Decent Work in Scotland’s Care Homes

The impact of Covid-19 on the job quality of front line workers

Hartwig Pautz, Stephen Gibb and Joan Riddell
December 2020

Report from the project ‘Social Care in Times of Crisis’. Funded by the British Academy’s Covid-19 Special Research Grant (COV19\200127).
Acknowledgements

The authors would like to thank all interviewees for giving up their time to help writing this report. In particular, the authors express their gratitude to the care workers who spoke so openly about difficult topics around their work during the Covid-19 crisis.

The authors also thank the British Academy for generously funding the research project of which this report is the main output (Grant: COV19\200127).

A special ‘thank you’ is for Jamie Livingstone, Head of Oxfam Scotland, for his immensely useful feedback on our project ideas.

Author information

Dr Hartwig Pautz is Senior Lecturer in Social Sciences at the University of the West of Scotland. He is co-lead of the UWS-Oxfam Partnership and conducted, in 2015/16, the ‘Decent Work in Scotland’ project together with Oxfam Scotland.

Dr Stephen Gibb is Reader in Human Resource and Organization Development at the University of the West of Scotland. His engagement with decent work research is about having impact on employers, including small and medium sized enterprises, through the soft power of culture change.

Joan Riddell is an independent business consultant with extensive management experience in the public sector and the third sector. Her specialisms include strategy and business development, tendering, research, and evaluation.

The report and further detail on the project can be found on Researching Decent Work in Social Care - www.dwsc-research.org.
Contents

Executive summary .................................................................................................................................................... 4
Introduction ................................................................................................................................................................... 6
1. Research approach .................................................................................................................................................. 9
2. The background: Social care in Scotland ........................................................................................................... 10
3. Voices from the front line and their key messages ............................................................................................ 14
   Decent work factor ‘decent pay’ .......................................................................................................................... 14
   Decent work factor ‘purpose and meaning’ ........................................................................................................... 15
   Decent work factor ‘safe work environment’ ....................................................................................................... 16
   Decent work factor ‘supportive managers’ ......................................................................................................... 17
   Decent work factor ‘feeling socially valued’ ....................................................................................................... 18
   Decent work factor ‘job security’ ....................................................................................................................... 19
   Decent work factor ‘terms and conditions’ ......................................................................................................... 21
4. Stakeholder views .................................................................................................................................................. 22
5. Analysis and implications ................................................................................................................................... 25
Conclusion .................................................................................................................................................................. 29
References .................................................................................................................................................................... 30
Executive summary

The background
During the first wave of the 2020 Covid-19 virus pandemic in Scotland, 46% of those who died of the coronavirus (a total of 4,482 people) died in care homes. Alongside these, at least 14 care home workers also died of the virus. While it is not possible to say whether they acquired the virus at work, it is clear that care home workers were at significant risk of becoming infected. In the wake of this crisis, many have argued for inquiries into care home deaths and social care more generally. We think that such inquiries must also address the job quality of the care home workforce and assess what needs to be done to assure ‘decent work’ for care workers. In other words, we think that job quality cannot be ignored when the quality of social care and the care system are under scrutiny. We also think that until decent work is a reality for all care workers, we will not see the high quality of care that we all profess to want and need to avoid future catastrophes such as that seen in the first wave of the Covid-19 pandemic.

The research
This report stems from a research project, financed by the British Academy, that sought to establish what care workers, in the wake of the Covid-19 crisis, think about job quality in the care home sector and what needs to change to improve it. Many of the insights in this report build upon what care home workers told us in interviews. In addition, what key stakeholders from government, industry umbrella organisations, and trade unions told us in interviews also helped us write this report.

The findings
Care workers’ experience during the first wave of the Covid-19 outbreak in Scotland demonstrates that pre-existing issues and deficits in the care sector related to job quality were amplified during the crisis.

Out of seven job quality factors specifically examined in this report, care workers told us that five factors had worsened during Covid-19. These relate to ‘supportive managers’, ‘terms and conditions’, ‘a safe work environment’, ‘decent pay’ and ‘job security’. Some care workers told us that they experienced more ‘social recognition’ at some points during the crisis. However, some also told us about how they felt blamed for the care home deaths and how they had, during the crisis, been an ‘afterthought’ to health care and health care workers. This confirmed their belief that care workers are generally forgotten or ignored, but quickly blamed when things go wrong. One last factor of importance to ‘make work decent’, that around the ‘purpose and meaning’ of work, was reinforced by the Covid-19 crisis. In fact, for many care workers this factor is key for staying in care work.

