WHO CARES?

Reinventing Adult Social Care: Insourcing and restoring the public good

This report was prepared by a Scrutiny Panel established by the Social Care and Health Select Committee of Liverpool City Council. The panel’s members are Councillor Alison Clarke, Councillor Angela Coleman, Councillor Elizabeth Hayden, Councillor Sarah Jennings, Councillor Steve Munby (chair), Councillor Nick Small, Jayne Davies (GMB), Kevin Lucas (UNISON).

Thanks to our clerk, Peter Seddon and for the input of Colin Haslam and the Foundational Economy Group, Mo Baines from APSE, Professor Lydia Hayes from Kent University, Paula Barker MP and Kim Johnson MP. Also thanks to the care workers who gave their time to give testimony to the panel.

Version 2 including corrections to chapter 2
# CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFACE</td>
<td>3</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER 1: WORK</td>
<td>8</td>
</tr>
<tr>
<td>CHAPTER 2: THE FINANCIALISATION OF SOCIAL CARE</td>
<td>16</td>
</tr>
<tr>
<td>CHAPTER 3: THE LEGAL FRAMEWORK GOVERNING ADULT SOCIAL CARE</td>
<td>24</td>
</tr>
<tr>
<td>CHAPTER 4: CHALLENGES AND OPPORTUNITIES FOR INSOURCING</td>
<td>27</td>
</tr>
<tr>
<td>CHAPTER 5: ALTERNATIVE MODELS</td>
<td>33</td>
</tr>
<tr>
<td>CHAPTER 6: THE COVID-19 PANDEMIC AND THE CARE SECTOR</td>
<td>40</td>
</tr>
<tr>
<td>CHAPTER 7: FUNDING SOCIAL CARE</td>
<td>46</td>
</tr>
<tr>
<td>CHAPTER 8: THE NEXT STEPS</td>
<td>52</td>
</tr>
<tr>
<td>APPENDIX 1</td>
<td>56</td>
</tr>
<tr>
<td>APPENDIX 2</td>
<td>57</td>
</tr>
<tr>
<td>APPENDIX 3</td>
<td>60</td>
</tr>
<tr>
<td>APPENDIX 4</td>
<td>65</td>
</tr>
<tr>
<td>APPENDIX 5</td>
<td>71</td>
</tr>
<tr>
<td>APPENDIX 6</td>
<td>78</td>
</tr>
</tbody>
</table>
The crisis in adult social care is one of the most serious and urgent issues facing our city and our country. If we did not know before, coronavirus has bought home to us the enormous problems in adult social care and the key role of care workers. Too long underpaid and undervalued, the pandemic has shown that we need to rethink our priorities and judgment as to who and what is important. When tens of thousands of people die in care homes unable to see or speak to their family we must realise something is very wrong. This report attempts to address some of the challenges in reinventing adult social care in a more humane and sustainable form.

Our Scrutiny Panel began work in September 2019 with the aim of looking at the merits and feasibility of insourcing adult social care. By insourcing, we mean looking at ways in which the public interest and management can be restored to a more central role in the provision of care - a reversal of the trend over the last forty years to move provision from the state to the private sector. Much of the report was written by February 2020. We were then engulfed by the pandemic. While this has brought about big changes, in many ways it reinforces and amplifies the provisional conclusions we had arrived at by February. We had to decide whether to completely rewrite the report in light of the pandemic. We decided instead to leave the bulk of the report relatively unchanged, include a new chapter on the pandemic and insert a preface. The introduction sums up some of the key issues we addressed and the structure of our work. At the end of each chapter are recommendations, which are combined at the end of the report. At this stage, we want to summarise our main arguments.

When we began our work, the main objection we encountered to the idea of insourcing adult social care was cost. As we outline, particularly in chapter 2 on Financialisation, this argument does not hold up. There is a financial crisis in adult social care but this relates to funding or the lack of it, not the supposedly greater cost of public sector delivery. As we make clear in the report, there is a need for a massive injection of public funds into the sector, but this should be matched by much higher levels of public service delivery and regulation to prevent money disappearing into the complex chains of ownership and debt established by some of the big care companies. This is an issue for both local and central government, as financialisation involves systematic tax avoidance through manipulating accounts to generate misleading figures on profit and debt.

It is clear from the evidence we heard that working conditions in the private sector are unacceptable: poor pay, long hours, casualisation, a lack of training and – as highlighted by the pandemic – health and safety issues. This is not only a problem for care workers, although the pandemic has created a welcome and long overdue re-evaluation of the skill and importance of their work. It is also a problem for the users and commissioners of services. There is a massive labour shortage in the sector, aggravated by poor pay and conditions, a steady exodus of staff to better-paid employment in the NHS and the impact of Brexit on staff recruitment. This strongly reinforces the call of the two Metro
Mayors, Steve Rotheram and Andy Burnham, to ‘Build Back Better’. We need significant improvements in pay and conditions, a national vocational qualification for care workers and a professional register. Social care needs to be put on the same footing as the NHS.

A much bigger challenge to insourcing than cost is the fragmented nature of the private care market, the loss of capacity by councils and the variety of demands for care. There is some scope for taking failing companies into municipal ownership, e.g. residential care homes (although this may not always be the most financially advantageous route). If we wish to expand public service delivery in this area, we will need to create capacity and new structures. Insourcing should be a process, not a destination. There will always be a key role for the voluntary sector, as illustrated by the section on Shared Lives and Wheel Meet Again in our report. But this should be based on their ability to bring particular skills to the table – a certain kind of flexibility – more easily found in the voluntary sector, not undercutting local authority pay and conditions.

Four kinds of public intervention are discussed in our report and we recommend piloting all of them:

- Enhanced training and vocational qualifications;
- Creating a new licensing and commissioning framework with private providers building on the work of the Foundational Economy group in Wales and the Preston model;
- Establishing new companies to create a framework for new approaches including a Local Authority Trading Company to act as a service delivery vehicle and to exploit the Teckal exemption;
- Direct employment of staff where contracts expire and finance allows.

Some of these are complementary, others are alternatives. An attraction of the enhanced licensing and commissioning model is that it appears to allow the authority to avoid long term financial liabilities and service responsibilities, in contrast to the latter two options. The recent pandemic has exposed yet again the difficulties involved in regulating the private market. Contrary to received wisdom, directly employing and managing staff provides for greater flexibility and freedom than managing relations by contract. Pilots allow us to explore the strength and weaknesses of different approaches.

None of this will work without increased funding and we recommend a local pilot of increased income tax to meet the need. This will not work if it is only used to plug gaps. It needs to offer a free and enhanced service to all, putting the care sector on the same footing as the NHS.
Introduction

Our panel was established to look at the feasibility of insourcing adult social care in Liverpool. This may seem a quixotic exercise in the aftermath of the election of a government committed to further deregulation and in light of the potential impact of Brexit. But the problems facing adult social care have not gone away because of this. Indeed, further deregulation and Brexit are likely to aggravate the problems facing the sector, particularly the labour shortage and the challenge of ensuring quality provision in a fragmented industry, which is difficult and costly to regulate.

The looming crisis in care

Over the last forty years, the provision of social care has shifted massively from the public to the private sector. “In 1979, 64% of residential and nursing home beds were still provided by local authorities or the National Health Service (NHS); by 2012 it was 6%; in the case of domiciliary care, 95% was directly provided by local authorities as late as 1993; by 2012 it was just 11%” (Centre for Health and the Public Interest, 2013). This has been accompanied and reinforced by a looming financial crisis affecting individuals, local councils and the NHS. Growing demand for care services that reflect longer-term survival rates for people of all ages with higher levels of morbidity and care needs has placed enormous strains on personal and public budgets. This has not been matched by political commitment to new funding mechanisms for social care. Over the last twenty years a variety of mechanisms have been floated for addressing the problem, from taxation to social and/or personal insurance. None of them has become policy. This government, like its predecessors, has made noises about providing new funding for adult social care, but no clear commitments have been forthcoming.

The broader problems facing the sector cannot be understood without recognising its overarching significance. In our report, we propose a local pilot to explore possible ways to fund social care. Equally, the impact of privatisation and financialisation (see Chapter 2) have been profound and generated problems, which cannot be addressed by additional funding alone. The focus of our work has been to look at these and suggest ways to mitigate and/or resolve these problems. None of this can deliver long-term solutions to the problems of the sector without a major increase in funding. But a major increase in funding without fundamental changes to the nature of provision, greater innovation in social care and a challenge to financialisation could be largely ineffective. This money could be diverted away from meeting the needs of recipients of social care and care workers to fuel the profits of large financial chains, or simply wasted.

Market Failure

If public funding for care has been inadequate, the sector as a whole is increasingly demonstrating market failure on a spectacular scale. This takes a number of forms. A reliance on low pay and bearing down on workers’ conditions has led to a massive shortage
of care workers. According to a recent article in the Guardian, there are 122,000 current vacancies and “the projected need for 580,000 additional social care workers by 2035 to keep pace with the aging population” (https://www.theguardian.com/society/2020/jan/07/nhs-nurses-social-care)

If the sector faces a looming labour shortage there have been equally spectacular failures in the residential and nursing care home sector. A recent report by the Centre for Health and the Public Interest “Plugging the leaks in the UK care home industry”, November 2019, outlines the scale of the problem. All four of the biggest care-home businesses have been up for sale in the past year and have failed to secure deals. A recent report by the Association of Directors of Social Services reported that almost half of councils have seen the closure of domestic care providers in the past year and a third have seen residential care homes closed. Care England, which represents independent providers, estimates that around £4 billion is needed from the government to stabilise the sector. While vacancy rates due to excess capacity are cited in some cases, the cuts in council budgets have undoubtedly contributed to financial instability. But while austerity and the lack of an adequate funding regime is critical, we should not let the sector, particularly major chains, off the hook. As we shall explore in Chapter 2 when we look at financialisation, the financial models deployed by large chains, particularly in residential care, are a major factor in the instability of the sector.

Austerity and Funding

The scale of government cuts which Liverpool has faced over the last decade has had an enormous impact on services. We have £436 million less to spend each year, in real terms, than we did in 2010 – equivalent to a 63% cut - due to reductions in funding from central government. Adult Social Care absorbs 42.2% of the Council’s net budget - £183.2M in 2019-20 - so the pressures on this sector have been particularly severe. We must add to this not just the pressure of growing demand for care but the impact of labour shortages in the sector and the Council’s commitment to meet UNISON’s Ethical Care Charter for Home Care Services. This commits the Council to ensuring all home care workers are paid the Real Living Wage. In addition, if care workers are outsourced the provider is required and funded to maintain these pay levels throughout the contract. It is estimated that the cost of implementing the Real Living Wage across social care services in the city in 2019-20 would have been £14.4 million. These problems have been further compounded by the coronavirus pandemic.

Structure

The panel took evidence from workers in the residential and domiciliary care sector, working for the public and private sector. It also received a report prepared by UNISON detailing some of the issues experienced by a worker in the region in the domiciliary care sector during her working day. This forms the bulk of our first chapter. The evidence highlighted problems with pay and conditions in the private sector, which affected service users as well as staff. We also identified problems with training, skills and staff shortages. These shape a number of recommendations at the end of the chapter.
The panel received a number of presentations on financialisation from UNISON and the Foundational Economy Group. We would like to express our thanks to Colin Haslam, from the latter, who has contributed substantially to this part of the report. The financial devices involved are outlined in Colin Haslam’s report. Further detail is provided in the CHPI report referenced above and the presentation by Kevin Lucas to the panel at our meeting on October 3rd (appendix 3). These reveal the complex financial devices by which private companies extract profit from the sector. This is the subject of Chapter 2, which concludes with an analysis of the current expenditure by LCC on home care and suggests that an alternative, high-quality model of provision is affordable.

Chapter 3, contributed by Professor Lydia Hayes looks at the legal framework governing the delivery of adult social care. Professor Hayes is the Principal Investigator in Social Care Regulation in Kent Law School at the University of Kent. The obligations laid on local authorities are contrasted with those applying to providers and the Care Quality Commission.

Chapter 4, contributed by Mo Baines from APSE, looks at the challenges and opportunities for insourcing adult social care. It explores the differences between insourcing social care and other services such as waste management. The need to adopt an incremental approach is explained, as well as the need to create in-house capacity before insourcing contracts, using an invest to save model, the basis for further recommendations.

In Chapter 5 we look at different ways of delivering social care which could improve service provision and workers’ conditions, based on a variety of models in the UK and internationally. We conclude with a number of recommendations to pilot some of these, supported by new training programmes.

Chapter 6 looks at the impact of coronavirus, drawing on evidence assembled by UNISON from care workers around the North West region, supplemented by reports from two local MPs. In many respects this experience reinforces the concerns and recommendations the panel had already reached. However, it gave them a heightened importance and urgency. The crisis created by the pandemic also creates new opportunities to make the case for improving workers’ pay and conditions, increasing funding for care and a revived role for the public sector.

Chapter 7, contributed by Mo Baines from APSE, looks at the issues around funding social care. Starting from the broader pressures on council budgets, it explores the various options for increasing funding for adult social care and the funding implications of different models.

Our final chapter, 8, looks at some of the challenges involved in reviving a central role for the public sector in care provision, notably the fragmented market. This is linked to the need for substantial increases in funding. It concludes with a number of recommendations on creating new vehicles for public provision, different approaches to commissioning and funding.
The panel began by taking evidence from workers in the residential and domiciliary care sector. Care workers employed within the public sector reported better pay, terms and conditions, training and employment practices compared to their private sector counterparts. The evidence suggests a higher level of staff morale, staff retention and superior standards of care within those services directly provided by the council.

Concerning themes from evidence presented by private sector care workers include:

- **Poverty pay.** Pay rates below the Real Living Wage. Sometimes further exacerbated by non-payment of travel time between home care visits and/or “sleep in” rates at below the national minimum wage.
- **Precarious employment** through the use of zero hours contracts, even where working hours have been consistent over the long term.
- **Unsupportive management.** Particularly where workers are employed on zero hours contacts
- **“Call cramming”**. An impossibly high number of rostered home care visits which overlap or provide insufficient travel time between appointments.
- **“Call clipping”**. The consequence of call cramming. Care workers are forced to cut short contact time provided within the council funded care plan in order to fit in every rostered visit.
- **Staff retention and recruitment problems.** Resulting in a lack of continuity of care and inadequate staff to service user ratios.
- **Incomprehensible pay-slips.** A failure to itemise hours worked, travel time, enhancements and deductions make it impossible for the worker to know whether they are in receipt of their correct pay. Consistently incomprehensible payslips within private social care have previously been found to conceal underpayment and in some cases deliberate and systematic breaches of minimum commissioning standards or national minimum wage legislation.

The panel received a presentation from Kevin Lucas of UNISON detailing aspects of the working day of a domiciliary care worker, whose case had been taken up by the union. The Roster Summary showed that on the first day recorded there were 48 visits, with a working day starting at 7.30 am and finishing at 12.20 am. On the second, there were 51 visits, with a working day starting at 3 am and finishing at 23.45 and so on. This included visits lasting no more than a few minutes. The worker was employed by a major chain and paid well below the national minimum wage.

Further evidence came from a number of care workers working across the care sector in Merseyside. These care workers shared their first-hand experiences of the realities of working in the sector. More evidence was gathered from privately employed care workers as they represent the majority of the workforce and this paper aims to shine a light on their experiences. This evidence is listed in the Appendices.
The first information heard was from a care worker in the public sector (to be referred to as Care Worker 1 for the purposes of the report). The care worker in question worked in day centres that offer care to people with learning difficulties and often with complex physical needs. A typical day consisted of setting up the activities for approx. 50 service users, who are generally at the centre from 9 am – 4 pm with a high staff to service users ratio. The care worker reported comparatively better pay and conditions than their private sector counterparts did. Care workers within this setting have set contracted hours, permanent contracts and pensions in line with Liverpool City Council terms and conditions. They enjoy high levels of training that benefit both staff and those under their care, with all staff receiving the same level of training (minimum of level 3 NVQ). The staff retention within the day centre is fantastic. The care worker thought this was mainly due to the training opportunities and the good terms & conditions of employment.

In contrast to the positive experience of Care Worker 1, the other three care workers questioned, who worked within the private sector, painted a very different picture.

Care Workers 3 and 4 are residential care workers. Their roles are most similar to Care Worker 1 as their care work is located in one setting. These workers report poor pay and conditions. They are employed on the minimum wage on 12 hour shifts with a one hour unpaid break and no additional pay for night shifts. The home accommodates up to 38 residents, many of whom are on end of life care. They report low levels of staffing, with only five carers to look after the residents. They believe this level of staffing makes providing good care almost impossible. The low staffing numbers mean that residents only receive two showers per week. The ends of shifts are often delayed due to seeing to a resident’s needs, with no additional pay for the extra time worked. The care workers explained that challenges brought about through low staffing levels are raised with management but nothing changes. Their further observations of management were that they are governed by a hierarchy who have no interest in change. Furthermore, a number of managers have no nursing or care experience and as such are incapable of dealing with the issues that arise when caring for residents.

They outlined a typical day in the home. The handover from the previous shift normally takes around half an hour. A number of carers then prepare breakfast whilst others assist residents who need help. Between 10 am and 11.45 am help is given to get residents ready prior to lunch, around 12.30 pm. Following this, assistance is given to toilet and then there is afternoon tea. 5 pm is evening meal and then later is suppertime and then preparing for bed. Most of the staff work until after 9 pm but are only paid until 8 pm. They also reported changes to staffing and management behaviour when there is a Care Quality Commission (CQC) inspection. There tend to be seven staff instead of five when an inspection takes place. The inspections should be unannounced but the managers always make extra provision when inspectors arrive, and create a high level of engagement with staff that does not occur ordinarily.

The care workers concluded that bringing services in-house with the local authority would bring about positive changes, stating ‘If services were brought in-house there would be better staff retention rates and care provision. In Runcorn a number of homes were taken
over by the Local Authority and the changes seem to be positive.’

The most telling remark came from Care Worker 3: ‘They shouldn’t call it care, because we’re not able to give the residents the care they need.’

These care workers reported extremely low job satisfaction due to poor pay and conditions, in contrast to Care Worker 1 who was employed by Liverpool City Council. In addition, the care offered to residents within the care home was extremely poor due to the low levels of staffing and lack of support from management.

The next set of care workers are domiciliary workers. Domiciliary care is the most common form of care work contracted out by Liverpool City Council. There are currently no domiciliary care workers directly employed by Liverpool City Council.

Care Worker 2 was the first domiciliary care worker to share her experiences. She is on a zero hours contract but she stated her rota is always full and has been for years. The fact that she is on a zero hours contract but has a full rota raises the question of why she cannot be on a contract with the minimum set hours she works each week. She spoke about a typical working day. It starts around 7.10 am. In the main, work is done as a ‘double-up’. This is when 2 carers visit together - usually for moving service users in and out of bed/bath etc. The calls typically last 50 minutes for a one-hour call and 25 minutes for a half hour. Following the morning calls, there is then a break before doing a ‘teas and bed’ rota of calls. The morning calls total 6 and a half hours and the evening/night calls up to 7 hours, meaning getting home around 10 pm. The above entails looking after around 10 people.

She also provided information on her rates of pay. Her pay had recently gone up to £9 an hour. She stated the reason for the increase was to improve staff retention rates, as previously lots of staff were leaving to go to work at hospitals and other care companies. It should be noted that when the pay was increased the double time rate for bank holidays was reduced to time and a third. Therefore, with one improvement in their pay another element was lowered. Also, incomprehensible payslips make it impossible for this worker to identify whether she is actually in receipt of the new £9 per hour rate or not.

Care Worker 5 is a male domiciliary care worker also employed by a contractor of Liverpool City Council. He also had a zero hours contract but in contrast to Care Worker 2 he did not receive regular hours from his employer. He stated that his hours were varied, ‘one week I get no hours and then the week after I do 12 hours a day. Before Christmas I was getting just 1 hour a day and struggled to pay bills.’ This caused him a great deal of anxiety as you would expect, with a sudden loss of wages. He explained that his day typically started at 8:30 am. He gets an hour’s break in the morning and finishes at 7 pm, but sometimes he get no breaks. His rates of pay were less than Care worker 2, with a rate of £8.21 per hour increasing at weekends to £8.50. A big issue for this care worker was unclear payslips that did not list the actual hours he worked and the rates of pay for those hours. He asked his employer about getting better payslips, to check if he was getting paid for calls when he had to cut them short because the service user did not
need him. He was given a clearer payslip on request, which showed they do pay for this and any extra time he may have to stay due to an emergency.

Travel was another issue for this care worker. He used to use a bike between calls, however due to his own ill health he was advised not to cycle anymore by a doctor. He now uses a bus to get to calls that are not within walking distance. On request, the provider agreed to pay for his travel costs. The fact that he had to request this is concerning, as you would expect a provider to make it clear that travel costs would always be paid during working hours. However it remains impossible to tell from payslips whether this worker receives pay for travel time between calls.

Care worker 5 often did not get notice of his shifts. His hours come through a few days before. For instance, for a weekend the rota comes through on a Thursday. You get your rota sent out a couple of times a week. When asked about pressures of the job, this care worker explained that pressure varies, “it goes from no pressure to a lot of stress and having to do long days.” He thought, ‘it will have a backlash on me with my service users. Sometimes I start at six am which affects my service users as I have to wake them up too early.’ He also stated ‘for the conditions we work in I don’t get paid enough. We should be paid £10 an hour with progression.’ The care worker felt they were not listened to by their employer and feared this would be exacerbated because he has now joined a union.

Another big problem for this care worker was other care workers with his provider ‘cram calling’. ‘Some girls do 20 calls in a day which is impossible to do and give the service users what they need....they only stay for ten minutes and the office is happy for them to do the calls.’ This sort of practice would surely have a detrimental impact on the people within their care. This disclosure from the care worker points to a proportion of people under this care provider getting extremely low levels of care due to the lack of time these care workers are spending in their homes. This is ultimately the responsibility of Liverpool City Council as they have contracted this provider.

