by the government on 18 March (and was to last until 16 June 2020) with travel restrictions, social distancing measures, closure of entertainment, hospitality, non-essential shops and indoor premises, and increased testing. Every care home and care provider would receive 300 face masks. The CQC soon reported that a majority of calls to its helpline were about lack of PPE and concerns about infection control and social distancing (CQC 2020a).

PROBLEMS PROTECTING CARERS AND THEIR CLIENTS

Providers also reported receiving incorrect or poor quality PPE. Carers UK highlighted that unpaid carers had not had access to PPE guidance or supplies and that the focus was too narrowly on care homes and did not include the mix of settings in the sector—including care homes, supported living and extra care housing, people’s private homes and elsewhere in the community. The government said there were “capacity constraints” and issued plans for local authorities to manage and distribute further national PPE stocks. Local authorities reported that the initial government funding was not enough to cover COVID-19 costs. Accessing proper PPE was a major additional expense for councils at this point (Dunn et al. 2020b).

At the end of March, the Coronavirus Act 2020 was enacted, including temporary “easements” on the Care Act, suspending the statutory requirement to assess care needs (in extreme cases permitting councils to meet a person’s need only if not doing so would breach their human rights) and creating unmet need and unintended consequences. Guidance for care homes stated that negative tests were not required prior to admission and while it advised against visitors except in exceptional circumstances, it continued to advise “care as normal” for those without symptoms (Dunn et al. 2020b).

Cases peaked in March and April. Midway through April, almost a month after social distancing measures had been put in place, an adult social care action plan for controlling the spread of infection was finally issued. It committed to testing all symptomatic care home residents and social care workers and all new residents prior to admission. At this point, a further £1.6 billion was given to councils. In late April, care provider leaders reported that money allocated

to local authorities for addressing COVID-19 was not being passed on. Age UK reported that some self-funded care home residents had been asked to pay an excess charge on top of normal fees to cover COVID-19 costs (Age UK 2020a).

LACK OF FINANCIAL SUPPORT FOR CARERS

In terms of workforce policy, the package of measures introduced in the social care action plan included a campaign to recruit 20,000 extra staff—but did not include improvements to the terms and conditions of these jobs. By the end of March 2020, an average of 25 per cent of the frontline care workforce were unable to work. This figure hid a wide range of reported staffing levels from some employers reporting no absences to others with up to 50 per cent (Skills for Care 2020b). In the same survey, 36 per cent of providers noted volunteers coming forward—although many (49 per cent) were not yet sure how best to utilise them.

Guidance for care providers in mid-March referred to financial support for affected workers across all industries and did not address the wider effect of sickness and self-isolation on the social care workforce in particular or the impact on their workloads. The easements to the Care Act were also designed to reduce workloads for social care staff. In April, the government changed its guidance on the job retention scheme to include people with caring responsibilities. However, its wider financial measures may not have helped all staff. While statutory sick pay was made available from day one of sickness due to COVID-19, those on zero-hour contracts are only eligible for sick pay if they earn a certain amount each week. As 56 per cent of domiciliary care workers are on zero-hours contracts, this may well have left many of them choosing between going to work with symptoms or losing income.

The social care plan also introduced measures aimed to ensure parity between the NHS and social care workforces. For example, supermarkets had to allow social care workers the same priority access and benefits as NHS workers, and comparable health and wellbeing guidance was provided. However, there was otherwise limited new support. Two policy changes impacted international staff working in social care. At the end of May, the bereavement scheme, offering indefinite leave to remain to the families and dependants of health workers who died from coronavirus, was extended to the families of social care workers (Woodcock 2020). The government also announced it would exempt health and social care staff from immigration health surcharges on visas, (as non-EEA nationals must pay for access to NHS services).

LACK OF TESTING FOR CARERS

By the end of April, testing was expanded to asymptomatic care home staff and residents but the government did not introduce a dedicated fund to support infection control in care homes until mid-May. Local authorities also reported that the additional government funding was not enough

to cover COVID-19 costs. While COVID-19 testing in England was expanded on 23 April to cover all essential workers with symptoms, personal care assistants and unpaid carers were not added to the list of essential workers until the beginning of May. Regular testing in care homes was not introduced until 6 July, with enhanced outbreak testing rolled out soon after.

In May, the House of Commons Science and Technology Committee concluded that: “the decision to pursue an approach of initially concentrating testing in a limited number of laboratories and to expand them gradually, rather than an approach of surging capacity through a large number of available public sector, research institute, university and private sector labs is one of the most consequential made during this crisis. From it, followed the decision on 12 March to cease testing in the community and retreat to testing principally within hospitals. Amongst other consequences, it meant that residents in care homes—even those displaying COVID-19 symptoms—and care home workers could not be tested at a time when the spread of the virus was at its most rampant” (Science and Technology Committee 2020).

WILL LESSONS BE LEARNT?

On May 10, the government set out a “road map” to ease the lockdown, with reopening to take place in three steps, starting on 13 May. By June, NHS support available to social care had been strengthened by supporting infection control training, advice and support (for example on PPE) and putting in place a named clinical lead for every care home in England. The number of people dying in care homes was also falling (CQC figures show a 79 per cent fall from the peak of the crisis). From July, face masks became mandatory in shops and supermarkets (Dunn et al. 2020b).

