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Institute for Employment Studies

Potential Impact of COVID-19 Government Policy on the Adult Social Care Workforce

Ed Griffin

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Institute for Employment Studies

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Executive Summary

This report is the output of a project conducted by the Institute for Employment Studies and commissioned by the Health Foundation. Its purpose was to identify how government COVID-19 related policy may have impacted upon the adult social care workforce in England. The project had a particular focus on Test and Trace, and the ways in which policy changes may have enabled and incentivised the necessary behaviours of care workers. The working hypothesis has been that care workers' behaviours are likely to be driven by a combination of commitment to those they care for, risks to themselves and their families from COVID-19 and impacts on incomes. Government policy changes were identified based on the assumed likelihood to impact on these factors.

The key findings and observations can be summarised:

- The adult social care workforce is a diverse and fragmented one, working in a complex sector with multiple models of ownership and "employment". This is likely to make it more difficult to develop and implement individual policies that are implementable and usable for the sector as a whole.

- The fragmented nature of the sector is likely to make it challenging to get information and support to the people that need it, and therefore ensure that the desired behaviour changes are happening.

- Government guidance and measures appear to have been rushed, heavily focused on care homes and their workers, and impossible to find in one place on the internet.

- Local authorities were made responsible for implementation of local support for care providers. This has had a focus on adult social care. Individual Local Authorities have approached this responsibility in different ways and with potentially different impact.

- Testing has been hard to access, schemes may not have worked as intended, and some schemes have been changed. Access has been a disincentive to get tested, as is the fear of being unable to work if testing positive.

- Potential benefits to workers of government policy may not have been accessible as some managers have been afraid of staff taking time off sick.

- Analysis of the Income Replacement Ratio for workers only entitled to Statutory Sick Pay suggests that for some workers their weekly income could be reduced by up to two-thirds if they had to self-isolate.

- Some measures introduced during the pandemic such as the CARE badge appear to be designed to create a "feel good" response, rather than really helping people.

- People working in the sector may have loyalty to those they care for and their colleagues, rather than their employers.

- Workers in the sector are likely to be low paid and financially constrained. A major concern for individuals is loss of income if having to rely on Statutory Sick Pay. Workers are familiar with this challenge as they may have faced similar issues with Norovirus and flu outbreaks in social care.

- Workers in employment may rely on their manager communicating to them government advice and their entitlements. Managers are likely to have found it difficult to access and understand all the relevant guidance and measures. Individuals working alone in the sector may have little or no awareness of guidance or measures.

- It seems likely that the structure of the sector and the differing modes of employment will have made it challenging for workers to access the appropriate advice and there may have been disincentives to follow key guidance that could protect workers and the people they cared for.

- We make recommendations for further research into the actual impact of policy on the workforce and suggestions for improving policy development, communication and implementation.

1 Context

The COVID-19 pandemic has seen an unprecedent focus on the role and significance of adult social care in the UK. What has emerged in the first half of 2020, in a large part through news stories, is a picture of a sector where there is no overall control or strategy, a low paid and highly committed workforce, and a service playing a critical role in the UK under extraordinary pressures. This workforce has had to deal with the unfolding tragedy of tens of thousands of the people they cared for falling ill and in many cases dying. The Office for National Statistics reported that between the 2nd March 2020 and the 20th June 2020 there were 19,934 deaths of care home residents in England and Wales that involved COVID-19. [i] 75% of those deaths occurred within a care home. The ONS report also shows that between the 10th April 2020 and 19th June 2020, there were 3,652 more deaths of those receiving domiciliary care than the three-year average. The Office for National Statistics reported there were 268 deaths due to COVID-19 between 9th March and 25th May 2020 amongst social care workers. [ii]

It is a sector that is currently subject to significant scrutiny and a workforce attracting greater levels of interest and concern. This report is part of a programme of work undertaken and commissioned by the Health Foundation to better understand the sector, the workforce, the potential impact of COVID-19, government policy, and ultimately to support the improvement of health and care outcomes. The purpose of this report is to identify the potential impact of government policy in encouraging the behaviours and outcomes that could protect both workers and service users, particularly through Test and Trace.

2 Approach and methods

The work that has led to this report has focused on a detailed review and analysis of government policy in response to COVID-19 impacting on the adult social care workforce during the pandemic up until the end of July 2020. This has included both general and sector-specific elements. This has been done on an ongoing basis as updates and new elements have been released, making particular reference to policy releases on www.gov.uk.

We reviewed data and commentary on:

■ the adult domiciliary and care home workforces, with a particular focus on England,

■ different employment models in the sector,

■ different business models of ownership/delivery of adult social care,

■ secondary research and grey literature,

■ media reporting on the pandemic and adult social care,

■ available sickness absence data for the sector, &

■ the Labour Force Survey.

We have conducted a number of targeted interviews with representative bodies for the adult social care workforce and the sector to build a picture of the challenges faced and the potential impacts of government policy. This range of inputs have then been assessed for their potential impact on the workforce.