In the view of care workers, how Covid-19 unfolded for them confirmed long-held beliefs that existing attitudes towards older people – attitudes characterised by agism and lack of valuing them – translate directly into a lack of recognition for those who care for them. Care workers told us how they have experienced the chronic under-financing of the care sector and its consequences on the quality of care and on job quality.

Societal attitudes towards older people, translating into a lack of recognition for care workers and inadequate resourcing, coupled with an absence of collective voice and sectoral bargaining, are, in essence, what care workers consider to be key barriers to ‘more decent work’.

Among stakeholders, there was genuine concern for, and sympathy with, the views of front line workers. However, there seems to be confusion about where the responsibility for leading ‘decent work change’ sits. This is complemented by what appears to be a widespread expectation that ‘others’ take on this responsibility.
What needs to change?
Decent work improvements for care workers require a dedicated approach and specified institutionalised ‘regime’ for job quality improvement. Other social care sectors also require such a dedicated approach – each sector is too complex to allow a ‘one-size-fits-all’ approach. All decent work factors, in particular the seven factors focussed on in this report, should be seen as interdependent and should be addressed by all stakeholders in a coordinated way.

The integration of health and social care may have resulted in joint strategic and policy initiatives and joint commissioning processes, but now needs to extend to the whole workforce. This need is reflected in the unacceptable differences in parity and esteem between care workers and health care workers. The same is true for pay levels and access to employee support services, including mental health support. The widespread absence of the latter proved particularly problematic in the Covid–19 crisis, given the very difficult experiences of many care home workers.

Overall, Scotland lacks a ‘culture of care’ which values older people specifically, but also other people needing social care. Covid–19, has again demonstrated this absence. A culture change is necessary. As crises can be catalysts for change, the right consequences drawn from the Covid–19 crisis will make decent work in social care a possibility.

Amongst the first steps could be the application of the concept of ‘social value’ to care work – this concept refers to how, for example, highly paid jobs do not necessarily create more social value than low-paid ones but may, in fact, destroy more than they create. The use of this concept could result in the calculation that decent pay for care workers should equal a wage which is commensurate with skills, responsibilities, tasks and competencies, plus a social value premium that accounts for how important the work that care workers do is.

The call for action
Quick fixes to the problem of job quality in the care sector will not simply emerge; nor will problems be solved by fixing only parts of the existing structures and operations.

Starting at the top, the culture needs to change. A culture of care would drive institutions and operations in a more sustainable direction and potentially pave the way for finding new ways of resourcing social care. This will require the courage to accept responsibility and the need for co-operation across all stakeholders, with front line care workers having a central place in this process of change.

We think it is critical that front line voices are systematically allowed to influence efforts towards creating a culture of care in Scotland in order to improve job quality in the care sector. An ongoing research process, which listens to front line workers and stakeholders should be considered an investment in enabling such improvements.
Introduction
This report, based on research conducted between June 2020 and October 2020, and financed through a British Academy grant, has its focus on the job quality of Scotland’s care home workforce and on what needs to be done to deal with longstanding deficits around ‘decent work’ in the adult care sector. Based on interviews – primarily with care home workers, but also with a range of stakeholders from local government, regulators, trade unions, and industry umbrella organisations – we aim to highlight how the failure to address these deficits became painfully evident during the first wave of the Covid-19 pandemic when both care workers and those cared for in Scotland’s care homes paid the price, in many cases with their lives. It is clear to us that the widespread absence of decent work for care workers has been well-known and has been ignored too long, and is part of Scotland’s wider ‘social care crisis’.

We believe there is a window of opportunity, with dialogue on change happening now after the first wave of Covid-19, to achieve a breakthrough and to overcome old barriers to progress. Currently, at the time of writing, many voices are being heard about social care reform in Scotland. We hope that the voice of front line care staff as it comes through in this report can be a critical part of future constructive change.

Decent work
The improvement of job quality, in the terminological guise of ‘decent work’, has been promoted by the International Labour Organisation (ILO) since the late 1990s. Decent work, according to the ILO, describes an objectively measurable certain level of job quality and, at the same time, serves as a normative-aspirational, and universally valid, policy objective that was developed to stimulate a global transformation in the world of work. The ILO developed a series of factors and indicators, encompassing both hard and soft variables, some extrinsic and some intrinsic in nature, which impact on whether or not work should be considered ‘decent’ (e.g. ILO 2008; ILO 2018). In 2016, decent work was adopted as one of the 17 United Nations Sustainable Development Goals (SDGs). In Goal 8, ‘Decent Work and Economic Growth’, the UN declares that all signatory states have agreed on the objective to ‘promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all’ (UN 2017). Scotland committed to the SDGs in 2016.