The National Audit Office (NAO) has catalogued the policy mistakes made and highlighted: “the tragic impact of delaying much needed social care reform”; the unclear lines of responsibility and accountability for the social care response to COVID-19; the “strain and trauma” experienced by front line workers in health and social care, as well as the impact on staff morale and confidence; and a lack of transparency about costs and value for money of policies designed to create additional capacity quickly.

Its recommendations include reviewing which care homes received discharged patients and how many subsequently had outbreaks and developing procedures to ensure patients are safely discharged into settings that limit the spread of COVID-19. Its recommendations also emphasise that “the needs of social care [need to be given] as much weight as those of the NHS”; that the DHSC must set out how it will meet this need, report “transparently and consistently on progress”; agree specific actions to support staff to recover from the pandemic; and disclose cost information on key elements of the response (NAO 2020).

At the end of July, the Coronavirus Act 2020: Equality Impact Assessment was published. In August, it was an-

nounced that Public Health England will be replaced by a National Institute for Health Protection. The new organisation will bring together Public Health England, NHS Test and Trace and the Joint Biosecurity Centre and work with the devolved administrations. The aim is to have a “stronger, more joined up response.”

By September, a rule limiting social gatherings to a maximum of six people had been introduced and a mass testing plan had been announced. By the end of the month, the government had been accused of making secondary legislation “on the hoof” and not allowing democratic debate in parliament. MPs voted to extend the Coronavirus Act 2020 and the government announced that parliament will be consulted and wherever possible, given a vote on significant national measures before they come into force.

COVID-19 and deaths in the care sector

From January to September, 49,104 deaths in England were registered as attributable to COVID-19 on death certificates (ONS 2020d). By the end of May, England had the highest overall relative excess mortality in a study of fifteen European countries (ONS 2020c).⁵ The majority of Covid-related deaths between January and September were people aged 65 years and older (47,200 out of 52,856 in England and Wales) (ONS 2020d). Among people diagnosed with COVID-19, those who were 80 years old and above were 70 times more likely to die than those under 40 (Public Health England 2020a). For every ten deaths among confirmed cases in women, there are 14 in men (Globalhealth5050, 2021). In the most deprived areas of the country, the age standardised mortality rate (ASMR) involving COVID-19 between March and July was more than double that in the least deprived (Public Health England 2020a).

UK figures on COVID-19 cases and deaths were not initially broken down to identify those receiving social care, either in care homes or in the community (Hodgson et al. 2020). The number of COVID-19 outbreaks in care homes was first made public at the end of March 2020. The scale of the mortality only became clear as the Office for National Statistics (ONS) began to report place of death in April. Up until then, the alarm had been sounded by those working in the sector. By October 2020, Comas-Herrera et al. found that 46 per cent of all COVID-19 deaths were among care home residents and that the UK had the highest proportion in comparison to 15 countries with comparable data (Comas-Herrera et al. 2020). Between 17 March and 16 April 2020, 25,000 patients were discharged from hospitals into care homes, many without requiring testing for COVID-19 (Bodkin 2020). By the end of May, 40 per cent of care homes had reported a Covid outbreak (Dunn et al. 2020a). According to the ONS year-to-date analysis up to week ending 13 November 2020, 65.5 per cent of deaths involving COVID-19 occurred in hospital (40,062) with the remainder occurring in care homes

⁵ For more information on excess deaths in England, please see Appendix 1.

(16,849),⁶ private homes (2,927), hospices (833), other communal establishments (242) and elsewhere (223) (ONS 2020d). While deaths in hospitals and care homes have now dropped below the five-year period since the first peak of the pandemic (as of December 2020), the ONS reports deaths in private homes well above the five-year average even though the majority of deaths are unrelated to COVID-19 (ONS 2020e). The Care Quality Commission (CQC) has published exploratory data on mortality in care home residents by ethnicity, finding that black residents had an increased likelihood of dying with confirmed or suspected COVID-19 on their death notification form (CQC 2020b).

Between May and June, 56 per cent of care homes were estimated to have reported at least one confirmed case of coronavirus (staff or resident) (ONS 2020b). In May, care homes accounted for 16 per cent of all COVID-19 deaths. However, this is considered an underestimate, both due to a reluctance to record the contribution of COVID-19 in the absence of a test and also because a significant proportion of the remaining additional deaths could be directly or indirectly attributable to it (Edwards/Curry 2020). More than 19,000 people had died in care homes from COVID-19 by late June (Herrera et al. 2020) but data on excess mortality suggests the figure was much higher (Herrera et al. 2020) with care home residents accounting for 39 per cent of all COVID-19-related deaths (Bell et al. 2020).

It remains unclear how many additional deaths were due to the indirect impacts of the pandemic or were undiagnosed cases. The national figures obscure substantial regional variation. Mirroring the spread in the wider community, London was initially the most heavily affected area, but outbreaks quickly spread. By June, the north-east of England had the highest proportion of affected care homes, at 54.2 per cent. Public Health England data track the number of new care homes reporting an outbreak but do not track the number of new infections in each care home over time in detail. While more detailed information is collected, the publicly available data do not show whether previously affected care homes are currently dealing with continued or new outbreaks, or whether infections have been successfully controlled.

Factors driving COVID-19 outbreaks in care homes

The factors driving COVID-19 outbreaks in care homes include community transmission and infections picked up during hospital stays. Between March and the end of April, discharges from hospitals to care homes in England decreased to 86 per cent of the historical average. However, due to lack of available data, it is unknown whether these discharges led to subsequent outbreaks in care homes. While discharges from hospitals to residential care homes were 75 per cent of the historical average, discharges to nursing homes increased to 120 per cent of the historical average.