He also sometimes faced pressure to take extra calls in a shift, ‘I do tell them to take off extra calls. They gave me extra calls and I got them taken off, but was told by management I was disrespectful.’ This demonstrates how difficult it can be for care workers to stand up for vulnerable clients and service standards when precariously employed on zero hours contracts.

Again, this care worker reported high stress levels due to low pay and conditions. If he had higher pay and a contract with set hours, it seems a lot of this stress would be alleviated.

Care Worker 6 works for another provider who has contracts with both a palliative care charity and Liverpool City Council. She is employed as a care worker to care for palliative care patients at home, but she often does additional non-palliative domiciliary care work during her shifts. She is paid £9.50 an hour for STARS (Supportive and End of Life Care Service) calls. Domiciliary care workers with her provider are paid around £9 an hour for domiciliary calls. She is paid £9.50 an hour for both STAR and domiciliary.
A typical day for this care worker starts at 8 am and finishes at 10 pm. Her contracted hours are 37.5, which is six hours of calls in the morning and then six hours of calls in the afternoon. They are meant to offer support to the family too, with tasks like shopping and cleaning. However, her calls have changed to now include travel time, reducing the amount of contact time available for family support. She also has to do domiciliary calls on top and these sometimes overlap, which makes her late for dinner calls. She stated, ‘So this affects the care. It means you’re always running late.’ With this level of work in one shift, it is quite clear that the care worker cannot physically deliver an adequate level of care.

This care worker also has issues with her pay slips. She stated that she is meant to be block paid but she cannot tell because her wage slips are very confusing and not itemised, so she does not know if they are accurate. She asked for payslips to be itemised properly but the office did not send it over. She is still unsure as to whether her payslips are accurate and whether she is being adequately paid for the hour she has worked.

There is no continuity of care within the domiciliary calls. She explained, ‘I was at a call the other day and I rang the doorbell. The relative was angry with me because that meant the service user could fall trying to answer the door. He’d rung the office six times to get it resolved, but the KEY safe number was not kept on the PASS system.’ She also raised concerns about who does the risk assessments in the houses and who assesses fall risks. She did not have the answers and the implication was this was not happening.

When asked whether she has enough time for calls she indicated that they get 25 minutes for domiciliary calls, which is not sufficient to do housekeeping, medication, personal care and check the laundry. Additionally, she was concerned about the fact that although she is employed to do STAR calls she spends much of her time doing domiciliary calls.

Furthermore, she reports very little communication with management and pressure to work even when ill: ‘We don’t get much support from them. I rang up sick with Norovirus during the Christmas period and received a poor attitude for it. Also, someone from the office told someone who was being physically sick to stay on their rounds. We’re dealing with people vulnerable to illness.’ This culture of pressuring care workers to work even when ill is extremely worrying and is likely to endanger the people under their care.

**Health and Safety**

‘Very vulnerable going into houses by yourself particularly at night. There is no safety protocol for lone working. Someone forgot to log out a call but the office did not chase it up when they came out on a call an hour late. But if you’re late for a call the office will ring you up.’

‘Another example is when a man had cancer and he pulled a knife out on one
of the girls but she knew she had to give him care. He put the knife away and threatened to use it on people. He had three other knives in the property.’

**If you could change three things about care, what would you change?**

‘I would have longer time on calls, change the structure of the calls so I don’t have to travel so far and a risk assessment on some of the houses because there’s rubbish everywhere.’

The main problems identified in evidence from staff were poor pay and conditions, poor training, travel costs and time. The panel also learned from listening to carers that Domiciliary Care Providers are not stable, and are prone to ‘buy outs’ from larger providers. This has already happened with Homecares Liverpool, a small family run company that has been bought out by a Spanish company Clece (see Chapter 2). Evidence from one carer highlighted the pressure to take extra shifts on days off. Annual leave has decreased since the takeover, and worryingly there is a culture of management not listening to staff concerns. This impacts on the quality of care provided and the ability to retain staff in the sector, which means poor continuity for service users. Continuity of staff affects the ability of experienced and trained carers to assess day to day the health and wellbeing of people in their care. Even the simple task of assisting a wash permits assessment of skin integrity, colour of urine etc., all of which are important diagnostic and preventative skills.

The evidence suggests that training and continuity are aspects that are undermined in areas of the private sector. The health and wellbeing of the people employed in this sector should also factor in any decision making. Staff giving evidence reported difficulties in getting to their own hospital appointments due to pressure from their managers and stated they felt stressed by the work environment. While low pay is an issue across the private sector, staff also reported difficulties in understanding their payslips, constant queries about accuracy of pay and not being paid on time. There is no reason why modern payslips cannot itemise hours worked, travel time, pay enhancements and deductions as is the norm in almost every other sector of employment. However consistently incomprehensible payslips within private social care has been demonstrated to conceal underpayment and in many cases deliberate and systematic breaches of national minimum wage legislation. It is a serious concern that incomprehensible payslips is such a consistent issue for private sector social care workers who presented evidence to the panel.

These factors add stress to a workforce already squeezed and under pressure and yet expected to deliver high quality care to vulnerable service users. It is important to look at the sector not simply in terms of the care provided but as a major area of employment. Improving the pay and conditions of workers, raising the level of training and improving staff retention has implications for the wider economy. Another factor, characteristic of the UK economy and the service sector in particular, is the low growth in productivity. This impacts in turn on pay rates and the ability to meet demand. We consider ways to address this in Chapters 4 & 5, where we look at alternative models for delivering social
care. This creates possibilities for a new and positive role for the public sector. Rather than only focusing on subsidising, commissioning or providing social care, the public sector has the ability to combine several goals in a way less likely to be achieved by markets. This shapes our recommendations.

**Care work in Liverpool**

Social care is an important sector in terms of providing employment in Liverpool and disproportionately so in more deprived communities. Care work provides entry-level jobs that are accessible to many residents without intermediate or higher skills levels. Care workers are disproportionately women. Social care is also an important sector in terms of providing employment opportunities for those entering the labour market after undertaking unpaid care work for family members.

Brexit gives rise to challenges for Liverpool’s future social care workforce. It is likely to result in fewer workers from the EU in lower paid jobs in the NHS. This, in turn, is likely to mean better-paid employment opportunities opening up in the NHS for Liverpool’s existing social care workforce, in roles like healthcare assistants. This is positive, but could pose challenges for recruiting and retaining workers in the social care sector in the future.

Several of the concerns we raise in this section were identified in a report prepared by the Liverpool City Region Combined Authority in 2017 (Skills for Growth Action Plan: Health & Care 2018-20). However, in light of both Brexit and the pandemic, this work needs updating as we suggest in Point 3 below.

**Appendix 1, 2 & 3**

Care worker 1 – public sector worker in a day centre for adults with learning difficulties and complex physical needs.

Care worker 2 – private sector domiciliary care worker

Care workers 3 and 4 – private sector care workers

Care worker 5 – private sector domiciliary care worker

Care worker 6 – care worker for end of life patients

**Proposal 1 – Training.** The City Council should work with the Metro Mayor, local councils in the City Region and social enterprises to develop a new training programme for adult social care. A requirement to ensure staff are supported to take part in training programmes should be built into the commissioning process.

**Proposal 2 - Professionalisation.** The City Council should work with the Metro Mayor and local councils in the City Region to explore ways to increase the professionalisation of care workers, including ensuring employment security for staff on zero-hour contracts, access to continuing professional development and piloting mandatory registration and
regulation (Nuffield Trust Briefing Paper: Social Care: the action we need; December 2019).

**Proposal 3 – Strategic analysis.** The City Council through its employment arm, Liverpool in Work, and its lifelong learning arm, Liverpool Adult Learning Service, should undertake strategic analysis and planning now, alongside NHS partners in the Liverpool City Region and the FE and vocational learning sector, to identify future employment opportunities and map out projected skills gaps to empower the existing social care workforce and recruit and retain the future workforce.

**Proposal 4 – Travel.** The City Council should work with the Metro Mayor, local councils in the City Region, Merseytravel, bus companies and care providers to develop new more sustainable travel options for carers. This could include developing a fleet of electric cars to provide cheaper and cleaner transport between visits and options such as block bookings with Arriva Click.

**Proposal 5 – Real Living Wage.** The City Council should work with the Metro Mayor and local councils in the City Region to develop a commissioning model requiring payment of the Real Living Wage by all providers.
CHAPTER 2: THE FINANCIALISATION OF SOCIAL CARE

Over the past decade, the largest domiciliary home care and residential care home provider chains have expanded rapidly. They are responsible for the financialisation of social care, whereby social care provision is treated as a commodity – a vehicle for wealth creation – rather than as a social good.

Attracted by an ageing population and the secure income provided by public sector funding, parent companies (often private equity firms) purchase social care providers at an inflated speculative price. They then load the provider company with huge debts, from which the parent company extracts money as interest payments at rates of up to 12%. These practices, combined with tax avoidance through complex and opaque global corporate structures, have mutated social care into a high return business model with all of the social risk and costs shifted onto commissioners, workers, vulnerable clients and their families.

For the model to work the providers must win public contracts, which they compete for by driving down costs. The largest single cost of all social care provision is labour. Providers therefore hold down levels of pay and take any opportunity to cut other terms and conditions, such as occupational sick pay, leave and pensions, whilst reducing staffing levels, training and demanding the “flexibility” of zero hours contracts. Once contracts are won, a hefty proportion of public social care funding is then extracted as corporate overheads (such as head office expenses, director pay, etc.) and interest on the debt owed to the parent company and its investors (to fund the inflated purchase price).

In total, the parent company would normally extract 20-30% of income, leaving the provider company accruing only a relatively modest surplus. This has the benefit for the parent and provider of being “tax efficient” (profit is taxable whereas interest payment on debt is tax deductible) and creates the impression of low operating margins, which allows providers to argue for even higher levels of public sector funding.

The effect on social care provision has been devastating. Skills for Care’s latest research shows a social care workforce turnover rate of over 30% a year. This results in huge vacancy rates and an often inexperienced, inconsistent and poorly trained workforce, stretched to the limit, with dire consequences for the safeguarding, wellbeing and dignity of the most vulnerable in our communities. The section below by Colin Haslam describes the mechanisms involved.
Financialising the provision of elderly care – Colin Haslam

More than eight out of ten care home beds are provided by profit-driven companies, including more than 50,000 by large operators owned by private equity firms. Roughly, four fifths of domiciliary care is provided by a mix of for-profit and not-for-profit independent providers. Private companies can specialise: providing residential elderly care or domiciliary home care or a mix of these activities, with funding received from local authorities, private fee-paying individuals and NHS payments.

Private companies delivering elderly care become financialised when they restructure and seek external funding: equity and/or debt finance. The investors involved are typically looking to generate a 12 percent return on their capital employed. These returns are what we would expect from a relatively high-risk investment portfolio. They are not what we would expect from a low-risk sector such as elderly residential and domiciliary care, where demand and income is generally guaranteed, so long as the care home or home care provider does not receive a Quality Commission embargo on taking in new residents.

1. Elderly care homes: financialised

The provision of residential elderly care in large chain providers has become financialised because restructuring through consolidation-led acquisitions inflates their balance sheet capitalisation. These operators most often capitalise their investments in the form of a holding company (hold-co). The holding company covers the costs of capitalisation from cash earnings (earnings before interest tax, depreciation, amortisation and management fees-EBITDARM) transferred from the operating company (op-co). In a typical large residential care operator, the EBITDARM takes roughly 30 percent of total revenue received (this margin falls to approximately 23 percent if the elderly care operator is 75-100 percent Local Authority funded).

The typical 12 percent return on capital expected from investing in elderly care translates into a higher percentage of total revenue because invested capital can be 2-3 times higher than revenue earned. The capital invested to purchase elderly care provider companies is based on a Market Value to EBITDAR (earnings before interest tax, depreciation, amortisation and rent). Assuming that the investor is investing in quality elderly care providers with new properties and a high occupancy rate, the market value to EBITDAR multiple might be a factor of 8:1. Table 1 reproduces a table produced by the Competition


2 https://assets.publishing.service.gov.uk/media/59b2bb0ae5274a5cf6ca2d18/financial_analysis_working_paper.pdf

and Markets Authority Care homes market study and it reveals that the total EBITDAR generated by 26 large private home care providers was £0.95bn in 2017. If the capital invested in these companies was made at an average 8:1 EBITDAR multiple it would amount to roughly £8bn and two times greater than the total annual revenue earned. Thus, a 12 percent return on $8bn of capital invested translates into a required cash (EBITDAR) margin of £0.96bn or roughly 21 percent of total revenue.

Table 1: Aggregated P&L for 26 large providers, 2017 (forecast)

<table>
<thead>
<tr>
<th>£mill</th>
<th>% revenue</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td>4453</td>
<td></td>
</tr>
<tr>
<td><strong>Staff Costs</strong></td>
<td>2548</td>
<td>57</td>
</tr>
<tr>
<td><strong>Non-staff costs</strong></td>
<td>720</td>
<td>16</td>
</tr>
<tr>
<td><strong>EBITDAR</strong></td>
<td>1185</td>
<td>27</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td>234</td>
<td>5</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>951</td>
<td>21</td>
</tr>
<tr>
<td><strong>Rent</strong></td>
<td>403</td>
<td>9</td>
</tr>
<tr>
<td><strong>EBIT</strong></td>
<td>548</td>
<td>12</td>
</tr>
<tr>
<td><strong>Exceptional items</strong></td>
<td>56</td>
<td>1</td>
</tr>
<tr>
<td><strong>Depreciation and amortisation</strong></td>
<td>237</td>
<td>5</td>
</tr>
<tr>
<td><strong>Earnings before interest and tax</strong></td>
<td>255</td>
<td>6</td>
</tr>
<tr>
<td><strong>Interest Expense</strong></td>
<td>189</td>
<td>4</td>
</tr>
<tr>
<td><strong>Profit pre tax</strong></td>
<td>66</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 1 reveals the average income and cost structure for the larger private elderly care provider operating companies. After charging all expenses to the income statement, the average elderly care op-co runs with very slim margins and in many cases, these companies run with negative earnings. These negative earnings are tax efficient. Losses accumulate to offset tax liabilities but, in the balance sheet, the op-co will record negative shareholder equity (net worth). For the op-co, the risk of insolvency is ever present because net operating margins are thin or negative and balance sheet capital reserves fragile.

After paying employee costs and overheads, the residual EBITDARM comes out at an average of roughly 27 percent of total revenue. It is these funds that would generally be transferred to a holding company, which would use them to cover the cost of capital invested, returns on rented of leases property and expensing of intangible assets such as goodwill. The hold-co will raise additional funds for the purchase of other companies up for sale and the process will repeat itself.

---

4. Source: Competition and Markets Authority Care homes market study financial analysis working paper.
2. **Financialising domiciliary care**

In domiciliary care it is difficult to separate out providers that are dedicated to just providing domiciliary care because most providers integrate residential and at home services. One characteristic that sets aside domiciliary care providers from their counterparts in residential care is that they are often tangible asset light, since they have less of a need to operate out of physical buildings/residential sites. However, as with residential providers, the provision of domiciliary care is being consolidated through ownership changes and acquisitions to inflate investor returns and asset value. In similar fashion to the residential elderly care providers, investors purchasing domiciliary providers will be paying a market value multiple to purchase cash earnings from acquisitions made.

In the resultant holding company, this results in a large intangible-goodwill item recorded on the asset side of the balance sheet. This goodwill represents the difference between the market value and book value of other companies acquired. This intangible asset (goodwill) tends to be very large relative to tangible physical property assets. After acquisitions/ownership changes are financed, there will also be a corresponding additional liability in the form of debt and/or loan financing. The goodwill recorded on the balance sheet will be amortised over a useful life expected by the directors of between 7-10 years. *This is an expense charged to the income statement.*

In addition, the outstanding debt that arises when one company acquires another at an inflated market value will incur interest payments as levels of debt outstanding increase on the balance sheet. *Interest payments will also be charged to the income statement.* These two charges set against revenues in the income statement can be equivalent to 25-30% of total employee costs. If market valuations and/or interest rates inflate, the additional financial pressure will be transmitted from the hold-co into the op-co income statement.

**Summary**

The financialised provision of elderly care in large privately run chains involves the buying and selling on of companies at inflated speculative market values. These market values are speculative because they rely on realising future cash flows to justify current market valuations, which are then expressed as a multiple: market value divided by cash earnings (EBITDAR). When one company acquires another or the ownership changes, the market value of the acquisition inflates asset values (intangibles such as goodwill), but also debt and/or types of equity funding employed to purchase the acquired company (such as preference share capital). The acquiring company will generally set up a hold-co to manage this capitalisation process and charge interest payments, rental and lease charges and amortisation of goodwill to the op-co. If speculative market valuations (capitalisation) run ahead of revenue growth, whether in elderly residential care or domiciliary care companies, this will inflate balance liability (interest payments) and asset expenses (rental, leases and goodwill amortisation) charged against earnings. This, in turn, will heighten financial instability and put stress on operations and service delivery.
**How is this relevant to Liverpool?**

**Home Care Commissioning Arrangements in Liverpool**

Liverpool prides itself on commissioning practices, which aim to avoid large provider chains. However, that does not make Liverpool immune to the effects of financialisation. Any provider competing within a contract tendering process is competing on the terms of the financialised providers – driving down staffing levels, employment conditions, training and standards in order to secure contracts.

Liverpool City Council has expressed a commitment to the minimum standards contained within the UNISON Ethical Care Charter and has increased payments to social care providers to support payment of the Real Living Wage. However, Liverpool does not contractually require providers to pay staff above the legal minimum rates provided by National Living Wage legislation. The Liverpool Framework for Help to Live at Home Services for Adults 2019 to 2022 General Specification includes the following provisions:

4.4.1 *The provider is required to be entirely responsible for the employment and conditions of service of the Staff…*

4.4.3 *The Provider will ensure that they pay Staff a minimum of the National Living Wage*

4.4.4 *Liverpool City Council is striving to be a Real Living Wage employer, and the Authority requires the Provider, and its subcontractors, to strive for this too. The Provider will therefore endeavour to pay care workers the Real Living Wage as set by the Living Wage Foundation.*

In the absence of any monitored and enforced requirement to set terms and conditions above statutory minimums, social care worker pay and terms of conditions of employment in Liverpool at outsourced social care providers can be assumed to be in line with national average rates. These are likely to be at or just above the national living wage of £8.21 p/h (over 25 years) with a heavy reliance on zero hours contracts and with all of the associated problems of recruitment, retention, turnover and high vacancy rates within the local social care workforce.

**Corporate Cash Extraction**

Whilst Liverpool may not currently commission any of the most recognisable financialised provider chains, that is not to say that Liverpool has prevented global corporations from extracting profit from limited social care funding.

A response to a Freedom of Information Request by UNISON shows that in August 2019 Liverpool Council worked with 23 providers of domiciliary home care for 2,151 clients at a cost to Liverpool Council of around £22m per annum. Around 60% of total funding goes to three providers – Homecarers (Liverpool), Local Solutions and Merseycare Julie Ann.
Homecarers (Liverpool)

Homecarers (Liverpool) received £3.5m p.a. from Liverpool to provide care for 415 clients. Their public accounts for December 2018 show a total income from UK sales of £6.2m and a cost of sales (in this case direct cost of provision of social care) of £3.8m leaving a total gross profit of £2.4m. From this, the company deducted £1.7m (28% of income) as administrative expenses (corporate overheads, etc.) and still managed to turn a healthy operating profit of more than £600,000. Homecarers Liverpool Ltd is owned by the Spanish company Clece. Clece Care has only been operating in the UK since 2013 but already operates 14 home care companies, employing over 4,000 staff, making it amongst the largest providers of homecare in the UK. Clece is owned by Actividades De Construccion Y Servicios S A - a giant multinational engaged in construction, infrastructure maintenance and facilities management. It had a revenue of €36.7bn and an operating profit of €1.4bn in 2018.

Unite members employed by Clece as support staff at Luton Airport took lawful strike action in July 2018 in their campaign against poverty pay and zero hours contracts. The Clece owned “Clece Care Service” in Gateshead received a damning CQC inspection report of inadequate. The inspection report stated: “The high volume of safeguarding issues demonstrated that people had been neglected and placed at risk of harm due to not receiving their care service...Concerns about staff turnover and resources, ineffective roster management and lack of a proper system to monitor visits meant people continued to be at risk of neglect...We concluded that the provider had failed to protect people using the service from abuse.” A subsequent inspection in 2019 concluded that improvements had been made but the service still “requires improvement” in the area of safety, mainly due to inadequate staffing levels.

Home Carers (Liverpool) last received a CQC inspection in September 2017 and at that time was rated as “good”.

Union members working for Homecarers (Liverpool) report a higher than average basic wage of £9 per hour but this is reduced significantly through the non-payment of travel time between client visits. In addition, as payslips are frequently incorrect and confusing, it is hard for workers to be confident that they are in receipt of correct pay, or even that their total pay is compliant with National Minimum Wage legislation. Call clipping (the requirement to cut the duration of scheduled visits to mitigate the impact of inadequate rostered travel time) is reported to be commonplace.

Local Solutions

Local Solutions is a very large charity with annual revenue of £13.6m. Their operating model means that corporate overheads appear to be much lower than Homecarers (Liverpool) (around £1.5m or 11% of income) but there remains a significant expenditure of £468,200 p.a. on directors’ pay. Local Solutions (Liverpool Branch) last received a CQC inspection in September 2017 and at that time was rated as “good”.
Merseyside Julie Ann

Merseyside Julie Ann has an annual turnover of below £10.2m and is therefore classified as “small” by Companies’ House and is only required to submit abbreviated accounts. In 2019, Julie Ann was commissioned by Liverpool to provide care for 540 clients at a cost to the council of £5.2m making it the largest single provider of homecare domiciliary services in Liverpool. Merseyside Julie Ann last received a CQC inspection in December 2017 and at that time was rated as “Good”.

Union members working for Merseyside Julie Ann report pay rates of £8.21 per hour, a failure to pay travel time, the extensive use of zero hours contracts and widespread call clipping due to inadequate rostered travel time. However, union membership is low as is workers’ confidence to challenge such practices.

Although only limited accounts are available they show the provider to hold £2.6m in assets, of which £2.2m is “cash in bank and in hand”.

