

Care and support workers’ perceptions of health and safety issues in social care during the COVID-19 pandemic.



Initial findings, 15th April 2020.

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Overview

We undertake research for Wellcome Trust about the legal rules that govern the care and support that is provided in care homes and by homecare providers in England, Scotland and Wales.¹ Our task is to assess whether these rules about care standards might be having an indirect effect on the quality of care workers' jobs.

Our research began in January 2020. We did not anticipate we would be looking at the legal rules in the context of a global pandemic. However, we are ideally placed to report on what is happening to the legal regulation of care and support in the UK as the COVID-19 crisis unfolds.

This is our first report. It is about care and support workers' perceptions of health and safety issues. It provides initial findings from legal and survey data about the role of care and support providers in the pandemic *as employers* with legal responsibilities for preventing harm to staff and people who use their services.² The evidence suggests that care and support workers, care home residents and other users of care and support services are exposed to the risk of SARS-CoV-2 virus without the protections to which they are legally entitled. We worked with UNISON in the North West of England to analyse findings from a survey of 2,600 care workers in approximately 1,200 different settings across residential care, home care, and support services for people with learning disabilities.³ Our analysis of results is split into three sections. Firstly, concerns about the need for Personal Protective Equipment (PPE). Secondly, pay problems. Thirdly, other COVID-19 related health and safety concerns.

A large majority of care and support workers said their employers were not doing enough to keep them and the people who use their services safe. Their accounts of what is happening on the ground in social care appear to be at odds with the picture of service provision set out in Guidance issued by the Department of Health and Social Care. Gaps in knowledge at policy level, about social care in practice, could be putting lives at risk. **In this report, we recommend that care workers are urgently appointed to problem-solving roles at national and local government level** so that their expertise can be brought to bear in making decisions about the distribution of personal protective equipment (PPE) and the use of resources, including staff resources.

We find that 8 out of 10 care workers think they will not be paid their normal wages if they have to self-isolate due to COVID-19. Care workers report that they and their co-workers are not always self-isolating because of poverty and fear of poverty. Care providers are not legally required to provide occupational sick pay and, unlike in the NHS, most not do so. The UK Government has to-date advised that care workers may be able to access SSP payments during a period of self-isolation. At £95.85 a week, SSP provides a woefully inadequate level of income. **In this report, we recommend that UK Government act urgently to ensure that care workers receive their normal wage incomes when in self-isolation.** We believe this is a necessary intervention to save lives.⁴

¹ Research funded by Wellcome Trust: Social Care Regulation at Work in England, Scotland and Wales. Principal Investigator Professor LJB Hayes.

² A note on terminology: This report refers to workers who provide both care and / or support to people who need care or assistance in everyday life. We understand that for many people the term 'care' does not cover the support they need or receive through the social care system. We use the terms 'care and support' and 'care and support worker' in this report as far as possible.

³ Data collected in two weeks to 6th April 2020 in an online survey by UNISON North West. 2,600 respondents in total completed all questions.

⁴ Scottish Government announced sick pay for care workers on 12th April and will provide monies to care providers to cover occupational sick pay for periods of illness and self-isolation backdated to 1st April 2020. <https://www.gov.scot/news/pay-rise-for-social-care-staff/>

The laws which set out how care providers are expected to meet minimum standards of care have not changed since the onset of the Coronavirus crisis. However, the regulatory bodies with responsibility for investigation, reporting and prosecution have decided to stop routine inspections of care settings. This means that in practice, the laws which govern what happens in care homes and homecare services are no longer being enforced by care sector regulators. The attention of care providers is being redirected to information and advice set out in a series of ad-hoc notices, such as those issued by the Department of Health and Social Care. In this report we identify our initial concerns that the advice of the Department of Health and Social Care is insufficiently tailored to the needs of social care workers and to those of individuals in need of care and support. Insufficient detail and a lack of sector-specificity means that managers of care homes and home care services are left to rely on 'common sense' and individual discretion to guide their decision-making about appropriate levels of care in the face of the SARS-CoV-2 virus and outbreaks of COVID-19. It is deeply concerning for the longer term that regulations which set out minimum acceptable standards for operating in the care sector have been displaced by appeals to managerial discretion and Guidance from the Department of Health and Social Care that has been inconsistent and is often unsuitable for application in care-settings.

On 6th April, news broke of the first two deaths of care workers in England from COVID-19, Carol Jamabo and an un-named care worker (both employed in the North West of England). The reporting of these tragedies, as well as those about deaths of residents in care homes, suggested lack of personal protective equipment (PPE) was a key factor.⁵ In this report we find serious breaches of safety standards across care and support settings. Over half of care workers expressing a view felt services were insufficiently safe, both for them personally and for the older and disabled people for whom they care. PPE is a major issue, and our report provides details of this. It also looks beyond the widely publicised problems with PPE *availability* to evidence other health and safety related COVID-19 concerns.

