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Building a resilient social care system in England

What can be learnt from the first wave of Covid-19?

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The interviews for this project were undertaken in spring and summer 2021. The focus of the interviews was on experiences during the first wave of Covid-19 (Feb–May 2020) and what had subsequently been learnt by the time of the second major wave (winter 2020/21).

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Executive summary

The aim of this research is to identify actions that could be taken to build a more resilient social care system in the wake of Covid-19. This report is the result of a thematic analysis of 17 in-depth interviews with key social care stakeholders, six hours of workshops with a range of different stakeholders from the social care sector, and analysis of 72 policy documents, published papers and reviews. The interviews for this project were undertaken in spring and summer 2021.

The focus of the interviews was on experiences during the first wave of Covid-19 (Feb–May 2020) and what had subsequently been learnt by the time of the second major wave (winter 2020/21). The intention was not to critique the response itself but to identify the underlying factors that shaped the response in order to identify priorities for building resilience in the sector.

Stakeholders represented a range of types of providers, service users, unpaid carers, social care workers, local government, arm's-length bodies, disaster response experts and primary care networks. Officials at the Department of Health and Social Care were invited to be interviewed but no one was available. As such, this report presents the experiences and reflections of those involved in social care during the inital months of Covid, triangulated with information in publicly available documents. Relevant documents and literature published up until December 2021 were included for analysis. Documents published after this date have not been systematically identified and analysed and are only referenced where important for context.

Much has been written about the speed and adequacy of the government's response to the Covid-19 pandemic in the social care sector. In this report, we seek to go beyond providing a descriptive account of *what* happened and to analyse *how* structural and systemic factors influenced the initial national response and affected the ability of the sector to respond to the pandemic.

Social care entered the pandemic in a fragile state – a decade of austerity had seen council budgets being squeezed and spending on care falling. As a result, there were growing levels of unmet and undermet need in society; unpaid carers were increasingly stepping in to fill gaps in care; many of the small and medium-sized providers that make up the majority of the social care market were struggling financially; and workforce shortages were widespread.[1]

Covid-19 has had far-reaching impacts on all those in the social care sector and has exposed and exacerbated many of these longstanding underlying issues. There is an opportunity now to use the learning gained during the pandemic to identify priorities so that the sector recovers and is put on a more resilient footing in the long term.

In the course of this work, we have tried to identify issues that stakeholders have highlighted that are amenable to change within the government's future reform plans. Through thematic analysis of interviews with stakeholders across the sector, workshop content and documents published during the spring, summer and autumn of 2021 (see Appendix 1), we have identified a number of lessons, with reference to the early months of the pandemic, that are grouped as follows:

- **The system.** A range of deeply rooted systemic issues, with unclear roles and responsibilities among levels and areas of government, impacted the coordination and timeliness of the response to the pandemic.

- **People.** A lack of deep understanding of the social care sector (in terms of who draws on support, the paid and unpaid workforce, and the range of different services) among those leading the response meant that measures and guidance were insufficiently sensitive to the diversity and complexity of this vast sector.

- **Resources.** A lack of sustained investment, and instead a reliance on sporadic injections of funding, over the preceding decade resulted in the sector entering the pandemic with patchy data, limited spread of technology and innovation and a residential care estate that was not fit for purpose.

Much learning took place over the course of the early months of Covid-19 and this report seeks to highlight where positive progress has been made as well as identifying where action is required for the creation of a more resilient system.

Lessons on the system: visibility, accountability, collaboration and preparedness

It was not sufficiently clear who, or which organisation, was responsible for different aspects of the response for social care in the initial months. The lack of clarity was mentioned by all stakeholders interviewed, and by many during the workshops, who said they observed or perceived there to be confusion around where responsibility lay at different levels of the system. For example, they mentioned confusion at national level between government departments and arm's-length bodies, between local and national government as well as between care providers and government and they felt that that confusion had delayed parts of the response (e.g. PPE procurement and supply and the roll out of asymptomatic testing in the sector). The complexity of accountability has been highlighted by the National Audit Office, with regard to PPE.[2,3] It is important that clarity around responsibilities and leadership for all parts of the system is established both in 'normal' times but particularly in preparation for a future crisis.

Adult social care voices were not sufficiently embedded in decision-making structures. This rendered social care largely invisible in the early stages of the response. While all eyes and efforts were focused on the National Health Service (NHS), social care representatives struggled to raise the profile of the sector, despite its vast scale and critical role in the pandemic. With no dedicated director general for social care in the Department of Health and Social Care (DHSC), no adult social care voice on the Scientific Advisory Group for Emergencies (SAGE) at the outset of the pandemic and no regular channels of communication between people drawing on and providing social care and central government, social care was overlooked other than as an adjunct to the NHS. However, over the course of the pandemic, effort was made to establish better and more regular engagement with those in the sector, a SAGE Social Care Working Group and a social care taskforce were established, and a director general and a (now permanent) chief nurse for social care were appointed.

Good relationships between health and social care at a local level were helpful in supporting the sector but too embryonic in some areas. In areas where relationships were well developed, there were examples of the two services working together to share resources and support each other. However, the level of collaboration was variable and in areas with limited or fractious relationships, stakeholders offered accounts of health and social care not operating in a mutually supportive manner. There is now an opportunity for place-level structures within integrated care systems to build on progress and put in place foundations for more effective collaboration in future.

Opportunities to prepare the sector for a pandemic, or other crises, were missed. Several opportunities to strategically prepare the social care sector in the years immediately before Covid-19 were overlooked. A number of pandemic-planning exercises either excluded social care or, where social care was considered, action was not taken to address identified deficiencies. As the pandemic advanced across the world, too little attention was paid to the experiences of social care (in particular, care homes) in other countries. And once infections took hold in England, pre-existing knowledge of infection spread in congregate care settings was not sufficiently applied to the emerging situation. Positive progress has been made during the pandemic to plan for ongoing outbreaks, for instance with the establishment of the social care taskforce in summer 2020 and the subsequent winter plan for 2020/21,[4] but longer-term planning is needed.

Lessons about people: complexity of the sector, the formal workforce and unpaid carers

There was too little understanding of the complexity and diversity of social care among those leading the response. Once social care did feature in response plans, guidance did not sufficiently take account of this vast and complex sector, paying insufficient attention to non-residential care and certain groups such as those with learning disabilities. Stakeholders felt that limited capacity within the DHSC adult social care team as the pandemic struck, combined with the practice of moving civil servants between specialties, meant there was limited operational knowledge or understanding of the structure of social care among those developing guidance. Blanket guidance, often written with the NHS in mind, was inappropriate or difficult to interpret within social care settings, leading to delays in implementation and confusion among those in social care. Stakeholders reported that tailoring of guidance improved as the pandemic continued. Social care capacity at the DHSC has since been bolstered and the knowledge gained now needs to be retained and developed.

The wider Covid-19 response did not adequately take account of the structure of and pre-existing issues in the adult social care workforce. The impact on the adult social care workforce of policies on, for example, isolation and testing for non-NHS workers was not adequately understood. Crucially, the majority of the social care workforce did not have access to occupational sick pay and that had far-reaching implications for the ability and willingness of staff to self-isolate. When initially proposed, policies to limit movement of staff introduced in September 2020 did not adequately take account of the nature of domiciliary care, high levels of staff vacancies and the fact that, as a largely low-paid sector, many staff often work more than one job. Although some progress has been made to adapt policies to take account of some of these challenges, underlying issues of low pay and unstable contracts continue to be a problem and need to be addressed to ensure the sector can better withstand future shocks.

The social care system relies heavily on unpaid carers but limited support was provided to them as part of the response. Carers have played a pivotal role in supporting people who draw on social care over the course of the pandemic yet they have had access to little tailored support or respite. In fact, many carers have reported diminishing support during the pandemic as the regular community and voluntary services on which they previously relied closed. Stakeholders pointed to a lack of clear accountability at a national level for carers policy, and delays in identifying carers in routine data, as factors that rendered carers largely invisible in much of the early response.

Lessons on resources: funding, data and estates

Emergency financial support was welcome but has not offered sufficient certainty or flexibility to stabilise the sector. Emergency funding for providers was crucial in supporting many organisations through the pressures of Covid-19 and interviewees clearly welcomed this and the Health and Care Act (2022) has since created provisions to enable faster emergency payments to providers in future. Many small and medium-sized organisations that provide the majority of care in the sector entered the pandemic with few financial reserves to meet the sudden increase in costs stemming from staff sickness, PPE purchases and lower occupancy (in residential care), and minimal back-office support to cope with new administrative burdens. While seen as a lifeline for providers, the short-term nature of the emergency funding – with extensions frequently announced with only weeks, days or in one case hours before the end of the scheme and in ways that interviewees felt did not allow providers sufficient flexibility in how it could be spent – offered little certainty to providers trying to plan into the future and did not allow those on the front line to spend it to meet the needs they could see. Interviewees reflected that the tendency over the preceding decade to allocate funding to social care in the form of sporadic injections of cash had limited the scope for strategic investment and had implications for how robust the sector, and its infrastructure, were entering the pandemic.

When Covid-19 struck, there was a lack of good quality data and information about who uses and provides adult social care services and how to communicate with them. Social care lacks a comprehensive information system or standard minimum dataset and, as a dispersed system funded via a mix of public and private money, many councils do not hold comprehensive information about everyone who draws on care services nor even all the people and organisations that provide care. This lack of adequate information and an absence of established routes of communication made coordinating and administering the response all the more complex. Covid-19 has accelerated efforts to collect data and this is helping to lay the foundations of a robust source of standard data.

The fragile state and the complexity of the adult social care infrastructure, in particular the residential care estate, were not adequately considered. In the run-up to the pandemic, the adoption of technology across all parts of the sector had been slow and innovation in service delivery had been patchy. In the absence of good data, the Covid-19 response made too many assumptions about the state of the social care estate and the ability of care homes to cope. Outdated buildings, many of which are small, had lacked investment in previous years and providers struggled to follow guidance to isolate or cohort infected residents and to accommodate wider infection control measures.

Recommendations

The system

- The progress made in embedding social care voices in core decision-making, and giving the sector the prominence and visibility it needs, should be maintained and developed within central government to create strong foundations for reform. Making permanent some of the advisory groups (such as the social care taskforce) and channels of communication between the sector and government may be one way of ensuring that those with deep operational knowledge and direct experience of social care inform national policy and guidance.

- The knowledge and understanding of the sector that have been gained across central and local government need to be retained and embedded to ensure that organisational memory and positive working relationships are not lost and that the new capacity in the DHSC social care team is retained and developed.

- Clear lines of accountability for national and local government actors, including wider stakeholders such as public health actors, need to be established during 'normal' times as well as during times of crisis, paying close attention to what works best at a local level versus national level.

- It is essential that the government places greater emphasis on long-term preparedness and risk monitoring, to put social care on a resilient footing to weather all types of potential future shocks. This should include:

learning from successes; learning from other countries; and creating a central support structure that can click into place in the event of a crisis. This may, for example, take the form of operational blueprints that set out accountabilities and protocols for emergencies, which could include a range of potential emergencies such as other infectious diseases, climate events and political, economic and social crises.

- Places within newly establishing integrated care systems need to nurture and build on the local relationships that have emerged between health and social care over the course of the pandemic. Places should endeavour to learn from each other about initiatives that have been effective in building relationships (for example, having a social care representative in a primary care network). Social care needs to be seen as an equal partner in these new arrangements if it is to be put on a more resilient footing in the long term.

People

- In times of crisis, the DHSC and other relevant bodies responsible for issuing guidance and advice need to fully consider the diversity and complexity of the social care sector to ensure that adequate and appropriate support is available to all in a timely and accessible manner.

- A comprehensive, long-term workforce strategy (akin to the NHS People Plan[5]) must be brought forward to build a stable, motivated and supported workforce with the skills and capacity to better weather future shocks. This must address not just the immediate issue of staff burnout but also the underlying weaknesses around pay and conditions. The strategy must also effectively build career opportunities for staff, address the lack of parity with the NHS workforce and tackle perceptions that care work is low-skilled.

- The government’s reform programme needs to invest in measures to better identify and support carers. Improved data collection, reinstating respite and day services and supporting those who want to remain in employment by introducing paid leave are some priorities that need to be included. Clarifying accountability around policy for unpaid carers at national and local government levels will help to drive progress in this area.

- As social care reform gathers pace, the DHSC and wider government need to ensure that unpaid carers are fully considered, paying attention to other policy areas (for example, work and pensions) that also impact on carers. Local government and social care providers (including voluntary and community groups) need to be given the tools and resources to ensure that support that has fallen away during the pandemic can be reinstated and expanded.

Resources

- Since completing this report in spring 2022, the government has announced that it will make available (from national funds and revenue to be raised locally) up to £7.5 billion for the sector over two years. However, there is a need not just for more central government funding for social care but also for funding to be more certain to enable stability and encourage strategic investment in new services that keep pace with need and changing preferences. A multi-year financial settlement would offer more certainty to the sector.

- Investment in better data is essential to ensure a good understanding of people who draw on, and work in, social care, making sure that no groups are excluded. Implementation of the new data strategy should build on positive progress made in the pandemic and ensure that data is integrated and coordinated across services, offering maximum benefit and minimal burden for people in the sector. As part of this, it will be important to ensure the digital skills of providers, staff and unpaid carers are sufficiently developed to facilitate adoption, improve connectivity of care records and ensure cyber security.

- Modernising the existing social care residential estate, including extra-care housing solutions, to withstand both future pandemics and other shocks (for example, those arising from climate change) is of utmost importance. In the course of that investment, new and innovative models of care that offer greater choice and independence should be explored and encouraged. Commissioners of new care models need to use their market-shaping powers to ensure that increased public funding is used to improve infrastructure.

- Evaluation of new models of care across all settings (including domiciliary care), as well as of the impact of digital technologies, innovations and treatments that have proven to be effective during the pandemic, will be important for generating an evidence base on which to scale and spread initiatives such as the 'Developing resources And minimum data set for Care Homes' Adoption' (DACHA) study and the 'Vivaldi' study. Evaluations will need to pay special attention to the impact on digitally excluded groups.

- In light of a shift in preference for home care over residential care that the pandemic has accelerated, and the government's commitment to putting housing at the centre of all care discussions, there is an opportunity to work with people who draw on and work in social care to develop innovative models of care that are fit for the future. It is important that sufficient funding is earmarked for such innovation.

1 Introduction

Covid-19 has had profound and far-reaching impacts on everyone involved in the social care system in England – from people drawing on care services, unpaid carers, the paid workforce and organisations providing care, to those involved in organising, leading, regulating and commissioning care. At the time of writing, the sector is still grappling with these challenges and their knock-on consequences.

A vast and complex sector which supports over a million people and employs 1.5 million staff in more than 14,000 diverse organisations, social care is a vital part of the country's infrastructure.[7] However, a decade of austerity preceding Covid-19 saw council budgets cut by half, putting a squeeze on spending on social care and leaving the sector in a fragile state.[8] Social care entered the pandemic with high levels of unmet need, a high number of staff vacancies and many care providers struggling financially.[9]

Successive governments repeatedly dropped proposals over the past 20 years to address issues in the funding and delivery of social care, despite growing consensus that reform was needed. Well in advance of Covid-19, the then Prime Minister Boris Johnson (like many of his predecessors) had publicly recognised the need for reform of this struggling system. In his first speech after taking office, he said: "We will fix the crisis in social care once and for all with a clear plan we have prepared."[10] And, at the point at which Covid-19 hit, a plan for reform was being eagerly awaited. Many of the issues that have come to the fore during the pandemic are, therefore, not new but pre-existing fault lines that the pandemic has exposed and exacerbated. These pre-existing issues shaped and impacted the response to Covid-19 in social care. Our theory of change workshops mapped out the pre-existing problems with the system to provide a basis from which to undertake this work.[11]

This is a pivotal moment in the history of the care system. As the government implements its White Paper on adult social care reform and starts to carry out funding and charging reform (now set to be introduced in 2025 following a delay),[12] there is now an important opportunity to learn from experiences during the pandemic. If social care is to recover from Covid-19 and to be more resilient in the face of pressures in the long term, the underlying factors that determined the effectiveness of the response need to be understood and addressed. The positive progress that has been made during the pandemic must also be embedded and built on.

In this report we aim to go beyond providing an account or critique of the government's and sector's response to Covid-19 in relation to social care. Instead, we seek to identify the underlying systemic and structural factors that shaped the response and that are amenable to change. We also seek to highlight where there have been positive changes and learning during the pandemic so that this progress can be harnessed and built on.

Our approach

This report is the culmination of several months of work that took place over the spring, summer and autumn of 2021. Its main intended audiences are system leaders, policy-makers and government as they seek to rebuild and reform the social care system post-Covid-19.

The report presents a collection of lessons that can be learnt from England's Covid-19 experience in social care, based on a thematic analysis of:

- in-depth interviews with 17 sector experts
- two theory of change workshops, with 31 stakeholders attending the first session and 26 attending the second session
- more than 70 documents published between April 2020 and November 2021.

Participants were identified through an extensive stakeholder mapping exercise and were selected to ensure representation from people who draw on care, unpaid carers, the paid workforce, providers of care, commissioners of care and those across national and local governmental and non-governmental bodies with a role in administering the system. An expert in disaster preparedness, Professor Lucy Easthope, was also interviewed specifically for Chapter 3.

For more on our methods and the limitations of this research, see Appendix 1.

Structure of this report

In the next chapter, we provide a high-level summary of some of the impacts of Covid-19 in social care. This is in no way exhaustive but serves as a reminder that conversations about structures and systems must always be grounded in the experiences of the people that those structures and systems affect.

In subsequent chapters, we explore a number of underlying factors that our work suggests played a role in determining the shape and effectiveness of the Covid-19 response in social care during the early stages of the pandemic. Within each chapter, we point to any positive progress that has been made during the pandemic and identify learning that needs to be taken from the experience.

The lessons have been grouped into three main categories for ease of presentation but it should be noted that the lessons are closely interlinked:

- **The system.** Chapter 3 focuses on the structural and contextual factors that were significant at the time the pandemic struck and impacted the approach taken to the response, and draws out themes around visibility, accountability, collaboration and preparedness.