3 The Adult Social Care Sector

The adult social care sector can be characterised as one that is both highly complex and poorly understood. This is a potentially dangerous combination given the need for clear guidance, communication, consistent standards, and support during the extreme and prolonged event that the COVID-19 pandemic has turned out to be. Even before the pandemic there was a growing public understanding that there were major issues with the organisation of social care, its funding, and the impact on the NHS. This was a debate that grew during both the 2017 and 2019 elections and highlighted the scale of commitment that was needed to address it.[iii] [iv] At the start of 2020 there was an ongoing legal case on the right of care workers to be paid for when they had to sleep in at work. This had a potential liability of £400 million to the sector to settle historic disputes. [v] These sorts of issues continue to generate many articles about the state and funding of social care in the UK. [vi]

Some of the guidance and measures explored later in this report are suggestive that those producing policy have not fully understood the complexity and needs of the sector and the workforce. This complexity also means that research and data is often fragmented and potentially incomplete in the view it provides.

Social Care can be categorised both in terms of the needs of the service users and by the ways in which the service is delivered. The needs are broad and varied, including support for elderly, and people of different ages with illness or disability.

In considering the adult social care workforce, it can be helpful to understand the delivery channels or settings in which care is provided. These include:

- care or nursing homes,
- domiciliary,
- live-in care,
- personal care assistants,
- assisted living,
- community care, and
- Shared Lives.

Much of the public narrative on adult social care focuses on care home and domiciliary, without reference to the other settings. Given this complexity it is perhaps not surprising that available data on the sector and the adult social care workforce is also fragmented. Many of the available up-to-date data sources focus specifically on care and nursing home settings for elderly residents, with less data being available on the care of 18 to 64

year old adults, despite there being 293,00 people in this group receiving long term care. [vii]This points to potential future areas of study to ensure that the sector and the workforce is more fully understood and supported.

In England, social care sits under the control of the Department of Health & Social Care, with the department's re-naming in 2018 to include social care. In Northern Ireland, the Department of Health is responsible for "all professional aspects on how social care is delivered in Northern Ireland"[viii]. In Scotland the Community Health and Social Care Directorate is responsible for helping to "achieve the best health and care outcomes for people, ensuring that high quality care and support is provided to those who need it most, as close to home as possible".[ix] In Wales, social care is also overseen separately from other parts of the UK.[x]

3.1 Sector models of ownership and management

The providers of adult social care range from multi-site commercial businesses with turnover of tens of millions of pounds, national and local charities, through to an individual going into the home of an elderly neighbour each day to provide personal assistance. This creates a sector with a large range of purpose, resources, scale, sophistication, and governance. With some providers being publicly listed companies or registered charities and regulated by the CQC, there can be much greater scrutiny of how they operate, and their quality of care and management. This contrasts with the individual carer with no access to professional advice, regulation, Personal Protective Equipment, or economies of scale. That "individual carer" could be a neighbour paid cash in hand to help out an elderly friend, one of the ten thousand Shared Lives carers in the UK who has someone living in their own home, an individual employed by a recipient of a direct payment as a personal carer, or a live-in carer.

LaingBuisson reported in December 2019 that in the UK the provision of residential and nursing care homes was worth £16.5 billion per annum, with 51% of that value coming from those paying for care privately. [xi] In England, local authorities are responsible for commissioning state-funded social care[xii], with a significant part of that activity contracted out to independent providers. In March 2020 it was reported that Private Equity firms own 13% of nursing and care home accommodation, and this accounts for 56,700 beds in the UK.[xiii] In the elderly care home market, the five biggest providers own 62,000, or 13% of bed capacity in the UK.[xiv] Provider size does not necessarily equate with quality of care. In the USA research showed that Private Equity ownership was associated with a decline in care quality, with higher service user to carer ratios. Two of the top five providers have had significant numbers of their homes rated by the CQC as 'Inadequate' or 'Requiring Improvement.' In one case 24% of one of the largest provider's homes were rated in these two categories in the past four years. In many cases this was a result of insufficient and inappropriate management and leadership. This is likely to have a direct impact on the quality of management that the adult social care workforce experiences in those settings. This could be a significant factor in how supported, informed and protected those staff have felt during this very difficult time.

In the UK there are 18,200 organisations providing adult social care. That one piece of data is indicative of the scale of the challenge in ensuring consistency in care and employment. Given that there are more organisations delivering adult social care in the UK than there are organisations making up the NHS[xv], providing a common set of guidance and measures that are followed consistently appears extremely unlikely.

The sector is represented by a wide range of organisations that seek to both support and champion the needs and issues faced by care providers and workers. These include the Care Provider Alliance, National Care Association, UK Home Care Association, Association of Director of Adult Social Care, UNISON and GMB.

