Briefing: Adult social care and COVID-19

Assessing the policy response in England so far

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Key points

- The coronavirus (COVID-19) pandemic has taken a grim toll on social care services in England. By 19 June 2020, there had been more than 30,500 excess deaths among care home residents in England, and social care staff have been around twice as likely to die from COVID-19 as other adults.
- A complex combination of policies has been introduced to limit the impact of COVID-19 on people and society. We reviewed national government policies on adult social care in England during the first phase of the pandemic – from January to the end of May 2020.
- Policies on adult social care have evolved over the crisis. Government interventions have focused on social care funding, the supply of testing and personal protective equipment (PPE), easing service pressures, and other measures to prevent and control infection.
- Overall, central government support for social care came too late. Some initial policies targeted the social care sector in March. But the government's *COVID-19: adult social care action plan* was not published until 15 April – almost a month after country-wide social distancing measures had been introduced. Another month passed before government introduced a dedicated fund to support infection control in care homes.
- Government policies to support social care have faced major and widespread problems. There have been significant issues with access to testing and PPE, leading to a lack of protection for some people using and providing adult social care. Local authorities report that additional government funding has not been enough to cover COVID-19 costs. The fragmentation of the social care system has made it difficult to coordinate support.
- Protecting and strengthening social care services appears to have been given far lower priority by national policymakers than protecting the NHS. Policy action on social care has been focused primarily on care homes and risks leaving out other vulnerable groups and services.

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- Unmet need for social care and other health services is likely to have increased. In a small number of areas, councils have made use of emergency legislation meaning that assessments of care needs do not need to take place and – in the most extreme cases – councils only need to meet a person's needs if not doing so will breach their human rights.
- The social care system that entered the pandemic was underfunded, understaffed, undervalued and at risk of collapse. Any response to COVID-19 – however fast or comprehensive – would have needed to contend with this legacy of political neglect.
- Government must learn from the first phase of the COVID-19 response to prepare for potential future waves of the virus. Short-term actions should include greater involvement of social care in planning and decision making, improved access to regular testing and PPE, and a commitment to cover the costs of local government's COVID-19 response.
- More fundamental reform of the social care system is needed to address the longstanding policy failures exacerbated by COVID-19. This reform must be comprehensive, including action to improve pay and conditions for staff, stabilise the care provider market, increase access to publicly funded services, and provide greater protection for people against social care costs. If reform is avoided, government will be choosing to prolong one of the biggest public policy failures of our generation, and people and their families will continue to suffer unnecessarily.

Introduction

Governments across the world are seeking to limit the impact of COVID-19 on health and society. The number of excess deaths – additional deaths compared to the 5-year average – in the UK during the pandemic so far has reached more than 64,000, among the highest in Europe.[1] Daily deaths linked to COVID-19 have been falling since their peak in mid-April, but there is a risk of a future resurgence in cases. The impact of COVID-19 has not been felt equally, with older people, people with underlying health conditions, people living in more deprived areas, and black and minority ethnic groups facing the greatest risks.[2]

The impacts of COVID-19 on people using social care – adults of all ages who need care and support as a result of disability or illness – have been severe. So far there have been more than 30,500 excess deaths among care home residents in England, and 4,500 additional deaths in domiciliary care (care provided in people's own homes).[3,4] There have been examples of services being overwhelmed, leading to failings in care.[5] And there has been a significant increase in deaths among people with learning disabilities and autism.[6] Social care staff – mostly women and more ethnically diverse than the general population – have been around twice as likely to die from COVID-19 as other adults.[7] The amount of unpaid care provided also appears to have increased substantially.[8,9]

A complex combination of policies has been introduced in response to COVID-19 in England.[10] The NHS reorganised services, built new hospitals, and increased the supply of staff, beds, and equipment. Government introduced a wide range of social distancing measures – most notably 'lockdown' – and passed emergency legislation to help implement these. And economic policy measures have been used to support individuals and businesses during the COVID-19 response, including a large-scale job retention scheme and government-backed loans.

Policies have also been introduced to support the adult social care system during the crisis, including additional funding, changes to legislation, and policies on testing and infection prevention and control. These changes have been developed at different speeds, and interact with policies in other areas, such as the NHS. The Health Secretary, Matt Hancock, claimed that the government has 'tried to throw a protective ring' around care homes since the start of the pandemic.[11] But local councils report that social care users and staff have not been adequately protected, and that government funding is not enough to meet people's needs.[12]

In this briefing, we analyse government policies on social care in England during the COVID-19 outbreak so far – covering the period from the first known COVID-19 case in England (on 31 January 2020) to 31 May. We provide a detailed description and timeline of the government's social care response. We consider the role that social care has played in the overall policy narrative. And we identify the underlying factors within the social care system, such as its structure and funding, that have shaped its ability to respond. Where possible, we use publicly available data to describe how policies have been implemented. We also provide a summary of the latest data on the impact of COVID-19 on social care.[13] In the final part, we make an assessment of the policy response and identify lessons for the future.

Approach and methods

We analysed national government policies on adult social care in England related to COVID-19 between 31 January and 31 May 2020. We also include a small number of other policy developments that took place after this period, if we thought this was needed to understand or reflect the policies we reviewed. We focused only on policies introduced by central government – not policies or guidance affecting the social care system from other national agencies outside government, such as the Local Government Association or major social care charities. We did not review the policies of individual local authorities or social care providers, nor did we assess policies introduced by NHS bodies to strengthen joint working with social care. Our analysis therefore only focuses on a limited part of the policy response.

Our analysis is based primarily on publicly available data. Data on adult social care policies includes government press releases, speeches, guidance documents, letters, and other sources. Much of these data are compiled and categorised in our COVID-19 policy tracker.[10] We used this database as a starting point for our analysis, before searching government and other websites for additional information. Data on the implementation of these policies includes government announcements, select committee papers, official statistics, statements from social care leaders and representative bodies, and other sources. There may be other government letters or communication to the social care sector that are not publicly available and that we do not have access to. Data on the impact of COVID-19 on social care users and staff are from publicly available sources, including the ONS and CQC, and original analysis of linked datasets reported in more detail elsewhere.[13] Differences in local context across England mean there has been significant regional variation in implementation of policies and impact,[14] but our analysis focuses on national level data.

Policies on social care during COVID-19

Government policies affecting social care in England have evolved over the course of the pandemic. The key national policies on adult social care are summarised in Table 1. In this section of the briefing, we describe the main national policy changes related to social care in England throughout the first stage of the COVID-19 response. We examine policies on funding, testing, infection prevention and control, workforce, and oversight – as well as the role of social care in the overall policy and political narrative. In each of these areas, we describe the policy timeline and available data on how these policies have been implemented.