- **People.** Chapter 4 focuses on how the vastness and complexity of the sector – the totality of what social care comprises and the characteristics of the people within it (including those who draw on care or provide it unpaid or paid) – were not sufficiently understood and taken into account in the national response.

- **Resources.** Chapter 5 focuses on a number of underlying issues around the resourcing of the social care sector and explores how the state of the sector entering the pandemic had implications for the effectiveness of the response.

A note on the wider project

This report is one output from a wider project – Social Care COVID Resilience & Recovery – which is funded by the National Institute for Health and Care Research. The study aims to inform policy and practice as the social care sector in England grapples with, and recovers from, the impacts of the Covid-19 pandemic. The project is structured in four parts:

- **situational analysis** to understand the impacts of the pandemic on the people and organisations involved in social care in England and the policies and practices that have supported or hindered the response to the pandemic in the social care sector – this will be used to co-develop an analytical framework from which to identify key areas of learning from international experiences and scientific evidence

- **evidence reviews**, including a mapping of the scientific evidence on Covid-19 and long-term care that is emerging

- **international case studies** to identify the experiences of other countries that can potentially provide relevant learning for key issues that need to be addressed in the English social care system

- **the development of policy and practice recommendations**.

2 Impacts of Covid-19 in social care

The early weeks of the Covid-19 response in social care have been widely criticised for being slow and poorly coordinated.[1,13,14] Although some measures were taken in March 2020, including the passing of the Coronavirus Act, some guidance around infection control (for example, around visiting in care homes) and some funding for councils that could be spent on social care, a full action plan for social care was not published until 15 April 2020. By this point, mortality in care homes was already peaking.[15,16] People we spoke to as part of this research commented that social care felt largely invisible relative to the NHS in the early weeks of the pandemic. For instance, 'hospital discharge service requirements' were issued to the NHS and social care leaders on 19 March 2020[17] but a social care-specific action plan did not follow for almost another month. Furthermore, interviewees said they felt unclear about key policies such as those relating to cohorting and testing in care homes and other accounts echo this experience.[18] The National Audit Office, too, noted that while letters and guidance issued to the NHS implied actions for the adult social care sector, care providers found them difficult to follow.[19]

The organisation, funding and distribution of PPE to social care were initially slow. The nature of the vast and complex social care provider landscape exacerbated global shortages of PPE* and providers reported feeling insufficiently supported in obtaining PPE in those early months.[2] Social care staff, too, were not initially prioritised for testing, so they had no greater access to asymptomatic testing than the general public until late April 2020. People drawing on care and those representing providers of care involved in our study described variation in the guidance and support they were able to access

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* For more on the market, see Curry N and Oung C (2021) Fractured and Forgotten? *The social care provider market in England*. Nuffield Trust. www.nuffieldtrust.org.uk/research/fractured-and-forgotten-the-social-care-provider-market-in-england#key-points. Accessed 23 January 2023.

across the country. Much learning has taken place over the course of the pandemic, and supply-chain and testing issues were eventually resolved, but the experiences in the first weeks of the pandemic help to identify underlying issues that could be addressed in relation to preparedness for future shocks. These themes will be explored in more depth in later chapters of this report.

The impacts of Covid-19 are worthy of a suite of in-depth papers and we cannot do justice to the extent of them in this report, but we have sought to highlight just some of the impacts that interviewees and workshop participants outlined in order to set the lessons that follow in context.

Impact on mortality

Mortality in care homes has been one of the most visible impacts of the pandemic. There were almost 20,000 deaths of care home residents of all ages where Covid-19 was mentioned on the death certificate between mid-March and mid-June 2020 (40% of all Covid-19-related deaths) and a further 16,355 deaths between October 2020 and early February 2021 (26% of all Covid-19-related deaths).[15] By 14 April 2022, the cumulative number of deaths of care home residents whose death was attributed to Covid-19 was 44,829.[20,*] Deaths of people in receipt of home care that are associated with Covid-19 are also estimated to be high but official figures are hard to come by.[21] It should be noted that official care home figures do not include deaths that may have been due to Covid-19 but were not identified as such, particularly at the beginning of the pandemic when access to testing was limited.

Impact on wellbeing and support

Many impacts other than mortality have been less visible. Implementing infection control measures in residential care and home care has raised ethical questions about the balance of rights of those who draw on social care – especially people with dementia. The isolation and shielding policies in place to mitigate the spread of infection (in particular, the ban on visiting in care

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[*] The report where this figure came from is a 'live' report and is being constantly updated. This figure was correct as of 14 April 2022 (accessed 7 February 2023).

homes) have affected people's wellbeing as many, potentially in their last years of life, have been separated from loved ones.[22] Measures, such as isolation and restricting visiting, are the subject of an evidence review undertaken as part of this project and have been reported on separately.[23]

For many people who draw on social care, and unpaid carers, the statutory and voluntary services and support that enable them to go about their daily lives were halted or stopped, and access to health services was rendered more difficult.[22,24] As of April 2021, more than half of directors of adult social care services reported that the temporary closure of services had led to an increase in the number of people presenting with needs or being referred to their local authority.[25] The impact of this discontinued support has been stark: for instance, it has been reported that carers lost an estimated 25 hours of support each month during the pandemic, and 69% of surveyed carers felt that their mental wellbeing had worsened as a result.[26]

Concerns have also been raised about reduced physical activity in older people over the course of the pandemic, especially among users of social care, leading to increased needs and costs in the long term.[27] Deterioration has affected many different groups, with analysis from the Alzheimer's Society finding:

- 82% of people affected by dementia reporting significant deterioration in their loved ones

- 39% of stroke survivors feeling they had not received enough rehabilitation therapies

- 21% of older people with a long-term health condition reporting a loss to their independence.[28]

Concerns have been raised that this loss of function could potentially be irreversible for some. The long-term implications of this will not be fully understood for some time.

Demand for social care support has been increasing steadily over the past decade across adults of all ages, but Covid-19 has accelerated that trend.

The Association of Directors of Adult Social Services (ADASS) estimates that as many as 400,000 people are waiting for a care assessment or support, as a result of a combination of growing demand and capacity constraints in the sector (as of autumn 2021).[29] Unpaid carers have increasingly had to step in to fill the gaps in services and Carers UK estimates that an additional 4.5 million people became carers as Covid-19 struck.[30] At the same time, many of the support and respite services on which unpaid carers rely shut down. Stakeholders have emphasised to us that the physical and emotional stresses of ongoing caring without breaks have taken their toll but are largely unseen, with the crisis contained to people's homes.

There have also been accounts of people who draw on social care having reduced access to health care services. This is explored further on page 32.

Impact on the social care workforce

The social care workforce has also faced significant pressures as many have made sacrifices to maintain safe service delivery, adapted to complex guidance and new tasks, and experienced the emotional cost of losing service users in their care.[22] The toll this has taken on an already fragile workforce must not be underestimated. A total of 922 care workers had died as a result of Covid-19 by 7 May 2021[31] and, with sickness absence rates almost doubling from five days on average pre-pandemic to nine and a half days by spring 2021,[32] there has been a capacity pressure as well as an emotional toll. Care workers – many of whom are on zero-hours contracts – have lost out financially as they have been unable to work when needing to isolate or while they have been sick, and many continue to experience burnout and fatigue. Experimental data published by the DHSC indicate that the adult social care workforce shrank by around 3% in the six months to October 2021, with the loss of an estimated 50,000 to 70,000 staff.[33] Staff burnout and stress was the third-highest reason (9.7% of weighted responses across care homes and domiciliary care) for staff leaving in a DHSC survey of providers in December 2021, after better pay and working conditions elsewhere. Concerns about the mandatory vaccination was the next most cited reason (9.6% of weighted responses).[34]

Impact on inequality

The impacts of the pandemic have not been spread equally across society. The pandemic has further exacerbated existing inequalities among both social care users and care staff. Care commissioners and providers feared that people from lower socioeconomic and/or minority ethnic backgrounds had experienced worse outcomes. The Care Quality Commission's (CQC) 2020 *State of Care* report found, for example, that the proportion of deaths in adult social care services was higher among Black people (49%) compared with White people (41%).[22,*] Stakeholders have noted the high number of social care staff from minority ethnic backgrounds: 12% of social care workers are from Black/African/Caribbean/Black British backgrounds, compared with 3% of the general population.[32] The disproportionate impact of the pandemic on people from some minority ethnic backgrounds is well known.[35] The high representation of other protected characteristics such as gender (82% of the social care workforce are female) and known determinants of health, such as wealth disparities, are also likely to have affected the impact of the pandemic on the social care workforce.

More than 150,000 people with learning disabilities receive local authority support for social care[36] on whom the impact of the pandemic was, and continues to be, especially pronounced. People with learning disabilities are estimated to be more than three times more likely to die of Covid-19 than the general population, and Covid-19 accounted for 54% of deaths for adults with learning disabilities living in residential care in April–May 2020, and 53% of deaths for people using community-based care.[37] In 2020, the excess death rate for people with a learning disability was 34.3%, and 21.5% in 2021.[38] As of 30 April 2022, an estimated 1,850 people with learning disabilities and/or autism were notified to the LeDeR programme as having died from Covid-19.[39] Interviewees also noted that the cumulative impact of the pandemic was such that "a group of people who have for many, many years [been] fighting very hard for a kind of level of recognition [and] independence have been rendered very invisible by the pandemic" (interviewee 12).

[*] Note that the CQC has not published mortality rates by ethnicity in granular categories beyond Black, Asian, White and Mixed or Multiple ethnic groups.

Financial impacts

Research by the Institute for Fiscal Studies reveals that the net local authority additional expenditure as a result of the pandemic in 2020–21 was £4.1 billion – less than originally predicted as a result of central government grants and the restriction of culture and leisure services during lockdown.[40] However, council budgets were put under great pressure at a time when locally generated revenues fell. Increases in council expenditure were highest in adult social care: public spending on adult social care (in line with local authority spending) was between 17% and 24% higher in 2020/21 than in 2019/20.[41] It is estimated that local authorities spent £3.2 billion on the Covid-19 response in adult social care in 2020/21 to put in place infection, prevention and control measures and manage the impact of additional demand from hospital discharge and workforce pressures on care markets.[40] By June 2020, only 4 per cent of directors of adult social services were now fully confident that the budget for adult social care will allow them to meet their statutory duties compared with 35 per cent 2019/20.[42] In the same survey in 2021, following more government funding for covid, 21 per cent of directors reported being fully confident.[43]

Providers of care have also been affected. A decade of sustained cuts to local authority budgets had put downward pressure on the fees paid to providers, which meant many were already struggling, and had low reserves, as they went into the Covid-19 crisis.[44] Providers have been hit hard by the excess costs arising from the pandemic, including the cost of procuring PPE in the initial stages, ongoing staff sickness, requirements for additional staff to care for people in isolation, rising insurance premiums and rising costs of agency staff.

At the same time that costs have crept up, high mortality rates and isolation policies have led to drops in occupancy rates. Demand for residential care has also fallen as more people have favoured home care – this was a trend that pre-dated Covid-19 but has accelerated possibly because of fears over the risk of infection and restrictions on visiting. Occupancy in non-specialist care homes for older people dropped as low as 77% in March 2021[64] and the CQC noted that care home providers with a high proportion of self-funders experienced an 11% reduction in occupancy rates between March 2020 and

March 2021.[64] ‘Those we interviewed feared that the drop in occupancy coupled with cost pressures would see care home providers become financially unviable when temporary Covid-19 funding had come to an end.

Government funding, in the form of Infection Control Fund money, had helped sustain them, but many providers expressed concern about their viability once funding ran out.[45] Demand for home care has seen a sharp increase but councils are increasingly struggling to find sufficient capacity, largely due to workforce shortages.[46]

Financial consequences are not limited to organisations but have also befallen individuals drawing on care. In some areas, people who use Direct Payments, for example, have seen their charges increase, despite receiving the same amount of budget.[47,48,49] Unpaid carers, too, have reported growing financial pressures, with 36% saying their financial situation had grown worse since the start of the pandemic.[50] There is a need for greater understanding of these impacts.

3 The system: visibility and accountability, collaboration and preparedness

Key points

- Historical low priority of social care within government, and a resulting lack of senior social care voices embedded within decision-making processes, rendered social care largely invisible in the early months of the pandemic, resulting in a slow and piecemeal response.

- Unclear accountability structures meant it was not sufficiently clear who or what organisation was responsible for supporting the organisations and people that make up the social care sector. This confusion was particularly noticeable when it came to PPE procurement and distribution.

- Coordination between health and social care services was variable across the country, with some examples of antagonistic relationships impacting on the Covid-19 response. Where local integration was well developed and relationships mature, health and social care worked together more effectively than in areas where integration was embryonic.

- Several opportunities were missed to ensure the sector was sufficiently prepared for a challenge on the scale of Covid-19 – stretching back years but also in the immediate period before Covid-19 infections took hold in England.

A set of systemic and contextual issues are key to understanding fully the Covid-19 response in social care. These issues relate to:

- the clarity of accountability
- the visibility of social care in the wider response
- the level of coordination and collaboration between health and social care services
- the level of preparedness for a sudden shock at a national level.

Stakeholders consistently highlighted these issues. In this section, we explore these categories, point to underlying factors that impacted the speed and effectiveness of the response, and reflect on positive changes that have been made during the pandemic. We also highlight a number of lessons that have emerged, which should be factored in to social care plans for recovery and future system resilience.

Visibility: social care was not sufficiently prominent in the response

> **I went to a meeting that the Secretary of State, the Prime Minister hosted in early February [2020]… [we]… could not get air time for social care's issues, could only get airtime for the requirements of the NHS in relation to social care.**
> (Interviewee 1)

The low profile of social care in government briefings and debates in the early stages of the pandemic was, according to interviewees, indicative of a historic neglect of social care within central government.[16] Going into the pandemic, interviewees remarked that the DHSC social care team had declined in number over time, leaving it with too few staff to cope with the scale of the crisis. At that point in time, there was no director general with sole responsibility for social care and had not been since 2016. One was not appointed until June 2020 – well past the first peak of Covid-19 infections. The position of chief nurse for social care was created in late 2020 as a temporary secondment initially. The post has since been made permanent, which much of the sector has welcomed.[51,52] However, it is notable that, while there is a chief social worker, there is no chief care worker, despite care workers making up the majority of the social care workforce.[53] Interviewees reflected that the lack of a dedicated social care director general and other senior representatives in place at the start of the pandemic meant there were too few senior social care voices at the table when crucial decisions were being made about the response.

People representing different parts of the sector told us that their attempts to raise the profile of, and issues within, adult social care among government decision-makers were largely unsuccessful in the early phases of the pandemic when the focus of concern was solely on hospitals. Social care had frequently been described as an adjunct to the NHS long before the pandemic[54] and so what played out during those early months was felt to be more of a continuity of status than a shift in priority, in the eyes of our stakeholders. While acknowledged as appropriate to focus on the health sector given the circumstances, there was seemingly a lack of appreciation of the interconnectedness of health and social care and insufficient consideration of the implications of health policies for social care. Several interviewees described social care as "an afterthought".

Perhaps the most notable manifestation of this dynamic in the early weeks of the pandemic was the decision to rapidly discharge people from hospital into care homes without testing for Covid-19 before transfer. While the overall impact of the policy on infection spread has been disputed,[55,56] the implementation of it raised a number of concerns. Stakeholders we spoke to understood the need to ready hospitals for the wave of infections and felt that the problem was not in the policy itself but in the lack of understanding of the state of the sector into which people were discharged. For instance, stakeholders reported that assumptions were made that care homes were essentially clinical settings with advanced infection control measures and that they were somehow not closely connected with the wider community. (See Chapter 5 for more on the state of the residential care sector.) Had social care had sufficient prominence at decision-making forums, and had the right voices around the table when key policies were decided, stakeholders felt that the implementation of the policy to rapidly clear hospital beds would have been smoother. The following comments from one member of the Scientific Pandemic Influenza group on Modelling (SPI-M), which the BBC quoted, highlight the importance of having insights from people with knowledge of how the sector operates at forums making decisions based on models:

> **The failure of those models, I guess, was that we didn't know how connected the social care settings were with the community… As modellers we didn't know – I'm sure there are lots of academics and policy-makers out there, that could have told us this, if we'd asked them.**[57]

The lack of prominence and visibility of social care at a national level also set the tone for what happened at a local level. In one extreme instance that an interviewee reported on, this imbalance of priority manifested in supplies that care providers had ordered being diverted to the NHS. That particular situation was quickly rectified but speaks to a dominance of concern for the NHS over social care that all but one of our interviewees reflected on and was a strong theme in our workshops.

Accountability: there was a lack of clarity over who had responsibility for social care

A lack of clear accountability for social care within national and local government compounded issues of low visibility and lack of voice at key moments in decision-making. Responsibility for social care is spread across a number of central government departments – the DHSC, the Department for Levelling Up, Housing and Communities (DLUHC, formerly the Ministry of Housing, Communities and Local Government [MHCLG]) and the Department for Work and Pensions (DWP) – and arm's-length bodies (for example, the CQC, Skills for Care, the UK Health Security Agency and the Office for Health Improvement and Disparities), with the commissioning and shaping of services the remit of local authorities. Delivery of services is via more than 14,000 separate organisations of different sizes and ownership models, in over 20,000 locations, with many more unregulated providers (for example, supported living providers and personal assistants) also in operation. Many of these providers of care hold contracts with local authorities but many do not, which means that there may be little information about them within local or national government; the NHS also commissions some of them, adding a further layer of complexity.* While responsibility for the NHS is also spread across an array of arm's-length bodies, it had NHS England to coordinate and lead the response to Covid-19, with clear oversight from the DHSC and clarity over the hierarchy of decision-making and accountability. Interviewees noted that complexities in social care are a source of ambiguity in 'normal' times, but the lack of clarity over where responsibility lay within the sector became a significant factor in the Covid-19 response. The procurement and distribution of PPE and the rollout of testing illustrate why this was problematic.