4 The Workforce

Until the pandemic the social care workforce was often portrayed as low skilled, unqualified, low paid and doing unattractive work. Anecdotally it was observed that there was an immediate assumption of the guilt of a care worker if a service user had unexplained injuries. Across the UK, there is a lack of a clear pathway into and through working in social care. There are differing requirements for registration and qualification in England, Scotland, Northern Ireland, and Wales. In England there is no compulsory registration as a care worker and no formal qualification requirement.

The most comprehensive and up-to-date analysis of the adult social care workforce in England is provided by Skills for Care. [xvi] Their report "The Size and Structure of the Adult Social Care Sector and Workforce in England, 2020" is based on data up to March 2020 and so does not include potential impacts of the pandemic. As the pandemic progressed and the specific impact on elderly people emerged, there were a range of stories about the lengths that this workforce was committed to protect the people that they cared for.[xvii]

The 18,200 organisations delivering adult social care in England operate out of 38,000 establishments and provide 1.65 million jobs. Only 2% of those organisations employed more than 250 people, but it was estimated that they employed 49% of the adult social care workforce. Of those organisations 57% are non-residential and 43% are residential care providers, with 68% of establishments CQC regulated.

Parts of the workforce are semi-visible or hidden because of the way services are purchased and provided. The personal budget and direct payment schemes allow for the assessment of individual care needs by local council that may find eligibility for financial support for care. One route for that support is that that money is paid as a direct payment to the individual for them to use as they choose to get the care and support, they require. There are around 230,000 people in England receiving a personal care budget, with an estimated 70,000 of those receiving it as a direct payment. It is estimated that there could be more than 130,000 individuals employed providing care to those receiving direct payment. [xviii] These individuals may initially have had no access to information on PPE, their own health and well-being or to guidance on their entitlement to benefits. Whilst guidance for domiciliary workers was later issued, individuals may not have the guidance explained or support channelled through the management line that workers in larger organisations may have had. Whilst the unpaid care workforce is not the focus of this report, it is worth noting that there are around 4.5 million individuals providing care and support to people at home. [xix]This may be cash in hand work with no support and no regulation, as well as unpaid carers, and helpers (in particular friends and family). The burden on this group may have grown significantly during the pandemic with the closure of day care services. This may be particularly so for elderly parents with young adults requiring care where day care facilities have closed during the pandemic. The unpaid care workforce is not the focus of this report but requires better understanding.

Across the adult social care workforce, 24% of workers are employed on Zero Hours Contracts (ZHCs)[xx] with 58% of domiciliary care workers on ZHCs. In London the use is even higher, with 41% of social care workers employed on ZHCs. [xxi] ZHCs are often characterised as being causes of insecure employment and unpredictable levels of income. The same study also shows that workers on ZHC are more likely to leave their job.

Whilst there is evidence that hourly pay rates have increased due to compliance with the National Living Wage, rates have been shown to be lower than those paid by most supermarkets[xxii]. When this coupled with the potential health risks of being a care worker during the pandemic, it is easy to imagine why workers may want to leave the sector. 40% of the workforce were identified as part time. The mean hourly wage was £8.30 in the independent sector or £307 per week based on a 37-hour week.

In London 67% of adult social care workers identified their ethnicity as BAME, with 21% nationally[xxiii]. This suggests a workforce with a potentially higher COVID-19 risk and may experience higher levels of stress and anxiety as a result. Turnover rates were higher for those travelling further to work, with less than one year's experience and for those under 20 years of age.

The Skills for Care sickness tracker shows that sickness absence in adult social care increased from a pre-COVID level of 2.4% lost days to around 8% between March and July 2020, with the highest levels at 16.1% in London. [xxiv]

5 UK Government policy and its potential impact

During the pandemic, the government has developed and released a range of COVID-19 related policy, issued through guidance, schemes and measures that had the potential to impact upon the adult social care workforce. Some of these policies were directly targeted at social care providers and the workforce, whilst others such as the Job Retention Scheme (JRS) were aimed more widely. The Health Foundation has produced a comprehensive analysis of the policy response for adult social care from January to the end of May 2020.[xxv] For the purposes of this report, we have focused specifically on government policy targeted at or most likely to impact the workforce. In this section we have provided a summary of the relevant policy areas and then explored the potential impact on the adult social care workforce in England.

An analysis of the guidance and measures suggests that they were designed to serve one or more purposes that included:

- seeking to ensure the safety of workers and the people they care for,
- ensuring no detriment to the individual or their family,
- seeking to reduce attrition and attract more candidates to work in the social care sector, and
- creating positive messaging about social care.

However, the release and application of some policy has resulted in highly emotive headlines and stories. This is unlikely to have helped in the communication and application of policy in some areas.

For the purposes of this report policy areas were identified as either having a direct or indirect impact on influencing worker behaviour, e.g. increased recruitment in the sector could create workforce capacity that takes pressure off workers, giving them time to get tested. From talking to representatives of workers in the sector, the biggest concerns were having to survive on reduced income on SSP, the fear of getting the virus or of transferring it to family members and those they care for. Based on this, we identified 5 areas of government policy to explore the potential impact on the adult social care workforce and their potential to incentivise the desired behaviours of workers.

