

A policy scandal of epic proportions: Why a public inquiry into adult social care and COVID-19 is necessary



Bob Hudson makes the case for an inquiry into the government's slow response to protecting adult social care settings from the coronavirus pandemic. He outlines the three key issues that such an investigation will need to address and the questions it must answer.

The longer the impact of COVID-19 in the UK has continued, the more the focus of concern has fallen upon adult social care. While the NHS has been relatively protected, social care has been overwhelmed: supplies of PPE have been unavailable; testing has been patchy or non-existent; patients have been discharged from hospitals into care homes and proceeded to spread the virus; [deaths among residents](#) have reached somewhere between 30-40% of all coronavirus-related deaths; and fatalities amongst social care staff are outstripping those of healthcare workers and the wider working population.

This is a policy scandal of epic proportions and now is exactly the right time to institute a public inquiry into events. At least three issues will need to be included in such an inquiry: fragility of provision; low policy salience; and unethical policy and practice.

Fragility of provision

The fragile financial structure of the industry is such that most providers were already unable to withstand even a minor downturn in income or an increase in costs. Within weeks of the outbreak, the Care Provider Alliance (representing about half of all care providers) [was warning](#) that the sector risked collapse without emergency funding to help pay wages and buy PPE. Similarly the [UK Home Care Association](#) said the financial pressures arising from the pandemic could force a significant number of the country's 8,000 home care providers to close. The pandemic will surely require a fundamental reappraisal of a care market consisting of thousands of independent companies making their own decisions on where to set up, what to provide, and whether or not to continue.

This widespread instability equally applies to the voluntary sector where inherent weaknesses have been starkly exposed by COVID-19. Bookings for training and services have been cancelled, charity shops closed, community fundraising halted, and (in the case of the larger charities) investment portfolios reduced in value. A survey of the sector undertaken during the lockdown period found over half [saying they would be bankrupt](#) within six months without financial help. With the sector estimating a loss of £4billion, the allocation of £750m by the Chancellor was generally seen as inadequate – a view [confirmed](#) by the Commons Digital, Culture, Media and Sports Committee. A sustainable future for the third sector has to be part of a new settlement.

Low policy salience

Adult social care is a residual means-tested service that has always struggled to achieve political attention. This has been exacerbated by COVID-19 in two ways: the easement of statutory duties, and the perception of the sector as a handmaiden to the needs of the NHS.

Rather than ensure that local councils are adequately funded and empowered to respond to the challenges thrown up by this crisis, one of the first [responses](#) of the government was to relieve them of their existing statutory obligations. The Coronavirus Act 2020 provided for the 'easement' of local authority duties in England and Wales around the provision of care and support needs. This meant they would no longer have to comply with their duty under the Care Act 2014 to conduct needs assessments and provide support unless failing to do so might constitute a breach of a person's human rights. The latter constituted a very high bar indeed.

Within weeks of the availability of these measures, eight local authorities had taken up powers of easement, even though there was [emerging evidence](#) of a *decline* in the number of people coming forward to seek help because of fear of contracting the virus. Concerns are now being expressed that local authorities are entering into easement without even providing evidence that they have met the necessary legal thresholds.

The tangled relationship between adult social care and the NHS has a long history, with repeated concerns that the shape of the former has increasingly been determined by the needs of the latter. This has been very evident in the response to COVID-19 with the two sectors being treated very differently in terms of the availability of testing, PPE, and even in the ways deaths are recorded and counted. However, the ‘handmaiden’ role of adult social care is best seen in the allocation to local authorities of £1.3billion to [rapidly free up](#) 15,000 hospital beds for coronavirus patients by expediting discharge from hospital back home or to alternative accommodation (notably care homes) for those patients for whom a clinical setting was no longer deemed appropriate. This decision alone threw the sector into chaos and is likely to have accounted for many thousands of deaths.

Unethical policy and practice

Over the decades there has been little reflection on the place of ethics in adult social care policy and practice, so there is some irony in the fact that it took the coronavirus outbreak to finally produce an ‘[ethical framework](#)’ for the sector. Eight principles for organising and delivering care have been identified: respect; reasonableness; minimising harm; inclusiveness; accountability; flexibility; proportionality; and community. These are useful principles to guide behaviour in any circumstances and it might be considered unfortunate that it took a global pandemic for them to be formulated. Guidance set out ‘an expectation’ that local authorities will ‘observe’ the framework, but application of these principles in the face of tightening of access to support is bound to be difficult – if not impossible – to deliver.

In the meantime, the policy response to COVID-19 has been characterised by a series of highly dubious ethical decisions. The political and scientific interest in ‘herd immunity’ (and the implied acceptance of the deaths of large numbers of older and more vulnerable people) was central to the government’s decision-making in the crucial months of February and March. It was abandoned only when it became clear in an advice paper from Imperial College London that the NHS would be overwhelmed and up to 250,000 deaths, mostly of older people, would be likely.

This assumption that the lives of vulnerable groups are of second-order importance is also evident in other policies – the absence of PPE and testing in the care sector have been noted, but the most gross ethical breach has been in the transfer of infected and untested patients from hospitals to care homes. Not only are there [reports](#) of councils refusing to release payments unless these patients are admitted, but where fatalities occur, care homes are not equipped to deal with them ethically. There is typically no GP presence, no palliation, no fluids, no syringe drivers and no staff with end of life training.

Reports also emerged of residents in some care homes for older people being categorised *en masse* as not requiring resuscitation should they contract the disease. The Care Quality Commission had to [step in and issue a warning](#) for the practice to stop. A similar tale applied to adults of working age, with the National Institute for Clinical Excellence being forced to change its emergency guidance to NHS doctors, after disability groups [threatened legal action](#) over what they feared could result in certain patients not getting equal access to critical care. Meanwhile, there are no reliable figures available for coronavirus-related deaths amongst working age adults with a learning disability, autism or similar conditions and disabilities. The contrast with the government’s ethical framework could not be starker.

Time for a public inquiry

All of this amounts to a very serious charge sheet indeed, one that requires accountability to be identified and justice being seen to be done. It is insufficient for the government to suggest in vague terms that these matters can be addressed in the fullness of time; they are too urgent for that. The best way to address them is through a [public inquiry](#). Some are already claiming [that this is required](#) as a matter of law under the Human Rights Act 1998 and the European Convention on Human Rights.

As former Department of Health permanent secretary Una O’Brien [has argued](#), the public would need to be confident that all relevant documents, minutes, emails, texts and even Zoom records were handed over to the Inquiry in a timely way. There would also need to be assurances that politicians, officials, scientific and health experts and others would give their evidence willingly, under oath and in public. And there are four questions to be answered: What has happened? Why did it happen? Who is to blame? What can be done to prevent it happening again?

About the Author



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