Interviewees and workshop attendees reflected on layers of confusion about which national or local body (if any) was responsible for ensuring social care providers, including personal assistants, were adequately equipped with PPE. The majority of provider organisations are in the hands of private or voluntary ownership and the governance and commissioning structures in social care added a further layer of complexity – with some social care users state-funded, others self-funding and yet others funded by the NHS. In the early weeks of the pandemic, although guidance had been issued around PPE requirements in social care, providers and people who employ personal assistants reported being unsure where to turn for help and there were delays in ensuring care staff and their clients were adequately protected. Before a regular government supply of PPE came onstream, individual providers had to purchase PPE on the open market and contend with rising prices.[58] This raises important questions about whether the state at local or national level has a role in a market that is almost entirely in private ownership and, if so, what that role should be and how it could be clarified in future emergency situations. The National Audit Office has highlighted the complexity of accountability with regard to PPE supply and procurement and called for the development of arrangements as part of emergency planning.[2,3]

* For more on the structure and governance of the provider market, see Curry N and Oung C (2021) *Fractured and Forgotten? The social care provider market in England*. Nuffield Trust. www.nuffieldtrust.org.uk/research/fractured-and-forgotten-the-social-care-provider-market-in-england#key-points. Accessed 23 January 2023.

If… people that are commissioned through social care providers, through local authorities, is that then the local authority's primary responsibility? If that's for people whose beds are commissioned through the NHS, is that the NHS's primary responsibility? If they're providing PPE to visiting NHS staff, should they be back charging the NHS for that?
(Interviewee 3)

The 2020 adult social care action plan established a central procurement and distribution system for PPE for social care.[59] The document notes the logistical and practical challenges of setting that up – the pre-existing supply chain, designed to deliver to 226 NHS trusts, had to be expanded rapidly to cover 58,000 social care provider locations. Described as 'an unprecedented shift in scale',[59] the fact that the DHSC did not hold contact details and addresses for all providers further complicated the execution of the plan. Although the CQC holds details of registered providers, there was seemingly no precedent of sharing these data with the DHSC and there were still many providers (including personal assistants) who sat outside that registry. For more on data, see Chapter 5.

Interviewees also highlighted testing during the spring and summer of 2020 as an issue that shone a light on the lack of clarity over accountability. Provider umbrella organisations reported that members experienced confusion over where to turn for help and guidance and felt that, as a result, testing was not rolled out seamlessly across the sector in a timely manner. One interviewee who represents providers described "going round and round and round in circles" (interviewee 2) in relation to the rollout of asymptomatic testing beyond care homes – an experience that several workshop participants also described. According to provider representatives, many providers assumed that the CQC was in charge of rolling out testing because it is the CQC with which they have most contact as the regulator for social care. In reality, however, responsibility for testing actually lay with Public Health England.* As a result, we heard that the CQC was left struggling with many contacts

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* The UK Health Security Agency and the Office for Health Improvement and Disparities replaced Public Health England in April 2021.

from providers who assumed it was leading an initiative for which it had no oversight. This example illuminates the fact that those in the sector had limited clarity over where responsibility lay for different parts of the response. As time went on, that situation improved but government and policy-makers will no doubt want to understand the root of that initial confusion and to explore how to ensure greater clarity in future in times of crisis.

> **[B]ut providers would be contacting CQC to say our tests have gone missing... but actually that was actually a really a Public Health England, you know the local teams, local health protection teams in areas... So for a time it did become very confusing.**
> (Interviewee 6)

A lack of central response led to local variation in responses

The devolved nature of social care, which allows councils autonomy over service delivery, organisation and commissioning, inevitably meant that – in the absence of a clear national response for the sector – there was wide variation in the shape and speed of the response for social care. While in ordinary times, there are benefits to having a variable approach that can flex to local needs, at a time of crisis this poses challenges in coordinating the response across the country. So, in relation to Covid-19, while central guidance could be issued, there was no mechanism for ensuring that it was implemented at a local level, as this interviewee explained:

> **[Y]ou were relying on DASSs [directors of adult social services]... or organisations like ADASS [the Association of Directors of Adult Social Services] or the LGA [Local Government Association] to make sure that that [guidance] was carried out, but no one can make [a DASS] do that if you see what I mean, then [the DASS]... can't make... 350 care homes in [a] particular authority and another 200 home care agencies and an x number of day care [providers follow the guidance]. There wasn't a real easy**

way of creating that accountability very quickly other than by creating common cause, or describing it as a common cause.
(Interviewee 1)

As a result, there was wide variation in how the response unfolded locally, with differing interpretations of the role of the local authority. Some interviewees described extremely proactive responses from some councils. In one case, the council proactively took on responsibility for sourcing PPE for providers and distributing it and was in close contact with managers of care providers. In other cases, interviewees reported that councils did not proactively contact providers or try to coordinate a response. For example, in one area, "the first meeting they [the council] had with their providers in this pandemic was the fourth of June [2020]" (interviewee 3).

Strong relationships between health and social care facilitated the local response

Improving collaborative working and integration between health and social care has remained a longstanding policy ambition[60,61,62,63] but development remains variable across the country. Our analysis suggests that where relationships between health and social care services were more developed, this brought a range of benefits to social care, and aided the pandemic response in several ways. We heard examples of where the pandemic had accelerated new ways of working, but that where relationships were embryonic, or where pre-existing relationships were fractured, it posed additional obstacles or hampered the response. It should be noted that the importance of interagency working, and the need for effective information exchange, stretch beyond health and social care and that there are many other services that impact on the wellbeing of people who draw on social care. However, for the purposes of maintaining a realistic scope, the focus for this study was limited to health and social care.

Where pre-existing relationships were strong, support for the social care sector was mobilised

As the CQC has noted,[22,64] pre-existing networks and relationships aided effective collaboration and many of our interviewees suggested that, where relationships were good, this continued into the pandemic response. For example, the CQC found that places with more mature relationships were better able to weather the pandemic.[22] Interviewees suggested that where there was an established history of hospitals, the local authority and public health teams working well together, "they managed to mobilise and get organised and were much more supportive of [care] providers much quicker" (interviewee 14) than in places where there was not such a precedent.

In some areas, the pandemic accelerated embryonic collaborative ways of working. For example, interviewees spoke of primary care networks where, as a result of the situation, social care provider representatives and commissioners began attending leadership meetings. This has been helpful in providing both primary care and social care with an insight into each other's pressures and the potential to identify solutions to issues that affect them both. Where relationships were well managed, Covid-19 was seen to have helped break through silos to improve multidisciplinary working across local authorities, the NHS, the voluntary and community sector and the wider community, including housing, schools and the faith sector. These positive developments have the potential to be further harnessed as we move towards more integrated structures at place and neighbourhood levels.

One of the good legacies of Covid is all of that multiagency working is now in place and has been accelerated as a result and I think that's fair to say across a lot of services as well, not just for care homes but lots of service provision... we are moving from a situation where care homes sat very much outside of the realms of primary care networks and now they're sat right with us.
(Interviewee 8)

In some instances, Covid-19 accelerated the development of new care models and strong pre-existing relationships aided that. Many existing models of health care in care homes, for example, have been designed to manage and support people drawing on social care on an individual basis but Covid-19 required a step-change in how these approaches operate. Professionals in both the NHS and social care needed to quickly adapt ways of working to respond to the scale of the new challenges posed. In one example that a primary care network representative gave, positive relationships provided a helpful foundation and links between the primary care network and care homes have been significantly strengthened. However, there still needed to be a significant shift in how the primary care network engaged with care homes in their area and this is likely to be the case in other areas.

> **[T]he connectiveness with our care homes… was nowhere near adequate to cope with a global pandemic because that relationship was never set up to do that… we interact with care homes on a patient-by-patient basis… We were suddenly in a situation of trying to communicate with all the care homes, all at the same time.**
> (Interviewee 8)

Where relationships were not established, health and care services did not always work effectively together during the pandemic

In some areas, where there was poor existing collaboration and limited established relationships between services before the pandemic, there was not always a clear incentive to work together and that had consequences for how well other services (in particular health) supported people drawing on social care. Some interviewees described ways of working that were antagonistic rather than collaborative – whether this was between NHS trusts and social care providers, or between local government and wider system partners – and this led to people in different services pulling in different directions. We also heard that, in some areas, local government was left outside of the NHS inner circle of decision-making, or did not play as proactive a role as expected: "The pandemic pushed a lot of people and organisations and charities into this kind of fighting mode – it's us and them – rather than working together" (interviewee 4).

Many of our interviewees described poorer access to health care for a variety of people drawing on social care and they felt that had there been more established collaborative ways of working, the impact on people could have been mitigated. Other reports have highlighted similar trends, with, for example, some NHS trusts initially denying some residents of care homes acute care, the inappropriate blanket use of routine ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) orders (without proper patient involvement) and some general practice surgeries’ refusal to provide face-to-face primary care support in care settings.[22,65,66,67,68] These measures had a disproportionate impact on older people, disabled people and people with learning disabilities.[67,69]

Strategies to plan people’s emergency clinical care (also known as ‘advanced care planning’), such as resuscitation, varied greatly by area and some of our interviewees felt that pre-existing relationships between health and social care were an important factor in how well such strategies were developed. Some areas had existing groups for decision-making, or set up new groups such as ethics committees; others had established ‘care provider cells’ to support local care providers with the latest information.[70] However, the CQC has expressed concern that ‘once DNACPR decisions were in place, it varied whether providers and local systems reviewed them’, and that it was not always clear whether local areas were working together to ensure oversight of the workforce ‘to ensure they were making sound clinical decisions that are person-centred and protect people’s human rights’.[70] Additionally, the CQC found that where there were two or more different approaches or models of advance care planning being used in a local area,* clinicians and staff experienced more difficulties than in areas where all providers used the same methodology. A number of other factors reportedly affected collaboration in advance care planning, including time pressures, lack of face-to-face meetings and complicated and confusing governance routes.[70]

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* For example, Recommended Summary Plans for Emergency Care and Treatment (ReSPECT), local treatment escalation plans and DNACPR decisions.

Limited data sharing hampered collaboration

Different data infrastructure in social care compared with the NHS, a lack of established routes for sharing data and complex information governance requirements created additional barriers to the NHS and the social care sector working together (as the CQC found in its 2020 report on the state of health care and adult social care in England[22]). For example, in some areas, the 'disconnected' and varying information that local authorities and placed-based NHS groups held hampered efforts to identify service users who might be at risk and their families (for example, those on the shielding list).

Interviewees felt frustrated that, in some areas, information governance requirements were preventing health, social care and voluntary sector organisations from working together to provide support to service users and informal providers of social care, and that: "It should have been easy just to swap databases [with local authorities] but it wasn't" (interviewee 8). A better read-across between health and social care, and wider local services, would furthermore have facilitated local planning and knowledge of likely pressures, such as risks to care homes arising from high rates of community infection.

> **It would have been useful to be able to share very specific patient data, particularly around shielding and around the support that was in place for the people that were shielding, formal social care but also carers, formal carers and informal carers. There were so many hoops that we had to jump over to comply with the local authority information governance that it really did delay things.**
> (Interviewee 8)

Preparedness: opportunities to prepare for a significant shock were missed

Interviewees described how the social care sector had been adapting over many years in response to financial, societal and demographic pressures and strains and that had left it in a weakened position from which to address a crisis on the scale of the Covid-19 pandemic. Sustained financial pressure meant much of the system lacked the capacity to prepare for, adapt to and mitigate a significant shock such as the pandemic while also sustaining the delivery of safe, high-quality care. The sector, with many thousands of – often small – organisations delivering care in upwards of 20,000 locations, relied on individual providers having the ability to manage the shock. Small or medium-sized organisations deliver around 70% of care and, on the whole, they run on low margins and consequently low financial reserves.[44] In the face of years of chronic pressures and in the absence of a central infrastructure to step in, these organisations were ill-equipped for the challenges Covid-19 brought.

Pre-existing pandemic plans identified flaws, which were not addressed

Local resilience forums have ‘a legal duty to plan, prepare and respond under the Civil Contingencies Act’ 2004; however, it has been reported that issues around information sharing led to some members of these forums feeling ‘isolated from national decision-making and unable to effectively plan and strategise [a] response’.[71] Similarly, an expert in disaster preparedness reflected that local emergency response and recovery plans did not sufficiently join up emergency hospital planning with local community emergency planning. A seeming lack of joint plans was also evident from local resilience forums being unprepared for the scale of the challenge, with haphazard management and guidance regarding PPE causing some providers to hold supplies.

[T]he local resilience forums, for example, suddenly came into the spotlight in ways probably that they've never imagined… Suddenly they were at the eye of the storm and having to manage things like supply of PPE.
(Interviewee 15)

Regarding emergency planning for all types of events, hospitals and other NHS facilities are required to meet NHS core standards for emergency preparedness, resilience and response, but no such requirement exists for care homes.[72]

Regarding pandemic planning specifically, the government's National Risk Register explicitly acknowledges pandemic risk as the highest national risk for both severity of impact and likelihood. However, a series of exercises to examine preparedness have either excluded social care or the learning has not been implemented. Furthermore, much of the focus has been on an influenza pandemic (see Box 1).

Box 1: Consideration (or absence) of social care in pandemic preparedness plans

- Exercise Alice was designed to explore the challenges that a large-scale outbreak of Middle East respiratory syndrome coronavirus (MERS-CoV) could present to the UK; however, the scope of the exercise was restricted to health care services. Of the 43 participants, no representatives for social care were present.[73]

- Exercise Cygnus was a cross-sector, cross-government exercise to consider the UK's preparedness and response to an influenza pandemic. It identified a number of substantial flaws in the response by Departments and arm's-length bodies. A report on the exercise recommended that capability be 'critically reviewed'.[74] It pointed to a lack of joint plans when demand for services outstripped the provision of social care, concerns about providers' business continuity and an assumption that there would be enough capacity in the voluntary sector to plug anticipated shortages of 20% to 40% in the formal workforce. It also flagged that, in the course of this simulation, little attention was paid to social care during Cabinet Office Meeting Rooms (COBR) meeting discussions or the discussions that fed into those meetings.

- The DHSC pandemic influenza team, DHSC community and transformation directorate and NHS England co-authored a pandemic influenza briefing paper, produced no earlier than June 2018 and made available to the public in 2021. This paper included an indicative prioritisation framework for various social care services. Little detail was provided on the established reporting mechanism between local resilience forums, local authorities and the DHSC.[75] The risk of an infectious disease such as Covid-19 was not anticipated, as shown in suggestions that capacity in care homes 'could be increased through installing extra beds in each room or using communal areas for nursing support'.

Notably, in 2021, the House of Commons Health and Social Care Committee and the Science and Technology Committee recommended that planning for future pandemics should have a more 'developed and explicit consideration of the intense interaction between the NHS and social care'.[1] They also suggested that the government should review the provision of infection prevention and control measures, including infection prevention and control nurses and care providers' conduct of regular pandemic preparedness drills. Our interviewees also noted the absence of continuing professional development for care home managers on readying for a pandemic.

There was also inadequate attention paid to learning from Asian countries, which were much better prepared for a pandemic of this nature. England had focused on influenza planning whereas many Asian countries had also prepared for severe acute respiratory syndrome (SARS)-like pandemics.[76] One interviewee highlighted that "[England has] never dealt with something that was so easily transmittable… transmitted asymptomatically and disproportionately target[ing] older people" (interviewee 7), but there was arguably an avoidable delay in understanding the implications of, and mitigating, asymptomatic transmission within congregate care settings.

There was a lack of prompt action in real time as new evidence came to light

While preparation is important, it is also critical that public services are able to take prompt action to address novel threats and to adapt as new evidence emerges. With Covid-19, the UK did this for some things – for example, health system leaders closely observed and learnt from events unfolding in countries that were ahead of England in the wave of infections. This led to the establishment of the Nightingale hospitals and a rush to commission ventilators (whether or not this was the correct response in hindsight). However, interviewees representing social care provider organisations told us it was not evident that close observation and similar proactive learning were put in place during the initial months of the pandemic in relation to social care and asymptomatic transmission in congregate settings, despite concerning news reports of the impact of Covid-19 in care homes in Spain and Italy.

Opportunities were missed to put learning from previous shocks into practice

Opportunities to learn from previous domestic shocks were also missed. In 1999/2000, the influenza outbreak caused 48,000 excess winter deaths,[77] and over the 10-day heatwave period in 2003, there were over 2,000 excess deaths.[78] Although a different situation, the challenges faced and approaches taken could and should have provided valuable learning for the Covid-19 pandemic.

An evaluation of national heatwave planning in England, published in 2019, recommended that:

- Public Health England could do more to improve awareness of emergency preparedness planning among local care managers and frontline staff.
- Public Health England and the Local Government Association should review the capacity and capability of local authorities and social care providers to implement protective actions.
- Public Health England should review the advice given to local authorities and providers on planning, including mandatory training for staff.[79]

In addition, interviewees raised concern that existing knowledge about basic infection control was not applied in some key policies, particularly in relation to the decision to discharge people from hospital to care homes who could have been Covid-19-positive. Plans around discharging people to care homes were developed at a point in the pandemic when understanding of the virus was relatively low and testing not well developed – crucially, asymptomatic transmission had not been fully understood. However, interviewees stressed that established learning about infection control, and the potential for infections to spread rapidly, could and should have been better used: “We know from past experience, infection can spread like crazy [in care homes], you know, we’ve got flu, we’ve got other you know, MRSA [methicillin-resistant Staphylococcus aureus]” (interviewee 15).

The system: learning the lessons from Covid-19

I think there has been a flourishing of the consciousness and the importance of this.
(Interviewee 3)

Over the course of the pandemic, the visibility and priority of the social care sector have undoubtedly risen among the public. While the government's ambitions to reform various elements of the system pre-dated Covid-19 and are accompanied by significant political pressure, the public's heightened awareness of the system's shortcomings and value provide an opportunity for building support for change.

