

Care After Covid: A UNISON Vision for Social Care

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

The social care sector was woefully under-prepared for the pandemic. Lack of PPE, an inadequate testing programme and employer pressure on care workers to attend work against public health advice meant that care workers were exposed to significantly higher risk of contracting Covid-19. Tragically this is reflected in ONS figures on death rates by employment sector.

The crisis has exposed long-term systemic problems in social care such as fragmentation, privatisation, lack of funding, poverty pay and the undervaluing of care work.

This paper a number of key objectives for adult social care in Scotland:

1. Failures of the market, broken system:
2. The impact of the pandemic, forgotten frontline, lack preparedness and contingency planning PPE, workforce and the impact upon BAME population and workforce:
3. Workers' Rights, Fair Work in Care,
4. Clarity of vision, public sector provision/delivery of Adult Social Care in Scotland.

UNISON Ethical Care Charter

<https://www.unison.org.uk/tag/ethical-care-charter/>

UNISON Residential Care Charter

<https://www.unison.org.uk/tag/residential-care-charter/>

CHPI Plugging the Leaks in the UK Care Home Industry

<https://chpi.org.uk/papers/reports/plugging-the-leaks-in-the-uk-care-home-industry/>

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

The response to the pandemic has been problematic in other sectors, however, given the prevalence of elderly and vulnerable people involved, the failure to properly prioritise the care sector seems likely to be recognised as major failing. The causes need to be recognised and addressed.

The delivery of social care is different in each of the four nations (particularly so in Northern Ireland, where health and social care have been fully integrated since the 1970s) and so responses to the pandemic have not been uniform across the UK. The fragmentation of social care and the complicated commissioning and procurement processes have highlighted the impossible task of trying to deliver a central or devolved government response to some of the most notable system failures, including the supply and distribution of PPE, the availability of testing, and the pressure placed on thousands of care staff to attend work against public health advice.

With the NHS, the chancellor was quick to promise that the service would receive all the funding it needed to make it through the crisis, but no such reassurance has ever been forthcoming for social care. Whether and how government will reimburse councils for all the extra work they have undertaken and paid for during the crisis is still being debated in all administrations.

The pandemic has also shone a light on the poor employment practices which are depressingly widespread across the care sector. Workers in high-risk groups have felt pressured into going to work; there have been lockdowns in some care homes with workers told to remain on site if staff or residents become infected; and some companies have refused to give sick pay to self-isolating members of staff, or even those who have tested positive for Coronavirus. In a low-wage, low-status sector such as social care, too often it is the workforce that bears the brunt of financial pressures and “light touch” regulation.

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

Why We Need a National System for Social Care

Prior to the crisis, the care sector was already in a precarious state – as a result of chronic underfunding, an unstable market system and workforce shortages – with successive governments failing to take meaningful action. The pandemic has made it clearer than ever that there is an urgent need for an entirely different, more ambitious approach to care – for the reasons laid out below.

The fact that up to 10 May, 57% of covid deaths were in Scotland’s care homes, also points to the failings of our privatised, fragmented and underfunded social care system. The majority of care homes in Scotland are private for-profit (59%), with the third sector accounting for 27%, and local authority or Health Board provision only 14%.²⁹ There have been warnings of collapse without greater Government funding.³⁰ Yet while more money is needed, in itself this will not resolve all the problems, when 15% of income leaks out in the form of profits.³¹ Addressing this will require Government intervention and public ownership models. There is also a need for sectoral collective bargaining so that we no longer have situations where care workers are not paid a living wage or adequate sick pay.

There would appear to be political space, opportunity and a will to develop the argument at this time.

Cuts and Unmet Need

Austerity has led to local authority spending on adult social care shrinking by 7% per person in the past decade. Price is by far the most dominant factor in decisions around care commissioning and

councils have tightened eligibility thresholds in recent years. The “time and task” delivery of care means workers are often expected to deliver homecare within a 15-minute visit (or even less).

Market Failure

Market failure remains an alarmingly prominent feature of the social care landscape, with many providers entering the pandemic on a financial knife edge. In recent years, several of the largest providers have either collapsed or faced serious doubts about their future; councils have seen providers in their area close, cease trading or hand back contracts. Constant changes in ownership of care homes and provider companies is also a feature as investors buy, sell and restructure operations with little regard for the interests of service users or staff. This creates huge uncertainty and upheaval, including for local authority commissioners who may find one of their care providers has been sold off to a previously unknown entity.

