COVID-19: Implications for the Support of People with Social Care Needs in England

Adelina Comas-Herrera, MSc

Assistant Professorial Research Fellow

Care Policy and Evaluation Centre, London School of Economics and Political Science,

A.Comas@lse.ac.uk

Jose-Luis Fernandez, MSc PhD

Associate Professorial Research Fellow

Care Policy and Evaluation Centre, London School of Economics and Political Science,

+44 207 955 6160, J.Fernandez@lse.ac.uk

Ruth Hancock, MSc

Professor in the Economics of Health and Welfare,

Health Economics Group, Norwich Medical School, University of East Anglia,

and Occasional Professorial Research Fellow, Care Policy and Evaluation Centre, London

School of Economics and Political Science [01603 591107], r.hancock@uea.ac.uk

Chris Hatton, PhD

Professor of Public Health and Disability

Centre for Disability Research, Lancaster University,

44-1524-592823chris.hatton@lancaster.ac.uk

Martin Knapp, MSc PhD,

Professor of Health and Care Policy

Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics

and Political Science, +44 207 955 6225, m.knapp@lse.ac.uk

David McDaid, MSc, MSc

Associate Professorial Research Fellow

Care Policy and Evaluation Centre, London School of Economics and Political Science,

+44 207 9556381 D.Mcdaid@lse.ac.uk

Juliette Malley, PhD, MPhil, MA

Assistant Professorial Research Fellow

Care Policy and Evaluation Centre, London School of Economics and Political Science,

+44 207 955 6134, J.N.Malley@lse.ac.uk

Gerald Wistow, M. Soc. Sci., PGCE.

Visiting Professor

Care Policy and Evaluation Centre, London School of Economics and Political Science,

+44 7968 988305 G.Wistow@lse.ac.uk

Raphael Wittenberg, MSc

Associate Professorial Research Fellow

Care Policy and Evaluation Centre, London School of Economics and Political Science,

+44 207 955 6186, R.Wittenberg@lse.ac.uk

Corresponding author:

Adelina Comas-Herrera, CPEC, London School of Economics and Political science, Houghton street, London WC2A 2AE, United Kingdom, +44 2079556238, a.comas@lse.ac.uk

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Abstract

This perspective examines the challenge posed by COVID-19 for social care services in England and describes responses to this challenge. People with social care needs experience increased risks of death and deteriorating physical and mental health with COVID-19. Social isolation introduced to reduce COVID-19 transmission may adversely affect well-being. While need for social care rises, the ability of families and social care staff to provide care is reduced by illness and quarantine. These challenges suggest that COVID-19 could seriously threaten care quality and availability. The Government has thus called for volunteers to work in health and social care, and the call has achieved an excellent response. The Government has also removed some barriers to effective coordination between health and social care, while introducing measures to promote the financial viability of care providers. The pandemic presents unprecedented challenges which require well-co-coordinated responses across central and local government, health services and private and voluntary sectors.

Key Words: Social care, care needs, family care, COVID-19, pandemic, England

Key Points

- COVID-19 poses risks to the health and wellbeing of people needing social care
- It reduces the ability of families, friends and social care staff to provide support
- The availability and quality of care are at risk due to the pandemic
- The Government has introduced measures to assist social care providers
- The challenges posed by COVID-19 require well-coordinated inter-agency responses

Care and support with personal and practical tasks are needed by many older adults and people with disabilities across the United Kingdom (UK). In England alone, the social care system received 1.9 million requests for support in 2018/19 (NHS Digital, n.d.). Social care helps people become and remain independent, retain their dignity, achieve better wellbeing, and be safe from abuse and neglect. It includes all forms of personal and practical support for children, young people and adults who need extra support, including the need for supported housing or residential care, as well as supporting unpaid family carers. While healthcare provided through the National Health Service (NHS) is mainly free of charge and is dominated by public providers, social care, which is the responsibility of local authorities, is means-tested and provided mainly by private and voluntary organizations as well as millions of unpaid family and other carers. For example, in 2015, nearly 200,000 people living with dementia in the community in England relied exclusively on unpaid care (Wittenberg et al., 2019).

People with social care needs experience increased risks of death and deteriorating physical and mental health with COVID-19. For many the consequences of infections can be serious, and people with dementia and learning disabilities have higher prevalence of risk-related conditions such as respiratory and cardiovascular disease, diabetes and dysphagia. This perspective examines the challenge posed by COVID-19 for social services in England (which accounts for 84% of the UK population). It also describes the social care sector's response to COVID-19 in light of this challenge. Since administrative structures vary across the UK we focus here on England, but the challenges currently faced across the UK are not dissimilar.