Table 1: Summary timeline of key events and social care policies, up to 31 May 2020*

Summary	Date
Cases of pneumonia of unknown cause in Wuhan, China, first picked up by WHO	31 December 2019
First confirmed UK COVID-19 cases	31 January 2020
Public Health England guidance states it is 'very unlikely' people in care homes will become infected	25 February 2020
Coronavirus action plan published by government	3 March 2020
First reported UK COVID-19 death	5 March 2020
WHO declares COVID-19 pandemic	11 March 2020
Budget 2020 COVID-19 response fund: £1.6bn for local authorities to help deal with pressures on services, including adult social care, and £1.3bn to support the NHS discharge process including social care costs (both announced 19/03/20)	11 March 2020
New guidance for social care settings includes advice to review care home visiting policies	13 March 2020
CQC suspends routine inspections	16 March 2020
NHS England asks hospitals to urgently discharge patients who are medically fit to leave, including into social care settings	17 March 2020
Prime Minister introduces lockdown	23 March 2020
Coronavirus Act 2020 (including Care Act easements)	25 March 2020
Guidance for care homes includes that negative tests are not required prior to admissions. Advises against visitors except in exceptional situations. Advises 'care as normal' for people without symptoms	2 April 2020
Five pillar plan for testing	2 April 2020
National PPE plan authorises the distribution of 34 million items of PPE for social care providers	10 April 2020
COVID-19 adult social care action plan. Commits to testing all symptomatic care home residents and social care workers, and all residents prior to admission to care homes. Commits to a recruitment drive, and establishing a new CARE branded website and app for the social care workforce	15 April 2020
£1.6bn for councils including for social care services	18 April 2020
National adult social care recruitment campaign	23 April 2020
Testing expanded to asymptomatic care home staff and residents	28 April 2020
UK government's COVID-19 recovery strategy includes 'protecting care homes' – every care home for those aged 65 and older to be 'offered' testing by 6 June. Asks care homes to limit staff movement between homes	11 May 2020
First steps to 'reopening society' from lockdown	13 May 2020
Ringfenced £600m infection control fund for local authorities to cover costs of measures to reduce COVID-19 transmission in care homes, alongside a broader package of support	15 May 2020

Source: COVID-19 policy tracker: a timeline of national policy and health system responses to COVID-19 in England.[10]

* Major non-social care related events and policies are also included in italics.

Funding

Government has provided additional funding for NHS and social care services during the COVID-19 response. Extraordinary measures have also been taken to provide financial support for businesses and households. The NHS was promised 'whatever it needs, whatever it costs' to deal with COVID-19.[15] Local authorities have received funding for the COVID-19 response in stages, but only some of this funding has been ringfenced for social care services.

Policy timeline

On 11 March 2020, the Chancellor used the Budget to announce an initial £5bn emergency response fund for the NHS, local authorities, and other public services to help deal with COVID-19 pressures.[15] On 19 March, it was announced that £1.6bn from the fund would be allocated to local authorities – allocated based on a mix of the social care relative needs formula and the settlement funding assessment,[16] and not ringfenced for spending on any particular service. £1.3bn was also allocated to the NHS to help discharge patients from hospitals, including to pay for the care and support they may need from social care services.[17]

A further £1.6bn additional funding for local authorities was announced on 18 April. Allocations were confirmed on 28 April, on a per capita basis, with a 65:35 split between county and district authorities.[16] Again, the funding was not ringfenced for social care – covering spending on children's services, public health, fire and rescue, shielding, homelessness, and other services alongside adult social care. Earlier in April, £850m in social care grant payments to councils was also brought forward by government to help provide immediate support for services.[18] At the daily briefing on 18 April, the Communities Secretary said that government was 'backing councils to ensure vital services such as adult social care, children's services, support for vulnerable people and waste collection continue despite the increased pressures'.[19]

A third announcement of additional funding came in May – this time ringfenced for adult social care. After being announced at Prime Minister's questions on 13 May,[20] government confirmed a £600m 'infection control fund' to tackle the spread of COVID-19 in care homes and other settings on 15 May. The funding was allocated to local authorities based on the number of care home beds and costs of operating in different areas.[21] Government requested that 75% of the funding is passed directly to care homes and used to fund a set of infection control measures (relating primarily to staff-related costs). The remaining 25% must also be spent on infection control, but can be allocated by local authorities based on need – for example, to support domiciliary care services.[22] The fund will be paid in two installments. The second installment is contingent on the first being used for infection control.

An additional £500m funding package for councils was announced in early July to help with spending pressures and cover lost income.[23]

Policy implementation

Government has said that 90% of the £3.2bn non-ringfenced funding was allocated to local authorities that provide adult social care.[24] In June, the Director General for adult social care at the Department of Health and Social Care said that local authorities had spent £1.25bn of the £3.2bn so far, and that £500m of this had been spent on social care.[25]

COVID-19 has created additional costs across a wide range of services as well as reducing income from charges and business rates. Local authorities have been clear that the additional funding so far is not enough to cover the financial implications of COVID-19.[26,27,28] Unlike the NHS, local government has a duty to balance its budgets. Only 4% of directors of adult social services surveyed by ADASS think they can do this while meeting their statutory duties – including safeguarding adults and providing care for vulnerable people.[12]

It is also not clear how additional funding for social care has been spent. Local authorities have reported that they are providing extra financial support to care providers[58] – for example, by providing upfront funding to cover costs, increasing fees paid, and setting aside funding for providers to claim back for additional costs – but some providers appear to disagree.[29] In late April, several care provider leaders said that money allocated to local authorities for COVID-19 was not being passed on and warned that this could lead to provider failure.[30] The Department of Health and Social Care asked local authorities to publish information on their websites with the financial support they have made available to social care providers in their area, and published links to these web pages in July.[31] The level of detail provided varies.

Age UK has reported that some self-funded care home residents have been asked to pay an excess charge on top of normal fees to cover COVID-19 costs (for example, for PPE).[32] But there are limited data to understand the financial impact of COVID-19 on different care users.

The impact of COVID-19 on broader local authority finances varies widely. Local authorities in more affluent areas are likely to be exposed to greater risk of losing revenue (for example, from local taxes and fees), while local authorities in more deprived areas are likely to be exposed to increased costs and service pressures over the medium to long term.[33] The IFS have warned that the government's use of 'out-of-date and overly-general' approaches to allocate COVID-19 funds may mean that funding will not end up where it is most needed.[34]

Testing

The Health Secretary has described the government's work on COVID-19 testing as 'world-beating'.[35] But the availability of COVID-19 diagnostic tests has been a major issue during the pandemic so far. Testing capacity has increased over time, allowing the government to expand testing eligibility to different settings and groups. The NHS has been prioritised for testing expansions, and testing policy in social care has largely focused on care homes.

Policy timeline

COVID-19 testing was largely unavailable to social care at the start of the pandemic. The government initially stopped community testing on 12 March, with testing prioritised for critically ill patients in hospitals.[36] On 17 March, national NHS bodies instructed hospitals to rapidly discharge all patients who were medically fit to leave, to free up capacity for COVID-19 cases.[29] This included discharging patients to care homes and other settings.

