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UKRI Economic and Social Research Council

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Bailed out and burned out?

The financial impact of COVID-19 on UK care homes for older people and their workforce

FICCH Financial Impacts of Covid on Care Homes
Implications for businesses and the workforce

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Voices from the frontline

From a survey and interviews conducted in spring 2022:

> *"I get my sense of good feeling from what my residents say to me if I walk into a room and they [clap] 'Oh, it's you!'"*
>
> (Care worker)

> *"I worked for two solid weeks with just a nurse on a dementia [unit]. (…) All 24 residents had COVID and half of them passed away within the two weeks. We had no cover, zero support from management or anyone else."*
>
> (Survey respondent)

> *"Our vacancy rates are much higher than they've ever been. Our [staff] turnover rate has gone up to about 33%, and we had it down at about 18% before the pandemic. We've had lots of staff leave through exhaustion, disillusionment, illness, and all of those sorts of things. Not being able to have staff move from one home to another, including agency staff, has meant that we've been chronically understaffed and asking staff to go the extra mile for over two years, which is too long to put pressure on people."*
>
> (Senior manager in a medium-sized not-for-profit organisation)

> *"We will probably change our registration so that we no longer offer nursing care because it's unsustainable, we can't get the nurses (…) when we're paying our starting salary for nurse of £21 an hour, it's a good rate of pay and we can't get good nurses"*
>
> (Senior manager in a small for-profit organisation)

> *"We've gone from a budget of £400,000 a year on agency spend to an actual cost this year (…) of over £3.2 million."*
>
> (Finance Director in a small not-for-profit organisation)

> *"The first three months of the pandemic, we didn't get anything at all. Then the grant funding started, which covered some of the cost. Then it increased, which covered most of the costs. And it's now ramping back down, so we're now in a net deficit again going forward, probably, from – around the autumn that's just gone past, through into next spring."*
>
> (Owner-manager in a small for-profit organisation)

> *"What's really hit providers is there's no financial compensation for effectively being told to cease trading [during outbreaks]."*
>
> (Senior manager in a medium-sized not-for-profit organisation)

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Key facts: Care homes for older people in the UK in the first year of the pandemic

377,800 – the total number of available beds in UK care homes for older people at the start of the pandemic

42,341 – the number of care home residents who died as a result of COVID-19 between March 2020 and April 2021

1,290 – the number of social care workers (including those working in domiciliary settings) who died as a result of COVID-19 between March 2020 and February 2022

60% – the percentage of care home beds for older people in the UK operated by companies which would be at risk of insolvency in the event of a mild economic shock

8% – the average reduction in occupancy in care homes for older people during the first year of the pandemic

£2.1 billion – the total amount of additional financial support for care homes for older people across the UK given by central, local and devolved governments as part of the pandemic response

£114 million – the total amount of furlough payments claimed by the care home sector for older people to support vulnerable staff who were shielding and unable to work

£174 million – the value of the free Personal Protective Equipment (PPE) provided by central government to the care home sector in England during the first year of the pandemic

80% – the percentage of surveyed care workers who reported working more hours during the pandemic than in the previous period

42% – the percentage of surveyed care workers who reported financial problems related to working in care homes during the pandemic

50% – the percentage of care workers who reported that their ability to meet residents' needs worsened during the pandemic

£120m – the amount paid out in dividends by 122 companies providing services to older people after the first year of the pandemic, an increase of £11.7m or 11% on the previous year

300% – the predicted increase in insurance costs for some care home companies because of the pandemic

11% – staff vacancy rates in residential care homes in January 2022, up from 6% in April 2021

Executive Summary and Recommendations

Care homes provide an essential public service to hundreds of thousands and employ over 600,000 people across the UK. Their financial stability matters: poor financial health can put pressure on staff and managers, lead to deteriorating service quality, or cause home closures, which can lead to very serious disruption for residents and staff and reduce the overall number of care homes available to meet the population's growing needs.

The financial health of the UK's 8,700 care homes for older people – 80% of them provided by for-profit companies – is, therefore, a significant matter of public interest. Although many residents in the UK's care homes are required to pay for their own care, public funding still makes up half of the sector's annual income, and so the functioning of the care home sector is highly dependent on financial support from government, particularly during a public health emergency.

Ensuring the financial viability of the care home sector and the well being of the care workforce must therefore be a key part of any pandemic response, particularly given the high vulnerability of people living in care homes.

This report examines how the UK's care homes for people aged 65 and over have been affected by the economic shock caused by the COVID-19 pandemic. It reviews the extent and effectiveness of government support prior to, during and after the peak of the pandemic, as well as the way care home companies responded to this challenge.

It also explores how staff experienced these financial impacts in terms of their workload, their well being, and the quality of care they were able to deliver in the various phases of the pandemic.

In general our research finds that despite clear warnings that the financial impact of a pandemic on the care home sector would prevent care home services from functioning effectively, there is no evidence that government had any contingency plans in place to address this challenge. This meant that care home companies did not know how much financial support they could expect or how it would be administered, which added avoidable burdens of stress on care home owners and managers at a time of significant trauma.

Financial support provided by the government during the first year of the pandemic mitigated the worst effects of the pandemic on the financial viability of the care home sector. However, the decision by government to end financial support for care home companies after the peak of the pandemic had passed has likely contributed to the current financial and operational difficulties experienced by the care home sector, with wider consequences for older people and the healthcare system.

The financial viability of the care home sector was partly dependent on care workers working harder and longer. However, there was no general increase in hourly pay. Some even faced reduced income as benefits were cut if they worked more hours. Very little of the additional financial support for the care home sector from government was dedicated to supporting staff and improving their health and well being, despite the immense pressure they were under both at work and in their personal lives. It is therefore not surprising that the care home sector has struggled to both recruit and retain staff since lockdown restrictions were removed and the wider economy re-opened.

Methods

This report is based on interviews and a survey of care workers and an analysis of company accounts filed with Companies House in the period prior to and during the first year of the pandemic. We examined all the publicly available financial data for care home companies, including all the publicly available financial data for accounts of 4,013 care home companies across the UK, providing 377,856 beds for people aged 65 and over. The data is drawn from accounts filed with Companies House by a range of organisations providing care on both for-profit and not-for-profit bases, all of which are described here as 'companies'.

The report also draws on a survey of 605 care home staff across the UK conducted between October 2021, and April 2022. Our survey sample was sufficient to produce statistically significant results, but given the diversity of the care workforce and of care homes around the UK, as well as the complexity of the issues at stake, our results should be treated only as indicative. In-depth qualitative data comes from interviews with 43 care home staff, including workers, managers and senior managers between December 2021 and April 2022. Unless otherwise stated, findings refer to care homes for older people across the UK. (See the Annexes for more details about the methodology.)

Key findings

Our research found the following:

1) Although care homes were financially fragile prior to the pandemic and the likely impact of a pandemic on their financially viability was well known, government failed to plan for the economic shock which hit the sector in March 2020.

- It was highly predictable that a pandemic affecting the older population would significantly impact the finances of the care home sector: revenue would decrease due to higher deaths and to fewer people being admitted to care homes, whilst costs would increase due to the introduction of enhanced infection control measures, such as cleaning and the provision of PPE, and additional costs associated with covering for sick or absent staff.
- Based on the pre-pandemic financial situation of the UK care home industry, we estimate that a 5% increase in costs and a 5% decrease in revenue caused by a pandemic would mean that companies operating over 60% of all care home beds would be at risk of significant financial distress.
- Despite this we can find no evidence that government planned for this in their plans for a pandemic. Due to poor data collection, the government had limited knowledge of the overall financial health of the care home sector for older people, or of how much public funding might be required to avoid significant financial difficulties.
- Government also lacked effective mechanisms to deliver funding, meaning that extra funding was slower to reach care homes, more burdensome to administer, and less precisely targeted than it should have been.

Government financial support for the care home sector came with more restrictions than for the NHS and other businesses.

- Despite providing a critical public service, care home companies had to comply with complex rules on state subsidies and other accounting restrictions to receive financial support, and some care homes had to employ staff to apply for it.

- A chief focus of the government's Infection Control Fund (ICF) was not to support the financial viability of the care home sector, or to support care workers, but to enable care home companies to comply with infection control regulations.
- In contrast, financial support for the NHS and other businesses was provided much more swiftly and often without conditions.

2) Government financial support worth over £2 billion meant that the sector avoided financial collapse during the peak of the pandemic[i].

Because of government financial support the overall income for most care homes in the first year of the pandemic remained broadly the same as in the previous year.

- In total the governments in England, Scotland, Northern Ireland and Wales provided the care home sector with an estimated £2.1 billion in support during the first year of COVID, worth around £5,900 per bed. This support included financial support from local authorities and the devolved governments as well as the Infection Control Fund and the Coronavirus Job Retention Scheme ('furlough').
- Despite an estimated reduction in occupancy of around 8% during the first year, this additional income, along with some increase in fees from private payers, meant that in both the for-profit and the not-for-profit sector overall revenues remained the same. Moreover, for more than half of care home providers (60%) total revenues increased.

To ensure their viability, some care home providers reduced their operating costs, including staffing costs, although there was significant variation across the sector.

- At an aggregate level total operating costs across the care home sector were reduced. In the for-profit sector, about half of all companies reduced their total operating costs, compared to 40% in the not-for-profit sector.
- Because around 11% of the care home workforce is employed on zero hours contracts it was possible for some care homes to reduce staff numbers as bed occupancy declined over the course of the pandemic. This meant that for some care homes, spending on staffing fell.
- In the for-profit sector, aggregate expenditure on staffing as a percentage of total revenue fell from 65% to 62%, and the total number of staff employed fell too. 27% of providers accounted for this reduction in the proportion of income spent on staff.
- In the not-for-profit sector, staff expenditure as a percentage of revenue increased from 66% to 69% with three-quarters of not-for-profit care home providers increasing spending on staff. 38% of not-for-profit care home providers saw a reduction in the proportion of income spent on staff.

Profitability for most care home providers improved marginally during the first year of the pandemic, although some companies increased dividend payments.

- The aggregate operating profit margin of the for-profit sector increased from 5% to 8% – a total increase of £215 million. Aggregate pre-tax profits increased by £117 million compared to the year prior to the pandemic.

i Based on an analysis of 460 medium and large care home companies which filed Profit and Loss accounts in May 2020 for a period covering at least 9 months between March 2020 and April 2021. These companies received £10 billion in revenue and operated 2800 care homes with 143,000 beds. This accounted for more than half of all medium and large care home companies in the UK (850), half of all revenue (£22bn) and a third of all care home beds (377k). There were 310 for profit companies and 150 not-for-profit companies which fell into this category.

- 64% of for-profit companies saw an increase in their total operating profits, and a similar percentage saw an increase in their operating profit margins.
- While there was an overall aggregate operating loss for the not-for-profit sector, this loss reduced by £21 million. 52% of not-for-profit companies saw an improvement in their total operating profits and operating margins compared to the previous year.
- The total amount of dividends paid out by for-profit care home companies increased during the first year of the pandemic. 122 (27%) of the 460 companies we analysed, paid out a total of £120m in dividends, an 11% increase compared to the year before the pandemic.
- The sector's overall financial risk profile improved over the course of the first year of the pandemic, with fewer companies at risk of financial collapse, while their liabilities as a proportion of their assets also fell.

3) In the later phase of the pandemic a financial crisis hit the care home sector due to workforce shortages, inflation, continuing infection outbreaks, and the removal of government financial support.

- As of winter 2022, care homes were still being affected by COVID, with outbreaks restricting new admissions. This has had a continued impact on occupancy rates which remain below pre-pandemic levels, even though the peak of the pandemic has passed.
- Care home companies were faced with unsustainable increases in insurance costs and, in particular, energy bills, with estimates in the autumn of 2022 that the average annual energy cost of a care home bed would rise from £660 to over £5,000.

Staff shortages since the peak of the pandemic have also driven up the spend on agency staff, jeopardising nursing home provision and risking the quality and safety of care

- One large care home provider reported that expenditure on agency staff increased from 6% of its wage bill in 2020 to nearly 23% in late 2021.
- As a result of nurse shortages and a nursing staff turnover rate of 38.2% (compared to 8.8% in the NHS), several senior home managers said they might cease to provide nursing care for older people, as they were unable to recruit staff.
- Staff shortages have also began to affect the safety and quality of some care homes. Around one in twenty care home providers formally flagged that they were at significant risk of being unable to meet their duty to provide safe care due to challenges to their agreed safe staffing ratios in the first five months of 2022.
- Despite these ongoing challenges, financial support from the government in England for the care home sector (including the provision of enhanced sick pay for care home staff) ended in March 2022. Enhanced sick pay for care home staff in Wales ended in August 2022, and was terminated in Scotland in October 2022.

4) Many staff reported personal financial problems.

- More than four in ten survey respondents reported financial problems related to working in care during COVID-19 in the context of low pay, restricted sick pay, and the broader impacts of the pandemic on households.
- The benefits system financially penalised some staff for covering absences to keep services running: where their pay increased as they took on extra hours it reduced their eligibility for benefits and resulted in a net loss of income that pushed them into greater hardship.

5) Staff pay was largely unchanged during the pandemic, except for a bonus for some, and limited changes to sick pay, despite the extra funding for the sector and a significantly increased workload.

- The vast majority of the £2.1 billion of support for the care home sector provided by the governments across the UK during year one of the pandemic – including furlough support – went to ensuring the financial viability of care home businesses and preventing the spread of infection, rather than supporting care workers financially. Despite longstanding concerns over low pay and staff shortages, and the additional pressures of the pandemic, there was no general uplift in pay aside from the uprating of the minimum wage.
- Care homes could use some state funding to support workers by improving their terms and conditions. We heard examples of employers offering increased pay, internal bonus schemes, improved benefits, and broader changes such as more flexible working and expanded wellbeing support.
- Care homes received funds to cover enhanced sick pay for staff during the pandemic, which was important for many of them. However, in contrast with the sick pay rules for staff in the NHS, this funding only covered the period when staff were legally required to isolate under the COVID regulations, and not the duration of any COVID-related illness, which could often last much longer. Even the more limited policy for this funding was not always adequately implemented, with widespread reports of staff receiving less than full pay being recorded in our research and in other surveys.
- Scotland, Wales, and Northern Ireland followed a slightly different approach from that of the government in England. In these countries, care workers were also provided with a direct bonus of £500, and pro rata for part-time staff.
- Some English local authorities offered additional funding to support employers in paying their employees a bonus. However, the administrative burden complicated implementation, and varying policies made it difficult for care companies operating across different areas to treat all their staff consistently.
- Although the impact varied between different staff groups and types of organisations, our survey showed that large majorities of all staff remained dissatisfied with their pay.

6) Workloads for care home staff increased – often to levels described as intolerable, with significant impacts on their health and well-being.

- Working hours increased for 82% of survey respondents, and 95% reported an increase in workload.
- For many, these longer hours came on top of a typical 12-hour shift for care workers and additional unpaid care for their families during the pandemic. This often affected respondents' work-life balance, health, and wellbeing.
- Care staff were already working at high intensity before COVID-19 in roles that, although often rewarding, were physically and emotionally demanding.
- Interviewees often said they had been struggling with their health and wellbeing, and feeling burnt-out, due to increasing workloads and other stress factors during the pandemic.

7) The financial impacts on staff varied by ownership type and size.

- Compared to not-for-profit homes, staff in homes owned by for-profit companies were more dissatisfied with their sick pay and reported higher increases in their hours and amount of work.
- Staff in not-for-profit care homes were also more satisfied with support from their manager than those in care homes owned by for-profit companies. This may have been due to differences in the financial resources available (e.g., charitable reserves), business models (e.g. paying dividends to investors vs. reinvesting surplus in the service), organisational values, and whether or not senior leaders had a background in front line care work.
- Homes that were part of bigger chains fared worse in staff satisfaction with workloads, pay (including sick pay), ability to offer good care, and support from their managers and organisations.

8) Care staff raised concerns about the quality of care delivered during the pandemic.

- More surveyed staff were satisfied with their ability to offer good care (42%) than were dissatisfied (30%).
- However, half of the survey participants reported that their ability to meet residents' needs worsened during the pandemic. Many interviewees commented that they had less time to 'care' due to staff shortages and pandemic-related tasks.

9) Staff valued in-person support from colleagues, managers, and external professionals, but such support was not accessible to all.

- There were many examples of employers seeking to support and retain staff by offering hardship funds, extra leave, length of service awards, increased regular pay and overtime, and small tokens of recognition. Many also sought to help staff access wellbeing support and counselling.
- However, these measures were widely constrained by organisational capacity, including finances, and were not universal. Workplace support was often felt to be insufficient, especially for support staff and agency workers.
- Staff were more satisfied with colleagues' support than that of managers or their organisation.
- Senior managers with experience in care, and a commitment to offering in-person support to staff and sharing risks, were viewed positively.