There appears to be considerable confusion in guidance issued by the Department of Health about whether, when and why PPE is necessary in care-settings. The regulatory framework that governs social care provision in all four of the UK nations has the primary objective of keeping citizens safe. Yet at a time when risk to life is acutely high, our findings suggests that sector-specific safety laws, as well as other health and safety laws, are not being complied with, even though in some instances regulatory breach is a criminal offence. For example in England, care providers must provide care in a safe way, do everything reasonably practicable to mitigate risks to the health and safety of people receiving care, and control the spread of infection.⁶ Where a breach of this regulation results in avoidable harm or exposes an individual to significant risk of harm, a criminal offence is committed. However, our data evidences the concern of care workers that care is not safe. These sector specific requirements sit alongside the requirements of the Personal Protective Equipment Regulations 1992 and the Health and Safety at Work Act 1974. All workers have a right to suitable PPE because every employer must ensure PPE is provided to employees who may be exposed to a risk to their health and safety while at work, unless the risk is adequately controlled by other means which are equally or more effective.⁷ A failure to provide PPE to workers at risk can also be a breach of human rights law, in particular the right to life at Article 2 of the European Convention on Human Rights.⁸ Importantly, human rights laws apply in all registered care settings in England, Wales and Scotland where care and support services are arranged or paid for, directly or indirectly, by local authorities.⁹

⁵ Booth R, Residential home 'desperate' for PPE as two care workers die, *The Guardian*, 6th April 2020.

⁶ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended), Regulation 12.

⁷ Personal Protective Equipment Regulations 1992, Regulation 4

⁸ See J Robottom 'The legal rights of healthcare workers to personal protective equipment during the COVID-19 pandemic', UK Labour Law Blog, 13 April 2020, available at <https://wordpress.com/view/uklabourlawblog.com>

⁹ Care Act 2014, section 73.

Context: COVID-19 and Social Care

In recent weeks, UK Government ministers have given increased prominence to the social care workforce in press briefings. The social care workforce is spoken about as though it is a workforce with equivalent status and importance as the NHS workforce. Indeed, the umbrella terms ‘health and social care workforce’ and ‘health and social care system’ have entered mainstream political debate.¹⁰ The recent ‘thank you’ letter from Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, addressed social care workers as his ‘brilliant colleagues’, and as though they were on a par with NHS employees and part of the same organisational family. Hancock also stated that his commitment to doing ‘whatever is needed.... applies just as much to social care as it does to the NHS’.

If this creates the impression of equivalence between NHS and social care services, it is an impression that is misleading. Unlike NHS provision, adult social care services are provided in a highly fragmented, privatised and resource-starved market in which staff shortages, breaches of employment rights and understaffing has become the norm. Unlike in the NHS, there is very little representation of care workers through collective bargaining by trade unions, there is little career progression for care workers, there is a severe lack of training, and pay in the sector is very low.¹¹

The impact of COVID-19 in social care is very different to its impact in the NHS, and risks of transmission of the SARS-CoV-2 virus are also distinctive in social care-settings. For example, it is increasingly evident that deaths in care home settings are collective in their nature.¹² Caring practices are largely collective in their execution, in care homes because residents live together in a single dwelling with support from a community of care workers, or because individual care workers are assigned to travel from home to home in a geographical community, according to a schedule of visits in which they assist individuals in need of care and support. Physical contact between care workers and people in need of care and support is frequent, essential and immensely intimate. Emotional contact sustains relationships of care to build the trust, knowledge and interpersonal understanding that makes caring and support possible.

There may also be distinctive risks for workers who provide care and support. Research about COVID-19 has found evidence that people can carry infective SARS-CoV-2 virus in their faeces, even if they are not displaying respiratory symptoms.¹³ Care workers are likely to be more frequently, and more extensively exposed to faeces in their work routines than nursing staff or doctors. For example, in residential care, people with dementia are four times more likely to suffer from faecal incontinence

¹⁰ See for example letter of the Secretary of State for Health and Social Care 28th March 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876573/2020.03.28_-_Letter_-_SoS_to_social_care_workforce_-_Covid_19_v7.pdf

¹¹ Hayes, Lydia and Johnson, Eleanor and Tarrant, Alison (2019) *Professionalisation at work in adult social care: Report to the All-Party Parliamentary Group on Adult Social Care, July 2019*. Project report. GMB trade union

¹² Note that on 8th April it was reported that 15 residents at Castleroy Residential Home in Luton had died with COVID-19, 7 at a care home in east London, eight at a care home in Dumbarton, 12 at a care home in Cranhill, Glasgow [BBC.co.uk/news/uk-england-beds-bucks-herts-512175891](https://www.bbc.com/news/uk-england-beds-bucks-herts-512175891)

¹³ Hindson Jordan (2020) COVID-19 Faecal-Oral Transmission?, *Nature Reviews Gastroenterology and Hepatology*. <https://doi.org/10.1038/s41575-020-0295-7>; Blair Jenny (2020) COVID-19, Evidence Builds for Viral Shedding in Stool, Even After Clear Respiratory Tests, *Clinical Essentials* <https://www.univadis.co.uk/viewarticle/covid-19-evidence-builds-for-viral-shedding-in-stool-even-after-clear-respiratory-tests-714654>

than others,¹⁴ 80% of residents in care homes have dementia and research estimates that approx. half of all care home residents in the UK have faecal incontinence.¹⁵ The extent of bowel care that takes place in residential and homecare settings may therefore create distinctive risks for care workers.

There are 1.3 million staff working in the NHS and 1.5 million people working in adult social care in England.¹⁶ When including workers from Wales, Scotland and Northern Ireland we can reasonably assume that in excess of 2 million people work in adult social care. The vast majority of those are hands-on care workers, and 85% are women. The risk of SARS-CoV-2 infection therefore hangs over a huge workforce who are low paid, undertrained, working behind closed doors in private settings, and are often employed on zero-hours or other precarious contracts. Prior to the outbreak of COVID-19, the sector was said to be 'at breaking point'.¹⁷ Many people in need of care and support are at high risk from COVID-19 and many of those in the UK Government's 'extremely vulnerable' category will be users of care and support services or residents in care homes.

