COVID-19 and care homes in England: What happened and why?

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Abstract
In the context of very high mortality and infection rates, this article examines the policy response to COVID-19 in care homes for older people in the UK, with particular focus on England in the first 10 weeks of the pandemic. The timing and content of the policy response as well as different possible explanations for what happened are considered. Undertaking a forensic analysis of policy in regard to the overall plan, monitoring and protection as well as funding and resources, the first part lays bare the slow, late and inadequate response to the risk and reality of COVID-19 in care homes as against that in the National Health Service (NHS). A two-pronged, multidimensional explanation is offered: structural, sectoral specificities; political and socio-cultural factors. Amongst the relevant structural factors are the institutionalised separation from the health system, the complex system of provision and policy for adult social care, widespread market dependence. There is also the fact that logistical difficulties were exacerbated by years of austerity and resource cutting and a weak regulatory tradition of the care home sector. The effects of a series of political and cultural factors are also highlighted. As well as little mobilisation of the sector and low public commitment to and knowledge of social care, there is a pattern of Conservative government trying to divest the state of responsibilities in social care. This would support an interpretation in terms of policy avoidance.
1 | INTRODUCTION

This article critically examines the policy response to Coronavirus (henceforth COVID-19) in care homes in the UK, with particular focus on England. Focusing on the first months of the pandemic—March, April, May, June—the research questions investigate the timing and content of the policy response and the factors that best explain what happened. A compound explanation of a mix of structural factors and more political and socio-cultural elements is developed. A core insight is that, whilst health and social care may be spoken of together in the UK, they are two different ‘entities’. This is true whether one takes a systemic or structural perspective or conceives of them as socially and culturally embedded. The care system functions in the shadow of the National Health Service (NHS) which enjoys far greater resource allocation and higher cultural and political capital.

Care homes are a critical case from which to view the COVID-19 policy response because of the major role they play in provision for one of the most vulnerable population sectors and also because they were recognised in advance as a high-risk setting. The relevant pandemic statistics to date are staggering. Between 2nd March and 12th June 2020, there were 66,112 deaths of care home residents in England and Wales, of which 19,394 (or 29%) are officially attributed to COVID-19 (Office for National Statistics, 2020). Once more accurate statistics become available and we have a better idea of the pandemic’s mortality trajectory, deaths of care home residents may account for between 30% and 40% of all COVID-19 related deaths in the country. In terms of excess mortality—which some epidemiologists believe to be the best measure of pandemic-related mortality (especially in countries like the UK where testing was scarce)—the mortality rate of care home residents in England and Wales from 28th December 2019 to 12th June 2020 was 45.9% up on the same period the previous year (Office for National Statistics, 2020). Not just residents but workers too are vulnerable. Care workers (which include care assistants, home managers, cooks, cleaners, inter alia) proved to have a higher risk of death from COVID-19 as compared with the general population—being twice as likely to die from the pandemic. The emerging commentary is of a parallel pandemic in care homes to that playing out in hospitals. Government’s claim to have tried to put “a protective ring around our care homes” needs to be carefully scrutinised.

This is a policy analysis, focused on government policy. For official purposes in the UK, care homes fall within the field of ‘adult social care’. Known generally as ‘social care’, the policy field is more recognisable as ‘long-term care’ in other countries. In the UK, adult social care is a broad and generic categorisation, ‘adult’ being essentially a crude age stratification to distinguish it from provision for children; it is defined to refer to care and support directed at all persons aged 18 years and over. Along with services for older people, adult social care encompasses services for disability, mental health, homelessness, domestic violence, inter alia. For the purposes of precision, England (and sometimes England and Wales) will be the article’s reference point. This is so for several reasons. First, key aspects of care-related and public health policy are devolved in the UK, making for some regionally-specific policies across the four jurisdictions. Second, statistical reporting conventions vary across the regions. For the analysis, care homes are defined following Eurofound (2017, p. 3) as: “institutions and living arrangements where care and accommodation are provided jointly to a group of people residing in the same premises, or sharing common living areas, even if they have separate rooms.” They may also be known as nursing homes or residential homes. Significant numbers of
people are involved: for care homes for older people in the UK we are talking about over 400,000 residents (for England it is around 320,000) and more than 500,000 staff (for England some 400,000) (Competition and Markets Authority, 2017; Office for National Statistics, 2020).

The article is organised into two main parts. The first part sets out the core elements of the policy response. Here there is a dual focus—content and timing—with NHS policy as a general comparator, especially for timing. Focusing on the relative gap vis-à-vis the NHS allows us to control for common explanations—like general weaknesses and preferences in government action—and extract the specific from the general. The article’s second part assembles an explanation. This draws in sector-specific factors but also—and more broadly—the political complexities and socio-cultural properties and location of social care in the English setting. The argument advanced is that English (and UK) government policy encountered a crisis in its handling of COVID-19 in care homes not just because of a failure of political leadership but also because of governance and other systemic weaknesses and relative lack of significant voice from or cultural valuing of the care sector.