There was no national policy requirement to test patients before being discharged. Testing in care homes was initially restricted to five symptomatic residents per care home to identify outbreaks.[29]

On 27 March, government announced a 'new drive' on testing for front-line NHS staff.[37] And the government's testing strategy, published at the beginning of April, committed to 'working with partners to expand swab testing to critical NHS and social care staff and their families'. A week later, the Health Secretary announced that there was enough capacity for all 'key' social care and NHS staff who needed a test to have one – in part delivered by 15 drive-through testing centres established across the country.[38] Testing for the social care sector was coordinated by CQC.[39]

Government published a social care action plan on 15 April, which committed to making testing more widely available. The plan confirmed that there was now capacity for 'every social care worker who needs a test to have one' and that tests would now be available for all symptomatic residents in care homes, and all residents prior to admission to care homes. The NHS was given responsibility for testing patients prior to discharge from hospital.[40]

COVID-19 testing was expanded to 'all essential workers in England' with symptoms on 23 April.[41] Personal care assistants and unpaid carers were not added to the list of essential workers until the beginning of May.[42] Anyone with symptoms aged 65 and older and those unable to work from home became eligible for testing from 28 April. Alongside this, government announced that testing would be 'rolled out' for asymptomatic care home staff and residents, as well as NHS patients and staff.[43] A 'whole care home' testing programme – led by Public Health England and the Department of Health and Social Care, working with CQC and ADASS – was piloted, with packages of 'satellite' testing kits sent directly to care homes. Care homes for those aged 65 and older and caring for people with dementia could register for testing through a new digital portal from 11 May.[44] The number of tests was capped nationally at 30,000 test kits per day (including for staff and residents).[45] By 18 May, testing eligibility had expanded to anyone with symptoms.[46]

The government's COVID-19 recovery strategy, published on 11 May, stated that every care home for those aged 65 and older would be 'offered testing' by 6 June.[47] On 7 June, government announced that this target had been met[48] and that whole care home testing was being expanded to all adult care homes, including for adults with learning disabilities or mental health issues, physical disabilities, and other homes for younger adults.[49] People in supported living settings, extra care, and domiciliary care were not eligible.[50] Regular testing in care homes – weekly testing of staff and monthly testing of residents – was introduced on 6 July, starting with homes caring for those aged 65 and older and those with dementia.[51] Enhanced outbreak testing for care homes was rolled out from 13 July.

In addition to diagnostic tests, a programme of antibody testing – used to identify whether someone has had the virus – began at the end of May. These tests were made available 'in a phased way', beginning with health and social care staff, patients, and residents.[52] Official guidance stated that NHS and care home staff who would like to be tested were being prioritised.[53] But the announcement gave little detail on how the testing programme would work in social care, stating that government 'will agree with local leaders the best place in the country to start' and will 'work with them to decide how this is implemented.'[52]

The NHS Test and Trace system was introduced at the end of May.[54] This means that anyone who has been in 'close recent contact' with someone with COVID-19 needs to self-isolate if the Test and Trace service advises them to. Government guidance for health and social care states that 'close contact' excludes circumstances where PPE is worn in line with current guidelines.[55] The contact tracing process involves local public health teams if the person testing positive works in or has recently visited a care home.[56]

Policy implementation

There are currently no regular data published on the number of tests delivered in different social care settings – either for care users or staff. Press releases and other government announcements often include high-level figures on testing. For example, the government's press release describing the expansion of whole care home testing on 7 June stated that, since the launch of the programme, government had provided 1,071,103 test kits to 8,984 care homes – and that they were now able to send out over 50,000 test kits a day.[48] High-level statistics on the number of tests carried out among care home residents and staff up to 8 July were published on 16 July. But these data do little to tell us how far the government's testing programme is meeting the social care system's need for testing.

Social care leaders have reported major gaps in testing throughout the pandemic.[57,58] An ADASS survey, carried out in May, found that the majority (78%) of social care leaders surveyed were not, or not at all, confident that there was an adequate supply of tests for people receiving care and support. Around half were confident that enough tests were available for staff. And there were major concerns about the availability of testing for unpaid carers and personal assistants. When testing has been made available, social care staff have reported challenges accessing testing centres.[59]

The ADASS president, James Bullion, told the Health and Social Care Select Committee on 19 May that 'we are nowhere near the level of testing required'.[60] Other expert witnesses told the committee that, while testing was improving, various issues remained – including tests arriving late, long delays between tests and receiving results, a lack of repeat testing, a lag between policy announcements and delivery of testing programmes, and more.[60] The CQC has identified issues with communication on testing policy in social care, saying 'there is an ongoing need for clarity about who is leading on testing and where to go for it'.[61]

PPE and infection prevention and control

Usually, care providers are responsible for sourcing their own PPE to keep staff safe. But during the pandemic, government has provided some help for social care services to access PPE and guidance on how to prevent and control COVID-19 infections. The array of different infection prevention and control (IPC) guidance has focused mostly on PPE, but providers have had problems sourcing adequate supplies.

Policy timeline

Initial Public Health England guidance on COVID-19 infection prevention and control, published in January, focused on measures in hospitals. On 25 February, Public Health England issued COVID-19 guidance for social care settings. The guidance advised that – based on the data available at the time – '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 present'.[62]

This initial guidance was superseded on 13 March by guidance for residential care, home care and supported living[63] services. The residential care guidance (now unavailable) advised providers to review their visiting policy 'by asking no one to visit who has suspected COVID-19 or is generally unwell, and by emphasising good hand hygiene for visitors.' All the guidance advised staff to wear PPE when caring for people with COVID-19 symptoms. To support this, Public Health England advised that there would be a free issue of PPE for residential and domiciliary care providers from the pandemic influenza stockpile, in addition to social care providers procuring their own PPE as normal.

On 18 March, the government announced that every care home and home care provider would automatically receive at least 300 facemasks. It anticipated complete distribution of these facemasks by 24 March.[64] The government advised providers to order from their usual suppliers for future PPE requirements and stated that it was working with wholesalers to ensure sufficient supplies in the longer term. A 'National Supply Disruption Response' (NSDR) with a 24/7 helpline would support providers with urgent requirements.

A letter from Department of Health and Social Care[65] on 1 April said that problems accessing PPE were due to 'capacity constraints' rather than insufficient stocks. The department announced the development of a new 'parallel supply chain' for core PPE products for COVID-19. Until this was 'fully operational', the NSDR would provide support.

On 2 April, Public Health England added tables of PPE recommendations for different settings to its *COVID-19: infection prevention and control (IPC)* guidance – a table on PPE for primary, outpatient and community care was later renamed to cover social care. New guidance for care homes was published on the same day.[56] This continued to advise 'care as normal' for asymptomatic residents. It recommended against visitors except in exceptional situations.

The government published a national PPE plan to get 'NHS and care staff […] the kit they need to protect themselves' on 10 April.[66] For social care providers, the government authorised the distribution of 34 million items of PPE. The plan said that local authorities would manage and distribute further national PPE stocks, prioritising health and social care.

On 15 April, the social care action plan included advice on controlling the spread of infection.[67] Among other measures, the plan asked local authorities to make alternative arrangements to isolate patients with COVID-19 being discharged from the NHS into social care in cases where care providers were unable to isolate or 'cohort' people (grouping them depending on their infection status) in their usual place of residence.

On 17 April, the main guidance on IPC measures was updated to reflect PPE shortages, recommending staff reuse single use PPE items 'if in extremely short supply'.[68] Guidance on 'how to work safely in care homes' was also published, applying the main PPE guidance to care home settings.[69] It recognised asymptomatic transmission and recommended using PPE when caring for all residents – including those without symptoms – during sustained COVID-19 transmission. It referred to (but gave limited detail on) the need for IPC beyond PPE. Similar guidance for domiciliary care was published on 27 April.[70] From 1 May, government applied a zero-rate of VAT to PPE sales to reduce costs for care homes and others.[71] This originally applied until 31 July but was later extended to the end of October.

The government's COVID-19 recovery strategy, published on 11 May,[47] asked care homes to 'restrict all routine and nonessential healthcare visits and reduce staff movement between homes.' Later that week, government announced a care home support package backed by a £600m Infection Control Fund for measures to reduce transmission in and between care homes (see section on funding).[72] The fund was intended to cover extra staffing costs incurred as a result of infection control measures – for example, to compensate for people working fewer hours because they have reduced the number of locations in which they work. The support package also asked local authorities to implement a care home support plan.