Funding an alternative model

The discussion above shows how under the current outsourced model of home care provision, money invested by Liverpool City Council is diverted variously to company bank balances, highly paid directors, company overheads and the profit streams of a multinational company. The model is not delivering high-quality care and is based on low-quality employment standards.

An analysis of the level of funding currently spent on home care by Liverpool City Council shows that an alternative, high-quality model of provision is affordable.

Figures provided by the Council in February 2020 confirm 2019-20 forecast expenditure (based on actual hours provided) of £23,874,445 for 2,434 service users. To employ a member of staff on a 35 hour week at the future Real Living Wage rate of £9.30 per hour (from May 2020), or £16,926 p.a. would cost an employer (including National Insurance and basic pension contribution) £18,394 p.a. Even if the Council were to deduct 20% (or £4.75m) to meet overheads such as management, HR and premises costs, the remaining £19m could employ 1,033 full time staff at Real Living Wage rates or 10 full time staff for every 24 service users.

Currently, Liverpool Council re-ablement workers (whose role is generally regarded as being at a higher grade than domiciliary home care work) are employed at Grade 4 pay point 9 on the Liverpool NJC pay scale. Pay point 9 is also the rate of pay for top of Grade 3. With a full time starting salary of £20,344, the employer cost (assuming basic rather than local government pension contribution) is £22,386.50. At this rate of pay, and still assuming a 20% allocation for overheads, the council could employ 849 staff, or 10 full time staff for every 29 service users. To employ staff at top of Grade 3/bottom of Grade 4 and make an employer Local Government Pension contribution would give an employer cost of around £25,680. At this rate of pay, and still assuming a 20% allocation for overheads, the council could employ 740 staff or 10 full time staff for every 33 service users.
At present, the ratio of care workers to service users adopted by outsourced care providers is not known to the Council. One of the advantages of moving away from the current model is that it would allow the Council to plan on the basis of better information. It is nevertheless apparent that a new model of home care provision could be expected to deliver quality staff training and support in addition to ratios that are more than adequate, within current spending levels.

This paper is not advocating any specific pay point for the direct employment of social care staff but does seek to demonstrate that even before savings such as cost of procurement and contract monitoring are realised, or before the potential to access additional resources through joint NHS working is considered, the council does have a substantial financial envelope from which to re-design the delivery of social care and raise the quality and dignity of service provision.

**Show me the money...**

The chief argument used against insourcing adult social care is that we cannot afford to do it and the private sector can provide a cheaper and affordable service. As we have shown above, this argument rests on the smoke and mirrors of financialisation. As has been demonstrated, Liverpool could afford to insource a significant portion of the contracts currently outsourced to the private sector.

Here are some of the ways private social care costs us more than public provision:

1. **Tax evasion.** As the figures above demonstrate, larger chains manipulate their finances to avoid paying tax.
2. **Benefits.** Low pay is subsidised by benefits. Care workers amount to around 5% of the workforce, but a much higher percentage of low paid workers in receipt of Universal Credit, Housing and Council Tax Benefit. The Real Living Wage would remove this hidden subsidy to poor employers and reduce expenditure on benefits. Most, although not all these savings would go to central government.
3. **Procurement, commissioning and managing contracts.** Moving to insourcing adult social care would require increased management capacity, but on balance would save on the costs of procurement, commissioning and managing contracts.
4. **Perverse incentives.** Contracts with private providers create perverse incentives. The provider has no financial incentives to stop being paid for providing care, either by referring to the NHS where medical care is required or working with the voluntary sector to reduce dependence. The opposite is the case for public providers.
CHAPTER 3: THE LEGAL FRAMEWORK
GOVERNING ADULT SOCIAL CARE

The obligations of local authorities to people in need of care are set out in the Care Act 2014. A local authority must conduct an assessment of care needs to determine whether a person has eligible needs for care and support or whether a carer has eligible needs for support (please note these duties have been suspended by The Coronavirus Act 2020). It must conduct a financial assessment and has a duty to ensure eligible needs are met (The Coronavirus Act weakens this duty such that meeting of care and support needs is required where necessary to uphold human rights). Eligible care needs must be evaluated, and local authorities are obliged to calculate a personal budget for each individual, which identifies the cost to the local authority if it were to pay for care provision. According to the wishes of the individual and in line with legal rules, a personal budget can be managed by a local authority, or an individual service fund provider, or it may be paid as a direct payment to the requesting individual. It is by acting as a manager of a very large number of personal budgets that a local authority enters into commissioning arrangements with providers of regulated services.

The statutory guidance to the Care Act also locates some responsibility with local authorities for the quality of care provided, to the extent to which issue of care quality become safeguarding issues in respect of individuals with care and support needs and carers in need of support. Local authorities are responsible for safeguarding all vulnerable adults in their area, irrespective of whether the vulnerable adult is a user of care and support commissioned by a local authority. However, as commissioners of social care services local authorities have, amongst other duties, an obligation under the Care Act 2014 to have regard for the importance of fostering a workforce (in their local area) whose members are able to ensure the delivery of high quality services because, for example, they have relevant skills and appropriate working conditions. This is a statutory duty yet the undervaluing of care work and lack of attention to connections between care quality and job quality is widespread across the sector throughout England.

Guidance from the Department of Health and Social Care places responsibility on commissioning local authorities to ensure that they assure themselves and have evidence that service providers deliver services through staff who are paid sufficiently ‘so as to retain an effective workforce’. However, there is overwhelming evidence that the sector cannot recruit sufficient staff, cannot retain them, and that very high staff turnover levels has a detrimental impact on the quality of care provided in care homes and by domiciliary care providers. These problems are not those of ‘rogue’ providers, they are sector wide. It is consistently the case that private sector providers have much higher staff turnover rates than public sector providers.

Local authorities must assure themselves and have evidence that the services they commission pay wages, which are at least as much as the amount required by minimum
wage law. The guidance is also clear that the need for assurance and evidence includes assurance and evidence about appropriate pay for time spent travelling between appointments in domiciliary care. The evidence presented in this report illustrates how difficult it is to ensure that basic employment standards such as minimum wage provisions are met by providers with which a local authority contracts.

Local authorities are also expected to assure themselves and have evidence that fees paid to providers are appropriate for them to be able to deliver care packages with agreed quality of care, including the meeting of minimum wage requirements and the provision of effective training and staff development. However, local authorities do not have direct control over how such fee money is used when providers are independent organisations. The level of fees paid should be sufficient to allow retention of staff commensurate with delivering services to the agreement quality and encourage innovation and improvement. However, a local authority cannot compel a provider to use fees for such purposes. Even though it may potentially impose contractual requirements, including requirement within procurement and commissioning process, the local authority does not have day-to-day control of the activities of independent providers.

The obligations on care providers pertaining to care quality principally stem from the Health and Social Care Act 2008. Providers of regulated services such as domiciliary care providers and care homes must register and maintain the requirements of their registration in order to be able to lawfully provide regulated services. The rules of registration apply irrespective of whether the services are conducted directly by a local authority or by an independent provider. Responsibility for registration and oversight of services lies with the Care Quality Commission (CQC). The CQC is a statutory body established by the Health and Social Care Act 2008. It has a statutory duty to review and investigate the quality of regulated services. The CQC Registration Regulations 2009 require CQC to keep information publicly on registered persons and regulated activities. The CQC has powers to cancel registration and it must publish information about its enforcement action. The legal standards required of care providers in England are laid down in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These set out the ‘fundamental standards’ that are to be met by registered providers and additionally require all providers to ‘have regard’ to guidance issued directly by the CQC. Standards are enforced through a combination of criminal law penalties, including the issuing of penalty fines, as well as potential for the removal of a providers’ registration. The fundamental standards include a requirement to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet all the requirements of the fundamental care standards. Providers must provide care in a safe way for service users and must do all that is reasonably practicable to mitigate any risks to the health and safety of service users. Concerns about service staffing levels and manageable workloads are a highly relevant consideration in the provision of safe care. Risk assessment for all service users are required and CQC guidance includes an expectation that the planning and delivery of care should include arrangements to respond appropriately and in good time to the changing needs of individuals. Issues of working conditions are intimately connected to those of care quality. For example, a
failure of providers to provide adequate time for effective handovers between shifts might constitute a breach of requirements for safe care and for the safeguarding of vulnerable adults. However, it appears that matters pertaining to working conditions tend to be overlooked within the current regulatory system because matters of employment are perceived to lie outside the responsibilities of the Care Quality Commission.

Local authorities who are providing regulated services are bound by the same regulatory requirements as are independent providers. As a registered provider, a local authority service would be subject to the same system of inspection, investigation and review by the Care Quality Commission, as are independent providers. Direct provision by a local authority gives the authority the ability to directly manage and control the quality of care provided and the policies and procedures in place to do so. There is evidence that care provided directly by local authorities is of a higher standard than care provided by large private sector organisations, and that evidence is international.

During the coronavirus pandemic it has been apparent that fundamental standards protecting the safety and wellbeing of people in need of care and support have not been met by care providers. However, the Care Quality Commission suspended its systems of normal inspection from 16th March 2020 as a measure intended to reduce bureaucracy and enable providers to focus on the provision of safe care. Evidently, care has not been safe in a large number of care settings. Notwithstanding the issue of exposure to Coronavirus and consequent risk of extreme harm or death, staffing shortages present considerable difficulties for the meeting of regulatory requirements. For example, service users must be protected from abuse and improper treatment. Time and staff-level implications are particularly apparent because care must not be provided in a way which is degrading for the service users and systems and processes must operate effectively to prevent the neglect of service users. CQC guidance expects that staff have enough time in their working schedules to ensure care is not provided in a degrading way. It also requires that care and treatment is planned and delivered in a way that enables all a person’s needs to be met, including sufficient time to provide care and treatment in accordance with the person’s assessed needs and preferences.

The potential for local authorities to provide higher standards of care and to diligently adhere to the requirements contained within the fundamental standards lies with the ability of local authorities to take responsibility for the basis upon which care workers are employed. It is by attending to the intimate connection between care quality and job quality that local authorities have the potential to secure true value for money from their funding of care and support services.
CHAPTER 4: CHALLENGES AND OPPORTUNITIES FOR INSOURCING

Defining insourcing

In this section we consider the issues involved in insourcing social care. Whilst the term has been used to define ‘remunicipalisation’, for the purposes of this section we draw upon the definition provided by ‘Rebuilding Capacity: The Case for Insourcing Public Contracts (Baines, 2019)’, which is:

“to ‘insource’ in UK local government…. is widely accepted as the cessation of a previously outsourced contract and the re-establishment of the service under the direct operation and control of the local authority”.

A similar definition was used in the Labour Party Community Wealth Building Unit document ‘Democratising Local Public Services: A Plan for Twenty-First Century Insourcing’ which used an outline draft clause in a proposed Bill to suggest that insourcing was:

‘to revert from contractual delivery of a service to direct delivery of a service by a local authority’.

In other words, the approach to insourcing is strongly defined by the role of the local authority, including democratic accountability for local public services. The loss of democratic accountability is a core criticism of outsourced contracts as it limits the ability for local elected members to influence the shape and scope of local services to the confines of a contractual relationship.

Can care services be ‘insourced’?

Council provision of care services is heavily regulated. There are requirements to ensure the availability of suitable provision, work within statutory guidance as to what those in need of care might expect, and ensure fairness in access to care services, alongside the safety of the services being delivered.

Outsourced contracts typically set out to ensure that these measures are in place with contractors. But there are concerns about how outsourced contracts are delivered. The limitations in funding often lead to service rationing, with an increasing number of people falling outside of the parameters to access the care that they might otherwise need.

A traditional model of care, even into the late 1980s and early 1990s, included a role for the local authority as a direct provider. This included both residential care provision and ‘home
Ongoing public spending cuts in the 1990s hindered investment in residential care and cost pressures in domiciliary care led to outsourced contracts. This was driven in the main by market ideologies and funding shortages. The idea of new delivery models, such as removing welfare catering (meals on wheels provision) and inflexibilities to respond to new service pressures, also played a part. One example was the growth in twilight hour care needs with an ageing population. The traditional care model limited available care hours to a relatively short day. But more older people simply did not want to be ‘put to bed’ at 7.00 pm, and given traditional local government terms and conditions it was difficult to extend working hours to meet new service demands. The advent of personal care budgets also created further pressures. The economies of the council care budget was impacted by effectively allowing care users to purchase care packages, personalised to them against an individual budget. Central government advice (this time under the Blair Government), effectively prevented councils being the provider of personalised budget care packages.

There is scope for local councils to directly provide care services, both residential and domiciliary care. The usual standards of inspections, quality, fairness in accessing care, the financial contributions of the local authority, must of course always apply, whoever is the ultimate provider. Nevertheless, there are different barriers to insourcing – none of which should be viewed as insurmountable.

**Insourcing domiciliary care**

The way in which domiciliary care was initially outsourced is a barrier to insourcing. In most cases of outsourcing, work was placed into a clearly defined contract, the scope of the work was obvious, and so too the pricing mechanisms and specifications for work. For example, in a refuse collection contract the number of households to be served, how frequently bins are to be collected and the waste streams within scope of the contract are clearly defined. The workforce undertaking the service is easily identifiable and generally (in later years of outsourcing at least) TUPE was applied to that group of workers. TUPE stands for the Transfer of Undertakings (Protection of Employment) Regulations and its purpose is to protect employees if the business in which they are employed changes hands. Its effect is to move employees and any liabilities associated with them from the old employer to the new employer. In the event of the contract failing, the work falling under the contract, the workers and the contract cost is reasonably identifiable; the contract can therefore be effectively picked up and ended, with the work being brought back in-house or insourced.

In domiciliary care, contracts were not offered to the market with any degree of homogeneity. Because demand is so variable and so changing (people will age, care needs will often
continuously evolve) prices were sought for spot purchasing care hours, with some scalable discounts. However, as in-house care workers worked across different service users, in place of TUPE councils often absorbed the costs of what would otherwise be a redundancy situation through redeployment. Rarely were contracts outsourced in a way which provided sufficiently large contract awards to identify a group of workers. This historical position means that the care market in domiciliary care is particularly fragmented. It is therefore not possible to simply insource contracts as is the case with more readily identifiable outsourced contracts. This presents a number of barriers:

- Unlike most insourcing where capacity to run the services is readily delivered by a TUPE transfer of the workers from the existing contracts, in the case of care contracts they effectively fall out of scope for TUPE to apply. This means capacity to deliver the service is not guaranteed upon insourcing.

- There has to be a guarantee of service continuity even if a new provider is needed – the service cannot be paused to allow a different model to be established or risk non-delivery from day one. A missed bin collection is not as critical as a missed care call.

- This means capacity to deliver has to be rebuilt before the contracts (spot purchased hours) can be insourced.

- To insource domiciliary care a shadow in-house service needs to be established in advance but before the monies spent on outsourced contracts can cease. This creates a double-funding issue initially drawing upon the care budget.

- As councils have reduced direct delivery, the capacity for managing the domiciliary care service has been hollowed out. So alongside frontline workers, internal management of the operational side of delivery, training capacity to ensure service quality, as well as inspection and reporting standards, need to be in place and thoroughly re-established before outsourced contracts can be ended.

Given these barriers, insourcing domiciliary care might be deemed ‘too hard to do’. However, there are other approaches to consider. Given the benefits of insourcing, both in cost and outcome terms, the local authority may consider the initial investment needed to create in-house capacity as essentially a spend to save approach. The rebuilding of capacity in these circumstances means that you would typically need to:

1. Agree the structures and an initial volume of hours to be delivered – for example, 10% or 20% of the current contracted-out hours and what capacity would be needed to deliver those hours and within what work schedule.

2. The type of work to be delivered – low, medium or high care needs – again this might be influenced by volume issues and costs.

3. How this could be produced operationally – recruitment, worker training, management and supervision arrangements, operational requirements.
4. Central service development - pay roll, IT, workforce, HR and finance functions.

5. Where will the service sit? It may be that the most appropriate place is within the social services department, but this need not be the initial ‘landing platform’ to re-establish a service. A wholly owned trading company could be used to incubate the newly formed company or another council department if delivery capacity is not available within a traditional departmental setting (not withstanding regulatory requirements).

This suggests something of a wedge-shaped return to insourcing care. The internal capacity is tested before it is expanded. The contract hours that follow can therefore be reconciled against a review of the existing provider arrangements. The most troublesome may be the ones to return in any calendar of review on the care contracts. But the ones that are easier to manage might be preferable, allowing the service to test and tweak its offering before further roll out.

It will be essential to develop a committed project team to deliver it. There may be a need to recruit suitable qualified managers to run the service or interim management arrangements pending full recruitment. This would enable the direct service to be ready in place. There is a further benefit to this option, which is that even if there is relatively small delivery capacity in-house at this stage, it helps to minimise risk. For example, in the event of a provider collapse (increasingly likely given the health pandemic care crisis) the local authority would be in a position to scale up its activities very quickly, by recruiting the workers from any collapsed care company very quickly to ensure service continuity. This model of upscaling was used by many authorities during the collapse of the Carillion contracts.

**A social value or community wealth framework to insource**

For clarity, there is little point in insourcing any contract to mirror the failed market models of care. From the outset, therefore, a key driver in direct care provision would be:

- To improve outcomes for service users; achievable through care continuity and better workforce retention.
- To better reward care workers providing localised training, development, and a stable workforce.
- To de-risk the local care market by rebuilding capacity to safeguard care users in the event of contractor collapses.
- To control pricing in a more integrated way – using prevention as the anchor for the service and encourage extra support provided by the voluntary and community sector.
- Creating a holistic approach to older peoples’ services – through housing provision, leisure and culture and community-based services. To ensure that the way some services operate enhances the experience of the older service users, rather than the potential for services to exacerbate problems due to the lack of integration with contract providers.
What about Residential Care?

Residential care provision is in serious jeopardy. More so since the advent of the pandemic. The volume of deaths in care homes has left empty beds that currently cannot be filled. Given the finances of care homes and the sector’s reliance on asset investors, who are rapidly leaving the marketplace, this has created further pressures on cash flow and the overall sustainability of the business model.

For similar reasons to domiciliary care, there are benefits in local authority direct delivery. However, like the current contractor model, the costs tend to be dependent on the availability of self-funders as a ratio to local authority funded beds. It would be wrong to make any assumptions as to what that ratio would need to be in advance of a detailed business case, but this would of course then involve a market analysis of the local area and be highly influenced by any changes on the care cost cap (should this materialise).

Asset investment

A key difference in residential care, compared to domiciliary care, is that capital is needed to purchase and develop the care home. This may be to create a new build facility or purchase and refurbish an existing building. Whilst revenue is under severe pressure, in terms of the running costs of council services, low-cost capital lending, under the Public Works Loans Board, has been readily available. In a bid to inhibit councils borrowing to invest in assets for investment, the Government announced increases to the PWLB shortly after taking office. They have also commented on the likelihood of not considering commercial losses brought about by the health pandemic as being within the scope for consideration as to how council finances may be addressed by any Government ‘rescue’ schemes. The message from Government is that it is not risk-free borrowing. That being said, interest rates remain low and accessible. Based on the differential costs of public sector borrowing and the higher rates of return expected by private equity care home chain owners, the Foundational Economy Group estimate that the capital costs per bed per week is £100 less for the public sector.6

Of course, once a residential home is established its business case would still need to ensure its revenues were sufficient to carry the facility forward. In places like Norfolk, Norse Care Ltd offers residential and nursing care, short-term reablement services, dementia services, care homes for adults with a physically disability, and housing with care schemes across the area and is seamlessly integrated with social worker referrals.

This model would allow for:

- Integration with housing policy for older people.
- Future service planning for care needs with step up facilities in place without moving providers.

6 Foundational Economy 2018 p. 67
• Integration with leisure, culture and other ancillary services to support residents.
• Training facility for both domiciliary and residential care workers.
• Career progression – a key barrier to care workers.

**Insourcing residential care**

Unlike domiciliary care, the development and planning of a residential facility may be slow to come to fruition. However, a care home provider that is in trouble and is potentially gearing up to leave the market may open up an opportunity for facilitating a purchase of both the physical asset and the ‘business’. This may be an option to consider as the health pandemic deepens the crisis in residential care. As a power of first resort the local authority may look to the General Power of Competence, under the 2011 Localism Act, to facilitate the purchase, though due legal advice should always be sought.

**A final word on costs between outsourced and insourced care models**

There are no guarantees that in-house domiciliary care or residential care provision will be cheaper when looking purely at costs such as wages, pensions, training and so forth. However, a fair comparator of costs between outsourced and insourced models should include the hidden costs of outsourcing and failure demand inherent in outsourced models. It should also include the management costs of contract performance monitoring and, most importantly, a risk analysis of market failure and capacity to intervene.

Future proofing the service will not treat care services in a cost silo but look at how better integration, across all council and other public services, could better meet need, and do so in a more cost-effective manner in the longer term.

**Proposal 6:** Create a Local Authority Trading Company (LATCO) or use an existing one as a vehicle for delivering adult social care services to pilot the options outlined above.

**Proposal 7:** Develop a shadow management structure capable of taking over existing domiciliary care contracts as they expire, either through a LATCO or as direct council employees.
Our panel was conscious of the need to look at different ways of delivering social care that could improve service provision and workers’ conditions, as well as to explore ways in which the voluntary sector could complement insourced delivery. The examples we looked at have a number of features, usually combining more than one:

- Devolving decision-making to carers and co-design with those being supported.
- Integrating nursing and social care.
- Community based schemes promoting activity and wellbeing.
- Social innovation in residential care.

**The Buurtzorg model**

Buurtzorg is a pioneering healthcare social enterprise established 14 years ago in the Netherlands with a nurse-led model of holistic care. The founder of Buurtzorg Nederland, Jos de Blok and a small team of nurses, based Buurtzorg on the idea that the notion of “public service reform” had fundamentally undermined their relationship with patients, compromising their vocation that had brought them into the nursing profession in the first place.