2 | THE POLICY RESPONSE

In a context where policy has to operate in a new and rapidly changing situation and where no finishing line is in sight, both the makers of policy and those of us who research it must carefully assemble a set of parameters for analysis purposes. The international review undertaken by Comas-Herrera, Ashcroft, and Lorenz-Dant (2020) is helpful in setting out an ideal-type policy response. Drawing from that and especially looking at the UK/English situation, the following four questions are both penetrating and have a clear counterfactual:

a. Were care homes the target of a specific policy or action plan?
b. Were testing and monitoring available?
c. Were staffing and workforce support measures put in place?
d. Was additional funding made available and what happened to existing responsibilities?

For the purposes of assessment, the timeline is vital given the immense potency of COVID-19 which propelled it around the globe in a matter of weeks. At the time of writing, the first two cases in the UK were confirmed on 31st January 2020, the first recorded death occurred on 5th March and the first death in a care home attributed to COVID-19 was reported on 20th March. Deaths in care homes (generally understood to refer to deaths of care home residents whether in hospital or in the care home) appear to have peaked in the week ending 24th April—those for the population at large peaked a week earlier. Policy started to become active from early March, with a highly intense period from then to mid-May (see timeline in Figure 1). The article’s clock is set by the response targeted on the NHS—which started on 3rd March—and the period considered is from then to mid-June, with the week beginning 2nd March as week 1. This covers the height of the pandemic and the most intense period of policy activity. I stress that the focus is on policy statements rather than practical roll-out of policy and delivery of promised resources. This is important to note given significant disjuncture between government claims for its policy and provision and the reality on the ground. I also stress that care home agency, either in response to government policy or autonomously, is not the focus of study here.

2.1 | Guidance and action plan

The first concerted policy effort was the action plan for the pandemic which was announced on 3rd March. This was a mix of information about the virus and the four-phased response strategy adopted: contain, delay, research, mitigate. Little or no attention was given in the action plan to the adult social care system (just one mention). The
sector was included alongside first responders, employers, the justice system and educational settings. Moreover, ‘health and care’ were elided in a classic double formulation in the UK (one that is misleading because they are two different systems as we shall see). Guidance for reducing the risk of transmission in residential settings (including care homes) was published on 13th March; prior to that care homes were represented as low-risk settings for COVID-19. The 3rd March plan focused on how to maintain delivery of care in the event of an outbreak or widespread transmission of the virus and what to do if care workers or individuals being cared for show symptoms. Rather than instructing care homes to shut down, this advised them merely to deny entry to unwell visitors and those with suspected COVID-19. On 23rd March what is now known as ‘lockdown’ was announced, instituting a policy of advising people to only go outside to buy food, exercise once a day or go to work if working from home was not possible. Police were granted additional powers to use ‘reasonable force’ if necessary to implement the lockdown measures (under the Coronavirus Act 2020 enacted on 25th March). In addition, the same Act amended existing legislation, allowing local authorities significant easements of their social care duties, effectively cutting back their obligations to meet care-related need to cases where not doing so would breach someone’s human rights (in the case of England) (Foster, 2020). The ‘duty to meet care and support needs was substituted by a ‘power to meet needs’. This is a hugely significant change, for it empowers the local authorities in responding to COVID-19 to reduce their core offer and set of responsibilities in social care. Notably, the legislation or guidance did nothing to enable or encourage care homes to reduce capacity. This would have been a wise move given what we now know about how the virus is spread and the fact that care homes following ‘business as usual’ incentives to remain at full capacity probably exacerbated infection and mortality rates (an example of ‘pandemic perverse incentives’).

Not until 15th April was a specific action plan for adult social care issued for England. Prior to that the sector—and care homes in particular—came to official attention mainly as places to which recovering COVID-19 patients could and would be discharged. A core element of early government response was to free up NHS capacity through rapid discharge into the community. Care homes were one of the locations mentioned in this context. They were thus positioned and instrumentalised to solve problems for the NHS, a downstream, supposedly low-risk, receiving location in the discharge channel. It is estimated that some 25,000 patients were discharged from hospitals to care homes in England in this period (National Audit Office, 2020). It would take nearly a month for government to act on the significance of this type of downgrading approach for care homes—on 15th April it announced a correction to the prevailing policy whereby all residents of the care homes into which COVID-19 patients were being discharged would be tested (as part of the targeted action plan on adult social care) as would those being discharged from hospital. But prior to that and in particular in the
guidance issued on 2nd April on admission to care homes, it was stated explicitly that negative tests would not be required before COVID-19 recovering patients would be transferred from hospital to care homes. According to the National Audit Office (2020), it is unknown how many patients discharged to care homes in this period had COVID-19.

