Institute and Faculty of Actuaries

COVID-19 report

Impact on Social Care

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1 Abstract

We have reviewed some key statistics and studies available to understand the impact COVID-19 has had, or will have, on the UK social care system and people who rely on social care. COVID-19 is a disease that is having a disproportionate impact on older populations and those with pre-existing conditions. As a result, its impact on those receiving social care is greater than it is on the wider population.

In this paper, we look to provide some insight into the impact of COVID-19 on social care and the health and wellbeing of those receiving care. We focus on the UK, but we consider the relative outcomes in other countries and any insight that provides.

Our main findings are that the pandemic has put further economic strain on the care sector which was already facing challenges and awaiting solutions via the delayed social care Green Paper. Excess all-cause mortality has been observed in care homes and in domiciliary care. As at the end of June 2020 there were no longer excess deaths reported in care homes and attention has been given to testing and staff sick pay arrangements to reduce the risk of COVID-19 infection. However excess deaths continue to be observed in own homes and domiciliary care. We recommend further investigation to understand whether the excess relates to COVID-19 infection or lack of access to healthcare and other services, along with adopting similar measures recommended for care homes to limit the risk of spreading coronavirus.

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2 Executive summary

The nature of providing social care means there can often be close contact between patients and carers. In settings, such as in care homes where there are many residents in a single home, there can also be close contact between patients. There is clear medical evidence that the risk of hospitalisation and of dying from COVID-19 increases by age, as it does for those with certain pre-existing medical conditions. Care needs are more prevalent among this population and so they are more likely to be receiving social care. The combination of the profile of those receiving care, the nature of the care given and the environment in which it is provided, resulted in the social care system being at greater risk of a disproportionate negative impact from COVID-19 relative to the wider population. Statistics show that there has indeed been a disproportionate negative impact on those receiving or working in Social Care in the UK between March and June 2020.

As of 19th June 2020, the were 18,555 deaths notified to the Care Quality Commission (CQC) as involving COVID-19 in care homes and care at home. However, in the absence of accurate reporting, a clearer indicator of the impact of COVID-19 comes from the analysis of the total number of excess deaths. This this still has some uncertainty due death rate variability seen from year to year. It is estimated that there have been just over 30,000 excess deaths among care home residents and almost 4,000 excess deaths among home care recipients in 2020, up until 19 June. Both figures represent approximately a 50% increase in deaths in the year to date. The 30,000 excess deaths represent 6.5% of the estimated 460,000 care home beds in England while just over 58,000 deaths from all causes, or 13% of the care home population, were notified to the CQC on or after 24 March 2020, the day the lockdown commenced in the UK.

98% of care home resident deaths occur in residents aged 65 and older and 91% in residents aged 75 and older. The Office for National Statistics (ONS) weekly death notifications, split by age for England and Wales, shows that age alone does not explain the 50% excess in care resident and care recipient deaths, with excess deaths in the general population of 24% for all ages and 28% for those aged 85+.

Emerging findings from an ONS study show that levels of infection in care home staff increases the likelihood of infection in residents, and vice versa. It also identified common factors in care homes that had higher than average levels of infections amongst residents. Care homes who regularly use bank or agency staff are more likely to report staff and resident COVID-19 cases compared to those care homes who never use bank or agency staff. Care homes where staff regularly work elsewhere are also more likely to have more cases in staff than those who have staff who never work elsewhere. Finally, care homes in which staff receive sick pay are less likely to have cases of COVID-19 in residents compared to those care homes where staff do not receive sick pay.

There has been much published on excess deaths in care homes but little focus on the excess deaths among those receiving care in their own homes. Excess deaths in home care continues to be high, whilst the excess is no longer apparent in care homes in death figures published for June. There is also evidence of a falling number of deaths in hospices, which could suggest that those in most need are no longer accessing the end of life care they require. Further investigation is required into the drivers of the home care deaths and access to hospices.

COVID-19 has changed demand for care. An Institute for Public Policy Research (IPPR) survey suggested that people are less likely to seek residential care than was the case prior to the pandemic and there is anecdotal evidence that Domiciliary Care Agencies (DCA) have received a greater number of enquiries and demand for their services.

COVID-19 has triggered a reduction in care services available, increased care costs and closures of day care centres. More people are now providing unpaid care for their family members, friends and neighbours. Figures release during Carers Week in June 2020 revealed that the COVID-19 pandemic resulted in an additional 4.5 million people starting to provide care for older or disabled people or those with physical or mental illness. Among these unpaid carers, 2.8 million have taken on care responsibilities whilst juggling paid work. The sustainability and long-term consequences of this on the health of those providing care and those receiving care is not yet known but will need to be tracked and monitored.

Although short term funding is now available from the government to support the additional costs of COVID-19 (e.g. provision of Personal Protective Equipment (PPE), testing, increased cleaning and the creation of smaller care bubbles) there is a real risk to the future of some care homes and those that survive need to restore confidence that they are adequately prepared should a second wave or new pandemic break out.