This is the context in which UNISON North West surveyed the opinions of 2,600 care workers working for hundreds of different employers.¹⁸ Our analysis reveals that the extent to which survey respondents do not feel personally safe in the conduct of their work is alarming, as is the extent of their concern that not enough is being done to protect the health and safety of people using care and support.

¹⁴ Grant, Robert et al (2013) First Diagnosis and Management of Incontinence in Older People with and without Dementia in Primary Care: A Cohort Study Using The Health Improvement Network Primary Care Database, PLOS Medicine, <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001505>

¹⁵ Goodman, Claire et al, (2015) Reducing and managing faecal incontinence in people with advanced dementia who are resident in care homes: protocol for a realist synthesis, *British Medical Journal (BMJ Open)*, <https://bmjopen.bmj.com/content/5/7/e007728>

¹⁶ The size and structure of the adult social care sector and workforce in England, Skills for Care, August 2019.

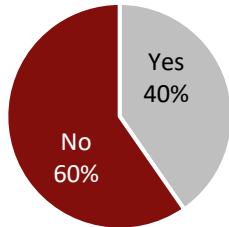
¹⁷ For example <https://www.lgcplus.com/services/health-and-care/social-care-at-breaking-point-say-15-organisations-22-03-2019/>

¹⁸ Approx. 1,200 social care organisations are named as their employers by survey respondents.

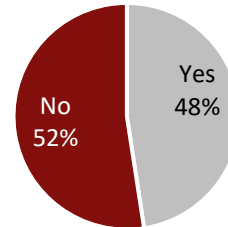
Key findings

1. A large majority of respondents believe too little is being done by employers to keep staff safe from the risks SARS-CoV-2 infection (69% of learning disability support workers, 60% of home care workers, 52% of residential care workers).
2. A large majority of respondents believe too little is being done by employers to keep people using care and support safe (58% of learning disability support workers, 56% of homecare workers, 43% of residential care workers).
3. 8 in 10 care workers that they would not be paid their wages as normal if they had to self-isolate. (79% of homecare workers, 83% of residential care workers, and 67% of learning disability support workers). Indeed, 61% of homecare workers, 72% of residential care worker and 57% of learning disability support workers believe they would receive only SSP payments, notwithstanding their high occupational exposure to the risk of infection.
4. Government guidance assumes PPE availability, but care workers state PPE is often unavailable or unsuitable. Evidence from care workers shows how lack of PPE is a safeguarding issue and there fears too about maintaining basic hygiene due to reported shortages of soap and hand sanitiser.
5. Official guidance has said no PPE is needed in certain situations, but evidence from care workers suggests this has created confusion and they believe lack of PPE is putting them, and others, at risk. Official guidance is not addressing the specifics of potential virus transmission in residential and homecare settings.
6. Care workers who are ill with COVID-19 are not all self-isolating. It appears that poverty, and fear of poverty, may be exacerbating the risk of transmission of SARS-CoV-2 in social care circles.
7. Care workers believe that lack of attention to minimising the risk of infection in care and support settings has directly contributed to outbreaks of COVID-19 in social care-settings.
8. Reports from care workers provide evidence that in some care-settings there have been few, if any, attempts to reduce risk of transmission and these risks are compounded by difficulties in achieving social distancing.
9. Care workers are concerned that some measures implemented to deal with staff shortages may be accelerating the spread of SARS-CoV-2 in social care.
10. Care workers are concerned that their reliance of public transport is likely to be transmitting the virus between care-settings and the wider community.

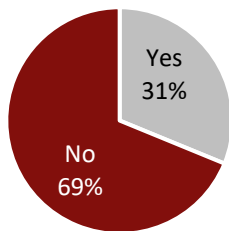
“Social Care - Homecare”
Do you feel your employer is doing enough to protect the health and safety of staff?



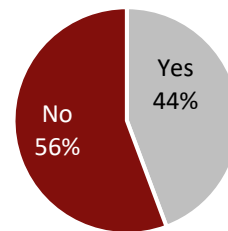
“Social Care - Residential Care”
Do you feel your employer is doing enough to protect the health and safety of staff?



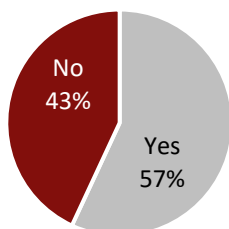
“Social Care - Learning Disability”
Do you feel your employer is doing enough to protect the health and safety of staff?



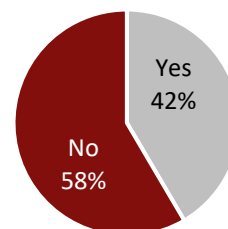
“Social Care - Homecare”
Do you feel your employer is doing enough to protect the health and safety of service users?



“Social Care - Residential Care”
Do you feel your employer is doing enough to protect the health and safety of service users?



“Social Care - Learning Disability”
Do you feel your employer is doing enough to protect the health and safety of service users?



Analysis of results: PPE problems

The most widespread concern reported by survey respondents across all care-settings was lack of PPE. In all four nations of the UK, it is a breach of legal requirements if failure to provide suitable and adequate PPE places people using care at risk of harm. It is a legal requirement that all employers ensure suitable personal protective equipment is provided to workers who may be exposed to a risk to their health or safety while at work. To be suitable, the PPE must be appropriate to the risks and conditions arising in care-settings. In the absence of suitable PPE, the risk must be controlled by other means.¹⁹

However, our analysis of survey results reveals that across social care and support settings, workers are experiencing a severe lack of PPE. Their comments reveal an acute lack of attention, in workplaces and at policy-level, to the risks faced by staff and care home resident and other people using care and support.

Government guidance assumes PPE availability, but care workers state PPE is often unavailable or unsuitable.

