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Decent Work in Care Homes; Lessons and Implications of the Pandemic Experience From Scotland

Abstract

Design/methodology/approach

Data from qualitative semi-standardised interviews with twenty care workers in care homes. A range of care system institutional stakeholders were also interviewed.

Purpose

The theme of decent work had long been highlighted as integral to improving social care for the elderly. The Covid pandemic experience reveals lessons and implications about the systemic absence of decent work in one place, Scotland, in care homes. The main lesson and implication is a need for change beyond the focus on levels of pay and systemic advocacy of decent work as it is conventionally understood.

Findings

Decent work in social care may only be progressed to the extent that a culture change is achieved, transcending the institutional stasis about who owns and engages with progressing decent work.

Limitations

This is a study in one place, Scotland, with a small sample of front-line care workers in care homes, and representatives from a range of institutions

Practical implications

Effective culture change for decent work in care homes needs to be a higher research priority. More explicit culture policies can be a mechanism by which overall decent work and system change may be catalysed and sustainably secured together. Explicit culture change is here set out with respect to operational, institutional, and national domains.

Originality

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3 The situating of systemic decent work progress within a broader culture change, and
4 modelling that culture change, are original contributions.
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8 **Social implications** 9

10 There needs to be social policy and political support for situating decent work to be part of a
11 broader culture change around care work with the elderly. A culture-oriented change plan as
12 well as new resourcing and structures, can together ensure that the nadir of the pandemic
13 experience was a historical turning point towards transformation rather than being just another
14 low point in a recurring cycle.
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23 **Introduction; Decent Work in Social Care & The Covid** 24 **Pandemic** 25 26 27

28 The crisis in attracting people to work in social care and care homes for the elderly was a
29 focus of (Cousins *et al.*, 2021) and the impact on carers (Jones, 2021). The theme of decent
30 work has been highlighted as integral to this (Addati, 2021). This is a study on the lessons
31 and implications of care workers experiences during the Covid pandemic, when events
32 revealed the cost of an intrinsic and longstanding lack of decent work (STUC, 2019;
33 Watterson 2020) in one place, Scotland.
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39 The health and social care ecosystem in Scotland, sharing aspects with other parts of the UK
40 but with some differences, is meant to be an 'integrated' one (Scottish Government, 2020a;
41 Scottish Government, 2020b), reflecting years of focus on that as a key policy goal (Christie
42 Commission, 2013). In theory health and social care are meant to be equal partners working
43 together. In practice there is a widely acknowledged and longstanding pattern of social care
44 being last in the queue and a lack of 'care for the care workers' relative to the health care
45 workforce (MacDougall and Wood, 2018; ICF Consulting, 2018; Donaghy and Fisher, 2020).
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51 There is a continuous struggle to recruit into the social care sector in Scotland and the UK, with
52 the system under resourced and staffed (Eksogen, 2019; Scottish Care, 2018). Difficulties
53 persist in recruiting generally and into management and leadership roles; a high staff turnover;
54 an exodus from the private sector for better terms and conditions in the public sector; increasing
55 strain created through staff covering unfilled vacancies with extra hours; and a lack of
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3 investment in people, evidenced by a significant proportion of staff not being funded to
4 complete basic training. That is why progressing fair and decent work in the sector had
5 commanded much attention. Then the Covid 19 pandemic happened.
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9 Since then many changes have been proposed and are under active development, to make the
10 sector more attractive to work in. New structures in Scotland (Feeley, 2021) including in
11 Scotland a National Care Service (NCS) (Scottish Government 2021) and working on 'Fair
12 Work First' criteria to be developed and included in the commissioning of care services (FWC,
13 2019), with higher pay for care workers, currently have the spotlight.
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18 Lessons from the experience of front-line workers, mainly in care homes for the elderly, in
19 Scotland during the first wave of the COVID pandemic suggest a broader agenda. Decent work
20 in contexts inclusive of talent management and wellbeing (Anlesinya *et al.*, 2021).
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24 25 **Methods**