HC-One, the largest nursing home company in Scotland and in the UK, has managed its facilities to maximise returns to shareholders at the expense of decent care and dignity for elderly residents. Underlying operational failures and misguided priorities have been exposed by the Coronavirus crisis and have led to an alarming and inexcusable death rate. The company, owned through complex tax haven structures, is now begging for increased government funding. While the company has been claiming losses and lack of public funding for years it has been sending millions worth of dividends to its offshore owners. Why should the government continue to fund foreign tax dodging billionaire investors who have abused residents, workers and the public trust? HC-One’s facilities need to be transferred to public control and run as part of the broader public health system.

Low Paid, Insecure and Transient Employment

Notwithstanding the Scottish Government’s commitment to Fair Work and the Scottish Living Wage in Care, many in the sector have yet to secure these employment benefits, largely due to the failure of the commissioning process and employers to pay for travel time and “sleep-in” shifts. Many care staff leave their roles each year and many are employed on zero-hours contracts. Shortages and high turnover affect the quality and continuity of care for service users, as does the low level of training many staff receive.

Skills, Training and Standards

The pandemic has led to care staff being redefined by the government as key workers – a welcome contrast to the pre-crisis situation in which they were repeatedly dismissed as “unskilled”. This elevated status must become an enduring feature of the sector – with a corresponding improvement in pay and conditions. Much of the work that care staff carry out requires considerable technical skills and inter-personal abilities that are often overlooked. But there is also a frustrated desire for greater training and development opportunities, which are virtually non-existent for large swathes of the workforce. Professional registration means costs carried by workers and little by way of staff development. Government recruitment campaigns and attempts at raising status have failed.

Complexity and Public Understanding

The crisis has shown that even the most basic understanding of how the care sector works is often lacking. There is a need for a simpler system that everyone can understand. In the current care market there are over 1,000 employers /providers involved in providing care across nearly thousands of establishments. Such complexity is compounded by the fact that there is effectively no one national budget for social care. Transparency is also hindered by the widespread involvement of private equity: the use of opaque financial structures by the parent companies of some care providers undermines public trust as well as allowing billions to leak out of the sector in profit, rent and interest.

“Light touch” Regulation

The pandemic has shown up the fact that there is no standardised reporting method for care homes. The sector has long suffered from the use of “light touch” regulation and self regulation of contracts.

The Care Inspectorate can scrutinise the actual delivery of care but cannot regulate council commissioning practices, nor ensure relevant and sustainable clinical governance. As a body primarily designed to regulate the quality of care, the CI is also ill-equipped to oversee the complex financial market that operates in social care. In addition, HMRC has been unable to properly enforce minimum wage regulations in the sector, with action to name and shame non-compliant employers restricted to small local companies.

Integration with the NHS/Local Government

Despite numerous attempts to bring about greater integration between health and social care, the pandemic has highlighted the continued failure of such approaches to bring about a genuinely joined-up system. Social care remains the “poor relation” of the NHS/Local Government and meaningful integration seems likely to remain out of reach while the two parts of the system operate from such different financial and organisational bases. In social care the lack of central levers available to ministers has been exposed by the crisis. The more disparate nature of many services is one reason why this is hard to replicate in social care, but so too is the existence of the hugely fragmented care market. These problems are compounded by the two representative bodies for care employers, together with the procurement process, makes it harder to set up partnership working and bargaining of the type that is well-established in the NHS and local government.

Towards a National Care Service

Longer Term Aspirations

The aspiration over time should be to deliver the vast majority of social care through public funding. This would begin to remove some of the differences in service quality between NHS and social care services, and would enable providers to have greater certainty over funding streams so they can plan better for future needs, particularly in terms of workforce. Ultimately the goal should be to bring social care up to equivalent levels of equity and access as those associated with the NHS/Local Government. There should be a corresponding aim to bring about greater parity between in terms of pay and training. This would hold out the future possibility of fully integrating the parts of the system.

Consolidation Measures

In moving towards a publicly funded and not-for-profit delivered care service there are a number of arrangements introduced during the past few months that should be consolidated and a number of further steps that should be taken to address immediate weaknesses in the system, secure the quality of the care being provided and improve the recruitment, retention and quality of staff.

