Social care, Covid-19 and gender

A policy briefing from the UK Women's Budget Group

Key points:

- **WBG is in favour of a Universal Care Service** that provides residential, domiciliary, and other forms of care, free at the point of delivery. It would have equal standing to the NHS.
- **The need to reform the social care sector is long standing.** After decades of cuts, deregulation and privatisation, the Covid-19 pandemic has made reform even more necessary and urgent.
- **The care sector is dominated by private providers focused on profits and cost minimisation** rather than appropriate care provision for those who need it.
- **Deregulation has** resulted in policy makers and practitioners with insufficient knowledge of the social care market and its fragilities. England has no national body responsible for the planning, registration and training of the workforce. Counted among key workers, social care staff are poorly trained, paid and treated.
- **There are increasing geographical inequalities in the social care system.** Central government grants to Local Authorities have halved since 2010. Income from local taxes have been insufficient to compensate for the cuts.
- **Shortages of residential and domiciliary services have been rising especially in those areas with the greatest needs.** In 2019 one in seven old people (1.4 million) living at home were not getting the care and support they needed, [1] a 50% increase since 2010. In some areas in the country there are 'care deserts' where there are no longer any residential care or nursing home beds. These services need to be *local*.
- **Staff shortages are high**: estimates suggest that in a workforce of 1.2 million there are 120,000[2] social care staff vacancies. Nearly a fifth of the current workforce were not born in the UK. The post-Brexit immigration system will exclude thousands of potential care workers because of their low pay and lack of qualifications. Investment in improving the training, pay and career opportunities of both the current and a future workforce is very urgent.
- **The numbers of unpaid carers** have grown steadily over the last two decades as overall life expectancies have increased but *healthy* life expectancies have not kept pace in the most deprived areas. Over the same period the number of adults with special needs and disabilities of working age has also grown. Since the onset of COVID-19 the numbers of unpaid carers have increased by an estimated 4.5 million to over 13.6 million in total.
- **The needs of carers for more support from local social care services are growing.** The ill-health and hardships experienced by family carers of all ages who have been shielding those needing their care during lockdown have remained invisible behind closed doors. As furlough is phased out their difficulties will become more visible.[3]
- **Those needing to combine paid employment with care will need services to support them** as well as for those they are caring for. They also need employers offering flexible work and the right to periods of paid and unpaid leave
- **The crisis in social care exacerbates gender inequality** since women are more likely than men to work in care, be in receipt of care in old age and to take on responsibility for unpaid care for children, elderly, disabled and/or vulnerable people.
- **WBG calls for a new settlement for social care** that provides a stable, sustainable funding base to ensure that rising care needs are met now and into the future.

[1] Age UK (2019) Fix care for good (https://bit.ly/331xHIV)
[2] Skills for Social Care (2019) The state of social care workforce 2019 (https://bit.ly/3kO3XW1)
[3] UK Carers (2020) Forgotten families in the coronavirus outbreak (https://bit.ly/3fk4kGQ)

- **The Universal Care Service should be funded at the national level** to avoid the entrenchment of regional inequalities but delivered in response to local need and becoming well-integrated with community health services, in particular, and other local community services in general.
- **Investment in care** is not only needed to transform our broken social care system, it is also a **good way to stimulate employment, reduce both the gender employment and pay gaps** and counter the inevitable economic recession as the UK comes out of lockdown[4].

Social care, coronavirus and the NHS

The Covid-19 pandemic has highlighted and exacerbated the crisis in the social care sector as well as its interaction with, and consequences for, the NHS. The consequences of decades of neglect and lack of regulation in a sector focussing on profits and cost minimisation - rather than on meeting need and ethical standards for the treatment of both service users and workers - are cruelly exposed by the levels of unmet need[5].

Although the crisis in care has been heightened by Covid-19, its origins are deeper: the interaction between the NHS and the social care sector has been made fraught by inadequate funding to both services. Prior to Covid-19, cuts in social care and local authority budgets resulted in delayed discharges from hospital thereby reducing bed spaces and increasing waiting times in the NHS[6].

In July 2020, the Public Accounts Committee in the House of Commons summarised the interaction between social care, the National Health Service and Covid-19:

"*This pandemic has shown the tragic impact of delaying much needed social care reform, and instead treating the sector as the NHS's poor relation*. *This committee has highlighted the need for change in the social care sector for many years, particularly around the interface between health and social care."* [7]

Residential care

Care homes have been worst affected because until mid-April it was government policy *not* to test all patients discharged from hospital to care homes despite it being well-known that elderly care home residents were particularly vulnerable to the virus. By this time 25,000 people had been discharged into care homes and by mid-May, 38% (5,900) of care homes in England had reported an outbreak[8].

