care workers for change

Care after Covid: A UNISON vision for social care

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The coronavirus pandemic has had tragic consequences for thousands of people in the UK. It has also exposed the fault lines in many aspects of public life, nowhere more so than adult social care where the virus has exacted a heavy toll on many of the most vulnerable members of society. This UNISON document looks at the impact of the pandemic on the sector, why we need a new system for social care, and the actions that need to be taken in pursuit of a national care service.[1]

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The impact of the pandemic on the care sector

As the UK moves past the peak of the Covid-19 pandemic and the lockdown begins to ease, there is increasingly widespread recognition that adult social care has been the "forgotten frontline" in the response to the crisis. Deaths in care homes rose even as they declined in hospitals and there remains a lack of clarity on the actual number of Covid-linked deaths in care homes, let alone those who receive care in their own homes.

The response to the pandemic has been problematic in other sectors as well: for example, the failure to guarantee a consistent supply of personal protective equipment (PPE) in hospitals or the inability to enforce social distancing in services such as refuse collection. But, given the prevalence of vulnerable elderly and disabled people involved, the failure to properly prioritise the care sector seems likely to be recognised as a major failing. The causes need to be recognised and addressed.

The delivery of social care is different in each of the four nations (particularly so in Northern Ireland, where health and social care have been fully integrated since the 1970s) and so responses to the pandemic have not been uniform across the UK. Likewise, the impact on care homes has differed between those focusing on the elderly and those caring for disabled people, particularly learning disabled people. And the experience for those receiving and delivering care through personal budgets has been particularly problematic, including a lack of back-up for service users when Personal Assistants were unable to work.

The fragmentation of social care has highlighted the impossible task of trying to deliver a central government response to some of the most notable system failures, including the supply and distribution of personal protective equipment (PPE), the availability of testing, and the pressure placed on thousands of care staff to attend work against public health advice. The crisis has shown that the standard of premises, processes and coordination of services are inadequate to deal with the challenge of a major pandemic.

With the NHS, the chancellor was quick to promise that the service would receive all the funding it needed to make it through the crisis, but no such reassurance has ever been forthcoming for social care. On the contrary, ministers have suggested that central government will not necessarily reimburse councils for all the extra work they have undertaken and paid for during the crisis. The pandemic has also shone a light on the poor employment practices which are depressingly widespread across the care sector. Workers in high-risk groups have felt pressured into going to work; there have been lockdowns in some care homes with workers told to remain on site if staff or residents become infected[2]; and some companies have refused to give sick pay to self-isolating members of staff, or even those who have tested positive for coronavirus. Too many care workers have been placed in the invidious position of having to choose between risking people's lives (including their own) or going without pay. The sad fact is that in a low-wage, low-status industry such as social care, too often it is the workforce that bears the brunt of financial pressures and "light touch" regulation.

The experience of the pandemic in social care has also highlighted wider inequalities. Due in part to the various issues listed above, the death rate from coronavirus has been particularly high for those working in social care.[3] And the care workforce is overwhelmingly female, with large numbers of Black staff and migrant workers among its ranks. The wider toll that Covid-19 has taken on Black communities is borne out by horrifying statistics, which show a considerably higher risk of death for those from Bangladeshi, Caribbean, Chinese, Indian, Pakistani, other Asian and other Black backgrounds compared to white British people.[4] The lack of PPE has been a bigger issue for Black workers as they face a greater risk of death than their white colleagues.

Why we need a national system for social care

Prior to the crisis, the care sector was already in a precarious state – as a result of chronic underfunding, an unstable market system and workforce shortages – with successive governments failing to take meaningful action. As a result, the needs of many of society's most vulnerable people are not being met and care workers are too often left exposed to exploitation.

The much-delayed social care green paper promised by the Westminster government never arrived. Instead the incoming Conservative administration promised in early 2020 that cross-party talks would take place in pursuit of some form of consensus on the future of care. The pandemic has made it clearer than ever that there is an urgent need for an entirely different, more ambitious approach to care – for the reasons laid out below.