The social care system was already under strain before the impact of COVID-19. This paper sets out the emerging evidence of the impact of recent events to help contribute to the understanding of exacerbating factors and aid improved actions and guidance for the future, while acknowledging that the pressures on the care system in light of COVID-19 run concurrently with pressures on the wider economy and therefore available funding.

3 Introduction

Social care covers the provision of social work, personal care, protection or social support services to children or adults with needs arising from illness, disability, old age or other issues such as poverty. This is broadly split between:

- Care provided in care homes
- Care provided in one's own home, known as domiciliary care or home care.
- Care provided in day centres
- Assisted living accommodation
- Unpaid or family care

In this paper we examine the statistics available on the number of deaths registered on the death certificate as being due to COVID-19. We also explore the available statistics on the excess deaths by age and place of occurrence (hospital, care home, elsewhere or not stated), as a means of understanding both the direct and indirect impact of COVID-19 to the social care sector.

The impact of COVID-19 on the social care sector and those receiving it is vast. In addition to the tragic loss of life that has been seen, we consider the short-term and long-term impact on provision of social care and on those receiving care. We consider this through the following lenses:

- **Mortality experience** within the care sector
- **Demand for care** during the pandemic and impact of any lack of access to social care could have on the health and wellness of those needing care. We will also explore the behavioural change in those seeking care.
- **Availability of social care** and the impact of staffing and use of agencies.
- **Cost and changes in the provision of care** and the impact of the change in practices, the cost of PPE, as well as the availability of paid staff and volunteers.
- **Support provided by the government** and local authorities
- **Economic effects** on social care funding

4 Social care overview

In the year of 2018/19, the NHS stated that around 842,000 people received publicly funded long-term care[i], which consists of domiciliary, nursing and community care, and around 216,000 had received short-term care. This does not include privately funded social care and people receiving care provided by unpaid carers.

Most people with care needs receive care in their own homes.

Statistics from care agencies do not include the large numbers of people who pay for their own care privately by employing carers directly and not from CQC registered care Agencies and those who receive unpaid care.

There is a range of estimates of the number of care home residents in the UK. The ONS estimated that there were 459,794 care home beds in England in 2017.[ii] Occupancy levels are typically below 100%.

Social care setting	Number of people receiving care in the UK	Data source
Care home	411,000	London School of Economics[iii]
Domiciliary care	500,000	UK Home Care Association (UKHCA)[iv]
Community-based care and support at home	417,910	NHS Confederation 2012/2013[v]

According to research by The King's Fund, 1.5 million people are employed in the adult social care industry in England, including care workers and registered nurses.[vi] They are mostly employed by private providers, and approximately 145,000 roles are directly employed by individual users of care services.

Prior to the COVID-19 outbreak, there were 9.1 million unpaid carers. An additional 4.5 million people are estimated to have taken on unpaid caring responsibilities since the start of the outbreak.[vii] Additionally 70% of unpaid carers are providing more care due to the pandemic and the closure or reduction of local services.[viii]

4.1 Care homes

There are around 21,000 care homes in the UK.[ix] The majority of care homes provide services for elderly people, with the remainder catering for younger adults with disabilities. The average size of a care home is around 20 beds and only 10% have more than 50 beds.

4.2 Home care

Home care can range from 30-minute visits to 24-hour care, to assist with personal and medical care and other everyday household tasks such as meal preparation.

4.3 Day care centres

Day care centres provide varying degree of care and people can choose to attend for a few days a week. Pick-ups and drop-offs from home, hot meals and activities during the day are provided. Some day care centres also provide personal care and specialist care, such as support for dementia or learning disabilities.

Day centres not only provide support for elderly or vulnerable people who needs care, but also give carers at home some valuable time off from caring duties. During the pandemic, many day centres were closed, therefore voluntary carers had to take on more care responsibilities temporarily, until the day care centres reopen. It is still unclear what the economic impact of COVID-19 is on day care centres and how many day care centres will be able to continue to operate after the pandemic.

4.4 Assisted living accommodation

Assisted living accommodation is a form of residential care where the residents retain independence but are assisted with tasks such as washing, dressing or taking medication. Residents with a minimum age of 55 or 60 normally live in a self-contained flat. Assisted living housing is regulated by the CQC.

4.5 Unpaid care

It is estimated that 44% of unpaid carers care for their parents, parents-in-law or grandparents and 26% care for partners or spouses. 13% look after disabled children or adult children. 9% of carers look after someone who is not a relative[x]. Around 15% of unpaid carers are over the age of 65[xi] It is estimated that around 700,000 people below the age of 25 have had caring responsibilities since the start of the lockdown.[xii]

5 Mortality experience

Death data collated by the ONS has been analysed to determine how COVID-19 has impacted mortality rates in various care settings.[xiii] This data covers England and Wales.

5.1 Death notifications determined from CQC data

5.1.1 Excess death notifications for care home residents and home care recipients

The tables below compare the number of deaths notified to the CQC, split by month. Note that June includes death notifications up until 19 June only. No adjustment has been made for the extra day in February in 2020.