Recommendations

Based on these research findings, we make the following 5 recommendations for policy-makers and those working within the care home sector.

Recommendation 1) As part of its plans for future pandemics the government should significantly improve its understanding of the financial situation of care home companies, model their potential impact on the financial viability of the care sector, and ensure that any extra funding is adequate, spent in line with public priorities, and easy to administer.

- To provide timely support and offer greater certainty to care homes in the event of an economic shock such as a pandemic, government should set out plans on how extra funds will be delivered. Insights from people using care services, staff, and employers, should be used to inform these plans and should consider the following issues:
  - The extent to which care home providers are expected to bear losses in the event of a pandemic or another economic shock, and under what conditions they should receive public funding to maintain their financial viability.
  - How financial risk should be shared – between fee-paying residents, care home companies and the state – so that those paying privately are not required to bear unfair additional costs.
  - The extent to which the state should pay for the additional insurance and indemnity costs imposed on care homes by a public health emergency, as happened in other areas of healthcare provision during the pandemic.
- As a condition of receiving financial support from the government, care home operators should provide full financial data on how their businesses operate, including how their income is allocated between staffing, facilities, rent, debt repayments, and profit, and the government should consider limiting financial support to those companies which are fully tax registered in the UK. This would ensure that any government funding goes to supporting frontline care workers and residents rather than other financial stakeholders, and that taxpayers' support does not go to paying out dividends, bonuses and other payments involving the extraction of value from the sector.
- Because many care home companies operate across the UK and across local authority boundaries, there should be a coordinated approach to managing the financial consequences of a pandemic between central and local government, as well as between the Westminster government and the devolved nations.
- Emergency financial support, and public funding for care in general, should take account of evidence showing varying outcomes by ownership type and should seek to promote forms of provision that offer both good quality care and good quality jobs.

Recommendation 2) Government should learn from the experience of COVID-19 that the worst financial impacts of the pandemic on the care home sector occurred after the first year. Preparations for future pandemics affecting the care home sector should ensure that adequate planning and funding is in place for restoring services to their pre-pandemic level after the peak of the pandemic has passed.

- Given that the worst financial aspects of the pandemic occurred after the first year, the wisdom of removing emergency financial support in 2022 remains to be seen. But there are clear indications that reduced occupancy rates due to COVID outbreaks, reduced profitability and workforce shortages due to burn-out have meant that the care home sector has thus far been unable to provide the critical frontline service to care for older people, or to provide optimal help to the wider healthcare system as it recovers from the peak of the pandemic.
- Emergency planners should learn from this experience and consider what additional funding and workforce support is needed to restore care home services to their full functionality and to support their financial viability.

Recommendation 3) In any future pandemic, government should improve pay, sick pay and benefit entitlements and provide support for unpaid caring responsibilities for care staff.

- During a pandemic, there is good reason for the state to contribute directly to hazard pay, enhanced overtime, and significant 'recognition payments' for care home staff, where employers are financially unable to do so. Such measures reduce turnover and show societal recognition of the value of care home workers' risky and challenging tasks.
- In order to avoid the recruitment and retention difficulties currently facing the sector in the latter stages of the pandemic, everyone working in social care in the UK, including ancillary staff, should, as a minimum, be paid in line with the real Living Wage, as is now happening in Wales and Scotland. There is a strong case for pay and conditions to match those of staff in the NHS to avoid recruitment and retention difficulties in care homes.
- Sick pay entitlements for social care staff during a pandemic must provide adequate compensation for the loss of income due to becoming ill (including being affected by a post-viral syndrome such as long COVID), and not just for the period of self-isolation. Because of the extraordinary nature of a pandemic it is legitimate for these additional staff costs to be borne directly by the taxpayer. There is a strong case for enhanced sick pay for care home staff, in general, to protect vulnerable residents from infection, support the health of staff, and make employment conditions more attractive.
- Given the likely need for staff to work extra hours during a pandemic, the benefits system should not financially penalise those care staff who are able and willing to do so. As a result, the government should ensure that the rules relating to in-work benefits (Universal Credit) do not disincentivise care staff from taking on extra hours, and should consider whether these rules might be altered during a pandemic or otherwise to help address emergency staff shortages.
- With the pandemic triggering a need for additional unpaid care (for example due to school and nursery closures), the government and providers must offer support such as access to key worker services and funds for extra paid care. This is particularly important in social care, where the workforce is predominantly female.

Recommendation 4) The government should develop plans to tackle staff shortages, including emergency staffing.

- General improvements to the terms and conditions of work in care homes are needed to address longstanding staff shortages. Future pandemics will again put additional pressure on staffing, and the government should plan for this.
- The government should support the development of a standby emergency social care workforce with proper training, support, and equipment.
- Local authorities should work with care homes on plans to redeploy furloughed staff into care with proper training and support, safety measures, and full pay.
- Plans to address workforce shortages should not be left to individual care home providers, as appears to have happened during COVID, and should instead be coordinated at national and regional levels.
- Greater oversight and regulation of employment agencies is needed to ensure fair pricing and good practice.
- To ensure that any future planning for a pandemic fully takes into account the role of the care home sector in the emergency response, care home providers need to be much more integrated into the new NHS Integrated Care Systems in England and into local decision-making regarding emergency planning in other parts of the UK.

Recommendation 5) Government should support care home providers to enhance the overall well being of care home staff both during and outside a pandemic.

Good working conditions underpin mental health and wellbeing, but targeted support is also needed to help care home staff deal with the experiences of the pandemic.

Governments should work with social care organisations to:

- Promote a better understanding of how care staff experience their working lives, through the regular collection of data such as an annual national workforce survey like that conducted by the NHS.
- Ensure adequate personal, professional, and clinical support is accessible to social care staff, particularly during a pandemic. For example, social care staff should have access to the same mental health support as is available to NHS staff.

Employers should build on existing efforts to:

- Facilitate peer support among staff in different roles (including managers) by providing time and space for group reflection, action learning, and other activities within their home, as well as promoting access to networks across different homes where appropriate.
- Identify and reflect staff preferences in terms of the further support provided, such as one-to-one sessions, helplines, or digital resources, and ensure that staff can access them in a timely fashion.
- Monitor employee experiences of support from managers and other sources, with regular positive dialogue to help build a culture of appreciation and shared endeavour.

Abbreviations

ADASS	Association of Directors of Adult Social Services
ADSS Cymru	Association of Directors of Social Services Cymru
CQC	Care Quality Commission
CMA	Competition and Markets Authority
DHSC	Department of Health and Social Care
HSCS	Health and Social Care Scotland
HMG	Her/His Majesty's Government
ICF	Infection Control Fund
MAC	Migration Advisory Committee
NAO	National Audit Office
NCHC	National Care Home Contract
NICs	National Insurance Contributions
NRS	National Records of Scotland
ONS	Office for National Statistics
CIGA	The Corporate Insolvency and Governance Act

Glossary

Care homes	In this report, 'care homes' refers to all homes providing residential and/or nursing care for people aged 65 and over unless otherwise specified.
Companies	Both for-profit and not-for-profit organisations providing care whose financial data has been drawn from accounts filed with Companies House.
Independent sector	Care homes outside the public sector, including both for-profit and not-for-profit organisations.
Providers	Organisations registered with the relevant regulator to provide care.
Self-funders / private payers	Care home residents required by government policy to pay towards the cost of their own care because they have assets exceeding the maximum threshold or because their care needs are not deemed sufficiently significant or serious.
The sector	Unless otherwise specified, this refers to care homes in the UK for people aged 65 and over.

Introduction

The care home sector in the UK has been profoundly affected by the COVID-19 pandemic. With the virus causing 42,341 deaths of care home residents between March 2020 and April 2021 and 1,290 deaths of social care workers (including those working in domiciliary settings) between March 2020 and February 2022 the scale of lives lost, and the trauma inflicted upon those on the frontline of the pandemic and their families is very painful to contemplate.[1,2]

Whilst numerous studies have examined the impact of the pandemic on the care home sector from an epidemiological and other perspectives, the focus of this report is on the financial impact of the pandemic on care home companies. It looks at how governments across the UK responded to these challenges, the strategies employed by the companies themselves, and the impact on care home workers and managers.

Why do the finances of care homes matter in the context of a pandemic?

From as long ago as 2008 the possibility of a pandemic has been the number one risk on the government's corporate risk register in terms of the likelihood of it occurring and the impact that it would have on health, wellbeing and the economy. Given the age and health needs of their residents, care home companies were known to be especially vulnerable.

The financial viability of the UK's mainly privately-owned care home sector was also known to be fragile prior to the pandemic. The 4,000 or so care home companies operating across the UK faced pressures from rising wage costs, low fees paid by local authorities, and in some cases, costly rent and debt payments, with many companies experiencing low and potentially unsustainable levels of profitability.[3] Any further shock to their finances – because of the rising costs and declining income caused by a pandemic – was, it was feared, liable to lead to widespread home closures.

Not only would a collapse in the care home sector in the middle of a pandemic significantly impede the government's response to the public health emergency, but care homes which experienced severe financial difficulties would be unable to protect residents from the virus effectively, or provide them with high quality care.

In addition, the financial health of the care home sector fundamentally affects the care workforce and determines its ability to recruit and retain staff and to offer good jobs. Again, staffing levels, staff training and job satisfaction shape the quality of care for residents and the conditions in which managers run their homes.[4,5,6]

Before COVID-19, the sector faced a range of well-documented issues in terms of staff recruitment, retention and job quality. Pay was low: across the UK, approximately half of frontline carers were paid below the real Living Wage, rising to 61% in England, where care workers earned on average £8.56 an hour when the pandemic began.[7,8] These wages had disproportionate impacts on certain groups, given that care staff are overwhelmingly female and more likely to be from ethnic minorities or to have been born outside the UK. Posts were left unfilled, putting greater pressure on existing staff (vacancy rates for adult social care exceeded 6% in England and Scotland).[9,10] Turnover was excessively high, creating instability for residents, staff and managers, with more than a third of adult social care staff leaving their jobs in England each year.[11]

Despite these challenges, the effectiveness of the pandemic response was highly dependent on care home workers being supported to provide care for residents in extreme circumstances, often when their own health and wellbeing was at risk.

In addition, because of the economic status, ethnicity and gender of care workers they were potentially more likely than other workers to experience the wider impacts of a pandemic. School and nursery closures, the need to protect vulnerable relatives whilst working in a high-risk environment, and other effects of economic lockdowns were also likely to affect their health and wellbeing.

The structure of this report

Based on an analysis of hundreds of company accounts, a survey of, and interviews with, care home workers and managers, this report sets out our research into the impact of COVID-19 on the financial viability of the care home sector for older people in the UK and the experiences of care home workers and managers. (See the Annexes for more details about the methodology.)

In addition to analysing the extent to which care home workers received both financial and non-financial support from employers, we set out how government and the care home companies responded before, during and after the peak of a pandemic which continues to impact the care home sector some 3 years later.

The report is divided into two main sections. Section 1, which focuses on the finances of the care home sector, covers:

- The financial health of the care home sector for older people before the COVID-19 pandemic
- Preparing for the financial impact of the pandemic and the challenges in providing financial support to a market based public service
- Assessing the financial impact of COVID-19 on the care home sector for older people during the first year of the pandemic.
- The ongoing financial impacts of the pandemic – a crisis postponed rather than averted?

Section 2, which focuses on the impacts of the pandemic on the workforce, is based on surveys and interviews with care home staff and managers and covers:

- The impact of COVID-19 on the pay and personal finances of care home staff
- The impact of COVID-19 on the staffing levels and workload of care home workers
- The non-financial support provided by employers to care home staff during COVID-19

The report concludes with a set of recommendations for policy-makers and the adult social care workforce which are designed to assist in addressing many of the issues identified by this study.

Section 1: Assessing the impact of COVID-19 on the finances of the UK Care Home Sector for older people

This section sets out an analysis of the impact the COVID-19 pandemic had on the finances of the UK care home sector for older people.

It looks at the financial health of the care home sector for older people across the UK in the period before the pandemic and the challenges facing the government in providing a policy response to the economic shock which hit this key frontline public service.

It also sets out an analysis of the financial accounts of both for-profit and not-for-profit care home companies after the first year of the pandemic (March 2020-April 2021) to assess the extent to which both the strategies employed by these companies and the financial and other forms of support provided by government were effective in mitigating the worst effects of the pandemic on their financial viability.

Because the financial impact of the pandemic has continued to persist beyond 2021, we also looked at the current challenges in the care home sector as the COVID-19 pandemic and its economic effects continued to impact care home services into the latter parts of 2022 using data from a range from regulatory bodies and other official government data. We raise the question as to whether the financial crisis in the sector has been postponed rather than averted.

The financial health of the care home sector before the COVID-19 pandemic

Key findings:

- The care home sector before 2020 was beset by a range of structural problems, particularly underfunding, which meant that it was highly susceptible to the type of economic shock it faced in March 2020 due to the COVID-19 pandemic.
- To provide a baseline of the financial health of the care home sector immediately before the pandemic outbreak (March 2020), we produced an assessment based on the publicly-available financial data on all the registered providers of care home services for people aged 65+ in the UK.
- According to this analysis a small increase in costs (5%) combined with a small decrease in revenue (5%) would jeopardise the financial viability of this key frontline public service. In this scenario, without financial support from the government, around two thirds of the care home beds for older people in the UK would be being operated by companies at high risk of financial collapse.

Research conducted in the years immediately prior to the 2020 pandemic identified the following underlying problems with the financial health of the care home sector for older people, leading to calls for government intervention:[12]

- Low levels of profitability amongst care home providers, particularly those which rely on fee income from local authorities. These fee levels were found to be insufficient to enable care home operators to make a profit;
- Owing to the low fees paid by local authorities, many care home companies had to cross-subsidise their budgets by relying on private payers (self-funders) – who frequently pay higher fees – to maintain their profitability;
- Some care home providers had high debt and high-cost rental obligations, which increased their risk of financial difficulties;
- A decline in investment in new care facilities in areas of the country where there were few private payers;
- An upward pressure on wage costs caused by the introduction of the national living wage and a shortage of care staff, particularly registered nurses;

To assess the financial impact of COVID-19, we undertook a detailed account of the financial viability of the UK care home sector for older people immediately before the pandemic (March 2020). We worked with the financial risk analysis company Company Watch to analyse the latest publicly available data for 4,013 companies, collectively providing 377,856 beds for older people in 8,705 care homes. 3,150 of the companies were small and micro-sized companies, and 851 were large.

Overall, the analysis painted a picture of a frontline public service that was highly susceptible to even a small economic shock. Company Watch rated 26% of all care home companies, providing 28% of all care home beds, as being likely to experience financial collapse or to require significant financial restructuring within three years (see Box 1).

Box 1: Overview: H-Score® and the Warning Area

Company Watch analysts examined several measures of financial health, including aggregate profitability, net worth, gearing (the ratio of total assets to total liabilities), and working capital, plus their own measure of financial risk – the H Score®.

The H-Score® provides an overall measure of a company's financial health based on detailed statistical analysis of a company's financial results.

It compares their financial characteristics to thousands of past filings from companies that have failed or remained healthy. In this context, failure is defined as a company's entering into a formal insolvency process, including administration, receivership (administrative or fixed charge), Company Voluntary Arrangement (CVA) or liquidation (excluding Members' Voluntary Liquidation).

The H-Score analytics consider a company's financial position from various perspectives, including profit management, working capital management, liquidity, and the funding of assets. Scores range from 0 (weakest) to 100 (strongest).

Companies with a score of 25 or less are placed in the Warning Area.

Not all companies in the Warning Area will fail. However, most of the companies that failed were in the Warning Area before the collapse.

The following specific indicators demonstrate the extent of financial vulnerability in the care home sector going into the pandemic, based on our assessment of the pre-pandemic baseline:

- 28% of the care home companies made a pre-tax loss in the period prior to the pandemic. These companies operated around one third of all beds.
- Companies with negative net worth – i.e. the company had total liabilities (debts) greater than their total assets, provided 15% of care home beds for people aged 65+.
- Companies with high debt levels (i.e. they had a gearing ratio measured as total assets to total liabilities of greater than 50%) operated nearly 70% of all beds.
- 42% of care home companies operating 45% of beds had negative working capital. This meant that they had insufficient short-term assets (e.g. cash and money owed) to meet their liabilities due within one year.