Further research is needed to explain this (Hodgson et al. 2020). There was also a substantial reduction in hospital admissions among care home residents. Elective admissions reduced to 58 per cent of the five-year historical average during this period and emergency admissions to 85 per cent. 14 per cent of admissions at this time had COVID-19 as the primary cause. By reducing admissions, care home and NHS teams may have reduced the risk of transmission. There may have also been an increase in unmet health needs. However, available data does not allow an assessment of whether this was the case. They conclude that “[t]hese difficult decisions to discharge patients were made in urgent and uncertain contexts but may have played a role in transferring risk to a poorly supported social care system” (Hodgson et al. 2020).

HIGHEST RISK OF COVID-19 MORTALITY FOR DOMICILIARY CARERS

Social care workers are among the occupational groups at highest risk of COVID-19 mortality, with care home workers and domiciliary carers accounting for the highest proportion (76 per cent) of COVID-19 deaths within this group. When adjusted for age and sex, social care workers had twice the rate of death due to COVID-19 during the peak of the pandemic in April and May compared to the general population, with the death rate being particularly high in adult social care (The Health Foundation 2020). By the end of July, the UK was second only to Russia for numbers of health worker deaths, with at least 540 health and social workers having died from COVID-19 in England and Wales alone (Amnesty International 2020). Available ONS data on care worker mortality (not distinguishing between care home and domiciliary workers) between 9 March and 25 May 2020 reports 97 male and 171 female deaths, but with no other disaggregation by factors such as age and ethnicity (ONS 2020a).

Deaths among those receiving domiciliary care have risen substantially since March to far above normal levels (The Health Foundation 2020). By July, an excess of 4,500 deaths was reported among this group. In proportional terms, the increase in deaths was higher in domiciliary care than in care homes (225 per cent compared with 208 per cent). Some of these deaths could be explained by not accessing treatment, considering that Accident and Emergency attendances were 57 per cent lower in April 2020 than April 2019 and far below normal levels in England. The data is insufficient to understand whether the pandemic progressed in a similar way across domiciliary care (Hodgson et al. 2020).

BAME AND FEMALE CARE WORKERS ARE OVERREPRESENTED IN COVID-19 RELATED DEATHS

The care sector is occupationally segregated, with a high proportion of women, people identifying as Black, Asian or minority ethnic (BAME), and migrant workers. BAME workers also appear to be “significantly overrepresented in the

⁶ See Appendix 1 for further discussion of reporting deaths in care homes.

total number of COVID-19 related health worker deaths, with some reports showing that more than 60 per cent of health workers who died identified as BAME” (Amnesty International 2020: 18). The pandemic has taken a toll on BAME communities, with elevated risk of death for people of Bangladeshi, Black Caribbean, Chinese, Indian, Pakistani, Other Asian and Other Black ethnicities (Public Health England 2020b). Those care workers who have died have been overwhelmingly female. Women are disproportionately represented both among high-risk occupations (in terms of exposure to COVID-19) and workers who earn poverty wages (less than 2/3 of the median wage) (Kikuchi/Khurana 2020). Over one million high-risk jobs pay poverty wages, and 98 per cent of the workers in these jobs are women.

6 FACTORS CONTRIBUTING TO THE IMPACT OF CORONAVIRUS ON THE SOCIAL CARE SECTOR

This section summarises some of the key factors affecting the impact of COVID-19 on the care sector. These include the sector’s status as the “poor relation” of the NHS; the lack of coordination at the beginning of the pandemic due to an absence of partnership between central government and the sector; inadequate PPE; problems with testing; and the lack of financial support for the sector and its workers. This part of the report also looks at the consequences of the crisis on the physical and mental health of care workers.

THE FORGOTTEN SECTOR

Adult social care failed to be prioritised at the start of the pandemic. While government funding was assured for the NHS, there was no such reassurance for the social care sector which only entered the public discourse relatively late. Schools had closed for a month before any action for social care was even announced. Care homes had to receive newly discharged patients from hospitals freeing up beds. Some of those patients had tested positive for COVID-19, some were still awaiting test results. Both groups required strict isolation, which put additional pressure on care homes. Although evidence emerged that half of all deaths may have taken place in care homes, the government downplayed the importance of social care. As deaths declined in hospitals, they rose in care homes where “the forgotten frontline” of social care workers experienced a raft of failures to protect them as a result of inadequate standards of premises, processes and co-ordination of services (Unison 2020b). They were working in a sector whose workplace and employment practices—a lack of a coherent national procurement system, for example—left it totally unprepared for the pandemic. As Guy Collis, a Unison Policy Officer interviewed for this report, put it, “The care sector entered the pandemic in just about the worst state it could really.”

The difficulty of coordinating became clear. The government, at ministerial level, did not understand why it was being asked to take responsibility for a largely privatised sector. The government, lacking an understanding of how the sec-

tor worked, struggled to drive necessary change. In the NHS, with a centralised structure and social partnership forum, it was much easier for information to pass both down and up the hierarchies. In social care, formulation of a policy by the government would be followed by a stand-off between local authorities, providers and central government about whose responsibility it was to actually make it happen.