In late May, government announced additional funding for local authorities to develop local outbreak control plans. These plans focus on identifying and containing local outbreaks in different areas, including in health and care settings.

Policy implementation

The social care sector required government support to meet increased demand for PPE. But Public Health England's central stockpile was prepared for a flu pandemic and, according to the Department of Health and Social Care, manufacturing and supply had long followed 'just in time' principles.[29] Gowns and visors were not added to the stockpile, despite independent advice in 2019, nor in early 2020.[29]

According to the National Audit Office, the government provided 60 million items of PPE to adult social care wholesalers from this central supply between 20 March and 9 May. And providers were able to access some through local resilience forums – 38 local partnerships in England made up of emergency services, government agencies, health bodies and local authorities that help coordinate how public services respond to emergencies at a local level.[29] Providers could also order emergency stock via the NSDR system, which provided around 3,000 packs of PPE between 16 March and 9 April.[66] But centrally distributed PPE to social care represented 15%, at most, of the modelled requirement for most items between 20 March and 9 May.[29] Most councils have provided PPE to residential and domiciliary care providers.[58] CQC inspectors have organised for providers to loan PPE to others in urgent situations.[61]

Distribution challenges also caused problems accessing PPE. In March, Clipper Logistics was selected to manage the parallel supply chain (announced on 1 April). But the Secretary of State for Housing, Communities and Local Government told a select committee at the start of May that it could be a further 3 weeks before the service was widely available.[73] Small domiciliary and residential care providers could use the service to order PPE from 5 June.[74]

There has been sustained concern about PPE in the sector. On 27 March, the Local Government Association and ADASS wrote to Matt Hancock to highlight that PPE was not reaching people working in social care and that the government should 'move faster'.[75] Between March and May, a quarter (26%) of calls from staff to CQC's national contact centre concerned a lack of PPE or other infection control items.[76] A third (32%) of calls raised concerns about infection control or social distancing. Providers have also reported receiving incorrect or poor-quality PPE.[61] Carers UK highlighted that unpaid carers have not had access to PPE guidance or supplies.[77]

Problems with PPE supplies continued into May. In the first week of May, over a quarter (28%) of domiciliary care agencies in London and the north-west of England that responded to the CQC had only enough PPE to last up to a week.[61] 90% of care leaders responded to ADASS that they required 'greater and more efficient access to PPE' to support the pandemic response.[58] Accessing the right PPE is a major driver of additional spending for councils during the outbreak.[26] There is growing concern about the impact of these costs on social care finances.

Particularly at the start of the pandemic, national policy on IPC measures beyond PPE was limited. Many providers restricted visits to care homes in early March – nearly a month before it was recommended in national guidance.[78] There was also a lack of guidance on isolation or cohorting practices. For example, 24% of senior care leaders reported to ADASS that patients were discharged from the NHS to care settings where they could not isolate.[58]

Workforce

The Health Secretary has said that 'this crisis has shown that this country values our health and care workers so much'.[79] Several policy measures were introduced by government early in the pandemic to help boost the NHS workforce – including the recruitment of 750,000 NHS volunteers by the beginning of April.[80] Major national policy support for the social care workforce came later in the government's response. A package of measures was introduced in the social care action plan on 15 April, including a campaign to recruit 20,000 extra staff.

Policy timeline

Initial guidance for care providers[63] in mid-March referred to financial support available to workers affected by COVID-19 in all UK industries. The guidance did not address the wider effect of sickness and self-isolation on the social care workforce, or the impact of COVID-19 on workload. Guidance on people defined as clinically extremely vulnerable from COVID-19 signposted the support available for carers on the Carers UK website.[81]

The Coronavirus Act 2020 – introduced as a Bill on 19 March and made into law on 25 March – included several changes that aimed to 'increase the available health and social care workforce' and 'ease the burden on front-line staff, both within the NHS and beyond'.[82] Most of the measures to achieve these aims related primarily to supporting the NHS, but the Care Act easements (see section on oversight) were brought in to help reduce workload for social care staff.

From 27 March, health and social care providers were offered free, fast-tracked DBS checks for staff and volunteers recruited in response to COVID-19.[83] On 30 March, further changes allowed unpaid carers to continue claiming Carer's Allowance if COVID-19 meant they had to take a break from caring.[84] Government also clarified that providing emotional support counted towards the allowance threshold of 35 hours of care a week.

On 4 April, the government changed its guidance on the Coronavirus Job Retention Scheme to explicitly state that the scheme included people with caring responsibilities, and to permit employees to work for another employer while on furlough 'if contractually allowed'.[85] Guidance for people providing unpaid care was published on 8 April.[86] It consisted mostly of existing government guidance and external resources, and advised carers and the people they care for to develop an emergency plan in case other people need to help deliver care.

The social care action plan on 15 April announced several government measures to address the impact of COVID-19 on the workforce.[67] Government committed to creating a new CARE branded website and app for the social care workforce by the end of April. The Care Workforce app was launched on 6 May, described as 'a single digital hub for social care workers to access relevant updates, guidance, support and discounts from their phone'.[87] The action plan also announced a national recruitment campaign to encourage 20,000 people into social care over the next 3 months. The campaign began on 24 April and targeted people made redundant from other sectors and those with previous experience in social care. The NHS recruitment drive in response to COVID-19 had begun on 19 March.

Other measures in the action plan aimed to ensure parity between the NHS and social care workforces. Social care staff were already designated key workers, meaning the children of those working in social care could continue to attend school after they closed at the end of March. The action plan asked supermarkets and other businesses to provide care workers with the same priority access and benefits as NHS workers. It asked local commissioners and providers to give letters to unpaid carers, so that retailers could identify them for similar benefits. It also promised social care workers access to the package of wellbeing support already available to NHS workers. Health and wellbeing guidance for people working in adult social care was published on 11 May.[88]

The action plan acknowledged the 'invaluable service' of unpaid carers but provided limited new support. It announced an unspecified amount of additional funding to the Carers UK helpline. It stated there would be tailored guidance for carers of adults with learning disabilities and autistic adults (published on 24 April). The government said it was working with young carers to produce guidance for them. This was not published until 3 July.[89]

Two policy changes in May impacted international staff working in social care. On 20 May, government extended its bereavement scheme offer of indefinite leave to remain to families and dependents of NHS support staff and social care workers with non-EEA nationality who die from COVID-19.[90] This had previously applied only to certain NHS staff when it was introduced in April. The provision of a life assurance lump sum of £60,000 to families of health care workers dying due to COVID-19, also introduced in April, already covered social care workers.[91] On 21 May, government also announced that it would exempt health and social care staff from the immigration health surcharge on visas, which non-EEA nationals must pay for access to NHS services.[92]

Policy implementation

There is some evidence that social care providers and charities filled the gap left by a lack of national policy interventions in March. Several large care providers launched recruitment campaigns.[93] And, in response to the government's NHS recruitment campaign, 'your NHS needs you', Care England – a representative body for independent care providers – launched a 'social care needs you too' campaign, calling for retired staff to rejoin the workforce.[94] A National Care Force initiative signed up 20,000 people to volunteer in social care.[95]