Recent research in Scotland, focussing on low-paid workers, not only found that decent work is largely absent for them, but also indicated that of the many different decent work factors, some have greater importance than others and thus can be ranked. One such ranking (Stuart et al 2016; also Gibb & Ishaq 2020) informed how we constructed the dialogue with care workers in our interviews and is described, in some more detail, in the Research Approach section.

Care in the ‘first wave’ of Covid-19
In March 2020, the whole of the United Kingdom (UK) went into ‘lockdown’ in order to slow down and reverse the spread of the Covid-19 virus. This strategy of drastically reducing contact between people was implemented in the UK later in than most other affected European countries and took place ‘after years of cuts in the health and social care sectors’ (Watterson 2020, 87) and with an NHS deemed incapable of coping with even a flu pandemic (Lambert 2020; Pickles & Rowland 2013; Carrington 2020; Freedman 2020). Perhaps as a result, the UK has (in October 2020) the third–highest death rate in Europe per 100,000 people (JHU 2020). By October 2020, just under 60,000 people had been registered, as per death certificate, as having died due to the coronavirus (UK Government 2020).

In Scotland, by late October 2020, 2,791 people had been officially registered as having died with a positive test result, while 4,482 death certificates had been issued with a mention of Covid-19. By the 13th of September, 46% of deaths had occurred in care homes. Another 46% had occurred in hospitals and 7% at home or in ‘non-institutional settings’ (National Records of Scotland 2020; National Statistics 2020). Compared to the rest of the UK, Scotland appears to have the worst record on care home deaths (Boothman 2020).
It seems that care homes – both their residents and their workforce – were overlooked by government, whether UK or Scottish. This may have been due, certainly in the early phase of the pandemic, to the focus being on the threat of ‘the NHS becoming overwhelmed’ with too many people requiring hospital care. When attention did turn to care homes, it was too late for many residents in Scotland’s care home and too late for at least fourteen of their care workers who had also died of Covid-19 (Scottish Government 2020a). And while the Scottish Government emphasises that it is unclear whether these workers had acquired the virus at work (Scottish Government 2020a), it is likely that there is a link between care work, reporting a positive Covid-19 test (CPEC 2020), and the risk of dying of Covid-19 (McArdle 2020; Siddique 2020).

It also seems that much of the debate about care home deaths has been about blame shifting. While Prime Minister Boris Johnson’s 6th of July 2020 comment that ‘too many care homes didn’t really follow the procedures’ (cited in Hurst & Lay 2020) may be more memorable, the Scottish Minister for Health, already on 4th of June, stated that the Scottish Government had provided clear guidelines to care homes, implying that those care homes with many Covid-19 cases must have not followed them (Scottish Parliament 2020). Furthermore, a Crown Office and Scottish Police investigation into care home deaths and deaths amongst care home staff started in May (BBC 2020). As a consequence, many in Scotland’s care home workforce are reported to feel that the blame for Scotland’s high death rate is laid at the feet of care homes alone and feel ‘emotionally distressed’ (Davidson 2020). Finally, an October 2020 report by Public Health Scotland rejected any claims that hospital discharges of patients to care homes played a significant role vis-à-vis Covid-19 outbreaks in care homes (Public Health Scotland 2020).

Where more measured debate and scrutiny has occurred on what caused the high mortality rates in care homes and what should be done to avoid a repeat, the focus appeared mostly to be on how personal protective equipment (PPE) can be stocked and provided more efficiently, how lockdown measures can be more appropriately set in motion for the next ‘wave’ of the virus, and how NHS Scotland and social care providers can work better together. Unfortunately, it appears that again the care home workforce itself and its working conditions are overlooked. This continues, we argue, a longstanding pattern of a lack of ‘care for the care workers’ in Scotland and a highly problematic undervaluing of the care home workforce in particular if compared to front line workers in the NHS.