Social care has also become increasingly visible within central government and given greater priority, particularly within the DHSC, which has significantly expanded its social care capacity. Recent workforce data indicate that 330 staff work in the DHSC social care team as of December 2020,[80] which we understand may represent a seven-fold increase on pre-pandemic levels, although there are no official pre-pandemic data that offer a breakdown. It is not clear to what extent the need to bolster the Covid-19 response has triggered this expansion and to what extent it is a response to the political imperative to reform social care. Either way, it represents a shift in prominence. The focus now needs to be the upskilling of new staff to ensure that the lessons from Covid-19 can be learnt and embedded as plans to realise ambitions outlined in the 2021 White Paper on adult social care reform, *People at the Heart of Care*,[6] are developed. The appointment of a director general for social care along with the creation of the now-permanent chief nurse for social care role are further indicators that social care is being given greater prominence.

Following widespread criticism of the government's handling of the first wave of Covid-19 infections,[16,81] there was evidence of efforts to more effectively embed social care voices in decision-making. During the summer of 2020, for instance, a social care taskforce was established with involvement from sector stakeholders. Interviewees reflected on how valuable this engagement has been and all expressed a desire to retain and develop the closer working between government and social care representatives, particularly as government embarks on wider social care reform. As further evidence of learning, a social care-specific working group as part of SAGE was also established in May 2020,[1] indicating a greater focus on the sector in the national Covid-19 response.

However, the lack of clarity over accountability for and within social care has been, and continues to be, deeply problematic. Many of the stakeholders we talked to were wary of creating a more centralised NHS-style system but stressed the need for greater clarity over responsibilities, particularly in a time of crisis. In the context of the White Papers on adult social care reform and health and care integration,[6,82] there needs to be a frank discussion about where responsibilities for social care should lie – what sits most practically at a national level to provide support and resilience and what requires flexibilities and knowledge best suited to those at a local authority level, working with wider community groups. What Covid-19 has clearly shown is that, in times of crisis, the current maze of confused accountabilities does not facilitate a smooth and seamless response. Much learning has taken place over the course of the pandemic and it is important that this positive progress is built on. For instance, PPE procurement and distribution networks and procedures should be embedded so that they can be used and adapted for future priorities.

We heard that, over time, and particularly after the second major wave of Covid-19 infections in winter 2020/21, collaboration between providers and some national-level bodies improved markedly:

> **[I]f there's anything to be said about learning curves then it's got to be the relationship between social care providers and the NHS arm if you like, Public Health England, because we've got much better relationships.**
> (Interviewee 11)

One interviewee cited the smooth rollout of vaccinations in social care settings as an example highlighting improved collaboration between the DHSC and social care partners, assisted by the cumulative learning from the first wave.

There have also been many examples of improved *local* collaborative working between health and social care over the course of the pandemic; and in places where good relationships were already in place, these have been strengthened. It is important that progress made around collaboration at the local level continues beyond the pandemic and that the spirit of collaboration and common cause is carried forward into newly developing places within integrated care systems. Evidence of previous attempts at better health and social care collaboration through various forms of integration suggests that relationships between professionals and a willingness to work together, more than structural or legislative architecture, are key to bringing about change.[63] In addition to relationship-building, there is a need to understand and spread learning about the approaches to health and social care delivery that have emerged, or have been strengthened, during the pandemic. It is also important to recognise and understand the full consequences for people of poor collaboration across services.

Although pockets of good collaboration are evidently achievable, as integrated care system structures and processes bed in, the fact that social care remains in a fragile state is likely to undermine more widespread integration of care. Over winter 2021/22, there were growing concerns over levels of delayed discharges from hospital. Far from being the only issue in the social care system, delayed discharges are one of the most easily measurable and visible manifestations of capacity constraints in social care. Growing staff shortages on top of tight budgets within social care are thought to be major contributors to this issue.[83] As long as social care lacks the capacity to meet the growing levels of demand for care – from both people coming out of hospital and those who are supported at home or in care homes – there will be problems in ensuring people experience a seamless health and social care journey. Since finishing this research, tackling delayed discharges has continued to be a priority for government. Considerable sums of money have been allocated to reduce delays[179] but, despite this, rates of delayed discharges remain high.[84] Analysts suggests that numbers remain high due to a focus on policies that are short-term and that do not tackle the underlying issues.[85]

Where there is an opportunity for learning is in preparedness. Warnings around the fragility of social care in the years leading up to the pandemic had not been heeded. Infrastructure to help it cope was not in place. Efforts have been made during the pandemic to prepare the sector for subsequent waves. Examples include two winter plans, published in the autumn of 2020 and of 2021,[4,86] building on some of the recommendations from the social care taskforce[87] that was established in summer 2020. A consultation on the provision of PPE purchased centrally for an additional year from April 2022 is a further positive sign that the sector will be given ongoing support in the short to medium term. For the longer term, there is an urgent need to ensure that the sector is better prepared for all manner of different, potentially equally damaging, shocks – whether these are epidemiological, environmental, economic or societal.[88]

There is value in examining what other countries did to ready their systems for shocks. Forging closer links with other countries on a long-term basis to share learning on long-term care would only serve to strengthen preparedness.

The system: key recommendations

- The progress made in embedding social care voices in core decision-making, and giving the sector the prominence and visibility it needs, should be maintained and developed within central government to create strong foundations for reform. Making permanent some of the advisory groups (such as the social care taskforce) and channels of communication between the sector and government may be one way of ensuring that those with deep operational knowledge and direct experience of social care inform national policy and guidance.
- The knowledge and understanding of the sector that have been gained across central and local government need to be retained and embedded to ensure that organisational memory and positive working relationships are not lost and that the new capacity in the DHSC social care team is retained and developed.
- Clear lines of accountability for national and government actors, including wider stakeholders such as public health actors, need to be established during ‘normal’ times as well as during times of crisis, paying close attention to what works best at a local level versus national level.

- It is essential that the government places greater emphasis on long-term preparedness and risk monitoring, to put social care on a resilient footing to weather all types of potential future shocks. This should include: learning from successes; learning from other countries; and creating a central support structure that can click into place in the event of a crisis. This may, for example, take the form of operational blueprints that set out accountabilities and protocols for emergencies, which could include a range of potential emergencies such as other infectious diseases, climate events and political, economic and social crises.
- Places within newly establishing integrated care systems need to nurture and build on the local relationships that have emerged between health and social care over the course of the pandemic. Places should endeavour to learn from each other about initiatives that have been effective in building collaboration (for example, having a social care representative in a primary care network). Social care needs to be seen as an equal partner in these new arrangements if it is to be put on a more resilient footing in the long term.

4 People: understanding complexity, the workforce and unpaid carers

Key points

- A lack of understanding about the social care sector among those leading the response to the pandemic – its complexity, structure, how it works and the diversity of those who draw on it – created confusion and difficulties for those seeking support.
- Crucially, a failure to take account of the characteristics and structure of the social care workforce meant wider Covid-19 policies affected this group adversely and left them inadequately supported.
- There was a lack of specific measures to ensure that unpaid carers were better accounted for in the response. This has left this growing group not only without Covid-related support but also without the support they rely on in 'normal' times.
- Blanket guidance, based largely on the NHS and not tailored to social care, and a lack of established communication channels between government and social care providers, resulted in frustration and stress for providers and those drawing on support and led to delays in putting infection control measures in place.
- Guidance was frequently reissued – reflecting the uncertain and ever-changing nature of the situation – but changes were not clearly highlighted, leaving providers feeling overwhelmed, and crucial updates (for example, around visiting) that required significant changes in practice were issued with very little notice.

Social care is a unique sector built fundamentally around people and relationships.[89,90] The sector employs over 1.5 million people who deliver care via more than 14,000 organisations. To illustrate its scale, it is worth noting that there are more than four times as many beds in care homes as there are hospital beds in the NHS. In reality, however, the majority of care is actually delivered in people's own homes. To be effective, therefore, an emergency response would necessarily require in-depth knowledge of the breadth of people working in the sector, those drawing on support, the diversity of care providers and their responsibilities, and the practicalities of how social care is delivered. Participants in this research consistently expressed concerns that the response was not sufficiently sensitive to the complexities of this vast sector.

There was too little understanding of the complexity of social care among those leading the response

A prominent theme throughout almost every interview and our stakeholder workshops was that one of the core weaknesses with the official response to Covid-19 was a fundamental lack of understanding about social care at the heart of government. Interviewees were complimentary and understanding about the efforts of the civil servants in the DHSC's small social care team to support the sector. However, the team lacked the capacity and the deep operational knowledge needed to navigate a crisis on this scale. The Minister for Care at the time, Helen Whately, remarked in an evidence session to the House of Commons Health and Social Care and Science and Technology Committees: 'In the Department we have a social care team that, initially, was purposed to look primarily at social care reform.'[1] The lack of operational know-how and capacity was laid bare in a number of ways.

> **[T]here's a lot of change because people move around in roles, you know, that's how the civil service works, you know, and it was almost like when the ball stopped, people were in roles that they might have only been in for a few weeks.**
> (Interviewee 15)

The response assumed that social care operates like the NHS

Where the lack of understanding of social care became all too evident was in the centrally issued guidance around PPE, testing and staff deployment. Advice over ‘sessional’ PPE use, for example, was oriented to hospital and clinical environments and of limited relevance to social care stakeholders. This caused much confusion:

> **[T]he descriptions of the settings and, you know, sessional use and all these sort of terms that might mean something in a hospital or a clinical environment don’t mean anything. So you put them into a piece of guidance and, of course, the immediate response from everybody is, well: ‘What does… you know, what does that mean? What is a session in social care? Is that with one person? Is that when I start up my shift at eight o’clock in the morning?’**
> (Interviewee 12)

Many participants highlighted the fact that care homes were considered for the most part as a step on the hospital discharge pathway and, as such, were treated as clinical settings. This framing ignored the fact that “a care home is not a clinical setting but someone’s home” (interviewee 5), embedded in a community. As a result, the approach taken to infection control was not always practical nor did it adequately take into account all potential routes of infection.

The diversity of this vast sector was not recognised in guidance

Once social care became visible in government briefings to the public, the narrative was very clearly focused on care homes. While this was understandable, given the concern about infection spread in congregate settings, interviewees representing non-residential care providers and service users reflected that guidance issued to the sector did not adequately recognise that social care is broad and varied and that, in reality, much care is delivered in other settings such as people’s private homes and supported living accommodation. Furthermore, people who hold their own personal budget, those who employ personal assistants and those supporting people with learning disabilities reported an absence of guidance that felt relevant to them.

One group that felt particularly overlooked in guidance was people with learning disabilities who reside in supported living settings. Blanket guidance around visiting for 'congregate settings' did not take into account the fact that these residences can be hugely variable in size and design. This meant that, once restrictions eased, people in supported living were unable to have visitors to their homes because of the classification of their home.

> **[Y]ou've got confusing and conflicting guidance, which often is written for settings that do not reflect what you're living in or running. It was like a perfect storm really of complexity for people to work through. So we were hearing stories, I can think of several, where people, because the support setting they lived in was called supported living even though they had their own front door, they just lived in a block of flats, were being told you can't have visitors in your flat.**
> (Interviewee 9)

The approach to communication left those in social care struggling to cope with ever-changing guidance

Developing and issuing guidance for the sector was a huge challenge for government over the course of the pandemic, and particularly in the early weeks. The situation was constantly changing as understanding of the virus evolved. As a result, there was a need to frequently update the guidance for the sector around infection control, PPE, testing and so on. "[A]t one point I think by about July I'd counted 150 different pieces of government guidance that had come out with, very often, with that guidance contradicting earlier guidance" (interviewee 7).

In its report on PPE, the National Audit Office found that some recipients of guidance found it hard to follow due to how it was communicated.[2] The CQC's 2021 *State of Care* report also noted concerns about the poor accessibility of guidance, which was unavailable in different languages and failed to take account of how people's 'individual characteristics affected the care they needed'.[64]

Our participants echoed these observations. When guidance was updated, it was typically re-released as an entire document. This would leave individuals who employ personal assistants and providers of all types and sizes having to read documents of several hundred pages to identify the change from the previous version. This was at a time when many providers described feeling overwhelmed by the volume of information hitting their inboxes. Provider representative bodies played, and continue to play, a critical role in supporting members, with many working "all the weekends last year just to keep on top of it [summarising updates] for the members" (interviewee 4).

Interviewees also repeatedly raised the timing of the publication of guidance as a challenge for providers and commissioners. Critical pieces of guidance around PPE, testing or care home visiting were frequently released late on a Friday evening for implementation the following Monday. This gave providers and commissioners little time to understand the implications of the guidance or to prepare for the changes, some of which were significant. Although the volume of communication reduced in the second wave of the pandemic (early 2021), the release of critical guidance with implications for providers and people who draw on care (for example, around visiting) continued to be published with little lead-in time. For instance, new guidance to changes to care home visiting was released at 5pm on 14 December 2021, including changes to staff testing, for implementation the next day.[91] This trend continued into 2022, with changes to visiting rules being announced via press release[92] and guidance being issued on the morning the changes took effect.[93]

Guidance around care home visiting has been particularly problematic, with care home providers who we interviewed reporting feeling unsupported and some residents and families setting up pressure groups around the issue (for example, Rights for Residents). Many homes had decided to close to visitors even before the national guidance came in through fear of importing infection and were relieved when official guidance supported their decision. However, as that guidance changed over time and became more advisory, providers were left to make extremely tough choices, balancing their responsibility for protecting residents from risk with the rights and freedoms of those residents.

Difficulties around accessing insurance added a further layer of complexity around these decisions (see p 80). Challenges to guidance from providers, residents and their families, including legal challenges, have led to regular changes in the approach to visiting[94] and prompted an inquiry into human rights in care settings.[68]

The Covid-19 response did not take sufficient account of the structure and nature of the workforce

1.5 million people work in social care – it's as many as work in the NHS and none of the infrastructure exists to support it.
(Interviewee 5)

Low pay, chronically high vacancies causing a reliance on transient agency staff and widespread use of zero-hours contracts are commonplace in social care – all contributing to high levels of staff movement and insecurity within the workforce.[95] Although the state of the social care workforce was known before the pandemic struck, too little attention was paid to its structure and characteristics in the pandemic response. In some instances, wider Covid-19 policies adversely affected the care workforce.

Lack of sector leadership and limited understanding of the characteristics of the workforce made guidance difficult to implement

Low pay and widespread use of zero-hours contracts within social care mean that many staff work multiple jobs across numerous settings, locations and sectors. Although infection spread as a result of staff moving between settings was identified as a risk in a document about influenza outbreaks, prepared by Public Health England in 2017,[96] there was no such recognition of this risk with regard to Covid-19 within the adult social care action plan (published in April 2020).[59] The winter plan for 2020/21 announced plans to introduce legislation to restrict all movement of staff between settings unless absolutely necessary.[4] However, the realities of the social care workforce – with high levels of vacancies – made the measures difficult to implement. Following consultation in November 2020, during which care providers and staff raised concerns around the logistical difficulty and costs of such a requirement, the government chose to introduce guidance rather than statutory regulations in March 2021.[97]

Funding was provided to assist with the implementation of the guidance. A £120 million Workforce Capacity Fund was announced in January 2021[98] to complement a £546 million extension to the Infection Control Fund, announced in October 2020, to be spent by March 2021.[99] While many in the sector welcomed these support measures, data show that the proportion of providers who had limited staff to one setting fell from 78% in March 2020 to 70% as of November 2021.[100] This suggests that the severity of workforce shortages has meant that, even with funding, such a policy is difficult to implement in the sector. Indeed, during summer 2021, some provider representatives continued to draw attention to 'unintended consequences' of the policy that rendered it 'unworkable'.[101]

Testing policy in the first wave of the pandemic also failed to consider the nature of social care work and the characteristics of the workforce – unlike NHS staff, who were quickly prioritised for testing, care staff were instead given the same advice as the general public and required to isolate if experiencing Covid-19 symptoms.[59] This failed to take account of the fact that more than a quarter of care staff were on zero-hours contracts with inconsistent access to sick pay, and could stand to lose two-thirds of their weekly income.[102] In the words of the Chief Medical Officer for England in his evidence to the House of Commons Health and Select Committee on 16 December 2021, "we didn't spot the effects of people not having adequate sick pay – it's one of those things that's obvious when you see it".[103] Some charities, such as the Care Workers Charity, turned to crowd-funding to provide crisis grants, funeral grants and bereavement support to care workers.

At the time when we had people on furlough on over £2,000 a month, well that really hurt, I think, with the people at home, not working, getting money to cover them, and we had people at the front line not getting their sick leave covered.
(Interviewee 4)

The introduction of the Infection Control Fund in May 2020 sought to address the lack of occupational sick pay for all social care staff. As of 23 November 2021, 83% of care homes were paying their self-isolating, directly employed staff at a full wage rate. However, by December 2021, the remainder of care homes were still yet to do so, and the reasons for this are unclear.[100] Less is known about sick pay for agency staff, home care staff and staff in other settings.

The tendency to treat social care as an institution-based service created challenges in implementing guidance for the workforce in the vast array of the sector that is delivered in people's own homes. The home care workforce is very mobile and few staff routinely visit an office. This made delivering training around infection control and the changing use of PPE very difficult. It also posed challenges for the rollout of testing and vaccinations. While efforts were made to maximise access to the Covid-19 vaccine for staff working across different types of settings, with for example social care staff prioritised for booking via the National Booking Service,[104] there remained challenges in reaching critical groups of homecare and agency staff, and personal assistants. One interviewee suggested that the DHSC's approach pointed to a potential lack of understanding at times about the nature of the workforce and the adaptions required to ensure support could get to where it was needed:

[T]he way the DHSC has approached anything to do with Covid, we're talking testing, vaccinations, picking up of PPE,... assuming everybody has a car, everybody has money for petrol, everybody can travel to a testing centre, everybody can travel to a vaccination centre, so making huge assumptions about a low-paid workforce that doesn't really have these things.
(Interviewee 4)

Compounding the lack of understanding of how national policy and guidance would impact the social care workforce, limited local knowledge of who works in care presented a further obstacle. With no register of care workers, local authorities did not have an accessible source of information about who the workforce is. This became a particular issue in the event of outbreaks in the community as there were delays in putting infection control measures in place, such as rapid tracing of close contacts who worked in social care. So while infections from hospital discharges were a source of concern, the transmission of infections via staff from the community was not always acted on quickly:

> **There was a big outbreak [in a local factory], lead[ing] to a big outbreak among the care community because the workforces are enmeshed… for the purposes of this you really needed to know, local intelligence.**
> (Interviewee 1)

Policies before and during the pandemic have not adequately addressed inaccurate perceptions of care work as low-skilled and low value, which continue to pose challenges for recruitment and retention

The social care sector has long struggled with recruitment and retention due to a range of underlying reasons. These include factors such as low pay, which have perpetuated perceptions that care work is low-skilled and of low value.[105] A failure to address this issue over the preceding two decades means that underlying challenges have been exacerbated during the pandemic, when retaining and supporting this critical workforce have been vital. Despite some efforts to boost the status of care staff during the pandemic and despite them taking on considerable responsibility, in the absence of more concerted efforts to boost pay and implement career progression, the sustainability and recognition of the social care workforce continue to be a source of deep concern.