The action plan for social care of 15th April was directed at all settings in which adults receive social care (therefore drawing in a wide array of settings). It announced a four-pillar approach: controlling the spread of infection; supporting the workforce; supporting independence, supporting people at the end of their lives, and responding to individual needs; supporting local authorities and the providers of care. Reading the action plan suggests that at that stage the UK policy was in control mode rather than prevention mode. Indeed, one could question whether there ever was a prevention phase for care homes in the UK for on 12th March the government announced that it was moving to the second—delay- phase. This meant abandoning the WHO’s standard containment approach of: find, test, treat and isolate (Scahy, Jacobson, & Abbasi, 2020). In addition, whilst a wide range of actions are mentioned in the action plan, there was limited targeting of care homes as particularly vulnerable. It would be a further month before a specific care home support package was put in place (on 15th May).10 This was in week 11 (starting the calendar from the first policy action in the week beginning 2nd March). In the intervening time much had been done for the NHS including: an appeal for retired staff to return to the service (on 20th March, week 3); a deal with private health care providers for extra beds, ventilators and staff (21st March, week 3); writing off of £13.4 billion of NHS providers’ debt (1st April, week 5); first NHS Nightingale Hospital (of 7) opened in London (3rd April, week 5).11

2.2 Monitoring

Monitoring in the form of testing but also counting mortality was a particularly weak and contentious point in the UK’s response, with much disputatation of government claims about the extent of testing and achieving testing-related targets. In effect, government policy made testing for the virus a very scarce resource for all, from 12th March effectively confining testing to those on the cusp of or already accepted for hospital admission (for which a high symptomatic threshold was set). Throughout March there was no specific procedure for monitoring the extent of the virus in care homes—only on 2nd April (week 5) was guidance issued on procedures for admissions and care of residents in care homes. This introduced what might be called a ‘light touch monitoring regime’ of in-house measures. Care homes were advised to assess each resident twice a day by checking for the usual COVID-19 symptoms. Only if they had two or more symptomatic residents were they obliged to report it to the Health Protection Team. Even this was no guarantee that a test would be forthcoming, however.

On 15th April government (as part of the adult social care action plan) announced that testing would be offered to everyone in social care settings eligible for it. This was the first specific targeting of testing on social care settings, even though an ambitious testing regime for NHS staff had been launched on 17th March and reinvigorated on 2nd April. Limits on testing capacity meant tests started to be rolled out to symptomatic NHS staff from 27th March only. This was extended to care workers on 15th April and to the rest of their households 2 days later (National Audit Office, 2020). From 28th April, all care home staff were made eligible for tests but the Department of Health and Social Care capped the daily amount of care home tests at 30,000, to be shared between staff and residents. A new digital portal for care home specific testing was announced on 11th May, with priority for those catering for people aged 65 and over.12 This was one of the first measures targeting the over 65s and can be taken as recognition—in week 11—that the testing policy was failing.

In a report issued by the National Audit Office on 12th June it is stated that the government does not know how many NHS or care workers were tested in total during the pandemic to that date (National Audit Office, 2020). What is clear is that the four main opportunities for prevention of transmission to care homes—through early lock-down of care homes, the non-transferral of COVID-19 and other patients from hospitals, measures to monitor and test, measures to prevent staff from spreading the virus—either came too late or were missed altogether.

Apart from tracking and diagnosing, counting and reporting mortality rates are crucial to monitoring. The UK has manifested special difficulties in this regard, the lack of widespread testing increasing the potential to under-record the
virus-related death rate. This is why excess mortality is so important as a measure in the UK context. But there are other problems as well, especially to do with procedures and mis-alignments between how COVID-19 related deaths in hospitals and in community settings are reported. To address this and render the statistics more accurate, on 15th April a new data series on deaths in care homes was set up. This included evidence which the Care Quality Commission (CQC) was receiving directly from care homes in compliance with statutory notification procedures (Office for National Statistics, 2020). It was only for the week beginning 20th April (week 8) that mortality statistics included deaths in care homes (prior to that deaths in hospitals were taken as the public record). Their inclusion came as media (broadly defined to include also scientists/academics’ use of the media to raise issues) began highlighting a deteriorating situation in care homes. When released retrospectively, the weekly statistics, particularly those from 3rd April to mid-May, showed exponential increases in COVID-19 deaths in care homes as well as in excess mortality, with the latter especially skyrocketing from early April. Significant upward revision of statistics announced earlier—particularly to take account of deaths in community settings—became a regular feature of the reporting scenario in this period.

It took nearly two months, then, for the deaths in care homes to be included as part of the official death toll announced each day by the government; doing so significantly changed understanding of the virus. As things stand, many questions have been raised about data inconsistencies and omissions, mainly around the number of deaths in care homes attributed to COVID-19 and how to assess and understand excess mortality in the community—which is largely excess mortality in care homes—during the pandemic (Comas-Herrera & Fernández, 2020).