Guidance issued by the Department of Health and Social Care on 13th March advised that when caring for **‘residents with symptoms’**, staff should use PPE for activities with **‘close personal contact’** including ‘washing and bathing, personal hygiene and contact with bodily fluids’.²⁰ The PPE referred to was aprons, gloves and fluid repellent surgical masks, to be used for each episode of care and securely disposed of. Our emphasis, in bold, of key phrases above serves to highlight that guidance did not urge the use of PPE where residents were not showing symptoms. It is also concerning that referring to ‘symptoms’ does not take account of growing evidence of SARS-CoV-2 transmission through contact with faeces (see Context section above). Further, in circumstances where residents *did* have COVID-19 symptoms, the Guidance is silent about the need for PPE when care workers were engaged in tasks other than personal care, for example when serving food or engaging in social activities.

The guidance of 13th March further noted that care homes are ‘routinely procuring PPE such as aprons and gloves’ and in addition, a ‘free issue of PPE’ from pandemic influenza stockpiles would be combined with other arrangements to enable adult social care providers to access ‘further PPE as necessary’. The Department of Health and Social Care Guidance for Homecare Providers about COVID-19, updated 6th April, also referred to routine procurement of PPE such as gloves and aprons, the ‘free issue of PPE’, and additional arrangements to provide PPE ‘as necessary’.²¹

Government guidance is therefore written on the basis of assuming the availability of PPE in care-settings, and this assumption continues. However, data from the UNISON survey reveals the extent to which PPE is not available. Reports of lack of PPE made up the overwhelming majority of comments from survey respondents. One care worker stated there is:

No communication, no PPE, no respect

¹⁹ Personal Protective Equipment Regulations 1992, Regulation 4(1) and (3).

²⁰ <https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance>

²¹ <https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-on-home-care-provision>

Another wrote of their employer:

They have just give[n] us nothing

And some care workers report they are not being given PPE despite them being especially vulnerable to negative outcomes should they become infected with SARS-CoV-2. For example, this care worker with COPD reported:

When I enquired 3 weeks ago about extra PPE [the manager] laughed and told me it's not going to be like Italy, and I was scaremongering. Then she was unable to get enough PPE for all staff, despite knowing I have COPD, I wasn't offered any.

Care workers are also aware that where PPE is available, this does not necessarily provide reliable protection. For example:

[We have] been told we will be provided with ppe but it's not the right equipment... for e.g. using dust masks

[I have] no PPE apart from a few loose fitting plastic gloves

Lack of suitable PPE impacts on the way in which care workers are able to undertake care tasks. The inability to protect staff and users of care services from COVID-19 produces circumstances and situations in which people are not being effectively safeguarded and infection control is jeopardised.

We have very little PPE, we are forced to tend to clients in a rushed way, making it difficult to follow correct infection control measures.

Lack of PPE is not the only issue, basic hygiene cannot be in place where there is a lack of soap and hand sanitiser. Care workers suggest supplies are running dangerously low:

Allowing people to work who are unwell and allowing people to work [when] a member of their family is in isolation we have no hand sanitizer and are running out of soap.

Not enough PPE or hand sanitiser. No checks on staff.

Health and Safety laws require that in the absence of PPE, protection against risk is achieved by 'other means'. The implication here is that it is unlawful to expose workers to health and safety risks without protection. Politicians have been slow to acknowledge the extent of risks caused by PPE shortage in adult social care and it remains unclear that they understand the vast size of the adult social care sector workforce and the risks to which the workforce is being exposed. It is concerning that government guidance assumes PPE availability in situations where PPE is missing.

It is of further concern that the presence of risk appears to be minimised in some aspects of official Guidance about COVID-19 in adult social care. As discussed below, data from care workers suggests that a lack of sensitivity to risk has been a feature of their working lives in recent weeks. It also appears that at a policy level there are considerable gaps in knowledge about the tasks undertaken by social care workers and the role they fulfil.

Official guidance has said no PPE is needed in certain situations, and evidence from care workers suggests confusion and elevated infection risk.

In the 13th March guidance from the Department of Health and Social Care, care homes were advised that where a resident has symptoms of COVID-19, they did not need to follow the same isolation procedures that apply to UK households in which one member is showing symptoms (meaning that it is not necessary for everyone in the home to self-isolate). This was explained as being because care homes have the ability to adopt isolation precautions. However, there is evidence directly from care workers that isolation is not always occurring. For example, one care worker commented in the survey:

We have a resident whose husband died from the virus so she was supposed to be in isolation but she was allowed visitors and staff [were] told off when she had a temperature and called 111. They were told not to call 111.

The Guidance of 13th March also stated that where neither the care worker nor the resident is symptomatic, **'then no PPE is required'**. This is concerning because it is well documented that people with COVID-19 can be asymptomatic but capable of transmitting the virus. It is advice which does not reflect the lag between contraction and becoming symptomatic, which is thought to range from 1-14 days.²² Guidance from Public Health England, at the time of writing most recently updated on 10th April, reports that SARS-CoV-19 can be present in blood, faeces and urine, as well as in airborne droplets.²³ Respiratory symptoms are poor indicator as to whether PPE is need to protect from the risk of SARS-CoV-2 infection.

Furthermore, a large proportion of care home residents will have medical conditions which put them in the 'extremely vulnerable' group and therefore minimisation of COVID-19 risk ought to be a top priority, irrespective of symptoms.

Care workers have evidenced in their survey responses that they think risk of transmission has not been taken as seriously as they would have liked. For example:

up until Monday 23rd March we were being told "business as usual" by the senior manager and still expected to have contact with very vulnerable older and sick people in care homes and hospitals with no guidance nor support in the way of PPE or measures for our own safety.