During the pandemic, care staff have frequently extended their responsibilities far beyond what has traditionally been considered to be care work.[106]

Interviewees also described care staff carrying out some of the tasks – such as verifying deaths, dressing wounds, installing catheters and giving insulin[4] – that other professions, such as GPs, nurses and social workers, would ordinarily have done. The DHSC's efforts to recognise and support the workforce included the introduction of a chief nurse for social care, which was well received by the sector (see p 25).[52] However, in the absence of concrete measures to address longstanding issues around pay and conditions, interviewees and workshop participants from across the sector felt that initiatives such as the Care Badge, launched in April 2020, missed the mark. This was also a feeling reflected in wider media reporting at the time.[107]

A lack of parity between NHS and social care staff has long since been a source of discontent and a sense of unfairness among care staff, but this is perhaps particularly so in light of their taking on tasks that NHS professionals would previously have delivered. This feeling of a lack of parity was further fuelled during the summer and autumn of 2021 with the handling of the mandatory Covid-19 vaccine policy. It was unclear to many in the sector why only care home staff, and not NHS staff, were included in the policy. After we undertook our interviews, the government announced that vaccination would become mandatory for NHS staff as well as wider social care staff from April 2022 (five months after the deadline for care home staff) but it has since dropped the policy entirely. It is difficult to know exactly what impact the handling of the policy had on recruitment and retention but one estimate suggests between 50,000 and 70,000 staff left residential care, domiciliary care settings and other settings between the point at which mandatory vaccines for care home staff were announced and the point at which they came into force.[33] These figures tally with monthly vacancy data from Skills for Care suggesting the vacancy rate had increased by half, from 6% in April to 9% in October 2021.[108] Survey data that the DHSC published in autumn 2021 pointed to mandatory vaccination being a driver for 14.7% of people leaving care homes and 4.4% leaving domiciliary care.[34] Other reasons for leaving included: more competitive pay; better hours and working conditions; and burnout and stress.[34] Whether that loss of staff is reversible is yet to be seen. "The same compulsion should be there for the staff in the NHS – we should not disproportionately be having this conversation about care staff" (interviewee 7).

There is arguably greater understanding of care work as a result of the pandemic. Survey data suggest the British public are more acutely aware of the challenges facing social care, and the two main reasons people give for dissatisfaction with social care are that the pay, working conditions and training for social care staff are bad and that people do not get all the social care they need.[109] However, the extent to which public perceptions of its value have shifted significantly remain less clear.[110] In some cases, the workforce has experienced abuse from the public, with a survey of front-line care workers suggesting that as many as one in four respondents experienced verbal abuse, bullying or threats of violence.[111] Experiences with access to petrol during shortages in autumn 2021,[112] along with the prioritisation of temporary visas for heavy goods vehicle (HGV) drivers[113] ahead of care workers, suggest that care staff still do not have the same status as workers in other sectors, either in the public's eye or in government priority. In line with the Migration Advisory Committee's urgent recommendation, the introduction of some care staff to the Shortage Occupation List in late December 2021 was welcomed by the sector as a recognition of the scale of the challenge around the workforce; however, questions have been raised about how effective the policy will be in the short term.[114]

In line with evidence heard at the House of Commons Health and Social Care Committee,[110] interviewees and participants at our workshops expressed considerable concern about levels of burnout in the sector, adding to fears that many will seek to leave care work if there is not a significant shift in perceptions and pay and conditions. At the time of writing this report, £500 million had been allocated from government's social care reform money for training, qualifications, wellbeing and mental health support for the workforce over three years.[115] Since writing, the government's subsequent 'Next steps' plan for reform has confirmed £250 million of this.[186] There remains an urgent need to put in place a longer-term strategy for the future. "We were certainly hearing… 'I'm going to stay until Covid's over then I'm leaving because we just don't have the, it's just not worth it, the impact on my family'" (interviewee 13).

The social care system relies heavily on unpaid carers but limited support was provided to them as part of the response

Unpaid carers have played a pivotal role in supporting people who draw on social care over the course of the pandemic, but the impact of caring during the pandemic remains largely unseen. There is limited availability of high-quality published literature on the impacts of caring both before and during the pandemic.[116] We acknowledge this when we set out our approach limitations in Appendix 1; this section therefore draws on the available evidence to date and what we heard from our interviewees and workshop participants.

When the pandemic hit, many unpaid carers were already experiencing poor health and wellbeing,[117,118,119] with limited access to financial and emotional support to help them manage the complexities of caring.[120,121,122]

The pandemic added to those existing pressures as some support services were closed and many families decided to stop formal care for fear of infection.[117] Estimates suggest that across the UK, an additional 4.5 million people have taken on caring responsibilities during the pandemic, of which 2.8 million are managing these alongside employment.[123] In April 2020, the government widened eligibility for the Coronavirus Job Retention Scheme to include employees with caring responsibilities; however, it is not clear how widely carers accessed the scheme as the government's experimental statistics do not record reasons for furlough. Survey data suggest that in April 2020, 13% of respondents with caring responsibilities had benefited from the scheme.[124] Qualitative data suggest that, while there were some benefits to unpaid carers with the flexibility afforded by furlough and home working, it also limited opportunities for unpaid carers to access respite and social participation in the workplace.[117] Beyond this, unpaid carers have received very little specific support over the course of the pandemic. Analysis of long and short term social care data (SALT) shows that satisfaction among carers with services received declined in the first year of the pandemic and there was a similar decline in the proportion reporting that it was easy to find information about services.[125]

Some people stopped their [formal] carers totally and tried to cope without, which then put a huge strain on family carers and other people that would have normally gone to day activities or day services, a lot of those things suddenly stopped. So, families were under real pressure suddenly having to care full time for people that perhaps normally that wasn't part of their role.
(Interviewee 2)

A lack of clear accountability and joined-up policy rendered unpaid carers often invisible in policy and guidance

Although DHSC is the lead for this, it does involve MHCLG [Ministry of Housing, Communities and Local Government], does involve DWP [Department for Work and Pensions] in other aspects so we shouldn't be seeing adult social care as solely DHSC. Actually, actions are required from across government.
(Interviewee 5)

Interviewees felt that at a national level, responsibility for unpaid carers could fall through the gaps as it is spread across multiple government departments: policy lies with the DHSC, local support and housing lie with the DLUHC and benefits sit with the Department for Work and Pensions (DWP). People we spoke to suggested that policy affecting carers needs to be better joined up across government. Similarly, at a local level, there is limited clarity about who is responsible for unpaid carers within local systems.[125]

This complex web of accountabilities, assumptions and lack of joined-up policy for unpaid carers at both national and local levels has contributed to the delays in organising timely support for carers during the pandemic. Unpaid carers were largely invisible in national policies and guidance in the early months of the pandemic. Detail on unpaid carers has been notably absent from key documents such as the social care winter plan for 2020/21, for example.[14] Some groups of unpaid carers have been especially hidden, despite their increased vulnerability to Covid-19: those caring for people who spend time in intensive care, carers with health conditions, carers on low incomes and carers from minority ethnic backgrounds.[123] "It's not only social care that play second fiddle, the carers play third or fourth fiddle" (interviewee 5).

In the early months of the pandemic, unpaid carers struggled in the absence of specific guidance, information and support that was reflective of their needs or their personal situations.[126] They found it difficult to get access to PPE for themselves – and free PPE was not made accessible to them until February 2021.[127] As a result, interviewees remarked that many had to use their own initiative to protect those they cared for, for example by purchasing PPE intended for home care workers and training themselves to use it appropriately. On some occasions, stakeholders felt that NHS England's communications were confusing. With vaccination, for instance, the NHS's website initially wrongly stated in early 2021 that individual carers were not able to access the Covid-19 vaccine unless they were in receipt of Carer's Allowance. This speaks to a lack of consistent understanding of the definition and identification of an unpaid carer: "[T]here is an ongoing problem I think with how the NHS recognises and communicates with unpaid carers" (Interviewee 5)

Furthermore, interviewees felt that insufficient regard was given to the impact of certain policies on unpaid carers. Some stakeholders we interviewed were concerned about the limited attention given to unpaid carers in the Discharge to Assess programme. Lengthy hospital stays – particularly in this scenario where risk of Covid-19 infection is high – can be detrimental to the wellbeing of people (especially older people and those with dementia who can deteriorate and lose their independence rapidly) and there is benefit to facilitating smooth and timely discharge.[128] However, interviewees told us that, although hospital discharge guidance sets out that unpaid carers should be asked about whether they are willing and able to take on caring responsibilities, in some situations assumptions were made about their ability to do so in the discharge process. Recent research has found that, in some cases, assessments of carers' ability to take on caring duties (a statutory responsibility of councils) were not undertaken.[129,130] The Health and Care Act 2022 explicitly introduces a duty on NHS trusts to involve carers in the discharge of people from hospital, which should hopefully ensure that the needs of carers are included earlier and more consistently in the discharge process in future.

People felt like they were discharged too early, often going almost straight back into hospital,... we had a severely disabled woman who was discharged into a cold home and no one put her coat on. They weren't having those communications with their family that, many people felt like they weren't asked whether they were able to care, that it was very difficult for them to stop discharge happening.
(Interviewee 5)

Although policies such as the winter plan for 2020/21[4] include actions targeted at unpaid carers, our interviewees reflected that the lack of a clear national strategy to support local authorities to consistently fulfil their statutory duties meant there has been variation in the level of support available to carers. We heard of some local authorities that had "prioritised carers", but in other areas unpaid carers received limited information from health services or local authorities about how to care for people who were shielding across different periods of the pandemic. Stakeholders noted some examples of good practice where local authorities worked collaboratively with local carer organisations, for example to provide free PPE for extra-resident unpaid carers (who live in a different household from the person being cared for), before the government made this available nationally in February 2021.[127] Difficulties in identifying unpaid carers in primary care records, especially in situations where carers were unable to register their status with their GP to access priority vaccination, complicated the provision of additional support to unpaid carers.[123]

A failure to provide support in a timely way has driven unpaid carers to burnout

The private nature of caring duties has meant that there is relatively little understanding of the varying and complex tasks that unpaid carers undertake and how these are balanced against other responsibilities, such as employment. The sudden closure of many services for both unpaid carers and the people they care for, when the pandemic hit, resulted in many carers being faced with additional responsibilities and few sources of support.[117] Analysis of the Understanding Society survey suggests that 45% of carers providing more than 20 hours of care a week had not previously provided care.[131] This would suggest that roles and responsibilities for carers have changed over the course of the pandemic.[81] Our interviewees reflected this:

Unpaid carers said they felt like they were given quite significant tasks, so they felt pressured to take quite medical-based tasks themselves and that [was] split into two reasons. It split into the fear and worry about having people in your house but there was also a big group of people who felt that there was pressure to do that from either medical staff or from social care themselves.
(Interviewee 5)

For example, people with learning disabilities and their carers reported that regular health checks and medications had been delayed or cancelled since the first lockdown. And more than 70% of people with learning disabilities had seen their regular health care professionals less or not at all in the year that followed the first lockdown.[132,133] Carers UK surveyed carers in 2020 and 78% reported an increase in needs of the person they cared for during the pandemic, and 81% felt that they had provided more care since the start of the pandemic.[134] Systematic reviews of the evidence highlight concerns from unpaid carers about whether care services for the person they cared for would become available again in the future, and the resulting feeling of 'sole responsibility' has driven carer fatigue.[135]

The general feeling seems to be that the emotional level of support has gone up and the complexity... coming through has increased so that's really a reflection of where people have been because they haven't had the services or support for so long.
(Interviewee 5)

Despite the increase in responsibilities that unpaid carers undertook after the pandemic hit, limited support was put in place to specifically address their growing needs. Stakeholders felt that many developed more complex emotional and physical needs as a result. This is reflected in wider research, which has found that many of these needs have not been met.[117,135] Interviewees expressed concern that the extent of the impact of the pandemic on unpaid carers' physical and emotional wellbeing remains mostly unquantified (interviewee 1).

According to survey data collected by Carers UK, almost three-quarters (74%) of unpaid carers are feeling 'exhausted and worn out' and more than a third (35%) feel unable to cope with their responsibilities as a carer.[25] Research into the impact of Covid-19 on carers of people with intellectual disabilities, as well as carers of people with dementia, has revealed an increase in anxiety and depression and a decrease in quality of life as a result of the pandemic.[136,137,138] Analysis by the Office for National Statistics reveals that, although all parts of the population have experienced a lack of freedom and independence and impacts to their wellbeing, the caring responsibilities of unpaid carers, and their access to health care, have been disproportionately affected compared with non-carers.[139]

The risk is that the prolonged toll of caring without adequate support could lead to high numbers of people experiencing emotional breakdowns. Survey data from ADASS appear to indicate that these concerns are coming to pass: 67% of directors of adult social services responded that the number of people seeking support due to carer breakdown was increasing in the first half of 2021.[25] This represents an increase from the first ADASS Coronavirus survey, published in June 2020, which reported that 53% of directors indicated an increase in the number of individuals presenting to local authorities as a result of carer breakdown since the onset of the pandemic.[140]

Stakeholders warned that, if and when the pandemic subsides, carers may face new and different challenges. The relative flexibility that the pandemic affords – allowing some carers, for example, to work from home and manage caring responsibilities – may not always be possible in the future and those who have become carers during the pandemic in particular will face increasingly stark choices if businesses require staff to return to offices full time. There is an urgent need to reinstate day services and other forms of support that enable carers to balance life and caring responsibilities. Stakeholders (at the time of interview in March to May 2021) were concerned that these services had not been opened up universally as lockdowns ended – and felt that even small delays to services opening up could have significant impacts on carers who were already struggling. Guidance and policy documents relating to Covid-19 must continue to explicitly mention unpaid carers in an accessible and understandable way, and be tailored to the needs to specific groups and communities.[123]

People: learning the lessons from Covid-19

Covid-19 has highlighted the need for people with in-depth knowledge of social care, its diversity and its complexity to be involved in developing guidance and making decisions about emergency responses. Participants in this project commented on the “steep learning curve” within central government about the sector and, while there continue to be some issues around the tailoring and timeliness of guidance and support, interviewees recognised the progress that has been made. Specifically, many commented on the strides made in communicating with sector representatives via working groups and the adult social care taskforce, which produced recommendations for the winter plan for 2020/21.[4]

The new links that the DHSC, other government departments and non-departmental bodies have built with the sector should be nurtured so that future guidance and policy have the benefit of expert input to ensure they are tailored and appropriate to different parts of this vast and complex sector. We heard that more effective links between local and national government could be encouraged through, for example, shadowing schemes to promote a better understanding of the pressures at play. An immediate change that could be enacted is to work towards issuing guidance in a clearer and more timely manner to facilitate effective implementation.

Some lessons with regard to the paid workforce were learnt as the pandemic progressed, particularly in terms of the funding for sick pay for staff isolating and for reducing staff movement.

At a local level, we heard of positive examples of clinical commissioning groups and councils readily providing additional training to volunteers that home care providers recruited to work alongside Covid-19-anxious staff as part of ‘Covid hot teams’. Establishing such support on a regular broader basis

could help to retain much-needed staff as the sector increasingly struggles with workforce shortages. Granting some workers greater autonomy has helped to demonstrate the enhanced skills and responsibility they are capable of, with some interviewees describing how this offers a greater opportunity to recognise care staff more widely as key members of multidisciplinary teams.[141] There is now an opportunity to "more explicitly recognise that social care staff are doing things now that you would have had a district nurse do 10 years ago and those skills are really changing"
(Interviewee 13)

However, there is still much to be done to address the serious underlying issues in the social care workforce. The extra funding that has become available to support the workforce has come in a series of bursts. At the time of writing, the government had earmarked £500 million of the new Health and Social Care Levy for workforce development and wellbeing, to be spent over three years.[115] And a series of grants to support the workforce was announced over the course of 2021: a Workforce Capacity Fund of £120 million in January 2021;[98] a Workforce Recruitment and Retention Fund of £162.5 million, introduced in October 2021;[98] and a further £300 million, which was made available in December 2021 to combat winter pressures.[142] This funding, as well as a new recruitment campaign,[143] have been welcomed although were initially met with concern among many in the sector about whether the funding was sufficient and timely.[144] Since finishing writing this report, the Health and Social Care Levy was abandoned in Autumn 2022 and, in April 2023, the government's Next Steps for reform document indicates that £250 million of the original £500 million had been confirmed for the workforce.[144]

Local authorities were able to pass funding directly to providers over the winter 2021/22, enabling them to introduce recruitment and retention measures such as pay enhancements for overtime or antisocial hours, annual leave buy-back schemes or bonus payments designed to retain staff over the winter, which a number of care leaders called explicitly for in winter 2021/22.[145,146] A number of local authorities have made use of this funding to develop incentive schemes such as 'golden hellos' and support with childcare costs.[147,148] However, many – including care providers, trade unions and royal colleges – remain concerned that the levels of funding provided to date fall short of what is needed to mitigate the deepening crisis in the short and medium term.[149,150] In addition, some of the recommendations that the

DHSC's own taskforce made in September 2020 to bolster the workforce ahead of winter 2020/21[151] were still to be implemented at the time of writing. These included, for example, an urgent recommendation that within three months, government should instigate a review involving employers, commissioners and staff representatives, with a view to implementing a new career-based pay and reward structure for social care, comparable to that in the NHS and other equivalent sectors.[151]

Interviewees pointed to the need for a longer-term strategy that addresses the deep underlying issues in the sector and to ensure staff are equipped with the resilience, skills and capacity to weather future shocks. A number of workforce proposals spanning the next three years have been set out in the government's White Paper on adult social care reform[6] and subsequent *Next steps* document.[193] However, there remains no comprehensive, longer-term workforce strategy to address fundamental issues around pay and working conditions, and to accompany the NHS workforce plans underway. Calls for just such a long-term workforce strategy, co-produced with staff, employers and people drawing on care, have continued to gather momentum.[152,153,154] During the pandemic, many care staff have worked beyond their usual scope and it is important to ensure that, as workers take on more complex tasks, they are adequately and appropriately trained and reimbursed. The Migration Advisory Committee has recommended that government should introduce, in the first instance, a fully funded minimum rate of pay set at £10.50 an hour for care workers, as has been introduced in Scotland.[155]

Covid-19 has demonstrated how vital unpaid carers are to the social care infrastructure but also how confused accountability and implicit assumptions often render them invisible in policy and guidance. Stakeholders reflected that guidance for unpaid carers improved over time as the government engaged with sector representatives in tailoring guidance to make it more understandable for services and carers. The prioritisation of carers in the vaccination rollout was seen as a positive step forward in making this group more visible in policy-making.