The model empowers nurses to deliver care based on a service-user’s need. The model has better pay and conditions for workers, reducing the number of administrators and flattening management structures, and it devolves decision-making to nurses and service-users. This results in higher costs per hour, but fewer hours in total. By changing the model of care, Buurtzorg has delivered a 50% reduction in care hours, improved quality of care and raised work satisfaction rates for employees. Buurtzorg has low overheads because of its flat structure (8% compared with 25% in comparable organisations). In the Netherlands, Buurtzorg now has over 10,000 nurses in 850 teams, supported by 15 regional coaches. It is now active in 24 countries, including England, Wales, Scotland and the Republic of Ireland.

The model is based on the following underlying principles: self-management, continuity, building trust relationships and establishing local networks. The model starts from the service-user’s perspective and works outwards to assemble solutions that bring independence and improved quality of life. It assumes that people want control over their own lives for as long as possible, that people strive to maintain and improve their own quality of life, and that people seek social interaction and relationships with others.

The social care professional under the Buurtzorg model seeks to build a service-user-centred solution, taking into account their living environment, family networks and their informal networks, like friends, wider family, neighbours and other professionals working with the service user.
Buurtzorg teams are self-managing and nurse-led with professional freedom and responsibility. A team of 12 work in a neighbourhood, taking care of people needing support in that area, as well as managing their own work in that neighbourhood. A team will find its own office in the neighbourhood and work with stakeholders in the area, like GPs and other professionals. The team themselves decide how to organise their work, share responsibilities and make decisions. Buurtzorg teams are entrepreneurial and continually improving.

The Buurtzorg model is in stark contrast to the standard model of social care provision in England where health and social care are provided by two entirely different, and often conflicting, systems. People requiring home care are often seen by multiple staff members. The care that is provided is stipulated by strict protocols for health and limited by tight time restrictions and a Taylorised, one-size-fits-all approach to social care. Staff in both health and social care work in very hierarchical management structures, often stifling innovation and the ability to mobilise the full caring skills of staff and the motivation to support service users.

These differences constitute considerable barriers to the adoption of the Buurtzorg model in the UK. As with other approaches we discuss, gradualism makes sense. One route towards this is offered by the North Monmouthshire Neighbourhood Care Network discussed below.

**North Monmouthshire Neighbourhood Care Network**

North Monmouthshire Neighbourhood Care Network in South Wales has a registered population of just over 47,000 people with eight GP practices operating in the cluster area. It covers a relatively affluent area, but one with several challenges including increasing overall population and projected ageing population, leading to existing and increasing pressures on service delivery and difficulties recruiting staff. North Monmouthshire NCN has adopted a model based on some of the underlying principles of Buurtzorg, albeit not nurse led. It involves budgets devolved to small clusters and flatter management hierarchies based around specific identified shared priorities, which include delivering care closer to home, tackling loneliness and social isolation, and building sustainable primary care models in the face of a growing population. There are six North Monmouthshire Care teams developing personalised, one-to-one support.

**Appendix 4**

**Joint Trusts**

A different framework is to create joint trusts between hospital trusts and local councils. This could hope to deliver the ‘Holy Grail’ of allowing funds to be transferred from hospitals to preventive care. We have not had the opportunity to seriously explore this option. However, it raises a number of broader questions. There are issues of local democratic accountability with NHS trusts: there isn’t any. This must be a concern if responsibility for managing a key local service, absorbing a high proportion of local councils’ budgets, is
handed over to an unaccountable body. The other call for caution is the poor record of the NHS in shifting resources from high tech hospitals to primary care. It is well established that a disproportionate part of the NHS budget goes to acute care at the expense of primary care and public health. A major shift in resources would lead to better health outcomes and save money. This has been known for over half a century, but little has changed. Why should it be any different for adult social care? We propose that the Metro Mayor explore a pilot in conjunction with NHS Trusts to deliver a joined-up approach to social care, with democratic accountability at its centre. However, this may best be preceded, as we also suggest, by trialling a variant of the Buurtzorg model, which could make financial transfers and integrated care more viable.

**PSS and Shared Lives**

Shared Lives is a personalised alternative to home care and care homes for disabled adults and older people. It is used by around 15,000 people in the UK and is available in nearly every area. Shared Lives was formerly known as “Adult Placement”, founded by PSS in 1978. PSS are the foremost providers of Shared Lives in the UK and the main provider in Liverpool. Shared Lives matches adults needing support with carers who are able to support them, often in the carer’s own home. It might be short-term to enable someone to move from foster care into independent living, or someone looking for 24-hour supported living within a family home environment. The benefits appear to be many for all concerned and can provide stability and security for the service users and an income for the carer. Carers are paid an allowance and the service users contribute to their keep.
### Table: Elements of Fee

<table>
<thead>
<tr>
<th>Element of fee (all are weekly)</th>
<th>What's it for?</th>
<th>Who pays whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer Fee</td>
<td>This is usually banded based on the need of the person being supported - at PSS they use Low, Medium, High and Exceptional. LCC currently use just one band but may be planning to move over to banding soon. At the moment it’s around £330 for LCC</td>
<td>LCC/person being supported to PSS to Carer (depending on who is managing their budget)</td>
</tr>
<tr>
<td>Management Fee</td>
<td>This is the fee paid to PSS for the carer recruitment, monitoring, quality assurance and matching etc. and is the only part of the fee PSS retain. £86 from April in Liverpool.</td>
<td>LCC to PSS</td>
</tr>
<tr>
<td>Lodgings/Rent</td>
<td>This is to cover rent and in the vast majority of cases comes from Housing Benefit. This is usually a standard figure per Local Authority area. At the moment it’s around £78 in Liverpool.</td>
<td>Person being supported – Carer (in some other schemes across the UK this is done by the provider – i.e. PSS equivalent. However PSS are very clear that this is about an individual having personal control of their money so they support anyone who joins the scheme to setup a bank account to ensure this is totally under their/their advocate’s control.)</td>
</tr>
<tr>
<td>Household Costs (sometimes called ineligibles)</td>
<td>This is the money the supported person pays to the carer from their own monies (benefits or personal funds) to contribute towards household bills, food etc. It is around £45 per week at present I think.</td>
<td></td>
</tr>
</tbody>
</table>
placed in residential care, or an annual saving of £11,922 compared to Supported Living.

These figures are broadly in line with a Social Finance UK report, which identified a potential cost-saving of approximately £26,000 per Shared Lives placement (Investing in Shared Lives, 2013, Social Finance UK). Service users are currently referred through social workers. PSS can quickly identify whether an individual needing care would suit this programme. Carers offer their time and home and are not necessarily trained care workers by profession to start with, but rather people willing to offer their time and home to look after someone, often long term.

The carer recruitment process is very robust, so PSS can be sure they are taking on exactly the right kind of person for this role. Training in professional caring skills is provided once other assessments of suitability have been made. The key to a successful placement is finding the right match: is it long or short term care? What is the nature of the care needed? What commitment can the carer offer? And, of course, do the carer and service user bond? From the range of carers in their employ, experienced Support Workers can identify which individuals/families would be a good match for any given service user.

There is of course a company structure, with management, administration and support workers who oversee the placements, but the carers themselves take the place of ‘staff’ in the traditional care-worker sense. This model therefore moves away from the clock-watching, paid or not paid travel time, inconsistency of care set-up of traditional care plans, and appears to put a genuine focus on user-led decision making. However, it’s not a quick fix. While a care worker can simply be allocated another visit on their rounds, with Shared Lives some time is needed to identify new carers and get the right match.

This type of care could be a far bigger part of the mix of social care options available.

**Wheel Meet Again**

Wheel Meet Again is a lottery funded project designed to engage with lonely/isolated older people 7 days a week. The project began in 2013 and has reached 850+ beneficiaries. The active ageing project gives ownership to members who make the decisions via a steering group on the activities that engage their interests. Its unique selling point is the provision of a door-to-door transport service – via a fleet of disabled friendly minibuses – for members who have mobility issues.

They are a city wide project with a diverse eclectic membership, many of whom are referred by GPs and other health providers. They run classes in I.T, Arts & Crafts, Ukelele, and Creative Writing, to name a few, at their base in Mill Street, Liverpool 8. They also provide day trips to places of cultural and historical significance. Many members have been with them since the outset. They feel their members are like family as they foster a real sense of belonging.

**Foundational Economy model in Wales**

This takes as its starting point the contribution of social care to the local economy. It then
Chapter 5 looks at a number of steps to develop a more ‘collective approach’:

- Piloting social care experiments in different parts of the country and bringing together those involved to learn, share and scale up what works.
- Shifting the culture of commissioning to create longer term trusting relations between commissioners and providers, providers and providers, employers and workers, professionals and citizen users.
- Reducing the influence of financialised chains and supporting SMEs.
- Piloting initiatives in residential care to take advantage of the lower borrowing costs of the public sector for capital investment.

In discussions with the Foundational Economy Group they have expressed a willingness to work in a support role with councils to deliver diverse experiments, initially in clarifying the pluses and minuses of different choices. Having worked with Welsh adult care experimenters they would be interested in setting up a formal network of adult care experimenters so that they could learn from each other.

Appendix 5

Holtham Report on Paying for Social Care

In 2017 the Welsh Government commissioned an independent report, Paying for Social Care by economist Professor Gerald Holtham of Cardiff Metropolitan University, to examine the economic case for a contributory tax or levy to fund social care, using the specific tax-raising powers of the Wales Act 2014. Holtham set out the case for Welsh taxpayers to contribute a proportion of their income to a social care fund, ranging from 1% (for those aged between 20 and 30 when they begin contributing) to 3% (for those over 60) of their income according to their age. The report suggested that people with assets (often family homes) should be able to retain a greater proportion of them in return for making contributions.

The Holtham Report also acknowledges the fact that wages for care workers are too low and that this needs to be addressed to improve quality of care and deliver sustainable levels of care in the future. Some of the funding raised would be used to support immediate pressures on social care, with the bulk invested in a fund to meet future needs. Holtham envisages that a socialised social care fund could grow to over £3 billion in the 2030s, allowing the projected social care spending gap to be bridged.

It is worth stressing that the Holtham recommendations are specific to Wales, using new powers given to the Welsh Assembly to introduce new taxes and vary the basic rate of income tax. The systems for funding social care currently in place in England and Wales are different. In England, people with savings above £23,250 must pay for their own care. For residential care, their home is included among their assets when assessing wealth. The UK Government has set out plans to introduce a cap in England of £72,000 for expenditure on care and an increase in the capital threshold to £118,000 for people with property and £27,000 for those without. In Wales, a capital limit of £24,000 currently applies for non-residential care and a threshold of £40,000 (rising to £50,000 by 2021) for residential care.
Such tax raising powers do not currently exist outside Scotland and Wales, but could be extended in the future to Mayoral Combined Authorities like Liverpool City Region. These could be used to establish a social care fund for the Liverpool City Region in the future, to address local pressures and fund a social care system that is sustainable and fair.

One of our recommendations is for the City Council and the City Region Metro Mayor to ask the government for new tax raising powers to meet the rising costs of adult social care. This could be explored in a pilot of a new local income tax. While it might seem unlikely that the current government would embrace such an idea there are reasons it might prove attractive. It would allow central government to offload responsibility onto local government and avoid the difficulties associated with levying new taxes. For local government there are clearly risks but also advantages:

- We are responsible anyway;
- It might help us off the financial cliff edge;
- An income tax would be both equitable and perhaps acceptable. Cuts in social care affect rich and poor alike so it might cut through resistance to taxation.

**Problems and possibilities:**

We highlight two examples of initiatives delivered by voluntary sector organisations delivering services differently from traditional domiciliary or residential social care. Provision of services by voluntary sector organisations is an important part of the range of options in adult social care. They are not an alternative to public services but are complementary. In particular, they highlight the difference between traditional care services provided by the public sector and private care services. While the former have every incentive to encourage innovation and referrals to the voluntary sector, the latter are incentivised to retain existing clients or residents.

**Proposal 8:** Accept the offer of the Foundational Economy group to work on pilots delivering different models of social care, including those suggested below.

**Proposal 9:** Devise a pilot in conjunction with voluntary sector organisations and the Foundational Economy to promote innovation, rehabilitation and referral to voluntary sector organisations.

**Proposal 10:** Devise a pilot to trial a variant of the Buurtzorg model or the North Monmouthshire approach.

**Proposal 11:** Devise a pilot in conjunction with the Metro Mayor and NHS Trusts to deliver a joined-up approach to social care, with democratic accountability at its centre.

**Proposal 12:** Devise a pilot with the Metro Mayor to deliver a new training programme for social workers, nurses and care workers to support these.

**Proposal 13:** The City Council and the Metro Mayor should approach the government to run a pilot exploring new ways of funding social care.
The Covid-19 pandemic has brought widespread public appreciation for care workers. At the same time, it has exposed the harsh reality of a fragmented and privatised sector reliant upon the exploitation of an undervalued and precariously employed workforce to deliver vital care services on the cheap. Despite the mental, physical and emotional skills and effort involved, social care is not recognised as skilled work. There is little career progression and a severe lack of training. Breaches of employment rights are commonplace and pay levels sit at or around the national minimum wage. Staff turnover is high resulting in shortages, inadequate staff to service user ratios and a lack of continuity of care for vulnerable service users.

Many social care providers have reaped the rewards of a steady source of public funding for many years. In addition to holding down pay and employment conditions within the sector, there is no evidence that those providers took seriously their responsibilities to protect service users during the early stages of the pandemic.

This crisis demonstrates that councils can never outsource their statutory obligations, liabilities and risks. However, in commissioning services Councils do cede control and thereby undermine their ability to intervene to protect standards and mitigate those liabilities and risks. This became even more urgent with the introduction of the Coronavirus Act 2020 and the accompanying announcement that social care standards and CQC inspections of providers had ceased. As Coronavirus took hold and Public Health England issued guidance for the use of PPE in community and social care settings, who was monitoring adherence to guidance and standards of care within commissioned providers? No one.

**Impact on Care Homes in my Constituency**

_Paula Barker MP (Member of Parliament for Liverpool Wavertree)_

_In April 2020, I was the first MP in the North West (probably nationally) to speak publicly about the ticking time bomb in our care home sector as a result of the pandemic. One of the care homes in my constituency had several residents who passed away from Covid-19 very suddenly. It was reported at this early stage that 42 of the 66 residents were exhibiting coronavirus like symptoms. The care home was operating with only a quarter of its usual staff numbers and was also struggling to source agency staff. This situation was garnering significant press attention at both local and national level. As I feared and expected, we soon began reading and hearing about the many other outbreaks in other care homes up and down the country._
Successive Governments have failed to address the issue of social care. Problems have built up in the system over an entire generation with social care becoming the ‘forgotten service’ or alternatively the ‘elephant in the room’ – depending on how one looks at it. What has preceded us in the last decade is an austerity of resources and of reform, which is failing to keep pace with rising demand due to an ageing population. This public health crisis has shone a spotlight on a sector that has been neglected by policy makers at all levels and left to develop within the confines of an unregulated private sector.

Returning to the outbreak at the care home in my constituency, my staff team contacted all care homes in the constituency to ascertain the level of concern in each home, identify the current numbers of affected residents and monitor levels of PPE.

What became apparent is that the home in question was an anomaly and we have been unable to establish why the situation in that home was so much worse compared to other care homes in my constituency. It is unacceptable that we do not know nor are we even beginning to understand why this happened. We really must find ways of being able to openly learn the lessons and avoid such instances in the future. Now is not the time for organisational protectionism in my view – we must harness the lessons of this period to rebuild the social care sector under the guise of a bold and transformative vision fit for the 21st century.

And in the immediate short term? The scars that this crisis has left cannot and should not be underestimated. In all cases, but particularly at homes that have suffered large-scale outbreaks, maximum assistance must be provided to residents and their relatives. At all times stakeholders should be taking into consideration their views and wishes. This will undoubtedly include appropriate bereavement and mental health support for staff and relatives of residents. This is a crisis that has affected people and our response must be one that has people, rather than the notion of customers, at its core.

Covid-19 Care Worker Experience

On 23rd March 2020, the day that the UK lock down commenced, UNISON released a survey to care workers throughout the NW. Over 2,600 responses were received in two weeks. The survey responses were analysed by Professor Lydia Hayes of Kent University and the initial findings report was released on 15th April 2020. Key findings included:

- A large majority of respondents believe too little is being done by employers to keep staff safe from the risks of SARS-CoV-2 infection (69% of learning disability support workers, 60% of home care workers, 52% of residential care workers).
- A large majority of respondents believe too little is being done by employers to keep people using care and support staff safe (58% of learning disability support workers, 56% of homecare workers, 43% of residential care workers).
- 8 in 10 care workers believe that they would not be paid their wages as normal if they had to self-isolate (79% of homecare workers, 83% of residential care workers, and 67% of learning disability support workers).
- Government guidance assumes PPE availability, but care workers state PPE is often unavailable or unsuitable. Evidence from care workers shows how lack of PPE is a safeguarding issue and there are fears too about maintaining basic hygiene due to reported shortages of soap and hand sanitiser.

Responses from Liverpool care workers were no better. Indeed, of Liverpool Care Worker respondents

- 65% stated that they did not feel they had been provided with adequate PPE
- 82% were worried about getting ill
- 73% were concerned about infecting service users
- 50% were concerned they may not be able to pay bills or living costs due to Covid-19

---

**Impact in my constituency**

*Kim Johnson MP (Member of Parliament for Liverpool Riverside)*

The Government response to adult social care during the Covid-19 pandemic has exposed their contempt for this sector – residents and staff alike. While resources to equip frontline NHS provision were far too slow off the mark, the care homes and domiciliary care providers were ignored far longer.

There is evidence of care homes in my constituency where residents were discharged from hospital without being tested, going on to develop Covid-19 and infecting others. Initially care homes were overlooked in the provision of PPE and they were the last to receive testing – a situation still prevalent in some homes. Deaths in care homes were not originally included in official figures for weeks, a political move which demonstrates how insignificant our elderly residents, and the workers who care for them, are to this Government. It is unlikely that we will ever know the accurate figures for deaths in care homes or those who have died in their own homes or the total number of deaths of frontline staff working in care homes or the domiciliary care sector.

I have received reports from constituents that domiciliary care workers were particularly badly supported. They had up to 20 visits daily to multiple homes
without adequate, if any, PPE. High numbers of staff on zero hour/precarious contracts forced to continue working when they were vulnerable or should have been shielding to support their families because £95 PW SSP was inadequate, or they were not eligible for SSP. There has been a disproportionate impact on Black front-line key workers who have died from Covid-19, with staff putting lives at risk because they have little option to continue working.

Prior to the pandemic, front line key workers were described as low/unskilled, often undervalued, and significantly underpaid. These care workers provide daily support to a growing ageing population, with long-term health conditions including dementia. The sector suffers from a high turnover of staff; reports indicate that there is a national shortage of care workers to meet demand, linked to low pay, poor terms and conditions including no pay for travel time and inadequate training.

We need to re-evaluate the role of the social care sector. Liverpool Riverside constituency has 21 private care homes and 3 domiciliary care agencies, contributing to a very fragmented and diverse service sector. The Constituency consists of long established diverse communities; Somali, Yemeni, Chinese and Afro-Caribbean. However, care agencies and care homes are unable to meet their cultural and religious needs, other than the Chinese community. There is a dedicated care service with Chinese speaking carers who are able to meet their cultural needs.

The need to make profits for shareholders has driven down wages and quality of care. Now we have an opportunity to turn the clapping into a career that offers, as a minimum, the living wage, employment rights and protections, training and progression routes. While the government have relaxed the criteria for NHS workers under their new points-based immigration system, this will not apply to carers. The Government thinking is that all the UK workers who have lost their jobs because of Covid-19 will be willing to take jobs in the care sector.

Covid-19 has demonstrated what we all knew: privatisation has led the sector to the brink of disaster. The time is right to evaluate how we approach care and to bring these critical services under public control to improve the lives of both our elderly residents and the incredible people who care for them. We need a National Care Service synonymous with the NHS, which removes the fragmentation and provides a high quality consistent level of care for all those that require it.
UNISON has collated a large number of Liverpool care worker case studies of workers provided with insufficient PPE and/or who were unable to self-isolate or shield contrary to government guidance due to the poverty pay of £95 a week provided by Statutory Sick Pay. Specific examples were raised with UNISON by members working in Liverpool for Residential Care providers HC-One & CIC, Home Care providers Alpha Care, Home Instead, Liverpool Homecare Ltd, Mountbatten Care, Yes Care, Learning Disability providers Lifeways, Natural Breaks.

**A Liverpool Home Care Case**

“One of our Ladies has died, suspected coronavirus. More than 12 of us have had contact with her. I have had no face mask or hand sanitiser. I have been asking for weeks but they say I do not need it. I see 15 or 20 (service users) a day – I’m scared stiff that we’ve all got it and we’re spreading it to the clients”

**A Liverpool Residential Care Case**

“I usually buy my own hand gel because there’s never enough here but I can’t get any now so we all have to work without it. We were told not to wear masks because it would scare the residents but we have now had 11 deaths, which are possible Covid. Everyone is scared and stressed and then the managers are rude to us which doesn’t help”.

Care workers are so concerned because they are on the front line. Social isolation is not possible in any social care setting. Care workers know that each of them is a potential “super spreader” to the elderly and vulnerable that they work so hard to care for and protect – not to mention the threat posed to their own life and that of their families and loved ones.

That is why UNISON NW members developed the CareworkerVsCovid Campaign with four clear demands of council commissioners

**Protect Our Health** – Priority testing for care workers to limit the spread of disease to vulnerable patients and service users. Guarantee all essential training and personal protection equipment (PPE) to all frontline workers (e.g. goggles, masks, hand sanitisers, thermometers) in line with Public Health England guidance.

**Protect Our Pay** – Full normal pay for all those required by government guidance to self-isolate or who become ill because of COVID-19, in order to prevent unnecessary spread of infection. This includes all staff on zero hour contracts, bank/relief contracts or multiple contracts.

**Protect Our Employment** – Ensure no one is dismissed or laid-off for staying at home to care for themselves or their family. Absence due to COVID-19 should be excluded from absence management triggers.