Deaths notified to CQC: Care home residents in England

Month	Deaths notified in 2019	Deaths notified in 2020	Excess deaths in 2020 vs 2019 in Month	Cumulative excess deaths in 2020 vs 2019 in Month	2020 as a % of 2019 in month
January	12,229	13,017	788	788	106%
February	10,954	10,527	-427	361	96%
March	10,333	12,875	2,542	2903	125%
April	10,836	30,569	19,733	22,636	282%
May	9,775	16,578	6,803	29,439	170%
June to 19 June	5,969	6,758	789	30,228	113%
Year to date	60,096	90,324	30,228		150%

Deaths notified to CQC: Home care recipients in England

Month	Deaths notified in 2019	Deaths notified in 2020	Excess deaths in 2020 vs 2019 in Month	Cumulative excess deaths in 2020 vs 2019 in Month	2020 as a % of 2019 in month
January	1,796	1,829	33	33	102%
February	1,496	1,637	141	174	109%
March	1,440	1,738	298	472	121%
April	1,530	3,359	1,829	2,301	220%
May	1,507	2,458	951	3,252	163%
June to 19 June	905	1,632	727	3,979	180%
Year to date	8,674	12,653	3,979		146%

There have been just over 30,000 excess deaths among care home residents and almost 4,000 excess deaths among home care recipients in 2020. Both figures represent approximately a 50% increase in deaths in the year to date. In April, care homes reported higher deaths relative to 2019 (282%) than was the case among home care recipients (220%). In June, the excess death notifications in care homes dropped to 13% while the excess was still at 80% among home care recipients. It is unclear whether the population of home care recipients has changed. Care homes are likely to have lower occupancy than usual because of excess deaths and reduced new admissions. The 30,000 excess care home residents' deaths represent 6.5% of the 459,000 care home beds in England in 2018[xiv] while just over 58,000 deaths, or 13% of the care home population, were notified to the CQC on or after 24 March 2020, the day the lockdown commenced in the UK.

There were 62,987 more deaths in the general population in England and Wales in the first 25 weeks of 2020 than was the case in 2019. This represents a 24% increase on the 2020 death count compared with the 50% excess reported among care home residents and 46% excess reported among home care recipients in England. [xv]. Week 25 ends on 19 June 2020 which corresponds to the last CQC notification date used in this analysis.

5.1.2 Age split in excess deaths

98% of care home resident deaths occur in residents aged 65 and older and 91% in residents aged 75 and older. The table below shows ONS weekly death notifications split by age for England and Wales. This shows that age does not explain the 50% excess death rate reported among care home residents and 46% excess death rate reported among home care recipients, compared with the general population excess death rate of 24%.

Age Group	England and Wales 2020 death notifications as a % of 2019 death notifications weeks 1 to 25
Below 65	114%
65 - 74	118%
75 - 84	126%
85+	128%
All ages	124%

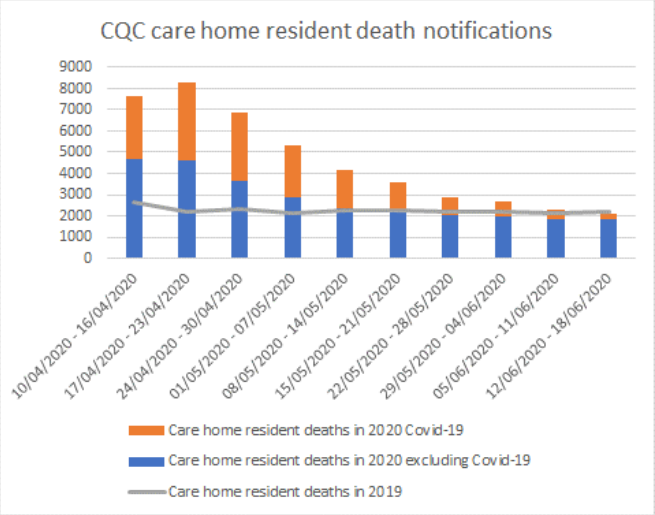
The 30,000 excess deaths implied by the CQC figures represent almost half of the total excess deaths in England in 2020. The CQC reported 126,996 deaths in care home residents in 2019 compared with the 492,859 death registrations recorded by the ONS for usual residents of England. This suggests that in 2019, 26% of deaths occurred among care home residents. However, 52% of death occurrences in England in the period 2 March to 12 June 2020 have been among care home residents.[xvi] It is clear that the events of 2020 have had a disproportionate impact on care home residents and home care recipients.

