Social Care Taskforce
Workforce Advisory Group
Report and recommendations

7 August 2020

Introduction

Members of the Workforce Advisory Group present this report and recommendations to the Social Care Taskforce.

The group, which comprised stakeholders from across adult social care (see Appendix 1) met virtually on five occasions, including the approval and prioritisation of these recommendations (see Appendix 2 for a summary of our brief and meeting schedule).

Narrative

Members of the social care workforce have done amazing work to support citizens during the coronavirus pandemic under extremely difficult circumstances. They have risen to the challenge of additional workloads, including providing cover for colleagues who were self-isolating or unwell. Many have upskilled at short notice, including roles usually undertaken by registered professionals.

However, the last five months have been exhausting for many and there are risks of staff burn-out, including amongst operational managers. Attrition from the workforce of both new and experienced staff, in the lead-up to an anticipated second wave of coronavirus could be disastrous.

The advisory groups were asked to focus on the short-term (under 12 months). Some of our recommendations will inevitably influence long-term reform.

The social care sector began the pandemic without a workforce strategy in place. We wish to draw Government's attention to the need for longer-term strategic planning. The publication of the NHS People Plan on 4 August 2020 makes the absence of equivalent arrangements for social care even more apparent.

A significant number of our recommendations relate to the need for Government to fund the sector adequately during the pandemic. We have confined ourselves to issues of funding which have a direct impact on the workforce. However, these recommendations are made in the context of the extreme financial pressures which employers and commissioners have experienced, including the costs of personal protective equipment (PPE), environmental cleaning, enhanced staffing costs, managing routine testing (where it has been introduced) and loss of revenue created by lower occupancy levels in residential care, or a lack of referrals of new packages of care in other community-based settings.

Time is not on our side, and actions to impact the workforce need preparation and a lead-in time to have an impact. In discussions at the advisory group we have been aware of some of the inherent tensions associated with responsibilities, and indeed the taskforce chair asked us to use our understanding of these to be directional in

our recommendations. Where we can, we have done this. However, we recognise that these are not normal times, and where traditional understanding of responsibilities sit – i.e. what sits centrally, locally and with employers are understood, these are not normal times and the social care workforce has a range of persistent challenges that this pandemic has exacerbated.

We believe that because of this, the task force needs to kick-start some of the longer term changes by particularly investing in some urgent infrastructure elements around occupational health, recruitment, retention and pay, in order for us to have a Covid-ready workforce to support the management and prevention of coronavirus transmission within all social care settings and to reduce avoidable pressures on the NHS.

The group has expressed its concern about the lag between public announcements about action plans compared to the availability of guidance and the operationalisation of delivery thereafter. This has had a significant impact on the social care sector.

The group has reviewed applicable sections of the World Health Organisation's policy brief, "Preventing and managing COVID-19 across long-term care services", dated 24 July 2020. We believe it represents a common-sense approach. Where applicable to the UK's social care and health system the recommendations should be considered as minimum standards which will ensure that the UK is broadly in-line with international recommendations.

Social care is a workforce in its own right and has a completely different structure to the NHS, for example, social care has multiple employers offering a wide range of setting, all with complex funding solutions. Based on our experience, we caution against developing and branding initiatives for the NHS and then trying to apply them to social care.

Two consistent themes have run throughout our meetings:

- The low priority given to planning and resource allocation for the workforce who support individual employers; and
- The importance of coherent and timely guidance which meets the needs of the workforce and their employers in their respective environments.

All our recommendations should be understood to apply across the full breadth of social care provision.

Recommendations

We make the following recommendations, which we have grouped as "top priority", "highly important" and "important". This has been a difficult process as there are three broad objectives which all need to be met:

- The reduction of transmission of coronavirus in residential and community-based settings.
- The needs of our workforce.
- The needs of employers.

1. Top Priority

Pay and recognition of the workforce

Immediate action:

(1) Measures should be in place to retain experienced members of the existing workforce, for example a loyalty bonus for those who remain in post for a specified period of time (eg. throughout the winter).

Within three months:

(2) Government should instigate a review involving employers, commissioners, and employee representatives with a view to implementing a new career-based pay and reward structure, *in-year*, for social care which will be:

(a) comparable with the NHS and equivalent sectors;

(b) fully-funded by Central Government; and

(c) mandatory on employers and commissioners of services.