2.3 | PPE, staffing and working conditions

The availability of Personal Protective Equipment (PPE) became another major flashpoint, with much on-the-ground skepticism by health and care service staff regarding governmental claims about widespread PPE availability. The normal supply chain was operated—through the NHS Trusts (which mainly channel resources to the health system). Only on 6th April (week 6) were there moves to direct PPE to care homes. Even this did not prioritise them though because, again, they were included alongside other providers such as hospices, residential rehab and community care organisations. A cross-government plan to ensure that PPE is delivered to so-called ‘frontline workers’ was published on 10th April. Care homes were mentioned here as amongst the 58,000 relevant providers, included alongside GP surgeries, hospices and other community providers. Only from 15th May were bespoke supply routes and specific guidance for care homes regarding PPE announced. This was part of the first care home-specific measure, a relatively late response to the evidence that PPE supply was minimal in care homes (with supplies in the NHS more widespread but also inadequate).

Staffing levels were given attention in the action plan. A capacity tracker introduced as part of the 15th April plan is to be used to monitor workforce absences as well as other resources (bed capacity, PPE levels and overall risks in care homes). The ambition was stated also to attract 20,000 people into social care employment over the (then) upcoming 3 months. This was to be achieved by a new national recruitment campaign, targeting returners to the sector, as well as new starters who may have been made redundant from other sectors, and those able to take up short-term work. As well as the tracker, the plan included another innovation: the development of a new online platform to give people who want to work in social care access to online training and the opportunity to be considered for multiple job opportunities via a matching facility.

2.4 | Funding and responsibilities

Funding for social care and care homes is a complex mosaic in England (and the UK as a whole). Looked at from the perspective of the service providers, funding comes via local authorities which commission the services but also, and increasingly, from so-called ‘self-funders’ (residents who pay privately). Local authorities obtain their funding from
three main sources: block grants from government; monies raised though taxes levied locally (the household Council Tax and rates paid by businesses for example); user contributions (through means-testing for services for example). Local authorities also obtain some funding from the NHS and other joint arrangements for the social care they provide. How they expend these funds to carry out their duties is largely up to them, provided they meet their statutory obligations. But spending is typically the subject of a highly-politicised negotiation at council level (especially in the austerity environment that has prevailed in the UK up to this year).

Extra funding for social care was part of the government’s early pandemic response. On 19th March some £2.9 billion additional funding was allocated “to strengthen care for the vulnerable” in England. Of this, £1.6 billion was for local authorities to help them respond to COVID-19 pressures across all their services, including adult social care (the remaining £1.3 billion was for the NHS to enhance discharge from hospitals). A further £1.6 billion to help English local authorities to respond to the pandemic was announced on 18th April. All of the £3.2 billion was to be shared widely amongst the services offered by the local authorities (including those for homeless people and a range of other services targeted at those considered vulnerable). Finally, targeted funding for care homes of £600 million was announced on 13th May as part of a new infection control fund and a ‘care home support package’ (announced on 15th May). The funds are intended especially to allow care homes to employ additional staff and pay for restrictions/constraints on staff movement and deployment (in order to reduce the risk of transmission).

Taking an overview, it is worth pausing for a moment to be precise about what is to be explained here, and which factors might be considered as causal. In terms of the former, there are two outstanding features of the policy response for care homes: its relative slowness, lateness and reactiveness in relation to the NHS; the inadequacy of the focus on care homes. To turn to possible explanations, the situation as described is generally true of all of the UK (apart from perhaps lockdown policy), so devolution is not a major part of the explanation (although there were some variations between the devolved regions). The political ideology of government is another potential causal factor. The neo-liberal orientation of the Johnson government certainly made lockdown slow to happen and its shifting ‘reading’ of the pandemic and the resources needed to address it led to inconsistencies, gaps and errors that cost lives. But government (in)competence and political handling of the virus are insufficient in themselves as explanations for the slowness and nature of the response to care homes. For a comprehensive explanation, I suggest examining two main sets of factors: structural/logistical and political/socio-cultural (see Figure 2). I do not ignore the role of government reaction but rather integrate it into the broader explanatory landscape in terms of the existing system and politics which enabled and, to some extent foretold, the response.