**Protect Our Families** – Carers leave on full pay for workers caring for a dependent who has COVID-19 or for whom childcare is unavailable.
Liverpool Council Response

On 21st April, Liverpool Council delivered an impressive £6.2m financial resilience package for social care providers to meet the additional costs associated with Covid-19 and fund full normal sickness and isolation pay and additional PPE for social care workers. Liverpool was possibly the first council in the country to deliver such a comprehensive package. Nevertheless, these provisions were announced four weeks after the lock down, just as Covid-19 was already reaching its peak and much of the damage had already been done. Furthermore, although the model of commissioned social care provision did allow the Council to provide additional funding for providers to help cover associated Covid-19 costs, the Council appears unable to actually require commissioned providers to increase sick and isolation pay. At the time of writing, over a week since the announcement, there was still no contractually binding commitment on the part of providers to ensure full sick pay for Covid19 related absence or isolation and UNISON members are continuing to report sickness and absence pay at below 100% full normal pay.

Conclusion

The truth is that the commissioned model of service provision has been undermining standards of social care provision for many years. Covid-19 has highlighted this further by creating real barriers to an effective public health response to the outbreak. Social care commissioning has hastened the spread of Covid-19 and resulted in unnecessary deaths of social care service users and workers.

As soon as this crisis broke care, workers needed:

- Adequate PPE including conveniently located hubs for the disposal and collection of stock and advice and guidance on its usage
- Full Covid-19 sick and self-isolation pay to ensure that poverty did not prevent care workers from following isolation guidelines
- Covid-19 testing so that self-isolating care workers could return to the front line ASAP
- Full staffing to cope with increased demand at a time of increased absence

The current model of fragmented commissioned social care provision proved itself unable to deliver on any of these additional requirements until significant Council intervention and funding some four weeks later.

There can be no going back. There must now be an honest account and acceptance of the failings of the current system. We urgently need to reduce fragmentation and raise standards within the sector. This can only be achieved with more cohesive and direct public provision of social care services. Without radical action the Thursday night clap was a hollow gesture to the vital key workers, that have worked so conscientiously and tirelessly, often placing themselves and their families at great risk, in order to deliver the much needed front line care to our communities throughout the Covid-19 crisis.
Appendix 6

CHAPTER 7: FUNDING SOCIAL CARE

Introduction

Issues around funding social care have dominated media discourse during the Coronavirus health pandemic. For local councils, the dominance of social care funding, as a budget issue, is decades old. The prism of the pandemic has brought the perilous state of social care funding and its current fragmented market-driven delivery models to the fore. As much as public values have been recalibrated to understand the importance of health investment, and looking after society’s most vulnerable people, so too we see a more discerning public that now recognises that care services are every bit as important to national well-being as the NHS.

Council funding and social care

To fully evaluate the issue of social care funding it is worth considering the context of council funding overall. English councils are increasingly reliant upon two property taxes to fund local services. Over the last decade, successive governments have gradually withdrawn Revenue Support Grant (RSG), under the pretext of encouraging local growth through councils retaining more business rates at a local level. The public policy idea behind this is to reward councils growing local economies. However, the policy was flawed. It still needed to rely upon some form of redistribution mechanism to protect the most financially vulnerable areas, and the very basis of the policy would inevitably be stymied by the ‘four-way split’ of those councils that were:

- At a low starting point but with real options to seriously grow business rates;
- At a low starting point and with no real prospect of growing business rates;
- At a high starting point and with the ability to grow even more;
- At a high starting point but with no realistic prospects for further growth.

Methodologies to smooth the introduction of the business rate retention schemes were mired in controversy. Now we witness a further blow to this policy direction. The health pandemic has led to a projected seismic recessionary impact on the UK economy. Therefore, the whole basis of a tax reliant upon business growth and physical premises is seen as increasingly defective, especially since the projections are that this will significantly decrease demand for business premises as home-working is set to become further embedded in many business models.

The other main source of income is council tax. Like business rates, this is reliant upon property. In spite of its poor reputation as a tax created from the ashes of the poll tax, the basis of council tax has stood the test of time; the collection rate is high, it is difficult to hide a house and thus avoid the tax, and there is reasonable scope for local variations. However, the same socio-economic issues that affect business rate income viability also
affect council tax. Many councils have a much higher proportion of low value properties, with little opportunity for growth, and there is no correlation between local needs and the money that might be raised through council tax. Revaluation has been systematically disregarded for political purposes by different political parties over decades, effectively decreasing the overall ‘tax take’. In addition, restrictions on increasing council tax, imposed through the Localism Act 2011 requirements for a local referendum, have prevented viable increases, effectively continuing to ‘cap’ council tax revenues.

Relatively recent changes permitting some increases in council tax to fund social care, wrongly labelled as a social care precept, whilst allowing councils to raise much needed additional funding, were again distorted by local circumstances. This meant these changes were little more than a sticking plaster over a gaping funding wound:

- The amount that could be raised in relatively affluent areas was far greater than in poorer areas.
- Funding was inadequate even in affluent areas. Older people may live considerably longer than in poorer areas.
- There was a growing overall numbers of calls for care packages.
- Poorer areas, still with inadequate funding, find that care packages are growing for those with multiple and often complex needs. Thus, even the growth in life expectancy is uneven, and in some areas is in reverse.
- This creates different challenges in different ways and in differing circumstances.

Either on a combined basis or singularly, Business Rates and Council Tax are not fit for purpose and are failing to reflect social care funding needs.

**What about other service budgets?**

The gearing of council budgets towards meeting care costs, is increasingly needed to meet the funding gaps created within the current system. These have an adverse impact on council budgets for all other locally delivered public services. Whilst few residents will directly experience care services on a day-to-day basis they will typically interact with a multitude of other councils services. From school meals to having a bin collected, from a local park to a cemetery, these other services, collectively described as ‘neighbourhood services’, have been squeezed out of necessity to ensure social care services are able to meet statutory obligations. Neighbourhood services were found by APSE to account for 27% of council budgets but have also suffered disproportionate cuts, particularly in those councils with social care responsibilities. By 2016/17 the cuts to neighbourhood service budgets amounted to £3.2 billion. Austerity did not create equal misery in council service budgets; it created a higher proportion of misery in the very services the vast majority of the public experience on a day-to-day basis. This is not to deny that it was (and still is) a necessity to prioritise social care, but this has been done at great cost to all other council services. Moreover, this reduces other services to functionality rather than a much more holistic role in the health and wellbeing of local residents; for example, the role of parks in mental health and physical activity or the role of leisure and cultural services in maintaining active lifestyles, amongst older people in particular.
The financing of social care cannot be separated from the overall make-up of funding local councils, nor can it be addressed in a silo, since this approach fails to consider a much more integrated approach to care. This includes the spend on prevention services, not just within the social care envelope, but the ability of all council services to work towards the care and wellbeing of older residents. These need integrating so all council services can enhance the wellbeing of older people; a prism of efficiency that is often overlooked when driven by financial issues alone.

**How should social care be funded?**

Much has already been written by many expert organisations on the potential resolutions to care funding. However, a neglected area is the hidden costs of outsourced care; the financial modelling is framed within a marketised service provision.

Current thinking on future funding centres on five core themes:

- Improving the current system;
- A revised means test and a cap on care costs which was contained in the Conservative Party’s proposals at the 2017 general election;
- A single budget for health and social care with some controversy as to where this would sit (within the NHS removing local councils?);
- Free personal care;
- A hypothecated tax for social care.

A more detailed report by the King’s Fund explores these options in greater detail [Approaches to Social Care Funding](#), and given the detail of the funding arguments in this paper – which largely still hold true – there is little point in rehearsing these issues again. Ultimately, at the last General Election, the promise of a cross-party consensus on social care was raised yet again; but this was against a backdrop of wildly differing views on care.

In summary, the following extract from the King’s Fund report suggests that:

- **There is scope for making small improvements within the current system:** This approach would recognise the great difficulty successive governments have faced in achieving major reform. However, it would not address many of the fundamental problems with the current system, including the downward trend in the numbers receiving publicly funded care. Nor would it protect people against “catastrophic” care costs.

- **A cap on care costs:** The Conservative Party’s proposals would, for some, have resulted in a more generous system than the one currently in place. However, there are real concerns around implementing and operating such a complex system. There is also a question as to whether this would be the best use of additional funding for social care.

- **Joint health and social care budgets:** Whilst a joint health and social care budget might support progress towards more integrated care, it will not in itself address the differences in eligibility between the two systems, or generate additional revenue for health or care.
• **Free personal care** would mean increasing the government’s ‘offer’ on social care. However, given this would require an increase in public spending, there is a question as to whether this would be the best use of additional funding for social care.

• **A hypothecated tax** may help gain public support for raising additional funding for social care. However, this would represent a significant shift from the existing system, and could exacerbate the lack of alignment between health and social care.

Most recently, it was suggested that a cap on care costs, as proposed by the 2017 Conservative manifesto was being considered prior to the health pandemic. This suggested that proposals originally cited in the Dilnot Commission in 2011, introduced but then dropped by David Cameron in 2014, would be reintroduced by the Johnson administration. This was set to include a proposal to cap care costs at £72,500, as opposed to the current cap in England of £23,250, with anyone with assets over this value expected to contribute towards their care costs.

This proposal would have been potentially popular with some demographic groups but is still a long way from any truly sustainable funding solution for social care. Free personal care is already available in Scotland, albeit ‘hotel costs’ in residential care are still payable. Within England, it is estimated that free personal care would cost around £10bn (in the first year). Some care costs are already capped in Wales, whilst in Northern Ireland home care is free for the over-75s.

However, all of the funding problems, growth in demand and care supply issues are framed within the current narrative of care services continuing to be delivered by market-based models. Interventions in social care have largely been through (often failed) attempts to make market models fit into the restraints of public sector commissioning, contractual realities and a lack of capacity within the public sector to make meaningful disruptions to a model dominated by the interests of the ‘seller’. Therefore, any exploration of social care finance must focus on the exacerbation of the crisis in care driven by care markets.

**Markets and funding**

In England, residential and domiciliary care are both mainly delivered by external care providers. Whilst there are differences in the operating and financial structures of each sector, there are also many similarities, which inflate the cost of external provision of care.

Essentially these are as follows:

• Company operating models demand returns for shareholders, which focuses decision-making on the maximisation of profit.

• External contracts must be monitored and performance managed; the poorer the contract performance the higher the cost of monitoring. These represent hidden costs to the public purse, including management time for contract performance, commissioning and even payments such as processing invoices and running supplier sourcing and development days.
• Cost-shunt to the public purse is commonplace. Workers are often paid less than the Living Wage and rely upon public welfare funds to support them, whether in-work top-up welfare credits, council tax and housing support, or a lack of future pensions. Non-payment of travel time and sleep-in treated as outside of ‘pay’ is well documented.

• Lack of capacity in the public sector to intervene means that a response to market failure is often to go to another provider, which inflates costs. Markets are driven by competition but the fundamental flaws in care markets mean competition is not effective - driving a sellers’ market, with the public sector buyer forced into higher cost relationships with providers.

• Care services are constantly evolving meaning training is fundamental, but fragmented provision in the care sector means care training costs are inflated. Prior to mass privatisation the economies of scale in public provision meant training and development were provided by local councils directly.

• Lack of integration inhibits more fundamental reforms; even where care services are co-commissioned or there are integration models with the NHS. These are only superficial integrations, as the responses from the ultimate provider will be anchored to provider contracts, limiting interventions.

• Lack of investment in new facilities is evident. Many residential homes were purchased as assets for investment but, as care demand standards have changed, the returns on these assets have become less attractive, leading to a retreat in the assets’ markets and making future investments unattractive. Many notable large providers, such as Mears, have announced their retreat from the sector.

• Operating models rely upon full capacity in residential care but as local authority budgets have been squeezed, the ratio of self-funders to local authority beds has been placed under increasing scrutiny. Hidden from the public gaze there is a stealth tax by which self-funders are cross subsiding the local authority beds. This also creates a question of hidden regional distortions, impacting more on affluent areas in terms of the cost issues, but also making investment in poorer areas less attractive in residential care

• In domiciliary care the higher the volume of contact hours the more viable the business. This disincentivises the private provider from prevention-based approaches. There is a financial imperative to grow the numbers of care hours. However, the costs of growth in care hours are then met by the local authority. The model also disconnects the more integrated approaches to care, such as an enhanced role for the specialist support services in the voluntary and community sector. Since they are dealing with multiple contracted providers and a high turnover of care staff, coordination is difficult and cumbersome.

All of the above creates hidden and avoidable costs to the public purse. Whilst many councils have adopted a ‘community wealth’ approach to service delivery, ensuring social
value outcomes and local spend from their activities, social care remains an elusive part of the jigsaw. In part, this too is down to financial restraints. Whilst services are costing more overall, such is the current funding that investing in future provision is highly constrained. Again, there are different constraints in residential to domiciliary care.

**Residential care**

Developing a public sector option in residential care will require investment through upfront capital in the asset. This would need to be of a sufficient scale to be a viable business model, and is likely to include, in the absence of more fundamental funding reforms, some capacity for self-funders. Whilst revenue streams will of course need to be secured once operational, the initial capital is arguably easier to come by through the Public Works Loans Board than through additional revenue.

**Domiciliary care**

This is obviously dependent on revenue streams to fund the care packages currently in place. Therefore, one difficulty in re-establishing a public sector service is that this may essentially mean ‘double funding’ to continue existing provision whilst creating new direct delivery capacity. In the section on ‘Insourcing Care’ ways in which this could be achieved in both residential and domiciliary care were explored in more detail.
CHAPTER 8: THE NEXT STEPS

We began by looking at the crisis in social care and ways in which the public interest and management can be restored to a more central role in the provision of care. There is no escaping the fundamental nature of the crisis facing the sector.

1. **Work.** At work, staff face poor rates of pay and working conditions in much of the private sector. In contrast to the public sector, training in skills is poor and there is little continuity of care. One consequence is a growing shortage of staff in this sector and an increasing reliance on agency staff. To address these problems, we recommend a number of proposals addressing training, professionalization, travel and pay.

2. **Financialisation.** Our report outlines the increasingly complex mechanisms adopted by private companies to extract profit from the sector, leading to extensive hidden costs to the public both through the cost of contracts and tax avoidance. We demonstrate that, contrary to the prevailing wisdom, cost is not the primary obstacle to insourcing and that, for example, domiciliary care could be delivered within the existing ‘cost envelope’ by staff employed by the council on improved pay and conditions.

3. **Legal duties.** Our report outlines the legal framework within which councils deliver social care and the problems this presents for local authorities.

4. **Insourcing.** We explore the challenges insourcing would present, which are primarily to do with the fragmented nature of the market and a loss of council capacity, rather than cost. Liverpool has previous positive experience of insourcing, which shows that it possible to transfer services from the private to the public sector, boost productivity and save costs. However, there are big differences between the structure of the market in environmental services, the subject of transfer to Liverpool Street Scene Services (LSSL), and adult social care. We explore the steps that would be required to insource adult social care – requiring a more incremental and pluralistic approach – and recommend a number of steps that would be required to deliver this.

5. **Other models.** We have been conscious of the need to look at different ways of delivering social care, which could improve service provision and workers’ conditions, as well as exploring ways in which the voluntary sector could complement insourced delivery. We do not advocate a monolithic, one-size-fits-all organisation run by the council. We looked at ways in which the voluntary sector can complement public services and why the latter has incentives to partner with the voluntary sector in contrast to the perverse incentives in private sector contracts. The need to challenge the divide between nursing and care through innovation was discussed, including both the difficulties and opportunities this entails. We looked at work elsewhere, notably by the Foundational Economy Group in Wales, and how a different approach to commissioning could work, including creating a stakeholder framework with smaller private companies. These form the basis for a number of proposals for local pilots to test out different approaches.
6. **Covid-19.** As coronavirus spread, the situation in care homes became increasingly dreadful and almost too painful to watch. While the government cannot escape responsibility for many of the problems, it revealed longer-term structural issues in the sector, which had already become clear in our work. Reports from two local MPs and from UNISON make clear the scale of the problems which confronted staff, residents and their relatives. ‘Clap for Carers’ indicated a new public realisation of the role of staff in this sector, but clapping is not enough. Care workers need to be on the same footing as NHS staff, including in respect of immigration status.

7. **Funding.** We explore some of the challenges in improving funding for social care. We highlight the need for this to be linked to measures to reduce the extraction of private profit from the public purse, as discussed in Chapter 2. Among our recommendations is for the City Council and the Metro Mayor to approach the government to run a pilot exploring new ways of funding social care.

Our approach to insourcing adult social care and improving services and outcomes is gradualist, focusing on areas where the public and voluntary sector can demonstrably deliver better outcomes than the private sector and develop capacity. It will take some time for the Council to develop the capacity to deliver adult social care services on a substantial scale, but the time to begin is now. We welcome the commitment of the trade unions involved in drafting the report and the Association for Public Services Excellence to explore this route with us.

Based on our discussions with the Foundational Economy Group we sketch out a route map drawing on their experience in working with the Welsh Government. They have offered to work with Liverpool on developing a number of pilots.

Our report makes clear that the current system for delivering adult social care is irretrievably broken. Unless local and regional government – in partnership with the trade unions and ideally supported by central government – take steps to create a new model, further disasters as we have seen with coronavirus will unfold.

*We have tried to make the case for change and mark out a direction of travel. Perhaps more importantly, we have tried to put forward a toolkit, which we believe can be used by different councils in different areas. This is not a wish list but a set of practical steps that can be adapted and delivered as appropriate.*
Our recommendations are as follows:

**Proposal 1:** Training. The City Council should work with the Metro Mayor, local councils in the City Region and social enterprises to develop a new training programme for adult social care. Requirement to ensure staff are supported to take part in training programmes should be built into the commissioning process.

**Proposal 2:** Professionalisation. The City Council should work with the Metro Mayor and local councils in the City Region to explore ways to increase the professionalisation of care workers, including ensuring employment security for staff on zero hours contracts, access to continuing professional development and piloting mandatory registration and regulation.

**Proposal 3:** Strategic analysis. The City Council through its employment arm, Liverpool in Work, and its lifelong learning arm, Liverpool Adult Learning Service, should undertake strategic analysis and planning now, alongside NHS partners in the Liverpool City Region and the FE and vocational learning sector, to identify future employment opportunities and map out projected skills gaps to empower the existing social care workforce and recruit and retain the future workforce.

**Proposal 4:** Travel. The City Council should work with the Metro Mayor, local councils in the City Region, Merseytravel, bus companies and care providers to develop new more sustainable travel options for carers. This could include developing a fleet of electric cars to provide cheaper and cleaner transport between visits and options such as block bookings with Arriva Click.

**Proposal 5:** Real Living Wage. The City Council should work with the Metro Mayor and local councils in the City Region to develop a commissioning model requiring payment of the Real Living Wage by all providers.

**Proposal 6:** Creating a LATCO as a vehicle for delivering adult social care services to pilot the options outlined above.

**Proposal 7:** Develop a shadow management structure capable of taking over existing domiciliary care contracts as they expire, either through a LATCO or as direct council employees.

**Proposal 8:** Accept the offer of the Foundational Economy group to work on pilots delivering different models of social care, including those suggested below.

**Proposal 9:** Devise a pilot in conjunction with voluntary sector organisations and the Foundational Economy to promote innovation, rehabilitation and referral to voluntary sector organisations.

**Proposal 10:** Devise a pilot to trial a variant of the Buurtzorg model or the North Monmouthshire approach.
Proposal 11: Devise a pilot in conjunction with the Metro Mayor and NHS Trusts to deliver a joined-up approach to social care, with democratic accountability at its centre.

Proposal 12: Devise a pilot with the Metro Mayor to deliver a new training programme for social workers, nurses and care workers to support these.

Proposal 13: The City Council and the Metro Mayor should approach the government to run a pilot exploring new ways of funding social care.

Proposal 14: Domestic care. Experiment with commissioning that breaks away from the round of set 30 minute visits based on biomedical needs to give clients more or less time flexibly + recognise a workforce that can take responsibility.

Proposal 15: Residential. Build community hubs, which combine facilities, open to the community, with residential home beds for those with significant health and social care needs and/or nursing beds for those with high dependency; plus a mix of other facilities like GP surgeries or childcare.

Proposal 16: The Social Co: A public reporting entity (PRE) or Community Interest Company (CIC) financing vehicle-underwriting delivery of new architecturally imaginative facilities that promote community and social engagement. It may also manage the facilities.
Evidence from Care Workers part 1

The Panel received information from a care worker with experience in the public sector (to be referred to as Care Worker A for the purposes of the minutes and any subsequent report).

Care Worker A provided information (including answers to questions raised by the Panel) –

- Staff receive better training in the public sector, examples being on medication, prevention of falls for the elderly and the use of hydrotherapy pools;
- If a private sector care facility is closing, it is the public sector who have to go in to sort things out;
- There needs to be promotion of the good work undertaken by the staff in the public sector;
- One of the roles undertaken was as a team organiser for adults with learning disabilities in the Granby Hub, which involved the planning of meaningful activities for service users;
- When working at the Lime Hub, the facility includes a hydrotherapy pool which staff were trained to assist the service users in utilising;
- The hubs at Sedgemoor, Granby and Townsend are re-ablement facilities which include occupational therapists;
- Other aspects of training includes moving and handling, and can be either face to face or online depending on the type of training. Other training requirements can be identified through PRD and KIT meetings;
- The medication training is very important as medication can change, and the implications of getting it wrong;
- All the staff receive the same level of training, with a minimum of level 3 NVQ;
- The staff retention is fantastic, mainly due to the training opportunities and the terms & conditions of employment;
- A typical day consists of setting up the activities for approx. 50 service users, who are generally at the centre from 9am – 4pm;
Evidence from Care Workers (Part 2)

An opportunity was provided for the Panel to receive evidence from care workers, as requested in the outline work programme.

The Panel received a submission from (Care Worker 2) –

Please note that Care Worker 2 is a domiciliary care worker. The name of the employer, employee and the area worked in is not being recorded in these notes.