Commitments to better support unpaid carers in the adult social care White Paper are welcome but there is much work to be done, particularly in reinstating and expanding support services and establishing clearer accountability. Health and social care services will also need to improve data collection to identify unpaid carers, for example through the introduction of 'a basic requirement of all GP practices to have a system in place to identify carers'.[150] Data strategies that sit alongside reform to the social care sector will need to explicitly include unpaid carers. In the short term, other solutions to facilitate identifying unpaid carers include ID badges akin to those given to key workers.[123] Long-term reform needs to explicitly consider the assumptions made around caring and generate a wider debate about the balance of responsibility between state, family and community.

People: key recommendations

- At times of future crisis, the DHSC and other relevant bodies responsible for issuing guidance and advice need to fully consider the diversity and complexity of the sector to ensure that adequate and appropriate support is available to all in a timely and accessible manner.
- A comprehensive, long-term workforce strategy (akin to the NHS People Plan) must be brought forward to build a stable, motivated and supported workforce with the skills and capacity to weather future shocks better. This must address not just immediate issues of burnout but also the underlying weaknesses around pay and conditions. The strategy must also effectively build career opportunities for staff, address the lack of parity with the NHS workforce and tackle perceptions that care work is low-skilled.
- The government's reform programme needs to invest in measures to better identify and support carers. Improved data collection, reinstating respite and day services and supporting those who want to remain in employment by introducing paid leave are some priorities that need to be included. Clarifying accountability around policy for unpaid carers at national and local government levels will help to drive progress in this area.
- As social care reform gathers pace, the DHSC and wider government need to ensure that unpaid carers are fully considered, paying attention to other policy areas (for example, work and pensions) that also impact on carers. Support that has fallen away during the pandemic needs to be reinstated and expanded as a matter of urgency.

5 Resources: funding, data and estates

Key points

- Although emergency financial support has been welcome, it has been characterised by short-term injections of money, announced at the last minute, and it has taken time to reach those who need it. This approach has failed to offer certainty to councils, providers and the people who draw on their services.
- A lack of data about the sector – its users, workers and providers – represented a significant obstacle in designing and rolling out the pandemic response.
- Those leading the response made assumptions that care home residents could be isolated but the old, converted buildings without en-suite bathrooms that make up a large proportion of the residential care estate made this very difficult.
- Progress made during the pandemic with regard to data – such as the rapid adoption of the Capacity Tracker – has built the foundations for further improvements, but further effort is needed to ensure providers are not overburdened if such innovations are to be embedded in the long term.

In the decade preceding the pandemic, state spending on social care had decreased and only just returned to similar real-term levels as 2009/10 by the time Covid-19 struck. This had consequences for the state of the sector, in particular the physical estate, the digital infrastructure and the stability of much of the provider market. As a result, the sector entered the pandemic in a fragile state. This starting point had serious implications for how well the sector was able to withstand the pandemic pressures and for the effectiveness of the emergency financial support made available.

Financial support has been welcome but has been slow, short term and inflexible

The first tranche of emergency funding was made available to councils on 19 March 2020 to support their pandemic response. By September 2020, £3.7 billion had been made available to councils – intended for all Covid-19-related costs, not just those relating to social care.[156] In addition, some social care-specific funding was made available and released in a series of stand-alone payments, the most substantial of which took the form of the Infection Control Fund (see Box 2). It is notable that, in contrast, the NHS was promised 'whatever it needs, whatever it costs'.[157] A report by the London School of Economics and Political Science gives a full breakdown of all the funds allocated to social care.[158]

Box 2: Infection Control Fund for social care

The Infection Control Fund was intended to support social care providers to reduce the rate of Covid-19 transmission through infection prevention and control and to encourage staff vaccination uptake. It was also intended to support the testing of staff and visitors in care homes and other high-risk settings.[99]

It was released in the following phases:

- May 2020: the £600 million Infection Control Fund was provided as a ring-fenced fund for care homes.
- September 2020: £546 million was allocated to infection control over the winter 2020/21 and extended to settings other than care homes.
- April 2021: £341 million was provided until late June 2021.
- July 2021: £251 million was provided until September 2021.
- September 2021: £388.3 million was provided until March 2022.

While emergency funding was welcomed – with some of the providers we interviewed describing it as a lifeline – there are some lessons to be learnt about the process by which the money was made available. Many suggested that the approach reflected some longstanding historic issues, which need to be addressed if a more resilient system is to be created.

There has been a precedent of short-term financial sticking plasters

> **[T]he whole experience in one sense is a quite neat distillation of the way that the whole system is being funded for, I don't know, 10 plus years so you get injections of short-term funding…**
> (Interviewee 15)

While those in the sector have welcomed the financial support, the short-term nature of it, and the uncertainty of last-minute announcements, have posed challenges and limited its effectiveness. Sporadic injections of cash into the social care system to keep it going through a defined period of time (often winter), or to prevent it from collapsing, have characterised the approach to funding social care in England over the past decade and that approach has continued during the pandemic. While there are large providers with sizable margins, small and medium-sized organisations provide around 70% of care and many of them entered the pandemic in a precarious financial state.[8] At the start of the pandemic, providers faced considerable and sudden increases in costs as a result of staff sickness and the sudden need for high volumes of PPE that they had to buy initially on the open market at inflated prices. With few reserves to fall back on, many organisations were on the brink of being financially unviable, as this interviewee described:

> **If you're [paying] 100 times more for something than what its street value was when you first budgeted for it, then that's going to blow your budgeting for that month out of the water. Add to that the staffing costs and the sick leave costs and everything else they were doing… I remember a**

conversation with a care home manager two months into this, so we're talking April, May, early June [2020], and… she thought her business was going to go under… and just in the nick of time, she was probably about three days away from going under, and the IPC [Infection Prevention and Control] funding arrived and fished her out.
(Interviewee 3)

The introduction of the Infection Control Fund has been vital in supporting providers' efforts to contain infection spread but the funding has been strictly time-limited, with extensions made at the last minute. Instead of giving certainty to providers (and their commissioners and people who draw on care) that the money will be extended, the announcement has often come with little notice. For instance, an extension of the Infection Control Fund that was due to run out on 31 March was announced on 18 March 2021; that again was due to run out on 30 June 2021 but extended on 27 June 2021; and, in the subsequent tranche due to expire on 30 September 2021, an extension was announced just hours before it was set to come to an end. Interviewees across the spectrum of providers, local authorities and user and carer representatives stressed that, while the funding was very welcome, the manner of its renewal did not facilitate planning or strategic allocation.

A further reflection on the funding from stakeholders was that it was slow to arrive. Funding for council services, including social care, was made available in March 2020 as infections rose but social care-specific funding that addressed the issues of lack of sick pay and staff movement was not put in place until 22 May 2020.[159] This was two months after the Coronavirus Job Retention Scheme had been made available to wider businesses.[160] This interviewee describes the mismatch in support in late March 2020:

We couldn't furlough staff, we couldn't benefit from any business support grants because of the way our services are set up so it was… SME [a small and medium-sized enterprise] is generally owned by one person – we didn't have much business support so I was on calls with BEIS [the Department for Business, Enterprise and Industrial

Strategy] alongside McDonalds and the Airport Authority and everybody, who were getting loads and loads of support, and I was saying: 'What about social care? We contribute £45 billion into the economy.'
(Interviewee 11)

Central government processes do not always translate at a local level

Among providers and councils, there was some discontent about how inflexible the extra funding has been. Although the original money to support councils was not ring-fenced for social care and councils had the autonomy to decide how to spend it, the infection control, testing and rapid discharge money came in separate pots, with requirements that some interviewees described as "rigid". While there is a clear need at a national government level to account for spending, and ensure it goes to the intended purpose, this created some frustration at provider level. There are perhaps lessons to be learnt about what the appropriate level of assurance is, which balances urgency with accountability.

For some, the frustration lay in the amount of paperwork involved in accessing money, which resulted in delays in the money reaching the front line. Small providers, many of whom lack extensive back-office functions, struggled with the burden of bureaucracy. For larger providers that operate across multiple local authorities, there was added frustration in that each council adopted its own different approach:

Local authorities each did their own thing. There were huge delays in accessing money and a lot of extra paperwork where[as] in an emergency response, money should have just been given to people and use it what you need it for.
(Interviewee 4)

For others, there were situations where rigid requirements meant providers and councils were unable to use the money for what was most needed and highlighted how a scheme designed to make sense centrally can become hugely complex for councils and providers alike:

> **[I]t's symptomatic of a centralised approach. We had quite narrowly defined funds for this, that and the other, infection control, testing over here, and Discharge to Assess over there, then we'd have something around Test and Trace over here, so you ended up with eight or nine funds, thinking: 'What are the criteria for these?' That's fine at one level, at government, and it's probably fine for local authorities who are used to being bureaucrats, but when it got down to the care providers thinking about, 'Sure I'll sign this contract, that says, I won't use it for that, I'll only use it for that and I'll pay it back if that happens', it was all a bit sub-optimal.**
> (Interviewee 1)

There was a lack of data and information about who uses and provides care services

> **We feel that Capacity Tracker for providers is the best of the worst worlds really. To expect providers to fill that in every day has been very onerous on them.**
> (Interviewee 1)

In the early months of the pandemic, an absence of good-quality accessible data and a historically slow adoption of digital innovation hampered the response. Social care lacks a standard dataset and, as a dispersed system funded via a mix of public and private money, many councils do not hold comprehensive information about everyone who draws on care services nor even all the people and organisations that provide care. This is mirrored at a national level – as the government itself admitted in its 2020 adult social care action plan, the logistics of retrieving the addresses of, and distributing PPE to, '58,000 different providers… is an unprecedented shift in scale' from its normal supply chain, which was designed to deliver to 226 NHS trusts.[59]

It was also difficult in the early months to get a full picture of the sustainability of providers. The completion of an information-gathering tool that had been developed before the pandemic – the Capacity Tracker for social care – was rapidly made a condition of receipt of infection control funding and was made permanent in summer 2022. This supported the pandemic response, by requiring providers to submit data on the number of beds in use, PPE stocks and workforce information such as absence due to sickness.[161] However, there were challenges in its rollout and use and providers were clear that it would need to be adapted to be suitable in the long term. Below, we examine the underlying factors that led to these circumstances and what progress has been made towards addressing them.

Entering the pandemic, chronic under-investment in social care had resulted in poor data and digital infrastructure

Compared with the NHS, the social care sector lags behind in terms of its data and digital infrastructure, although there are pockets of innovation. A decade of tightening social care budgets and sporadic, unpredictable injections of money for state-funded care have limited the potential for widespread investment in data, information systems and digital innovations. The uptake and spread of innovation are highly variable, however, and where technological innovation has taken place, the sector also suffers from limited evidence about its impact.[8,162] Limited routine data about the sector had been recognised as an issue before the pandemic[163] and interviewees reported that this had an impact on the speed and effectiveness of the response.

At the beginning of this they [the government] didn't know how many people [in social care] had Covid, how many people had died of Covid or anything, and we had to basically [build] a minimum dataset to understand what the pandemic was doing.
(Interviewee 3)

Entering the pandemic, there was no central information on key questions such as the sickness and isolation rates of workers, community transmissions, accurate occupancy rates of residential care providers or who even was in receipt of social care (both publicly funded and self-funded). There was also a delay to the publication of sickness and death rates for people in contact with social care services. Knowledge of 'less visible' groups such as people with learning disabilities and Direct Payment users continues to be especially poor,[164] and there is no workforce register. Without access to high-quality data on people drawing on care or working in the sector, our understanding of the potential inequalities in needs and access linked to protected characteristics, and their intersectionality, has been hampered.[64]

A lack of established data flows meant providers were burdened with multiple data requests

A digital tool created in 2019 – the Capacity Tracker – has been (and continues to be) further developed and providers' access to infection control funding, when it was introduced in May 2020,[165] was made contingent upon them completing information in the tracker. This was later made an at least weekly requirement.[99] Interviewees, on the whole, were supportive of the rollout of the tracker and viewed it as a necessary development at the height of the pandemic response. However, concerns were flagged about the significant burden placed on providers to keep information up to date and it will be important that a number of design issues are addressed if the tracker is to be embedded on a permanent basis.

On top of having to fill in the Capacity Tracker, providers often found themselves responding to data requests from multiple different parts of the system (local authorities, the DHSC and the CQC, to name a few that stakeholders cited) who were having “arguments about which system should be used and what data should be collected” (interviewee 14).

We heard from interviewees that providers (especially smaller ones, in the early months of the pandemic) often struggled to find sufficient capacity and resources to keep up with the ever-growing requirements for new data as the pandemic evolved, particularly during peaks of infection when the day-to-day running of safe services was the priority – an issue which local authority representatives also recognised. This is consistent with findings from research elsewhere.[166] With the burden on providers to meet these overwhelming and diverging data needs, response rates to the Capacity Tracker have varied over time.

> **But even though [providers] completed the Capacity Trackers, some, for example local authorities and CCGs [clinical commissioning groups], will still ask for the information and say: ‘Well we still want it in a different way.’ And [providers] just get very frustrated about that because they’re saying: ‘Well the whole point of having this is so we have access to it and we are having to do it again and’… when they’re in crisis mode managing.**
> (Interviewee 6)

At the time of our interviews, providers stated that they had been required to enter data but were unable to see their own information or to benchmark themselves against others. Providers we interviewed felt there was huge potential value in them being able to access combined information from local providers in real time for driving quality and adopting good practice, and to prepare against local outbreaks. There was a clear feeling among stakeholders that, for the Capacity Tracker to be viable in the long term (and especially in the absence of other incentives such as the Infection Control Fund), providers would need to be able to derive some clear benefit from the data. While we understand that providers are now able to see some benchmarking information, there are still limitations in what they can access in terms of up-to-date data. However, the Capacity Tracker marks a significant step forward in creating a high-quality dataset in this sector and there is an opportunity for policy-makers and providers alike to work together to build on that progress and to ensure the tool delivers value for all stakeholders.

Data quality has limited the accuracy of decision-making

Although the Capacity Tracker was rapidly deployed to generate useful data in challenging circumstances, stakeholders raised concerns about the quality and accuracy of the data within it that were being used to make decisions. The speed at which events in the pandemic unfolded has allowed limited time to undertake the usual processes of cleaning and sorting data and carrying out quality assurance.

Data pertaining to care staff, such as testing and vaccination data reported in the Capacity Tracker, have been deemed hard to obtain, especially in the first half of 2021 before the introduction of the NHS Covid-19 pass as proof of vaccination in May 2021.[167] Providers spent significant amounts of time obtaining testing and vaccination statuses from their staff, with initially no streamlined processes such as QR codes for this information to be collected, no national staff register and no obligation for staff to disclose their vaccination status to their employer.

> **Vaccination relies on providers inputting the data, and that relies on the care workers actually telling them, and if they choose not to, there's nothing you can do about that. The testing is even worse because what happens is, if you're an employer, you order the tests, that bit all works, they come to you, you give them to your care workers and then there's no feedback looped to you as the employer. So, you have to then chase your care workers to get them to tell you if they've done it and to put the results up.**
> (Interviewee 14)

As a result, stakeholders have been concerned that some national policy decisions could be based on potentially erroneous or incomplete data that were available at the time. This has been a particular concern around the introduction of the mandatory vaccination policy, which was announced in the summer of 2021 in response to seemingly low uptake rates as reported in the tracker. The DHSC informed us that it ran engagement activities with providers to understand the low vaccination rates being reported, but some interviewees felt there was a missed opportunity in the introduction of the mandatory vaccination policy to use the Capacity Tracker in a way that could help understand vaccine hesitancy:

> **Our providers haven't had the time to upload their data to Capacity Tracker. So, that becomes tricky if government are looking at the data… and going 'Oh my god, things are really bad in x local authority' and are sending people in… to this part of the system that appears not to have good numbers, only to discover that it's purely an issue about uploading data. It doesn't mean the people aren't getting vaccinated, it just means, literally, nobody's had the chance, the time to press the button.**
> (Interviewee 15)

While progress was undoubtedly made in collecting administrative data, there are ongoing challenges in collecting information relating to the impacts of the pandemic on particular groups of people who draw on social care and their experiences (for example, in relation to automated data collection).[168] This issue has been raised throughout the pandemic. For example, the DHSC's learning disabilities and autistic people advisory group, that fed into the social care taskforce, noted the limited statistics published on death rates for people with learning disabilities and autism.[164] Collecting data on underrepresented groups, and the intersections between different protected characteristics, will be essential to getting a full picture of how the pandemic has affected people receiving social care and unpaid carers.