LACK OF PPE AND TESTING

Meanwhile, providers had to make very difficult decisions about whether or not to stay open for admissions, not wanting to put existing residents and staff at risk. They had to establish PPE supply chains before any help from the government was forthcoming (BBC 2020). The lack of a supply of adequate equipment to residential care settings has been described as a “significant” oversight (Thomas/Quilter-Pinner 2020: 15). As some providers learned that their PPE orders had been diverted to the NHS, the cost of privately sourced PPE also meant that many providers could not obtain adequate quantities for their staff while hugely inflated prices threatened their financial viability. Social care workers faced enormous challenges in doing their jobs. The lack of PPE is a bigger issue for black workers as they face a greater risk of death than their white colleagues (Unison 2020b). While provision of PPE has improved since the peak of the first wave of the pandemic and been allocated funding through the Infection Control Fund, provision varies across the country with continuing concern—at the time of writing this report—across care staff about preparation for the remainder of winter 2020–21.

Lack of testing has also been a key failure. The disparate nature of social care services, particularly domiciliary care, and a hugely fragmented care market meant it was very difficult for the government to reach all care workers. By mid-April 2020, the number of positive critical key workers had increased to 16.2 per cent. This hugely increased the workload and stress of frontline workers, thereby weakening the capacity of the healthcare system, and had grave implications for the ongoing rise in the number of health and social care frontline workers with infection (Nyashanu et al. 2020). GMB and Unite surveys during the pandemic found that care workers felt unsafe at work, without (adequate) PPE and not being tested. The majority of those without adequate PPE felt their health was being put at risk and were worried they would pass COVID-19 on to their family or household. Care workers did not know where to get tested and reported that their employers did not have a procedure in place for situations where workers and service users had been found to have COVID-19 symptoms. A lack of testing capacity meant some care workers having to travel hundreds of miles to get themselves tested.

LACK OF SICK PAY

Workers also faced enormous pressure to attend work even if it was against public health advice, with no assurance that they would receive sick pay when self-isolating or after a positive test. Evidence suggests that there were

lower levels of infection in care homes where staff received sick pay (ONS 2020b). However, a Unison survey of care workers in July 2020 still showed far too few workers getting proper sick pay, with 52 per cent paid less than £100 a week (and in some cases nothing at all) if they needed to shield or self-isolate (Unison 2020d). There were lockdowns within care homes during this period, with reports of care workers sleeping in tents because no accommodation had been provided by their employers (Peart 2020).

THE FORGOTTEN COUSIN: DOMICILIARY CARE WORKERS

Providers of domiciliary care are the most vulnerable in the care sector. 97 per cent of UK domiciliary care is provided by private providers making more than one million visits per day to equally vulnerable people in their homes. Domiciliary care has been described as “the forgotten cousin of the already second-class social sector both in terms of lack of attention and understanding from government” (Hill 2020); there are no central records of the numbers who rely on its support and very little oversight of providers’ financial stability. By April 2020, it was being reported that many were at breaking point and could soon cease trading leaving vulnerable people to die alone at home (Hill 2020). And there was little clarity as to the numbers who had already died.

The experience of those receiving care from PAs has been particularly problematic, due to a lack of back-up service when PAs were unable to work (Unison 2020b); a failure to provide care due to easements to the Care Act, and the “time and task” nature of care delivery, a cut-price approach to homecare in the UK, in which workers are expected to deliver care in 15 minutes or less. PAs are largely unregulated and very few belong to a union. Local authorities hold no details of them. They were given very limited general guidance from the government and relied on their own initiative in getting tested, obtaining PPE and learning safe practices (in relation to testing their clients and fellow workers for example). Most stopped working during the crisis or were asked by employers to stop and suffered a sudden and drastic loss of income (Woolham et al. 2020: 21). Not all were eligible for furlough or self-employment payments and very few had insurance against sickness.

NEGATIVE IMPACT ON PHYSICAL AND MENTAL WELLBEING

COVID-19 has had a huge impact on the physical and mental well-being of workers in the health and social care sector (Enback 2020; Thomas 2020). One in two health and care workers across the UK felt their mental health had declined during the crisis. 35 per cent had used alcohol to cope with work-related stress; 56 per cent said they were emotionally exhausted and 63 per cent had difficulty sleeping (Thomas/Quilter-Pinner 2020). One in two said that they had experienced detriment to their family’s safety. While guidance for support and wellbeing of workers was issued by a number of government and voluntary sources (DHSC 2020a; Skills for Care/The

Tavistock and Portman NHS Foundation Trust 2020), it is difficult to assess how useful it was in practice during the pandemic. Care workers have also been struggling with a range of welfare issues during the pandemic, including childcare, accommodation and extra costs. In the same survey, one in 20 healthcare workers said their housing security had been affected. One in three health and care workers felt wider provision of hotel accommodation near their place of work should be an immediate government priority and that the government should acknowledge a wider range of reasons why staff might need accommodation. These included increased travel times due to the outbreak; significant anxiety around their families’ safety; and increased working hours (for example more than 14 hours in a 24-hour period).

INCOMPLETE DATA AND MISSING VOICES

Problems of fragmentation, lack of partnership between the government, unions and providers, light touch regulation and lack of standardised reporting methods have meant that even the most essential data—how many people are dying and where—has not been fully collated and a coherent picture has not been built up. Data collection is incomplete. Much of the data quoted in this report covers both health and care workers in forms resistant to disaggregation. What is more, care workers still appear largely spoken for. Their voices are missing in part due to the vulnerability of both carers and cared for, and the low levels of unionisation.