According to the National Audit Office, the Department of Health and Social Care does not have information about its progress against the action plan target to recruit 20,000 people.[29] Some care providers have reported receiving significantly more applications for jobs than usual.[96] And the vacancy rate in the sector fell from 8.1% to 6.5% between March and May 2020.[97] But social care providers and charities have also criticised the action plan for not including improvements to terms and conditions for people working in social care.[98]

Across the whole adult social care workforce, around 3.4 million additional days were lost to sickness in March, April and May than would be expected looking at the pre-pandemic period.[99] Between mid-April and mid-May, absence rates among staff in care homes were around 10% on average.[29] In domiciliary care, around 9% of the workforce were absent due to COVID-19 in early May – and overall absences were likely higher.[61] 85% of social care leaders have worked with volunteers to support their paid workforce since March 2020.[58]

Several features of the social care workforce (see section on factors shaping the policy response) mean that the government's wider financial support measures may not have helped all staff. For example, government made statutory sick pay available from day one of sickness due to COVID-19,[100] but people on zero-hours contracts are only eligible for statutory sick pay if they earn a certain amount a week.[101] 24% of adult social care jobs are on zero-hours contracts – rising to 58% of domiciliary care workers. And 12% of jobs have no fixed hours. Depending on people's circumstances, this may have left some choosing between going to work with symptoms or losing income.

A survey of carers in April suggested that the burden on unpaid carers had increased during the pandemic, including as a result of reduced care and support available from their local authorities.[102] The carers surveyed were concerned about lack of access to COVID-19 testing and wanted more help with contingency planning in case they were

unable to provide care. More than half of social care leaders have reported a rise in people presenting with adult social care needs during the pandemic due to carer breakdown, sickness or unavailability.[58]

Oversight

Several regulatory and legislative changes have been introduced in recognition of the growing pressures on social care during COVID-19. The CQC suspended routine inspections in March, continuing only in cases where there were concerns of harm. More controversial and wide-ranging were emergency government powers introduced in the Coronavirus Act 2020 – a Bill described by the Health Secretary as introducing 'extraordinary measures of a kind never seen before in peacetime'.[103] This included changes to the Care Act 2014 to enable local authorities to prioritise care for people with the most urgent needs.

Policy timeline

Regulators of health and social care services have published several joint statements for professionals during the pandemic. In early March, the professional regulators issued a statement recognising that 'professionals may need to depart from established procedures' to care for people during the outbreak.[104] In April, the CQC and Care Provider Alliance, along with the British Medical Association and Royal College of General Practitioners, issued a statement on the importance of individualised advance care plans, 'especially for older people'. This advised that decisions should be made on an individual basis according to need, and that applying advance plans to groups of people – with or without Do Not Attempt Resuscitation (DNAR) forms – is 'unacceptable'.[105]

The CQC suspended all routine inspections on 16 March, shifting to 'other, remote methods' to provide assurance. Inspections continued in a 'very small number of cases' where there were concerns of harm.[106] Inspection teams would 'provide advice and guidance' and CQC would take an 'active role in coordinating information locally and centrally'. At the end of April, CQC set out its regulatory approach during COVID-19, including a new emergency support framework for conversations between inspectors and providers.[107,108] CQC started using this emergency support framework in May, beginning with adult social care providers.[107]

CQC adapted several other processes in response to COVID-19. This included developing a COVID-19 registration framework for new and existing providers,[109] introducing remote methods for monitoring use of the Mental Health Act,[110] and updating data collection to make it easier to record and collate data on COVID-19 deaths in social care settings.[111]

The Coronavirus Act 2020, passed on 25 March, created a range of temporary powers to help the state respond to the COVID-19 outbreak – including action to ease pressures on front-line staff and resources in health and social care. A 'sunset clause' means that most of the provisions in the Act will expire after 2 years, with an additional option to suspend (and revive) some powers before then. To enable rapid discharge of patients from hospital, and to free up clinical commissioning group and local authority resources,[112] the Act allowed NHS continuing healthcare assessments to be delayed 'until after the emergency

has ended'.[103] This followed guidance published in March that set out the requirements for hospital discharge during the pandemic.[113] The government allocated additional funding to the NHS to pay for out-of-hospital care and social care support packages for people being discharged (see section on funding).

To help local authorities and care providers manage growing pressures from COVID-19, the Act allowed a relaxation – or 'easement' – of some local authority duties introduced under the Care Act 2014. The Care Act defines local authorities' responsibilities to assess people's care needs and eligibility for publicly funded support – and describes the core purpose of adult social care as promoting individual wellbeing. These 'temporary' powers to relax the Care Act came into force on 31 March 2020,[114] with the aim of terminating them 'as soon as possible'. Government guidance states that local authorities should 'do everything they can' to comply with their duties under the Care Act.[115] But where 'workforce is significantly depleted, or demand on social care increased' and this is no longer 'reasonably practicable', local authorities can trigger the easements, allowing them to 'streamline' some arrangements and prioritise care for those with the highest need.

The easements are described over several stages. Local authorities streamlining social care services under 'stage 3' of the easements do not have to carry out detailed assessments of people's care and support needs, or financial assessments (though local authorities can retrospectively charge people for the care and support they receive*). Nor do they have to prepare or review care and support plans. For those operating under 'stage 4' of the easements, duties to meet eligible care and support needs, or the needs of a carer, are replaced with a power to meet needs[115] where not doing so would breach an individual's human rights. These local authorities can prioritise existing care for those with the most pressing needs and temporarily delay or reduce other care.

Government has also published ethical guidance for managing social care services. The Department of Health and Social Care published a framework setting out eight ethical principles – including respect, minimising harm, inclusiveness, flexibility, and other areas – for local authorities, policymakers, and adult social care professionals planning their response to COVID-19.[116] This framework recognises that constrained resources or increased demand may mean that it is not feasible to consider all eight principles, and that each 'must be considered to the extent possible in the context of each circumstance with appropriate risk management and considerations of individual wellbeing, overall public good and available information and resources'.

Policy implementation

In the 3 months following suspension of routine inspections on 16 March, CQC conducted 17 inspections of adult social care providers. 11 of these were a result of concerns raised by staff or the public, six were in response to a notification from the provider or information from other stakeholders.[76] CQC has identified examples of serious failures.[5]

* Local authorities can retrospectively charge people for the care and support they receive during this period subject to providing information in advance and a later financial assessment. The guidance states that all assessments will be completed once the easements are terminated.

Guidance on hospital discharge arrangements noted several implications of deferring full continuing healthcare eligibility assessments, anticipating a backlog of around 5,000 assessments per month and noting that a post-COVID-19 'handling plan' will need to be developed to help the system 'normalise'.[113] It also noted that expectations of people who have received 'free' social care during the pandemic (and may not be funded afterwards) must be 'managed'.