3 | EXPLAINING DEVELOPMENTS

3.1 | Systemic/structural factors

3.1.1 | Two separate (and complex) systems

Arguably, the COVID-19 virus required an integrated response, one crossing health and social care. But this was highly unlikely in a policy setting characterised by a long-standing, systemic divide between the two. Despite a common heritage in the Poor Law—local provision for poor or destitute people—they have been growing apart since the middle of the 19th century. Publicly funded health services came to be provided free of charge whereas local authorities retained the right to charge for social care services (Thane, 2009). The 1946 Act establishing the NHS and the National Assistance Act 1948 were especially significant in institutionalising the divide, in several respects. The NHS was established as a national service whilst social care remained under the auspices of the local authorities. Second, whereas providers of health care were public entities, social care provision was a mixed system, either directly delivered by the local authorities or through independent providers contracted by them. Third, the NHS was and is a centralised, tax-funded service free for all whereas social care is local, dependent on a test of means (as well as [dis]
ability) and is in significant respects privately funded. Amongst other things, this means two separate funding, governance, legislative and service regimes.\footnote{Having two systems is not fatal (and indeed is relatively common in Europe [Incisive Health, 2018]), provided there is co-ordination between them. However, the border between health and social care in the UK can be accurately described as a ‘hard boundary’ (Lightfoot, Heaven, & Henson Gric, 2019, p. 41). Its deep institutionalisation can be appreciated from the fact that, in the past 20 years, integration has been the subject of some 12 white papers, green papers and consultations, and five independent reviews and consultations (House of Commons Committee of Public Accounts, 2018). Whilst the NHS/social care interface or indeed integration are talked about and planned, there are grounds to be sceptical about the degree of commitment to integration. First, the resources given to their achievement are relatively small and there is a high usage of pilot and localised initiatives. Second, they tend to be technical and bureaucratic initiatives, removed from democratic accountability. “Different organisations with different budgets working under different policy guidance have found it difficult to work effectively in a joined-up manner” (Lightfoot et al., 2019, p. 23).

The significance of a systemic divide in COVID-19 times is that it hampers joined up functioning and resource flows. There are many examples of relative failures of the channels or supply routes for testing and PPE for both hospitals and care homes. But the failure was greater in the latter and this was caused, partially anyway, by the fact that care homes are not part of the routine supply channel for the NHS. Two relatively ‘silied’ resourcing and provision channels were operating, with that of the NHS by far the better resourced.

There is another aspect to logistical or efficiency issues as well. The social care system and care homes in particular are embedded in a long and complex policy/governance chain. Although statutory responsibilities mainly lie with 152 local councils/authorities, the Department of Health and Social Care retains significant authority. One has to factor in also the existence of a separate route for quality monitoring and resident safeguarding: this is the function of the CQC which is constituted as an executive, non-departmental body of the Department of Health and Social Care. To be properly understood, this complexity should be placed in a recent history of shifting government

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positions on centralised versus localised responsibilities in regard to social care and also public health. Blurred lines and channels of authority made for some key logistical and governance vacuums in the pandemic and—whilst evidence about what happened on the ground is still not available in sufficient detail—it does appear that government was inconsistent and confused about the degree of reliance it placed on local (authority) versus national channels and supply routes and oscillated between a heavily centralised response and expecting a more bottom-up one.

There is also, though, a tradition of weak governance in the field. To function well any governance system needs resources such as detailed strategic knowledge of its sector. Robust strategic knowledge is not available for the care home sector in England (or the UK). Why is this? The sector is private and largely market based. Some 97% of beds in all care homes in England are provided by the independent sector—commercial for-profit (84%) and charity-run (13%)—with only 3% operated by local government or the NHS (Blakely & Quilter-Pinner, 2019). Trends over time describe a rapid financialisation of the sector, characterised as an increasing encroachment of financial motives, financial markets and financial institutions, with larger for-profit companies (which tend to have very complex corporate structures) especially gaining a greater foothold. And all the time the central state passes on the responsibility, devolving it to the local authorities which in turn outsource social care provision (Blakely & Quilter-Pinner, 2019). Whilst local authorities have a statutory duty to undertake market oversight (e.g., monitoring the performance and finances of the providers), research suggests that as a result of both the complexity of larger, private, equity-owned care providers and the capacity and capabilities of local authorities, this is an unrealistic expectation (Blakely & Quilter-Pinner, 2019). There is no other market regulation and most of the information available comes from private market analysts (such as Laing-Buisson). This feeds into and off a ‘habit’ of weak regulation, especially of the market in care homes. This may also help explain the rather ‘hands-off’ approach taken to care homes during the pandemic. Compare this to the NHS—where: (a) far greater information exists; (b) this information is readily available to government planners; and (c) there is a strong tradition of regulation.

Apart from structural complexity and weak regulation, there is also the very large matter of resources.

### 3.1.2 Under-funding, under-resourcing and austerity

The sector—like the UK generally—has been exposed to austerity policy since 2009/2010 and this has significantly weakened capacity for decision-making and resourcing as well as service provision.