These findings suggest that there was a clear need for policy-makers to have plans to intervene in the care home market in case it faced a shock such as a pandemic. To understand how the sector would be affected by a financial shock – such as a pandemic – without government support, Company Watch modelled the impacts of a modest increase in costs and a decrease in revenue to see how the financial indicators set out above would change. Under a scenario where the sector experienced a 5% increase in costs and an equivalent decrease in revenue, the number of beds provided by companies at high risk of financial collapse would double to 239,000, representing over 60% of beds in the sample.[ii] In addition:

- The total number of beds operated by companies across the UK with high levels of gearing (debt) would increase 70% to 72.4%. Under this scenario, companies operating almost three quarters of care home beds would have high levels of indebtedness.
- The percentage of care homes operated by companies with negative working capital in England would rise from 28% to around 60%.
- The proportion of large companies with negative net worth would increase from 14% to 25%, and the proportion of medium sized companies with negative net worth would increase to 17%.

ii We also tested a 10% and 15% increase and decrease in costs and revenue but we have only reported on the 5% scenario here.

Conclusion

This analysis shows how even relatively small cost pressures and revenue changes could move a substantial number of care home companies into a situation of significant financial difficulty. It highlights the need for plans for government intervention to ensure their viability, and corroborates previous research in this field.

Preparing for the financial impact of the pandemic and the challenges in providing financial support to a market-based public service

Key findings:

- The financial fragility of the care home sector going into the pandemic was well known to policy-makers, and the impact of an economic shock was highly predictable, but there is no evidence of plans to address this before March 2020.
- The lack of financial planning increased the stress for those on the frontline concerned about both protecting residents and staff and their financial viability.
- The market-based nature of the UK's care home provision made it complicated to provide public financial support. The government had to avoid breaching trade rules on state aid when providing support to companies and could not make transfers directly to care homes providers as it could to NHS organisations.
- The government did not have sufficient data on the finances of care homes to understand their financial needs, and some of the large for-profit care home companies were known to operate with highly opaque business structures. These structures made it difficult to know whether government funds to care home companies to support the pressures caused by the pandemic would assist frontline care staff or generate returns for shareholders.
- The government also lacked mechanisms to provide financial support to all care homes, particularly those that cared for residents who funded their own care. As a result these care home companies and their residents may have been financially disadvantaged, by missing out on government funding.
- Application for government grants required significant administrative work for which care home companies often had to employ additional staff.

I. Failure to prepare for the financial impact of the pandemic

The financial impact of a pandemic on the care home sector was highly predictable. A reduction in the number of older people in care homes – the occupancy level – would necessarily result from a highly contagious respiratory virus such as COVID-19, due to higher mortality levels amongst those aged 65 and over.

The average occupancy level in care homes before the pandemic was around 85%, a necessary minimum to generate a profit, according to the Care Quality Commission.[13] Once occupancy levels fall below 80%, care homes are unable to cover their costs. For example, when the UK experienced a virulent strain of winter flu in 2017, one large care home operator experienced a reduction in occupancy of 2%, impacting its profits.[14]

In addition, to protecting residents from infection outbreaks, care homes were required to spend more on cleaning and personal protective equipment (PPE). Since the virus was also likely to affect staff and their family members, a pandemic would substantially add to the costs of delivering care.

However, as far as we know, there is no publicly available official impact assessment of the financial consequences of a pandemic for the sector. Key recommendations for social care, which came from the government's pandemic simulation exercise, Operation Cygnus, were not implemented and in any case contained no mention of measures to mitigate the financial effects of the pandemic on the sector.[15]

In the end, an announcement of dedicated financial support for the adult social care sector from the UK government came in March 2020, some 49 days after the WHO declared the pandemic to be a public health emergency issue of global concern.[16]

This failure to prepare in advance inevitably added to the stress of managers and care staff responding to the pandemic on the front line. This was a missed opportunity, which added to the stress of a major public health emergency. As one care home manager told us:

> *The stress behind all of this is that all of this funding all tends to be really last-minute. The government announce it – it's about to start (…). It then goes through our local authority, who then take three, or four, or five weeks to put the grant applications out, get them back, process them, and then make the actual payments. So, you – you'll get a payment. [The third Infection Control Fund round] I think it started in October (…). We carry all of that risk for October and November, and then get paid at the end of November sort of thing. You're never quite sure what you're going to get and whether it's going to cover all of those costs.*
>
> (Owner-manager of a small for-profit provider)

II. Challenges in providing financial support to the care home sector in a public health emergency

While planning for the financial impact of COVID on the care home sector ought to have been a vital aspect of the UK's pandemic preparedness, the nature of the care home market in the UK creates a significant number of challenges in delivering such an intervention. For example, while the government was able easily to increase funding to NHS hospitals through direct transfers to their budgets, and eliminate their debts of around £13.4 billion, making such payments to the private businesses and charities that operate most of the care sector was legally and practically complex.[17]

Not only were payments to private companies such as care homes covered by international rules on state aid – which has a bearing on the nature of the support that can be provided – but government also lacked the necessary financial data on the operations and financial position of many care home companies, complicating decisions on the amount of support to provide.[18,19] Local authorities have data on the care homes they contract with, but not necessarily on care homes which cater to predominantly private payers.

In their review of pandemic preparedness, the National Audit Office (NAO) found in relation to the social care market that: "*Prior to the outbreak there was no process in place to collect a wide range of daily data from care providers. The Department did not know how many people were receiving care in each area, while local authorities only know about those people whose care they pay for.*"[20]

Research has shown that there is also a particular lack of transparency in the finances of several large for-profit providers, which although making up a small proportion of the overall care home market have annual revenues of around £4bn. Twenty six care home companies comprise about one third of the total market. Between six and eight of these companies have been shown to use opaque company structures to extract revenue from care home fees to pay off high levels of debt, provide high levels of return to financial stakeholders, and to fund management fees.[21]

This lack of transparency about where money ends up has recently been criticised by the Public Accounts Committee, which stated: *"Provider costs and their financial structures are opaque; individuals and local authorities should not be in the dark as to what they get for their money."* [22]

It also arguably makes it difficult for the government to be confident that any additional funding provided to companies with these types of company structure will not be diverted to financial stakeholders to generate excess profits, rather than facilitate an effective response to the pandemic.

Additionally, since 2000 responsibility for care home provision has been devolved to the four countries of the UK, which have taken different approaches to the funding and organisation of their care home markets. While care home operators deliver care services in just one part of the UK, many large companies deliver care in all four countries. This means that the financial viability of a UK-wide care home company can be affected by the decisions taken by four different governments and the local authorities responsible for administering support.

In England, central government also experienced difficulties in funding care home providers which did not have long-term contractual arrangements with local authorities, primarily because they mainly delivered care to self-funding residents. For example, a survey in 2020 by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) found that while over 60% of councils provided additional emergency funding to providers with whom they had contracts, only 30% did so for those with whom they did not hold contracts.[23] This was presumably because local authorities did not see companies providing care to self-funders as their financial responsibility.

Such a situation arguably placed care home companies dependent on private fee income at a disadvantage in receiving state-funded support. These companies initially suffered a greater deterioration in their finances during the first year of the pandemic compared to those reliant on local authority fee income.

Analysis by the CQC during 2020 found that providers which generated more than 40% of their income from private payers saw a 21.5% reduction in profit margins. In contrast, those who generated less than 40% of their income from private pay saw a reduction of only 1.5%.[24] This difficulty in accessing state financial support also potentially contributed to these companies increasing the fees of private payers, so that the additional costs of the pandemic were transferred to individuals and their families.

To address the problem of care homes that relied on private pay income and were unable to access support from local authorities, the government came up with two solutions. The Department of Health and Social Care (DHSC) introduced the Infection Control Fund, which required local authorities to provide funds directly to all care home providers, irrespective of whether they received local authority funding. In addition, the Westminster government also introduced legislation in the Health and Care Act 2022 to provide financial support directly to care home providers, bypassing local authorities.[25]

III. Providers faced significant administrative burdens in accessing financial support

Despite the nature of the emergency faced by the care home sector at the height of the pandemic, care home providers were required to complete large amounts of paperwork and provide data to local authorities and the DHSC to access financial support. Some care home providers told us that they employed additional staff simply to apply for financial support. Others had to ask the existing staff (including those in non-administrative roles) to do extra work. This administrative burden added to the stress and additional cost of responding to the pandemic and contributed to the significant increase in workloads which we explore in more detail in the workforce section of the report.

Those we spoke to contrasted this process with how financial support was provided to other areas of the economy which had much fewer administrative requirements. As one finance director of a care home told us:

> *Yes, we got some COVID grants that we had to justify to the nth degree on what we were going to spend it on. And they even told us what we could and couldn't spend it on. Yet, we have all these businesses that are shut during COVID that they just got a business grant for £50,000. There you go. That will sort you out. No questions asked. But we have to keep records of everything that we spent it on so that's more work to do. For the sake of 2 or 3 or 4 grand. We're not talking about tens and thousands of pounds. So, did it help a little bit? Yes, of course, it did. But was it worth all the work that went into it to get it in the first place? No.*
>
> (Manager in a small for-profit home)

Conclusion

The fact that care home services operate in a market-based system in the UK means that government faced several key challenges when providing the necessary financial support during a public health emergency, including a lack of financial data on the large majority of care home providers. The lack of planning by the government and the absence of mechanisms to deliver financial support to the care home market exacerbated the stress and the challenges for the frontline staff during the pandemic. Government also faced the challenge of providing additional public money to some companies where there was little clarity about how this money would be used.

Assessing the financial impact of COVID-19 during the first year of the pandemic

Key findings:

- In the first year of the pandemic, care home companies faced decreased income and increased costs due to reduced occupancy, increased staff costs, PPE, and infection control costs. However, governments across the UK provided care homes with an estimated £2.1 billion in financial support (worth about £5.9k per care home bed), including the furlough scheme.
- Care home providers adopted a strategy of increasing average revenue per bed through increased fees, reducing labour costs, and accessing government funding. Although there was a mixed picture at company level, at the aggregate level the overall operating costs of the care home sector , including labour costs, declined, as did the total number of staff employed by care homes, particularly in the for-profit sector.
- Despite an estimated reduction in occupancy of around 8%, overall income levels for the care home sector increased slightly during the first year of the pandemic compared to the previous year. This was mainly due to the substantial financial support the central and local government provided and increased fees paid by private payers.
- At an aggregate level, the overall profitability of the care home sector increased, particularly amongst for-profit companies: the aggregate operating profit margin of the for-profit sector increased from 5% to 8%.
- The total amount of dividends paid out by for-profit care home companies also increased during the first year of the pandemic. 122 out of the 460 companies we examined, or 27%, paid out £120m in dividends – an increase of £11.7m or an 11% increase on the previous year.
- Ultimately, the sector's overall financial risk profile improved over the first year of the pandemic, with a smaller number of companies at risk of financial collapse and reduced debt levels compared to the year prior to the pandemic.

To understand the financial impact of the pandemic on the care home sector, we analysed the financial data of companies that had published their annual accounts with Companies House by May 2022, covering a period of more than nine months of the first year of the pandemic (March 2020 to April 2021). This sample was determined by the filing of the companies and covers companies providing care homes services to people aged 65 and over in all the countries of the UK, and did not involve any selection by the authors.

The financial analysis presented here is based on the profit and loss accounts of 460 large and medium sized care home companies which had filed accounts by May 2022. These companies operate around 142,000 care home beds and have annual revenues of around £10 billion. They account for around 38% of the registered care home beds (377,856). The regional distribution of the companies in this analysis was representative of the wider distribution of registered care homes.

We also examined the accounts of a further 1,540 small and micro-companies that also filed their annual accounts by May 2022; full profit and loss data is not available for these companies due to Companies House reporting requirements. We were, however, able to analyse their balance sheet data to understand certain aspects of financial risk. As a result, we have included the data for these companies only in the section which examines financial risk. (See Annex A for more details on the methodology.)

The nature of the financial impact caused by COVID-19 on care homes for older people

The care home sector experienced three main challenges to its financial viability during the first year of the pandemic (from March 2020 onwards):

- a major decline in revenue caused by a reduction in occupancy rates;
- an increase in costs due to the need to provide Personal Protective Equipment (PPE) and other infection control measures;
- and an increase in staffing costs due to higher staff turnover, sickness absences, and use of agency staff.

A decline in occupancy rates, particularly amongst in private payers

There was a reduction in bed occupancy due to several factors. Firstly, the high mortality rates and premature deaths in care homes reduced the average length of time a resident spent in a care home. Secondly, the high mortality rates in the wider population and negative publicity about COVID-19 outbreaks in care homes reduced the number of new admissions. This meant that the beds which had become empty due to high mortality in care homes were not being filled. Thirdly, care homes struggled to accept new residents due to the risk of infection or staff shortages.

Reduced admissions to care homes during the first year of the pandemic from those who paid privately – as opposed to local authority-funded residents – was a particular problem for care providers. As these residents paid higher fees (around 40% higher), many homes relied on this payment to cross subsidize the low fees paid by local authorities. As the Competition Market Authority had found in its 2016 study, income from private payers was critical to the overall profitability of the care home sector.[26] Though this was a pre-existing issue, it became particularly relevant under the financial pressures of the COVID-19 pandemic.

One large care home provider reported a reduction in the percentage of its private pay income from 77% to 74% over the first year of the pandemic,[27] while another saw private pay occupancy fall by 19%.[28] The Office of National Statistics (ONS) also observed a 12.4% decline in the number of people in care homes who were self-funding compared to prior to the pandemic.[29]

Overall, during the first year of the pandemic, average bed occupancy amongst the largest care home providers fell by 8%. Without any support from the government or without substantial fee increases, this would have left the 460 companies in our sample with an estimated aggregate revenue shortfall of £810 million.[iii]

An increase in costs, due to the need to purchase high-cost PPE, and other infection control costs

On top of reduced income due to falling occupancy, care home companies faced additional cost pressures. Staffing, infection control and cleaning, and personal protective equipment (PPE) were the key areas where costs significantly increased.

Affording and being able to purchase personal PPE was a significant challenge for the sector before the government provided free PPE from September 2020 onwards.

iii This is based on the assumption that a one per cent (1%) reduction in bed occupancy is equal to a one per cent (1%) reduction in income.

For example, one large care home provider with a revenue of £330 million a year spent £3m on PPE between March and September 2021, around 1% of its annual income.[30] Another large provider with revenues of £663.4m spent £2.4 million on PPE or 0.4% of its annual income.[31] Others spent more on PPE, with one company identifying £2.8 million in additional costs caused by COVID-19 of which a significant proportion was on PPE. This was around 5.5% of its total income for that year.[32] The manager of a small home said that in addition to the amount they used, the rising prices for PPE was a significant challenge:

> *When the COVID first started, we were having to provide all the PPE [..]. But the prices absolutely skyrocketed. We were getting charged something like £20 for a box of 50 face masks that prior to COVID were like 20 pence. And [..] we chose to make a visiting area so we bought some perspex screens to go across one of our rooms. And prior to COVID, I think that would have cost us probably about 300 quid. And it cost us the best part £3,000 during COVID to have these movable screens bought. So, financially, it's been very difficult.*

Similarly, some homes were impacted by wider price increases in the early stages of the pandemic when supply chain disruptions and stockpiling led to inflation, as another interviewee explained:

> *Prices of things changed because it was harder to get things. So, for example, meat on the food order before the pandemic would've cost £700, but after and during the pandemic it was closer to £1,000. Cleaning products were just harder to get hold of.*

It is difficult to quantify the total additional costs of providing services during COVID-19. However, one large care home company with revenues of £383 million during the first year of the pandemic estimated that the additional costs were up to £12m, or around 3% of its total annual income.[33]

The strategies of care home companies in response to these challenges

An examination of the financial accounts and strategic reports of the largest care homes in our sample reveals that these companies employed three main strategies to maintain their financial viability.

- Increasing the average revenue per bed
- Accessing government grants and support for free PPE
- Keeping costs (in particular, labour costs) under control

Given the challenges the care home companies faced, these strategies were highly rational and were likely to be deployed by any business facing the economic shock of the pandemic.

For example, one large care home company which increased its operating profit margin during the pandemic described its strategy for dealing with the financial impact of COVID in the following way: "*fee rate inflation, reduced labour hours reflecting lower occupancy, reduction in agency usage and central cost savings.*"[34] Another large care home provider, attributed its 9% increase in profit margin to a "*continual focus on optimising occupancy during the pandemic and securing appropriate staffing and operational cost efficiencies whilst maximising average weekly fees*".[35]

Increasing the average revenue per bed to compensate for occupancy reductions

Due to reduced occupancy levels, care homes sought to increase the average weekly revenue per bed. This was achieved partly through increasing the fee levels for private pay residents but mainly by negotiating increased fee levels with the NHS or local authorities who received emergency funding to support the financial viability of their local care homes.