Several concerns were raised in parliament and by other stakeholders about the potential implications of the Care Act easements enabled by the Coronavirus Act, including the risk of care being withdrawn for vulnerable people.[103] Disability Rights UK had 'serious concerns' about the implications of the Bill on human rights and published a template for people to write to their MP, saying the Bill presented a 'real and present danger' and that plans were 'effectively rolling back 30 years of progress for Disabled people'.[117]

So far, only a handful of councils have reported using the Care Act easements.[58,118] A government report in May stated that seven local authorities had notified the department that they were making use of the easements.[119] According to an article published in Community Care, some councils have approved the use of the easements but not subsequently triggered them, and most councils using the easements were operating at stage 3.[120] The article mentioned two areas considering moving to stage 4. In board papers related to this decision, one council describes a long list of pressures, including: increased demand and supporting people with issues that would not usually be the remit of adult social care services, additional work associated with shielding, depleted staff due to sick leave, self-isolation and bereavement, lower productivity due to social distancing, PPE supply chain issues, more complex cases being discharged from hospital, 'unprecedented challenges' in the provider market, and more.[121] Other councils are reported to have faced challenges over the legality of decisions to trigger the easements.[122] At the time of writing, no local authorities were currently using the easements.[118]

Status of social care in the policy response

Starting on 16 March, the government used a series of daily televised briefings to update the general public on the status of the pandemic and to announce new and changing policy. Alongside ministers and scientific and medical advisers, five NHS representatives made more than 25 appearances at the 77 daily briefings between 16 March 2020 and 31 May 2020. Eight subject-area experts appeared, including Louise Casey (leading the government taskforce on rough sleeping during the pandemic) and Helen Dickinson (Chief Executive of the British Retail Consortium). Social care was not represented at the briefings, except by the Secretary of State for Health and Social Care, until the inclusion of David Pearson on 8 June – appearing as chair of a new COVID-19 social care support taskforce announced that day. The taskforce was set up to oversee implementation of the action plan and care home support package and to 'advise on a plan to support the sector through the next year'.[49,123,124]

The content of prepared statements from ministers provides some indication of government priorities throughout the crisis. These contain many words of 'thanks' for those working in social care services – including Matt Hancock pointing out that 'it's not "clap for the NHS", it's "clap for our carers"' – and some discussion of social care in

relation to funding, testing and PPE. The issue of COVID-19 spread in care homes was first acknowledged by ministers in these prepared statements in mid-April.[125,126] Social care was a major focus of only two briefings between March and the end of May: announcing the social care action plan on 15 April,[127] and the care home support package a month later.[128] The first recorded deaths from COVID-19 among care home residents in England occurred on 6 March. Data on deaths in care homes were not added to the daily figures presented at these government briefings until the end of April.[129]

The Scientific Advisory Group for Emergencies (SAGE) is a group of experts from within government, health care and academia that provides scientific and technical advice to government. SAGE has been a key mechanism for informing government decision making during the outbreak. Members come from over 20 different institutions and cover a wide range of expertise.[130] Scientific advice on care homes has been produced for and considered by SAGE.[131] Minutes from SAGE meetings and the government's care home support package mention a care home subgroup, but this is not currently listed on the SAGE web page and its membership is not published.[132]

It is unclear what is discussed at SAGE, and when, in any detail – partly because the minutes from meetings are limited. Comments from former and current members of SAGE at committee evidence sessions suggest that COVID-19 spread in care homes was raised as an issue in February or March, but that this did not necessarily translate into policy action until later.[133] For example, in June, former SAGE member Neil Ferguson said, 'The policy has always been to protect care homes and the elderly […] the policy has simply failed to be enacted until very recently, and there are multiple causes of that.' Matt Keeling – a member of SAGE's Scientific Pandemic Influenza Group on Modelling – commented 'We were very concerned about losing control within the NHS, and about ICU and ITU units becoming full, and there are only so many of us and there is only so much time. We were all focused on one area. It was mentioned – we thought about it, and we said, "Care homes are important," and we thought they were being shielded, and we probably thought that was enough.'[155]

Political statements at the daily briefings and publicly available data on SAGE provide only a limited picture of the role of social care in the national policy response. There are many other ways that government communicates with the social care sector and involves them in policy decisions. Scientific evidence related to COVID-19 in care homes and other settings can also be produced and influence policy through a number of routes – both formal and informal. But the lack of prominence given to social care, particularly compared to the NHS, provides an illustration of the overall status of social care in the policy narrative so far.

Impacts on social care

The impact of COVID-19 on social care in England has been severe. In this section of the briefing, we summarise data on COVID-19 cases and outbreaks, movement to and from hospital for care home residents, and deaths of social care users and staff. We place deaths in England in an international context – though comparable data between countries are limited. We also identify gaps in data that limit our understanding about the impact on social care.

Cases and outbreaks

By the end of May, 40% of all care homes had reported a COVID-19 outbreak.[134] Outbreaks varied significantly across the country: 51% of care homes in the north-east had reported an outbreak, compared to 28% of care homes in the south-west. Initial results from a survey of over 9,000 care homes for older residents and those with dementia in England, published in July, estimated that over half of the care homes included in the study had reported at least one confirmed COVID-19 case among either staff or residents.[135] Of these care homes, it was estimated that 20% of residents and 7% of staff had tested positive for COVID-19 since the start of the pandemic. Between 2 and 8 May, CQC reported that around a fifth of domiciliary care providers were caring for at least one person with suspected or confirmed COVID-19.[61]

Hospital discharges to care homes

Hospital discharges to care homes dropped, overall, between 17 March and 30 April.[13] But discharges to nursing homes actually increased compared to the historical average.[13]

Access to health care: hospital admissions among care home residents

Admissions to hospital for care home residents decreased substantially as the pandemic unfolded, with 11,800 fewer admissions during March and April compared to previous years.[13] Elective admissions dropped more dramatically than emergency admissions. And admissions from residential care homes decreased more substantially than from nursing homes. There may be several reasons for this reduction in activity, including policy choices to create hospital capacity – for example, national policies in the NHS to cancel planned operations to help free up space for COVID-19 patients – and changes in the way that care is provided. Infection risks in hospitals may have affected clinical decisions. But the data suggest that there may be unmet need for health care among care home residents as a result of COVID-19.

Deaths

Excess deaths are used to count the number of deaths caused by a particular event, such as a pandemic, that would have been unlikely to occur if the event had not happened. Between 23 March and 19 June 2020, there were more than 30,500 excess deaths among care home residents in England (208% of the average deaths seen in 2017–2019).[3] There were more than 17,700 notifications of deaths involving COVID-19 among care home residents.[3]

CQC introduced a new method of identifying deaths involving COVID-19 for providers registered with CQC on 10 April. By 19 June, CQC had been notified of 819 deaths involving COVID-19 in domiciliary care*. Between 23 March and 19 June, there were an estimated 4,500 excess deaths among people receiving domiciliary care (225% of the average deaths seen in 2017-2019).[3] The majority of these deaths have not been linked to COVID-19. Several factors may have contributed to the increase in non-COVID-19 linked deaths in care homes and domiciliary care, including unidentified COVID-19, unmet needs, changes to place of death, and changes in reporting.

There have been high numbers of deaths among people with a learning disability[136] and those subject to the Mental Health Act (including people detained in hospital and those in the community who are subject to the Act) during the pandemic so far.[136] There has also been a disproportionate number of deaths among those from black and minority ethnic groups in adult social care.[137] There has also been a grim toll on staff: people working in social care have been around twice as likely to die of COVID-19 than the general population.[7]

Data

New data collection approaches have been established throughout the pandemic, but not all the data is made public and there are still significant gaps. Data on testing and the spread of infection are lacking across all social care settings, but particularly in domiciliary care. And data on the impact of COVID-19 among domiciliary care users and staff remain limited. There are no data to understand the impact of COVID-19 on those receiving unpaid care.

International data on impacts

England is not alone in experiencing challenges protecting social care from the pandemic. Early data suggest that the impact of COVID-19 among residents and staff in care homes has varied widely between countries.[138,139] There are no good comparable data to help understand the impact of COVID-19 on community-based social care services internationally.