This error was compounded by the use of agency workers working in multiple settings, the issue of confusing and constantly changing guidelines and the early insistence that it was *not* necessary to provide staff with sufficient PPE and testing soon enough, in contrast to health workers in hospitals These factors contributed to the spread of the virus within care homes as well as to workers and their families[9]and to the estimated 30,000 Covid-19 deaths in care homes[10].

There is now reliable evidence that disabled, older and people with serious health conditions or learning disabilities may have been denied treatment for Covid-19[11], even where their conditions would not have reduced their chance

[4] WBG (2020) A care-led recovery from coronavirus (https://bit.ly/3kMO428)
[5] Age UK (2019) The number of older people with some unmet need for care now stands at 1.5 million (https://bit.ly/3pJTY7H)
[6] NHS England (2019) NHS referral to treatment waiting times data March 2019 (https://bit.ly/2pmWCpT)
[7] House of Commons, Public Accounts Committee (2020) Readying the NHS and Social Care for the COVID-19 peak, HC405 (https://bit.ly/3nI0RER)
[8]House of Commons, Public Accounts Committee (2020) Readying the NHS and Social Care for the COVID-19 peak, HC405 (https://bit.ly/3nI0RER)
[9] BBC News (2020) Coronavirus: What guidance did care homes get from the government? (https://bbc.in/3lPLXMg)
[10] William, L. and Buisson. (2020) 34,000 older care home residents in England will have died from Covid-19 and collateral damage by the end of June, it is projected. *Care markets*. (https://bit.ly/3fsFqVp)
[11] In breach of the UN Convention on the Rights of Persons with Disabilities EHRC (2020) UN Convention on the Rights of Persons with Disabilities (CRPD) (https://bit.ly/2IU7ipA)

of benefiting from such treatment. Research for the Queens Institute of Nursing [12]found one in ten care homes surveyed were told by NHS managers to change Do Not Resuscitate (DNR) plans without discussion with residents, their families or the nursing staff. This was happening in homes for those with disabilities, autism or learning difficulties as well as in homes for the elderly. Excess death rates in homes for adults with learning difficulties or autism were over 30% higher than those of the previous five years[13].

Social care-a sector hidden from view

Privatisation

Thirty years on from the Community Care and NHS Act 1990, which turned local authorities into 'purchasers' of social care, the sector now comprises a hybrid mix of local authority, not- for -profit providers alongside privately owned residential care facilities and home care agencies which form the majority of 'providers'. These range from small family-owned individual homes and local agencies, to large-scale multi-home chains owned by private equity finance. The latter, which account for a quarter of the care home market in the UK, use complex and opaque financial structures involving many subsidiary companies which are mostly listed offshore, thus avoiding UK corporation tax. Their care homes are large, and debt ridden (up to £40,000 per bed). Should they fail and their homes close, it is the local authorities with 'the duty of care' towards the residents they placed in these homes which are responsible for arranging alternative care. The owners can walk away and only held to account if an *intention* to harm can be proved. They pay little or no corporation tax and their shareholders expect-and get- a 10-12% rate of return on their capital.[14]

Many care providers have made vigorous efforts to protect both care recipients and their staff from the pandemic, who have suffered disproportionately due to lack of government action (and the misguided actions described above). However, care regimes cannot create and sustain care *relationships* if they rely heavily on agency staff and/or part-time staff employed on insecure, badly paid zero-hour contracts. Many care workers[15] in both domiciliary and residential care, do not qualify for sick pay due to the £120 per week eligibility floor and many, as migrant workers, have no access to public funds. Those that do self-isolate face severe financial hardship, and some have been accused of breach of contract and risk dismissal [16].

Recent research indicates staffing and occupancy rates are key to infection rates in care homes.[17] This corroborates previous research in the UK and elsewhere who have long reported that staffing is lower and more precarious in corporate-owned residences than it is in not-for profit ones[18]. The recent revelation that England's Care Quality Commission and the Care Inspectorate in Scotland have agreed *not* to release home-by-home mortality figures because to do so would '*likely prejudice the commercial interests of care providers'* confirms the view that profits rather than residents' welfare takes priority[19].