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28 The interest in job quality in the guise of 'decent work' includes improving pay and other
29 factors. It has been promoted by the International Labour Organisation (ILO) since the late
30 1990s (ILO, 2008; ILO, 2018). The model of decent work adopted here was one that had been
31 previously used to explore the experiences of low paid workforces in Scotland (Stuart *et al.*,
32 2016).
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37 This is a study of care workers experiences at the height of the pandemic first wave. The aim
38 was to use what care workers said to distil key messages for policy-makers and other
39 stakeholders. Data was obtained from qualitative semi-standardised interviews with twenty
40 care workers from across Scotland. Care worker interviewees were found through word of
41 mouth, personal contacts, and via social media. Some care homes managers were also very
42 helpful by linking us with members of their staff. Most interviewees were from Scotland's
43 central belt between Edinburgh and Glasgow and from its West coast. Most care worker
44 interviewees were female, reflecting that, in 2019, 83% of the Scottish social care workforce
45 were women. A majority (64%) of care worker interviewees had had five or more years'
46 experience of working in care, with 14% having more than 20 years in the sector. 36% of those
47 we interviewed had been employed in care work for up to five years. Of those interviewed,
48 67% were working in the private ('independent') sector, 20% in the public sector, and 13% in
49 the third sector.
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3 Interviews were conducted between July and October 2020, mostly via the telephone and in
4 some cases via video conferencing platforms such as Zoom or MS Teams. Interviewees were
5 asked to describe their experience of the Covid-19 crisis; and asked to consider their work with
6 regards to seven specific ‘decent work’ factors: supportive managers; a safe work environment;
7 decent pay; terms and conditions; job security, social recognition, and purpose and meaning.
8 These factors come from previous decent work research with low-paid workers (Stuart *et al.*,
9 2016); Gibb and Ishaq 2020) and research with those working in the social care sector on how
10 they assess overall job quality (Ross *et al.*, 2016). Lastly, interviewees were asked to identify
11 one or several changes which would impact positively on their job quality and what the barriers
12 to making these changes might be.

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21 There were also interviews with a range of care sector stakeholders. Care policy, standards,
22 commissioning, and regulation involve a range of bodies including the Scottish Government,
23 the 32 Scottish local authorities and their umbrella pressure body COSLA (Convention of
24 Scottish Local Authorities), the 31 Health and Social Care Partnerships, Scotland Excel, the
25 Care Inspectorate, and the Scottish Social Services Council (SSSC). The SSSC (2019) registers
26 the whole social care workforce and ensures that basic training standards are adhered to, while
27 the Care Inspectorate registers care homes and quality assures care provision. Employer
28 networks including Scottish Care (for the independent sector) and the Coalition of Care
29 Providers Scotland (CCPS, for the third sector) are also key stakeholders, and trade unions
30 including GMB, Unison and Unite offer support and representation to members employed in
31 care homes. Ethical approval was obtained within our institutions policy and process.

40 **Findings; Front Line Views at The Nadir**

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43 This is a summary account of all the decent work factors discussed with interviewees at what
44 would come with hindsight to be seen as the nadir for the workforce as the severe impact of
45 the Covid 19 pandemic on care homes for the elderly occurred.

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49 Care workers want strong and consistent support from their managers. Interviewees suggested
50 that this was not always so before the crisis and was not always the case during the Covid-19
51 crisis. One interviewee working for a homecare provider told us that while his managers were
52 working from the relative safety of their private homes, he and his colleagues not only
53 continued to provide personal care in service users’ homes but also had to go to the office to
54 pick up material and receive information on their shifts. Too little came from management with
55 regards to ‘dealing’ with the virus when going into service users’ homes: ‘You can send as
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3 many emails as you like about PPE, but the manager should be there in person to tell you how
4 to do it. We were putting our own lives at risk and those of our families, but we didn't feel well
5 supported when it came to Covid and our health and safety'. Another carer, working in care
6 home, said about their managers that 'we are spoken down to as if we don't matter. But already
7 before the crisis, managerial support was lacking – for example with regards to training. Carers
8 are obliged to undertake training in line with what the Scottish Social Services Council
9 stipulates. This should be done during carers' paid time, but de facto staff shortages mean that
10 many of our interviewees undertake training in their own unpaid time: 'The manager tries to
11 allow staff paid training time but it's almost impossible because there is always some staff
12 member off.'