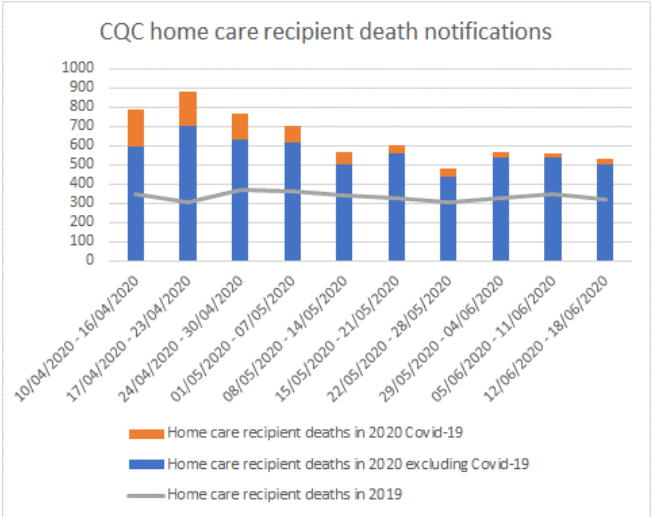
The CQC started reporting COVID-19 death notifications among care home residents and home care recipients on 10 April 2020. The table below shows death notifications between 10 April and 19 June 2020 and compares these with the corresponding period by week day in 2019.

Metric	Care home residents	Home care recipients	Total
Deaths in 2019	22,950	3,401	26,351
Deaths in 2020	46,131	6,523	52,654
Made up of:			
Deaths in 2020 excluding COVID-19	*28,395*	*5,704*	*34,099*
COVID-19 deaths only	*17,736*	*819*	*18,555*
2020 all cause deaths as a % of 2019 deaths	201%	192%	200%
Excess 2020 deaths vs 2019 deaths	23,181	3,122	26,303
COVID-19 as a % of excess	77%	26%	71%

Deaths in 2020 are double those reported in 2019. Among care home residents the excess is largely explained by COVID-19 attribution. The majority of the excess deaths among home care recipients have not been attributed to COVID-19. This is may reflect either under-reporting of COVID-19 deaths, deaths from conditions that may have been treated or cared for better under normal circumstances or deaths among people who would ordinarily have transferred to a care home.

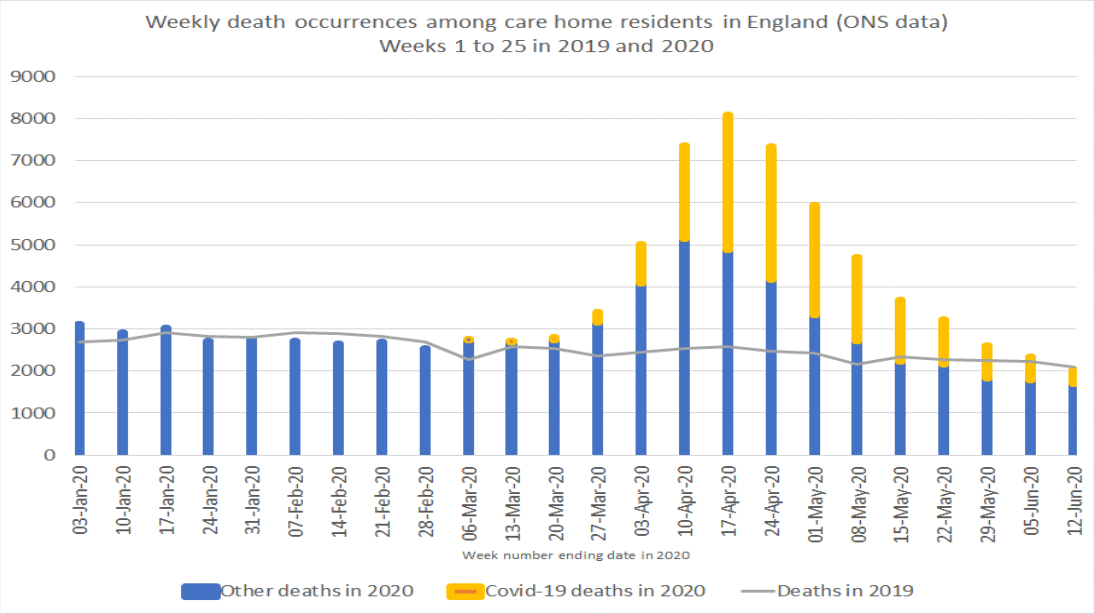
The following graphs show how death counts in care homes have reduced to 2019 levels in the most recently reported weeks, but that an excess death rate persists in home care recipients.





5.2 Deaths occurrence patterns from ONS care home resident data

The ONS has released data on deaths among care home residents and home care recipients by date of occurrence for the period 2 March to 12 June 2020, including registrations up to 20 June 2020. This gives a more accurate picture than notification data which is subject to reporting delays. The ONS also gives a longer time series of data reflecting COVID-19 deaths than is shown in the CQC data which starts in April 2020.