Deregulation

The House of Commons Public Accounts Committee acknowledged in their latest report that "*…the thousands of independent providers and the funding model for social care made for a*

[12] The Daily Telegraph (2020) NHS told care homes not to resuscitate all residents (https://bit.ly/33a5fok)
[13] Care Quality Commission (2020) CQC publishes data on deaths of people with a learning disability (https://bit.ly/3fgtoy8)
[14] Centre for Health and the Public Interest (2019) Plugging the leaks in the UK care home industry (https://bit.ly/2Kvcr89)
[15] Community Care (May 2020) Covid-19 deaths among social care staff far outstripping those in healthcare (https://bit.ly/2UY292l)
[16] UNISON (2020) Care After Covid: A UNISON Vision for Social Care (https://bit.ly/2IVrRBK)
[17] ONS (2020) Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020 (https://bit.ly/3kPZHp0)
[18] See for example a study based on care homes in six countries, Baines, D and Armstrong P, *Promising Practices in Long Term Care: Ideas Worth Sharing*, Canadian Centre for Policy Alternatives, Canada, 2016.
[19] The Guardian (2020) Data on Covid care home deaths kept secret 'to protect commercial interests' (https://bit.ly/3pMTaiw)

very challenging and tough context in which to respond to Covid-19. This was apparent in the imperfect data it had to work with." [20]

The challenges faced by the Care Quality Commission (CQC) and Public Health England (PHE) in establishing a clear picture of the impact of Covid-19 on the home care sector and its workforce, illustrates this. Altogether 97% of care is provided by about 10,000 agencies employing 520,000[21] . The CQC records neither the total number of agencies nor the number of staff employed by each one of them at any point in time. There is considerable 'churn' of the agencies [22] as well as of their workers. Prior to the onset of Covid-19, 58% of domiciliary care workers were on zero hours contracts and turnover rates were 31%[23]. Some worked for more than one agency. Many workers are still not paid adequately for overnight care and many not for travel time. The obligation to visit numerous clients a day, often making multiple visits, has contributed to spreading the virus in the community and amongst the work force and their families.

There has been much less publicity about the impact of Covid-19 on domiciliary care workers. They were therefore almost certainly the last in the line to get PPE or testing. Despite exhortations from the Department of Health and Social Care to reduce dependence on agency workers, the health and social care sector accounted for 35% of the increase[24] in the number of workers on zero-hours contracts since the outbreak of Covid-19 (Overall, the sector increased to 1.05million, a 17% increase over 12 months.)[25].

ONS data now shows the fatal consequences of this precarity for care workers who are twice are likely to die from Covid-19 than non-key workers, with Black, Asian and ethnic minority (BAME) workers at a particularly increased risk[26]. Care workers are more likely to die from Covid-19 than their NHS counterparts (19.1 deaths per 100,000 women for care workers compared with 15.3 deaths per 100,000 women for NHS staff)[27].

The higher risks of exposure to Covid-19 among BAME care workers also puts vulnerable members of their families to greater risk. 18% of over 65s from BAME groups are likely to be receiving informal care from their children (18%) compared to 10% from white groups and 44% of BAME seniors receive care from a child living in the same household compared with 18% of those from a white group.[28]

Funding

Prior to the pandemic, adult social care was already facing significant challenges. In the past decade English local authorities' funding from central government was halved. This meant a loss of £8 billion to fund their key services, including social care. Government plans to make local authorities 'self-sufficient' and more dependent on their own business rates and council taxes impacted unevenly across local authorities. Those with the lowest receipts from business rates are likely to have the poorest populations and the highest social care needs.

Increases in *healthy* life expectancies in the most deprived areas have not kept up with overall life expectancies, meaning people living in these areas can expect to enjoy *two decades less* in good health than their counterparts in the least

[20] House of Commons, Public Accounts Committee (2020) Readying the NHS and Social Care for the COVID-19 peak, HC405 (https://bit.ly/3nI0RER)
[21] Skills for Care (2019) Domiciliary care services in the adult social care sector 2018-19 (https://bit.ly/3fhefg9)
[22] ADASS (2019) MPs briefing note: adult social care (https://bit.ly/38Zh44f)
[23] Skills for Care (2019) Domiciliary care services in the adult social care sector 2018-19 (https://bit.ly/3fhefg9)
[24] TUC (2020) Key Workers Report (https://bit.ly/2IZwQkY)
[25] TUC (2020) Key Workers Report (https://bit.ly/2IZwQkY)
[26] ONS (2020) Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020 (https://bit.ly/3kPZHp0)
[27] ONS (2020) Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020 (https://bit.ly/3kPZHp0)
[28] ONS (2019) Living longer: caring in later working life (https://bit.ly/3705Nye)

deprived areas. Their need for social care for longer periods in old age is increasing. At the same time the percentage of the population of working age reporting a disability has increased – from 15% in 2010/11 to 18% in 2017/18. Some local authorities now spend more on social care for this group than they do for older people, and their needs now account for 64% of the pressures on the adult social care budgets compared with 58% in 2018-19[29].