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21 Insufficient support also extends to the trauma that some interviews experienced during the
22 pandemic. Some were unable to access any support for dealing with that, either in their own
23 organisation or from the wider resources provided on-line by others. The lack of easy to access
24 employee assistance was an immediate and for many a major unmet need. The absence of
25 access to mental health support led to a deterioration of interviewees' job quality as they were
26 exposed to higher levels of stress, anxiety, over-work, risk to physical health.

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32 What interviewees told us here amounts to a lack of a 'safe work environment', a crucial
33 ingredient to decent work and one often absent for the low-paid. And this was not restricted to
34 times of crisis. Being a carer is emotionally and physically stressful also in 'normal times', we
35 were told: 'And this stress never gets addressed by management until its bursting out at the
36 seams, or until staff are all ill, or until I stand in the office crying', one home carer told us. He
37 also reported that his employer now has outsourced its mental health support. 'Now you go to
38 the manager's office, and they might listen to you for twenty minutes and then give you a leaflet
39 and say, "call this number, they'll help you". They don't want to sit down with you, they don't
40 want to hear about your stress. There is not much care for the carer.'

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48 If supportive managers are at the heart of decent work improvements for the care home
49 workforce, then a sustained effort at supporting managers is needed. Perhaps a
50 professionalisation of the position would help to attract the best talent to this demanding job.
51 Likewise, care home managers might also be simply too overworked and torn into too many
52 directions to make time for the highly significant task of caring for their workforce.

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58 During and 'after' Covid-19, in the summer 2020, expectations to receive mental health
59 support following harrowing experiences were not fulfilled. Staff were simply referred to
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3 their GP not given access to specialist counsellors. When recounting their experiences many
4 interviewees broke down in tears. During the first wave of Covid-19, it seems that few had
5 ever spoken to anyone about their experiences. One interviewee said ‘They did put out
6 questionnaires about our mental health at work, but nothing’s come of it. I’m feeling
7 traumatised – fill out a questionnaire. We didn’t get any telephone numbers and we don’t
8 have an employee assistance programme. We talk to each other, to pals, to other care
9 workers. I don’t think anyone understands what we’ve been through unless they’ve been
10 through it themselves’.

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12 The experiences during Covid-19 not only impacted strongly on care workers in care homes
13 directly affected by the virus. For example, some care workers told us how they experienced a
14 surge of fear and anxiety where ‘Do Not Resuscitate Orders’ were issued to all residents by
15 link GPs – it was, in the main, the care workers who had to deal with very distressed families
16 who demanded explanations. The confusing and sometimes outright contradictory guidance
17 received from a variety of agencies added to a feeling of helplessness. Care workers also
18 reported that they felt they were ignored and forgotten when it came to access to personal
19 protective equipment (PPE) to keep themselves and residents safe. The contrast was plain with
20 ambulance staff and undertakers. These professionals were well equipped with PPE while early
21 in the crisis, care workers had to resort to bin-liners for aprons. They had no hand sanitiser and
22 no masks but were instead told by the care home’s GP to gurgle with saltwater. The lack of
23 testing in care homes, for both staff and residents caused a significant degree of distress for
24 care staff.

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26 The great majority of care workers were still immensely committed and take personal pride in
27 their work, despite feeling under-resourced, under-paid, and under-valued; they really cared,
28 and had often decided to work in the care sector because they are ‘interested in people,
29 fundamentally’. It is from this understanding of purpose and meaning that job satisfaction
30 derives from, and it ‘keeps you going when other aspects of the work aren’t so good’.