In the UK the system of public funding of care is supply rather than demand led. Although local taxes are the main source of revenue for local authorities, there is a fundamental dependence on central government funding. Almost 10 years of austerity policy oversaw an estimated funding reduction of 49.1% in real terms to local government, with the cumulative reduction forecast at 56.3% by 2019/2020 (National Audit Office, 2018). This did not translate directly into falls of the same magnitude in adult social care services, for two main reasons. First, local authorities sought to protect adult social care services in their spending cuts and they were also enabled by government to raise additional revenue through local taxation from 2015. Second, funding pressures were somewhat eased because recent governments (all Conservative led) were forced to commit additional resources to stem potentially catastrophic shortages. As a result of both protecting the sector and additional monies, local authority spending on adult social care services in England reduced by only 2% in real terms between 2009/2010 and 2018/2019 (Atkins et al., 2019). However, this still represents a severe shortfall in income when the growing demand from an ageing population and rising costs are factored in. The hard reality is that adult social care services in England are estimated to face a £1.5 billion funding gap in 2020/2021, and £6 billion by 2030/2031 (at 2018 prices) (Bottery, Varrow, Thorlby, & Wellings, 2018). This was pre-COVID-19—a recent report calculated that the sector will face an extra £6.6 billion in costs due to COVID-19. There are no stated plans to meet the pre-existing shortfall and in the meantime dependence on time-limited, emergency funding grows. The comparison with the NHS, again, offers a strong contrast. Although it too has experienced major funding shortages, a multi-annual funding plan was put in place, prior to the pandemic. The settlement announced in June 2018 would
increase the NHS England budget by 3.4% a year on average in real terms between 2019/2020 and 2023/2024 (Atkins et al., 2019, p. 41).

Notwithstanding some financial easement, the austerity-induced cuts did significantly undermine the social care sector and, directly and indirectly, impacted the capacity to respond to the crisis. This is because the local authorities, whilst protecting the adult care sector, were underfunding both other services and their own resources (using up their financial reserves, cutting staffing and infrastructural resources). This affected their governance and resourcing capacity, including that in public health (Scaly et al., 2020). In sum, prior to the pandemic, the local authorities and the social care sector had experienced nearly a decade of austerity and were continually propped up through special interventions or increasing marketisation. The sector was in no fit economic or structural state to meet a major challenge.

### 3.2 Political and socio-cultural explanations

Part of what has to be explained about the policy response to care homes centres around the government’s downgrading of the significance and vulnerability of care homes in the pandemic. Whilst we do not yet know how the official advice given by the expert SAGE committee affected policy, an interpretation of the government response as politicised is credible. Both sectoral and socio-cultural politics are involved.

#### 3.2.1 Social care as a relatively depoliticised field

If we accept the government response as political, one set of factors that helps explain the priority given to the NHS over social care and care homes relates to differences in the degree of political mobilisation of the two sectors during the ‘shock’ weeks of the pandemic. During this period, the social care sector was relatively poorly mobilised and generally ‘quiet’. This is at least partly explained by the fact that there is no overall convening advocate or voice for care homes. And in the ‘system’ as a whole, the platforms that exist are sub-sectoral. Two such platforms dominate the rather sparse field: those of the local authorities and the commercial providers. Both were vocal during the pandemic period covered by this article, especially the latter, but they ‘discovered’ their voice quite late in the day. In another difference to the health sector which has very strong professional organisations and trade unions, social care workers are poorly organised. There is a national association of care and support workers but this is small and, whilst some of the workers are unionised, most are not. There is a carers’ association, representing mainly informal carers and cohort or age group organisations (such as Age UK) also exist. But, again, unlike health which has many patients’/clients’ organisations and platforms for patient feedback, there is no national representation of the voices of those receiving care in care homes. To all intents and purposes then, the sector is unorganised representationally and so there was little push from this source against government policy.

What about broader political resonance?

Despite its name, social care is for many in the UK a private good and this, amongst other things, complicates the politicisation around it. Looked at from a social politics perspective, a core feature of the system is limited risk pooling. Local authorities typically only fund packages of care for adults assessed as having high needs and limited means. They operate two thresholds to entry: level of disablement and income and means (with a cut-off of income/assets in excess of £23,250 annually). Around 41% of residents in care homes (in the UK as a whole) fund their care privately (self-funders) and a further 12% pay top-ups. So care home residency or future residency does not mobilise a particular constituency and solidarity has no convening political power. The contrast with the NHS is striking: ‘risk pooling’ is a core organisational and political principle—everyone contributes to total costs through taxation and people receive the amount of care they are deemed to need, however expensive that is.
With scarce interest group or wider political organisation, there was little 'political clamour' until the infection and death rates in care started to be reported in early- to mid-April. The media played a major role in shaming the government into action but it was the sharply rising death toll that was the main spur to action.

There was also some likely policy avoidance involved. Social care had been effectively 'parked' by the previous Theresa May administration, which had been damaged in the 2017 election by its proposal to increase the amount that people would have to pay for social care. Prior to that reform had been frozen by the various Conservative-led governments which have failed over their 10 years in office to come up with a credible plan to resolve the many problems in the sector. Whilst the Labour Party's long-term position is for a nationally-funded service, the Conservative Party is riven by division over the threshold for the means-test and whether there should be a lifetime cap on how much an individual will pay for care (which is currently unlimited). Social care, therefore, is a policy field in which government was reluctant to get involved.