For the financial year 2020/21 only 3% of Directors of Adult Social Services were fully confident that their budget would be sufficient to meet their statutory duties[30]. Following the Coronavirus Act 2020,which gave local authorities a range of new duties and powers including for social care, housing rough sleepers, fire and rescue and educational functions to protect vulnerable children, the government promised an additional £3.2billion for social care plus £3 billion to assist in carrying out these additional responsibilities. However, it is estimated this will only meet a quarter of the estimated financial impact of those councils with social care responsibilities and takes no account of the loss of income for use of their assets such as car parks and commercial properties[31]. In addition, there was an estimated £6.6 billion needed to meet the additional cost pressures facing adult social care by the end of September 2020 including over £4 billion for PPE.[32]

The additional funds provided, therefore, fall far short of what will be needed in this financial year. Local authorities are obliged to balance their budgets year on year and they fear a situation 'whereby adult social care services are stripped to a statutory minimum to the detriment to those people, carers and families that access care and support services."[33] In contrast NHS Trusts can carry over deficits. A total of £13.4 billion of NHS debts have been written off and an additional fund of £588million, announced on August 21, has been allocated to the NHS for services to support patients discharged from hospital for up to 6 weeks[34] In October the Select Committee on Health and Social Care estimated that annual funding should be increased by £3.9billion by 2023-24 just to keep pace with demographic changes and increases in the National Minimum Wage.[35]

Workforce

Shortages and retention challenges

Estimates suggest that there are 120,000[36] social care staff vacancies while a recent survey found that 1 in 4 carers were thinking of leaving their roles due to lack of support[37].

In 2020, women made up 83% of the 840,000 care workers and home carers.[38] The Communities and Local Government select committee's concluded in 2017 that there were 'severe challenges in the social care workforce', citing 'low pay not reflecting the amount or importance of the work involved, low status, poor terms and conditions, and lack of training opportunities and career progression'[39] as the roots of the problem. This analysis shared by the Migration Advisory Committee still stands especially after the Covid-19 pandemic.

The CEO of the Queen's Nursing Institute warned in 2019, after the numbers of district nurses had halved in a decade: *'District nurses are the*

[29] ADASS (2020) ADASS Budget Survey 2020 (https://bit.ly/3pLIosP)
[30] ADASS (2020) ADASS Budget Survey 2020 (https://bit.ly/3pLIosP)
[31] TUC (2020) A Better Recovery (https://bit.ly/3fhH7F2)
[32] LGA and ADASS (2020) COVID-19: Financial pressures in adult social care information provided to the Minister of State for Care (https://bit.ly/335ZJmG)
[33] ADASS (2020) Submission by the Association of Directors of Adult Social Services to the Public Accounts Committee Inquiry-Readying the NHS and social care for the Covid-19 peak (https://bit.ly/392irz6)
[34] Gov.uk (2020) More than half a billion pounds to help people return home from hospital (https://bit.ly/3kReBv7)
[35] House of Commons Select Committee on Health and Social Care (2020) Social Care: funding and workforce inquiry, HC206 (https://bit.ly/35UwAwy)
[36] Skills for Care (2019) The State of the Adult Social Care Sector and Workforce in England (https://bit.ly/3pLRXYC)
[37] CIPD (2020) 1 in 4 working carers consider giving up their job entirely as many struggle to balance their responsibilities without employer support (https://bit.ly/2HpR86I)
[38] Skills for Care (2019) The State of the Adult Social Care Sector and Workforce in England (http://bit.ly/31UezsV) p. 9
[39] Communities and Local Government Select Committee (2017) (http://bit.ly/2jsjaCa)

backbone of community healthcare in this country. They provide a solution to the current crisis in acute hospital care by reducing delayed transfers of care and ensuring that patients are kept safe at home, preventing thousands of unplanned admissions and attendances in the Emergency Department every day.'[7] In 2012, when the required earnings threshold for non-EU migrant nurses was raised to £30,000, residential-home owners subsequently reduced their employment of qualified health professionals. By 2019 the number of nurses employed in nursing or residential homes had fallen by 20% (10,000).[40]