Care Worker 2 provided information as follows –

- A typical working day starts around 7.10am for the first call;
- In the main work is done as a ‘double-up’ assisting people to get washed, dressed and receive medication;
- The calls typically last 50 mins for a one hour call and 25 mins for a half hour;
- Following the morning calls, there is then a break before doing a ‘teas and bed’ rota of calls;
- The morning calls total 6 and a half hours and up to 7 hours for the evening / night, meaning getting home around 10pm;
- The above entails looking after around 10 people.

The Panel raised the following (with responses) –

- The rota must result in some people getting a call very early whilst others late in the morning. People tend to state their preferred times. E.g. there is one lady who likes to be up very early, whereas the last call in the morning which is around 11am is for a lady who only needs help getting washed;
- Are you able to provide any information on pay rates? The pay is now at Living Wage rates, which last month went up to £9 per hour, which has helped a lot with the retention rates, as previously lots of staff were leaving to go to work at hospitals;
- Do you have contracted hours? The work has always been on zero hours contracts, however the hours have always been filled on the rotas;
- How far in advance is the schedule received? The schedules are received on a phone app system, and if extra calls are required this is done by a phone call;
- Do you get paid travel time? Starting next week there will be pay given for travel time;
- What is the geographical area covered by the calls? The calls are all in one area. Previously used to do a wider area but now there are more staff to cover;
- Are you trained for the use of hoists? Yes, which is why the calls are doubled up so can use the hoists, however there are issues which have been reported of people refusing to have the work done to their homes to enable a hoist to be put in place;
- Have there been any occasions where you don’t get the hours as outlined? No, as a long standing employee, the hours are always given as outlined;
- Do other employees not get the hours they would like to have? Aware of employees on single calls only getting 4 hours instead of 6 hours;
- Was the pay increased only when staff began to leave? Generally that was the case,
with some leaving to work for other care providers who had a better pay rate or to hospitals. It should be noted that when the pay was increased the double time rate for bank holidays was reduced to time and a third;

- What are the holiday entitlements and sick pay arrangements? The current rate is 28 days holiday entitlement and Statutory Sick Pay;
- Are any of the workers employed on a part-time basis? Yes, there are a number of workers who can only work up to 20 hours;
- What are the biggest gripes you may have? The biggest gripe is trying to understand wages, as there is no breakdown provided, as such it is unclear if correct rates have been paid for bank holidays or training. For the single run workers they have the issue of not getting the hours that they want;

The Panel received a submission from (Care Workers 3 and 4) –

Please note that Care Worker 3 and 4 are care home workers. The name of the employer, employee and the area worked in are not being recorded in these notes.

Care Workers 3 and 4 provided information as follows –

- The care workers at the home are employed on minimum wage, and receive no extra for nights. On each shift there is a one hour break which is unpaid;
- The home accommodates up to 38 residents, many of whom are on end of life care. Having only 5 carers to look after this many residents makes providing good care almost impossible;
- The low staffing number means that residents only receive 2 showers per week;
- If the end of a shift is delayed due to seeing to a resident’s needs, there is no pay for the extra time;
- Change is not easy but needs to be achieved, and can be as providers make a lot of money.

The Panel raised the following (with responses) –

- Do you raise with the hierarchy the problems you have with having such a low level of staff? The challenges brought about through low staffing levels are raised with management but nothing changes;
- What do you think needs to change to bring about real improvements? Bringing services in-house with the local authority would bring about positive changes;
- Can you outline what a typical shift starting in a morning entails? The handover from the previous shift normally takes around half an hour. A number of carers then prepare breakfast whilst others assist residents who need help. Between 10am and 11.45am help is given to get residents ready, prior to lunch around 12.30pm. Following this assistance is given to toilets and then afternoon tea, and then 5pm is evening meal and then later it is supper time and then preparing for bed. Most of the staff work until after 9pm but are only paid until 8pm;
- How often do the staff interact with the management? The management are governed by a hierarchy who have no interest in change. A number of managers have no nursing experience and as such are incapable of dealing with issues;
- Do the staff feel as though they are firefighting as things occur that disrupt the structure? Yes they do, things such as a resident having a fall can put a lot of things out;
• Are the staffing levels the same when there is a CQC inspection taking place? There tends to be 7 staff instead of 5 when an inspection takes place. The inspections should be unannounced but the managers always make extra provision when inspectors arrive, and create a high level of engagement with staff that does not occur ordinarily;
• What other things apart from pay and staffing levels would you change? Looking to see how we can make residents happy and enjoy their care home. They should be in a safe and comfortable environment with correct staffing levels and choices;
• Do you find there are differences between big providers and smaller family run providers? There can be large providers who give good care, and generally the smaller firms are better. It is concerning that failing providers are allowed to purchase more homes. If services were brought in-house there would be better staff retention rates and care provision. In Runcorn a number of homes were taken over by the Local Authority and the changes seem to be positive;
• What is the relationship of staff with the relatives of the residents, how do they view the care provided? In general the relatives understand the pressures the staff are under due to low numbers;
• What does your employer provide in the way of personal care products? The employer provides uniforms, gloves etc, however pads tend to be rationed.

The Panel thanked the care workers for their attendance and submission, which was noted.
APPENDIX 3

Home Care Case Study

Care Provider – Case Study
Roster Summary
NB – Roster developed by MEARs but similar continued for a period post TUPE to Careline. Subsequent NMW claims were against both MEARs and Careline.

Day 1 – Fri 07:30 – 00:20 16hrs 50 mins 48 visits
2hrs 40mins rest

Day 2 – Sat 03:00 - 23:45 20hrs 45mins 51 visits
4hrs 45 mins rest

Day 3 – Sun 04:30 – 23:05 18hrs 35mins 44 visits

Pay – including travel time:-
£4.30 p/h

Why?
ZERO Hours

Care Provider – Case Study

CITY & COUNTY HEALTHCARE £13m profit 2016
Care Provider – Case Study

GRAPHITE CAPITAL
£124m annual revenue 2016

- £10m for tax purposes

2013 – 2016
£17m new debt

CITY & COUNTY HEALTHCARE
£13m Profit

£75m
15%

£65m off shore loans
## Private Equity in UK Social Care

<table>
<thead>
<tr>
<th>Provider</th>
<th>Owner</th>
<th>Care For</th>
<th>Debt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Care</td>
<td>Aurelius Capital</td>
<td>13,500</td>
<td>£19m + “hidden debts” CVA 4 weeks to restructure debt</td>
</tr>
<tr>
<td>Care Watch</td>
<td>Lyceum Capital</td>
<td>16,000</td>
<td>£45m + £20m interest</td>
</tr>
<tr>
<td>City &amp; County</td>
<td>Graphite Capital</td>
<td>16,000</td>
<td>£65m + £17m interest</td>
</tr>
<tr>
<td>Four Seasons</td>
<td>Terra Firma Capital</td>
<td>17,000</td>
<td>£525m £26m interest payment deferred in Dec 2017 + £70m injected</td>
</tr>
<tr>
<td>HC One</td>
<td>FC Skyfall LP</td>
<td>22,000</td>
<td>£600m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>84,500</td>
<td>£1.29 billion +</td>
</tr>
</tbody>
</table>
RAGLAN: A NEW APPROACH TO SUPPORT PEOPLE WITH DEMENTIA IN MONMOUTHSHIRE

INTRODUCTION:
The Raglan Project asks can domiciliary care be delivered differently. The service supports 14 people living with dementia in a small rural community and replaced the existing homecare service. The ideas arose from discussions with managers and staff. For staff, to be treated with respect, have regular work and know the people they support. For managers, the need to move to relationship based care.

The project moves away from the current model of service delivery to one that doesn’t focus on tasks to be performed at specific times by staff in their traditional role of homecarers. Staff are given autonomy to support the choices of the service user. Each member of staff is full-time salaried and employed as part of a team to work flexibly across a service area. Only five staff work in that area and cover for each other. The time spent and activities undertaken are discussed daily with the service user and their family and respond to how they feel. Minimum service levels remain but to deliver flexibility the care plan is a framework for delivery rather than a prescriptive list of tasks.

The project has explored new ways of communicating and recording outcomes. Each member of the team was given an ‘iPad’ and set up on ‘Evernote’ to journal their experience and those supported. This has provided extensive case evidence built up over 8 months which continually demonstrates positive outcomes for the people supported.

The principles of the project are as follows:
- Care cannot be provided without establishing a relationship with the person receiving care.
- No uniforms.
- The emotional and social needs of the people supported are as important as their physical needs.
- The needs of the informal carer must not only be assessed but met.
- Decisions are best made by those closest to the issues and we must trust our staff.
- There must be a direct dialogue between the care co-ordinator and the team.
OUTCOME: WE PROMOTE A RELATIONSHIP BASED EXPERIENCE OF RECEIVING CARE - care supports a natural life; promotes choice, control and independence

Homecare traditionally focuses on the physical needs of people to the detriment of other needs. The RP recognises that in supporting people we have to understand their social and emotional needs as well. To support someone to get up, get dressed, means that staff will work with vulnerable people at their most vulnerable. Outside of the RP common practice is that care commences with tasks so in reality staff who do not know the person will commence a relationship by helping them with intimate personal tasks. The RP approach is that we must know the person ordinarily so they spend time establishing a relationship.

M came home from hospital; not eating, drinking, or communicating. She had lost all ability to walk, had short term memory loss and her will to carry on had gone. M was under 5 stone, prone to chest infections and malnourished.

M has a devoted daughter and refused for her ‘Ma’ to give up. There had been other agencies visiting M so we were just another agency. She had formed an opinion, ready to give battle after what she says was appalling care in hospital.

M’s lust for life has returned at 93. We sit and eat with M which the family likes. M enjoys cooked meals, pudds, cuppas, chocolate. M now goes out on Wednesdays, tea dance on Thursdays. M sings along with us, dances with her arms; loves touching, hugging us and communicating. She enjoys her music at home, has visitors enjoys the socials with Friends of Dingestow where she meets old friends and neighbours - connecting with the community.

Something her family never thought would be possible was for her to attend her only Granddaughter’s wedding with our support. Her daughter says she has never experienced care like it.

OUTCOME: IMPROVED LISTENING AND ASSESSMENT - we understand ‘what matters’ to the person.

Mrs SH was becoming forgetful, not paying bills, not eating hot meals, neglecting herself and her home and becoming increasingly isolated. The assessment details her private nature and how she refuses to let people enter the home. At 94 she had been independent up until this point.
The first conversation with Mrs SH was through the letter box to persuade her to let them in. They have worked gently and slowly with this lady to establish a relationship of trust. Mrs SH now sees our team as friends and the team have promoted this relationship because they know that she is reluctant to accept care.

The SW had been worried that Mrs SH didn’t have enough money in her house for her daily living expenses. She had been reluctant to spend much on food etc. There had been issues with her bank accounts, she had closed some and could not remember doing so. Consequently she felt uneasy with any talk of her finances. It was not until I parked outside the bank that Mrs SH decided she would withdraw some cash. What a difference it was seeing her do her shopping. She bought lots of nice things to eat, spent ages walking around Waitrose looking at things. Mrs SH looking through the magazines, she has never shown an interest before. She purchased herself a magazine. Tomorrow she is going out for lunch at the Chase with a friend.

OUTCOME: SERVICES SUPPORT THE CARER - they will feel involved and listened to. Their health and well-being will be supported.

The RP team really invest time in supporting the carer

The impact of strangers coming to your home cannot be overestimated. Often a difficult time in people’s lives, adjusting to changes; loss of freedom, esteem, mobility and changes to relationships.

I felt threatened having people walk around my home. I felt anxious and out of control - I had looked after my wife for the last 13 years and I had been in total control. (Husband and Carer)

Consultation with informal carers reveals a catalogue of complaints about not being listened to, care staff changing and repeatedly asking the same questions; but now... One daughter now describes her confidence when going away and how the staff remind her of things to do when she has forgotten. Another carer outlined how nice to be able to say come a little later or earlier.

Intimacy in relationships is not often discussed and having people come into your home can be a barrier. The team have described helping one lady to dress up, put make up and the way her husband saw her for the first time in a long time – saw past the dementia and saw his wife. Other examples have seen staff help overcome moments of stress and bring people closer. The fact that the team acknowledge their relationships is key. One lady explained the importance...
of the simple recognition that they are married and that the team treat them as a couple.

“...you girls make me feel wanted and part of the care team. It gives me strength to carry on; a purpose and I can talk freely about anything that worries me.”

**OUTCOME – RECONNECTING PEOPLE WITH THEIR LOCAL COMMUNITIES**

Communities will become more aware of dementia.

During initial discussions with the staff team we discussed our role to support people in the community; to re-establish links and to help people become involved in their local community. What the team have achieved is remarkable.

The team have established two groups; Friends of Raglan and the Friends of Dingestow. Critical is that the team now support people to attend but the people we support are in the minority. The group is independent of social services and sustainable both in terms of the commitment of the local community and financially.

In the journals detailing the work of the team, each is working with the people supported to reconnect. Not just through the socials above but by supporting people to visit friends, go to local shops, buying mobile phones so people can access a local taxi service to get about independently.

**OUTCOME: THE ROLE OF OUR STAFF DEVELOPS.** Staff feel empowered, valued and their well-being improves.

Poor care is not due to poor terms and conditions as the great work of the majority of homecare demonstrates. Good care is delivered despite this. How valued the team feel and their financial security are crucially linked. The employment status of domiciliary care workers is unique in social care and health. As homecarer employers we are uncertain as to the level of demand. This in itself presents a risk in that we look to avoid a position of over provision. As employers we look to mitigate this risk by passing the liability to our employees. This results in employment practices such as limited guarantees and in some cases ‘zero’ hour contracts.

Homecare has traditionally operated on command style structures which are reinforced by processes of allocating work. Authority is not derived from position in the organisation but as a result of knowledge and proximity to the subject of the decision. In the context of the RP the role of management is support; not control. Good outcomes for the people who receive our services are linked to the welfare of the staff. The staff are enthusiastic and motivated. There has
been no sickness since September 2012 (initial discussions about the project) to date. In honest interviews the team have described that sickness was a choice previously when faced with low hours of work as they would be paid more.

TWO OF THE TEAM VISIT THE LOCAL COLLEGE TO TALK TO H&SC STUDENTS

What a shock; the students listened to our stories, they were so interested, they looked at our photos of real people, who’s life’s we have altered, thanks to the way we can work through the project.

Students were crying, taking notes, asking us questions, what an experience we had....

OUTCOMES: THE POTENTIAL TO DELIVER BETTER OUTCOMES AT THE SAME COST IS EXPLORED...

The simple answer; yes it can. Autonomy for staff and direct communication with the care manager has shown costs are actually less. By removing limiting terms and conditions that prevent staff using their own judgement staff will make informed decisions that are mindful of the financial constraints within which they work.

Mr M now feels confident to administer his own medication, we have encouraged and assisted Mr M to cook and he has taken a keen interest again in this task. He is attending tea dances again now that J has attended with him to regain confidence. He now calls on neighbours he feels are vulnerable to encourage them to attend the socials at Dingestow. He now has a purpose and a spring in his step. His care had reduced from 7 hours to just a 1/4 per week.

Care is broken down under different headings in the RP. Daily essentials include help to prepare food, help to dress or wash. Weekly essentials are those things that need supporting each week such as shopping. Flexi is hours allocated to support the person socially. For comparative purposes only daily and weekly essentials have been included in the planned hours.

Because of the autonomy that the staff have, care increases / decreases in response to need. Behind these figures there are people who are being supported at the end of their lives or carers who need additional support as their ability to cope changes. Similarly the planned hours are changing in direct response to the feedback from the staff.
Following consultation with the team and care manager an attempt to predict outcomes without the Raglan Project was attempted. For each person and based on reviews, journaling and interviews we can say that outcomes have improved for everyone supported. If the project did not exist then possibly we can say that three people will have gone into permanent care, one would have died in hospital and for a number of others that they would not have engaged with social services at all.
1. Introduction

This paper is based on our collective knowledge and insights, representing the statutory, private and third sectors. It endeavours to show the importance of Social Care to the Welsh economy and how some elements are helpful, and others less so. However, it particularly seeks to encourage action, and therefore actions are placed at the start, with the detailed assessment of the sector set out in two Appendices. Those needing the context for understanding the actions may wish to read the Appendices first.

We believe Welsh legislation and a range of relevant policies are helping to build a positive shared vision for social care, and we wish to work with Welsh Government and others in order to bring this vision to full fruition. In taking forward this agenda, it is vital that Wales maximises the benefit of a good number and range of FE Challenge experiments in social care, ensuring that lessons are learned and shared across Wales and all care sectors. We will collaborate to this end and look for others to do likewise.

It is our hope that this short paper provides a clear picture of the importance of social care for the FE, and of the areas where investment and experiment (and supportive leadership) can lead to even greater economic benefit from care in the future: short, medium and long-term.

Sue Evans and Iwan Williams, Social Care Wales

Mario Kreft and Mary Wimbury, Care Forum Wales

Adrian Roper, Cartrefi Cymru Co-operative

2. Actions - How can we make social care more helpful for the economy?

2.1. Short term

a. Bring together all those who are engaged in Foundational Economy Challenge social care experiments with a view to creating a Community of Practice that can share learning and help with the transfer and scaling up of “what works”.

b. Identify others outside of the Challenge who are already engaged in relevant experiments in order to ensure that the Challenge participants learn from them and avoid reinventing wheels or errors.

c. Identify local authorities and commissioners who have a strong interest in new ways of commissioning and delivering services in order to include them in the learning and development work arising from the Challenge.
2.2. Medium term

a. Address the widespread ignorance of the economic benefits of social care

b. Shift the culture and practice of commissioners and procurers in the direction of creating long-term trusting relations:
   - between commissioners and providers
   - between providers and providers
   - between employers and workers
   - between professionals and citizen users

c. Encourage long-term contracts and/or grants and/or local concessions to trusted local providers and/or collaboratives of providers

d. Encourage the scoring of tenders (or grant applications) to include points for meeting FE-related specifications:
   - being locality or Wales-based
   - being a good employer
   - giving voice and control to the citizen-user
   - being committed to collaboration
   - being committed to innovation
   - being outward facing and engaged with the local community

e. Take action to address the fragilities of SMEs and the causes of SMEs selling up to out-of-country businesses:
   - Providing support for management (not just support for tendering)
   - Simplifying systems of commissioning, providing and monitoring
   - Providing support for succession planning
   - Shifting culture and practice in the direction of trust and relational commissioning
   - Providing support for producer co-operatives / consortia

f. Surface and address the abuses of commissioner power which are detrimental to those providing care:
   - Damage to the cash-flow of SMEs by commissioners (including NHS Wales) not paying them on time.
   - Business uncertainty caused by commissioners not announcing fee rates until well into each financial year
   - Address duplications in bureaucracy between commissioners and regulators.
2.3. **Long term**

a. Make significant additional and on-going investment in social care in order to:
   - Address projected demographic needs
   - Shift care work wages towards parity with health work wages.
   - As the First Minister said in his manifesto we should “Use the power of procurement and public investment to secure quality services in, for example, the care sector by linking that investment to fair pay and career development”.

b. Create cross-department support for the Social Care Levy or other mechanism within the powers of the Welsh Government
c. Take forward the recommendations of the Fair Work Commission, including the creation of a Social Care Forum to ensure care sector wage inequities are prioritised and actioned
d. Make Wales (in the First Minister’s words) a “co-operative country” for social care:
   - partly by increasing the number of care providers who can demonstrate their accountability to their users, workers and localities
   - most importantly by embedding within the whole system a new culture and practice that allows Wales-based organisations of every description to work collaboratively and efficiently for the good of every stakeholder, from user to Welsh Government

3. **General reflections**

Social care is identified in the Economic Action Plan as a pillar of the Foundational Economy and a prime target for new thinking and improvement. There is plenty of good care in Wales and a lot of committed providers, but there are also fall-offs from the standards we expect, gaps in provision, and waste within an often over-bureaucratic and supposedly managed market system. We can do better for people using services, working within the sector and for the public purse.

We do not believe that these short-comings can be addressed without significant investment, but equally we recognise that simply putting more money into a flawed system is not the answer. Obtaining major new investment will take time, and we should use this time to create the roadmap for a new system and begin to put it in place.

Commissioning organisations are starting to implement changes to models of care and support, in line with Social Services and Well-being Act, but progress is slow and short term grant funding does not enable a strategic approach to service transformation. Therefore, we should simultaneously ensure that actions are pursued to deliver the necessary new recurring investment as soon as possible.
Appendix 1

How is social care helpful to the economy?

Employment

a. Provides employment in care (90,500 jobs (more people than NHS Wales), 7th largest employment sector in Wales, 127,000 jobs created by the wider impact of adult social care on the Welsh economy)

b. Enables people to work in non-care jobs by addressing their own support needs (e.g. through supported employment) or their dependents’ care needs (in the same way as child care)

c. Provides jobs in most localities

d. Provides career opportunities across Wales

e. Provides work and career opportunities including for hard-to-reach groups (including people in deprived areas or from workless households) Provides employment for people beyond retirement age (reducing pension costs)

f. Provides apprenticeship opportunities for school and college leavers, supporting the government’s targets (although changes to criteria for funding currently being considered may be detrimental to the social care sector)

g. At a UK level, Wales (5.9%) has the highest proportion of the workforce employed in adult social care (Scotland 5.7%, England 4.6%, Northern Ireland 4.3%)

Local economic development

h. Circulates and recycles public and other money (private fees and wages) locally

i. Makes communities attractive to employers and workers in all sectors

j. Enables people with support needs to remain active consumers

k. Offers good evidence of and scope for SME development (cf. Wales’ missing middle)

Use of public funds

a. Saves money for the NHS (making public expenditure go further)

b. Provides services which are (in the main) not at risk of out-of-country outsourcing

c. Aligned with other local authority and community services to reduce “back office” costs

National economic development

d. Provides scope for Wales-based innovation in the use of Assistive Technology and ICT

e. Provides a major opportunity for economic growth through new and much needed additional funding (e.g. through a Social Care Levy, insurance scheme or similar)

f. Provides scope for providing jobs with a low carbon footprint (e.g. through highly localised services where workers can walk or cycle to and in work, and through care sector commitment to reducing usage of things like plastic and palm-oil).
Economic value of the adult social care sector¹

a. 7th largest contributor to the Welsh economy;
b. Adult social care sector GVA was £1.2 billion (2016 estimation). Most of this was estimated to be in residential care (£328 million, 28%).
c. This represents 1.9% of total GVA in Wales;
d. It was estimated that the average level of productivity (GVA generated per FTE) in the adult social care sector was £18,700; and
e. The estimated GVA in the adult social care sector in Wales is estimated to be higher than agriculture, forestry and fishing, arts, entertainment and recreation, water supply, sewerage and waste management sectors.
f. The total direct, indirect and induced value of the adult social care sector in Wales was estimated to be 126,800 jobs (93,600 FTEs) and £2.2 billion in 2016.