These are:

- Action Plan for Adult Social Care[xxvi] and Social Care Sector COVID-19 Support Taskforce[xxvii],
- Statutory Sick Pay,

- Coronavirus Bereavement scheme and compensation for families of care workers who die as a result of COVID-19,

- Care Home Support Package, and

- Health & Well-being for Adult Social Care.

Towards the end of this project much of the relevant policy has subsequently been brought together and updated in one key www.gov.uk location. [xxviii]

The effectiveness of these policies is largely dependent on social care providers and workers being able to access, understand and apply them. We heard anecdotally that for a small care organisation with two managers, one of them may have spent 95% of their time trying to source PPE. If that was replicated in other homes, it may suggest there would be little time available to find and act on new government guidance. Throughout the life of this project there have been frequent changes to policy, along with almost daily stories in the media about the impact of the pandemic on the sector. This level of change raises the question of how care providers and managers would be able to keep up with what they may be entitled to and what they should do. It is interesting to see how other countries have collated and provided information for the sector. [xxix] [xxx] In some care providers inconsistencies have arisen where different managers made different interpretations of the guidance resulting in inconsistencies and potential disadvantage or risk for staff across different locations.

Set out below are details of these measures and the ways we have hypothesised they could have impacted upon the adult social care workforce.

5.1 Action plan for Adult Social Care and Social Care Sector COVID-19 Support Taskforce

The action plan was published in April 2020 with 4 key elements. These were:

1. controlling the spread of infection,
2. supporting the workforce,
3. supporting independence, supporting people at the end of their lives and responding to individual needs, and
4. supporting local authorities and the providers of care.

Alongside this plan, a Social Care COVID-19 Support Taskforce[xxxi] was established to ensure the delivery of the plan and the Care Home Support Package (described later in this report). The news of the Taskforce was positively received in the sector media[xxxii]. There is apparently no publicly available report or minutes on progress of the Taskforce. The specific actions in the plan which focused on supporting the workforce were:

- access to testing,

- designation as key workers so that their children could continue to attend school,

- guidance on mutual aid and redeployment of staff to areas of greatest need,

- attracting 20,000 new staff in the next 3 months,

- enhanced Universal Credit and Working Tax Credits,

- the ability to furlough members of the social care workforce who were in a high-risk group or were shielding,

- access to a new support line provided by the Samaritans and Hospice UK,

- access to a CARE website and app for support and guidance, and appreciation through the introduction of the CARE badge and access to similar recognition and benefits as those with the NHS badge.

5.1.1 Access to Testing

The Policy

Early in the pandemic testing was only available through the drive-through test centres or through home delivered test kits. Where an outbreak was suspected at a care establishment, health protection teams from Public Health England tested residents on site. In May 2020, the government announced a specific scheme for testing care home residents and workers.[xxxiii] This was to be made available for both symptomatic and asymptomatic people and would be bookable through an online portal. The process would ensure a specific focus on those over the age of 65 due to their increased risk and enable people to be tested every 28 days. Tests kits would be delivered to care homes and then collected by courier for processing.

On the 31 July 2020 the DHSC wrote to Directors of Public Health and those involved in adult social care with an update on coronavirus testing in care homes.[xxxiv] This identified the need to move the target date for regular whole care home testing specifically impacting homes for older people and those with dementia. It also introduced the bulk registration of tests for care homes as a way of speeding up processing, and updates on the replacement of Randox test kits which had not met the necessary safety standards.

On the 28th May, the government launched Test and Trace in an effort to reduce transmission through the notification and self-isolation of individuals who had been in close contact with someone testing positive for COVID-19.[xxxv] Where a worker wearing PPE is exposed to someone they care for that tests positive, this is not treated as "close contact" for the purposes of Test and Trace.

Potential Impact of Policy

The success of the policies relating to testing are predicated on individuals seeking a test when symptomatic, being able to access testing, then self-isolating whilst waiting for results, and then self-isolating if they tested positive. In addition to this, the effectiveness of Test and Trace needs individuals to accept a phone call from Test and Trace telling

them they had been in contact with someone who has tested positive, and now need to self-isolate for 14 days.

One of the potential issues with this is that the testing of staff requires them to be on site to do the test at the same time so that tests can be collected whilst still viable by a courier. This means that for a regular testing cycle to be maintained, some staff will have to come into work when it is not their shift. This may not be possible for all care home staff and risks some missing out on testing at times. It is worth noting that this testing scheme was only available for care homes, not for domiciliary care. For those workers, their only access to testing would be to visit a test centre or to order a home test. This may mean that workers in care homes are more likely to be tested as it will be coordinated by their employer.

We heard anecdotally that some workers in care homes asked if they could refuse tests because they were concerned that a positive test would stop them working and only provide them with reduced income from SSP.