The urgency of starting this action now was strongly held by the Advisory Group. We also note the risk of high levels of unemployment having a perverse incentive of eroding the existing terms and conditions available within social care.

Maintain the safety and wellbeing of our workforce

(1) ensuring the adequacy of the supply chain for PPE to social care employers and their workers, providing the same priority as PPE supplied to the National Health Service.

(2) regular asymptomatic testing for workers with client-and resident-facing contact, volunteers, and visitors.

(3) initiatives to ensure that providers engage with testing regimes.

(4) suitable guidance on the safe deployment of workers who have previously been shielding.

Government should fully-fund measures to minimise staff movement and self-isolation

Employers must be funded (and pass-on that funding) to ensure workers in all care settings do not experience financial loss as a result of infection control measures, including:

(1) Payment of a workers' average wages when required to self-isolate following exposure through their workplace or community transmission within the UK.

(2) A realistic loyalty bonus for workers required to remain exclusively in one location and/or continuing to work at the same location.

(3) Government guidance for employers on managing safe travel arrangements to and from workplaces.

Supporting workers' mental and physical health

(1) Ensure all members of the social care workforce (including those who have left the sector due to coronavirus) are protected by Government investing in occupational health services, signposting, mental health first-aid, and bereavement services, including access to face-to-face consultations, where appropriate.

(2) Embed an active promotion of a positive view of occupational health for the wellbeing of the workforce, recognising cultural sensitivities and including those who may be more reluctant to engage with them.

(3) Ensure that employers can access training and resources to manage sickness/absence fairly and efficiently; and (where it is unavoidable) to terminate contracts on health grounds fairly and lawfully.

Maximise uptake of seasonal influenza vaccination

Prioritise the campaign planning and ensure that free influenza vaccinations are available to the social care workforce, including:

(a) covering the costs of work-place administration;

(b) the rapid training of 'peer-vaccinators'; and

(c) the availability of free vaccination through general practice and pharmacies for the peripatetic workforce and those where work-place administration is not available.

The Advisory Group believes this requires a significant culture and practice shift for both the workforce and employers, and learning from this year will be vital to plan for the delivery of a future coronavirus vaccine, and uptake of other vaccines recommended for social care workers.

2. Highly Important

Short-term workforce planning

Undertake a rapid assessment of the staffing needs of the social care sector, including replacing likely losses to the workforce from burn-out.

Nurse returners and nursing students

Urgently address the ongoing barriers to enabling nurse returners and nursing students to be available to the social care workforce.

Invest in upskilling the workforce

Recognise the positive response from members of the workforce who have become competent and skilled in undertaking 'extended' or 'delegated' roles and reinforce this development by investing in training and support to a level which satisfies the needs of safe working practices; the needs of people with care and support needs; and the requirements of insurers. Ensure that pay and recognition is associated with these additional skills and responsibilities.

3. Important

Short-term workforce capacity arrangements

(1) Provide temporary arrangements to mitigate the impact of the points-based migration system which will be introduced at the end of the transition period from the European Union.

(2) Maximise the use of available volunteers.

Maximise the effectiveness of COVID-19 workforce initiatives

(1) Review the effectiveness of existing initiatives, including (but not limited to) the social care recruitment campaign, volunteer schemes, rapid induction, recruitment app (“Join Social Care”) and carers’ app.

(2) Develop a communications strategy to increase take-up, amend, or withdraw initiatives which have not demonstrated effectiveness and are unlikely to do so.

Appendix 1 – Taskforce membership

Taskforce members:

- Colin Angel, United Kingdom Homecare Association and co-chair
- Rob Assall-Marsden, Care Quality Commission
- Zameer Bhunnoo, Health and Safety Executive
- Delyth Curtis, Association of Directors of Adult Social Services
- Matthew Egan, Unison
- Hilary Garratt, Deputy Chief Nursing Officer
- Karolina Gerlich, Careworkers' Charity
- Miro Griffiths, National Coproduction Advisory Group
- Ann MacKay, Care England
- Anna McEwen, Shared Lives Plus
- Vic Rayner, National Care Forum and co-chair
- Susie Singleton, Public Health England
- Georgina Turner, Skills for Care
- John Sutcliffe, Local Government Association
- Melanie Weatherley, Care Association Alliance

Policy advice and secretariat support:

- Victoria Dare, Department of Health and Social Care, Policy advice
- Fran Naish, Department of Health and Social Care, Secretariat
- Chloe Allcock, Department of Health and Social Care, Secretariat

Acknowledgements

The co-chairs would like to thank members of the Advisory Group and their deputies and members of the workforce team at DHSC for working at speed, including providing e-mail feedback when diary commitments made participation at virtual meetings difficult.