Cuts and unmet need

Since 2010 local government has shouldered the largest burden of spending cuts and, even though social care has been relatively protected compared to other council services, austerity has led to local authority spending on adult social care shrinking by 7% per person in the past decade.[5] As a result, price is by far the most dominant factor in decisions around care commissioning, with most councils failing to pay the minimum amount considered necessary to provide safe levels of care. As of January 2020, there were 30 councils paying less than £500 per week for an older person in a residential care home, equivalent to just £2.97 per hour.[6]

Councils have also tightened eligibility thresholds in recent years, such that only those with critical or substantial levels of need are able to receive publicly funded care. It is estimated that 1.5 million older people now have an unmet care need,[7] and the past year has seen a doubling in the number of providers of care for disabled people who have been forced to cut the support they provide due to financial pressures.[8] The "easements" to the Care Act 2014 permitted by the emergency Coronavirus legislation may lead to further people failing to receive the care they need. The "time and task" delivery of care is another feature of this cut-price approach, in which workers are often expected to deliver homecare within a 15-minute visit (or even less).

Market failure

Market failure remains an alarmingly prominent feature of the social care landscape, with many providers entering the pandemic on a financial knife edge. In recent years several of the largest providers have either collapsed or faced serious doubts about their future.[9] Others have retrenched from parts of the sector (particularly domiciliary care) in order to consolidate work in more profitable areas.[10] Last year three-quarters of councils reported that providers in their area had closed, ceased trading or handed back publicly funded contracts,[11] and the additional pressure exerted by the pandemic has tested this fragile system to breaking point, with fears that many of the UK's 8,000 homecare providers could soon cease trading.[12] Constant changes in ownership of care homes and provider companies is also a feature as investors buy, sell and restructure operations with little regard for the interests of service users or staff. This creates huge uncertainty and upheaval, including for local authority commissioners who may find one of their care providers has been sold off to a previously unknown entity.

Low paid, insecure and transient employment

The problems encountered by care workers are well-known but no less shocking for it. More than half earn less than the real living wage set by the Living Wage Foundation, and thousands still do not even receive the lower National Minimum Wage[13] – largely due to the failure of employers to pay for travel time in homecare and "sleep-in" shifts in care homes. A third of care staff leave their roles each year and a quarter are employed on zero-hours contracts (both of these figures are even higher in the homecare part of the sector).[14] Given these factors, it is unsurprising that social care has a major problem with staff shortages: 122,000 at the last count,[15] with projections suggesting this figure could double by 2030.[16] Staff shortages and high turnover directly affect the quality and continuity of care for service users, as does the low level of training that many staff receive. New immigration proposals, that will prevent migrant workers being recruited to roles paying below £25,600, will have a damaging effect on recruitment in a sector where nearly 17% of the workforce are non-British nationals.[17]

Skills, training and standards

The pandemic has led to care staff being redefined by the government as key workers – a welcome contrast to the pre-crisis situation in which they were repeatedly dismissed as "unskilled", notably in government immigration plans. But rather than a temporary reclassification, this elevated status must become an enduring feature of the sector – with a corresponding improvement in pay and conditions. A crucial part of retaining this higher standing for care work is to end the perception that it is unskilled. Much of the work that care staff carry out requires considerable technical skills and inter-personal abilities that are often overlooked. But there is also a frustrated desire for greater training and development opportunities, which are virtually non-existent for large swathes of the workforce, some of whom receive very little training before they begin work. (This applies at all levels, with many care managers taking on their jobs without any training.) During the pandemic care workers have been expected to carry out important Covid-19 swab tests on residents and fellow workers, but the training is just an online video and some written guidance.

While a step in the right direction, the Care Certificate only covers a basic induction into care rather than more specialised training. Moreover, it is not a mandatory requirement for employers, contributing to

the inconsistency across the care sector.

Not all parts of the UK currently have professional registration for care workers, which is one way of at least ensuring a more consistent approach to standards and boosting the prestige of care work.

Complexity, transparency and profit

The crisis has shown that even the most basic understanding of how the care sector works is often lacking – among the public, the media and even government. The greater media coverage afforded the sector during the pandemic may have gone some way to addressing this problem, but there remains a need to raise the profile of social care – and care work – within society.

More fundamentally, this highlights the need for care to be delivered as part of a simpler system that everyone can understand. In the current care market there are around 18,500 employers involved in providing care across nearly 40,000 establishments (in England alone).[18] Within one local authority, as many as 800 different care businesses can be delivering care services at any one time.[19] Such complexity is compounded by the fact there is effectively no one national budget for social care: there are private self-funders and those that receive public funding through councils, as well as publicly funded personal budgets that individuals are then responsible for spending on their own care.