Although data on fee rates are not available for all care home companies, particularly for those with privately paying residents – a fact which was raised by the National Audit Office – our review of the largest care home companies who filed accounts by May 2022 found that five large care home companies reported in their annual reports an increase in average fee income per bed of between 8% and 12.5%.[iv] In addition, a survey of care home providers in 2020 found that fee increases for private payers had increased by 5%.[36]

Most local authorities in England increased their fees between 5% and 10%, recognising the impact of reduced occupancy on the financial viability of care homes.[37] In other cases, local authorities and the governments in Scotland and Wales paid care home providers for "voids" (beds they couldn't fill because of the pandemic).

Others switched to block contracts so that payments for beds would be made irrespective of whether they were filled. In Northern Ireland, care homes were guaranteed 96% of their pre-pandemic income. Local authorities also made direct grants and lump sum payments. Some care home companies also benefitted from higher fees per bed because of agreements with the NHS to enable the faster discharge of older people from NHS hospitals.

We were told by the Department of Health and Social Care that the total financial support provided by local authorities in England to secure the income for care homes for people aged 65 and over was around £1.04 billion during the first year of the pandemic. This funding was part of the £4.6 billion in emergency funding paid by central government to local authorities, who then used a significant part of this to support the social care sector. In addition, other types of funding were made available in Scotland, Northern Ireland, and Wales. As discussed below, other government grants, in particular the Infection Control Fund and the Coronavirus Job Retention Fund, were also made available to care home providers during the first year of the pandemic. (See Box 2).

Box 2: Financial Support provided to Care Homes for Older people in the UK during year one of the pandemic

England
- Support from local authorities through emergency funding £1.04 billion
- Infection Control fund £760 million

Total: £1.8 billion

Scotland
- Sustainability payments: £126 million
- Adult Social care support fund: £8 million

Total: £134 million

Northern Ireland
- Income guarantee: £15.4m
- Grants to care homes: £5.4m
- Additional funding: £32.1m

Total: £53m

Wales
- All additional costs funded by government: £45.1 million
- Unexpected costs funded by local authorities: £5.9 million
- Funding for unfilled care home beds: £36.4m
- Fee increases to support sector: £48.9m

Total: £136.5 million

UK wide: Coronavirus Job Retention Scheme (Furlough) £114m

Total: £2.1 billion
(Equivalent to a subsidy of around £5,920 for each of the 377.8k care home beds for older people in the UK)

(Source: Correspondence with relevant government departments in England, Wales, Northern Ireland and Scotland in 2022)

iv To note, these figures relate to the average weekly fee income for all beds and not just for private payers

Another way of making up for lost revenue was to access the government grants made available to providers during the first and second years of the pandemic. These came in two forms in the first year of the pandemic. In England, the Infection Control Fund was worth around £1660 per bed for each care home, costing around £760 million during the first year of the pandemic. In Scotland, sustainability payments worth an estimated £129m were also made available to cover the additional costs of responding to the pandemic, along with an additional £8m, which went to the sector to support the care workforce. In Wales, the government provided funds totalling an estimated £136.5 million to care homes, a combination of support to cover additional and unexpected costs, fee increases and funding for 'voids'. In Northern Ireland, the government provided an estimated £53m, including income guarantees to cover the income lost from reduced admissions and additional funding to assist with the pandemic response.

These grants were provided to enable care homes to meet the additional requirements of the COVID restrictions (i.e., preventing staff from working on more than one site and requiring those who were off sick to isolate while on full pay). At the same time, it helped care home companies to compensate for a loss in occupancy.

In addition, care home companies made significant use of the Coronavirus Job Retentions Scheme (furlough). The government permitted care homes to claim 80% of the employment costs of those vulnerable care staff who had to stay away from work due to the risk of exposure to the virus. Providers could also claim 80% of the costs of those care staff who were not needed to deliver frontline care because of a reduction in the number of residents.

Over the first year of the furlough scheme, those employing staff in care homes for older people claimed approximately £114m in furlough payments.[v] The HMRC data suggest that during the first five months of the scheme, around 26,500 workers had been furloughed, with around half of all employers in the sector making some use of the scheme. By March 2021 this had fallen to around 13,300 staff in the residential and nursing care home sector, with around one-third of employers making some use of the scheme.[38]

We found that payments to care home companies through the Infection Control Fund and the furlough scheme were often recorded in their accounts as income from government grants. Analysis of the accounts of the twenty-six care large providers, which record this data, shows that government grants on average made up 5% of their annual income. In some cases, up to 12% of the income of these providers came from these two government grants during the pandemic.

Importantly, these care home companies would also have received additional funding from local authorities – for example, in the form of fee increases and payments for voids – that are not recorded as separate items in their accounts. As a result, the impact of the additional government funding for care home providers is likely to have made up a more significant proportion of care home provider income than we can report.

The impact of government grants and fee increases on care home revenue during the pandemic

Overall, government grants and fee increases for residents coming from local authorities, the NHS and private payers addressed the potential drop in income from reduced occupancy levels. For the 460 large and medium sized companies in our study, with revenues of around £10 billion and 142,656 beds, we estimate that the financial support provided by the government (excluding furlough

v The HMRC data for this period only covers March to July 2020 and November 2020 to March 31st, 2021. The data for the care home sector derives from the Sector Industry Code (SIC) for residential and nursing care home businesses. SIC 87.1 and SIC 87.3. See: https://www.gov.uk/government/statistics/coronavirus-job-retention-scheme-statistics-16-december-2021 and https://www.gov.uk/government/statistics/coronavirus-job-retention-scheme-statistics-august-2020

funding) was worth around £5,920 per bed for each provider, or £844m in total, sufficient to make up for an 8% drop in income caused by reduced occupancy rates. So the loss of income and raised costs appear to have been largely offset by the various forms of government support.

As Table 1 shows, the aggregate revenue for the care home sector remained remarkably stable over the first year of the pandemic, with only a slight decrease compared to the period before the pandemic. For two thirds of care home companies in our study, revenues actually increased over this period.

Table 1 Revenue change for care home companies during the first year of the pandemic

	Revenue pre-pandemic £000	Revenue pandemic £000	Difference £000	Number of companies revenue increasing	Number of companies revenue decreasing
All companies	10,099,429	10,023,502	–75,927	273	186
For profit	6,937,325	6,882,708	–54,617	178	131
Not-for-profit	3,162,104	3,140,795	–21,309	95	55

Controlling costs – accessing free PPE and keeping labour costs down

To ensure financial viability during the pandemic, care home companies sought to keep their operating costs down, particularly labour costs, which on average comprise around 65% of total expenditure.

Care home companies are in a position to reduce their labour costs in the face of substantial pressures because many of them rely on a 'flexible' workforce. For example, in England 11% of social care staff and 13% of registered nurses in care homes are employed on "zero contracts", which means that they only get paid when they are required to work.[39] This means that care home providers can reduce labour costs if staff are not needed, for example if occupancy levels decline, as happened during the pandemic.

As a result, despite work intensity increasing during the pandemic, the aggregate labour costs for the care home sector decreased, the total number of care home staff employed decreased, and the aggregate percentage of income spent on staffing fell. (see Table 2 below)

This aggregate reduction in staff expenditure is remarkable because the introduction of a 6.2% increase in the national living and minimum wage in April 2020 should, in theory, have led to significant upward pressure on wage costs.[40]

There were notable differences between the for-profit and not -for-profit sector. At an aggregate level, the for-profit sector reduced expenditure on staff relative to income by 3%, compared to the period prior to the pandemic whilst the not-for-profit sector increased it by 4%.

However, this aggregate figure masks different experiences at a company level. For example, the number of companies which reduced staff expenditure were in the minority, with 27% of for-profit care homes reducing staff expenditure compared to 38% in the not-for-profit sector. This means that the overall reduction in staff expenditure relative to income during the first year of the pandemic was due to a small number of larger companies.

Table 2 Total staff expenditure during year one of the pandemic compared to the previous year

	Staff costs pre pandemic £000	Staff costs pandemic £000	Difference £000	Number of companies increasing total spend on staff	Number of companies decreasing total spend on staff
Total	6,680,452	6,410,346	–270,106	332	102
For profit	4,601,845	4,237,430	–364,415	222	65
Not-for-profit	2,078,607	2,172,916	+94,309	110	37

Table 3 Staffing numbers during year one of the pandemic compared to the previous year

	Staff head count pre pandemic	Staff headcount pandemic	Difference	Number of companies increasing staff numbers	Number of companies decreasing staff numbers
Total	289,517	287,968	–1,549	215	207
For profit	197,046	194,350	–2,696	143	139
Not-for-profit	92,471	93,618	+1,147	72	68

Table 4 Percentage of total income spent on staff during year one of the pandemic compared to the previous year

	% income spent on staff pre-pandemic	% income spent on staff during the pandemic	Difference
All companies	66%	64%	–2%
For profit	66%	62%	–4%
Not-for-profit	66%	69%	+3%

Despite predictions that other (non-labour) costs in the care home sector would go up – primarily because of the additional cost of PPE – our study found that the care home sector's overall aggregate costs (operating costs) marginally fell, from £9.6bn to £9.4bn, in the first year of the pandemic compared to the previous year.

We assume that the main explanation for this was the significant amount of assistance provided by government in the form of PPE. Whilst several care homes recorded large outlays on PPE and increased costs for medical equipment, in general providers were able to meet these costs through financial support from local authorities, as well as the government's "portal" which made PPE free to care homes from November 2020 onwards.

A survey by the Association of Directors of Adult Services found that 96% of councils had provided free PPE to care home providers before the introduction of the government portal.[41] We were told that the government provided care homes with PPE worth £92 million during the first year of the pandemic in Northern Ireland.

The Department of Health and Social Care told us that in England, £174m worth of PPE was provided to all care homes during the financial year 2020-21 and we identified that expenditure by some care home providers on PPE dropped over the course of the pandemic. For example, the large care home company cited above which reported 1% of its income on PPE between March and September 2020 saw this drop to 0.3% of its income in the following year, after the government made free PPE available to care homes across the UK.[42]

While the for-profit care home providers saw a 1.5% reduction in aggregate operating costs, the aggregate costs for not-for-profit companies remained almost the same during the first year of the pandemic compared to the previous period.

And not all care home providers saw a reduction in operating costs. Whilst 47% saw an overall reduction, 53% saw an increase. (see Table 5).

Table 5 Care home operating costs during year one of the pandemic compared to the previous year

	Operating costs pre-pandemic £000	Operating costs pandemic £000	Difference £000	Number of companies costs increasing	Number of companies costs decreasing
All companies	9,645,450	9,465,697	–179,753	244	215
For profit	6,523,509	6,343,881	–179,628	155	154
Not-for-profit	3,121,941	3,121,816	–£125	89	61

Aggregate profitability increased and most companies, particularly in the for-profit sector, saw an increase in operating profit margins

Because many care home companies succeeded in maintaining revenues while also controlling costs the care sector's aggregate profitability improved over the first year of the pandemic. Measured in terms of operating profit as a percentage of revenue, the aggregate profit margin of the care home sector increased from 4% to 6% (a net increase of £194m). In comparison, the aggregate pre-tax profit margin increased from 1% to 2% (an increase of £130m in total).

While the aggregate picture reveals the overall trend for the care home sector, there are differences between the for-profit and not-for-profit sectors. The aggregate operating profit margin for the for-profit sector increased from 5% to 8% (a total increase of £215 million), which also resulted in a pre-tax profit increase of £117 million compared to the year prior to the pandemic (see Table 6).

In addition, 64% of for-profit companies saw an increase in their total operating profits, and 62% saw an increase in their operating profit margins. By comparison, the not-for-profit sector saw an aggregate operating loss for amounting to £21 million. However, this aggregate loss disguises the fact that 52% of not-for-profit companies saw an improvement in their total operating profits and margins compared to the previous year.

Table 6 Operating profits during year one of the pandemic compared to the previous year

	Total Operating profit pre-pandemic £000	Total Operating profit pandemic £000	Difference £000	Operating profit margin pre- pandemic	Operating profit margin pandemic
All companies	363,675	557,805	194,130	4%	6%
For profit	323,512	538,827	215,315	5%	8%
Not-for-profit	40,163	18,978	–21,184	1%	1%

Total dividend payments increased during the first year of the pandemic

The dividend payments to shareholders also revealed increased profitability for some for-profit care home companies. Out of the 460 companies in our study that filed profit and loss accounts during the first year of the pandemic, about a quarter (122) paid out £120m in dividends. This represents an increase of £11.7m or 11% on the previous year.

An examination of the 25 companies which paid out more than £500k in dividends found that they paid out a total of £30.6 million in dividends and received a total of £21.7 million in government grants – from both the furlough and the Infection Control Fund scheme. On average, 5% of the income of these 25 companies came from government grants, which also equals 24% of their operating profits.

This means that government financial support has enabled some care home companies to make and sometimes increase their dividend payments.[vi] Government grants amounted to over 70% of the total dividends this group of companies paid out, raising questions about the fair and appropriate use of public funds.[vii] Again, as noted above, it is important to note that the government grants declared by companies in their accounts only relate to the furlough scheme and the Infection Control Fund and do not include other financial support provided by local authorities through increased fee income or other grant support. Thus the extent to which government financial support benefitted dividend payments is likely to be significantly higher than we have reported here.

The overall financial risk profile of the care home sector decreased over the first year of the pandemic

In addition to assessing the Profit and Loss Accounts of the 460 large care home companies in our study we also examined their balance sheets, and those of a further 1,450 smaller care home companies which also published this information, in order to build an overall risk profile of the care home sector after the first year.

Although not all care homes experienced an improvement in their profitability, the injection of financial support from the government led to an overall improvement in the risk profile of the care home sector as a whole.

As explained earlier, one of the measures of the financial health of a company is the ratio of total assets to total liabilities recorded as a company's 'gearing'.[viii] Before the pandemic, the proportion of companies with gearing exceeding 50% was 67.5%, whereas after one year of the pandemic, the proportion of companies with over 50% gearing had fallen to 61.6% (see Table 7). The proportion of for-profit care home companies that saw their gearing decrease was 75%, compared to 67% that saw their gearing decrease.

vi Out of the 30 companies which recorded dividend payments over £500k there were 5 companies which did not record any receipt of government grant income or any other operating income.

vii In most cases, the data on government grants is recorded in the accounts of those filing profit and loss accounts as "other operating income", mostly specifying the Infection Control Fund or the furlough scheme as the source of the income.

viii The gearing of care home companies can often be higher than other parts of the economy due to the fact that, like other property-based industries, large numbers of care home companies have outstanding debts to pay on the purchase or lease of their care homes.

Table 7 Gearing ratios for care home companies during year one of the pandemic compared to the previous year[ix]

	Pre-pandemic	Pandemic	Difference	% Change	Number of Companies Increasing	Number of Companies Decreasing
Number of companies with gearing over 50%	543 Companies 67.5%	486 Companies 61.6%	–57 –5%	–10.50%	227	678

As noted above, another measure of financial risk is the Company Watch H-Score which is used to identify companies at risk of filing for insolvency or of requiring major financial restructuring within 3 years. Any company which scores less than 25% is at significant financial risk. Before the pandemic, 24% of companies had an H score of less than 25%. After one year of the pandemic, this had fallen to 380 companies, 19% of the total.

Table 8 Changes in the risk profile of care home companies during year one of the pandemic compared to the previous year

	Pre-pandemic	Pandemic	Difference	% Change	Number of Companies Increasing	Number of Companies Decreasing
Average H Score	56.4%	61.5%	5.06	+5.06%	1237	685
H-Score Warning (% <25) number of companies with less than 25%	481 Companies 23.7%	380 Companies 18.8%	–103 –5.0%	–5.03%		

As seen above, both of these measures (i.e. gearing and H-Score) show that in the first year of the pandemic the financial health of the sector improved. This was despite reduced income and increased costs, thanks in large part to the cash injections by the government.

Conclusion

The significant financial support provided by the government to the care home sector meant that its overall aggregate position improved during the first year of the pandemic compared to the previous year. The four governments of the UK spent an estimated £2.1 billion on the care home sector to cover additional costs caused by the pandemic and to compensate care home companies for an estimated (8%) drop in revenue caused by reductions in occupancy. For-profit care home providers also successfully kept costs down, especially staffing costs. This led to several care home companies increasing their operating profit margins and their dividend payments to shareholders.

ix This data covers all companies which filed company accounts covering at least 9 months of the first year of the pandemic period, including those which do not file profit and loss accounts. This data is taken from the balance sheet data which they are required to submit.