The delay on the care home testing policy potentially put the onus back on individual workers attending drive-through or walk-through test centres if they were symptomatic. The risk here is that individuals may not be able to make the time or afford the cost of travelling to a test centre. We have seen examples of people having to travel for an hour to attend the nearest test centre and access to a car was a requirement to get tested. This may have resulted in some workers being unable or unwilling to get tested, and potentially increasing the risk of transmission. There may also be some adult social care staff who avoid getting tested because they are concerned about the income impact of testing positive and then having to self-isolate. This is described in more detail below in section 5.4. A lack of testing in care homes was reported[xxxvi] and this has meant some homes have had to delay allowing visits to residents. Some care homes have provided smart phones and tablets for resident to have video calls with family and friends. Whilst this gives residents more social contact and stimulation, it can also create more pressures on staff who must schedule calls and provide support to residents to use the technology. Absence of the regular testing and visits being delayed means workers continue to have this additional work pressure in an already highly demanding environment. These are pressures that could further impact the health and well-being of workers.

There are several potential issues with the effectiveness of the Test and Trace service that could impact upon adult care workers. An 0300 telephone number has been used to call individuals identified as having had close contact with a person who has tested positive. It is possible that some people will ignore a call from either an unknown number or may choose to ignore it because it is Test and Trace. There have also been news stories and warnings about fraudulent callers claiming to be from the Test and Trace service. [xxxvii] This may result in some people rejecting the call for fear it is fraudulent. These issues may be reduced by the current move to more localised tracing services coming from local telephone numbers.

There was no explicit mention from government about those providing informal care to vulnerable adults (and children), and it seems likely that their only route to testing would

have been if they were symptomatic. There may have been an increased risk to those they were caring for.

5.1.2   Designation as key workers

The Policy

Social care workers were explicitly designated as key workers. A reason for doing this was that it would enable those workers with children to still send them to school, and thus the parent could still work.

Potential Impact of Policy

The TES school survey[xxxviii] in May 2020 showed that 89% of state schools did remain open. There were reports of some schools not being able to accommodate children, some parents being concerned of sending their children to school during the pandemic, and where schools were not open parents finding it difficult to get children to an alternative location.

5.1.3   Mutual aid and re-deployment of care staff

The Policy

Th Adult Social Care Action Plan referenced mutual aid and the potential to redeploy staff where and when needed. [xxxix] The Plan reports case studies of two local authorities putting in place the measures that would support these activities, but there are no examples of it being put into practice.

Potential Impact of Policy

It is possible to speculate that re-deployment of care staff would have been difficult to deliver. Anecdotally some care home providers sought to stop workers working for different providers because of the fear of transmission. For the same reason, some providers do not use agency staff as there was no control on where else they may be working and the risks in that other setting. In addition, for some care workers there may have been additional challenges if required to travel to another location. Given that workforce turnover data for adult social care in 2019 showed that staff who travel further to work are more likely to leave, there is a potential that asking workers to travel to other locations could increase staff turnover.[xl]

5.1.4 Attracting 20,000 new staff

The Policy

In April 2020, a new campaign was launched to attract new workers to adult social care. In May 2020 Join Social Care[xli] was launched as the portal to recruit new staff to the social care sector. The portal offers a simplified application process with the potential to upload a video CV, and for care providers to find available care workers and post jobs.

Potential Impact of Policy

There was no data available on how many new workers had joined the sector through this this specific campaign and portal. The economic impact of the pandemic may create a short-term benefit for recruitment into the sector. It has been noted that social care organisations do well in recruitment during a recession as there are always jobs available. The corollary of that is that when the economy starts to recover and the job market picks up, staff turnover in the sector may increase. Given the need to attract and keep more workers in the sector, the scale and nature of news stories about social care are unlikely to help. However, in the monthly adult social care vacancy tracking carried out by Skills for Care, the overall vacancy rate in July 2020 dropped to 6.7% from a pre-COVID level of 8.1%. [xlii]

5.1.5 Changes to Universal Credit and Working Tax Credits

The Policy

The basic rate of Working Tax Credit and Universal Credit standard allowance were both increased by £20 per week for the current financial year. [xliii] This was positioned in the guidance as a means of allowing those workers receiving state aid to take on additional shifts because of the pressures created by the epidemic.

Potential Impact of Policy

Whilst the financial incentive to take on more shifts may be significant for some workers; the challenges of time and health and well-being could also be significant. It was clear from our research that for many providers there was a basic need for workers to take on more shifts. However, it was also clear that there are providers who do not want their staff working elsewhere in order to minimise transmission risk.

5.1.6 Use of Furlough (Job Retention Scheme)

The Policy

When the Job Retention Scheme was first introduced it was stated that it was not for use for key workers, however, with the realisation that there were key workers who needed to

shield the guidance was changed in early April.[xliv] This meant that the social care sector could make use of furlough for staff, for both shielding of clinically vulnerable workers and for cost reduction.