International comparisons of COVID-19 impacts on social care are complex and risk being misleading. The structure and design of social care services differs between countries. And various other contextual factors – funding levels, integration with health care services, workforce gaps, and other structural issues – will have shaped the policy response and impact in different countries.[140] There has also been no common international approach to testing and recording deaths during the pandemic, limiting what we can learn from early comparisons. That said, there has also been wide variation in the policy measures put in place to protect social care services during the initial stages of the pandemic – including in approaches to testing, financial support, and medical care available to care homes.[140] These differences offer policymakers opportunities to learn from each other as the outbreak unfolds.

* CQC is notified of deaths from care providers that they regulate where the person died while a regulated activity was being provided – or where their death may have been a result of the regulated activity or how it was provided.

Five factors shaping the policy response

The impact of COVID-19 on social care has been shaped – in part – by the underlying structure of the social care system. Measures to support care homes and other services have been implemented in the context of a system scarred by decades of political and policy neglect. Five factors in particular have influenced the social care policy response in England.

Funding levels

Social care services in England entered the crisis enfeebled by many years of underfunding. Spending per person on adult social care fell by around 12% in real terms between 2010/11 and 2018/19.[141] Spending reductions affect access, with fewer people eligible for state funded services. Estimates suggest that a significant number of adults go without the social care they need.[142,143] But cuts in spending also affect the ability of providers to deliver high-quality care. The amount local authorities are able to pay for somebody's care in a care home is less than what it costs to provide it. The Competition and Markets Authority estimate that care homes are underpaid by around £1bn a year.[144] People paying for their own social care typically pay more than those receiving publicly funded services, cross-subsidising the low fees paid by local authorities.

Some care providers are going bust, others are handing back their contracts, and the provider sector is at risk of collapse. Even before COVID-19, an estimated £2.1bn would have been needed by 2023/24 just to meet demand for care.[141] COVID-19 has created additional cost-pressures that appear not to be being met (see section on funding).

Workforce issues

Social care services are also in the midst of a deep staffing crisis. Workforce shortages before the pandemic were estimated at 122,000. Staff turnover is high, many staff are on low pay, and a quarter are on zero-hours contracts.[145] COVID-19 can exacerbate these issues, as staff may need to self-isolate, and the need to manage residents in isolation creates challenges for pre-pandemic staffing ratios.[146] The reliance of many providers on agency staff also adds to the risk of transmission – in one survey, 30% of care homes said they were dependent on staff working across several sites.[147] Staff working on zero-hours contracts may have been faced with the choice of going to work with COVID-19 symptoms or losing income (see section on workforce policies). Early data suggest that care homes using bank and agency staff – and the minority of care homes that did not offer staff sick pay – have seen higher COVID-19 infection rates among residents.[135]

The social care sector is also reliant on international migration. People with non-British nationality make up around 17% of the adult social care workforce,[145] but COVID-19 has severely restricted international mobility. For some people coming from outside the EU, many social care roles are not eligible for work visas because they are low paid. This – and the fragmented nature of the sector – has made it difficult for government to offer the same support to social care workers from other countries that it has provided to NHS workers.[148]

Workforce issues in social care also affect the people delivering it. There are an estimated 1.5 million people working in adult social care.[145] Most staff working in social care are women, and 21% of roles are carried out by people who identify as black, Asian or from other minority or multiple ethnicity groups.[145] The system's reliance on unpaid carers also creates additional challenges in coordinating support. The majority of people providing social care are the families of people with care needs. Carers UK estimate that there were around 9 million unpaid carers in the UK before COVID-19 – and that millions more people have now become carers as a result of the pandemic.[8]

System fragmentation and variation

The social care system is complex and fragmented. There is no single, national system like the NHS. Services are provided by around 18,500 organisations working in 39,000 locations across England.[145] These providers deliver services in a wide range of settings – including care homes, supported living, retirement and extra care housing, people's own homes, and elsewhere in the community – to adults of all ages.

The scale and diversity of the sector has posed practical and logistical challenges in organising effective policy responses – for example, in ensuring that providers have timely access to sufficient PPE and to testing. National procurement arrangements for the NHS have not always reflected the needs of local care providers who have faced the challenge of navigating their way through various organisational layers to access clear advice, guidance, and support – including access to testing and PPE. Giving evidence to the Public Accounts Committee in June, Chris Wormald, Permanent Secretary at the Department of Health and Social Care, said that he did not think that social care services had been left out of the policy response, but that 'it is clearly more challenging for us to act in the social care sector, given its fragmentation, than in the NHS'.[25]

Quality and access to social care also varies widely by region.[149] Different local authorities make decisions about how much they spend on which services. Care providers face different recruitment challenges depending on local context. And relationships between social care and the NHS vary across the country – based on historic relationships and other factors. As a result, the ability of social care services to respond to COVID-19 will have varied locally too.

Governance and accountability

These issues have been exacerbated by governance and accountability arrangements in social care. Commissioning of publicly funded social care is done locally, by 151 local authorities. National policy responsibility for social care rests with the Department of Health and Social Care. But responsibility for local authority finances and other issues sit with the Ministry of Housing, Communities and Local Government. The result is a complex web of national and local bodies, with far less national oversight and coordination than the NHS.

There are also historic differences in planning, funding, and decision making between the NHS and social care – contributing to persistent challenges in coordinating services.[150] Local authorities have often not been treated as equal partners by NHS leaders.[151] In this

context, the overwhelming priority given to preparing the NHS for COVID-19 and the absence of a clear national strategy for social care in the early stages of the pandemic is – unfortunately – unsurprising.

Lack of data

Quality data on what is happening in social care are lacking. Before COVID-19, there was no system for collecting daily data from care providers. This meant that in the early stages of the crisis, it was difficult to establish an accurate and timely picture of deaths in care homes and other settings.[152] The Office for Statistics Regulation has previously concluded that the social care system is 'very poorly served' by data, creating challenges for effective policy development and analysis.[153] And the various data that do exist are not produced in a timely and usable way to inform emergency responses.[154] Matt Keeling told the Science and Technology Committee in June that 'I remember asking at some point, probably late March, what we knew about care homes, and we did not even know how many people were in care homes at that point. We can only generate models from the data available.'[155]

Discussion

The impact of COVID-19 on adult social care has been severe. The death toll in care homes and domiciliary care is significant, and people working in social care have been at greater risk of dying from COVID-19 than other adults. Many of those who use social care services face higher risks from COVID-19 because of their age, pre-existing health conditions and given that many live close together in residential and nursing home settings. England is not alone here: most countries have experienced challenges in managing and preventing outbreaks in long-term care settings. But could the scale of the crisis in social care have been reduced?

Based on our analysis of the national policy response in England, the Health Secretary's claim that the government has 'tried to throw a protective ring' around care homes since the start of the pandemic does not appear to be grounded in reality. We identify five lessons from our analysis of national government policy on social care in first phase of the pandemic.

1 Policy action was too slow

Government support for social care services was slow to arrive. Several policies targeted social care in March, including emergency funding in the budget and guidance for social care providers. But the government's COVID-19 social care action plan was not published until 15 April. This was almost a month after country-wide social distancing measures had been introduced, nearly 2 weeks after the NHS had constructed and opened its first Nightingale hospital, and the same week that the number of excess deaths in care homes peaked.[3] Another month was to elapse before the introduction of the infection control fund for social care. Government launched a national social care recruitment campaign on 24 April, with the aim of bolstering the workforce with 20,000 new staff. Yet the recruitment drive to get retired doctors and nurses back into the NHS to support the COVID-19 response had begun on 19 March – and 750,000 volunteers had already been recruited to support

the NHS by early April. There has also been a delay between policies being announced and implemented in some key areas. Overall, government support for social care services came too late.