The ongoing financial impacts of the pandemic – a crisis delayed rather than averted

Key findings:

- Since the end of lockdown restrictions in 2021 the financial impacts of the pandemic on the care home sector have worsened, as a result of COVID outbreaks, rising inflation and workforce shortages. Despite this government financial support has been withdrawn.
- As of July 2022 COVID-19 outbreaks were still affecting over 250 care homes in England, contributing to ongoing occupancy reductions and increasing financial pressures on the providers.
- As of March 2022, the profitability of the largest care home companies have fallen to the lowest levels since 2015. This decline in profitability occurred after the first year of the pandemic, reported on above, and prior to the removal of all government financial support for the sector.
- Workforce shortages – especially of registered nurses – are causing some care home providers to consider ceasing to provide nursing care. In addition, staff shortages are affecting safety and quality within care homes.
- Rising staffing agency costs due to workforce shortages, and sharp increases in energy and insurance costs, pose a significant threat to the financial viability of care homes.
- Some care home businesses are highly vulnerable to wider inflationary pressures, especially those with annual debt repayments and rental agreements linked to inflation indexes.

> *...the first three months of the pandemic, we didn't get anything at all. Then the grant funding started, which covered some of the cost. Then it increased, which covered most of the costs. And it's now ramping back down, so we're now in a net deficit again going forward probably from – around the autumn that's just gone past, through into next spring.*
>
> (Owner-manager in a small for-profit organisation)

The financial data for the first year of the pandemic analysed above tells only part of the story of the financial impact of the pandemic. Since 2021, financial pressures have increased and additional risks have emerged, including lower occupancy rates, staff recruitment issues, and higher running costs due to inflation, but government support has been scaled back. Whilst our analysis of the first year of the pandemic shows that the overall profitability of the sector marginally increased, according to the Care Quality Commission overall profitability then started to fall. By March 2022 the CQC reported that the profitability of the largest companies providing care homes for older people had fallen to its lowest levels since 2015, when the CQC began monitoring the finances of these companies and was now 3.7% lower than before the pandemic.[43]

This data on declining aggregate profitability in the care home sector is concerning, as the decline began prior to the withdrawal of government financial support for care homes in England in March 2022.[44] Although free PPE was to continue to be made available until March 2023, this removal of funding occurred despite a survey of operators published in January 2022 which estimated that care home costs were likely to increase by 30% in 2022.[45]

The post-lockdown financial challenge for the care home sector has led to a reduction in the number of registered care homes in England. Between March 2021 and August 2022, the CQC reported a 2.4% reduction in the number of registered care homes for all people in England (meaning 366 fewer care homes providing services), with care homes in the South West seeing a 3.7% reduction.[46]

Our qualitative data from interviews and open-ended survey responses also suggest that the financial impacts have worsened since the pandemic lockdowns ended, and that many senior managers were seriously concerned about their medium to long-term financial viability. These impacts included the following:

- Low occupancy amid continuing outbreaks and restrictions on admissions
- Workforce shortages in general, and particularly for nurses, leading to high expenditure on recruitment and staff agencies, and a decline in the safety and quality of care
- Sharp increases in energy and insurance costs, as well as other inflationary pressures

Low occupancy amid continuing outbreaks and restrictions on admissions

Data on COVID outbreaks in care homes revealed the extent to which the pandemic was still affecting many care home providers well into the summer of 2022. For example, in July 2022 there were 249 outbreaks in care homes, compared to 586 in January 2022, at the peak of the Omicron wave, suggesting that while the total number of outbreaks had declined, the virus was still having a substantial impact on the ability of care homes to admit residents.[47]

In July 2022, almost 5% of care homes could not accommodate visitors due to COVID outbreaks, which was similar to the numbers in the summer of 2021.[48,49] As of August 2022, the CQC reported that whilst care home occupancy had risen to 82.5%, it was still below the pre-pandemic level of 85%.[50]

According to one HR director we spoke to in March 2022:

> *we just had a seven-week rolling outbreak at [Home Name] which meant we could not admit a single resident, which meant we started in week one, as it happens, with 16 residents just because we had several die and we remained at 16 residents for seven weeks despite the fact we had 11 people lined up to admit.*
>
> (HR Director in a small not-for-profit organisation)

Despite the impact on their businesses, care home managers could not access any financial support for complying with public health regulations by closing their homes to new residents when an outbreak occurred. As another manager told us: *"What's really hit providers is there's no financial compensation for effectively being told to cease trading."* (Senior manager in a medium-sized not-for-profit organisation)

Workforce shortages cause high expenditure on agency staff and a reduction in the provision of nursing care and an increase in safety and concerns

In England, staff vacancy rates in residential care homes increased from 6% in April 2021 to 11.4% in January 2022. Turnover rates rose 8% to 34.8% in the year to April 2022.[51] There are numerous reasons for these workforce shortages.

In January 2022, the CQC found that 40% of the care home providers those surveyed identified vaccination as a condition of deployment to be a barrier to recruiting staff.[52] Our interviews with care home managers supported this. For example, a home manager in a medium-sized for-profit organisation reported losing 5 of their 40 staff for this reason. A senior manager in a large not-for-profit organisation employing 7,500 people said they had lost more than 300 staff members when the vaccination mandate was imposed.

Some care home managers attributed the workforce shortages to staff exhaustion and burnout. One told us:

> *Our vacancy rates are much higher than they've ever been. Our [staff] turnover rate has gone up to about 33%, and we had it down at about 18% before the pandemic. We've had lots of staff leave through exhaustion, disillusionment, illness, and all of those sorts of things. Not being able to have staff move from one home to another, including agency staff, has meant that we've been chronically understaffed and asking staff to go the extra mile for over two years, which is too long to put pressure on people*
>
> (Senior manager in a medium-sized not-for-profit organisation).

The shortage of registered nurses has been particularly acute. According to the CQC, turnover rates amongst registered nurses working in adult social care had increased to 38.2% as of August 2021 compared with 8.8% for equivalent roles in the NHS.[53]

The difficulty in recruiting nurses has led many care home providers to consider ceasing to provide nursing care. Between March and December 2020 (prior to the full onset of the recruitment challenges of late 2021 to early 2022), care home services in some areas were already changing their registration from nursing to residential care.

The CQC found that over this period, 19 local authorities saw at least one home change registration from nursing to residential, accounting for more than 1,000 beds.[54] They also stated that they had heard examples of care homes cancelling their registration to provide nursing care because their recruitment attempts have failed. This meant that residents needed to find new homes in local areas that, given staffing challenges, were already at, or close to, capacity. Again, our research confirms this:

> *we will probably change our registration so that we no longer offering nursing care because it's unsustainable, we can't—you know, we can't get the nurses… You know, when we're paying our starting salary for nurse of £21 an hour, it's a good rate of pay and we can't get good nurses*
>
> (Senior manager in a small for-profit organisation)

Staff shortages and turnover have also propelled agency staff costs upwards. For example, the large chain Four Seasons Health Care reported that "as a percentage of total payroll, agency costs have increased from a low point of 6% in mid-2020 to an average of 18% in Quarter 4 2021".[55] This seemingly unsustainable rise in agency costs was echoed by our interviewees, one of whom told us:

> *To give you a figure, we've gone from a budget of £400,000 a year agency to an actual cost this year [..]of over £3.2 million.*
>
> (Finance Director in a small not-for-profit organisation)

Data also shows that the staffing crisis that has emerged during the second part of the pandemic is beginning to affect safety and quality within the care home sector. In January 2022 nearly 1% of providers flagged that their agreed staffing ratios had been breached. In May 2022 4.8% of adult social care providers flagged that there was a "significant risk of escalation due to challenges to their agreed safe staffing ratios."[56]

Sharp increases in energy, insurance costs, and inflationary pressures.

Care homes for older people tend to have higher heating bills than other residential businesses. In our interviews in March 2022, the finance director of a large not-for-profit provider spoke of how they planned for an increase in their energy bills of 50%, even before the huge increase in global energy costs that began to emerge in the summer of 2021. Another large care home company whose existing energy contracts were fixed until September 2022 reported in July 2022 that it had been quoted prices amounting to an increase of between 200% and 300%.[57]

Subsequently, in August 2022, Care England, a representative body for the care home sector, produced research showing that annual energy costs per bed would increase from £660 to £5100, making large parts of the care home sector unsustainable.[58] Care homes and staff are also facing rising food and transport costs.

Throughout the pandemic, care home operators have also been concerned about the withdrawal of indemnity coverage by insurance providers and increased insurance premiums. The Financial Times reported in June 2022 that some care home operators were seeing insurance costs increase by 300 – 400% and at the time of publication this issue remains unresolved.[59] All of the above factors are impacting the financial viability of care homes and increasing the costs for self-funders.

The financial situation of care home providers with debt repayments and rental costs indexed to the rate of inflation, and subject to other inflationary pressures will have further, as yet unassessed, implications for the viability of many care homes.

In addition, such inflationary pressures are likely to have an impact on the fees charged to residents who pay for themselves, who already pay around 40% more than local authority-funded residents. During the first year of the pandemic, 2020 to 2021, fee increases for self-funders averaged around 4% for those paying privately; by the financial year 2021 to 2022, they had increased by a further 5.5%.[60] In January 2022, the Financial Times reported that one large private care home provider mainly focused on self-funders intended raising fees by 10% in the coming year.[61]

Conclusion

The financial impact of the pandemic on the UK care home sector extended into the latter parts of 2022 and into early 2023. These impacts include reduced occupancy levels due to infection outbreaks in care homes, inflation and workforce shortages, especially since lockdown restrictions were lifted in the summer of 2021. Without dedicated financial support from the government the care home sector faces potentially greater levels of financial risk compared to those faced before the pandemic. In addition to the potential for care home companies to suffer financial collapse, these growing financial challenges are highly likely to impact upon the quality of care provided to residents and the terms and working conditions of the care home workforce.

Section 2: How the care home workforce experienced the financial impact of COVID-19

There have been longstanding concerns about the pay and conditions of care home staff. Improvements are constrained by the level of income from local authority funding, private fees and other sources. Some major care companies have also been criticised for business models involving high levels of interest payments, rents and distribution to shareholders, which may reduce resources available for staff expenditure and support.[62,63] The pandemic brought new financial pressures for care homes, as well as government intervention to help mitigate these. During the pandemic, some positive changes were introduced (most notably in the shape of modest bonuses, and sick pay), but eligibility for these depended on location and contract.

Staff experiences are a measure of the quality of jobs offered to a large workforce. They influence recruitment and retention for the sector, which are significant for care home finances, whilst staffing levels, staff training and levels of turnover affect the standard of care services.

Findings are divided into the following 3 sections:

A) The impact of COVID-19 on the pay and personal finances of care home staff

B) The impact of COVID-19 on staffing levels and workload

C) The non-financial support provided by employers to care home staff during COVID-19

Method

In this section we draw on a survey and interviews to explore the perspectives of staff on financial changes in their workplace, and in their personal finances, during the pandemic. The research was undertaken with staff in care homes for older people around the UK, between October 2021 and April 2022. Our survey sample of 605 staff was sufficient to produce statistically significant results, but given the diversity of the care workforce and of care homes around the UK, as well as the complexity of the issues at stake, our results should be treated only as indicative. In-depth qualitative data comes from interviews with 43 care home staff, including workers, managers and senior managers. While we sought to recruit a diverse sample, the following groups were over-represented relative to the overall workforce: staff in Scotland compared to other parts of the UK; staff in roles other than care assistants; white staff; and men. Details of data and analysis are provided in Annex B.

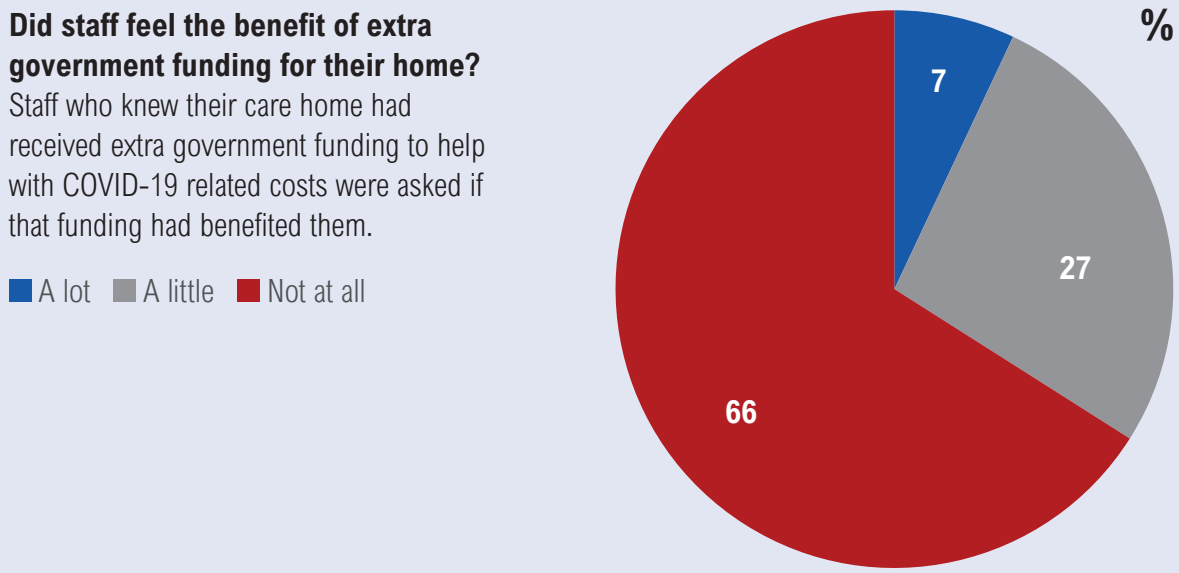
The impact of COVID-19 on the pay and personal finances of care home staff

Key Findings:

- Despite the extra public funding provided to care homes from government during the first year of the pandemic, half of the staff who responded to our survey believed that the finances of their care home had worsened.
- Additional government funding for care homes was not felt to benefit most staff. Most survey respondents (64%) said that they knew their care home company had received extra funding, but a large majority of staff (66%) said it had not benefited them, whereas only 7% suggested that it helped a lot.
- 42% of respondents reported personal financial problems linked to working in care during COVID-19.

Figure 1

Did staff feel the benefit of extra government funding for their home?
Staff who knew their care home had received extra government funding to help with COVID-19 related costs were asked if that funding had benefited them.



The impact of COVID-19 on the pay of care home staff

The issue of low pay in the sector is a long-standing issue, but the demands and pressures of the pandemic highlighted this further. Almost six in ten survey respondents were somewhat or extremely dissatisfied with their pay. Critically, despite greater hazards and greater intensity of work, 78% of the care home staff in our survey said that their hourly pay did not increase during the pandemic.

Although the lowest paid staff will have benefited from increases to the statutory minimum wage, the absence of pay differentials within the care sector failed to reward additional experience and responsibility, or to incentivise staff to take on more senior roles. Although staff were conscious of the unsustainability of wage rises in a context of financial pressures, some also questioned the distribution of revenues between staff and managers:

> *I care about the budget, but, you know, I also would like to be paid for work I've done (…) When the owners drive Porsches and their kids go to 40 grand a year private schools, you think actually, you can afford to pay me an extra £10 a day for work I'm actually doing.*
>
> (Support role worker in a medium for-profit provider)

Additional unpaid overtime was also common:

> *You come in early and leave late. No extra – I mean it's not all about money. It's not why we're doing it necessarily, but no extra pay. Lots of like, "Oh, okay, we do appreciate you coming at half past 7''. [Managers say,] "We can't afford to pay you. Just go to do it". Well, actually, that means I'm working a job for free every day. That's actually pushing me under the minimum wage because you're getting free labour.*
>
> (Support role worker in a medium for-profit provider)

All categories of staff were more dissatisfied with their pay and sick pay arrangements than care home managers. More specifically, senior care workers and registered nurses reported more severe personal financial problems during the pandemic in comparison to their managers.

The vast majority of managers and care workers that we interviewed expressed their concerns about pay and the struggles to retain staff due to the inability to compete with wages and conditions in other sectors. Some employers were able to offer improved conditions and benefits, such as length of service awards, extra leave or hardship funds. In addition, two charitable providers in our sample (one small, one large) moved to being Living Wage employers.