The Challenge Posed by COVID-19 for Social Services

The UK faces an unprecedented challenge in responding to the COVID-19 pandemic. The four UK governments—England, Scotland, Wales, and Northern Ireland—are implementing

stringent measures to slow the spread of the virus and avoid overwhelming the National Health Service (NHS) and social care services. Nationally, the Coronavirus Act 2020 (UK Government, n.d.) emergency legislation suspends the statutory obligations of local authorities[1] to conduct detailed assessments of care and support needs and to meet these needs; but many individuals still require help with care tasks involving frequent face-to-face contact with care workers and local authorities are still expected to take all reasonable steps to continue to meet needs.

Moreover, the ability of both families and the social care workforce to provide care is increasingly reduced by illness and self-isolation. Shortages of personal protective equipment (PPE) increase both risk of disease transmission and anxiety in staff, volunteers, carers and people with care needs. Precarity of employment for much of the social care workforce is an enduring issue, with most paid at or close to minimum wage. There are already serious concerns about the financial situation of care providers, as austerity policies have resulted in reductions in the fees local authorities pay to providers. COVID-19 may further threaten their financial viability if staff absences reduce their capacity, more vacancies arise from higher than normal numbers of residents' deaths and there are fewer admissions.

In the context of already significant pressures on the sector, COVID-19 could seriously threaten care quality and availability. Countries that are ahead in terms of infection rates, such as Spain and the United States, provide stark warnings (Barnett & Grabowski, 2020; Davey, 2020): some care homes are already overwhelmed by large numbers of deaths and substantial levels of sickness absence. Early international evidence suggests that nearly half of all COVID-19 deaths in 5 European countries were among care home residents (Comas-Herrera & Zalakain, 2020). Covid-19 could similarly pose a risk to the quality of care in care homes and other congregate settings in England.

The lockdown increases other risks, including domestic abuse and social isolation, with health consequences (Courtin & Knapp, 2017). Pressure on online delivery services means that interrupted access to food and other essentials may turn into urgent social care issues. Unpaid carers also face an invidious dilemma as they are sources of both support and risk. While non-resident carers are wondering whether they should still visit, co-resident carers, often with their own support needs, may face even greater responsibilities if no-one else can now visit.

The Immediate Response of the Social Services Sector

There needs to be the best possible coordination between health and social care bodies, food-distribution systems, civil contingency and military services to mobilize community resources to provide support to older adults and others in need of social care. Without such coordination some of those needing care may not get the full range of support they require; and services may prove less effective and efficient due, for example, to duplication of processes.

The response to the call for NHS volunteers (Royal Voluntary Service, n.d.) has far exceeded its target, but the registration system for additional support (UK Government, 2020) is based on a restricted set of medical conditions rather than *circumstances* requiring such support, thereby excluding many in need of assistance. Volunteers potentially play vital roles in supporting social care, for instance through Community Response volunteers who, for example, can deliver food and medicine to vulnerable people during a lockdown, and the Check-in and Chat service providing telephone support to help reduce social isolation and loneliness.[2] For this to work well co-ordination between local authorities responsible for social care and NHS bodies responsible for health care is essential. A rapid training program would also help ensure volunteers can support people safely and effectively.

As was noted above, the NHS and local authority social care services operate within separate and distinct administrative structures. Integration of their activities has long been advocated but with very limited results (Smith, Wistow, Holder, & Gaskins, 2019). Baggage from past relationships could obstruct integrated approaches that the current emergency demands. The reported face-off between NHS hospitals and residential care service providers funded through social care in North West England is a worrying development: it emerged over the apparent reluctance of residential and nursing homes to accept discharged hospital inpatients without testing for COVID-19, particularly as staff lacked PPE ("NHS told to 'up its game' in helping social care respond to crisis | News | Health Service Journal," n.d.).

Other recent developments are potentially more positive, not least policy-makers' attempts to remove barriers long considered too difficult to handle, especially barriers to effective coordination between health, social care and other public services. One example is the remarkably comprehensive (given timescales) guidance published on 19 March 2020 about the discharge of patients from hospital to their own homes or care homes, aiming to streamline in-patient pathways and processes through more clearly specified responsibilities and accountabilities (NHS England, 2020). Charges/co-payments for social care services after hospital discharge have been temporarily removed, and restrictions on information-sharing between health and social services relaxed. There remain many risks, however, including relaxation of councils' statutory duty to assess and meet needs, already fragile social care services being swamped by unmanageable levels of demand on hospital and community services, and unsustainable staffing pressures.