Excess deaths are observed continuously between 1 March and 5 June 2020 (weeks 10 to 23). The total 2020 excess death count suggested by this data set is 28,186, of which only 18,562 deaths have been attributed to COVID-19. The COVID-19 attributed deaths represent 21% of the total deaths occurring in the period among care home residents and a 4.5% death rate if we assume 411,000 care home residents. Another study estimated the rate of COVID-19 death in a care home at 5.3%.[xvii] In weeks 10 to 19 it is possible that a number of COVID-19 related deaths were not attributed to COVID-19 due to lack of testing and therefore did not contribute to total COVID-19 deaths. This feature of underestimation has been reported in many countries.[xviii] In weeks 22 to 24 deaths excluding COVID-19 deaths are noticeably below the levels observed in the same week in 2019 which may suggest:

- over-attribution to COVID-19
- some prior COVID-19 deaths were an acceleration of deaths
- lower occupancy levels in care homes in June 2020

The ONS has not published similar statistics for home care recipients.

5.3 Deaths notifications by place of occurrence

Statistics on notifications by place of occurrence provide further insights as they are published weekly by the ONS alongside the provisional weekly death notifications. They are therefore more frequently reported and updated than is the case for other care sector statistics which are released in special reports.

To set the scene, the table below is from the July 2020 ONS special report on the care sector and shows the proportion of death occurrences by location of death among care home residents in England.[xix]

Period	Care home	Hospital	Elsewhere
2 to 17 March	85.9%	13.8%	0.3%
18 to 31 March	85.4%	14.4%	0.3%
1 to 30 April	87.1%	12.6%	0.3%
1 to 31 May	88.2%	11.5%	0.3%
1 to 12 June	88.8%	10.8%	0.4%

March is split into the period up to 17 March when NHS hospitals were asked to free up inpatient capacity which included the urgent discharging of all patients who were medically fit to leave. [xx] This would have included care home residents. The proportion of deaths in care homes has been increasing while hospital deaths have been reducing between March and June. The increase in care home deaths was still observed in June and appears to suggest that care home residents who would otherwise have been hospitalised are still in care homes. Another possibility is that previous COVID-19 -related deaths were accelerations of deaths of residents who would otherwise have been transferred to a hospital and then died there.

We are also able to compare the ONS provisional weekly death notifications split by location of death in 2020 with historic death notification by location to get a sense of the position up until week 26.[xxi] The historic reported notifications are not adjusted for seasonality. The q2 2018 to q1 2019 annual data was converted to a weekly death count and then updated to reflect the q2 2020 estimate by using past exponential growth trends in the death counts by location.

As noted above, around 10% of care home resident deaths will be reflected in the hospital deaths at present and the percentage would have been closer to 15% in 2019. Hospital deaths may include care home resident and home care recipient deaths, along with other deaths, while some home care recipients die at home. For reference, the CQC reports that 67% of home care recipients with a reported death location died at home in April to June 2020 but 14% of deaths do not have a recorded location. There were 3,740 home deaths out of 6,523 home care recipient deaths notified between 10 April and 19 June 2020. There were over 38,000 deaths in the home that were notified to the ONS over the same period, so home care recipients accounted for approximately 10% of deaths in the home.

The following table shows that there were 50,878 excess deaths between 28 March and 26 June 2020.

Metric	Home	Hospital	Hospice	Care home	Other	Total
Total deaths in 13 weeks to 26 June 2020	44,647	69,294	6,289	50,823	4,014	**175,067**
Expected deaths in 13 weeks	29,848	56,121	7,371	27,781	3,068	**124,189**
Excess deaths	14,799	13,173	-1,082	23,042	946	**50,878**
Actual vs Expected	150%	123%	85%	183%	131%	

Distribution of deaths by location	Home	Hospital	Hospice	Care home	Other
Deaths in 13 weeks to 26 June 2020	26%	40%	4%	29%	2%
Historic deaths	24%	45%	6%	22%	2%
Proportion of excess deaths by location	29%	26%	-2%	45%	2%

Almost half of this excess (45%) occurred in care homes with the next highest excess occurring in homes (29%) followed by hospitals (26%). The more pronounced increase in deaths at home may include deaths that would otherwise have occurred in other settings, including hospitals and hospices. There are currently fewer deaths in hospices than was the case in 2019 which suggests that intake has

been reduced during the lockdown with resulting deaths at home, reflecting a lack of access to end-of-life care.

The following table shows that there were 4,387 excess deaths between 28 March and 26 June 2020 that were not attributed to COVID-19. This is made up of 21,633 excess deaths in homes and care homes and largely offset by reductions in deaths in hospitals and hospices. Hospitals had 16,066 fewer deaths than expected suggesting that some deaths have occurred in homes and care homes that would otherwise have occurred in hospitals. The high number of excess deaths in homes may also suggest that COVID-19 related death is being under-reported in this setting.

Metric	Home	Hospital	Hospice	Care home	Other	Total
Deaths excluding COVID-19 attributed cases in 13 weeks to 26 June 2020	42,538	40,055	5,625	36,724	3,634	128,576
Excess non COVID-19 deaths	12,690	-16,066	-1,746	8,943	566	4,387
Actual vs Expected	143%	71%	76%	132%	118%	104%

The following table compares split of deaths not attributed to COVID-19 with the historic split of deaths by location and emphasises the increase in non-Covid deaths at home and reductions in deaths in hospitals.