While overtime was not paid a higher rate in all organisations, a nationwide charitable provider was one of several to increase overtime rates (in this case, a permanent 25% increase). In general, employers have still struggled with recruitment and retention because these were improvements from a low base, in a tightening labour market, as this example demonstrates:

> *In October [2020], we were haemorrhaging staff. They were just leaving hand over fist. Morale was really low. And so, (…) one morning, I walked into my office and I had three resignations on my desk. So, instantly, I put everybody's pay up by a pound [an hour]. I then sat down after I'd done it and it worked out that I needed £200,000 a year to make that payment. So, I wrote to the local authority, I wrote to the CCG, and, you know what, they've given us a 4.2% increased when, actually, what we needed was 7.8% increase. And I evidenced why we'd done it (…) We're between an Amazon factory and a Co-op distribution centre. So, they're paying, on average, £12.85 an hour, plus on top of that, they're paying shift enhancements. We're nowhere near that. We're paying £10.30 an hour or if you've got a Level 3 diploma, we're paying £11.*
>
> (Owner-manager of a small for-profit provider)

Bonuses and sick pay for care home staff during COVID-19

Whilst our survey found significant dissatisfaction with rates of pay for care home staff, there were other interventions by governments, local authorities and care home companies in the form of bonuses and enhanced sick pay that benefited staff financially, although it is important to note that access to them varied geographically and was also based on terms of employment.

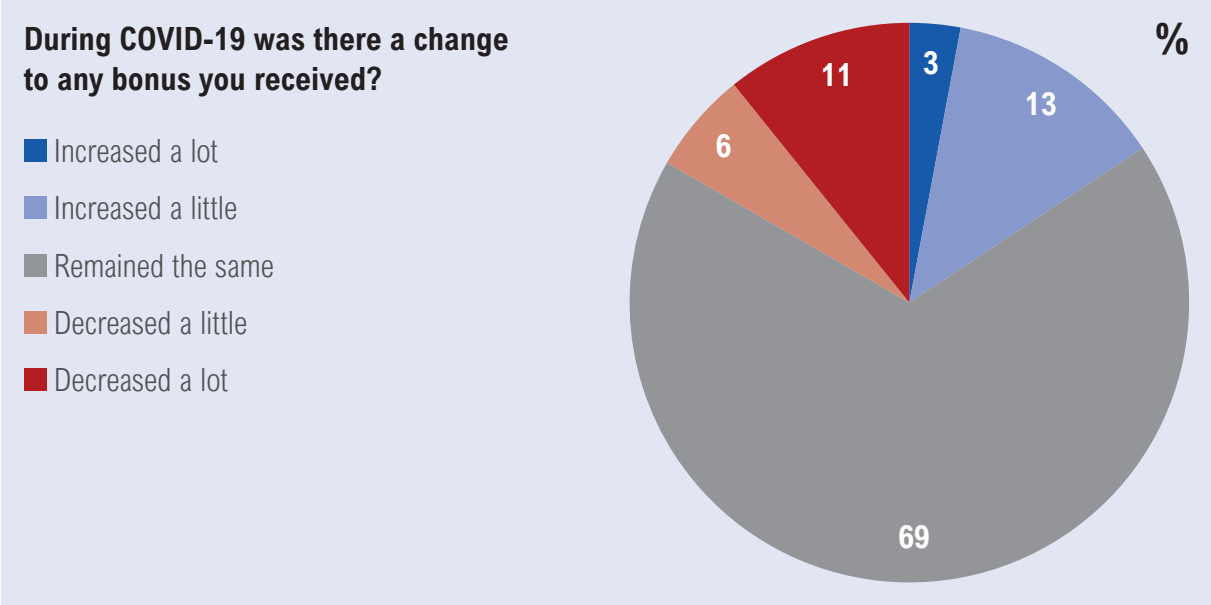
First, occasional 'recognition payments' or bonuses were publicly funded in Scotland, Wales and North Ireland (£500 per full-time staff member, with extra in Wales to cover tax deductions). England was notable in its lack of a national approach to paying bonuses.

Some English local authorities did pay bonuses and providers had the discretion to use the Workforce Recruitment and Retention Fund for such payments.[64,65] However, employers reported difficulties caused by local authorities applying complex conditions to funding.

Providers operating across different local authorities in England also had to contend with varying approaches, for example where one council announced a bonus but another did not fund one; ensuring consistent treatment of their staff across different geographical areas therefore required use of organisational funds.

Out of those care workers that we surveyed 13% of said that their bonus increased a little, 69% reported no change and 16% reported that their bonus decreased.

Figure 2



Several interviewees reported that employers, including major providers, failed to pass on earmarked government funds to staff until they or their union pursued them. Moreover, these payments were not seen as sufficient recognition for the work and risks assumed by staff, nor as likely to have a major impact on turnover given excessive workload pressures:

> *I think the owner did receive some government money (…). I can't remember how much, but it wasn't very much, but we did get a little extra something in one of our pay cheques. They basically could have kept it and we would have had no idea. It wasn't very much.*
>
> (Support worker in a medium for-profit provider)

Staff employed through sub-contracting agencies could not benefit from some of the additional support. Furthermore, they were unlikely to have been eligible for profit-share schemes operated by individual providers pre-COVID, while some employment terms were inferior (such as payment for breaks). However, our survey suggests that staff on a fixed-term or zero-hours contract had higher increases in hourly pay than those on a permanent contract.

Second, sick pay generally improved thanks to dedicated government funding to cover COVID-19-related illness and isolation, with government guidance stating that care workers should be paid their

full wages for the time that they were required by law to isolate.[66] Without this, employers told us they would not have been able to meet the cost. A care worker in a medium-sized for-profit provider described the positive impact of full sick pay:

> *Oh my God, I'm really ill. And I'm thinking (...) that I can't afford to be off. But then, when I got the test and it was positive, and so I phoned them and said look, you know, what can I do? And they said, "Don't worry. Just get better. You're getting paid."*
>
> (Care worker in a medium-sized for-profit provider)

However, approximately half of survey respondents were somewhat or extremely dissatisfied with their sick pay. There were high levels of variability in practice. Some staff received full pay, but others reported only receiving statutory sick pay, and no support when caring for affected household members:

> *My son got COVID in beginning of December [2020] and I had to isolate with him, and I got nothing, absolutely no pay. So I lost out, I got no pay for that. And then I got COVID and I had to isolate obviously, and then I got statutory sick pay, so I got £96…. I only worked eight days that month, and it was really hard, and that was just after Christmas, and financially, it was awful.*
>
> (Support role worker in an individual for-profit provider)

Part of the issue with the enhanced sick pay introduced across by the government across the UK was that it only covered care workers for the period when they were required to self-isolate by law because of testing positive for COVID-19 – usually around 10 days – rather than for the period when they were actually unwell. This contrasted with the more generous scheme for NHS workers in England who were provided with full pay for the time whilst off sick with COVID-19 which could be for an extended period beyond the 10 day period.[67] In addition, care home staff could not apply for enhanced sick pay to a separate body, but were dependent on their employers to use the funding from the Infection Control Fund.

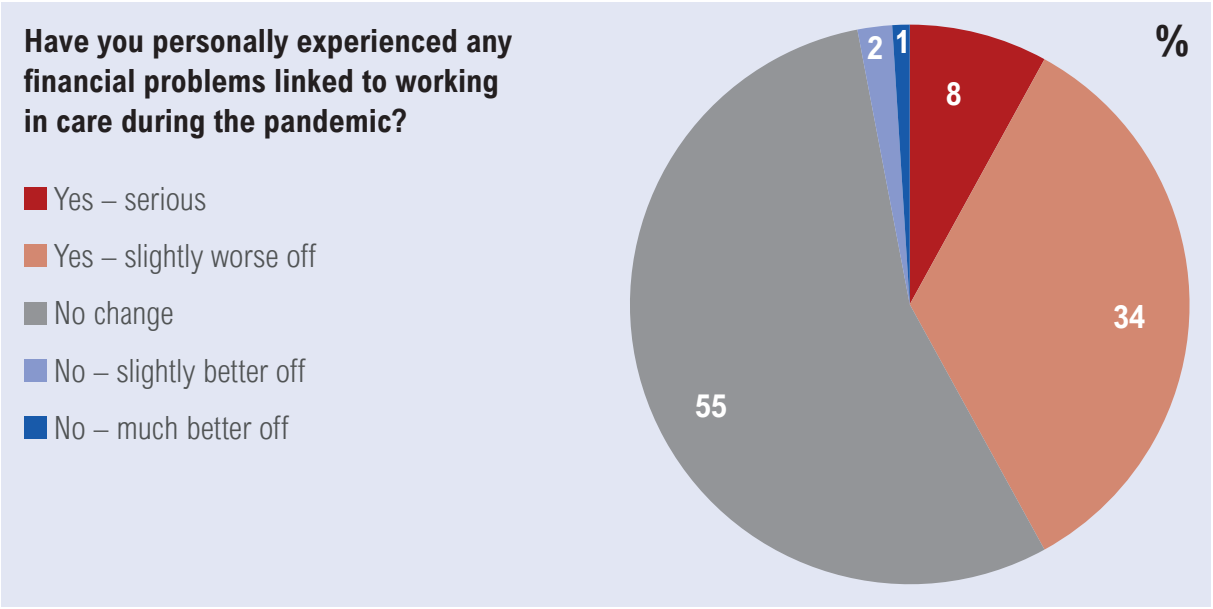
Aside from bonuses and sick pay, small, practical rewards, like cakes or hand cream, were viewed positively – but certainly not as a substitute for improved pay in the sector. Public recognition of the importance of care is essential. However, our interviews with staff suggest that decision makers need to avoid purely symbolic gestures, for example, the care worker badge, which seemed tokenistic and insulting without proper action to address fundamental conditions:

They put on a week of celebration for the carers. So I had to blow up 150 balloons and put them on an arch so there's lovely, big, red, white, and blue arch when they walked in. And then each day, they provided a lunch, so it was like snack-y stuff. The budget for each carer for the week was £1.56.
(Support role in a large not-for-profit provider)

The impact of COVID-19 on the personal finances of care home staff

Financial difficulties were widespread among staff responding to the survey: asked whether they had personally faced financial problems linked to working in care during the pandemic, 42% reported 'serious' financial problems or being slightly worse off.

Figure 3



The cumulative impact on the lowest paid staff of the challenging financial situation in their workplace, as well as the wider economic shutdown, also came through in our interviews. Within households, we heard examples of the partners of care workers being laid off without eligibility for government payments or sick pay. Among care home staff, furlough was granted unevenly: some employers allowed staff with a vulnerable household member to take up the scheme, while others refused it to single parents who needed to care for their children.

Some employers offered emergency hardship funds for staff facing financial distress. This account from a manager-owner simultaneously demonstrates flexibility in responding while also outlining the depth of problem:

> *We were trying to stop [our staff] taking payday loans. (…) And with some people, we actually (…) just said, "Look, here's a couple of hundred pounds, just go and use it as you see fit."*
>
> (Manager-owner of a small for-profit provider)

Changing hours led to volatile earnings and benefits, meaning some care staff worked extra hours without an increase in income and indicating a lack of appropriate flexibility in the welfare system:

> *I was getting more [pay] during COVID but that was because I was putting in the overtime. But then it became hard (…) because obviously I wasn't doing as much overtime and we weren't really getting the double enhanced rate. Financially, it impacted me a lot because I get tax credits. (…) When it came to renewing my tax credits, I'd worked over and above my contracted hours, so I lost my tax credits, the majority of it. So I was penalised.*
>
> (Support role worker in an individual for-profit care home)

It is also important to contextualise the experience of staff working in care homes during the pandemic by understanding their wider personal and family life. 41% of respondents had to do more unpaid care for their relatives alongside work. In addition, we did not find any evidence of staff receiving support for other costs such as childcare, despite some policies identifying these as legitimate costs to support.

Influence of care home ownership type and size on staff pay and job satisfaction

Our survey revealed significant variations within the sector in relation to staff pay and job satisfaction. The type of ownership – whether for-profit or not-for-profit – also had an impact. Surveyed staff in care homes owned by a for-profit company were more dissatisfied with their sick pay compared to staff in the not-for-profit part of the sector. This reflects wider evidence of inconsistent implementation of enhanced sick pay supported by government.[68]

Additionally, in terms of organisational size, individual care homes were more highly rated than chains by staff across a range of metrics. Staff in individual homes (i.e. those which were not part of a large chain of care homes) were more satisfied with both their pay and sick pay. They were also more satisfied with their ability to offer good care and to make or influence decisions affecting their work.

Conclusion

Despite a greater degree of recognition of the importance of care homes and their role on the frontline of the pandemic, improvements to pay and conditions were not part of the government response to the pandemic, with the exception of limited changes to sick pay and 'recognition payments' to some care home staff. It is striking that 42% of our survey respondents reported financial problems related to working in care (including 8% who said they had 'serious' problems). All groups of staff acknowledged the need to increase both pay and recognition for care to parity with other similar roles, for example in the NHS. Many respondents also argued that action by policy-makers was required to address these disparities. The lack of value attributed to care work and its relationship to staff pay, was summarised thus:

> *This is one of the things that's galling. You know, we'll say to our commissioners, be it the local authority or the CCG, "Pay us so we can pay our staff what you pay yours". I worked out how much it would cost us to pay our staff the NHS enhancement, so 25% on a Saturday and 40%, I think it is, on a Sunday, and then they'd get 60% on a bank holiday. And so, I worked that out: in a year, that would cost us over £100,000.*
>
> (Owner-manager of a small chain with approximately 80 staff)

Although the impact varied between different staff groups and types of organisations, large majorities remained dissatisfied with pay, experiencing no increases despite greater hazards and intensity of work.

The impact of COVID-19 on staffing levels and workload

Key Findings

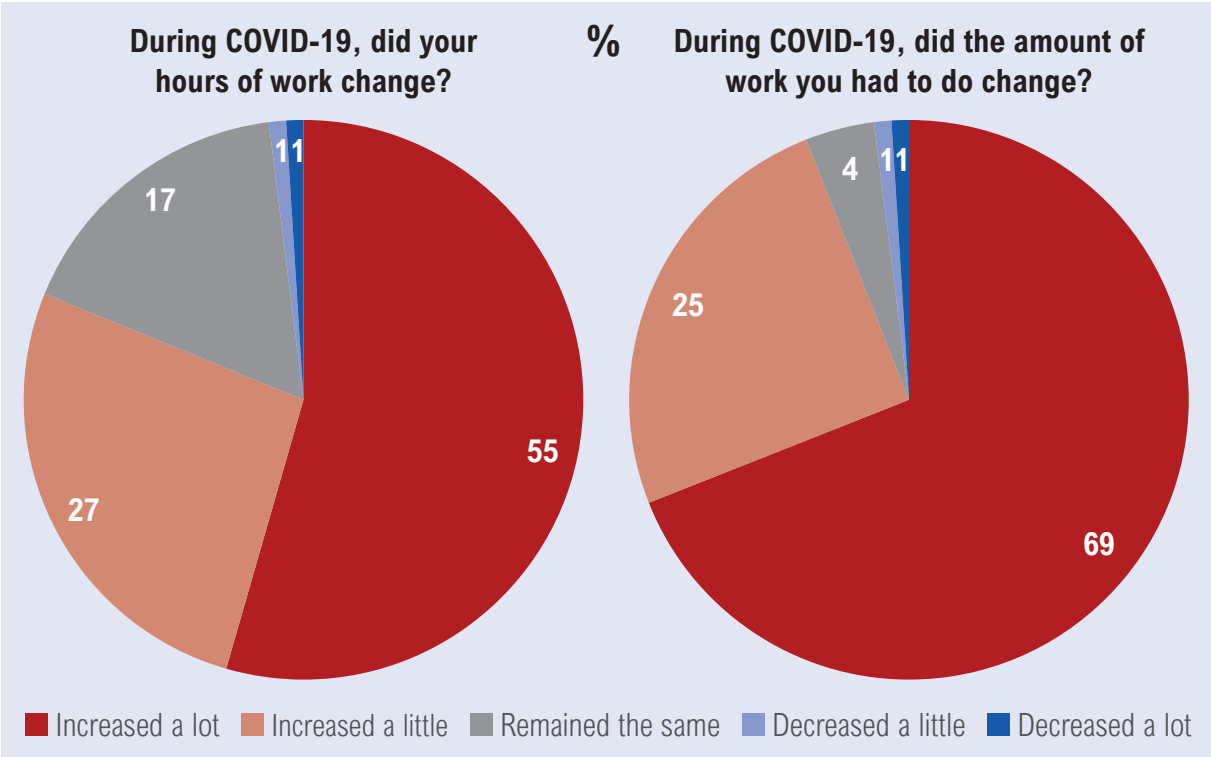
- 95% of survey respondents said their work intensified to varying degrees. Hours of work increased a lot for 55% of staff and a little for another 27%.
- Staff reported greater increases in hours and the amount of work they performed in for-profit homes compared to not-for-profit homes.
- Excessive workloads and staff shortages were widely perceived to have adversely affected the quality of care provided to residents: one in two survey participants reported that their ability to meet residents' needs got a little or much worse during the pandemic.
- One of the common reasons given for staff working more intensely was the fact that staff had to perform additional tasks owing to infection control measures. Staff also had to perform additional administrative tasks which they had not undertaken prior to the pandemic.
- As detailed in Section 1, the number of people working in care homes during COVID-19 did not rise overall. And despite increased staff expenditure by most providers, a substantial minority of for-profit providers cut spending on staff in 2020-1 as part of their strategy to maintain their financial viability.
- Within this overall context of pressure on staff numbers and staff expenditure, care home staff had to undertake their roles amid high rates of absence for COVID-19 exposure and infection, while also dealing with a range of extra responsibilities brought by the pandemic. Unsurprisingly, work intensified and extended for most care workers who responded to our survey. Here we identify the key causes of this increased intensity, how these levels varied by the type of provider and the job role, and provide some reflections on the impacts on care.