Potential Impact of Policy

We found examples of employers using this policy to furlough office staff to reduce costs, as well frontline care workers who had to shield due to their own health risks. Given that care work is one of the roles that has close physical proximity to others and the potential for increased risk of transmission, there may have been many staff hoping to be furloughed but not qualifying.[xlv] This raises a question of if some staff will have left the sector because of the perceived risks to themselves or their families. What is also unclear is the impact of ending shielding on those workers who continue to feel at risk. This could be a cause of additional stress and anxiety or result in someone leaving their job.

Anecdotally, one national care provider found they had over 1,200 staff that need to shield and were put on furlough. The initial assumption was that they would have around 100 staff who needed to shield. This was interpreted as an indication that an employer did not understand how many of their staff had potentially serious medical conditions that meant they often worked when ill.

5.2 Health & Well-being for Adult Social Care

The Policy

In May 2020, the government launched a series of initiatives and resources to support the health and well-being of the workforce. [xlvi] These focused on mental, physical, and financial wellbeing. This was one of very few measures that specifically identified the different needs that managers, workers, self-employed and lone workers faced. The information was published on a new www.gov.uk web page with links to new and existing content provided by a range of organisations including the British Psychological Society and Shout. It is unclear how these resources were publicised to and within the care sector or the extent to which they are being used. In the same month, the government launched the Care workforce app under the new CARE branding. [xlvii] The launch page stated that:

- "Care workers get access to guidance, learning resources, discounts and other support all in one place
- Support will be offered on mental health and wellbeing through toolkits and resources
- The Care Workforce app will unite 1.5 million care workers across more than 18,000 care providers".

Potential Impact of Policy

In reviewing the Care workforce app there are four open discussion groups available, with each showing "39.2k members". This seems to suggest that there are around 39,000 registered users for the app, or less than 3% of the workforce it is aimed at. The availability and uptake of the app may be an issue for some workers if they do not have a smart phone or are unable to afford the credit to use it. There are some discussion threads mainly on topics to do with health and well-being, and bereavement. The comments give some insight into the issues and impact on these individuals working in the sector.

These measures have been associated with the CARE Badge. The badge was launched in June 2019 as "a unifying symbol of pride and quality in care**".[xlviii]** This idea having been prompted by seeing the Secretary of State for Health and Social Care wearing the NHS badge. On the 15th April 2020 Matt Hancock re-announced the badge in the daily briefing. The potential benefit of the badge was that it could be a recognition of the critical work done by adult social care workers and a way of ensuring that they got access to the benefits that were already available to NHS staff, such as the 'queue free first hour' of shopping in supermarkets. The reaction in the press and on social media was rapid and brutal. Criticism focused on the reality that many care workers had insufficient and inadequate PPE, that the badge cost the equivalent of an hour's pay of a low paid worker and that it was a distraction from more significant issues.[xlix l]

5.3 Care Home Support package

The Policy

In May 2020, the government put in place a scheme[li] to provide £600 million to local authorities in England. The package was designed to support Infection Prevention and Control in every care home, ensuring support for residents and workers. The fund was allocated to local authorities based on the number of care beds, and was to be paid in two instalments. There was no overall control over how local authorities have given out the money to care homes or any measurement of the impact it needed to have. Individual authorities are required on their websites to show how they have used the money, although this is presented in differing ways and with differing levels of detail. [lii]

Potential Impact of Policy

Reporting by local authorities shows there are significant factors that have not been addressed by the funding, for example, multiple care homes in one local authority were unable to access required levels of testing or additional staffing when required.[liii] This is likely to increase pressures on workers and increases fears of transmission. We were told that in the first months of the pandemic some domiciliary workers had been criticised by district nurses for not having the appropriate PPE. District nurses were supplied with PPE through NHS channels and may have had access to more PPE with sufficient to change between visits. This was likely to increase stress and anxiety for care workers, increasing

the risk of workers leaving their jobs. It was noted in a report by the Healthcare Safety Investigation Branch that confusion over PPE for domiciliary care workers may have contributed to a worker infecting a client with coronavirus, who then died. [liv]

5.4 Statutory Sick Pay (SSP)

The Policy

In April 2020, the government introduced a scheme that allowed employers to claim back up to two weeks' SSP paid to employees due to COVID-19. [lv] The eligibility criteria for the employee were "if they meet the criteria and cannot work if any of the following apply:

- were self-isolating on or after 13 March 2020 because they or someone they live with had symptoms of coronavirus

- have been shielding since 16 April 2020

- started self-isolating on or after 28 May 2020 because they were notified by the NHS or public health authorities that they've come into contact with someone with coronavirus

- were self-isolating on or after 6 July 2020 because someone in their support bubble (or extended household in Scotland or Wales) but not their own household had symptoms

Employees will not qualify for SSP if they are self-isolating after entering or returning to the UK, and do not need to self-isolate for any other reason."[lvi] Changes were also made so that qualifying days were not required meaning that workers were entitled to SSP from the first day of absence.