Appendix 2 – Background

The Workforce Advisory Group were asked to consider issues affecting the workforce primarily arising from, but not limited to:

- Implementation of the Social Care action plan;
- Implementation of the Care Homes Support Package:
- Proposals as part of the overall advice to government on what should be in place in the coming months and in time for Winter.

We aimed to cover social care settings, including people's own homes, regardless of employer. The short duration of this Advisory Group requires us to focus primarily on the front-line (paid) workforce over the next 12 months in response to COVID-19.

Our five meetings covered the following broad areas:

1. What has - and should - change for the front-line workforce? (Appendix 3)
2. Ensuring we have the staff we need (Appendix 4)
3. Security and wellbeing of staff
4. Organising the workforce
5. Agreeing recommendations

Appendix 3 – What has - and should - change for the front-line workforce?

[These notes were prepared at the end of the Advisory Group's first meeting on 8 July 2020.]

How has the role of the frontline care worker changed during the Covid 19 pandemic?

Front line staff have taken on additional clinical duties – staff have had to take on new responsibilities around the delivery of infection control, wound management and other clinical tasks in the absence of community health colleagues.

Communication has become an ever more central attribute to care work. The range of people to communicate with has increased – and front line staff have had to have more direct contact with relatives, medical colleagues during virtual treatment sessions, peers to update on changes in guidance. In addition, staff have had to learn how to communicate using full PPE.

Bereavement – staff have often had to cope with bereavement, however, in many settings there will have been concentrated levels of bereavement and the delivery of end of life care, and the communication with members of families who may have been unable to be with the individual because of lockdown restrictions.

Managing changing behaviours – The absence of additional services including supported employment, day centres and other services has been incredibly disruptive to individuals. Front life staff have had to become the full support for individuals, who may be scared, frustrated, bored or isolated from friends during the pandemic. Staff have had to develop new skills and expertise to manage this and ensure that they are able to offer the widest range of support to people, and where appropriate manage any changes in their behaviour.

Infection Prevention and Control – This has dominated the workforce around access to PPE and to following the rapidly changing guidance. Staff have had to cope with wearing unfamiliar kit, and to be ready to read and interpret changing guidance, and to explain to those who are receiving care and support why their practice is consistently changing. In addition individual employers have had insufficient detail to carry out risk assessments for their PA to continue to work, with the lack of guidance on this area leading to tension and stress for individual employers and their staff, alongside a postcode lottery of enabling access to PPE via their local authority.

Flexible working has become the norm – Staff have responded in an exceptional way to the demands of Covid 19. They have worked additional hours, taken on new tasks, worked directly with people who are Covid 19 positive and take on specialist roles. This position is not sustainable, and this crisis borne response shouldn't become an expected part of the norm of social care workforce delivery without training and infrastructure support to ensure they remain and feel that their new skills are recognised.

Formal identification of the social care workforce has caused problems in relation to accessing services either for themselves or for those they are providing care and support to. This has been particularly challenging for PAs who have often been refused access to priority slots to carry out shopping for disabled people and collecting medication.

What has been the impact on care workers?

There are real concerns about burnout and stress of care workers. They are delivering in an extremely intense situation and against a backdrop of fear and anxiety in the wider community. This can lead to others strongly valuing their role, or conversely being fearful of them due to their close proximity to people and settings where Covid 19 might be present.

Workers have needed to be able to speak up. They have needed to be free to be able to say when things are going wrong during the crisis, which is hard to do in many settings, and particularly hard during a crisis. In addition some workers may have felt they have needed to advocate for their own safety, asking for additional protection or changing working practices if from at risk groups such as being a member of a BAME community or having health conditions.

Limited or no respite from the caring role. This has been particularly the case in Shared Lives, Live in Care or in residential settings where workers have ‘lived in’. In these settings, there has been no respite from the caring role, and often increased isolation from their own family and friends in order to deliver the job.

Burden of grief is significant. Many front line staff will been part of the provision of end of life care during this period for people with whom they have long standing relationships, and the absence of family or friends will likely place the burden of grief more immediately on the care worker. Provider organisations may have limited range of services available to support people.