Assumptions were made that the adult social care estate could cope

The rapid spread of Covid-19 in congregate care settings – well documented elsewhere – has brought to light the fact that the residential care estate was in a poor state entering the pandemic. Moreover, the policies and guidance put in place to manage Covid-19 in residential care failed to adequately take account of the condition and limitations of many care homes, making assumptions about the sector's ability to cope with widespread infection.

Guidance on managing infections in residential care did not take sufficient account of the state of the care home estate

Before the pandemic, care quality ratings were high on the whole but there had been little overall improvements over time. Some providers remained rated as inadequate or poor for consecutive years.[22] Furthermore, narrow financial margins – especially in care homes with high numbers of local authority-funded placements – have meant limited opportunities for investment in improving care home infrastructure.[169] As a result, the residential care sector entered the pandemic with an estate that was largely unmodernised and unsuitable for managing outbreaks of Covid-19 and other external shocks such as extreme climate events. According to the National Audit Office, fewer than half of care home beds are housed in purpose-built estates, and a significant number of bed spaces within these homes (28%) do not have en-suite facilities.[44,170] Similar concerns have been raised about the state of buildings in community services, including supported living and extra-care services.[44]

Yet guidance for managing residents infected with Covid-19, and policy intended to facilitate rapid discharge from hospital, failed to adequately take account of these realities. The impact of the rapid discharge policy without pre-discharge testing on infection rates in care homes has been a source of controversy[81] but, regardless of the extent to which it contributed to the spread of infection, the approach certainly paid too little attention to the realities of the care home estate. Testing capacity in the early stages of the pandemic was limited, and guidance issued on 2 April 2020 stated that 'negative tests are not required prior to transfers/admissions into the care home'.[171] Instead, care homes were to isolate or cohort Covid-19-positive residents or those awaiting a Covid-19 test result (once testing was a requirement, as of 15 April 2020[59]). However, the majority of care homes are small or medium-sized, and operate at high occupancy rates, so lacked the space and flexibility not only to isolate residents but also to house sufficient PPE and testing stations.

Guidance also fundamentally failed to recognise that a care home is, first and foremost, a person's home and not a clinical setting. Care homes that had residents with dementia, in particular, struggled to implement some elements of the guidance, as this interviewee highlighted:

> **There was something PHE [Public Health England] had produced quite early on, which was completely... completely useless for social care... it was all about isolating people and getting people to keep all their waste in the same room with them, which you know if you work with anybody with dementia, all of which are completely inadequate responses.**
> (Interviewee 12)

The policy of designated settings has been largely positive but insufficiently sensitive to the realities and diversity of the sector

To limit the spread of Covid-19 infection into care homes and to free up beds in acute health care settings, the DHSC devised a policy to introduce 'designated settings' as part of the winter plan for 2020/21. These were intended to provide settings for service users with a positive Covid-19 diagnosis transferring out of hospital into a care home, to support 'safe and timely discharge'.[172] The costs of administering these designated settings were accounted for in the £588 million discharge fund,[14] which came to an end in March 2022.[86]

The sector saw the development of designated settings as a welcome improvement as England moved into the second wave of Covid-19 in late autumn 2020. Stakeholders welcomed the collaborative working that emerged to facilitate their set-up. Examples of good practice included the CQC undertaking rapid inspections of potential settings and the NHS providing adequate infrastructure to ensure there were designated settings in each local authority.[173]

It was a move in the right direction so you weren't discharging people out of hospitals into care settings and you were discharging them into designated settings from where they would recover and then go back to their care homes hopefully.
(Interviewee 11)

However, there have been some practical obstacles to implementation. The universal guidance assumed a uniform model but the care home sector is extremely diverse, in terms of the physical infrastructure, the types of services delivered and the complexity of residents. We heard from interviewees that some providers have been nervous about the potential complexities of managing service users with Covid-19 infection, especially if they have maintained their usual services in parallel. This is a particularly key issue for smaller providers already grappling with staffing shortages.

There was wide variation in the number of providers within each local authority that were suitable to be a designated setting.[173] The CQC reported that some local authorities initially put forward providers that did not meet the criteria, such as settings where Covid-19-positive people could not be separated from other service users and settings where there was no dedicated workforce. In some situations, providers were not aware they had been put forward for the scheme.[64]

No evaluations of the impact of designated settings on care provision have been undertaken and more analysis is needed.[14,64] However, the CQC found variations across the country between the number of designated settings and the number of occupied hospital beds and noted that coordination was largely smooth between services but that some issues did arise (for example, people being discharged without medication or when they were not well enough).[64] The contribution of designated settings to more effective hospital discharge is as yet unclear.[37] The pandemic has limited the extent to which researchers have been able to conduct research in care homes and assess health or wellbeing outcomes, further complicated by the availability and quality of administrative data in these settings. It will be important that robust research is carried out to understand not just the effectiveness of designated settings in ensuring the flow of people through hospital but also the impact on the wellbeing and outcomes of people being moved into them and any issues that arose during the transitions.

A further obstacle to implementation has been the fact that many providers have struggled to obtain insurance to operate as a designated setting under a "chaotic" process (interviewee 12). The government's introduction of indemnity insurance was somewhat disjointed – it was only introduced three months after the rollout of designated settings in January 2021. While the introduction of indemnity cover was welcome, the temporary nature of the offer, as well as its relatively last minute extension, have been sources of uncertainty for providers.[14] Accessing affordable insurance has been a challenge for providers more generally throughout the pandemic. Many have seen their insurance premiums increase by several hundred percent and some have found it impossible to find coverage for Covid-19 infections. The government has recognised this issue in its winter plans (most recently, for winter 2021/22[86]) and has committed to better understanding how to support providers to obtain insurance; however, no concrete action has yet been taken.

> **Our insurance market… moved in such a way that Covid was excluded from any insurance cover so if you had a claim against Covid you were not covered and your premiums were going up – they were doubling, in some cases trebling.**
> (Interviewee 11)

Resources: learning the lessons from Covid-19

It was clear before the pandemic that social care's infrastructure was in need of improvement, and the National Audit Office had already warned that 'it will take several decades to modernise the care home estate'.[44] Stakeholders similarly highlighted concern around the lack of data and the lack of investment in technology and innovation across social care.

In many ways, Covid-19 has proved a catalyst in moving towards some ambitions around technology and digital adoption. In other areas, Covid-19 has simply, but helpfully, shone a light on issues that previously were less well understood. There is an opportunity now to build on this progress, and to use the new-found understanding, to develop infrastructure for social care that not only is resilient to future shocks, but also helps the system achieve its goal of supporting people to live independent and fulfilling lives. *People at the Heart of Care*, the government's White Paper on adult social care reform, has set out an ambition to make 'every decision about care a decision about housing' and invest in digital and data infrastructure to support people's lives.[6] If dire predictions about climate change come to pass, it will be all the more important to ensure the residential estate, including extra-care and accessible housing, is able to withstand not just future pandemics but also extreme climate events, from heatwaves to flooding.

The most visible progress has been in the steps taken towards establishing a central social care dataset. Since writing this report, the DHSC has recognised the need to minimise burdens on data collection having made the Capacity Tracker mandatory as of July 2022. While the Capacity Tracker requires some development to ensure it is fit for purpose (the government's White Paper acknowledges this), it is one tangible benefit emerging from Covid-19. There is potential for it to become embedded as a useful tool for providers, local and central government, and people wanting to access services. It is important now that the momentum that has built up around it is not lost and that it is used proactively and made widely available so that its value can be demonstrated. There is potential for it to be used alongside other existing datasets too, such as local authority assessment data, local carer organisation data, Carer’s Allowance data and workforce data, to provide a much greater depth of intelligence about the sector than currently exists.

> **We’ve not had anything like this before. It’s now given us some national data… from regulated care providers, that we’re able to pull out national themes and issues [from]…, that’s definitely helpful. And I think it’s only something as we progress it that it can be developed even more.**
> (Interviewee 6)

If progress towards better, and more sustained, data collection is to be made, it will be vital that adequate funding and support for providers and local authorities are provided. Agreement is needed over a single and shared vision of what a national dataset for social care will look like, and what it will be used for.[174] Consideration also needs to be given to how datasets across different services (in particular, health and housing) connect. To avoid overburdening providers (especially small ones), a single, streamlined point of data entry through the Capacity Tracker is necessary to avoid multiple government departments collecting the same information. To ensure providers willingly contribute high-quality data to the tracker, it is important that they see the value in doing so. Access to local performance data, while taking account of commercial sensitivities, would enable providers to benchmark themselves against local information and would create an important resource with the potential to drive quality, choice and innovation. The *People at the Heart of Care* White Paper on adult social care reform has acknowledged this[6] – achieving this ambition in practice will be crucial. Progress will need to factor in the need to train staff in digital skills as well as the need for cyber security.

The introduction of designated settings in autumn 2020, ahead of the second big wave of Covid-19 infections, demonstrates a degree of learning in government from events that unfolded in the first wave and a willingness within the social care sector to adapt. It is important that this scheme is properly evaluated so its impact can be understood and improvements made so that it can be smoothly rolled out in the event of a future shock that requires a similar solution.

Covid-19 funding for social care has, to date, been short term and afforded with limited flexibility and this reflects an established trend in social care, which has come to rely on ad hoc short-term injections of funding. If sustained improvements in the system are to be made, the sector needs not just *more* investment but also a more *stable* source of funding. This will be essential to enable councils and providers to work together to invest in estates and data and digital infrastructure rather than living from cash injection to cash injection. In the short term, careful thought needs to be given to how best to support providers as emergency Covid-19 funding and support are brought to an end. It was clear in our interviews that many providers in the sector have become reliant on that funding and there is a high risk of provider exits as that support is withdrawn. During the course of this research project, the government both introduced and then abandoned its Health and Social Care Levy. Although sums allocated to social care raised from that were initially modest, there was a stated intention to increase the proportion that would flow to social care. There was much debate about whether the revenue source was the correct one but, that aside, it represented a potential sustainable source of funding for social care for the long term.

Since finishing this research, in autumn 2022, the government announced that it would make available up to £7.5 billion from national and local sources (the latter having to be raised by councils) over two years. Some of this was diverted from planned charging reform. This will help councils keep pace with inflationary pressures but leaves little for reform[175] and falls short of estimates made by the Health Select Committee in 2020 of a need for £7 billion per year.[176] Beyond the immediate two-year period, there remains little certainty around the future of social care funding. Now that it has been abolished, uncertainty again surrounds the future of social care funding (at the time of writing).

The Health and Care Act 2022 includes provision for central government to fund providers directly in emergency situations. While that proposal seeks to address the delays in getting money to the right place during the pandemic and has some merit in an emergency, it is important that the mechanism is only used in extreme circumstances and does not undermine councils' long-term strategic market-shaping efforts. Even in an emergency, there will still be a need to balance speed with due process to ensure that public money is spent appropriately. Close examination of exactly what the frustrations and problems have been in distributing funding during the pandemic should provide government with valuable insight for the future.

Covid-19 has accelerated not just some changes in the provision of care but also changes in people's preferences and need for care. It has also prompted discussions about the types of care available now, what might be possible and what the right models of congregate care support might be in future.[177] The government's White Paper commitment to put housing at the heart of all care decisions[6] will require a thorough appraisal of not just the dedicated social care estate but also the wider housing stock, paying attention to its ability to withstand future pressures such as other pandemics and climate change. Parts of the provider market are in a fragile state and many organisations lack the resources to invest in their infrastructure or to innovate. The government's funding to support local authorities to move to a fair cost of care[178] is an important step towards stabilising the existing market but it is clear that sustained investment will be needed if real improvements and innovations are to be made.

In addition to the desire for greater resilience in social care's physical and digital infrastructure, there is now also an opportunity in the wake of Covid-19 to develop more flexible, innovative, collaborative care that is led by the people who draw on it. A number of movements with these ambitions led by people with lived experience, such as Social Care Future and Think Local Act Personal, are gathering momentum and have the potential to drive change.

> **We need to have some honest discussions about where people want to live and then start planning to build those sort of homes now or to start developing extra-care housing and other forms and other community models that people can remain where they want to be for longer and feel supported to do that and families don't reach breaking point.**
> (Interviewee 2)

Resources: key recommendations

- There is a need not just for more central government funding for social care but also for funding to be more certain, to enable stability and encourage strategic investment in new services that keep pace with need and changing preferences. A multi-year financial settlement would offer more certainty to the sector.
- Investment in better data is essential to ensure a good understanding of people who draw on, and work in, social care, making sure that no groups are excluded. Implementation of the new data strategy should build on positive progress made in the pandemic and ensure that data is integrated and coordinated across services, offering maximum benefit and minimal burden for people in the sector. As part of this, it will be important to ensure the digital skills of providers, staff and unpaid carers are sufficiently developed to facilitate adoption, improve connectivity of care records and ensure cyber security.
- Modernising the existing social care residential estate, including extra-care housing solutions, to withstand both future pandemics and other shocks (for example, those arising from climate change), is of utmost importance. In the course of that investment, new and innovative models of care that offer greater choice and independence should be explored and encouraged. Commissioners of new care models need to use their market-shaping powers to ensure that increased public funding is used to improve infrastructure.
- The evaluation of new models of care across all settings (including domiciliary care), as well as of the impact of digital technologies, innovations and treatments that have proven to be effective during the pandemic, will be important for generating an evidence base on which to scale and spread initiatives such as the 'DACHA' study and the 'Vivaldi' study. Evaluations will need to pay special attention to the impact on digitally excluded groups.
- In light of a shift in preference for home care over residential care, which the pandemic has accelerated, and the government's commitment to putting housing at the centre of all care discussions, there is an opportunity to work with people who draw on and work in social care to develop innovative models of care that are fit for the future. It is important that sufficient funding is earmarked for such innovation.

6 Discussion: Social care reform and building a resilient system

You wonder if the national debate might have shifted to a point where it's impossible to ignore and they have to do something about it. You hope that's one of the silver linings that has come out of the past year.
(Interviewee 3)

Social care was in a precarious state at the point the pandemic hit and Covid-19 has heaped on pressure and further exacerbated its underlying issues. To put the system on a road to recovery, immediate short-term measures are required to stabilise providers, boost the ailing workforce and address the long waits for assessment and care.[29] And, as Covid-19 is clearly here to stay, there is the added challenge of continuing to manage the ongoing risk of infection while trying to address growing demand and complexity. But, while those short-term measures are urgently needed, there is also an opportunity and a need to build a resilient system that is fit for the 21st century and able to withstand future shocks, be they another pandemic, extreme climate events or a serious economic downturn. There is an opportunity too to reimagine care and to put the people who draw on care firmly at the heart of the future vision. The devastating impact of Covid-19 can be felt in every part of this vital sector and it would be a further tragedy if nothing positive was built out of it.

Covid-19 has enabled us to see clearly the root causes of some of the underlying fragilities within the current system of social care and has generated a huge amount of learning that needs to be understood and harnessed. Over the past two decades, politicians have shied away from addressing those root causes, instead applying short-term sporadic support patches and repeatedly kicking difficult reform decisions into the political long grass. But Covid-19 has drawn wider public and political attention and forced this issue to a point where it is impossible to ignore. The government's White Paper on adult social care reform[6] has been framed as a starting point in the process of building an improved system. The document sets out a broad vision for a future system and a direction of travel but it stops short of triggering fundamental reforms. In taking the first steps on that journey, it is essential that learning from Covid-19 is taken into account. Since undertaking this research, the government has announced that it plans to delay some key elements of its reform plan.[179] There is a real risk that the momentum that has gathered around social care reform will yet again be lost.

Positive legacy

Out of the harrowing tales of suffering and stress during the pandemic have emerged some positive examples of progress and change for which Covid-19 has been a catalyst. These positive changes should be harnessed and built on. At a local level, Covid-19 has triggered and accelerated innovative approaches to care and helped to forge relationships across organisational boundaries. It has prompted an interest in the use of technology in the social care sector and spurred on efforts to collect better data. At a national level, Covid-19 has raised the public's awareness of social care – what it is and what is wrong with the current system – and prompted a significant investment in social care capacity at the DHSC. There are now established channels of communication between national government and care providers that did not exist before and greater representation of social care experts on strategic decision-making forums. All of these examples highlight the fact that some change that has taken place as a result of Covid-19 has been positive and could and should be nurtured.

However, it is clear that to fully embed the positive developments and to significantly reform the social care system, some deep fundamental shifts need to take place both in its systemic underpinnings and infrastructure but also in the societal value invested in it.

What is a resilient care system?

There is no single definition of what constitutes a resilient long-term or social care system. Most of the focus within this field is on health care systems, for which there are a number of different frameworks. Indeed, the European Commission's report on the topic of health care resilience notes that, while high numbers of countries had evaluated the resilience of different parts of their *health* systems, fewer than a third of countries had done a similar exercise in their long-term care sectors.[87] This suggests that social care resilience is not as prominent as it should be. It is possible, though, to take some of the concepts of health care system resilience and use that as a framework through which to identify priorities for the English social care system.

The World Health Organization defines resilience in the health system as 'the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (a shock being a sudden and extreme change)'.[180] Within this, it identifies four areas of significance when considering resilience:

- governance
- financing
- resources
- service delivery.

The European Commission, similarly, identifies a list of elements that contribute to a resilient health system. These include:

- a protected and diversified funding mechanism
- adequate reserves of resources
- regularly updated risk management plans
- managers' and policy-makers' easy access to detailed and timely health and care information
- a motivated and supported workforce of appropriate size, with the right skills
- strong and transparent system leadership
- a 'learning from failure' culture.[87]

It is notable that many of the key elements of resilience (albeit for health) map closely onto the areas identified as root causes of fragility in our analysis of the English social care system. And, while our research cannot claim to be exhaustive, it points to a number of areas that are worthy of the government's and policy-makers' close attention as they seek to support the recovery and future resilience of social care in England.