Workloads and working hours for care home staff increased compared to prior to the pandemic

Care home staff reported a significant level of increase in workloads: working both harder and longer, 95% of respondents said their work intensified to varying degrees.[x] Hours of work increased a lot for 55% of staff and a little for another 27%, according to our survey.

x Our interview data suggest part-time and hourly-paid contracts served as a buffer against increase in hours of work. Staff on such contracts typically worked only during their contracted days/hours. This may partly explain why hours did not increase for 18% or increased 'a little' for 27% of staff who responded to the survey.

Figure 4



Care home staff at all levels worked long hours, sometimes weeks in a row without a day off:

> *We're doing so much. We never stop and we're just exhausted. Some of the staff feel like a machine, like a factory, it's never finished. We don't actually have proper time to speak with the residents, not even to give proper care to be really honest because we're short staffed and we can't.*
>
> (Care worker/assistant in a large for-profit care home)

Owing to staff shortages, many were effectively always on-call:

> *I love going to watch rugby, but I'd have the work phone tucked in my bra because I was constantly on call. You know, I'd get a call at three in the morning, and you've got to jump in the car and go.*
>
> (Support worker in a large not-for-profit care home)

Outside work, many staff juggled increased unpaid care with efforts to avoid passing on COVID-19 to family and friends. Overall, our interviews found that the lack of work-life balance and social isolation strained relationships, impoverished their free time, and negatively affected their wellbeing. Interviewees said they were often anxious and exhausted. As has been reported elsewhere, overwork and strain on their wellbeing brought much of the care workforce to a breaking point: high levels of burnout have been reported.[69] Across health and social care since the start of the pandemic, there is evidence of significant increases to overtime; 58.8% reported feeling overwhelmed by increased pressures and rates of burnout have risen.[70]

Ownership, size of the care home and job role influenced the number of hours worked and the intensity of work

Workloads varied across different types and sizes of homes. In for-profit homes, staff reported greater increases in hours and the amount of work they performed compared to staff in not-for-profits.

Some interesting variation by size was observed. Working hours and workload rose more for those in small organisations than larger ones, according to survey responses. Despite these higher increases in work, staff in individual homes were more satisfied with their workload and range of duties than those in bigger groups of homes. That could reflect how changes were decided, but staff satisfaction with their ability to make or influence decisions affecting their work did not differ by organisation size.[xi] It may be that levels of work in smaller organisations were lower initially and the increases were therefore more manageable. It could also reflect how changes were distributed within the workforce and the degree of support for staff: larger organisation size was associated with lower staff satisfaction with support.

An increase in the number of hours worked was common across all staff groups but there was some variation. Based on the self-reporting of experiences by survey respondents, home managers and senior care workers saw greater increases in hours compared to registered nurses and support staff. In addition, our survey found that the number of hours of work increased more for female staff compared to male staff, and more for staff who are British nationals than EU/EEA nationals.

Increased work was driven by staff shortages

The availability of care staff was a major cause for concern. Senior staff and care home managers reported in interviews that a combination of factors led to shortages. Staff absences were significant due to increased rates of sickness and self-isolation due to COVID-19 infections.[71] Compared to 2019-20, the average number of days that a staff member was absent rose by 86% in England in 2020-1.[72]

Staff retention also became more difficult during the pandemic, interviewees reported. Some staff left during the early stages of the pandemic out of fear for their own and their families' wellbeing. Others worked harder than before with a sense of duty and camaraderie, only to find that the mental and physical toll of the work they were expected to do was unsustainable.

In some areas, such as Cornwall, care homes struggled to compete with the better pay and conditions offered in other sectors (e.g., tourism and retail). In response, some homes offered improved pay, but many could not afford to do so. Most care home managers experienced significant levels of staff shortages, adding to the demands on existing staff who covered for their absent colleagues or vacant positions.

The need to implement infection control measures and carry out new administrative tasks drove up workloads for care home staff

One of the common reasons given for staff working more intensely was the fact that staff had to perform additional tasks owing to infection control measures. These included enhanced cleaning protocols; administration and reporting of daily tests for all staff and visitors; PPE use; restrictions on visits, which added to care needs; limitations on staff movement between units, hindering effective staff collaboration; and isolation of residents in their rooms, making it harder for staff to monitor and care for multiple residents at the same time.

In addition, staff time was taken up with carrying out additional administrative duties which resulted from frequently changing government advice, additional reporting requirements by regulators and government, and applications for financial support, including government grants. High levels of staff turnover also added to this administrative burden with more time spent recruiting new staff and their induction into the organisation.

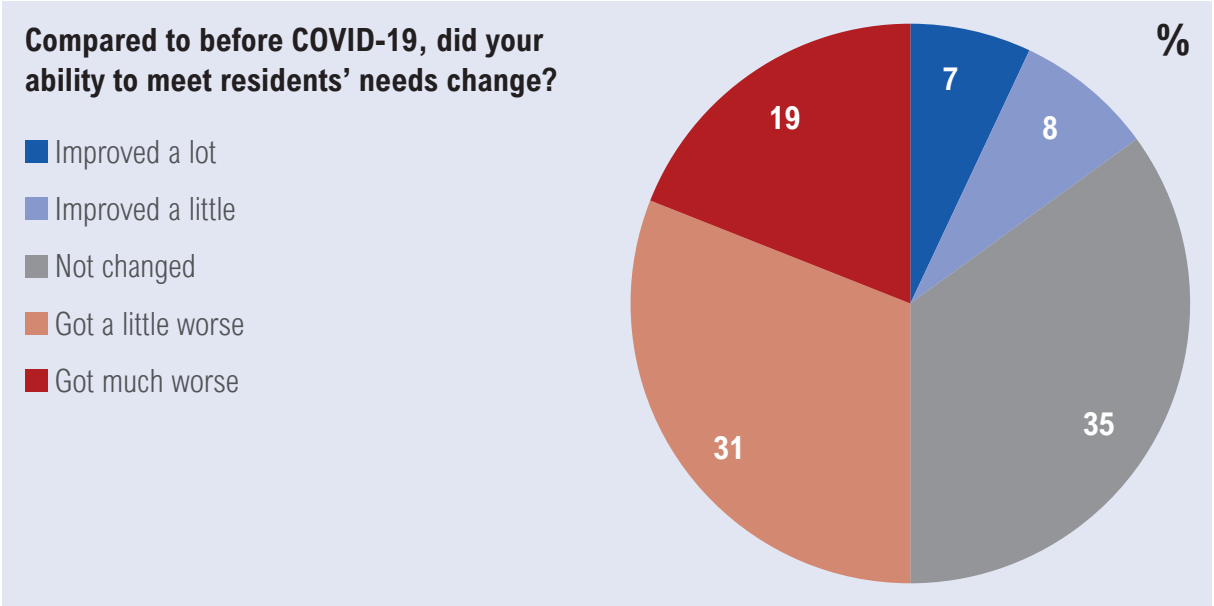
xi There was a difference by home size: staff in larger homes (>50 residents) were more dissatisfied in this respect than those in smaller sites.

Major shifts in the day-to-day role of care staff were also common, based on interviews and survey responses. To be able to continue the core operation of a care home amidst staff shortages, organisations often deployed available staff to undertake tasks beyond their typical duties, blurring the lines between the different roles and responsibilities within the organisation. For example, home managers and support staff often worked alongside carers. We were also made aware of instances where staff had to undertake clinical tasks beyond their remit and expertise because primary care teams and community health suspended care home visits.

The impact of COVID-19 on the ability of care home staff to meet the care needs of residents

Excessive workloads and staff shortages were widely perceived to have adversely affected the quality of care provided to residents: one in two survey participants reported that their ability to meet residents' needs got a little or much worse during the pandemic.

Figure 5



Some interviewees also expressed concern about the impact of prolonged working at high intensity on service quality:

> *I think we're all going through a very drawn-out period of just… exhaustion, really. (…) I suppose the impact there is that you're then a bit less able, a bit less equipped to support other people. You're probably a bit less caring, a bit more task-orientated if you're a carer (…). So, we're asking people to do long days and meds rounds at the end of a 14-hour shift, and we're asking managers to do supervisions when they're not feeling very well. We're asking people who should be doing office-y stuff to work waking nights. So, we're (…) asking an awful lot of people, and you can do it for a while.(…) The problem is when it carries on for 18 months, 24 months, and beyond (…) and it gets sort of harder and harder. So, you know, and like a slow burnout is there, obviously.*
>
> (Owner-manager of a small care home)

One consistent view which came through amongst those we interviewed was that care home staff at all levels sought to work above and beyond their duty to provide a safe and supportive environment to residents, for whom they expressed deep care and affection. However, many felt exhausted and

abandoned by government, society and, in some cases, by managers, as the pandemic persisted. Many interviewees still reported the impact of high-intensity working due to repeated COVID-19 outbreaks and staff shortages in the spring of 2022. It was because of this experience that many of the research participants and stakeholders we engaged with called for immediate steps to address staff shortages, in addition to designing a national long-term workforce plan (see recommendations).

BOX 3: Furloughed staff redeployed to care in Wigan

As an example of efforts to address staff shortages, in Wigan the council supported the staffing of care homes by organising a substantial redeployment of staff who were unable to perform their usual work during the pandemic. Here we summarise the reflections of the council's director of leisure, James Winterbottom, from a discussion in July 2022.

At the start of the pandemic, the council prioritised delivering key services, including social care. To help ensure that care settings had enough staff to function, about 900 people who had been furloughed from their roles in wider council services agreed to be redeployed. The redeployment was organised rapidly (within a few weeks) but had a sustained impact, with most people staying in their new roles for a year or even longer.

The council collated information on roles to fill, what kind of personal attributes were needed, and ran online sessions in which managers from care settings could address queries and concerns from potential redeployees. Importantly, trade unions were involved in the process, and support was also provided with training, a buddy in their new setting, and regular check-ins with their usual manager.

For staff who volunteered, the council topped up the standard 80% of pay provided through furlough to 100% of their wages. This helped maintain people's incomes, but the council had to shoulder the financial burden. That represents a subsidy to the mostly independent sector care providers – another example of the complexities of organising financial support to a mixed economy of care companies.

The redeployment is said to have been extremely positive for care services and redeployees alike. The new staff members brought enthusiasm and skills to their roles in care (for example, leisure services staff were good at encouraging service users to do activities). They built relationships and helped achieve some really positive outcomes for service users. Some of the staff have stayed in care, finding it a great development opportunity.

To create longer-term impacts, the council has been working on creating 'reservists' – staff who have 3-4 weeks of paid training and are available for emergency staffing, for example, in a winter flu crisis or future pandemic.

Conclusion

Substantial extra public funding for care homes did not effectively shield staff from unsustainable workloads, and indeed its administration contributed to some of the rise in workloads. Staff in for-profit homes were particularly badly affected in terms of increased hours and intensity of work, reflecting existing evidence of poorer employment conditions in that part of the sector.[73] Our evidence also suggests that staff in individual homes were more satisfied with their workload, pay and ability to offer good care than those working for care home companies which operated care home chains.

While many providers made enormous efforts to staff their homes fully, they struggled to do so. Some care homes were unable to afford, find, or manage the recruitment of extra staff. However, some informants believed that providers were choosing to save money by not filling vacant posts, using agency staff, or paying employees for more hours to cover extra work or colleagues' absences.

Although the rate of staff vacancies initially fell, due to the availability of labour from other sectors that were unable to operate in lockdown, overall staff shortages were severely exacerbated by the impact

of the pandemic. Alongside high rates of sickness absence, the proportion of posts that were unfilled on an ongoing basis rose from 5.9% in March 2021 to 10.3% in June 2022.[74] An insufficient, unstable and overworked workforce jeopardises the provision of services and the quality of care.[75] Half of those surveyed said their ability to meet residents' needs had deteriorated during the pandemic.

Other research has found that lack of work-life balance, pressures on their physical and mental health and low levels of job satisfaction are the primary reasons for high staff turnover in the sector.[76,77,78] Our survey found that 63% of respondents planned to stay in the sector for the following six months – and more staff in individual care homes said they planned to stay, than those working for a care home chain – while 11% wanted to leave and the remainder were unsure.

This aligns with research on retention before the pandemic, according to which "nearly a third of workers left their job in the previous 12 months, although the majority (67%) stayed in social care".[79] However, when we presented initial findings to care home staff during interviews, and in meetings with sector representatives, they thought our numbers underestimated the exit rate and said that their colleagues were leaving the sector "in their droves".

The non-financial support provided by employers to care home staff during COVID-19

Key findings

- Staff in not-for-profit care homes were more satisfied with non-financial support from their managers than those in care homes owned by a for-profit company.
- Staff in care homes with more than fifty residents were less satisfied with support from their manager than those in homes with fewer than fifty residents. Those working in homes that were part of a chain – rather than an individual home – were also less satisfied with support from their manager or their organisation.
- Employer support for care workers to help them cope with distressing experiences was not routinely available in all care homes, with many interviewees describing their colleagues as the only effective source of support.

Non-financial support – such as mental health and bereavement therapy, emotional support and managerial support – has been vital for staff during the pandemic who have faced new risks to their health, experienced higher rates of death among residents, and extreme workload pressures. We found that the availability of non-financial support is influenced by organisations' financial resources and – relatedly – staffing, which affect providers' capacity to fund and coordinate managerial, peer and specialist forms of support.[xii]

Satisfaction with the non-financial support provided by employers varied by ownership type and the culture of the care home provider

Staff in not-for-profit care homes were more satisfied with non-financial support from their managers than those in care homes owned by a for-profit company. More effective cultures of support were linked by interviewees to:

- availability of financial resources to support staff;
- the values and experience of senior managers (for example, those with a nursing background were seen as having a better understanding of the realities of care);
- a charitable rather than a commercial ethos.

The values and ethos of a care home can be expressed by the extent to which managers and senior staff were present to support workers, and the extent to which they shared some of the more challenging experiences.

xii Here we have focused on formal sources of support, but it is important to acknowledge the role of workers' family and friends, who provided emotional and practical help; of care home residents who offer recognition, meaning and joy; and their relatives, many of whom gave appreciation, gifts and donations. These forms of support were valuable but not without cost: care staff often worried about the impact of their need for support on their personal relationships. Support from the community was variable and not a substitute for formal provision.

Amid the intense additional work, care staff were acutely aware of whether managers and administrators were sharing the workload, the hazards and the emotional stress. Some care workers reported that managers were "staying away from the units" (care worker in a large for-profit provider) or "going home at a decent hour when everybody else is staying working their asses off" (support staff worker in a medium for-profit provider).

In contrast, the redeployment of administrative and managerial staff to frontline roles, where possible, was seen by the care workers who responded to the survey as an example of managers expressing a shared commitment to meeting the challenges faced by the whole staff team.

Generally, carers appreciated the physical presence of managers within units to check in on staff and how things were going.

> *Normally, my office is in the attic. But I spent quite a lot of time just trying to sit in visible places so that people could come and talk to me if they wanted to. (…) You hear a lot more when you're on the floor of a space like that. And I can remember team members of staff talking and just going over and giving one of them a hug. Because I couldn't quite hear what they were saying, but you can pick up on vibes, and people were just really, really struggling. (…) Our focus, really, through that time was about communication, about being there, about being present, about being one team.*
>
> (Support role in small not-for-profit provider)

The size of a care home influenced how satisfied staff were with the non-financial support they received from their employers

Our survey also showed that the size of the care home and the organisation that owned it were statistically significant in relation to how satisfied staff were with the non-financial support provided to them. Staff in care homes with more than fifty residents were less satisfied with support from their managers than those with fewer than fifty residents. Those working in homes that were part of a chain were also less satisfied with support from their managers or their organisation.