Sentiment of ‘all in this together’ may have created a climate that will have pressurised some into working in ways that they didn’t feel they had a choice about, and may have had to do so at great personal sacrifice. Care workers do not have a code of practice in the same way that nurses and social workers would have, that would be instrumental in supporting them in saying no.

Whilst the majority of staff working in care will have had continual employment during this period, individual employers have had support packages changed, leading to changing working arrangements for PA’s and some redundancies.

There has been positive recognition of the role of care work by the general public. This will have had a positive impact on many staff, who might feel for the first time that their work is more broadly valued and understood.

Members of the workforce see value in the new skills they have developed around clinical, digital and communication activities. These have all enabled them to enhance the way the can work with people they provide care and support for, their colleagues and wider stakeholder.

Appendix 4 – Notes from "Ensuring we have the staff we need" – 15 July 2020

	What has worked	What has not worked	What else we need
Employers and workforce	Recognition from central government and general population (but a risk that this may be short-lived), but locally recognition (in terms of financial reward) was more of a mixed picture. Employers have been able to up-skill staff, but now need to be able to formalise those though (eg. training, recognition, etc). The ability to recruit staff from other business sectors, including simplification of recruitment requirements (DBS and references) has worked well for employers. 'Rapid training' has helped and should be built upon but must be backed up with more in-depth induction, learning and development and competency assessment. In addition, there is still the need for the wider L&D needs in the sector has (ie. Clinical skills, leadership and management, delegation).	Infection control fund has been cumbersome, difficult to access and excluded large parts of the sector. Statutory Sick Pay vs. the need to provide full pay when workers are sick / isolating (to reduce cross-infection), which needs to be combined with managing sickness/absence well. Access to testing (including repeat testing), including reluctance to testing. We cannot assume that workers have the means to travel to testing centres (access to vehicles, travel costs). Mandatory testing in other areas (eg. Homecare) would need to be organised in a way which recognises the needs of a mobile workforce. Apprenticeships need to be more flexible than they currently are. Volunteers may have been left out of development opportunities.	Central support for vaccination. Dire need for occupational health system accessible for all.

	What has worked	What has not worked	What else we need
Local and regional	Collaborative efforts on recruitment and retention in local areas, where they have taken place, were generally regarded positively, but… Collaborative relationships have been variable and there are different views on how effective it has been (eg. extra funding). Where regional initiatives have worked well (eg. NW region), it has been characterised by triaging prospective recruits directly to providers and saving advertising costs. There may be a role for mandatory requirements in some areas (eg. funding) but note tension with "localism".	Getting money from the Infection Control Fund was difficult to get money out quickly (and it was not necessarily equitably distributed). Nurse returners – The programme produced high numbers of returners for the NHS, but did not highlight roles in social care well. The NHS may not have been prepared for the numbers centrally or locally. Returners need support. Student nurses joining register early didn't extend to social care, because of a lack of structured placements and supervision. Care settings need to be good learning environments. ICS have limited voices from adult social care; which (1) undermines their role in developing an integrated workforce; and (2) limits the focus needed on wider issues affecting adult social care.	

	What has worked	What has not worked	What else we need
National and arms-length bodies	National and regional bodies working well together during the crisis. But need to be clearer about what can only be done nationally and what should be done regionally / locally. Role of resources and support for delegated duties which may work across health and social care (or could be developed to ensure that they do). Potential for role of passporting prior training between jobs (eg. manual handling) where there is an agreed syllabus? Could the Care App hold the digital passport? DHSC recruitment campaign; On-line platform for recruitment (eg. operated by Cera) – Awareness raising, and initial enquiry is positive. It needs to dovetail with local groups and employers.	How to join-up recruitment campaigns for the NHS and Social Care, where they have quite different brands and employment structure. Need to join up the National Recruitment Campaign (care) which is likely to produce it's outcomes over the longer term, with local campaigns where the immediate impact is more tangible. Call for volunteers was aimed and branded by the NHS, and missed opportunities to direct volunteers to social care. National testing programmes have been confusing and messaging inconsistent. The ask should be for clear communications and support for implementation.	National workforce strategy (probably takes longer than this action requires), which includes the ambition for a workforce which can develop flexible skills. National campaigns need a clear narrative, and clear allocation of responsibility for delivery. Ability for nurses and other registered staff working in social care to get professional indemnity insurance. Does H&SC Act Code of Practice Infection Control Act need to be reviewed, including whether it recognises the roles and experience needed within social care.