¹ The Economic Value of the Adult Social Care sector – Wales – Final report (ICF, June 2018)
Appendix 2
How is social care (currently) unhelpful to the economy?

Employment

a. Marred by the low value attached to care work, expressed most obviously and
damagingly in the low wages paid to care workers, with a majority of female
workers. (The average full-time salary in adult social care sector is £16,900, but full-
time jobs are not standard and many receive less than the average)².

b. Has an unjustly and inequitably tiered wage structure, with workers in independent
care agencies often paid at minimum wage levels (£15,796) and commissioned at
such by the state, while local authority workers paid much higher (£17,700)³, and
NHS equivalent roles paid even higher (£19,020). (NHS recruitment destabilizes local
care provision)⁴.

c. Marred by an element of out-of-country provision, structured for excessive profit
extraction and the best jobs (and decision-makers) located outside Wales or even
the UK.

d. Marred by an element of in-country provision by outside organisations, importing
people with high support needs into Wales with excessive profit extraction and (if
they are not Wales-based) the best jobs located outside Wales.

Local economies

e. Marred by a growing two-tier system, with private investors developing services
aimed at self-funders who can afford it, state commissioners paying higher rates for
their own provision or leaving providers with no choice but to charge higher rates to
self-funders to stay in business, or sometimes leaving those who rely on state
assistance with a poor or non-existent service. The inequity affects both individuals
and localities, depending on their wealth and increases the poverty gap across
Wales.

f. SMEs are constantly at risk of market-failure collapse or sell-out to global agencies.

Use of public funds

g. Constantly wastes money on the recruitment and training of staff who leave in
significant numbers for easier and/or better paid work in other sectors, often leaving
care altogether. In Wales, the domiciliary care sector had a staff turnover of around
32% in 2016⁵, with 50% of them joining a neighbouring care provider. For social

---

² “Approximately half of the workforce (51%) worked on a full-time basis” – The state of the adult social care sector and workforce in England (Skills for Care, September 2018)

³ “Around 84% of adult social care organisations in the independent sector in February 2019 were paying at least some of their workers below the next mandatory National Living Wage (£8.21)...the vast majority (99%) of local authority sector workers were already paid above the 2019 NLW prior to its introduction” – Pay in the adult social care sector (Skills for Care, March 2019)

⁴ The need for “parity of esteem between all health and care professionals, who have similar levels of responsibility and accountability”; Care England calls for social care nurse pay parity

workers in Adults’ Services (2017-18), there’s a 11% turnover rate. For social workers in Children’s Services (2017-18), there’s a 15% turnover rate. Social care staff turnover in England has risen to 42.4% (a 7.6% increase over five years). At the UK level, the care sector “has the highest staff turnover rate of all sectors in the UK, with one in three workers leaving the sector every year.”

h. Wastes money operating a home-care system in which there is no join-up between those who professionally assess and commission “time and task” contracts for multiple clients in multiple locations and those who have to meet these demands (whether as workers or as hard-pressed frontline managers).

i. Wastes money through a lack of freedom for, or focus on, meeting each client’s individual needs creatively and efficiently. (The arms-length commissioner, pressed to measure activities to meet auditor demands, often resorts to “time and task” contracts, as it is much more difficult to measure outcomes for people. A new mature commissioner provider relationships is essential to eliminate these inefficiencies.)

j. Is dispersed both geographically and organisationally, reducing the scope for efficient and responsive service delivery, and for appropriate economies of scale.

k. Wastes resources and reduces opportunities for better wages by requiring care workers to take hours of unpaid down-time every day, because “tasks” are clustered at meal-times with a lack of creativity from many commissioners about what this “down” time could be used for, with some parts of Wales leading the way.

l. Wastes money by viewing contracted care providers (and workers) as untrustworthy and therefore in need of vast expenditure and time spent monitoring them rather than working in partnership.

m. Wastes money as a result of an inefficient and insufficiently collaborative interface between health and social care.

n. Operates as a highly competitive market-place which reduces the potential benefits of sharing and collaboration, and is the main driver of distrust and waste.

---

6 Social Worker Workforce Planning 2017-18 (Social Care Wales, ADSS Cymru, Data Cymru, WLGA, May 2019)
APPENDIX 6

Care and support workers’ perceptions of health and safety issues in social care during the COVID-19 pandemic.

Initial findings, 15th April 2020.

Professor Lydia Hayes, Dr Alison Tarrant, Hannah Walters

Contents

Overview ............................................................................................................................................. 2
Context: COVID-19 and Social Care ................................................................................................. 4
Key findings ......................................................................................................................................... 6
Analysis of results: PPE problems ....................................................................................................... 8
Government guidance assumes PPE availability, but care workers state PPE is often unavailable or unsuitable. .......................................................................................................................... 8
Official guidance has said no PPE is needed in certain situations, and evidence from care workers suggests confusion and elevated infection risk. .......................................................................................... 10
Analysis of results: pay problems ..................................................................................................... 12
Care workers who are ill with COVID-19 are not all self-isolating. It appears that poverty, and fear of poverty, may be exacerbating the risk of transmission of SARS-CoV-2 in social care circles. ........................................................................................................................................... 12
Analysis of results: Other COVID-19 related health and safety concerns. ............................................. 14
Care workers believe lack of attention to minimising risk of infection in care-settings has directly contributed to outbreaks of COVID-19 in social care-settings. ......................................................................................... 15
Care workers’ report that in some care-settings there have been few, if any, attempts to reduce risk of transmission and these risks are compounded by difficulties in achieving social distancing. ........................................................................................................................................... 15
Care workers are concerned that measures to deal with staff shortages are accelerating the spread of SARS-CoV-2 in social care. ................................................................................................................................. 17
Care workers are concerned that their reliance of public transport is likely to be transmitting the virus between care-settings and the wider community. ......................................................................................... 18
Our Recommendations ..................................................................................................................... 19
Overview

We undertake research for Wellcome Trust about the legal rules that govern the care and support that is provided in care homes and by homecare providers in England, Scotland and Wales. Our task is to assess whether these rules about care standards might be having an indirect effect on the quality of care workers’ jobs.

Our research began in January 2020. We did not anticipate we would be looking at the legal rules in the context of a global pandemic. However, we are ideally placed to report on what is happening to the legal regulation of care and support in the UK as the COVID-19 crisis unfolds.

This is our first report. It is about care and support workers’ perceptions of health and safety issues. It provides initial findings from legal and survey data about the role of care and support providers in the pandemic as employers with legal responsibilities for preventing harm to staff and people who use their services. The evidence suggests that care and support workers, care home residents and other users of care and support services are exposed to the risk of SARS-CoV-2 virus without the protections to which they are legally entitled. We worked with UNISON in the North West of England to analyse findings from a survey of 2,600 care workers in approximately 1,200 different settings across residential care, home care, and support services for people with learning disabilities. Our analysis of results is split into three sections. Firstly, concerns about the need for Personal Protective Equipment (PPE). Secondly, pay problems. Thirdly, other COVID-19 related health and safety concerns.

A large majority of care and support workers said their employers were not doing enough to keep them and the people who use their services safe. Their accounts of what is happening on the ground in social care appear to be at odds with the picture of service provision set out in Guidance issued by the Department of Health and Social Care. Gaps in knowledge at policy level, about social care in practice, could be putting lives at risk. In this report, we recommend that care workers are urgently appointed to problem-solving roles at national and local government level so that their expertise can be brought to bear in making decisions about the distribution of personal protective equipment (PPE) and the use of resources, including staff resources.

We find that 8 out of 10 care workers think they will not be paid their normal wages if they have to self-isolate due to COVID-19. Care workers report that they and their co-workers are not always self-isolating because of poverty and fear of poverty. Care providers are not legally required to provide occupational sick pay and, unlike in the NHS, most not do so. The UK Government has to-date advised that care workers may be able to access SSP payments during a period of self-isolation. At £95.85 a week, SSP provides a woefully inadequate level of income. In this report, we recommend that UK Government act urgently to ensure that care workers receive their normal wage incomes when in self-isolation. We believe this is a necessary intervention to save lives.

1 Research funded by Wellcome Trust: Social Care Regulation at Work in England, Scotland and Wales. Principal Investigator Professor LJB Hayes.

2 A note on terminology: This report refers to workers who provide both care and / or support to people who need care or assistance in everyday life. We understand that for many people the term ‘care’ does not cover the support they need or receive through the social care system. We use the terms ‘care and support’ and ‘care and support worker’ in this report as far as possible.

3 Data collected in two weeks to 6th April 2020 in an online survey by UNISON North West. 2,600 respondents in total completed all questions.

4 Scottish Government announced sick pay for care workers on 12th April and will provide monies to care providers to cover occupational sick pay for periods of illness and self-isolation backdated to 1st April 2020. https://www.gov.scot/news/pay-rise-for-social-care-staff/
The laws which set out how care providers are expected to meet minimum standards of care have not changed since the onset of the Coronavirus crisis. However, the regulatory bodies with responsibility for investigation, reporting and prosecution have decided to stop routine inspections of care settings. This means that in practice, the laws which govern what happens in care homes and homecare services are no longer being enforced by care sector regulators. The attention of care providers is being redirected to information and advice set out in a series of ad-hoc notices, such as those issued by the Department of Health and Social Care. In this report we identify our initial concerns that the advice of the Department of Health and Social Care is insufficiently tailored to the needs of social care workers and to those of individuals in need of care and support. Insufficient detail and a lack of sector-specificity means that managers of care homes and home care services are left to rely on ‘common sense’ and individual discretion to guide their decision-making about appropriate levels of care in the face of the SARS-CoV-2 virus and outbreaks of COVID-19. It is deeply concerning for the longer term that regulations which set out minimum acceptable standards for operating in the care sector have been displaced by appeals to managerial discretion and Guidance from the Department of Health and Social Care that has been inconsistent and is often unsuitable for application in care-settings.

On 6th April, news broke of the first two deaths of care workers in England from COVID-19, Carol Jamabo and an un-named care worker (both employed in the North West of England). The reporting of these tragedies, as well as those about deaths of residents in care homes, suggested lack of personal protective equipment (PPE) was a key factor. In this report we find serious breaches of safety standards across care and support settings. Over half of care workers expressing a view felt services were insufficiently safe, both for them personally and for the older and disabled people for whom they care. PPE is a major issue, and our report provides details of this. It also looks beyond the widely publicised problems with PPE availability to evidence other health and safety related COVID-19 concerns.

There appears to be considerable confusion in guidance issued by the Department of Health about whether, when and why PPE is necessary in care-settings. The regulatory framework that governs social care provision in all four of the UK nations has the primary objective of keeping citizens safe. Yet at a time when risk to life is acutely high, our findings suggest that sector-specific safety laws, as well as other health and safety laws, are not being complied with, even though in some instances regulatory breach is a criminal offence. For example in England, care providers must provide care in a safe way, do everything reasonably practicable to mitigate risks to the health and safety of people receiving care, and control the spread of infection. Where a breach of this regulation results in avoidable harm or exposes an individual to significant risk of harm, a criminal offence is committed. However, our data evidences the concern of care workers that care is not safe. These sector specific requirements sit alongside the requirements of the Personal Protective Equipment Regulations 1992 and the Health and Safety at Work Act 1974. All workers have a right to suitable PPE because every employer must ensure PPE is provided to employees who may be exposed to a risk to their health and safety while at work, unless the risk is adequately controlled by other means which are equally or more effective. A failure to provide PPE to workers at risk can also be a breach of human rights law, in particular the right to life at Article 2 of the European Convention on Human Rights. Importantly, human rights laws apply in all registered care settings in England, Wales and Scotland where care and support services are arranged or paid for, directly or indirectly, by local authorities.

---

6 *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (as amended), Regulation 12.
9 *Care Act 2014*, section 73.
Context: COVID-19 and Social Care

In recent weeks, UK Government ministers have given increased prominence to the social care workforce in press briefings. The social care workforce is spoken about as though it is a workforce with equivalent status and importance as the NHS workforce. Indeed, the umbrella terms ‘health and social care workforce’ and ‘health and social care system’ have entered mainstream political debate.\(^\text{10}\)

The recent ‘thank you’ letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, addressed social care workers as his ‘brilliant colleagues’, and as though they were on a par with NHS employees and part of the same organisational family. Hancock also stated that his commitment to doing ‘whatever is needed… applies just as much to social care as it does to the NHS’.

If this creates the impression of equivalence between NHS and social care services, it is an impression that is misleading. Unlike NHS provision, adult social care services are provided in a highly fragmented, privatised and resource-starved market in which staff shortages, breaches of employment rights and understaffing has become the norm. Unlike in the NHS, there is very little representation of care workers through collective bargaining by trade unions, there is little career progression for care workers, there is a severe lack of training, and pay in the sector is very low.\(^\text{11}\)

The impact of COVID-19 in social care is very different to its impact in the NHS, and risks of transmission of the SARS-CoV-2 virus are also distinctive in social care-settings. For example, it is increasingly evident that deaths in care home settings are collective in their nature.\(^\text{12}\) Caring practices are largely collective in their execution, in care homes because residents live together in a single dwelling with support from a community of care workers, or because individual care workers are assigned to travel from home to home in a geographical community, according to a schedule of visits in which they assist individuals in need of care and support. Physical contact between care workers and people in need of care and support is frequent, essential and immensely intimate. Emotional contact sustains relationships of care to build the trust, knowledge and interpersonal understanding that makes caring and support possible.

There may also be distinctive risks for workers who provide care and support. Research about COVID-19 has found evidence that people can carry infective SARS-CoV-2 virus in their faeces, even if they are not displaying respiratory symptoms.\(^\text{13}\) Care workers are likely to be more frequently, and more extensively exposed to faeces in their work routines than nursing staff or doctors. For example, in residential care, people with dementia are four times more likely to suffer from faecal incontinence

---

\(^\text{10}\) See for example letter of the Secretary of State for Health and Social Care 28\(^\text{th}\) March 2020

\(^\text{11}\) Hayes, Lydia and Johnson, Eleanor and Tarrant, Alison (2019) Professionalisation at work in adult social care: Report to the All-Party Parliamentary Group on Adult Social Care, July 2019. Project report. GMB trade union

\(^\text{12}\) Note that on 8\(^\text{th}\) April it was reported that 15 residents at Castleroy Residential Home in Luton had died with COVID-19, 7 at a care home in east London, eight at a care home in Dumbarton, 12 at a care home in Cranhill, Glasgow BBC.co.uk/news/uk-england-beds-bucks-herts-512175891

than others, 14 80% of residents in care homes have dementia and research estimates that approx. half of all care home residents in the UK have faecal incontinence. 15 The extent of bowel care that takes place in residential and homecare settings may therefore create distinctive risks for care workers.

There are 1.3 million staff working in the NHS and 1.5 million people working in adult social care in England. 16 When including workers from Wales, Scotland and Northern Ireland we can reasonably assume that in excess of 2 million people work in adult social care. The vast majority of those are hands-on care workers, and 85% are women. The risk of SARS-CoV-2 infection therefore hangs over a huge workforce who are low paid, undertrained, working behind closed doors in private settings, and are often employed on zero-hours or other precarious contacts. Prior to the outbreak of COVID-19, the sector was said to be ‘at breaking point’. 17 Many people in need of care and support are at high risk from COVID-19 and many of those in the UK Government’s ‘extremely vulnerable’ category will be users of care and support services or residents in care homes.

This is the context in which UNISON North West surveyed the opinions of 2,600 care workers working for hundreds of different employers. 18 Our analysis reveals that the extent to which survey respondents do not feel personally safe in the conduct of their work is alarming, as is the extent of their concern that not enough is being done to protect the health and safety of people using care and support.

---

14 Grant, Robert et al (2013) First Diagnosis and Management of Incontinence in Older People with and without Dementia in Primary Care: A Cohort Study Using The Health Improvement Network Primary Care Database, PLOS Medicine, https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001505
16 The size and structure of the adult social care sector and workforce in England, Skills for Care, August 2019.
18 Approx. 1,200 social care organisations are named as their employers by survey respondents.
Key findings

1. A large majority of respondents believe too little is being done by employers to keep staff safe from the risks SARS-CoV-2 infection (69% of learning disability support workers, 60% of home care workers, 52% of residential care workers).

2. A large majority of respondents believe too little is being done by employers to keep people using care and support safe (58% of learning disability support workers, 56% of homecare workers, 43% of residential care workers).

3. 8 in 10 care workers that they would not be paid their wages as normal if they had to self-isolate. (79% of homecare workers, 83% of residential care workers, and 67% of learning disability support workers). Indeed, 61% of homecare workers, 72% of residential care worker and 57% of learning disability support workers believe they would receive only SSP payments, notwithstanding their high occupational exposure to the risk of infection.

4. Government guidance assumes PPE availability, but care workers state PPE is often unavailable or unsuitable. Evidence from care workers shows how lack of PPE is a safeguarding issue and there fears too about maintaining basic hygiene due to reported shortages of soap and hand sanitiser.

5. Official guidance has said no PPE is needed in certain situations, but evidence from care workers suggests this has created confusion and they believe lack of PPE is putting them, and others, at risk. Official guidance is not addressing the specifics of potential virus transmission in residential and homecare settings.

6. Care workers who are ill with COVID-19 are not all self-isolating. It appears that poverty, and fear of poverty, may be exacerbating the risk of transmission of SARS-CoV-2 in social care circles.

7. Care workers believe that lack of attention to minimising the risk of infection in care and support settings has directly contributed to outbreaks of COVID-19 in social care settings.

8. Reports from care workers provide evidence that in some care-settings there have been few, if any, attempts to reduce risk of transmission and these risks are compounded by difficulties in achieving social distancing.

9. Care workers are concerned that some measures implemented to deal with staff shortages may be accelerating the spread of SARS-CoV-2 in social care.

10. Care workers are concerned that their reliance of public transport is likely to be transmitting the virus between care-settings and the wider community.
“Social Care - Homecare”
Do you feel your employer is doing enough to protect the health and safety of staff?

Yes 40%
No 60%

“Social Care - Residential Care”
Do you feel your employer is doing enough to protect the health and safety of staff?

Yes 48%
No 52%

“Social Care - Learning Disability”
Do you feel your employer is doing enough to protect the health and safety of staff?

Yes 31%
No 69%

“Social Care - Residential Care”
Do you feel your employer is doing enough to protect the health and safety of service users?

Yes 44%
No 56%

“Social Care - Homecare”
Do you feel your employer is doing enough to protect the health and safety of service users?

Yes 57%
No 43%

“Social Care - Learning Disability”
Do you feel your employer is doing enough to protect the health and safety of service users?

Yes 42%
No 58%
Analysis of results: PPE problems

The most widespread concern reported by survey respondents across all care-settings was lack of PPE. In all four nations of the UK, it is a breach of legal requirements if failure to provide suitable and adequate PPE places people using care at risk of harm. It is a legal requirement that all employers ensure suitable personal protective equipment is provided to workers who may be exposed to a risk to their health or safety while at work. To be suitable, the PPE must be appropriate to the risks and conditions arising in care-settings. In the absence of suitable PPE, the risk must be controlled by other means.\(^{19}\)

However, our analysis of survey results reveals that across social care and support settings, workers are experiencing a severe lack of PPE. Their comments reveal an acute lack of attention, in workplaces and at policy-level, to the risks faced by staff and care home resident and other people using care and support.

Government guidance assumes PPE availability, but care workers state PPE is often unavailable or unsuitable.

Guidance issued by the Department of Health and Social Care on 13\(^{th}\) March advised that when caring for ‘residents with symptoms’, staff should use PPE for activities with ‘close personal contact’ including ‘washing and bathing, personal hygiene and contact with bodily fluids’.\(^ {20}\) The PPE referred to was aprons, gloves and fluid repellent surgical masks, to be used for each episode of care and securely disposed of. Our emphasis, in bold, of key phrases above serves to highlight that guidance did not urge the use of PPE where residents were not showing symptoms. It is also concerning that referring to ‘symptoms’ does not take account of growing evidence of SARS-CoV-2 transmission through contact with faeces (see Context section above). Further, in circumstances where residents did have COVID-19 symptoms, the Guidance is silent about the need for PPE when care workers were engaged in tasks other than personal care, for example when serving food or engaging in social activities.

The guidance of 13\(^{th}\) March further noted that care homes are ‘routinely procuring PPE such as aprons and gloves’ and in addition, a ‘free issue of PPE’ from pandemic influenza stockpiles would be combined with other arrangements to enable adult social care providers to access ‘further PPE as necessary’. The Department of Health and Social Care Guidance for Homecare Providers about COVID-19, updated 6\(^{th}\) April, also referred to routine procurement of PPE such as gloves and aprons, the ‘free issue of PPE’, and additional arrangements to provide PPE ‘as necessary’.\(^ {21}\)

Government guidance is therefore written on the basis of assuming the availability of PPE in care-settings, and this assumption continues. However, data from the UNISON survey reveals the extent to which PPE is not available. Reports of lack of PPE made up the overwhelming majority of comments from survey respondents. One care worker stated there is:

\[\text{No communication, no PPE, no respect} \]

\(^{19}\) Personal Protective Equipment Regulations 1992, Regulation 4(1) and (3).


Another wrote of their employer:

They have just give[n] us nothing

And some care workers report they are not being given PPE despite them being especially vulnerable to negative outcomes should they become infected with SARS-CoV-2. For example, this care worker with COPD reported:

When I enquired 3 weeks ago about extra PPE [the manager] laughed and told me it's not going to be like Italy, and I was scaremongering. Then she was unable to get enough PPE for all staff, despite knowing I have COPD, I wasn’t offered any.