Relationships within smaller scale organisations, and the access that staff had to managers, seem to have played an important role. As one care worker in a small for-profit care home told us:

> *The owner is easily attainable (…) [Recently] he came in and he basically literally went through the whole plans of what they were talking about extending [the building]. He was showing us it all, showing how, you know, how it will change, how things will work. And it's only because we've got staff that have been there like 22, 23 years. (…) It's good in that you can sort of talk to him almost like he's not, you know, you can have a good laugh with him.*
>
> (Care worker in small for-profit provider)

Many larger providers made significant efforts to enhance digital communications and, when permitted, to arrange visits from head office staff to homes. These were seen as effective by some, but frontline staff often lacked time to engage with online calls and some felt that offsite managers were in an "ivory tower":

> *We were being told when there was no PPE available that we were going to get sacked for not wearing it and we're like, "But we can't get hold of any."*
>
> (Senior carer in small for-profit provider)

Employer support for care workers to help them cope with distressing experiences was not routinely available in all care homes

It was clear from interviews that care home staff have been through often frightening, distressing and traumatic experiences. Those who had benefited from specialist psychological support, including bereavement counselling, found it helpful. However it was too often unavailable, late, or impersonal.

> *That loss of residents to outbreaks impacted all of us hugely. Absolutely hugely. The staff mental health really suffered and is still suffering actually. A lot of us were diagnosed with post-traumatic stress disorder and have had to have counselling and all sorts of support.*
>
> (Home manager at a small for-profit provider)

Indeed, many interviewees described their colleagues as the *only* effective source of support. Although some staff were able to access phone helplines and found them useful, especially given long waits for in-person support, there was a common view amongst those we spoke to that these were rarely used, and online platforms were also of limited value. Lack of time and energy were also barriers to accessing support.

> *We could have been offered bereavement counselling as we lost so many residents. Online self-help is no good.*
>
> (Survey respondent)

Across health and social care in the UK, other research has found that only around a third of employees had taken up the option of receiving support from their employers, with social care workers being even less likely to do so.[80]

Conclusion

Ensuring that staff are supported is essential for job satisfaction, well-being and safety. All of those affect the quality of care services. A lack of support has been a factor in staff leaving, reducing their hours or declining promotion in ways that exacerbate staffing problems, some said:

> *There was no support. So, there's a lot of people have cut their hours back.*
>
> (Care worker in a large for-profit provider)

Our findings suggest that resources for, and cultures of, support are influenced by the size and mission of providers. In particular, a charitable rather than commercial ethos may encourage greater focus on staff, which fits with the evidence that not-for-profit organisations did not cut labour costs in the way that a substantial minority of for-profits did (see above). Senior managers with experience of care, and a commitment to offering in-person support, were viewed positively. Smaller homes and organisations may be more successful in fostering such relationships, in line with some existing evidence that smaller homes offer better quality care.[81]

In our recommendations, we set out some key measures that government and employers should take to improve pay and conditions, and support for unpaid caring responsibilities; to tackle staff shortages, including preparing for spikes in workload and absence during a public health emergency; and to enhance the wellbeing of staff and ensure quality of care provided.

Conclusions

Despite clear warnings that the financial impact of a pandemic on the care home sector would prevent care home services from functioning effectively, there is no evidence that government had any plans in place to address this challenge. This meant that care home companies did not know how much financial support they could expect or how it would be administered, which added avoidable levels of stress for care homeowners and managers at a time of significant trauma.

Financial support provided by the government during the first year of the pandemic did mitigate the worst aspects of the pandemic on the financial viability of the care home sector. However, the decision by government to end financial support for care home companies after the peak of the pandemic had passed has likely contributed to the current financial and operational difficulties experienced by the care home sector, with wider consequences for older people and the healthcare system.

The financial viability of the care home sector was dependent to a degree on care workers undertaking more intense work without additional remuneration. Very little of the additional financial support for the care home sector from government was dedicated to supporting staff and improving their health and well being, despite the immense pressure they were under both at work and in their personal lives. Therefore, it is not surprising that the care home sector has struggled to both recruit and retain staff since lockdown restrictions were removed and the wider economy re-opened.

Many issues concerning low pay, funding models, and the governance of the care home sector for older people predated the pandemic. The COVID-19 crisis brought their urgency into stark relief, prompting a need for sustainable solutions beyond the pandemic. Our recommendations are set out in the executive summary at the start of this report.

Annex A: Methodology relating to the Financial Analysis

Financial Analysis: Pre-pandemic

CompanyWatch used data from the regulatory bodies in England (the Care Quality Commission), Wales (the Care Inspectorate Wales), Scotland (Care Inspectorate Scotland) and Northern Ireland (Regulation and Quality Improvement Authority). CompanyWatch relied on the Laing Buisson Care Home database to identify organisations that provide residential and/or nursing care to people aged over 65 in the UK as of January 2021. The same database was also used to stratify these organisations in terms of their for-profit and not-for-profit status and the ONS postcode database was used to identify their geographic location.

Using the CompanyWatch data base and manual matching techniques, the organisations providing care home services for people over 65 were linked to company registration numbers held by Companies House.

Table A1 Summarised results of the care home matching process, showing the number of care homes whose providers were (i) matched to a CRN; and (ii) included in the final analysis

Nation		Total Locations†	Matched to CRN	Matched %	Final Analysis	Final Analysis %
England		9,483*	8,204	87	7,487	79
Wales		624	492	79	442	71
Scotland		695	602	87	556	80
NI		358	250	70	220	61
Total		11,160	9,548	86	8,705	78

*For England, the reference date was 3rd March 2021, and the total excludes deregistered care homes (see Methodology section).
†These totals include a small number of care homes that were included twice in the Laing Buisson lists.
These occur most often for NI, where some care homes have separate residential and nursing registrations with the RQIA.

This analysis generated 4013 companies covering 8,705 care homes and 377,856 beds. 851 companies were companies with full Profit and Loss accounts and 3,150 had no profit and loss accounts due to their size.

	Full P & L	Abridged P & L	No P & L	Total
Number of Companies	851	12	3,150	4,013
Number of Care Homes	4,977	13	3,715	8,705
Number of Beds	255,632	606	121,618	377,856

Because a number of the companies involved are part of a wider corporate group and have a large number of intermediary companies, for these companies, CompanyWatch focused on the accounts of the highest relevant company in the group structure. Where there was some uncertainty about which set of accounts related to its care home division we sought expert advice and assistance.

Company Watch estimated the financial risk faced by these care homes prior to the pandemic in relation to the following key measures of financial sustainability; profitability; net worth; working capital, and gearing (which is measured as the ratio of total assets to total liabilities) and also the CompanyWatch H Score – a specific measure of financial risk.

Financial analysis: Post Pandemic

Using the same data set of companies generated by CompanyWatch for the pre-pandemic financial analysis, we used the CompanyWatch data set to search for financial accounts submitted by these companies before May 2022. We intended to understand from these accounts the financial performance of these companies during the first year of the pandemic between March 2020 and April 2021.

Because not all of the care home companies have the same reporting periods, it was not possible to find filings for all of these companies. In addition, the reporting period for many of the companies often did not match the financial year (for example, the reporting period was December to December). Therefore, we focused on those care home companies that had filled accounts covering at least nine months of the period from March 2020 to April 2021.

This approach generated 2,000 care homes of which 460 were large and medium sized care home companies and a further 1,540 small and micro companies which also filed their annual accounts by May 2022 but which did not file profit and loss accounts. The 460 companies operate around 142,000 care home beds or around 37% of the total number of beds identified in the data set created by CompanyWatch for the pre-pandemic analysis, and have annual revenues of around £10 billion. We assessed this data in terms of its regional distribution and found that it was representative of the original dataset developed by Company Watch.

We also carried out a manual review of the annual reports and strategic statements of the 26 largest care home companies operating in the UK that had filed accounts covering at least nine months of the pandemic. This was to understand their business strategies and the percentage of their annual revenue comprising government grant funding (for example, the Infection Control Fund or the Coronavirus Job Retention fund).

We further carried out a manual review of the accounts of those companies that had reported dividend payments of over £500k to understand the value of the government grants these companies had received.

Assessment of Government financial support for the pandemic

To accurately quantify the total amount of government support for the pandemic, we received support and assistance from the relevant government departments in Scotland, England, Northern Ireland, and Wales, who provided us with accurate and up to date data.

We also sought information from HMRC regarding care home providers' use of the furlough scheme.

Limitations of this methodology

As reported by the National Audit Office and the Public Accounts Committee, financial data relating to the care home sector in the UK is poor, particularly relating to smaller care home companies that are not required to file profit and loss accounts.

As a result, the financial impact of the pandemic on the UK care home sector can be mainly understood through an examination of the larger care home companies. This introduces a bias into the analysis, which cannot be avoided but should be acknowledged. The CompanyWatch system, however, allows a financial risk assessment based on the balance sheet data produced by smaller care home companies. We have included this in the report to give some insights into the financial impact experienced by these companies.

In addition, while we made every attempt to focus on the care home sector for people aged 65+, it is likely that the companies we analysed will also provide services to people of other ages. We do not consider that this significantly affects the findings in terms of the financial impact of the pandemic.

Annex B: Methodology relating to the workforce analysis

Workforce Survey

The survey questionnaire was designed by Dr Horton, Dr Gain and Dr Ozdemir Kaya, and responses were analysed by Mr Papantoniou. The survey consisted of 25 questions, took approximately 10 minutes to complete, and was hosted on Qualtrics. It also included an abridged participant information leaflet and informed consent question. It ran from 15 October 2021 to 15 April 2022 and received a total of 605 responses.

The aim was to understand how COVID-19 has affected care homes for older people and their staff. The survey sought to understand the impact of the pandemic on:

a. care home finances and personal finances of care home staff
b. workloads, working patterns and duties of care home staff
c. staffing levels, retention and recruitment in care homes
d. staff wellbeing, job satisfaction and intention to keep working in care
e. support for care homes and their staff

Participants were recruited through formal and informal research partners including the National Care Forum (an association of UK not-for-profit care providers) and their networks across the care home sector, as well as two trade unions, UNISON and GMB. Other organisations such as the National Institute for Health and Care Research (NIHR), 'Contact, Help, Advice and Information Network' (CHAIN), and some regional care associations also supported recruitment. In addition, we used social media advertisements (Facebook and LinkedIn) to reach relevant groups. Survey respondents were given the opportunity to enter a prize draw for £50 worth of high street shopping vouchers.

Sample

Through the above methods we achieved 605 responses. We aimed to reach a substantial and diverse sample distributed around the UK, within resource constraints and the challenges of conducting research during a pandemic. Our survey sample was sufficient to produce statistically significant results, but given the diversity of the care workforce and of care homes around the UK, as well as the complexity of the issues at stake, our results should be treated as indicative.

Of the 605 individuals who participated in the survey, 89% were female, 91% of white ethnicity and 75% had British nationality. These figures suggest that female participants are over-represented in our data given 82% of the social care workforce in England and 80% in 2022 in Scotland are female, while these two nations account for 89% of the total workforce in the UK. Those of white ethnicity are also overrepresented as they form only 83% of the social care workforce in England, and 73% of care home staff in Scotland. British nationals, however, were slightly under-represented as they make up 84% of the adult social care workforce in England.

The largest group of respondents were care workers (38%), followed by home managers (21%) and senior care workers (19%). Home managers were over-represented in our sample (they account for 16% of the workforce in England and 3% in Scotland, although the overall workforce is measured differently around the UK and includes a range of settings beyond the remit of this study.

Approximately 9 in 10 participants started working in a care home before February 2020 whereas only a minority (3.5%) started working after March 2021. 92% of participants were employed on a permanent contract whilst 4% of them worked on a temporary or fixed-term contract.

As for the number of residents living at the home in which respondents worked, six in ten replied that approximately 11-49 people lived in the home whereas three in ten reported that their home hosted more than 50 residents.

In terms of the region of the home, 19% were in Scotland, followed by South-east England (16%) and Yorkshire & Humber (13%). Small proportions were based in Wales (1%) and London (2.6%). Scotland and Yorkshire & Humber are over-represented (overall, they host 7.6% and 8.33% of the social care workforce in the UK respectively).

71% of the homes were owned by a private company while 23% of homes were owned by a charity or a not-for-profit organisation (a higher proportion than overall provision, around 10%). This may reflect our recruitment process (which was supported by the National Care Forum, which represents non-for-profit providers, alongside other approaches).

Eight in ten homes were part of a bigger group of homes with 31% of them being part of a group of up to 10 homes. As for the services provided, 41% were a mix of residential and nursing services while 33% were residential homes only. More than 60% of the residents living in these care homes got some financial help to pay for their fees whilst 21.5% paid for their own care.

Analysis

Survey data was analysed using Statistical Package for Social Sciences (SPSS) version 27. Firstly, Cronbach's alpha was calculated and checked whether scale variables were normally distributed using the Shapiro-Wilk test. Descriptive statistics were performed to describe the demographic characteristics (e.g., gender, age group, ethnicity), job characteristics (e.g., role, full- or part-time, fixed- or long-term employment) and the key variables about the respondents' workplace (i.e., region, size, ownership type). One-way ANOVA was conducted to explore the relationship between ordinal demographic variables (e.g., work experience, age group) with scale variables. A p-value of less than 0.05 was considered statistically significant. To evaluate the reliability of the questionnaire, Cronbach's Alpha was calculated. The latter is an estimator of internal consistency, which shows how closely related a set of survey questions are as a group. The entire scale Cronbach's alpha was 0.792 which indicates a good and an acceptable level of reliability.

Cronbach's Alpha	N of Items
.792	21

To deal with missing data, multiple imputation was employed, which accounts for the uncertainty about missing data by creating various plausible imputed data sets and appropriately combining results obtained from each of them (Sterne et al., 2009). The imputed data sets are sampled from their predictive distribution based on the observed data – hence this approach relies on Bayesian statistics.

To create the imputed datasets we used MICE, a linear regression model that relies on the observed data to generate the imputed values. Multiple imputation generates crucially more effective inferences than other approaches towards missing data but also eliminates bias under more realistic distributions of missing data. Estimates obtained from each imputed value were combined by averaging the

imputed values of the 100 new imputed data sets. We purposefully decided to run a large number of imputations (more than the five which is common) to maintain the power level and control the Monte Carlo error. The imputed data sets did not yield any 'false' statistically significant differences.

Workforce Interviews

Two interview schedules, one for senior managers and one for care home staff, were co-designed by Dr Horton, Dr Ozdemir Kaya and Dr Gain. Interviews were conducted (online or by phone), lasting about an hour each, by the named team members and Prof Fotaki between 15 December 2021 and 30 April 2022.

The research questions underpinning the interview schedules were same as in the workforce survey. We adopted an abductive approach in interview design and analysis to address the gaps in the academic and grey literature.

Participants were identified from among the survey respondents who opted to participate in an interview and left their contact information. We also advertised the interviews through our partners and the networks named in the previous section. Informed consent was obtained. All interviewees were given high street vouchers worth £25 to compensate them for their time.

Our sampling strategy for interviews was a combination of purposive and convenience sampling. We targeted both for-profit and not-for-profit providers of all sizes from all four nations of the UK.

To understand the financial impact of the pandemic on care homes and their staff at all levels and include diverse perspectives, we recruited people in executive management, home management, care and support roles. We interviewed 43 people in total. All interviewees self-identified as White (British / Other). 10 self-identified as male and 33 as female.

Their role distribution was:

- 8 executive managers (e.g., managing director, finance director, CEO) from 2 large, 2 medium-sized and 2 small charities, plus 1 medium-sized and 1 small-sized private operator;
- 4 owner-managers: 1 small private chain and 3 individual private homes;
- 7 home managers, from 2 small homes (operated by a small private company and a charity) and 5 medium-sized homes (operated by 1 individual, 1 medium-sized and 1 large private company, and 1 individual charity and 1 large charity);
- 13 staff in care roles: 1 senior care worker, 9 care workers/assistants, 1 registered nurse and 2 nursing assistants.
- 11 support staff (administration, catering, domestic, ancillary).

Among these interviewees:

- 31 were from a private company and 12 from non-for-profit organisations;
- 7 were from individual homes, 12 with small organisations, 8 with medium-sized organisations, 16 from large organisations;
- 8 were in Scotland, 3 in Northern Ireland, 2 in North-west England, 3 in Yorkshire & Humber, 5 in West Midlands, 2 in East Midlands, 8 in South-west England, 15 in South-east England, 2 in East of England, 2 in London, and 1 across Britain.

Unfortunately, we were unable recruit any non-white participants for interviews and males are over-represented in our data. Scotland is overrepresented while Northern Ireland, England and Wales are underrepresented despite our efforts to recruit from all countries of the UK. We also experienced difficulty with recruiting frontline carers.

Interviews were thematically analysed in NVivo by Dr Gain, Dr Horton and Dr Ozdemir Kaya. The data were coded into 4 themes (and further sub-themes): key characteristics of respondents and their workplaces, impact of Covid-19 on staff and working conditions, impact of Covid-19 on care homes, and the future.

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