### 3.2.2 Socio-cultural factors

Cultural politics also have a critical part to play in explaining the relative neglect of care homes and adult social care in the pandemic response. And here we see politicisation on the part of the government clearly at play. It was government strategy to place the NHS front and centre in its battle cry (it favoured bellicose idioms); in the discourse representing it as vulnerable. Government's main slogan—repeated ubiquitously on all public information from early March to 10th May—'Stay Home—Protect the NHS—Save Lives'—illustrates this kind of thinking and messaging. Whilst reference to the NHS did not survive the change of messaging in England from 11th May (Stay Alert—Control the Virus—Save Lives), neither care nor care homes ever received any public billing or specific recognition. In this and almost every other communication, the main terms and measures pertinent to both health and social care were given a primary reference to health. In the process, the term 'carer'—not a label normally adopted by health service personnel who tend to prefer professional titles—was appropriated for care in a health setting (although its meaning did open out over time towards more inclusive terms such as 'frontline workers' or 'key workers').

All of this draws from deep cultural politics which locate and construct health and social care in very different narratives. There are at least two dialogues in relation to the NHS, and both are relatively positive. One, predating but carried through in the COVID-19 representation, is about the NHS as being at risk, especially from underfunding, austerity and the creep of privatisation. The Brexit referendum was a focusing event with a prominent promise by the Vote Leave campaign that the monies saved by not having to make the EU funding contribution could be spent on the NHS. But public concern about the NHS dates much further back and has to do not just with public awakening to the fact that the system might be at risk (mainly from Conservative policy of austerity and privatisation) but also people's sense of their own entitlements in this context. The meaning of health as a right has depth in the UK, unlike, say, welfare benefits where public opinion has shifted and the rights perception of social security has diminished. Social care is at best a weak social right (Daly & Lewis, 2000). A second and related dialogue construes the NHS as public property, associated with the British nation. Despite considerable criticism, the NHS has assumed the status of a valued cultural entity in the public imagination, an icon of Britishness.

By comparison, social care is a poor shadow. It lacks a clear public identity—on 2018 evidence nearly half (48%) of adults in England have little or no understanding of what the term 'social care' means. And social care does not have a positive image as a public good. Unlike the NHS where 83% of the population said they would support additional spending on health (in 2016), public opinion surveys suggest a bifurcation in support for social care with most people (55%) favouring options where responsibility for care is shared publicly and privately, although a sizeable 41% favour government funding (paid for by taxes) (Bottery et al., 2018). It is also noteworthy that a half of...
English adults say that they have never thought about how they will pay for care when they get older and only 15% say they have made any plans in this regard (Bottery et al., 2018).

Against such a backdrop one could see government making a calculated decision that there was a real possibility that its policy on care homes would not generate much (negative) political reaction.

4 | CONCLUSION

The treatment of care homes in the COVID-19 pandemic in the UK is fast generating the sense of a scandal. The analysis undertaken here, which focused on explaining the government’s policy response rather than the outcome of the pandemic per se or what care homes did, showed that it is the slow, late and inadequate response to the risk and reality of COVID-19 in care homes as against that in the NHS that has to be explained. Policy inadequacy and relative downgrading are found right across the policy elements considered here: the specific targeting of care homes, monitoring and testing, staffing and working conditions or funding. The NHS was front and centre of the national response, whilst care homes were poorly targeted and in many senses neglected until late in the pandemic when a response was unavoidable.

Undoubtedly, part of the explanation for this lies in government ineptitude and erroneous policy choices. Boris Johnson and his government made many mistakes which included a generally delayed response and jettisoning of a preventive strategy very early on. Causation is more complex though, especially if our focus is on the relative policy inaction around care homes until infection and death rates began to pile up and the subsequent inadequacy of the response. In the preceding pages, I have suggested a compound explanation for this situation, pointing the explanatory dial towards a mix of both structural and politico/socio-cultural factors. Amongst the relevant structural factors are the complex systems of provision and policy prevailing in adult social care and the deep separation from the health system. These make governance complex, having to operate different supply routes and governance channels. In the event, government policy was confused about the appropriate response, sometimes using centralised and at other times localised decision-making and resource channels. One must also factor in how logistical difficulties were exacerbated by years of austerity and resource cutting which, amongst other things, have depleted local authorities' resources and capacities. But the weak regulatory tradition of the sector also contributes to explaining the inadequacy of the response. Care homes and social care in general are far down the chain of public policy and the majority are market providers which see relatively little regulation (other than some monitoring of quality and safeguarding). Explanation also extends wider, to take account of a series of political and cultural particularities which see the NHS and health care elevated to a high plane in public opinion and national politics, whereas social care is in comparison the ‘Cinderella service’ (Lightfoot et al., 2019). In social care in particular, there is a trend of government, especially Conservative government, trying to divest itself of responsibilities and, moreover, the social care policy story in the last decade is one of relative reform failure on the part of successive Conservative governments. All of this points to a role for avoidance of the social care field as part of the explanation for the policy response to COVID-19 suggesting, in addition, a possible calculation by government that its policies towards the care sector and care homes were far less important than those for the NHS and policy errors would not ‘hurt them’ as much as would NHS mistakes or mis-steps.