Priorities for resilience

Although many of the problems with social care were already known before Covid-19 struck,[53,181] the crisis has highlighted just how severe and deep-rooted they were. A system recognised as in need of reform in 2011[182] was then subjected to a decade of financial cuts that saw spending fall in real terms, only returning to 2010/11 levels as the pandemic hit,[183] at the same time as need and demand for care increased.[184] At the point that Covid-19 struck, several years of budgetary pressures had left council finances in a precarious state and left social care providers with few reserves and limited scope to invest in improvement.[169] In the absence of any major overhaul of pay or working conditions, workforce vacancies and staff turnover were high,[185] leaving providers struggling to provide a safe service and councils increasingly anxious about meeting their statutory duty.[186] In the autumn before Covid-19 hit, already 90% of directors of adult social services had concerns over the capacity to manage winter pressures.[186] As a result, the sector was in a relatively weak position from which to cope with a shock on the scale of Covid-19. Covid-19 further exacerbated these existing pressures and we are now seeing the consequences, with record numbers of people awaiting care and assessment[29] and growing numbers of unpaid carers under increasing pressure to fill in the gaps.[50]

Our analysis of the Covid-19 experience in social care in England has identified a range of underlying issues that determined the shape, scope and speed of the response. There are valuable lessons to be drawn that need to be taken into account in the recovery and reform of the system. The issues and lessons have been loosely grouped into three broad categories – the system, people and resources – but it is important to recognise that there is a complex interconnectedness between the factors in each of those categories.

The system

The resilience frameworks discussed above emphasise the importance of governance and clarity of leadership. At a system level in social care in England, it became painfully clear during the early weeks of the pandemic that no one knew who was in charge. In stark contrast to the command-and-control structure of the NHS, social care's dispersed and devolved nature seemed chaotic. It is perhaps partly this lack of clarity over who is in charge that had allowed social care to become so invisible within national government. By the time Covid-19 struck, the DHSC social care team was so depleted that its numbers were nowhere near enough to cope with a crisis on such a scale. Crucially, a lack of senior voice on key decision-making forums with in-depth knowledge of social care meant it was largely absent in the initial response, with far-reaching consequences. While the stakeholders we spoke to felt there was a clear need to establish clarity over accountability, not just in a crisis but in 'normal' times, there was little support for a more centralised system. There was concern that there may be a temptation to try to replicate the command-and-control model of the NHS – an approach that they felt would not observe the importance of local flexibility in social care. Instead, stakeholders called for a greater clarity over accountability within the devolved system.

The visibility and capacity deficit we identified in our analysis has, partly, been addressed with significant bolstering of the social care team at the DHSC and a higher profile for social care in government plans and forums. That is welcome but there is a danger that, without concerted effort, this will wane over time as Covid-19 shifts from being an acute crisis to an issue of ongoing management. Crucially, the organisational memory that now exists within the DHSC is precious and needs to be retained. Social care is a hugely complex area and new joiners in the department have been on a steep learning curve. Newly established links between national and local government and providers in social care are also valuable and could be used not just for communication but also for shadowing opportunities, to encourage a deeper understanding of the challenges each part of the system faces.

In a similar vein, the public's awareness of this crucial area appears to have been raised as a result of Covid-19 and support for reform is relatively high. Ipsos/Deloitte public polling in 2020/21 indicates that social care is the second highest priority for public spending after the NHS/health.[187] This is a clear shift from 2019 when 'social care for older people' came in fifth after the NHS, education, the police and social services for children and vulnerable adults.[188]

A further priority for the wider system in becoming more resilient is for a greater focus on preparedness and learning from failure. Despite government having carried out a number of exercises that identified key weaknesses in social care, little action had been taken before Covid-19 struck. Although a pandemic on the scale of Covid-19 may be a once-in-a-century event, there will be other shocks that a resilient system needs to be able to withstand. Some of the more likely scenarios would be associated with extreme weather events such as flooding. Whatever the shock, it is of vital importance that the cumulative knowledge amassed as a result of previous exercises and Covid-19 is applied to more effective preparedness. An openness (which is evident in the commissioning of this work) to observe what other countries are doing and learning will also put England's social care system in a stronger position for the future.

People

Social care is not a set of buildings and institutions. Rather, it is comprised of networks of people spanning family, community, the market and the state. Those who work in it (paid and unpaid) and those who draw on it are valuable assets that need to be nurtured and supported. Much of what went wrong in the Covid-19 response can essentially be traced back to the fact that social care was treated as a homogenous institution-based service akin to the NHS. Its complexity was not fully accounted for and that had far-reaching consequences for people across the sector. The structure of the workforce was not adequately accounted for and consequently too little tailoring of wider measures took place. This left much of the workforce poorly supported relative to the workforce in other industries. Longstanding issues around low pay and poor conditions have been highlighted during the pandemic. Short-term injections of money to help support the workforce (for example, the £162 million over winter 2021/22[98]) are welcome but are inadequate in the face of the scale of the problem. Social care's key asset is its people and so to ensure there is a long-term strategy, to develop, nurture and adequately remunerate staff and to better support unpaid carers, needs to be a key plank in building resilience.

The failure to also recognise the diversity of those who draw on social care meant that groups of people were forgotten or fell through the cracks in the response. Assumptions were made that social care is much like the NHS and that it is comprised of older people in care homes. And that those care homes are clinical settings, not people's homes. Guidance, as a result, was at best unhelpful and at worst misleading, particularly in the early weeks of the pandemic. There has been a visible shift in this framing over the course of the pandemic, with a growing recognition that home care and supported living are important parts of social care. Policy-makers' greater engagement of different sector representatives has aided this. But there is still some way to go. The full impact of Covid-19 on people with learning disabilities, for instance, is still not fully understood and there is potential to improve self-directed support. Whitehall cannot develop a resilient system for the future in isolation and the positive steps towards a process of co-production should be maintained and embedded.

Resources

Finally, a resilient system cannot operate without adequate resources and infrastructure. Secure funding and access to reserves are a large part of resilience.[75] This had been identified as an issue long before Covid-19 struck but what has really become clear in this crisis is that it is not just the *amount* of money available that is important but also *how* it is allocated and over what timeframe. Social care commentators have long criticised the tendency to keep the system afloat in the short term with sporadic injections of cash. This offers councils, providers and service users no certainty and stifles innovation and strategic thinking. Instead, it forces people to think about individual packages of care for the lowest price.[8] In the short term, as providers grapple with ongoing waves of Covid-19 infections alongside the growing cost-of-living crisis, it is important that they are adequately supported so as to avoid sudden departures from the market.

In the longer term, for social care to be truly resilient, it needs a steady, stable and certain flow of funding that offers certainty and enables and encourages the development of new approaches to care. Much has changed over the past decade and Covid-19 appears to have accelerated trends towards a preference for home care over residential care.[189] There is an opportunity to think differently about care in future and break out of the cycle of buying more of the same. But that will only happen if providers, councils and others are given the financial certainty and room not just to do things differently but also to think about resilience in the face of future shocks. The government's White Paper on adult social care commits some money to invest in an 'innovative models of care programme',[186] which is welcomed, but that investment needs to be sustained and grown to deliver a significant and sustainable shift. Since finishing this research, in autumn 2022, the government announced that it would make available up to £7.5 billion from national and local sources (the latter having to be raised by councils) over two years. Some of this was diverted from planned charging reform. This will help councils keep pace with inflationary pressures but leaves little for reform[175] and falls short of estimates made by the Health Select Committee in 2020 of a need for £7 billion per year.[176] Beyond the immediate two year period, there remains little certainty around the future of social care funding.

Covid-19 has exposed just how neglected much of the social care estate and infrastructure is and how the sector has not kept pace with digital and technological innovations taken for granted elsewhere. The paucity of reliable and high-quality data was an underlying weakness that put the response on the back foot. A resilient system needs to be built on sound understanding of the people and organisations involved in the sector. Having a better understanding of the sector is also vital in ensuring that it works alongside, and with, other public services so that people who draw on support experience coherent collaboration and not fragmentation. A strong underpinning culture of collaboration across services will put social care in a more resilient position from which to weather future shocks. The threadbare state of much of the sector's infrastructure weakened the response to Covid-19. Investment in core infrastructure, including the built estate for residential care and technology across the spectrum of care services, will be an essential part of building resilience. The government's White Paper on adult social care reform recognises the importance of better data and investment in technology and commits some money towards this.[6] As with wider infrastructure, investment needs to be sufficient and sustained if transformation is to be genuine.

An opportunity for change

There is now an opportunity not just to fix the problems in the current system but also to reimagine what a care system should be. What has become clear in the course of this work is that simply fixing operational or governance issues that plague the current system will be a lost opportunity to bring about a positive legacy from Covid-19.

It is important, for instance, to understand the challenges facing people now as society re-opens and to develop care and support that enable people to fully participate in their communities. Some disabled people have reflected that they actually felt more a part of society during lockdown because so much was suddenly available to them that they had previously not had access to (for example, they had greater independence from the shift to online services and the growth in virtual social events and use of innovations).[190,191] At the same time, there are people who have been profoundly affected by lockdown and will have greater needs as a result – for example, older people who may not have ventured out for many months may have lost confidence and need extra support to regain their independence.[192] And, of course, it is important to note that social care does not operate in a vacuum. Covid-19 has underlined how important the wider voluntary and community sector is in working alongside formal social care services to support people at a local level and that established infrastructure should be supported and bolstered in future social care reform. The importance of the voluntary and community sector and its contribution to supporting people during the pandemic is recognised but fell outside the scope of this work.

Covid-19 has prompted a wide range of deep societal and cultural debates and the ambition for, and the value of, social care needs to be one of them. In the course of this research, we identified a number of tensions that now need to be navigated when building a new system. The terrible dilemma that care homes found themselves in during the first couple of years of the pandemic exemplifies the heart of this debate as they attempted to undertake a balancing act between their duty to safeguard and protect residents from infections versus respecting individual rights and freedoms. Similarly, tensions between the benefits of a command-and-control system and those of subsidiarity came to the surface. Careful consideration needs to be given to what social care is intended to achieve and how it should be delivered – should it be a safety-net service delivering units of life-and-limb care that protects people from the worse harm or should it be a network of support that enables people to live as fulfilling and independent a life as possible with control and choice? The answer to that question will ultimately determine how the underlying problems in the system should be addressed, and will need of course to be adequately resourced.

Next steps

The scope for the Social Care COVID Recovery & Resilience project is to examine social care's recovery and resilience in relation to the Covid-19 pandemic and to identify learning from the experiences of England and other countries for the future. This report has sought to identify the underlying faultlines that explain the shape and impact of the Covid-19 response in England and to identify where lessons need to be learnt. It has identified a number of priority areas that have influenced the choice of case study countries that offer pertinent lessons. In the next phase, we will be exploring the experiences of these four case study countries (Japan, Denmark, Netherlands and France) to identify what lessons England can learn from them as it embarks on its plans to reform adult social care.

Appendix 1: Methodology

This research involved an extensive document and literature review, semi-structured interviews with a range of people across social care and two theory of change workshops with stakeholders from across social care.

Document and literature review

A review of Covid-19-related documents and published literature was undertaken based on an existing piece of work that the team had completed in advance of this project starting. This previous work (published in November 2020)[81] had involved mapping and reviewing documents that described the government's response to the first wave of Covid-19 infections (for example, policy documents such as PPE guidelines) as well as papers that assessed or critiqued the response (for example, National Audit Office reports) or explored the impact of Covid-19 on the social care sector.

The stakeholders identified in preparation for the theory of change workshops were used as the basis to select documents for review, from which we updated our previous works. All relevant documents (guidance, standard operating procedures, reports, briefings, blogs, articles and noteworthy press releases) that were published on stakeholder websites between October 2020 and November 2021 were recorded. Further documents were located through key-term searches and purposively identified from stakeholder recommendations and references. In total, 182 documents were identified and 72 that were most relevant were reviewed in detail according to a thematic framework. The documents were then coded by theme in NVivo according to the analytical framework the team had developed to understand impacts, measures taken and evidence for success in the English social care response to Covid-19. Findings have been synthesised into this final report alongside evidence from the interviews.

Interviews

A series of 17 semi-structured interviews were undertaken during spring and summer 2021. Interviewees were identified using a comprehensive stakeholder mapping exercise based on guidance produced by STRiDE (https://stride-dementia.org), which aimed to encompass the full spectrum of types of organisations and people involved in social care. Care was taken to ensure that as broad a range of perspectives as possible was captured in the interviews to help identify underlying factors. As such, interviewees represented the views of people who draw on care, unpaid carers, the paid workforce, providers of care, commissioners of care and those across national governmental and non-governmental bodies with a role in administering the system. We also had a focused interview with an expert in disaster preparedness, Professor Lucy Easthope.

Interviews explored people's experiences of Covid-19 and, through those experiences, encouraged them to identify the underlying systemic factors at play that shaped the response and its impact. The conversations aimed to go beyond a pure description of what happened and what was already known, to explore the reasons *why* what they experienced happened.

Key themes that had emerged from the document review were used to guide and focus the interviews. While a standard interview schedule was used for all interviews, the team also tailored the interviews to probe into particular areas where the interviewees had expertise.

Interviews were recorded and transcribed in full by professional transcription services and transcripts were analysed thematically using NVivo qualitative coding software. The initial deductive coding framework that was used to undertake the documentary analysis was used in the first instance and was adapted iteratively to capture new insights from the interviews. The team then searched inductively for patterns across the coded data to identify cross-cutting themes, which were reviewed, interpreted and then developed into a final set of lessons.

Theory of change workshops

Two theory of change workshops were held with stakeholders from the social care sector, which sought to identify key structural and systemic issues that need to be addressed if the social care system is to effectively recover from Covid-19 and to be made more resilient in future. The first workshop involved 33 stakeholders from across social care and the second involved 26.

Participants for the workshops were identified using the extensive stakeholder mapping exercise described above for the interviews. Although a small number of interviewees also took part in the workshops, the events were an opportunity to validate and triangulate the themes that had been emerging from the interviews and to identify new issues that then fed iteratively back into the interviews.

Other contributions

A public webinar, during which high-level findings were presented, enabled a further layer of validation and challenge. The project advisory group (see Appendix 2 for a list of group members) as well as regular meetings with NIHR representatives and others at the DHSC have also provided challenge and validation to the findings. Feedback and input from these various strands have been incorporated into the development of the lessons that are presented in this report.

Next steps

The next stage of work will be to use the series of lessons and priority areas discussed in this report to create a framework through which to examine the experiences of other countries during the Covid-19 pandemic. This will offer insights into what more England can learn from other countries in building a new and resilient system.

Limitations

This study has a number of limitations that are important to note. While every effort was taken to talk to a broad range of stakeholders representing all parts of the social care sector, there were challenges in recruiting some participants, particularly those in central government. Although invited to take part, no one from DHSC was made available for interview. Undertaking the research during the pandemic meant that we were unable to undertake site visits to social care settings, although arguably the use of remote video-calling techniques actually enabled us to include a wide range of people (for example, those who may have struggled to access an in-person workshop). To mitigate concerns about the breadth of participation in the interviews and workshops, we analysed a large number of official policy documents, research reports and reviews as well as media sources. While every effort was made to triangulate findings from the interviews with the workshop findings and documentary analysis, there may be certain perspectives that are not as well represented as others. For instance, there is limited high-quality evidence of the experience of unpaid carers both before and during the pandemic. While the existing evidence helps us start to paint a picture of the experience of unpaid carers, more research is needed to fill those evidence gaps.

One of the major challenges in undertaking this work was that the situation was constantly developing. The idea for the study was conceived in the summer of 2020 when the most pressing issue was immediate infection control. Once the study started (early 2021), the context had changed and there was greater value in shifting our focus to longer-term resilience and reform. Interviews and workshops were, for the most part, undertaken over the spring and summer of 2021. The focus of the interviews was on experiences during the first wave of Covid-19 and what that illuminated in the system. Much changed over the subsequent waves and we have tried to recognise and capture that in the learning sections of this report but this is not comprehensive. Instead of trying to present a comprehensive account of all that has happened during the pandemic, we have tried to focus on what constructive learning can be taken from the experience.

Since finalising the report, several significant policy announcements were made. Where directly relevant to this research, they have been referenced but it's important to note that new policies or documents published after December 2021 were not analysed thematically.

Appendix 2: Project advisory group membership

Caroline Abrahams, Age UK/Care & Support Alliance

Hugh Alderwick, The Health Foundation

Rob Assall, Care Quality Commission (CQC)

David Behan, Health Education England and HC-One

Simon Bottery, The King's Fund

James Bullion, Norfolk Council

Fiona Carragher, Alzheimer's Society

Margaret Dangoor, London School of Economics and Political Science (LSE)

Sarah Deeny, The Health Foundation

Jon Glasby, IMPACT

Caroline Glendinning, retired

Claire Goodman, Hertford University

Chris Hatton, Manchester Metropolitan University

Melanie Henwood, Melanie Henwood Associates

Matthew Hibberd, Local Government Association (LGA)

Emily Holzhausen, Carers UK/Care & Support Alliance

Richard Humphries, independent

Liz Jones, National Care Forum (NCF)

Martin Knapp, Care Policy and Evaluation Centre (CPEC) and NIHR School for Social Care Research (SSCR)

Ana Llena-Lozal, Organisation for Economic Co-operation and Development

Nick Mays, NIHR Policy Innovation and Evaluation Research Unit (PIRU)/London School of Hygiene and Tropical Medicine (LSHTM)

Ellen Nolte, NIHR Policy Innovation and Evaluation Research Unit (PIRU)/London School of Hygiene and Tropical Medicine (LSHTM)

Selina Rajan, London School of Hygiene and Tropical Medicine

Kate Regan, Department of Health and Social Care/NIHR liaison

Leanne Dew, Department of Health and Social Care/NIHR liaison

Eileen Roccard, Organisation for Economic Co-operation and Development

Anna Severight, Social Care Future

Laura Shallcross, University College London (UCL)

Aida Suarez-Gonzalez, University College London (UCL)

Jude Teicke, Skills for Care

Jane Townson, Homecare Association

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Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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