Timely data on suspected infection rates and deaths amongst people using social care services and support staff availability are key to monitoring and targeting of support to at-risk

populations, and there are some encouraging international developments (Comas-Herrera & Fernandez-Plotka, 2020). But many people with social care needs in the UK are not known to local authorities or voluntary organizations best-placed to respond to their care needs, including people who pay for their own care and adults supported solely by their families. Engaging private and voluntary sector providers is crucial to identifying those individuals. Many adults with dementia or learning disabilities are not eligible for long-term social care support, and councils may be unaware what is happening to them or to recent care leavers and other younger people at high risk.

Preventing and controlling infection in care homes and among vulnerable groups in the community will be hampered unless there is more rapid distribution of PPE and access to testing is ramped up to care home residents, social care staff, family members providing significant personal care and volunteers in front-line roles, as is happening in South Korea (Comas-Herrera & Fernandez-Plotka, 2020). The Department of Health and Social Care (DHSC) has published a plan for PPE which provides guidance on who needs PPE, what type and in what circumstances and explains the arrangements for the delivery of PPE to those who need it and the actions being taken to buy more PPE from abroad and make more at home. Public Health England (2020) has updated its guidance on PPE in the light of covid-19. To date, however, policy has focused on challenges facing the NHS to a greater extent than social care.

Technology could be used more extensively to ensure access to up-to-date safety guidance. The UK government launched an app for the public that provides updates. Specialist initiatives are needed for social care staff on minimizing risk of spreading infection. Similar technology might match people with urgent needs to available staff and volunteers, for example to obtain shopping or medical supplies. Social care staff who find themselves having to perform

palliative care tasks for which they are not trained could be supported by medical personnel through telehealth.

Measures are needed to expand the workforce. Some countries are already widening the potential staff pool by, for example, recruiting students, allowing staff with restricted visas to work more hours and offering pay supplements. Other measures include planning for rapid-response teams to support care homes or other care services that become overwhelmed, or isolating staff and care home residents together, which has been successful in containing outbreaks in South Korea (together with PPE and testing) and is starting to happen in New Zealand, Spain and the UK. People who have recently left the NHS have been invited to return, and 20,000 retired health care professionals are re-joining the NHS. In social care, councils and (some) service providers are urgently seeking former carers to contribute as volunteers to expand capacity ("Coronavirus: 20,000 retired NHS staff have returned to fight Covid-19, Johnson says | The Independent," n.d.).

Measures to ensure financial viability of social care providers announced by the government are welcome. They include a COVID-19 response fund that is providing support for local authorities to manage pressures on social care, as well as direct financial support for charities to help them provide key services and support for vulnerable people during the Covid-19 crisis. Other measures include government funding of 80% of the previous income of self-employed workers unable to work as normal in the sector. Support is also needed for families and other carers (e.g. extending eligibility for Carers Allowance, a small weekly payment to carers (mainly below state pension age) providing at least 35 hours support per week.

At the same time, the social sector needs to be careful that reductions in obligations during the crisis, such as the right to assessment of care needs, do not become permanent, as this could reduce long term access to social care services.

Moving forward

These extraordinary challenges to social care require immediate, well-co-coordinated responses across different tiers of government and private and voluntary sectors, and with the general public. It is critical that information about best practice is shared as it emerges; NICE, the National Institute for Health and Social Care, which is producing rapid guidelines and evidence summaries on COVID-19, the Local Government Association representing all local authorities and government departments have responsibilities here. We can learn from international experience, which offers advance warning of difficulties ahead, but also good examples. Previous patterns of unconstructive, sometimes self-destructive, fighting between the NHS and councils must be avoided. Innovation is always easier said than done, but has never been more urgently needed.

Notes

[1]Local government authorities in England are responsible for a wide range of services, including social care. Elected councilors are responsible for the overall direction of policy in each local authority. There are 343 local authorities in England; in some localities responsibilities are split between a county council (upper tier) and a district council (lower tier). In other areas, there is a single unitary authority.

[2] NHS Volunteer Responders has been set up to support the NHS and the care sector during the COVID-19 outbreak. The program enables volunteers to provide care or to help a vulnerable person. It includes Community Response Volunteers who deliver shopping, medication or other

essential supplies to the homes of people who are self-isolating and Check and Chat Volunteers providing short-term telephone support to individuals who are at risk of loneliness as a consequence of self-isolation. See https://www.goodsamapp.org/NHS

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