7 TRADE UNION PERSPECTIVES

The trade unions representing care workers in England include Unison, GMB, the RCN and the umbrella organisation of British trade unions, the Trades Union Congress (TUC).⁷ Pre-pandemic, these unions were campaigning for a new long-term funding settlement for the sector that would end the for-profit model in an essential public service and ensure greater stability for commissioners, workers and the cared for; greater value for money to the public; increased accountability, transparency and standards; and the limiting of private sector involvement initially through the introduction of legislative and regulatory measures to end financial extraction in the sector. They campaigned to bring adult social care back in-house by introducing an insourcing first policy for all services and a review of all outsourced council-funded services, ending contracts for failing services, and opening the books. They called for changes to the local commissioning system to relieve local authorities of cost pressures and tackle high workforce turnover, in order to eventually expand eligibility thresholds and relieve the pressure on unpaid carers.

Unions have also called for a national care body to be set up, like the Social Partnership Forum in the NHS, to enable proper collective bargaining in the sector. This would be the most effective way to negotiate a £10 (€11) per hour mini-

⁷ A federation of trade unions in England and Wales: <https://www.tuc.org.uk/national/about-tuc>.

mum wage, an end to zero-hour contracts, and better sick pay, pensions, terms and conditions, and working practices. They are campaigning for investment in and career development of the workforce—including a national skills and accreditation framework linked to a transparent pay and grading structure, ensuring genuine career progression, proper recognition and fair reward. The unions are fighting for the development of a workforce strategy, that would then be used to negotiate, organise sectoral interests, meet growing demand and to improve pay and conditions in the sector.

Union campaigns on improving pay in the sector, in particular, setting a wage floor that is sufficient to attract and fairly reward workers, also emphasise that raising pay alone would not address wider challenges facing the workforce. Building on the Unison Ethical Care Charter, unions have campaigned for a set of commitments to fix minimum standards to protect the dignity and quality of life of vulnerable people and the workers who care for them (Unison 2012). These include training, job security, fair payment, occupational sick pay, occupational pension and well-being. A sectoral agreement would also have to include pay for defined roles and pay scales that include increments (reflecting increased experience and expertise to give workers greater opportunity for pay progression and greater incentives to stay in the profession).

ORGANISING CHALLENGES

The organising challenges working against unionisation of care workers include difficulty reaching potential members in a disparate market (particularly in domiciliary care), a high turnover of workers, and employers unsympathetic to unions. Despite this, the unions continue to win significant victories in improving working life for carers. Recently, in a long-running case going back to 2016, the court acknowledged that the time that domiciliary carers spend travelling and waiting up to 60 minutes between appointments should be treated as working time and paid at the minimum wage. Additionally, the court ruled that employers should provide a clear method of calculating how much their employees are owed (Matheou 2020). Unison have also fought for carers' sleep-in shifts to be counted as working time and paid accordingly (Unison 2019).

The pandemic has shown the value of key workers, thereby increasing their potential to exert some control over the conditions in which their work is performed. Union membership has surged, with largely women joining (TUC 2020f). Nevertheless, membership is still too concentrated in the public sector, while most workers, particularly in social care, are employed in the private sector. Just one in five care workers (including senior care workers) are a member of a trade union or staff association, while four in five NHS nurses are union members. Low-paid workers with lower levels of qualifications and a lack of individual bargaining power—who would most benefit from membership—are least likely to join a union (Dromey/Hochlaf 2018). Less than one quarter of current members are aged under 34, more than 40 per cent are aged 50 and over (TUC 2020f).

While a majority of workers in local authority employment are covered by collective bargaining, very few in the private sector are. This leaves pay to be set by employers at a level dictated by the market, and again contrasts with the NHS, where pay and conditions are collectively agreed nationally. Although the UK has an obligatory minimum wage payable to workers aged 25 and over, this has not been enforced in the care sector, with legal action restricted to restricted to small local companies, with often only one worker identified as having been illegally underpaid.⁸ Care workers on zero-hour contracts who raise concerns, join a trade union or push for pay are vulnerable to having their hours reduced (Dromey/Hochlaf 2018). There is no representative body for social care employers. This makes it harder to establish partnerships and bargaining of the type that is commonplace in the NHS. The NHS Social Partnership Forum works on issues important for staff (such as terms and conditions and well-being) and has allowed the system to respond quickly during the pandemic, offering guidance to NHS employers (Unison 2020b).

UNION CAMPAIGNS DURING THE PANDEMIC

Unions have continued to campaign for structural reform. Unison's "5 demands for a national care service" campaign advocates for a national care service paying at least a real living wage, government emergency funding for the sector, provision of standard employment contracts for care work and professional standards. The latter includes upgrading and expanding the Care Certificate and standardising professional registration throughout the UK. The fifth demand is for a partnership/working group of commissioners, providers, government and trade unions to action solutions to the crisis. Unite has called for safe workplaces, fair pay, fair treatment, sustainable funding and also a national care service.

Unions also provided immediate support for their members, negotiating with the government on the coverage and conditions of the initial job retention scheme (TUC 2020c), self-employment income support (SEISS) and the job retention scheme's extension into autumn (TUC 2020g). They campaigned for the health and safety of workers, raising awareness of what it means to be a frontline worker. Unison and GMB surveys highlighted that carers did not feel safe at work, that without adequate PPE, their lives had been put at risk, that almost no carers had been tested, and that they had concerns about passing COVID-19 on to their families. Four out of five care workers were expecting colleagues to quit at the time of the survey (GMB 2020). Unions also campaigned for further clarity from government guidance on the use of PPE in the care sector. The GMB reported staff threatened with disciplinary action if they wore face masks and who were told not to wear them because it was scaring residents. Staff bought their own PPE regardless. At the same time, Unison set up a dedicated hotline for members to report

⁸ For an explanation of the national minimum wage, the national living wage and the living wage, please see: <https://www.thelegalpartners.com/national-minimum-wage-national-living-wage-rates-for-2020-explained/>.

problems, which were overwhelmingly about the lack of PPE. Unions also campaigned for a centralised system for PPE and to increase the UK’s own manufacture of PPE (BMA 2020).