Perhaps more worryingly, the Department of Health and Social Care produced updated guidance for residential care homes on 2nd April which stated that care home staff who come into contact with a COVID-19 patient **while not wearing PPE, can remain at work**. This, the guidance stated, is because **'in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing'**. This guidance suggested a considerable lack of understanding in senior level policy circles about practices in care homes, which are highly intimate and rely upon considerable personal physical contact.

²² See World Health Organisation <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses>

²³ Public Health England, 10th April 2020, COVID-19 Epidemiology, Virology and Clinical Features. <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-background-information/wuhan-novel-coronavirus-epidemiology-virology-and-clinical-features>

A lack of clarity and lack of attention to risk has frightened care workers. Responses from care workers which shed light on their concerns in care homes and other settings include:

A colleague ill in work didn't get told to go home and [was not told the] shift would get covered. Now I am in fear that myself or our clients are going to become ill ourselves.

We are told we are not allowed to wear PPE due to it scaring the people we support. We are not being able to social distance whilst in work due to the amount of staff [on duty].

We work in the community in and out of people's homes. We do not know who has it and could be passing it on through our uniforms, our cars.

The 2nd April Guidance was withdrawn on 6th April, the same day as reports of the deaths of two care workers in the North West of England. It was replaced by Guidance (also issued on 2nd April) that is entitled: 'Admission and Care of Residents during COVID-19 Incidents in a Care Home'.²⁴ With regards to PPE, this document refers care providers to guidance relating to both health and social care workers, as though it is a single workforce.²⁵ The document acknowledges it may be difficult to determine if individuals in need of care meet the definition for suspected COVID-19 prior to providing them with care. It makes PPE recommendations for a wide range of health and social care contexts but it appears that none of those 'contexts' include homecare settings or residential care homes. The text of the guidance refers to a social care worker being in a 'specific clinical care-setting or exposure environment ... which might include a ward round or taking observations of several patients in a cohort bay or ward'. This does not sound like a description of the work undertaken in social care and support settings. In what seems to be the most relevant paragraph of the guidance, headed 'Individual's home or usual place of residence', it is stated that provision of direct care to any member of a household in a **possible or confirmed case**, requires the use of plastic gloves, eye protection, a fluid resistant surgical mask and aprons. There are widespread reports that neither care homes nor homecare services have sufficient PPE supplies to be providing this level of protection during care-giving interactions (notwithstanding doubts as to whether, in 'confirmed' cases, this level of protection is sufficient for workers undertaking personal care). Furthermore, it is unclear who is to be classified as a 'possible' case. As has been discussed above, the presence of respiratory symptoms is not a good indicator of risk of SARS-CoV-2 transmission. Should care workers be protected when providing personal care on the basis that all users of care and support services are 'potential' cases? This is not what is currently being advised.

Tables have been published by Public Health England to explain PPE recommendations for workers in primary, outpatient and community care settings.²⁶ However, it is unclear whether the information in

²⁴https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878099/Admission_and_Care_of_Residents_during_COVID-19_Incident_in_a_Care_Home.pdf

²⁵ www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/COVID-19-personal-protective-equipment-ppe

²⁶ See <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>

any of those tables is aimed at social care and support workers or domiciliary or residential care providers.

A lack of clarity about PPE requirements in domiciliary care provision continues to be evident in guidance issued by the Department of Health and Social Care on 8th April for people who provide unpaid care to friends and family.²⁷ This has included advice relating to concerns about paid carers coming in and out of the home and the risk of infection. The assurances offered are merely about risk reduction through ‘appropriate levels of hygiene’ and there is **no reference to PPE**. Indeed, in discussion of face masks, this guidance specifies that **face masks are solely recommended for clinical settings** because there is ‘little evidence of benefit from their general use outside these settings’.

It appears that Guidance issued by the Department of Health and Social care has been drawn up without adequate consideration of the particular needs of workers in residential and homecare setting, nor the UKs approximately 500,000 care home residents and over 800,000 people using domiciliary care and support in their own homes.²⁸

Analysis of results: pay problems

Care workers who are ill with COVID-19 are not all self-isolating. It appears that poverty, and fear of poverty, may be exacerbating the risk of transmission of SARS-CoV-2 in social care circles.

In the Department of Health and Social Care Guidance of March 13th, any member of staff who was concerned they might have COVID-19 symptoms was advised to self-isolate and to ‘not visit or care for individuals until it is safe’. But poverty, or fear of poverty, is a key issue that is resulting in workers not self-isolating. For example, care workers’ comments included:

staff are at work while ill as they fear losing pay, putting other staff and clients in danger.

Pressured to attend work because [...] income worries

Another reason for not self-isolating is because some care workers are unwilling to give up their responsibilities for care:

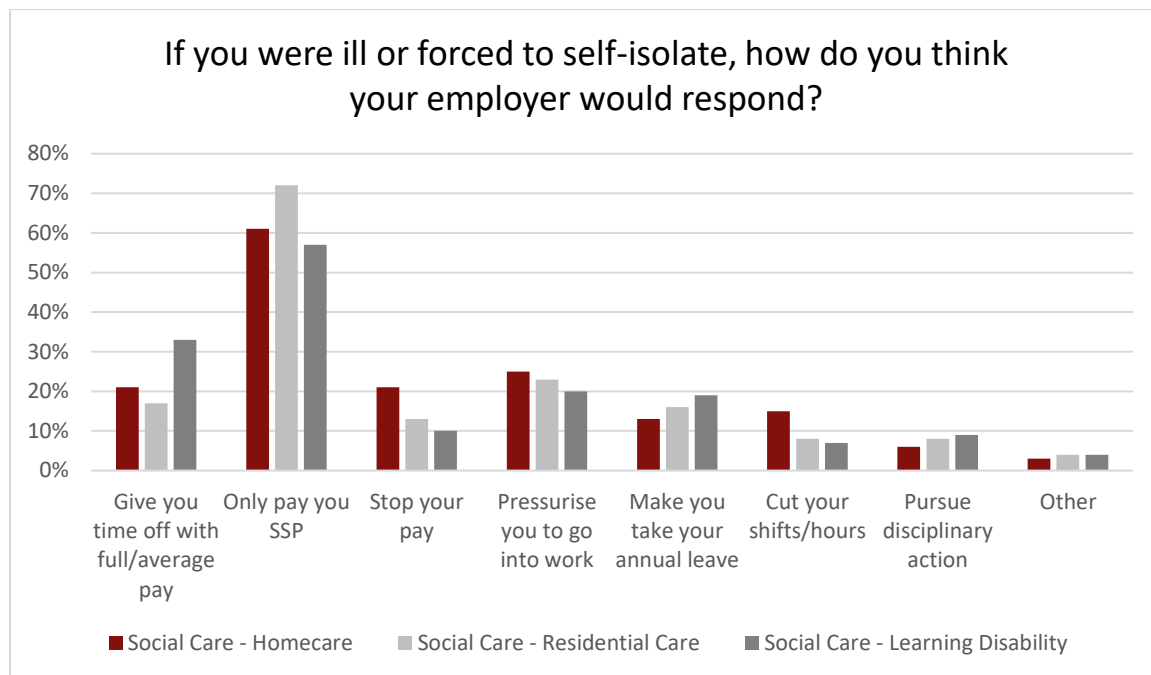
Symptoms are subjective to [self] diagnosis. Staff feel symptoms could be hayfever etc. Staff caring nature could result in them unknowingly passing the virus on as they may feel obliged to work instead of disclosing personal/family symptoms.

Guidance to care homes and home care providers issued on 13th March and subsequent updates provide **no** assurance that **all** workers in the social care sector are at least entitled to Statutory Sick Pay (SSP), rather it is stated than workers employed on zero-hours contracts *may be* entitled to SSP if their average earnings are of at least £118 per week, while those who are ineligible ‘are able to

²⁷ <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe>

²⁸ United Kingdom Homecare Association 2016, An Overview of the Domiciliary Care Market in the UK

claim Universal Credit'. It is little wonder therefore that survey participants express fear and confusion about what will happen should they need to self-isolate.



The bar chart above reveals that the vast majority of care workers believe they would not be paid their wages if they had to self-isolate. 79% of homecare workers, 83% of residential care workers, and 67% of learning disability support workers stated they did not think their employer would pay their full wages in the event of self-isolation due to COVID-19 concerns. Indeed, 61% of homecare workers, 72% of residential care worker and 57% of learning disability support workers believe they would receive only SSP payments, notwithstanding their high occupational exposure to the risk of infection.

Should a care worker have, or suspect they have, COVID-19, the low level at which SSP is set (£95.85 a week from 6th April) could put a self-isolating care worker in circumstances of extreme poverty because, under normal circumstances, care workers are typically paid less than the living wage. The impact of the low level of SSP on workers in the care sector illustrates that the failure of the UK Government to improve SSP benefits has a disproportionate impact on women and is arguably discriminatory in law. Women who were experiencing minimum wage level pay prior to the pandemic, will be driven further into poverty by the inadequacy of SSP.

Many care workers in the survey reported being confused about their rights to statutory sick pay, some were worried about reprisals and bullying should they withdraw from caring duties because of experiencing virus symptoms. As the graph indicates, some care workers thought that they would be subject to disciplinary proceedings and 15% of homecare workers thought they would face reductions in their ongoing contractual hours as a reprisal for self-isolation. These findings are consistent with what is known about the widespread nature of zero-hours contracting in homecare services and the precarious nature of work across the care sector. Survey comments from care workers included:

We have been bullied and belittled and some of the communication from management has been awful and upsetting

Pressure to work, no support

Pressured to give reasons why we can't undertake home visits

Feel like I'm being pressured into work, [there are COVID-19] cases in the workplace and I have slight COPD.

Lack of availability of occupational sick pay is a considerable barrier to self-isolation in social care and it is a marker that significantly distinguishes this work group from staff employed in the NHS.

Lack of attention to the detail as to whether or not care workers are experiencing symptoms of COVID-19, and lack of regard for the need to self-isolate, appears to be at odds with legal requirements to report work-related exposure to disease. The risk, and impact, of COVID-19 must not be 'hidden' in care homes or other care and support settings.²⁹

Analysis of results: Other COVID-19 related health and safety concerns.

The care sector is currently effectively operating without regulatory oversight. The Care Quality Commission (CQC) is the regulatory inspection body for registered care providers in England. The CQC wrote to registered providers on 4th March in a letter entitled 'How we're responding to the outbreak of coronavirus'. At this point there was no mention of suspending inspections. Rather, the CQC placed importance on ongoing inspection, stating that it would focus activity on ensuring 'people receive safe care' and 'will always act in the best interests of people who use services', referring to its 'responsibility to check that the safety of service users is maintained'.