2 The NHS was prioritised

Protecting the NHS has been a consistent government objective throughout the pandemic so far. The NHS was promised 'whatever it needs, whatever it costs' to deal with COVID-19.[15] It responded fast with widespread changes to services and block purchasing of private sector capacity. This focus on ensuring sufficient acute hospital capacity made sense – particularly in the early stages of the crisis, when reports were emerging from Italy of hospitals being overwhelmed with COVID-19 cases,[156] and given the NHS entered the crisis with fewer doctors and nurses, and less equipment per capita than most comparable countries.[157] But protecting and strengthening social care services appears to have been given far lower priority by national policymakers – with slow access to PPE and testing, and less certainty for councils about funding. Data about deaths in care settings were not available in the early weeks of the crisis, and social care leaders were absent in daily press briefings until 8 June.[123]

Ultimately, health and social care services interact in a complex system. The overriding priority given to protecting the NHS in the early stages of the pandemic may help to explain why the potential unintended consequences of rapidly discharging patients from hospitals to care homes – without testing for COVID-19 – appear not to have been fully foreseen. Decisions to discharge patients were made by clinical teams in good faith and in an unknown and urgent context.[158] And leaving medically stable care home residents in hospitals would have carried other risks.[158] But the national push to free up space in hospitals may have played a role in transferring risk to a poorly prepared social care system lacking the right protection.[159]

3 Narrow focus on care homes

The adult social care system delivers a wide range of services to adults of all ages. Around 842,000 adults received long-term support from local authorities in England in 2018–19. While debates about social care often focus on older people, 35% of those receiving care are aged 18–64.[143] Social care is delivered in a mix of settings – including care homes, supported living and extra care housing, people's private homes, and elsewhere in the community.

While there has been a growing focus in the media on deaths in care homes during the pandemic, there has also been a significant increase in deaths among people receiving care in their own homes. National policies on social care during the pandemic so far have focused primarily on care homes – not the wider social care system. Policies on testing are one example of this. A government announcement on 28 April stated that testing would now be expanded to all asymptomatic NHS and social care staff, but the testing expansion in social care only covered staff in care homes. And personal care assistants and unpaid carers were not added to the list of essential workers until the beginning of May. Whole

care home testing was initially implemented for care homes for people aged 65 and older. The risk is that government protection and support has not reached all parts of the social care system.

4 Unmet need and unintended consequences

Temporary powers to relax the Care Act and widespread pressures on services are likely to create unmet need and have potential unintended consequences. Even before COVID-19, unmet need for social care among both younger and older adults was high.[142,143] While data on unmet need are limited, the pandemic appears to have made this worse: almost a quarter of council leaders surveyed by ADASS reported that unmet need for social care in their area could have increased by around 1–5% during the outbreak so far.[58] Data on hospital admissions among care home residents also suggest that there may be unmet need for health care services as a result of the pandemic.

Emergency measures to relax the Care Act have been implemented in a small number of local authorities – meaning that assessments of care needs do not need to take place and, in the most severe cases, councils only need to meet a person's needs if not doing so will breach their human rights. These decisions to delay or reduce social care for some groups are a product of constrained resources and challenges delivering care safely, but will inevitably store up problems for the future. There may also be unintended consequences of the government's decision to allow local councils to provide 'free' social care services for people during the pandemic but charge for these services retrospectively – including unplanned financial strain on people and families, and reduced trust in services.

5 A backdrop of political neglect

No policy action on social care during COVID-19 could undo the effects of decades of political neglect. As we have outlined, the social care system that entered the pandemic was underfunded, understaffed, undervalued, and at risk of collapse. Cuts in social care have been one part of wider cuts to local government budgets, including for public health.[160] This was no secret: adult social care services in England are widely thought to be inadequate and unsustainable. Publicly funded care is only available to people with the highest needs and lowest means. Despite this, successive governments have avoided fundamental reform of the system.

Any response to COVID-19 – however fast or comprehensive – would have needed to contend with this legacy of political neglect. The failure of successive governments to reform social care is being laid bare. While the Prime Minister has restated the government's commitment to reforming social care as the country emerges from the first peak of the virus,[161] history tells us that we should see it before we believe it. And the Prime Minister's framing of 'the problem' in social care – the unfairness of some people having to sell their homes to pay for care – suggests a very narrow interpretation of the issues to be addressed.

Policy priorities

At the daily briefing on 3 May, Michael Gove, Minister for the Cabinet Office, said 'undoubtedly, this government, like all governments, will have made mistakes'.[162] It will be for a future inquiry to make judgements on these mistakes and how they could have been avoided. In the short term, the priority for government must be to identify lessons from the first stage of the pandemic to help prepare for potential future waves of COVID-19.[163] Our analysis of the policy response on social care points to several immediate priorities.

In next phase of the COVID-19 response, national government leaders should:

- Give the same political priority to protecting social care services as hospitals and the NHS.
- Include the social care sector as equal partners in planning and decision making. At a national level, the new social care sector COVID-19 support taskforce offers one route to do this. Greater involvement of social care expertise and experience, including in areas such as learning disabilities and autism, will improve national decision making.
- Ensure that national policies, including those related to the NHS, encourage the meaningful involvement of social care in local planning and decision-making processes – including sustainability and transformation partnerships and integrated care systems.
- Give equal recognition to the value of NHS and social care staff and reflect this in any new support schemes and the policy narrative used to describe them.
- Continue to improve the availability of regular testing and PPE for the social care sector, and ensure access to the training and other support needed to reduce infection risks.
- Commit to providing the necessary funding to cover additional COVID-19 costs incurred by local government and care providers, such as extra staffing and PPE costs.
- Recognise the interdependency of health and social care in COVID-19 policies and guidance. Identify gaps in services that need to be addressed and ensure that care homes can access enhanced support from primary and community health services. This includes the national implementation of the NHS enhanced health care in care homes service.[164]
- Ensure that plans to manage and prevent further outbreaks take into account the diversity of social care services and the varied requirements of staff and users in different settings – including in domiciliary care, other settings outside care homes, and for unpaid carers.

- Work to improve the quality, accuracy, and timeliness of data in adult social care to inform local and national decision making. This should include a minimum dataset for care homes and improved availability of data on other services. Plans to improve social care data should be included in the government's forthcoming National Data Strategy.

More fundamental reform of the social care system is also needed to address the longstanding policy failures exposed by COVID-19. Priorities for government include:[165]

- Stabilising and sustaining the social care system so that it can better meet people's needs. This should include policy action and investment to improve staff pay and conditions.
- Increasing access to publicly funded social care services to help address unmet need.
- Reforming the social care funding system to provide greater government protection for individuals against social care costs. One model to do this – a cap on lifetime care costs – already lies on the statute book. This could be used flexibly by government depending on choices about the balance of responsibility between individuals and the state.

Comprehensive reform of the social care system will require additional government investment.[141] But reform is not unaffordable. If it chooses to, government can afford to provide more generous care and support for vulnerable people in society. If it does not, government will be choosing to prolong one of the biggest policy failures of our generation.

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