Many of the deficits identified in this article have been addressed in the interim period but all by short-term, stop gap measures. Nothing has happened to suggest that what I have recounted is past history or that the structural, political and cultural barriers have been overcome. The UK needs a new model of care for older adults. The large and diverse network of independent providers does not look like a resilient form of provision and is likely to have become even less resilient following the pandemic. Ultimately, the country has to answer the question of what is an acceptable way of caring for its older people and view the pandemic outcome as associated not just with short-term failures of policy and political leadership but a much deeper undervaluing of the came home sector, the activity of caring and those who require care. Long-term care policy has to become a meaningful part of the British welfare state in which the rights and entitlements of those involved are given a central place, unseating the far more dominant risk, exigency and need perspectives.
ACKNOWLEDGEMENTS

I would like to thank Ertugrul Polat for invaluable research assistance and comments. The comments of Gemma Hughes and those of the journal’s reviewers are also acknowledged with thanks.

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ENDNOTES

1 https://www.theguardian.com/world/2020/may/07/revealed-the-secret-report-that-gave-ministers-warning-of-care-home-coronavirus-crisis.
2 Based on COVID-19 reported deaths in England and Wales between 9th March and May 25th, 2020; see https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020.
3 https://www.health.org.uk/news-and-comment/charts-and-infographics/deaths-from-any-cause-in-care-homes-have-increased?gclid=EAIaIQobChMi8_SWwwfmw6gVSLDrCh0rNQpOEAYASAAEd6YID_BwE.
4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869827/Coronavirus_action_plan_-_a_guide_to_what_you_can_expect_across_the_UK.pdf.
5 https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance.
6 https://www.gov.uk/government/publications/guidance-for-social-or-community-care-and-residential-settings-on-covid-19/guidance-for-social-or-community-care-and-residential-settings-on-covid-19.
7 https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan/covid-19-our-action-plan-for-adult-social-care.
8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf.
9 https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes.
10 https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package.
11 See https://www.health.org.uk/news-and-comment/charts-and-infographics/covid-19-policy-tracker.
12 https://www.gov.uk/government/news/government-launches-new-portal-for-care-homes-to-arrange-coronavirus-testing.
13 https://www.health.org.uk/news-and-comment/charts-and-infographics/deaths-from-any-cause-in-care-homes-have-increased-by-99-per-cent.
14 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending24april2020.
15 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879221/Coronavirus__COVID-19_-_personal_protective_equipment__PPE__plan.pdf.
16 https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package.
17 https://nationalcareassociation.org.uk/news-events/news/covid-19-statement-from-the-board-of-national-care-association.
18 https://www.gov.uk/government/news/2-9-billion-funding-to-strengthen-care-for-the-vulnerable.
19 This would also see additional monies to Northern Ireland, Scotland and Wales. See: https://www.gov.uk/government/news/government-pledges-extra-16-billion-for-councils.
20 https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package.
21 Note that Northern Ireland is a UK exception, though, as it has had integrated structures for health and social care since 1973.
22 Note regional differences in this regard: as of 2017 in England 3.2% of the homes were in the public sector, in Northern Ireland it was almost 10%, in Wales 13.5% and in Scotland 15.3% (Lightfoot et al., 2019, p 28).
That year a Social Care Precept was announced enabling local authorities to increase council tax levels by up to 2 percentage points—any monies raised had to be ring-fenced for spending on adult social care.

https://www.localgov.co.uk/Social-care-is-running-out-of-cash-experts-warn-/50642.

On the local authority side there is the Local Government Association and the Association of Directors of Adult Social Services. On the providers’ side there is a number of associations and groupings, many of which speak for a relatively small number of mainly commercial providers. These include Care England, the Care Provider Alliance, National Care Forum.

https://www.kingsfund.org.uk/publications/how-have-public-attitudes-to-nhs-changed.

https://www.local.gov.uk/about/news/majority-people-unprepared-adult-social-care-costs.

https://www.kingsfund.org.uk/publications/how-have-public-attitudes-to-nhs-changed.

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How to cite this article: Daly M. COVID-19 and care homes in England: What happened and why? Soc Policy Adm. 2020:54:985–998. https://doi.org/10.1111/spol.12645