These steps should include

1. Consolidate the nationally co-ordinated security of supplies of PPE into a system of national provision, taking full advantage of the economies of scale that can be achieved through procurement contracts where care providers will order and access supplies through national contracts and distribution. This can be extended beyond PPE to include other essential supplies to providers in all sectors.
2. Building on the work done by the Fair Work In Care Group and the interventions to secure both the Living Wage for all workers in the care sector and the payment of wages to staff when isolating and shielding during the pandemic, establish a timetable for the introduction of a Social Care Sectoral Bargaining arrangement that covers wage rates and terms and conditions across the sector. This would start with the consolidation of the SLW across the sector but would develop a timescale for raising levels of pay to the equivalent in health and local government over a period to be agreed, for example 5 years.
3. Build on the current framework and responsibilities for clinical governance across the sector with the Directors of Nursing in each IJB (or Health Board) having responsibility for ensuring that clinical standards are maintained in their area by all providers.

4. A national workforce plan for social care is urgently required and should be the responsibility of Ministers working with CoSLA, Health Boards, trade unions and providers. This should be based on the principals of Fair Work, and include a strategy to address immediate training issues and professional development.

Interim Measures

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

1. A substantial funding boost

There needs to be substantial extra investment in social care as a matter of urgency. This should be used to begin targeting levels of unmet need and should include dedicated investment in the workforce, as well as funding for councils to begin to rebuild in-house capacity. The aim should be to reframe social care as no longer just a “cost” but an important economic sector, with investment in it helping to rebuild local economies – particularly in the wake of the economic fallout from coronavirus.

2. Improved pay and conditions

Poverty pay must be ended with all workers in adult social care paid at least the Scottish (real) Living Wage, or at least £10 an hour, until the living wage reaches this level. But a pay rise on its own is insufficient given the poor practice of many care employers. There needs to be a standardisation of employment procedures within the sector. A standard contract template should be used for all care contracts, which would give universal weighting to workforce matters, which would include full sick pay, contracted hours (rather than zero-hours contracts), and a guarantee of pay for all hours worked (to include items such as travel time and “sleep-ins”). The template should be produced through partnership working, with a requirement for commissioners to reference it in tenders and for regulators to make this part of provider registration and enforcement.

3. A new focus on training and professionalism

The initial training requirements should be expanded to cover the technical skills required of care workers and should become a necessary pre-requisite for the future employment of all care workers. There should be a new focus on continuing professional development. In anticipation of greater integration between health and social care, place-based care systems should be used to join up recruitment, induction, training and development provision for both health and care staff, including apprenticeships.

4. Workforce strategy

Social care has so far been conspicuous by its absence from workforce planning undertaken by the NHS arms-length bodies, so a comprehensive workforce strategy for social care should be produced which would cover the issues above on pay, conditions, training, development and registration. It should seek to encourage a system in which workers have a greater voice within the workplace in accordance with the Fair Work principles. While Scottish Government has sought an extension of the visa scheme, it would be necessary to add care work to the UK government’s Shortage Occupation List, so that social care is not deprived of the migrant workers who have helped keep the sector afloat in recent years.

5. Ethical commissioning

The procurement and commissioning model is proven not fit for purpose, in terms of the number of tiers of government and agencies involved in the process. It is time-consuming, repetitive, largely dependent upon self-regulation, and the duplicated processes and administration leak funding and/or deny potential for ethical care, economy of scale in business support.

Commissioners should only purchase care from providers that are transparent about their operations, pay their taxes, recognise unions, and can demonstrate compliance with the workforce requirements above. To ensure that providers’ primary aim is to work for people rather than profit, the level of profits that can be extracted from contracts should be capped. Commissioners should work with regulators to

assess the sustainability of providers' financial models before awarding contracts, and both should have a responsibility to enforce commissioning requirements and maintain standards.

Wider Considerations

There is a need for realism; the more ambitious elements of this vision cannot be achieved overnight. However, the pandemic has illustrated clearly the undervaluing of this essential service and its rightful place in any caring society.

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

Any such plans should be undertaken in conjunction with both the NHS and local government. Along with other mechanisms – such as fair wages clauses – the merits of sectoral bargaining in social care should be adopted, particularly for those workers who cannot be covered by existing national Agenda for Change or SJC agreements.

As a minimum, the Fair Work in Care forum represents a move towards a “social partnership” approach in this sector, bringing together commissioners, providers, governments and trade unions to scope out solutions to the already well-known problems. This work had begun before the pandemic. It should be reconvened urgently.