The inspection of services is not a legal obligation on the part of the CQC, however, its core functions include 'review and investigation', as per s2 and s46 of the Health and Social Care Act 2008. According to its statutory duties it must conduct reviews of the carrying on of regulated activities, assess the performance of service providers and publish a report of its assessment. The Care Quality Commission (CQC) announced the cessation of routine regulatory inspections of registered social care providers in England from 16th March. In Wales, The Care Inspectorate announced that it too would suspend routine inspections from 16th March. In Scotland, Care Inspectorate ceased inspection from 13th March, closed its phone lines from 24th March and stated complaints would be received only via email, be risk assessed and passed on to the provider about whom the complaint was made.³⁰ The suspension of inspection across the UK is concerning. Clearly inspection is difficult in the current circumstances but the safety of individuals in need of care, and the safety of workers who provide that care, may not be best served by stopping inspections. **It is precisely at the point when regulatory compliance is most difficult that attempts to maintain minimum standards are of maximum importance.**

In England, the CQC has stated that it will reserve its inspection powers for 'a very small number of cases when we have concerns of harm, such as allegations of abuse', although inspections would be undertaken differently, and physical inspection would occur only when deemed appropriate. It is to

²⁹ The Reporting of Injury, Disease and Dangerous Occurrences Regulations 2013 require that where a care worker is diagnosed as having COVID-19 because of the work they do, their employer must report this, without delay, to the Health and Safety Executive (Regulation 9). The report should be made wherever there is 'reasonable evidence suggesting that a work-related exposure was the likely cause of the disease'.²⁹ The diagnosis of the medical condition must be made in writing by a registered general practitioner (Regulation 2). The employer must also make a record of the fact that the care worker has COVID-19, and keep that record on the workplace premises for at least three years (Regulation 12). These requirements also apply to care workers who are self-employed.

³⁰<https://www.careinspectorate.com/index.php/news/5619-covid-19-update-for-complainants>

be hoped, although it is by no means certain, that a heightened risk of acquiring COVID-19 due to failures to meet the safety standards set out in the regulatory framework will be seen to qualify as a 'concern of harm' for which inspection will continue. In Wales, the Care Inspectorate has announced it will not take retrospective action for incidents arising while inspections are stopped unless these incidents occurred because of wilful neglect or deliberate harm.³¹ In Scotland however, the Care Inspectorate is adopting a proactive role in gathering information about staffing levels in care services, asking for notification where there is crucial need for PPE, documenting outbreaks of COVID-19 and counting deaths of people who use care and support services in Scotland.³²

This approach in Scotland appears to contrast sharply with the situation in England, where the CQC has ordered that care providers should not notify it of confirmed COVID-19 cases.³³ Regulation 18 Care Quality Commission (Registration) Regulations 2009 requires care providers to notify CQC of events which prevent, or threaten to prevent, providers from carrying their service 'safely and properly'.³⁴ In a clarification letter of 17 March, the CQC advised that this requirement meant providers must notify CQC 'if your service operation is being negatively affected by COVID-19'. Again, it is to be hoped – but is uncertain – that an inability to provide adequate PPE, staff shortages or non-adherence to advice about self-isolation will each be recognised as events which prevent or threaten to prevent the provision of safe services and are notified to CQC.

As we summarise below, the survey findings suggested a range of important issues in addition to PPE concerns that would warrant investigation and reporting by regulatory agencies.

Care workers believe lack of attention to minimising risk of infection in care-settings has directly contributed to outbreaks of COVID-19 in social care-settings.

A member of staff who returned from Italy was allowed to come in to work. Now staff and residents have symptoms.

After being in contact with someone in the home who had COVID-19 and passed away we are not in isolation, management haven't even contacted me to tell me he had it and passed and they are aware we do not have any protective wear. I also don't get any sick pay so I should be in isolation but can't.

Care workers' report that in some care-settings there have been few, if any, attempts to reduce risk of transmission and these risks are compounded by difficulties in achieving social distancing.

Official guidance from the Department of Health as of 2nd April recommends that care home providers should follow social distancing measures for everyone in the care home, wherever possible, and observe the shielding guidance for residents who are in the extremely vulnerable group. However, evidence from care workers suggests that social distancing is not possible in many care and support

³¹ <https://careinspectorate.wales/coronavirus-covid-19>

³² <https://www.careinspectorate.com/index.php/coronavirus-professionals>

³³ <https://www.cqc.org.uk/guidance-providers/notifications/notification-finder>

³⁴ Care Quality Commission (Registration) Regulations 2009, Regulation 18(1) and (2)(g)

relationships, even when there are no personal care tasks being performed. For example, care and support workers for people with learning disabilities reported:

The ppl I support have autism they do not understand the 2 metre gap, some also need personal care we cannot do this at 2 metres, & employers know this & as it's a day centre NOT RESIDENTIAL I do not understand why it is an essential service & cannot close.

Many people with learning disabilities are not able to follow social distancing rules and many may also need more time outside than other people. Guidance should therefore take account of this and give clear advice on how to support people safely in these circumstances.

We have had no support from higher management, service users are still attending some day Centers, we have limited PPE (gloves and aprons) we are still expected to go out on public transport with service users.

We have had to ask about stopping activities with families due to the risks of being in public places and mixing with others. The company were still willing for us to be going out mixing with others and visiting public places. Very low-grade PPE is available. Our young people don't understand social distancing due to their disabilities, so we are very vulnerable.

We do various shifts & are obviously going back to our families. We cannot maintain 2 meters apart in our job or ensure our safety from infection from fabrics etc.

Concerns about social distancing and shielding are particularly complex in homecare settings because care workers are one of perhaps many people with whom individuals come into contact. One homecare worker was concerned because:

[my employer] is not informing clients they need to stay at home to protect us and themselves.