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32 Care workers see some recognition of this from families and the service users themselves:
33 ‘People say “you’ve done a good job”. It’s the families of residents – I get a lot of respect from
34 the client and the family’. However, wider societal valuation was lacking. While some
35 interviewees stated that they do not really care about what ‘the public’ thinks about them – one
36 said that only when people say ‘caring is just about wiping people’s bottoms, that angers me’
37 – they do think that how seriously they take their work is in a stark mismatch with how they
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3 are seen in public. ‘Social care is very hard and difficult; people forget about us and only focus
4 on doctors and nurses. It was all about “save our NHS” – how about us?’.

7 The sense of purpose and meaning emergent in the interviews is also evidenced in the actions
8 of care workers during the first wave of Covid-19. Care workers were taking on extra hours so
9 that their care homes would not have to bring in agency staff – and with it, an increased risk of
10 the virus spreading. That meant that care workers undertook, for weeks, 14 to 24-hour shifts
11 and had to cope with pleas from their own family to stay away from work. They were ‘powering
12 on’ to keep people safe and well and to help sick residents by holding their hands, hoping for
13 recovery. One care worker told us that she was ‘scared of taking the disease home. I sent my
14 daughter to stay at my mum’s for a month and didn’t see either of them for their own safety’.

21 Such accounts reflect care work as a vocation rather than ‘unskilled’. A change in public
22 recognition would be important, we were told by care workers, to bring about more ‘decent
23 work’, help reduce high staff turnover, which is so detrimental to the quality of care, and to
24 attract more people into care work.

28 While care workers’ voices are key what the other stakeholder interviewees experienced
29 around decent work and the time of the worst of pandemic impact was also important. Three
30 themes emerged from these interviews: ‘responsibilities, resources and remits’, ‘social care and
31 the NHS’ and ‘trust’. Stakeholder interviews suggested that the core responsibility for assuring
32 decent work for the social care workforce was ‘in someone else’s court’. For some
33 interviewees, many problems around job quality stem from care home managers who are not
34 sufficiently skilled or overworked, possibly both. The onus was seen to be in the Government’s
35 court as it could introduce, analogous to the Safer Staffing Act (Scottish Government, 2019),
36 a ‘Safer Supervision Act’ that recognises the importance of staff supervision and the duties of
37 home managers to their staff, plus the resources needed to ‘get it right’. The Care Inspectorate
38 and Scottish Social Services Council seem to be regarded, by all other stakeholders, as a central
39 actor in the provision of decent work; a role, it appears, that neither of them has a key focus on
40 as per their official remits.

51 Interviewees were of the view that improvements of the quality of care are inextricably linked
52 to job quality. In other words, only when care workers deem their work to be decent with
53 regards to the seven factors discussed throughout this report can it be expected that social care
54 quality is good – the expansion of the regulators’ remits was deemed as one approach to dealing
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3 with job quality issues. Equally all interviewees agreed that the resourcing of the social care
4 sector is at the heart of the problem.
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7 Stakeholder Interviewees agreed that the relationship between health care and social care were
8 too complicated and needed addressing. For many, social care had been an afterthought for too
9 long in funding decisions with regards to the NHS. This is exemplified by differences in pay
10 for care staff and for managers. Professionalisation of social care was mentioned by some
11 interviewees, but others said that social care was so much more about ‘caring’ than health care
12 professions that e.g., an academisation of social care along the lines of, for example, the nursing
13 profession would not be desirable. Some interviewees said that the integration of health and
14 social care has not led to an approach to workforce planning in the social care sector which
15 compares well with that used in the NHS.
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23 Finally, trust between organisations from different sectors, including private, third, and public
24 sectors, and across different levels, from local to national, was mentioned by all interviewees
25 to be an important ingredient for running a social care system which offers high quality care to
26 its users and a ‘decent work environment’ to its workforce. Among the three trade unions which
27 represent social care workers – GMB, Unite and Unison – seem to exist differences with
28 regards to strategies for job quality improvement. Unions representing mostly public sector
29 workers are less confrontational and keener on a ‘social partnership’ approach than those
30 representing third and private sector care workers.
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37 In reflecting on these experiences at the nadir of the pandemic, from the interviews with care
38 workers and stakeholders, it certainly seems as if decent work shortfalls contributed to the
39 ongoing crisis experienced in the care home sector at the time. And that the lack of decent work
40 mattered not only for those working in care homes, but also for those receiving care. In the
41 stakeholder interviews ‘decent work’ in care was an objective that is shared by all, in principle,
42 and that there ought to be common ground for working together towards that.
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48 **Conclusions**