A clearer system would boost transparency and make it more obvious to taxpayers where their money was going and exactly what it was paying for – an important part of winning the argument for a greater share of national spending going on social care in future. But transparency is also hindered by the existence of the profit motive and the widespread involvement of private equity within the care market. The use of opaque financial structures by the parent companies of some care providers undermines public trust as well as allowing billions to leak out of the sector in profit, rent and interest payments.[20]

"Light touch" regulation

The pandemic has shown up the fact that there is no standardised reporting method for care homes, which is why it has proved so hard to get even the most essential data from the sector, such as how many people are dying and where. The sector has long suffered from the use of "light touch" regulation. The Care Quality Commission (CQC) can scrutinise the actual delivery of care but cannot regulate council commissioning practices, after the Coalition Government removed this feature from its own Care Act before it became law in 2014. As a body primarily designed to regulate the quality of care, the CQC is also ill-equipped to oversee the complex financial market that operates in social care; its "market oversight regime" warns local authorities if a major provider is about to go bust but can do nothing to prevent it.[21] All the while the CQC's budget has been cut,[22] with too much bad practice allowed to persist. In addition, HMRC has been unable to properly enforce National Minimum Wage regulations in the care sector, with action to name and shame non-compliant employers restricted to small local companies, sometimes with only one worker identified as having been illegally paid.

Integration with the NHS

In the words of the Care Quality Commission, the need for whole system working across different sectors is "more acute than ever".[23] Despite numerous attempts (particularly in England) to bring about greater integration between health and social care, the pandemic has highlighted the continued failure of such approaches to bring about a genuinely joined-up system. The controversy surrounding the transfer of patients from hospitals to care homes without first being tested for Covid-19 has been the most obvious example of this.

The subordinate status of social care has been amply demonstrated by the failure, even several weeks into the crisis, to ensure care staff are receiving adequate PPE and the fact that social care seems so far back in the queue for testing compared to the NHS, despite the vulnerability of those being cared for. Unfortunately, social care remains the "poor relation" of the NHS, and meaningful integration seems likely to remain out of reach while the two parts of the system operate from such different financial and organisational bases (a free-at-the-point-of-need NHS versus means-tested social care).

In social care the lack of central levers available to ministers has been exposed by the current crisis. Though staff testing and the distribution of PPE has been far from perfect in the NHS, there are at least ways for the centre to effect change in hospitals and other healthcare settings. The more disparate nature of many social care services (particularly in homecare) is one reason why this is hard to replicate in social care, but so too is the existence of the hugely fragmented care market described above. Compared to the NHS, this has made it harder, for example, for the government to reach all the care

workers they need to get tested. The "Exercise Cygnus" pandemic modelling carried out in 2017 found that it was extremely difficult for the centre to locate capacity in the care sector, due in part to the fact that care homes are almost entirely privately run and therefore at greater arm's length from government than NHS hospitals.[24]

These problems are compounded by the lack of one obvious representative body for social care employers. Which also makes it harder to establish partnership working and bargaining of the type that is well-established in the NHS. The extensive work of the NHS Social Partnership Forum on important issues for staff – such as terms and conditions, and health and wellbeing – has allowed the system to intervene relatively quickly during the pandemic to offer guidance to NHS employers.

Towards a national care service

Longer term aspirations

The aspiration over time should be to deliver the vast majority of social care through public funding, and to substantially increase the direct public provision of social care. This would begin to remove some of the differences in service quality between NHS and social care services, and would address the glaring inequality around access to care that is built into the current care system. It would also enable care providers to have greater certainty over their funding streams and therefore to plan better for future needs, particularly in terms of workforce.

Ultimately the goal should be to bring social care up to equivalent levels of equity and access as those associated with the NHS. And there should be a corresponding aim to bring about greater parity between health and social care in terms of pay and reward, training and development. This would then hold out the possibility of fully integrating hospital and NHS community care with care homes and domiciliary care – in terms of both service delivery and pay systems – as part of a genuinely integrated national health and social care service, based on NHS principles.

Interim measures

To lay the groundwork for these bigger picture reforms, there are a number of more immediate actions that could be taken to stabilise the social care system and bring instant benefits for those delivering and receiving care services.

1. A substantial funding boost
There needs to be substantial extra investment in social care as a matter of urgency. Before the pandemic, the cross-party House of Lords Economic Affairs Committee called for an immediate investment of £8 billion.[25] This gives an indication of the size of the extra funding that is required, as does a November 2019 projection by the Health Foundation which suggested that restoring access to care to 2010/11 levels of service, along with providing pay increases, would require government spending £31.8 billion on social care by 2023/24, which is £12.2 billion more than current spending projections.[26] This should be used to begin targeting levels of unmet need and should include dedicated investment in the workforce, as well as funding for councils to begin to rebuild in-house capacity, so they are better able to take on service delivery themselves. The aim should be to reframe social care as no longer just a "cost" but an important economic sector, with investment in it helping to rebuild local economies[27] – particularly in the wake of the economic fallout from coronavirus.