In summer 2020, Unison reported serious issues with testing in the adult care sector. This included the lack of testing, testing that did exist being focused on care homes rather than domiciliary care, and a real failure to repeat test staff in the sector. The union highlighted the lack of local capacity due to cuts having decimated much of the country’s local public health capacity. Centralised “super-labs” have been unable to meet the testing targets and unions have raised legitimate questions about capacity and future mass testing and vaccination plans. Many health and social care staff had to self-isolate rather than driving the long distances to testing centres (often far from where they lived and worked) with some then being turned away when they arrived. Workers also reported a lack of flexibility as to when testing took place at work (Unison 2020a).

Early on, GMB highlighted how workers were being asked to stay at work, with some care homes setting up their own lockdowns. The union called for the government to fund accommodation directly, on the same basis as for health professionals. Unison campaigned for an active service payment and for statutory sick pay to be increased (paid at the national living wage), reminding government that care workers are low paid workers already, do not have any buffer in their own finances and therefore cannot survive on statutory sick pay for two weeks (£95 or €106 per week) (McLaughlin 2020). They warned that without it, workers would be pushed into debt and the test and trace system would be completely undermined. They flagged up that the central government infection control funds set up to cover care workers’ additional costs, to allow them to afford to self-isolate or cover the cost of alternate accommodation, were not getting through to the care workers themselves (Unison 2020e).⁹ Just 40 per cent of care workers said they had remained on full pay if they needed to take COVID-19-related absence, dropping to just 25 per cent for those working in care homes. 44 per cent of all care workers—and 56 per cent of care home workers—that needed to be off work were only on statutory sick pay—with 8 and 10 per cent respectively receiving nothing at all (Unison 2020d).

The unions pointed out that workers who were not financially supported would face a stark choice—go to work and risk contaminating service users or stay at home and have no money to live on (Unite 2020). Funds were not getting through partly because providers had to apply for the money and central government was not paying local authorities to administer the fund. The latter have no spare capacity to administer the fund on account of their losses resulting from COVID-19 (estimated to be about £11 billion). Unison have also identified low levels of trust where providers feel it is more important to ensure that staff are there to provide care than to permit them to stay away

from work as a precaution. The decentralised nature of the sector makes it difficult to gather this information about how effective the fund has been.

COPING WITH THE RESTRICTIONS

In October 2020, when Unison officials were interviewed for this report, they were preparing a response to the government’s plan to legislate against care workers moving between multiple sites. At that point, there was no suggestion that the government intended to compensate workers for this restriction, when working jobs in multiple places is the only way that they can keep themselves afloat.

The TUC were instrumental in working for safe returns to work after lockdowns (TUC 2020b), developing the processes required to ensure that comprehensive risk assessments and safe working practices were put in place. These included pressing for risk assessments to be carried out in non-unionised workplaces and specific consideration for BAME workers. For those who lose their jobs, it has also argued the case for a new jobs guarantee, as a scheme providing a minimum six months’ employment with accredited training, paid at least the real living wage or the union-negotiated rate for the job (TUC 2020d)

All through the crisis, unions have called on the government to stand by key workers and honour their contribution. In its recent *Fixing Social Care* report, the TUC sets out its long-term campaign priorities for the sector: a long-term funding settlement, fair pay and decent work, sectoral bargaining, and limits on private-sector involvement (TUC 2020g). They have campaigned for fair pay and conditions for care workers, calling on the government to legislate for a minimum wage of at least £10 (€11) per hour, and to ensure that no care professional is paid less than the real living wage, through rigorous minimum income standards, an end to zero-hour contracts and an end to poor or non-existent sick pay (TUC 2020i). They also called on the government to introduce a COVID-19 pay bonus of 10 per cent for all workers in health and care for 2020/21 in recognition of how they have gone above and beyond. As this report was being written, the government announced a public sector freeze for all workers outside the NHS. Following on from a decade of wage stagnation, this was described as a “kick in the teeth” by TUC General Secretary Frances O’Grady (Inman 2020). Although the review also increased the minimum wage, now rebranded the national living wage, by 2.2 per cent to £8.91 (€9.88) per hour from April 2021, this is still far from the living wage called for by unions.

8 CONCLUSION

The COVID-19 pandemic in adult social care is a “crisis within a crisis” (TUC 2020a). It has exposed and aggravated many long-standing issues within social care, including long-term underfunding of the sector, a deep staffing crisis with high vacancy rates, a complex and fragmented organisational structure, and a problematic lack of data. The government, having

⁹ For information on the infection control fund, see: <https://www.gov.uk/government/publications/adult-social-care-infection-control-fund/about-the-adult-social-care-infection-control-fund>.

been warned in January that the sector was vulnerable, failed to prioritise social care. This will be seen as a major failing (Unison 2020b) that allowed the virus to exact a heavy toll on some of the most vulnerable in society. Care workers—disproportionately female, Black, minority ethnic and migrant and long underappreciated and underpaid in insecure, low status work—have put their health and wellbeing, their lives on the line, and faced enormous challenges in doing their jobs.