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51 The scope of progress of decent work in care will always have pay at heart, though a systemic
52 advance across all areas of decent work this study is clearly needed. What is seen to be missing
53 though, and highlighted starkly by the impact of the covid 19 pandemic, is that systemic decent
54 work progress will only come as part of a culture change around.
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3 This is grounded in the experiences and perceptions of front-line care workers. Care workers
4 need an integrated/combined approach to more 'supportive managers'; better 'terms and
5 conditions'; a 'safer work environment'; 'decent pay'; more 'job security'; and more 'social
6 recognition' to make their work 'more decent'. More general attitudes towards people in care,
7 predominantly in this study older people, result in a lack of valuing them that translate directly
8 into a lack of recognition for those who care for them.
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14 Recent explorations of attitudes on older people in the UK demonstrate widespread ageist
15 views (Centre for Aging Better, 2020; Swift *et al.*, 2016). The first consequence of such
16 attitudes is minimal resourcing in terms of quality of care and job quality. A second
17 consequence is higher resourcing for health care services, predominantly those aspects geared
18 towards 'productive' generations (Taylor, 2011; RSPH, 2018). A third consequence is a general
19 worsening of health outcomes for older people (Chang *et al.*, 2020). In a way, the undervaluing
20 of care workers and of those needing care, in particular older people, are two sides of the same
21 coin. A culture change requires challenging such attitudes towards older people as they hinder
22 the development of a better social care system and progress towards decent work.
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31 At the time of the study no institutional stakeholder felt themselves to be responsible for 'decent
32 work change', nobody owned an integrated decent work agenda. An explicit culture change
33 should prioritise the valuing together of those cared for and those providing care. It must
34 include, challenge, and transform all these institutions. This is frequently suggested (Shaw,
35 2017; Noddings, 2013; Stacey, 2005; Bengoa, 2016) but rarely explored through research or
36 action priorities around care system integration. Evaluations of care systems, designed to
37 reflect choices made and implemented through top-down policy decision-making and rational
38 design, rarely consider the broader care culture. There is no evidence base on this.
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45 One starting point can be to explore more some well attested and critical issues with integrating
46 care with leadership, culture, workforce, difficulties with demonstrating impact and managing
47 a challenging financial context (Hendry, *et al.*, 2021). The conclusion is that culture change
48 can help get the right balance in a system between centrally directed organisations including
49 the NHS and flexible arrangements for local delivery through strong horizontal integration with
50 community partners is of significance. The extent to which culture change supports enablers of
51 integration (see Figure 1) can be more central.
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Figure 1 HERE