Lack of training

Despite the size of the adult social care sector the workforce of 1.3 million is affected by high turnover, a lack of training and limited levels of professionalisation in care work.[41]

The Initial Training Certificate offered since 2015 to social care workers in health and social care skills is very basic and optional. Conducted mainly online and measured in days, in 2018-19, only 54% chose to study 'awareness and safe-handling of medication)'[42] Had care workers received more extensive training, in particular to recognise problems arising from over-medication which accounts for one in ten older people's admissions to hospital, over a third of these admissions could have been avoided in the first place.[43] Maybe when COVID-19 arrived there would have been fewer old people to return from hospital to residential care taking the virus with them. If health and social care services are to be better integrated the government will have to do a great deal more than '*explore* options to align and integrate the two workforces.[44]

Immigration reform and staffing shortages

The impact of the Brexit vote and subsequent immigration reform will have a significant impact on the social care workforce. 8% of care workers (115,000) have an EU nationality.[45] Skills for Care estimate that 47% of them were eligible to apply for 'settled status' and 33% for 'pre-settled status' (remaining 19% also have British citizenship[46].) A greater number (9%) of social care workers (134,000) are immigrants from outside the EU. This flow of labour into care jobs is under distinct threat from the UK's proposed points-based immigration system to be implemented in January 2021.

The new system will exclude millions of care workers on the basis of their low pay and lack of qualifications: The median wage for a social care worker is £15,522, well beneath the threshold for 'low-skilled' salary threshold (£25,600) and, beneath the 'skilled' threshold (£20,480.) 47 IPPR finds that 71% of EU migrants who are currently defined as 'key workers' would be disqualified from working in the UK under current immigration plans.[48] 63% of EU national women and 79% of EU national men would not qualify due to low wages in the care, transport and construction sectors where migrant workers dominate. 66% of health and care workers, where more than 80% of workforce are women, would not qualify. 55% of education professionals would not qualify[49].

Workforce reform

If the sector is to become more attractive to UK workers, it must dedicate substantial and long-term investment to improve the poor pay and conditions that currently lead to low levels of staff recruitment and retention, and strengthen opportunities for development and progression.

[40] Royal college of Nursing (2020) Evidence to Public Accounts Committee HC405 (https://bit.ly/36YeCso)
[41] Skills for Care (2018) The state of the adult social care sector and workforce in England 2018 (https://bit.ly/2xB5GIz)
[42] Skills for Care (2019) The State of the Adult Social Care Sector and Workforce in England (https://bit.ly/3pLRXYC) p93
[43] NHS England (2019) Army of NHS experts to tackle over medication (https://bit.ly/2IXK6qi)
[44] Department for Communities and Local Government (2017) Adult social care: government response to the Select Committee report (http://bit.ly/2hAXK5b) (para.73)
[45] IPPR (2017) Care in a Post-Brexit Climate (http://bit.ly/2zERuAA)
[46] Skills for Care (2019) The State of the Adult Social Care Sector and Workforce in England (http://bit.ly/31UezsV) p. 10
[47] ONS (2019) Annual Survey of Hours and Earnings (https://bit.ly/3kMalgl)
[48] IPPR (2020) Immigration plans analysis: two thirds of current EU migrants in health and social care sector would have been found ineligible (https://bit.ly/3fgE0x0)
[49] IPPR (19 Feb 2020) Immigration plans analysis: two thirds of current EU migrants in health and social care sector would have been found ineligible (https://bit.ly/3fgE0x0)

As the Migration Advisory Committee argues: 'the sector's problems are not primarily migration related. A sustainable funding model, paying competitive wages to UK residents, would alleviate many of the recruitment and retention issues.'[50] The social care service should not rely on workers who have no recourse to public funds and will be charged for using the NHS.

Care in the Community: domiciliary and unpaid carers

Domiciliary care

The number of deaths in hospitals and care homes fell over the summer but are now in excess of the 5-year average of deaths in these locations. The numbers dying at home have been in excess throughout, but this has attracted far less attention. Women comprise over 72% of those aged over 75 years old and living alone, and form the majority of the 850,000 people with dementia, of whom 120,000 live alone.[51] Some 60% of those reliant on home care have dementia compared with over 70% of care home residents. Dementia has been the main cause of death, irrespective of location, among women throughout. Their lives under lockdown, with only limited or no contact from paid carers whom they may be unable to recognise when wearing PPE, together with restricted contact with family, can be frightening and bewildering. '…lives are blighted, distress and pressure increased, and the resilience of individuals and their families is ground down.' [52] This together with banning family members from visits in care homes are examples of the failure to recognise that the maintenance of relationships is the foundation of good and safe care.