Unions and their members have been instrumental in improving the working conditions of care workers during the crisis, fighting for PPE, testing, sick pay and accommodation. Unison has formed a new cross-party alliance, the Future Social Care Coalition, which brings together more than 80 organisations and individuals calling for an immediate £3.9 billion emergency support fund to get the care sector through the pandemic's second wave (Future Social Care Coalition 2020; Unison 2020f). At the same time, the Coalition highlights how these immediate problems are connected to the longer-term systemic issues within the sector.

Unions and their members have also played a vital role in shifting public opinion, with a majority of the public now believing that care workers are undervalued and should be paid better (National Care Forum 2020; Quilter-Pinner and Sloggett, 2020). They continue to campaign for an end to the low pay and insecure work that leaves many of the most essential workers not earning enough to get by (Robertson, 2020; see also Unison's "No going back to normal" campaign, Prentis 2020). Evidence also suggests that better pay can improve the quality of care and increase staff retention. The sector's structures and organisation—and the means-testing at its heart—must also change to a much simpler, more equitable and more transparent system (Cominetti et al. 2020). A system of care that the public but also the government and the media can better understand. Improving public support by explaining where the money goes and what it pays for is a crucial aspect of winning the argument for a greater share of national spending going on social care in future.

The crisis has revealed to the wider public the structural inequalities that impact on care workers. The role of unions in expressing the collective voice and interests of working people has never been more vital. England entered this crisis with a safety net much reduced and public services damaged by years of austerity; now the trade union movement is making the case for building a fairer society with a new settlement for public services:

"The way to do this is through everyone having a decent job, on better pay and working conditions, alongside revitalised public services and a stronger safety net. We must invest in a fairer future; we cannot afford not to" (TUC 2020e).

APPENDIX

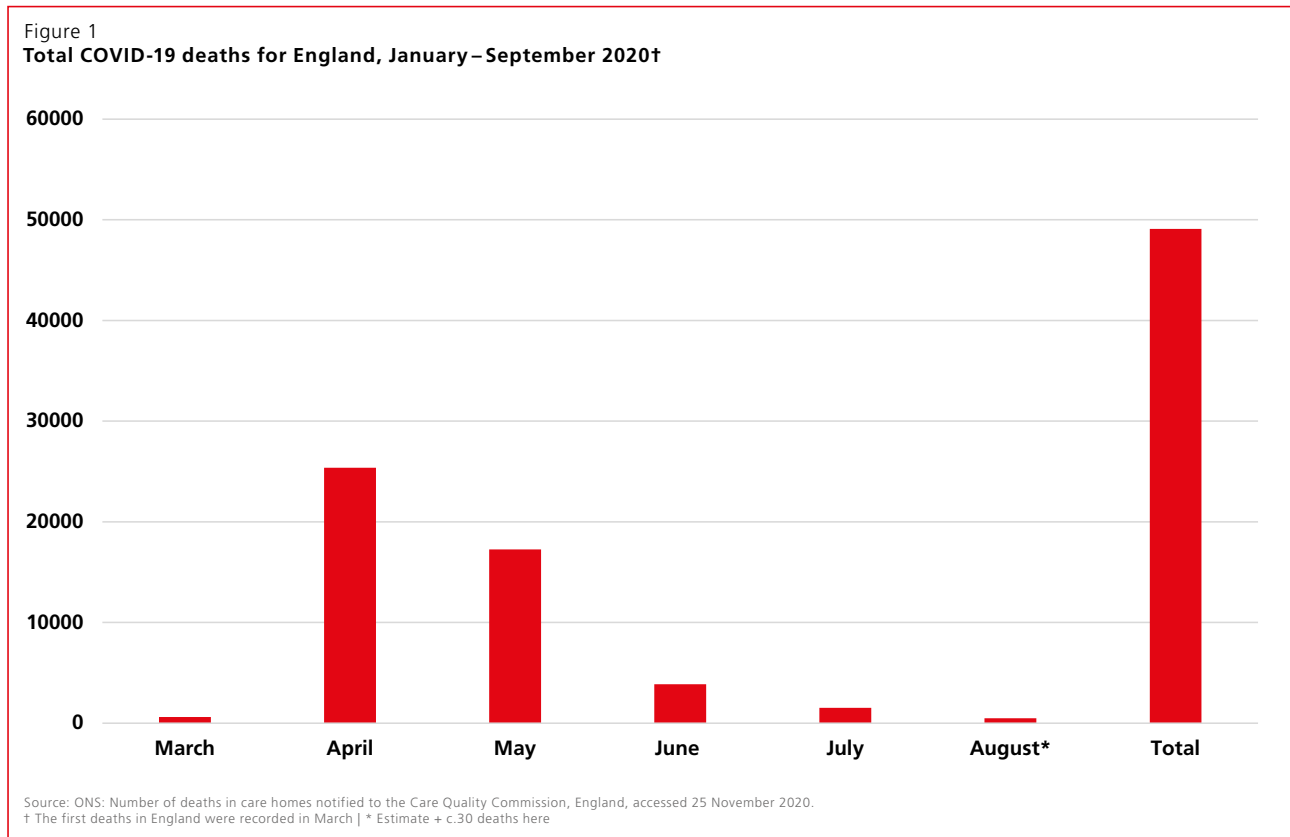


Figure 2, for the same period, compares excess deaths with and without COVID-19. This can provide insight into how many excess deaths are identified as due to COVID-19, and how many excess deaths are reported as due to other causes of death. These deaths could represent misclassified COVID-19 deaths, or potentially could be indirectly related to the COVID-19 pandemic (for example, deaths from other causes occurring in the context of health care shortages or overburdened health care systems). The surge in excess deaths for April and May in Figure 2 can be clearly attributed to COVID-19. Note the increase in deaths from non-Covid causes in May, followed by decreases in June and July.