Care workers are also aware that where PPE is available, this does not necessarily provide reliable protection. For example:

[We have] been told we will be provided with ppe but it's not the right equipment... for e.g. using dust masks

[I have] no PPE apart from a few loose fitting plastic gloves

Lack of suitable PPE impacts on the way in which care workers are able to undertake care tasks. The inability to protect staff and users of care services from COVID-19 produces circumstances and situations in which people are not being effectively safeguarded and infection control is jeopardised.

We have very little PPE, we are forced to tend to clients in a rushed way, making it difficult to follow correct infection control measures.

Lack of PPE is not the only issue, basic hygiene cannot be in place where there is a lack of soap and hand sanitiser. Care workers suggest supplies are running dangerously low:

Allowing people to work who are unwell and allowing people to work [when] a member of their family is in isolation we have no hand sanitizer and are running out of soap.

Not enough PPE or hand sanitiser. No checks on staff.

Health and Safety laws require that in the absence of PPE, protection against risk is achieved by 'other means’. The implication here is that it is unlawful to expose workers to health and safety risks without protection. Politicians have been slow to acknowledge the extent of risks caused by PPE shortage in adult social care and it remains unclear that they understand the vast size of the adult social care sector workforce and the risks to which the workforce is being exposed. It is concerning that government guidance assumes PPE availability in situations where PPE is missing.

It is of further concern that the presence of risk appears to be minimised in some aspects of official Guidance about COVID-19 in adult social care. As discussed below, data from care workers suggests that a lack of sensitivity to risk has been a feature of their working lives in recent weeks. It also appears that at a policy level there are considerable gaps in knowledge about the tasks undertaken by social care workers and the role they fulfil.
Official guidance has said no PPE is needed in certain situations, and evidence from care workers suggests confusion and elevated infection risk.

In the 13th March guidance from the Department of Health and Social Care, care homes were advised that where a resident has symptoms of COVID-19, they did not need to follow the same isolation procedures that apply to UK households in which one member is showing symptoms (meaning that it is not necessary for everyone in the home to self-isolate). This was explained as being because care homes have the ability to adopt isolation precautions. However, there is evidence directly from care workers that isolation is not always occurring. For example, one care worker commented in the survey:

We have a resident whose husband died from the virus so she was supposed to be in isolation but she was allowed visitors and staff [were] told off when she had a temperature and called 111. They were told not to call 111.

The Guidance of 13th March also stated that where neither the care worker nor the resident is symptomatic, ‘then no PPE is required’. This is concerning because it is well documented that people with COVID-19 can be asymptomatic but capable of transmitting the virus. It is advice which does not reflect the lag between contraction and becoming symptomatic, which is thought to range from 1-14 days. Guidance from Public Health England, at the time of writing most recently updated on 10th April, reports that SARS-CoV-19 can be present in blood, faeces and urine, as well as in airborne droplets. Respiratory symptoms are poor indicator as to whether PPE is need to protect from the risk of SARS-CoV-2 infection.

Furthermore, a large proportion of care home residents will have medical conditions which put them in the ‘extremely vulnerable’ group and therefore minimisation of COVID-19 risk ought to be a top priority, irrespective of symptoms.

Care workers have evidenced in their survey responses that they think risk of transmission has not been taken as seriously as they would have liked. For example:

up until Monday 23rd March we were being told “business as usual” by the senior manager and still expected to have contact with very vulnerable older and sick people in care homes and hospitals with no guidance nor support in the way of PPE or measures for our own safety.

Perhaps more worryingly, the Department of Health and Social Care produced updated guidance for residential care homes on 2nd April which stated that care home staff who come into contact with a COVID-19 patient while not wearing PPE, can remain at work. This, the guidance stated, is because ‘in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing’. This guidance suggested a considerable lack of understanding in senior level policy circles about practices in care homes, which are highly intimate and rely upon considerable personal physical contact.

---

22 See World Health Organisation https://www.who.int/news-room/q-a-detail/q-a-coronaviruses
A lack of clarity and lack of attention to risk has frightened care workers. Responses from care workers which shed light on their concerns in care homes and other settings include:

A colleague ill in work didn’t get told to go home and [was not told the] shift would get covered. Now I am in fear that myself or our clients are going to become ill ourselves.

We are told we are not allowed to wear PPE due to it scaring the people we support. We are not being able to social distance whilst in work due to the amount of staff [on duty].

We work in the community in and out of people’s homes. We do not know who has it and could be passing it on through our uniforms, our cars.

The 2nd April Guidance was withdrawn on 6th April, the same day as reports of the deaths of two care workers in the North West of England. It was replaced by Guidance (also issued on 2nd April) that is entitled: ‘Admission and Care of Residents during COVID-19 Incidents in a Care Home’.24 With regards to PPE, this document refers care providers to guidance relating to both health and social care workers, as though it is a single workforce.25 The document acknowledges it may be difficult to determine if individuals in need of care meet the definition for suspected COVID-19 prior to providing them with care. It makes PPE recommendations for a wide range of health and social care contexts but it appears that none of those ‘contexts’ include homecare settings or residential care homes. The text of the guidance refers to a social care worker being in a ‘specific clinical care-setting or exposure environment … which might include a ward round or taking observations of several patients in a cohort bay or ward’. This does not sound like a description of the work undertaken in social care and support settings. In what seems to be the most relevant paragraph of the guidance, headed ‘Individual’s home or usual place of residence’, it is stated that provision of direct care to any member of a household in a possible or confirmed case, requires the use of plastic gloves, eye protection, a fluid resistant surgical mask and aprons. There are widespread reports that neither care homes nor homecare services have sufficient PPE supplies to be providing this level of protection during care-giving interactions (notwithstanding doubts as to whether, in ‘confirmed’ cases, this level of protection is sufficient for workers undertaking personal care). Furthermore, it is unclear who is to be classified as a ‘possible’ case. As has been discussed above, the presence of respiratory symptoms is not a good indicator of risk of SARS-CoV-2 transmission. Should care workers be protected when providing personal care on the basis that all users of care and support services are ‘potential’ cases? This is not what is currently being advised.

Tables have been published by Public Health England to explain PPE recommendations for workers in primary, outpatient and community care settings.26 However, it is unclear whether the information in

any of those tables is aimed at social care and support workers or domiciliary or residential care providers.

A lack of clarity about PPE requirements in domiciliary care provision continues to be evident in guidance issued by the Department of Health and Social Care on 8th April for people who provide unpaid care to friends and family.27 This has included advice relating to concerns about paid carers coming in and out of the home and the risk of infection. The assurances offered are merely about risk reduction through ‘appropriate levels of hygiene’ and there is no reference to PPE. Indeed, in discussion of face masks, this guidance specifies that face masks are solely recommended for clinical settings because there is ‘little evidence of benefit from their general use outside these settings’.

It appears that Guidance issued by the Department of Health and Social care has been drawn up without adequate consideration of the particular needs of workers in residential and homecare setting, nor the UKs approximately 500,000 care home residents and over 800,000 people using domiciliary care and support in their own homes.28

**Analysis of results: pay problems**

Care workers who are ill with COVID-19 are not all self-isolating. It appears that poverty, and fear of poverty, may be exacerbating the risk of transmission of SARS-CoV-2 in social care circles.

In the Department of Health and Social Care Guidance of March 13th, any member of staff who was concerned they might have COVID-19 symptoms was advised to self-isolate and to ‘not visit or care for individuals until it is safe’.

But poverty, or fear of poverty, is a key issue that is resulting in workers not self-isolating. For example, care workers’ comments included:

- **staff are at work while ill as they fear losing pay, putting other staff and clients in danger.**

  Pressured to attend work because [...] income worries

Another reason for not self-isolating is because some care workers are unwilling to give up their responsibilities for care:

- **Symptoms are subjective to [self] diagnosis. Staff feel symptoms could be hayfever etc. Staff caring nature could result in them unknowingly passing the virus on as they may feel obliged to work instead of disclosing personal/family symptoms.**

Guidance to care homes and home care providers issued on 13th March and subsequent updates provide no assurance that all workers in the social care sector are at least entitled to Statutory Sick Pay (SSP), rather it is stated than workers employed on zero-hours contracts may be entitled to SSP if their average earnings are of at least £118 per week, while those who are ineligible ‘are able to

---


28 United Kingdom Homecare Association 2016, An Overview of the Domiciliary Care Market in the UK
claim Universal Credit’. It is little wonder therefore that survey participants express fear and confusion about what will happen should they need to self-isolate.

The bar chart above reveals that the vast majority of care workers believe they would not be paid their wages if they had to self-isolate. 79% of homecare workers, 83% of residential care workers, and 67% of learning disability support workers stated they did not think their employer would pay their full wages in the event of self-isolation due to COVID-19 concerns. Indeed, 61% of homecare workers, 72% of residential care worker and 57% of learning disability support workers believe they would receive only SSP payments, notwithstanding their high occupational exposure to the risk of infection.

Should a care worker have, or suspect they have, COVID-19, the low level at which SSP is set (£95.85 a week from 6th April) could put a self-isolating care worker in circumstances of extreme poverty because, under normal circumstances, care workers are typically paid less than the living wage. The impact of the low level of SSP on workers in the care sector illustrates that the failure of the UK Government to improve SSP benefits has a disproportionate impact on women and is arguably discriminatory in law. Women who were experiencing minimum wage level pay prior to the pandemic, will be driven further into poverty by the inadequacy of SSP.

Many care workers in the survey reported being confused about their rights to statutory sick pay, some were worried about reprisals and bullying should they withdraw from caring duties because of experiencing virus symptoms. As the graph indicates, some care workers thought that they would be subject to disciplinary proceedings and 15% of homecare workers thought they would face reductions in their ongoing contractual hours as a reprisal for self-isolation. These findings are consistent with what is known about the widespread nature of zero-hours contracting in homecare services and the precarious nature of work across the care sector. Survey comments from care workers included:

We have been bullied and belittled and some of the communication from management has been awful and upsetting

Pressure to work, no support
Pressured to give reasons why we can’t undertake home visits

Feel like I’m being pressured into work, [there are COVID-19] cases in the workplace and I have slight COPD.

Lack of availability of occupational sick pay is a considerable barrier to self-isolation in social care and it is a marker that significantly distinguishes this work group from staff employed in the NHS.

Lack of attention to the detail as to whether or not care workers are experiencing symptoms of COVID-19, and lack of regard for the need to self-isolate, appears to be at odds with legal requirements to report work-related exposure to disease. The risk, and impact, of COVID-19 must not be ‘hidden’ in care homes or other care and support settings.29

Analysis of results: Other COVID-19 related health and safety concerns.

The care sector is currently effectively operating without regulatory oversight. The Care Quality Commission (CQC) is the regulatory inspection body for registered care providers in England. The CQC wrote to registered providers on 4th March in a letter entitled ‘How we’re responding to the outbreak of coronavirus’. At this point there was no mention of suspending inspections. Rather, the CQC placed importance on ongoing inspection, stating that it would focus activity on ensuring ‘people receive safe care’ and ‘will always act in the best interests of people who use services’, referring to its ‘responsibility to check that the safety of service users is maintained’. The inspection of services is not a legal obligation on the part of the CQC, however, its core functions include ‘review and investigation’, as per s2 and s46 of the Health and Social Care Act 2008. According to its statutory duties it must conduct reviews of the carrying on of regulated activities, assess the performance of service providers and publish a report of its assessment. The Care Quality Commission (CQC) announced the cessation of routine regulatory inspections of registered social care providers in England from 16th March. In Wales, The Care Inspectorate announced that it too would suspend routine inspections from 16th March. In Scotland, Care Inspectorate ceased inspection from 13th March, closed its phone lines from 24th March and stated complaints would be received only via email, be risk assessed and passed on to the provider about whom the complaint was made.30 The suspension of inspection across the UK is concerning. Clearly inspection is difficult in the current circumstances but the safety of individuals in need of care, and the safety of workers who provide that care, may not be best served by stopping inspections. It is precisely at the point when regulatory compliance is most difficult that attempts to maintain minimum standards are of maximum importance.

In England, the CQC has stated that it will reserve its inspection powers for ‘a very small number of cases when we have concerns of harm, such as allegations of abuse’, although inspections would be undertaken differently, and physical inspection would occur only when deemed appropriate. It is to

29 The Reporting of Injury, Disease and Dangerous Occurrences Regulations 2013 require that where a care worker is diagnosed as having COVID-19 because of the work they do, their employer must report this, without delay, to the Health and Safety Executive (Regulation 9). The report should be made wherever there is ‘reasonable evidence suggesting that a work-related exposure was the likely cause of the disease’.29 The diagnosis of the medical condition must be made in writing by a registered general practitioner (Regulation 2). The employer must also make a record of the fact that the care worker has COVID-19, and keep that record on the workplace premises for at least three years (Regulation 12). These requirements also apply to care workers who are self-employed.

be hoped, although it is by no means certain, that a heightened risk of acquiring COVID-19 due to failures to meet the safety standards set out in the regulatory framework will be seen to qualify as a ‘concern of harm’ for which inspection will continue. In Wales, the Care Inspectorate has announced it will not take retrospective action for incidents arising while inspections are stopped unless these incidents occurred because of wilful neglect or deliberate harm. In Scotland however, the Care Inspectorate is adopting a proactive role in gathering information about staffing levels in care services, asking for notification where there is crucial need for PPE, documenting outbreaks of COVID-19 and counting deaths of people who use care and support services in Scotland.31

This approach in Scotland appears to contrast sharply with the situation in England, where the CQC has ordered that care providers should not notify it of confirmed COVID-19 cases.32 Regulation 18 Care Quality Commission (Registration) Regulations 2009 requires care providers to notify CQC of events which prevent, or threaten to prevent, providers from carrying their service ‘safely and properly’.33 In a clarification letter of 17 March, the CQC advised that this requirement meant providers must notify CQC ‘if your service operation is being negatively affected by COVID-19’. Again, it is to be hoped – but is uncertain – that an inability to provide adequate PPE, staff shortages or non-adherence to advice about self-isolation will each be recognised as events which prevent or threaten to prevent the provision of safe services and are notified to CQC.

As we summarise below, the survey findings suggested a range of important issues in addition to PPE concerns that would warrant investigation and reporting by regulatory agencies.

Care workers believe lack of attention to minimising risk of infection in care-settings has directly contributed to outbreaks of COVID-19 in social care-settings.

A member of staff who returned from Italy was allowed to come in to work. Now staff and residents have symptoms.

After being in contact with someone in the home who had COVID-19 and passed away we are not in isolation, management haven’t even contacted me to tell me he had it and passed and they are aware we do not have any protective wear. I also don’t get any sick pay so I should be in isolation but can’t.

Care workers’ report that in some care-settings there have been few, if any, attempts to reduce risk of transmission and these risks are compounded by difficulties in achieving social distancing.

Official guidance from the Department of Health as of 2nd April recommends that care home providers should follow social distancing measures for everyone in the care home, wherever possible, and observe the shielding guidance for residents who are in the extremely vulnerable group. However, evidence from care workers suggests that social distancing is not possible in many care and support

31 https://careinspectorate.wales/coronavirus-covid-19
33 https://www.cqc.org.uk/guidance-providers/notifications/notification-finder
34 Care Quality Commission (Registration) Regulations 2009, Regulation 18(1) and (2)(g)
relationships, even when there are no personal care tasks being performed. For example, care and support workers for people with learning disabilities reported:

The ppl I support have autism they do not understand the 2 metre gap, some also need personal care we cannot do this at 2 metres, & employers know this & as it's a day centre NOT RESIDENTIAL I do not understand why it is an essential service & cannot close.

Many people with learning disabilities are not able to follow social distancing rules and many may also need more time outside than other people. Guidance should therefore take account of this and give clear advice on how to support people safely in these circumstances.

We have had no support from higher management, service users are still attending some day Centers, we have limited PPE (gloves and aprons) we are still expected to go out on public transport with service users.

We have had to ask about stopping activities with families due to the risks of being in public places and mixing with others. The company were still willing for us to be going out mixing with others and visiting public places. Very low-grade PPE is available. Our young people don't understand social distancing due to their disabilities, so we are very vulnerable.

We do various shifts & are obviously going back to our families. We cannot maintain 2 meters apart in our job or ensure our safety from infection from fabrics etc.

Concerns about social distancing and shielding are particularly complex in homecare settings because care workers are one of perhaps many people with whom individuals come into contact. One homecare worker was concerned because:

[my employer] is not informing clients they need to stay at home to protect us and themselves.

The most recent Guidance from the Department of Health and Social Care for homecare providers was updated on April 6th.35 It makes no mention of the specific ways in which homecare workers are in contact with members of the family of the individuals who use care and support services, nor that those family members are also engaged in care and recreational activities which may expose the individual and the care worker to increased risk of exposure to SARS-CoV-2. There is nothing about safe travel to work and matters of pay are addressed solely with respect of the expansion of SSP eligibility from day 1 of sickness. As one care worker observed:

Families are still visiting service users from other households when they don't need to. Some families are not shielding adults, I have dementia patients that are still be taking out to the shops etc by family just to give them fresh air. This is not essential and putting service users at risk. My employer says there is nothing they can do.

---

However, difficulty in maintaining social distancing is, in some instances, resulting in the abandonment of any attempt to reduce transmission risk – even where staff members are extremely vulnerable to COVID-19.

We have **no** policies in place. [There are] more people in the building than normal. So we can’t follow the social distancing advice. Been told we still have to come to work even if family members are showing symptoms. We have to come even if we have colds or coughs. Also, the people in the high risk categories that have been told not to work, have to work. [These are] people with asthma and COPD.

Showing respect for the human rights of care workers requires that the law is upheld. Health and Safety laws require that COVID-19 infections must be recorded as work-related diseases where there is reasonable evidence to support the likelihood of this conclusion, particularly in light of the lack of PPE and other concerns of care workers.

Care workers are concerned that measures to deal with staff shortages are accelerating the spread of SARS-CoV-2 in social care.

On 18th March, in an House of Commons opposition day debate about social care, Barbara Keeley M.P. (then Shadow Minister for Social Care) asked the government for certainty that all measures would be taken to protect care workers, provide them with PPE and provide extra funding to the sector to cover infection control costs. She said that many providers were already on the brink of collapse and there were 122,000 vacancies in the sector. Evidence reported by care workers in our survey convey their belief that staff shortages are putting staff and people who use care and support at risk. They reported this is happening because they are needed to cover shifts, for example:

A few people have expressed concerns because of coming into contact with infected people and have been told to still come to work regardless.

They also reported that staff shortages have changed routines and patterns of work in ways they believe increase risk, for example:

Staff are now working split shifts with [additional clients] now, which increases our contact with more people, more houses and it increases the amount of outdoor exposure, we are under staffed, which is why we are working split shifts, and although management are putting safety protocols in place, no one is ringing staff to check on our mental health and wellbeing, we are all stressed, anxious and worried about getting the Coronavirus or making our loved ones sick, because of not isolating;

A lot of staff coming in and going house to house to cover shifts. Not providing enough PPE.

I work a double run and my normal colleague is off. That means this week I’m with 4 other carers. Surely we should be limiting who is contact with who because there moving staff
around instead of keeping them in one house and not providing proper ppe.

They are cutting the staffing and moving staff around homes... spread everywhere.

In the COVID-19 guidance for residential care provision issued by the Department of Health and Social Care on 13th March, care home providers were advised to work with local authorities to plan for a sharing of the workforce between providers. This was intended as a measure to pre-empt the effects of worsening staff shortages. However, it seems that care workers believe that a sharing of workers between care-settings presents a significant transmission risk. Comments from respondents in the UNISON survey include:

There are possible cases of COVID-19, management are telling staff its d&v. Staff are being moved around different units to work.

[we are at risk] By randomly moving staff around from one residence to another. Not for the fact of staff shortages due to illness which is understandable but taking regular permanent staff from houses and moving them on somewhere else. Making it harder in my opinion to narrow down and track where the virus could of been picked up and also to whom it may of been passed on should the need arise.

[It is not safe] Because r having to work in different houses.

Care workers are concerned that their reliance of public transport is likely to be transmitting the virus between care-settings and the wider community.

[Care homes] still have staff coming into work on buses that are overcrowded and full of health care workers.

Getting to and from work, no taxis, daren’t get in a bus for fear of getting infected. Can’t walk 2.5 miles home late at night alone.

I’m on zero hours being demanded to do more than expected in a pandemic on public transport right now.
**Our Recommendations**

Social care regulators across the UK announced the cessation of routine regulatory inspections of registered social care providers from mid-March. This is concerning. Clearly inspection is difficult in the current circumstances, but evidence presented in this report suggests a yawning gap between the safety standards required in law and the lack of safe working practices reported by care workers. The research team finds a severe degree of diversion from regulatory standards. Routine inspections are unlikely to be the best means of sourcing information about the current crisis, but regulatory bodies should be playing a role in tracking, understanding and reporting on the present problems in social care settings. While it is critically important that action is taken to reduce the risk of infection, it should also not be forgotten that the COVID-19 emergency will impact on the safety and quality of care beyond the risk of infection. The manner in which people in need of care and support are cared for when they contract COVID-19 must be examined by regulators, but regulators must also not overlook how care and support is routinely being provided when the sector is facing very difficult challenges. It is also important that the trauma that is likely to be experienced by both care workers and those they care for and support in the current circumstances is not ignored in official accounts, now and in the future.

1. In response to evidence that care workers are unable to self-isolate without experiencing considerable economic hardship, and in order to save lives, the Government must make arrangements for the provision of normal wage income to be paid to all care workers who are self-isolating.

2. The evidence presented in this report shows that care workers have expert information about what is happening on the ground in care settings. This expertise is lacking at policy-level and knowledge gaps could be costing lives. We call for the urgent appointment of care workers to problem-solving roles. They can bring their expertise to bear on decision-making about the use and distribution of protective equipment in local authority areas and in decision-making about best allocation of resources including staff resources.
Notes
Notes
Notes