Metric	Home	Hospital	Hospice	Care home	Other
Proportions of non-Covid deaths by location of death in 13 weeks to 26 June 2020	33%	31%	4%	29%	3%
Historic proportions of deaths by location of death	24%	45%	6%	22%	2%

The next table shows the time trend in 2020 weekly deaths counts by location vs the expected death counts.

Week	Week ending	Home	Hospital	Hospice	Care home	Other	Total
11	13-Mar-20	112%	106%	95%	111%	113%	108%
12	20-Mar-20	109%	102%	94%	105%	104%	104%
13	27-Mar-20	112%	110%	87%	110%	102%	109%
14	03-Apr-20	157%	172%	93%	168%	125%	162%
15	10-Apr-20	169%	188%	88%	220%	152%	184%
16	17-Apr-20	185%	206%	100%	328%	175%	221%
17	24-Apr-20	197%	180%	96%	355%	178%	218%
18	01-May-20	175%	139%	85%	288%	155%	178%
19	08-May-20	131%	96%	76%	190%	127%	125%
20	15-May-20	155%	117%	93%	200%	146%	144%
21	22-May-20	144%	100%	83%	149%	128%	121%
22	29-May-20	113%	83%	78%	111%	100%	97%
23	05-Jun-20	139%	88%	76%	107%	123%	105%
24	12-Jun-20	131%	85%	82%	95%	105%	98%
25	19-Jun-20	124%	77%	81%	86%	102%	91%
26	26-Jun-20	124%	74%	79%	81%	84%	88%

The care home excess notifications in the weeks from 11 April to 1 May correspond to the peaks observed between 4 April and 24 April in the ONS date of occurrence data and therefore suggest that notification delays are approximately 1 week long for care home resident deaths. This is the setting with the highest excess deaths in both absolute and percentage terms.

The following timeline is made to help understand when different events happened since the outbreak started.

January 30	•WHO declares a global health emergency
March 14	•The number of confirmed cases rises to 1,140 in the UK, 925 in England, 121 in Scotland, 60 in Wales and 34 in Northern Ireland.
March 17	•NHS England and NHS Improvement request discharging of more patients to make room for COVID-19 cases
March 19	•The government announces £1.6bn for local authorities, to help with the cost of adult social care workforce and for services helping the most vulnerable, including homeless people; £1.3bn will be used to enhance the NHS discharge process
March 23	•Lockdown announced on the evening of March 23
April 10	•The CQC started reporting COVID-19 death notifications among care home residents and home care recipients
April 14	•Several UK charities, express their concern because they focus on hospital deaths and do not include those in care homes
April 15	•NHS England and the CQC begin rolling out tests for care home staff and residents
April 28	•The ONS report indicates a third of COVID-19 deaths in England and Wales are occurring in care homes
May 5	• Deaths per week in hospital are falling while those in care homes continue to increase.
May 12	•Care home death rate starts to decrease.
May 15	• Announcement that every resident and staff member in care homes in England will be tested for COVID-19 by early June
June 8	•The Department of Health and Social Care extends availability of tests to all adult care homes

In the week ended 26 June 2020, the only setting where excess deaths were notified was the home. Excess deaths have persisted longest in this setting. The excess care home deaths have sparked investigations and highly publicised political comment. The excess home deaths should and may be the next area that gets attention to determine how to resolve the potential contributing factors of undiagnosed COVID-19 and access to appropriate treatment and care.

381 COVID-19 deaths were notified in the “other” locations. These include places away from home other than hospitals, hospices and care homes. These “other” locations include communal settings such as schools for people with learning disabilities, holiday homes and hotels, common lodging houses, aged persons’ accommodation; assessment centres, schools, convents and monasteries and nurses’ homes. 205 COVID-19 deaths have been reported in the communal settings which, by their communal nature, may be more prone to spread of infection.

5.4 International comparisons

A study by the London School of Economics found that 5.3% of UK care home residents had died from COVID-19. Of the countries included in the study, the UK ranked second only to Spain where a figure of 6.1% was estimated. The COVID-19 care home death rates in other countries were New Zealand (0.04%), Austria (0.3%) and Germany (0.4%).[xxii] The estimates are affected by prevalence of testing, accuracy of death recording and the scale of the pandemic in the country.

6 The demand for care

6.1 Changing demand for care due to COVID-19

Demand for residential care home beds has reduced while demand for home care may have increased as a result of COVID-19. A survey by the Institute for Public Policy Research (IPPR) found that a third of people were less likely to seek residential social care for relatives and 40% of people aged 65+ were less likely to consider care home for themselves than was the case prior to the pandemic.[xxiii]

Since the outbreak of COVID-19, anecdotally, domiciliary care agencies have received greater enquiry and demand for their services which may reflect the findings of the IPPR survey around reluctance to seek residential care.

There has also been increased demand by local authorities for care agencies to provide care for those discharged from hospitals who are recovering from COVID-19, or for those who were discharged early to release hospital space. The local authorities are often prepared to pay the domiciliary care agencies a premium rate to accept patients leaving hospital, or those having been tested positive with COVID-19. This enhanced fee does not necessarily encourage agencies to accept the work especially if it challenges their ability to maintain “bubbles” and reduce the spread of the virus.