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6 Improvement on decent work that will impact on care quality, and improvements in care quality
7 that will impact on decent work are interdependent. But more than better pay and supportive
8 rhetoric on the workforce is needed, and a serious and sustained efforts to bring about a culture
9 change is essential. That means an explicit rather than an implicit culture policy (Ahearne,
10 2009) being part of the way forward for both better care quality and better decent work,
11 mutually reinforcing each other. Such an explicit culture change in social care as a context can
12 be understood using three levels of analysis: the operational, institutional, and national domains
13 or levels. There has not yet been a conceptual framework developed that enables culture and
14 social care to be fully inter-related.
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21 In the operational domain, for example in care homes themselves, there are some great role
22 models for what is possible with decent work, but there appears to be little in the way of
23 motivation to effect job quality improvements across the sector or develop a coherent cross-
24 sectoral approach. Operational change is to come in Scotland with the development of the NCS.
25 While the different potential forms of such a service are not yet clear, many are not convinced
26 that this is the answer to improving job quality. If a NCS were to extend health and social care
27 integration to the health and social care workforce, then it might contribute to a solution. At
28 the operational level, among the providers in the private, public, and third sector; there is going
29 to be continuity of many agents here, and also support for front-line innovation to create
30 progress.
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41 Among big institutions engaged in the social care sector, with new national ‘control’ and
42 ‘collaboration’ arrangements, an opportunity to lead an explicit culture change is open. In the
43 institutional domain, looking at the big agencies involved in the sector, and themes like co-
44 production (Patton *et al.*, 2021; Akehurst *et al.*, 2021). In Scotland these include the Scottish
45 Government, NHS, local authorities, HSCPs, Care Inspectorate and the SSSC. In this domain,
46 it seems as if variable standards in job quality have become accepted between the private,
47 public and third sectors. There is no combined leadership for a decent work agenda, and there
48 is no single stakeholder willing to take leadership and responsibility so that, in the end, no-one
49 ‘owns’ the agenda of job quality improvement.
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57 Culture change in terms of place, most typically understood to mean the national domain, what
58 might be called the general culture domain, is the greatest gap in evidence and knowledge.
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3 Currently, the understanding of ‘place’ is neglected as it is assumed that most places are equally
4 characterised by not valuing those needing care as they are seen as ‘unproductive’ and as a
5 ‘burden’. The reputation and experience of job quality in the sector and its appeal to potential
6 employees in Scotland as a place has been a concern and subject of attention for some
7 time (Simmons and Macer, 2019). Linked to this is that the national domain is also
8 characterised
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14 The most significant areas of future research are then to generate a thorough understanding of
15 the origins of the current culture of care, with an evidence-based exploration of required policy
16 shifts and what an all-encompassing culture change might involve. It is also essential to create
17 space to discuss and to develop an approach on how social value can be incorporated into
18 culture change. In the context of Scotland the implementation of the NCS in Scotland ought to
19 be informed by a desire not just to pay more to care workers but to transform decent work and
20 the culture enabling that. The practical focus will be workforce planning and of attracting
21 people into care work. The theoretical focus can be ‘how do we change the culture to enable
22 that practical goal?’. A culture-oriented change plan as well as new resourcing and structures,
23 can together ensure that the nadir of the pandemic experience was a historical turning point
24 towards transformation rather than being just another low point in a recurring cycle.
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35 Significant proposals on resourcing and structural change in social care are being generated
36 and implemented. Yet the cultural aspect is still not seen to be as legitimate a focus of interest
37 as other areas of change. In Scotland a NCS can develop and provide universal services and
38 targeted services to reduce the need for specialist services. But it will not change the culture
39 and might even become a victim of the prevailing culture unless that is appreciated and
40 sustainably changed. That will take time, and investment in research to make happen.
41 Ambitions for change in other contexts face similar demands as they look to resource and
42 structure care for the challenges ahead. Research on and support for culture change is the key
43 lesson and implication to for systemic decent work and the greatest quality of care being
44 realized together.
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Working with Older People

Integrating health and social care enablers	Could Culture Change Support These?
Collaborate and coordinate, for successful transformation through coordinated efforts across the whole of government, the whole of the health and care system at every level, and with citizens.	Yes
Engage and involve with a compelling vision about improving lives and creating a better, more sustainable future, with equal partners	Potentially
Empower and enable at the local level, because transferring solutions, no matter how well tested, will fail if implemented without due regard for local culture, history and buy in	Yes
Innovate and improve by adopting technology and new ways of working though this is complex	Potentially
Reflect and learn, as new ways will only make sense if anticipated improvements can be evidenced, and unintended consequences minimised	Yes
Figure 1; Enablers of Integration, Based on Hendry <i>et al.</i>, 2021	

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