On the 26th August 2020 the government announced additional financial support for low paid workers needing to self-isolate during a local lockdown. [lvii] This is targeted support to those living and working in areas with high levels of COVID-19 cases. The measure will allow anyone on low income (on Universal Credit or Working Tax Credits) to receive the equivalent of £13 per day if they tested positive or have to self-isolate because of contact with someone who has tested positive. The payment is up to a maximum of £182 and does not reduce any other benefits they may receive.

Potential Impact of Policy

SSP is a potentially critical factor in decisions for employees to get tested or to self-isolate. Where employees are struggling financially, they may be more likely to avoid anything that stops them from working. Being symptomatic or having a positive test both mean that someone should self-isolate, and for some workers this could cause financial hardship if they were contractually entitled only to SSP. In the case of those providing informal direct care and paid cash in hand, there would be no entitlement to SSP and so the loss of income would be potentially even greater.

The policy allowing the claim back of SSP only applies to organisations with a workforce under 250 people. Given that 49% of the adult social care workforce are employed by

organisations with more than 250 staff, there are over 800,000 staff in England unable to benefit from this in any way. The scheme could in theory make it more affordable for employers to allow staff to self-isolate on full pay as they would be able to claim back the £95.85 per week value of their SSP. However, anecdotally, there are two factors that have made employers reluctant to support their staff in this way. Firstly, it was said that some employers have been reluctant to top up SSP to full pay for employees who have had to self-isolate in case it was used as an opportunity to get two weeks off work on full pay. Secondly, some employers were concerned that they would have insufficient staff available to care for the people using their services. Given that in a late March 2020 survey of care managers 25% of staff were unavailable for work and 34% of providers reported they urgently needed more staff, then it seems likely that some employers would be reluctant to do anything that may reduce their staffing levels any further. [lviii]

In a comment on the CARE workforce app[lix], one worker observed that having been told to isolate for a week by their GP they received £95 SSP compared with the £300 they would have received for working that week. Assuming a care worker working an average 37 hour week on the National Living Wage (NLW) rate of £8.72 per hour (rate for an over 25 year old as from 1st April 2020), their take home pay net of income tax and National Insurance Contributions would be £289.42 per week. Given that SSP is paid at £95.85 per week the Income Replacement Ration would be 1:0.33. So, a care worker on NLW working a 37-hour week would lose two-thirds of their income if they had been only entitled to SSP and were ill or had to self-isolate. This is potentially a strong disincentive to getting tested or taking time off sick from work. Using the higher level mean annual pay rate for a local authority care worker from the 2019 Skills for Care report earning £19,500, would face an even worse Income Replacement Ratio. Their weekly take home pay would be £325 meaning an Income Replacement Ration of 1:0.29 if they had to claim SSP. The disincentive for a care worker only entitled to SSP is even greater on these higher rates of pay as they would lose nearly three-quarters of their income.

When comparing this with NHS employees, a Health Care Assistant even in their first year of service is entitled to one month's sickness absence on full pay and then two months' sickness on half pay.[lx]

The policy to provide additional financial support for those having to self-isolate in areas with higher COVID-19 case levels has the potential to encourage workers to get tested and to register with Test and Trace. However, the income replacement ration for a care worker taking home £289.42 per week receiving SSP and the new allowance would still only be 1:0.65.

Given the high number of workers on Zero Hours Contracts and the potentially associated unpredictable levels of income, it is possible that these workers may be even more reluctant to receive only SSP. Workers on Zero Hours Contracts may also be less likely to have beneficial contract terms that would entitle them to full pay when sick. The regional variations in the use of ZHCs could also mean that some regions may be more susceptible to workers being reluctant to take time off to self-isolate due to the potential impact on income that is already unpredictable.

5.5 Coronavirus compensation and bereavement schemes for families

The Policy

In March 2020 the government launched a scheme[lxi] to provide compensation of £60,000 to the family of frontline NHS staff and care workers who die as a result of COVID-19. The advice specifically identifies that "within social care, the scheme will cover employees of publicly funded care homes, home care, directly employed carers including personal assistants and frontline child and family social workers."

In May 2020 a new policy[lxii] was launched to support the families of workers who died from the virus who were non-European Economic Area nationals.

Potential Impact of Policy

At the end of July 2020, it was reported[lxiii] that 8 families had been confirmed that they would receive compensation and that 25 families in total had applied. This compares with more than 260 care workers having died of the virus.

As a footnote on policy it is important to understand that there have been different policies across England and the devolved authorities. This has included in Wales the payment of a one-off £500 bonus to care workers. [lxiv] These differences will have been particularly challenging to understand and implement for providers working across the different countries of the UK.

6 Conclusions and Areas for Further Research

6.1 Conclusions

The adult social care workforce and sector have played a vital part in the response to the COVID-19 pandemic, and yet remain poorly understood. The impact of this has been clearly felt by both service users and members of the social care workforce. We believe it is vital that more is done to understand the challenges faced and to work systemically to make improvements. In our conclusions we have focused upon:

- the complexity of the sector and policy development,

- potential barriers to safer practice,

- future development and communication of policy, and

- a second wave of COVID-19.