7 Availability of Social Care

7.1 Home care services in the short term

While demand for home care services may have increased, care agencies have difficulty increasing the availability of services as they need to increase the number of carers. The need to create bubbles to limit spread of infection means that more carers are needed even in the absence of an increase in demand.

Even in normal circumstances the recruitment and retention of carers has always been one of the most difficult tasks for care agencies. Typically, carers are poorly paid, have long and unsociable working hours and need to be compliant with regulations of their employers as set out by the CQC. Carers must adhere to strict guidelines and complete paperwork for each visit, although much of this has been replaced by the use of mobile devices. Even experienced carers are required to undergo training by their employer, which has become difficult under social distancing. Whilst some elements of the training can be done remotely, aspects such as “manual handling” requires close contact, making the employment of new staff difficult. Moreover, interviewing remotely is not at all ideal when recruiting people for such personal care provision.

Carers themselves have also been isolating for various reasons, either because they have COVID-19 symptoms or members of their family might have shown symptoms, this reducing the pool of carers available to the agencies.

Supply could increase if the price paid for social care were to be increased as care agencies could increase their spend on recruiting and training more staff. Local authorities and private payers would in turn need to pay more for the services.

7.2 Day care services in the short term

Social distancing requirements have resulted in the closure or limiting of many services, including schools, basic health care and day care centres. Unpaid care has had to compensate for the lack of these services.

7.3 Unpaid care in the short term

As previously stated, an additional 4.5 million people have taken on unpaid caring responsibilities during the lockdown and among these unpaid carers, 2.8 million have taken on care responsibilities while juggling paid work. Unpaid carers will have had to manage their exposure to others in order to provide support safely during the pandemic. The long-term consequences of the increased provision of unpaid care on the health of those providing care and those receiving care is not yet known.

7.4 Care homes in the short-to-medium term

Care homes normally have an occupancy rate of over 88% but a combination of high mortality rates, restrictions on new resident intake and changes in residential care demand have reduced occupancy levels in recent months. Sector analysts Carterwood have forecasted that the occupancy rate will return to pre-pandemic levels between June and October 2022. Occupancy levels below 85% are detrimental to the financial viability of care homes.[xxiv] Carterwood estimated that in 2020, 1,500 beds will be lost in care homes due to staff issues, increase in agency fees and increased running costs. Many care homes were already in financial difficulty before COVID-19 and the pandemic may result in additional care home closures.

8 Changes in the provision and cost of care

There have been significant changes in the provision of social care with changes in the operation practices of both carers and those receiving care. In care homes this is centred around the separation of those suspected or known to have COVID-19, to reduce the interactions with different carers, residents and visitors. There has also been a significant increase in the testing and use of PPE. These factors combined with the increased absence due to those staff self-isolating or suffering with COVID-19, are putting increased finance strain on those providing social care.

8.1 Operational practices

The government's recommended way of reducing the risk of exposure to COVID-19 is for providers to divide the people they are caring for into 'care groups' or "bubbles" and allocate subgroups of their staff team to provide care to each. Other suggestions include reducing the number of different agencies visiting any one service user and limiting the number of carers from any one service provider who should visit any one service user. This creates a logistical problem for care providers at a time, when because of sickness and self-isolation, fewer carers are available to them. Care providers have also been requested to reduce contact between their own staff, such as holding team meetings and completing carer supervisions by video link.

Anecdotal evidence suggests that some agencies who have taken on too much additional work may have run into problems with increased infection between clients. This has led to fear amongst other agencies, so they are more cautious about balancing accepting new clients and putting sufficient safety procedures in place. This dampens the supply of care.

There is quite detailed guidance coming from the local authorities about working during this period, with service users with or without COVID-19 symptoms, but it is an extra layer of compliance for the agency and its staff.

On site supervision of carers by the management of a domiciliary care agency, required by CQC in the normal running of the business, is also reduced due to social distancing requirements with the overriding desire to prevent the spread of COVID-19 within the "bubbles" as much as possible.

8.2 COVID-19 testing

The government's Department of Health and Social Care (DHSS) recognised the importance of testing social care workers and those receiving care in its adult social care action plan first published on 15 April 2020.[xxv] This made a COVID-19 test available to anyone in working in social care and any symptomatic care home residents. It also moved to a policy of testing all residents prior to admission to care homes.

On 28 April, the government announced that testing would be expanded in the care sector to include both symptomatic and asymptomatic care home staff and residents. This recognised the likelihood of asymptomatic transmission by both staff and residents. It also recognised the existence of underlying health conditions that masked the typical symptoms of COVID-19 and the emergence of other non-typical symptoms in the elderly. Testing was made available through either Public Health England or at drive-through testing sites, mobile testing units and via satellite testing kits - packages of tests sent to care homes for staff to use on residents.

The regular testing of social care staff going forward is going to be critical in reducing the spread of the disease but also in reducing staff absence.