Figure 2
Total excess deaths in England, January–September 2020
 (Calculated by comparing 2020 deaths with the five-year average for the same periods)

Month in 2020	Excess deaths attributed to COVID-19	Percentage change from five-year average	Excess 2020 deaths not attributed to COVID-19	Percentage change from five-year average
March	+930	+3.1 %		
April	+36,045	+92.5 %	10,675	+27 %
May	+18,885	+42 %	1,627	+3.6 %
June	+862	+2.4 %	-3,001	-8.4 %
July	-1,018	-2.4 %	-2,535	-6 %
August	+1,349	+4 %	873	+2.5 %

Source: ONS: Number of deaths in care homes notified to the Care Quality Commission, England, accessed 25th November 2020.

Notes:

- (a) Since we do not have access to the actual data of the 5-year average deaths (in particular the standard deviation) it is not possible to make definitive statements about the statistical significance of these figures. However, the 5-year averaged death figures do not vary widely from month to month (or even week to week) and have regular seasonal peaks and troughs so it is relatively clear that the increases in deaths of 92 % and 42 % recorded in April and May are abnormal to the point of significance. It also seems likely that the final week of March (+ 10 %) and the first week of Sept (– 16 %) are significant, although the latter might be a reporting artefact connected with the public holiday.
- (b) We have included excess deaths not attributed to Covid since it is possible that they represent undiagnosed Covid deaths. However, the data show a different pattern to the Covid deaths. They increase substantially in April (+27 %) but then appear to decrease significantly in June and July (–8 % and –6 %). This implies that the majority are indeed non-Covid deaths “brought forward” by measures taken to control Covid rather than undiagnosed Covid. However, the reduction in the number of non-Covid deaths later (June/July) is smaller (approximately 5,500) than the increase in April (approximately 10,500) so it is likely that some are undiagnosed Covid deaths.

Deaths in Care Homes, England, Jan–Sept 2020

The ONS compiles CQC (Care Quality Commission) notifications of deaths in Care Homes in the UK, broken down by nation.

Total care home deaths notified to the CQC (England) to 31 August 2020 – 14,341

However, the ONS also compiles its own data and cites a much higher figure, although it is very unclear why that is. Whereas the figure above is to the end of August, the ONS stated on 2 July: “The total number of care home resident deaths involving COVID-19 in England was 18,562 (8,328 male deaths and 10,234 female deaths).”¹⁰ These appear to be deaths registered after 20 June. The most likely reason for the difference is that the extra deaths occurred in hospitals rather than in care homes, but were of care home residents, but we cannot confirm that.

Percentage of overall deaths occurring in care homes/hospitals/at home

“Of all deaths registered as COVID-19 related in the UK, 17,127 (31 %) occurred within care homes and at least 21,775 (40 %) were accounted for by care home residents. There were differences across the UK. In Scotland, 47 % of deaths attributed to COVID-19 occurred in care homes. This compares with 42 % in Northern Ireland, **30 % in England** and 28 % in Wales. In terms of deaths accounted for by care home residents, once again there are differences between the home nations. In Northern Ireland, care home residents accounted for 51 % of all COVID-19 related deaths, compared to 50 % in Scotland, 50 %, **39 % in England** and 34 % in Wales.”¹¹

¹⁰ <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenlandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional#country-and-regional-breakdown-of-deaths-involving-covid-19-among-care-home-residents>, accessed 23 November 2020.

¹¹ Bell et al. (2020).

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The Friedrich-Ebert-Stiftung (FES) is the oldest political foundation in Germany with a rich tradition dating back to its foundation in 1925. Today, it remains loyal to the legacy of its namesake and campaigns for the core ideas and values of social democracy: freedom, justice and solidarity. It has a close connection to social democracy and free trade unions.

FES promotes the advancement of social democracy, in particular by:

- political educational work to strengthen civil society;
- think tanks;
- international cooperation with our international network of offices in more than 100 countries;
- support for talented young people;
- maintaining the collective memory of social democracy with archives, – libraries and more.

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Dr. Philipp Fink

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EUROPA

Covid-19 has uncovered many societal fault lines. The virus hit the elder care sector in many countries especially hard, leading to many deaths and pushing care workers fighting on the corona frontline to the end of their limits. The pandemic has underscored deficiencies in elder care that have been warned about and protested by trade unions for years. Precarious working conditions, understaffing and underfunding devastatingly undermined the ability to protect the most vulnerable during the corona pandemic: our elderly.

It is high time we listen now.

The Friedrich-Ebert-Stiftung has, on the initiative of the Swedish municipal workers' union, Kommunal, and the Swedish progressive thinktank Arena Idé, commissioned reports from several European countries. By focusing on the plight of those in need of care and their caregivers, the reports shed light on the pandemic's impact on elder care and highlights the justified demands of the care workers' trade unions as well as the long overdue need for reform of the sector as a whole.

Further information on the project can be found here:

www.fes.de/en/on-the-corona-frontline