The most recent Guidance from the Department of Health and Social Care for homecare providers was updated on April 6th.³⁵ It makes no mention of the specific ways in which homecare workers are in contact with members of the family of the individuals who use care and support services, nor that those family members are also engaged in care and recreational activities which may expose the individual and the care worker to increased risk of exposure to SARS-CoV-2. There is nothing about safe travel to work and matters of pay are addressed solely with respect of the expansion of SSP eligibility from day 1 of sickness. As one care worker observed:

Families are still visiting service users from other households when they don't need to. Some families are not shielding adults, I have dementia patients that are still be taking out to the shops etc by family just to give them fresh air. This is not essential and putting service users at risk. My employer says there is nothing they can do.

³⁵ <https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-on-home-care-provision>

However, difficulty in maintaining social distancing is, in some instances, resulting in the abandonment of any attempt to reduce transmission risk – even where staff members are extremely vulnerable to COVID-19.

We have **no** policies in place. [There are] more people in the building than normal. So we can't follow the social distancing advice. Been told we still have to come to work even if family members are showing symptoms. We have to come even if we have colds or coughs. Also, the people in the high risk categories that have been told not to work, have to work. [These are] people with asthma and COPD.

Showing respect for the human rights of care workers requires that the law is upheld. Health and Safety laws require that COVID-19 infections must be recorded as work-related diseases where there is reasonable evidence to support the likelihood of this conclusion, particularly in light of the lack of PPE and other concerns of care workers.

Care workers are concerned that measures to deal with staff shortages are accelerating the spread of SARS-CoV-2 in social care.

On 18th March, in an House of Commons opposition day debate about social care, Barbara Keeley M.P. (then Shadow Minister for Social Care) asked the government for certainty that all measures would be taken to protect care workers, provide them with PPE and provide extra funding to the sector to cover infection control costs. She said that many providers were already on the brink of collapse and there were 122,00 vacancies in the sector. Evidence reported by care workers in our survey convey their belief that staff shortages are putting staff and people who use care and support at risk. They reported this is happening because they are needed to cover shifts, for example:

A few people have expressed concerns because of coming into contact with infected people and have been told to still come to work regardless.

They also reported that staff shortages have changed routines and patterns of work in ways they believe increase risk, for example:

Staff are now working split shifts with [additional clients] now, which increases our contact with more people, more houses and it increases the amount of outdoor exposure, we are under staffed, which is why we are working split shifts, and although management are putting safety protocols in place, no one is ringing staff to check on our mental health and wellbeing, we are all stressed, anxious and worried about getting the Coronavirus or making our loved ones sick, because of not isolating.

A lot of staff coming in and going house to house to cover shifts. Not providing enough PPE.

I work a double run and my normal colleague is off. That means this week I'm with 4 other carers. Surely we should be limiting who is contact with who because there moving staff

around instead of keeping them in one house and not providing proper ppe.

They are cutting the staffing and moving staff around homes... spread everywhere

In the COVID-19 guidance for residential care provision issued by the Department of Health and Social Care on 13th March, care home providers were advised to work with local authorities to plan for a sharing of the workforce between providers. This was intended as a measure to pre-empt the effects of worsening staff shortages. However, it seems that care workers believe that a sharing of workers between care-settings presents a significant transmission risk. Comments from respondents in the UNISON survey include:

There are possible cases of COVID-19, management are telling staff its d&v. Staff are being moved around different units to work

[we are at risk] By randomly moving staff around from one residence to another. Not for the fact of staff shortages due to illness which is understandable but taking regular permanent staff from houses and moving them on somewhere else. Making it harder in my opinion to narrow down and track where the virus could of been picked up and also to whom it may of been passed on should the need arise.

[it is not safe] Because r having to work in different houses

Care workers are concerned that their reliance of public transport is likely to be transmitting the virus between care-settings and the wider community.

[care homes] still have staff coming into work on buses that are overcrowded and full of health care workers.

Getting to and from work, no taxis, daren't get in a bus for fear of getting infected. Can't walk 2.5 miles home late at night alone.

I'm on zero hours being demanded to do more than expected in a pandemic on public transport right now.

Our Recommendations

Social care regulators across the UK announced the cessation of routine regulatory inspections of registered social care providers from mid-March. This is concerning. Clearly inspection is difficult in the current circumstances, but evidence presented in this report suggests a yawning gap between the safety standards required in law and the lack of safe working practices reported by care workers. The research team finds a severe degree of diversion from regulatory standards. Routine inspections are unlikely to be the best means of sourcing information about the current crisis, but regulatory bodies should be playing a role in tracking, understanding and reporting on the present problems in social care settings. While it is critically important that action is taken to reduce the risk of infection, it should also not be forgotten that the COVID-19 emergency will impact on the safety and quality of care **beyond** the risk of infection. The manner in which people in need of care and support are cared for when they contract COVID-19 must be examined by regulators, but regulators must also not overlook how care and support is routinely being provided when the sector is facing very difficult challenges. It is also important that the trauma that is likely to be experienced by both care workers and those they care for and support in the current circumstances is not ignored in official accounts, now and in the future.

1. In response to evidence that care workers are unable to self-isolate without experiencing considerable economic hardship, and in order to save lives, the Government must make arrangements for the provision of normal wage income to be paid to all care workers who are self-isolating.

2. The evidence presented in this report shows that care workers have expert information about what is happening on the ground in care settings. This expertise is lacking at policy-level and knowledge gaps could be costing lives. We call for the urgent appointment of care workers to problem-solving roles. They can bring their expertise to bear on decision-making about the use and distribution of protective equipment in local authority areas and in decision-making about best allocation of resources including staff resources.