Complexity of the sector and policy development

The range and complexity of the policy that may be relevant for the social care workforce is potentially bewildering. Care workers and managers are most likely to need to access this at times when they are facing additional pressures and stress, e.g. outbreaks, sickness, financial hardship. It takes time and persistence to locate, understand and follow the relevant information, and the information is not all available in one place. Given some of the negative reporting on government policy and measures in relation to the pandemic, it is possible to imagine people thinking that there is no value in accessing it.

Policy has been developed at speed and potentially with a lack of understanding of the context in which it will be applied. This has meant that issues faced by different types of provider during the pandemic are not addressed by a "one size fits all" policy. The SSP changes for organisations with fewer than 250 employees are a good example of this; an apparently simple and helpful policy that excludes organisations employing a total of around 800,000 workers.

Potential barriers to safer practices

Our work on this project suggests that there are potentially numerous obstacles in the way of helping workers act in the safest ways during this pandemic. Earlier in this report we recorded that the biggest concerns for workers appeared to be the fear of having to survive on reduced income on SSP, the fear of getting the virus or of transferring it to family members and those they care for. Ensuring the availability of PPE for care workers

may address some of the key concerns of care workers. However, there remain significant challenges for low paid workers experiencing financial hardship if they are only entitled to SSP. While care workers continue to be low paid, the margins between just surviving financially and experiencing significant hardship may be small. A better funded adult social care sector in England could go a long way to addressing these issues, but with no White Paper on social care and major financial constraints, this seems highly unlikely.

Future development and communication of policy

Whilst there are representative groups contributing to policy development nationally, the complexity and challenges for the sector are still not properly addressed through these policies. More thought needs to be given to both the development and dissemination of policy to ensure it is relevant, easier to understand and implement. This takes time and has been happening during a pandemic when speed is most critical. More thought needs to be given to how providers and workers are reached most effectively. Recent moves to more localised managing of Test and Trace, together with devolved powers to respond to manage local outbreaks may provide the key to addressing these issues. This allows a tailoring of communication and response to the providers and workers in an area, using existing and new channels. Given that this response is being targeted at a Ward or electoral district level, there could be a better understanding of the providers and adult social care workers in that very specific area. For example, local Facebook groups seem able to reach to an individual level and are often used by local or parish councils to communicate to workers and residents. This requires additional resources for local authorities that were already resource constrained coming into the pandemic. It also needs national level policy setting to be connected at a local level to ensure issues and needs are understood, along with an understanding of the resources required to respond.

A second wave of COVID-19

There has been a lot of speculation about a "second wave" of the pandemic in the winter with differing views on if this will be nationwide or the current ongoing localised spikes of infection. Whichever it is, we believe it is critical that further work is done now to review existing policy that affects the adult social care workforce and take action to ensure that it is having the reach and impact that is needed. The phrase "on its knees" has been frequently used in recent months to describe both the NHS and social care. If there is a second wave then whilst protocols and resources may be better available to care providers, the workforce may now be less resilient and less able to tolerate the pressures they face.

6.2 Areas for further research

We have identified three areas where we believe further research will improve understanding and enable more effective policy development and implementation for providers and the workforce.

The workforce

The major focus in much of the research is on care homes and specifically adult social care. This may mean that the domiciliary workforce and others are insufficiently understood. This is particularly important for domiciliary care as it is a growing part of the sector. We recommend that specific research is undertaken to understand this workforce better in terms of its makeup, needs and issues being faced. In addition, it may be helpful to understand:

- How have care workers who are not employed, working directly for individuals receiving direct payments, coped during the pandemic?
- How has policy specifically impacted workers on Zero Hours Contracts?
- How has policy specifically impacted agency staff, live-in carers and informal and unpaid carers?
- How has the pandemic impacted retention and recruitment?
- Have there been differences between the experiences of care workers working with younger adults (aged 18-64) and those working with older people?
- What have been impacts of the pandemic on the informal care workforce and how can they be better supported?
- How have other countries supported the care sector?

It could also be valuable to develop case studies on the actual financial impact on workers taking time off sick during the pandemic and how they have coped.

Local Response

With the move to local authorities managing more of the response to the pandemic, it will be important to understand how aspects of this are working. This may include understanding:

- How have local workforces been impacted by the pandemic? – levels of testing, sickness, staff turnover, vacancies, workforce demographic locally.
- How did local authorities use the COVID-19 fund to care homes and are there relationships with levels of the virus?
- How have different spending patterns impacted staff turnover in local authorities?
- Historic local data on how the adult social care workforce acted during previous Norovirus and flu outbreaks,

  And

- Collecting case studies of how local authorities have most effectively worked with the sector.

Communication

A better understanding of how policy comes through to managers and workers is needed. This may include understanding:

- Where do care workers go to for advice about factors impacting their job and their income?
- What were workers aware of and able to access?
- How well have managers understood and communicated about the guidance, measures and support to workers?
- How do workers and managers prefer and are best able to access information and advice?
- How have the CARE app and government web pages been used?

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