Unpaid care and gender inequality

Cumulatively, these political decisions have huge consequences for gender inequality, not only within the care workforce but also among unpaid carers and those needing their support. Since March the number of unpaid carers has increased by an estimated 4.5 million, 58% of them women, nearly 3 million who were juggling paid work with care.[53] Research conducted by the university of Sheffield and CIPD prior to the onset of Covid-19 found one in four of carers in paid work were thinking of giving up paid employment because of getting so little support from their employers.[54] The raising of women's state pension age to 66 years is exacerbating the problem

Women are more likely than men to be looking after someone living in another household though men over 65 are slightly more likely than women to be caring for a spouse. Many more people born with learning disabilities or long-standing conditions who, in the past would have died young, now survive well into adulthood but many need some social care - either residential or in the community. But half of their community services have been cut. The average age of their unpaid carers is 75 years with 20% over 80 years[55]

The need for social care and health services does not decrease when lockdown is eased. The evidence from Carers UK survey[56] found that 70% reported caring had had a negative impact on their physical and mental health. They found it hard to access health advice from NHS111 and even harder to access any services. Fearful of accepting help from domiciliary care workers without PPE, some rejected their help. Nearly two thirds had no respite from their caring responsibilities with those of working age feeling the most insecure. Many carers all faced a range of financial hardships including having to use a foodbank and getting into debt[57].

Recommendations:

[50] Migration Advisory Committee (2018) Migration Advisory Committee (MAC) report: EEA migration (https://bit.ly/35M34cg)
[51] The Guardian (2020) Eight in 10 people living alone with dementia completely isolated since March (https://bit.ly/3m1XFTS)
[52] The Guardian (2020) Social care at breaking point in England after 'lost decade' – report (https://bit.ly/3nJdS0Y)
[53] Carers UK (2020) Caring behind closed doors (https://bit.ly/3pMWcDq)
[54] CIPD (2020) Supporting working carers (https://bit.ly/2IPkCuZ)
[55] UK Carers (2020) Forgotten families in the coronavirus outbreak (https://bit.ly/3fk4kGQ)
[56] University of Birmingham (2020) Covid-19 leaves unpaid carers without physical and mental health treatment (https://bit.ly/3fjeoj6)
[57] ADASS (2020) ADASS Budget Survey 2020 (https://bit.ly/3pLIosP)

- The need for social care services is growing fast because unpaid carers are more likely to be combining care with paid employment than in the past. However, as the ADASS has pointed out: 'If you reach the tipping point where there is a crisis and insufficient care, you start pulling unpaid carers from the working population which will impact on the economy.[58]
- Investing in care and care workers is economically prudent: calculations using Eurostat data find that investing in care produces 2.7 times as many jobs than the same investment in construction, 6.3 times as many for women 10% more for men.[59]
- Better integration of social care and health services is urgently needed. The pandemic has shown that treating social care services as the poor relation of acute hospital care in the NHS is not only dysfunctional but also endangers health and even lives. Social care should not be taken i*nto* the NHS but better integrated with local public health services together with other community services, especially housing.
- Ending workforce shortages is very urgent and could provide new job opportunities all over the country for both young and older workers. As the Select committee on Health and Social Care recommended[60] the training, pay and career progression of social care workers should be put on a par with health care workers, including the opportunity to share some training. We cannot continue to rely on migrant labour.
- Just to keep pace with the growing numbers of those over the age of 65 years, the social care workforce will have to grow by 580,000 by 2035.
- The pandemic has also shown that social care services based on a business model which prioritises minimising costs and maximising profits over delivering safe standards of care, provided by well trained and paid workers, has cost lives. This model has no part in a future, viable social care service which recognises that good and safe care is founded on relationships which take *time* to establish and sustain.

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[58] ADASS (2020) Coronavirus survey (https://bit.ly/2IKQvFv)
[59] WBG (2020) A care-led recovery from coronavirus (https://bit.ly/3kMO428)
[60] House of Commons Select Committee on Health and Social Care (2020) Social Care: funding and workforce inquiry, HC206 (https://bit.ly/35UwAwy)