2. Improved pay and conditions
Poverty pay must be ended with all care workers paid at least the real living wage, or at least £10 an hour outside London until the living wage reaches this level (the Living Wage Foundation rate is currently £10.75 for London and £9.30 elsewhere). But a pay rise on its own is insufficient given the poor practice of many care employers. There needs to be a standardisation of employment procedures within the sector. A standard contract template should be used for all care workers (including personal assistants), which would include full sick pay, contracted hours (rather than zero-hours contracts), and a guarantee of pay for all hours worked (to include items such as travel time and "sleep-ins"). The template should be produced through partnership working, with a requirement for commissioners to reference it in tenders and for regulators to make this part of provider registration and enforcement.

3. A new focus on training and professionalism
The Care Certificate should be expanded to cover the technical skills required of care workers and should become a necessary pre-requisite for the future employment of all care workers. It should be flexible enough to recognise the variety of skills in different parts of the care sector and should not discriminate against disabled people working in care roles. Workers should be helped to keep their skills relevant through a new focus on continuing professional development (for staff at all levels, including management) and a ladder of qualifications

to aid career progression. In anticipation of greater integration between health and social care, place-based care systems should be used to join up recruitment, induction, training and development provision for both health and care staff, including higher level apprenticeship programmes. (This would need to take place as pay rates increased in social care, to prevent the "brain drain" of staff leaving for the NHS.) England has yet to embrace registration of care workers, but this is a necessary step if care work is to be perceived as a professional occupation rather than continually dismissed as "unskilled". (There is a need to avoid creating an additional burden on staff, so the cost of registration should be borne – or at least offset – by government and employers once the wider funding for the sector has been secured.)

4. Workforce strategy
Social care has so far been conspicuous by its absence from the People Plan work undertaken by the NHS arms-length bodies, so a comprehensive workforce strategy for social care should be produced which would cover the issues above on pay, conditions, training, development and registration. A realistic long-term strategy should be designed to counter the recruitment and retention crisis that blights the sector and to help establish care work as an attractive career choice. It should seek to encourage a system in which workers have a greater voice within the workplace and it would be necessary to add care work to the government's Shortage Occupation List, so that social care is not deprived of the migrant workers who have helped keep the sector afloat in recent years.

5. Moving away from the commissioning model
UNISON has led the drive for more ethical commissioning in recent years.[28] But the current dysfunctional system, that too often places profit above people, is too fragmented to provide those in need with the modern care services that staff want to deliver. An integrated, publicly delivered care system would benefit both service users and care workers. Public sector capacity, which has been hollowed out by marketisation and austerity, must be rebuilt to ensure care services can be delivered with improved accountability and transparency. In the interim, commissioners should only purchase care from providers that are transparent about their operations, pay their taxes, recognise trade unions, and can demonstrate compliance with the workforce requirements outlined above. Commissioners should work with regulators to assess the sustainability of providers' financial models before awarding contracts – to deter the use of heavily leveraged private equity operations and to protect service users from the possibility of providers failing to fulfil their obligations to deliver care. Commissioners and the CQC should have a responsibility to enforce commissioning requirements and maintain standards.

Wider considerations

While the more ambitious elements of this vision cannot be achieved overnight, there is an urgent need for a better care system and, prior to the 2019 election, there was already a growing consensus that personal care at least should become free at the point of use.[29] And actions taken in the devolved nations during the pandemic suggest that some of the workforce aspects of a national care system are already becoming a reality: for example, the Welsh government gave workers in care companies a pay bonus, and the Scottish government directed payment of the real living wage to care workers.

None of the longer-term goals or more immediate actions suggested above would be cheap, but the benefits of having a quality integrated social care system would leave the UK economy, and crucially the NHS, better able to withstand future health crises as well as having a long-term positive impact across many aspects of society. The substantial investment necessary to deliver meaningful change in social care must be funded by collective rather than individual means.

Any such plans must be undertaken in conjunction with both the NHS and local government. Along with other mechanisms – such as fair wages clauses in public procurement – the merits of sectoral bargaining in social care should be considered, particularly for those workers who cannot be covered by existing national Agenda for Change or NJC agreements. As a first step, a move towards a "social partnership" approach in social care is essential to bring together commissioners, providers, governments and trade unions to at least begin to scope out solutions to the already well-known problems in the sector.

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