8.3 Personal Protective Equipment (PPE)

In order to protect both carers and service users, during the COVID-19 outbreak, carers have increased the usage of PPE. This essentially takes the form of masks, aprons, gloves and in some cases, eye protection. During the early stages of the pandemic there was limited supply and the demand for PPE caused their unit cost to rise. Recognising the difficulties, the government has zero rated VAT on PPE products for a period of three months and the government funding. Some local authorities have or will rebate to the agencies their additional PPE costs. Guidance was also given on the use of PPE equipment to care homes and to domiciliary care agencies.

9 Current funding and support provided by the government

On 18 April, the government announced £1.6 billion of new funding for councils, in addition to the £1.6 billion provided in March. This takes the total funding provided to councils to over £3.2 billion, which councils can use to address pressures produced by COVID-19 including in adult social care. A further £850 million in social care grants to councils has been brought forward to help with cashflow.[xxvi]

9.1 Further government and local authority assistance

Recognising that many carers are foreign nationals, the UK government has added to the one year working visa extension to non-NHS frontline health workers and carers.

Like other businesses, domiciliary care agencies have been given a 12 months exemption on business rates.

Local authorities have been offering guidance through publications and webinars, in particular such as end of life support and the creation of volunteer support roles with help regarding:

1. Health and wellbeing checks
2. How to handle laundry
3. Shipping and food preparation
4. Support with IT services for service users

9.2 Social care recruitment

The DHSS adult social care action plan describes the ambition to attract 20,000 people to work in social care over the next 3 months.

The government is supporting providers' workforce needs through this £4 million social care recruitment campaign, encouraging job seekers to work in the care sector and giving access to free initial training.

This plan targets returners to the sector, as well as new starters who may have been made redundant from other sectors, and those able to take up short-term work (including those who have been furloughed).

The DHSS is developing a new online platform which will give people who want to work in social care access to online training, however it is unsure how "manual handling", one of the pillars of the training process, can be achieved remotely. Key elements of the Care Certificate are available from Skills for Care, free of charge, to make it easier for employers to access rapid online induction training for new staff.

The government has put in place arrangements for fast track Disclosure and Barring Service (DBS) checks that are free of charge for a list of roles, including emergency volunteers for health and social care services. CQC also has guidance on interim DBS checks in this time.

9.3 COVID-19 testing for home care workers and individuals receiving home care

Every social care worker who needs a test can access one, as confirmed in the DHSS's adult social care action plan, and this includes those who work in the home care sector. Naturally, if a carer has symptoms of COVID-19, they should be self-isolating and can access testing through the self-referral or employer referral portals This applies to home care staff, domiciliary carers and unpaid carers.

9.4 Testing for patients and discharge from hospital into the community

All people admitted to hospital to receive care will be tested for COVID-19, and hospitals should share care needs and COVID-19 status with relevant community partners planning the subsequent community care. Where a test has been performed in hospital, but the result is still awaited, the patient will be discharged as planned and, while the result is pending, home care providers should assume that the person may be COVID positive for a 14-day period and follow guidance on the correct use of PPE. This correct step is a further challenge to care providers who have to manage this within their "bubbles".

9.5 Financial Assistance requested by the domiciliary care industry

To maintain viability of the homecare sector during the pandemic, the United Kingdom Homecare Association (UKHCA) has written to the government to act with urgency to:

1. Provide an emergency social care resilience fund, bypassing local authorities, to enable the homecare sector to survive the COVID-19 pandemic, as the Irish government has done. This fund would enable payment for additional costs incurred during COVID-19, particularly PPE and sick pay, including for organisations with more than 250 employees. Extra costs for homecare have been estimated at £1 billion over the next 12 months.

2. Extend the temporary removal of VAT on personal protective equipment (PPE) to exempt all welfare services from VAT. The UKHCA estimate the impact on HM Treasury to be £100 million but state that it would greatly assist the sustainability of care providers.

3. Exempt homecare agencies from business rates to create parity with care homes, which are not required to pay business rates.

4. Mandate and fully-fund, in a ring-fenced manner, a national minimum rate for homecare, calculated using the UKHCA's model which takes into account compliance with the National Living Wage, improvements in quality of care and costs of meeting regulatory requirements.

10 Economic effects of COVID-19 on social care funding

We have already examined the additional costs suffered by care providers as a result of COVID-19 and the additional support, both financially and practically offered to care providers by government and local authorities. However, whilst the potential implications on the provision and cost of social care are expected for the foreseeable future, the financial support currently expires at the end of September 2020, so an extension or other support is likely to be required.

The challenges in the funding of social care were well documented prior to COVID-19, both in terms of the increasing demand for care with the ageing population and the funding options. The impact of COVID-19 on the wider economy cannot be predicted with any certainty at this time but this is likely to constrain any future spending, including the funding of social care.

The government Green Paper on the funding of social care has been delayed. The impact of COVID-19 has only increased the need for a paper to consider intergenerational, tax efficient and other methods of funding for social care.

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