The case for change
All this intensifies the need for a radical review of Scotland’s social care sector, most certainly in the adult care sector. Public anger about care home deaths and about the deaths among the care home workforce has opened a window of opportunity for policy makers to make the long-needed changes. We hope that this report, with its focus on the job quality of care workers and its demand that care work must be ‘more decent’, feeds into the debate and ensures that decent work is a key part of the solution to Scotland’s ‘social care crisis’ (e.g. STUC 2019; Naysmith 2019). With the focus of our report being on job quality we do not wish to shift attention away from the need to improve the quality of care itself – in fact, we think that care quality and the job quality of the workforce are linked. To put it bluntly, it is hard to imagine how consistently high quality care can be provided with a workforce experiencing low pay, little public recognition, high risks to physical and mental health, an insufficiently supportive managerial layer, and limited job security coupled with poor terms and conditions regarding, for example, sick pay. Furthermore, we do not propose to prioritise care home workers over other social care workers in any reform – our focus on care home workers for this report does not suggest a ‘hierarchy’, and we suggest in the conclusion to this report, a research agenda that addresses aspects of the whole of the social care sector.

Our calls for change are directed at a number of stakeholders that have for some time before Covid-19 grappled with the various challenges in the highly complex social care sector. Individual employers, care provider networks, and local and national governments have all contributed to moves seeking to reform the social care sector. Discussions and efforts at reform have been, in their majority, conducted within the existing framework of the Scottish Government’s Public Bodies (Joint Working) (Scotland) Act 2014 (Scottish Parliament 2014), stipulating that social and health care should ‘integrate’ to ‘improve care and support for people who use services, their carers and
their families [by] putting a greater emphasis on joining up services and focussing on anticipatory and preventative care’ (Scottish Government 2020d).

To us it seems that none of these past efforts have dealt with Scotland’s social care crisis that has fed into the Covid-19 crisis for care homes. Collectively, there has been an impasse. That impasse is, we think, significantly rooted in the absence of decent work in the sector. And this, we argue and detail later in the report, could be to do with the lack of a larger culture of care in Scotland – a culture which truly values the people requiring care and those providing it.

This report has the objective to a) provide insights into job quality in care work and to b) provide a set of implications that could guide future attempts to make care work more decent and to start building a culture of care. Importantly, these implications are informed by our interviews with care workers and, to a lesser extent, with other stakeholders. We took this approach as we are convinced that the insights for reform must consider the ‘front line voices’ to avoid a top-down approach. Taking seriously the voices of care workers, we think, can make the difference between progress or a continuity that neither improves job quality nor the quality of care itself.

The report
After a description of the research approach (Section 1), a short background section outlines the main characteristics of social care in Scotland with a focus on care homes. In this section we first introduce the notion of a ‘culture of care’ across national, institutional and operational domains in Scotland’s social care sector (Section 2). The main part of the report follows (Section 3), putting the voices of care workers in the foreground and distilling from these a number of ‘key messages’ for change. Following this, we detail what further stakeholders have told us in terms of how they see their role in the process of changing job quality in Scotland’s social care sector for the better (Section 4). The final part puts together what we call ‘implications’. It focusses mostly on culture change as we believe that this is where change towards more decent work in the care sector would be most effective (Section 5). In the conclusion, we offer suggestions for a change-focussed research agenda that has front line care staff and other social care stakeholders at its core.
1. Research approach

Data was mainly generated from qualitative semi-standardised interviews with twenty care workers from across Scotland. Following these, we conducted a further ten stakeholder interviews with local government representatives, Health and Social Care Partnerships, regulators, trade unions, and provider umbrella organisations. Interviews were conducted between July and October 2020, mostly via the telephone and in some cases via video conferencing platforms such as Zoom or MS Teams.

The interviews with care workers began with general questions about interviewees’ working lives, their training, their employers, and their hourly income and contractual status. Following this, interviewees were asked to describe their experience of the Covid-19 crisis; we then asked them to consider their work with regards to seven specific ‘decent work’ factors: supportive managers; a safe work environment; decent pay; terms and conditions; job security, social recognition, and purpose and meaning. We chose these factors as previous research had established that they are central specifically to low-paid workers (Stuart et al 2016), with the notable exception of purpose and meaning (or ‘intrinsic motivation’) and social recognition. In this study we included these two factors in the interviews as well because it was clear from other research that those working in the social care sector see them as important for how they assess overall job quality (e.g. Ross et al 2016). Finally, interviewees were asked to identify one or several changes which would impact positively on their job quality and what the barriers to making these changes might be. These interviews lasted between one hour and two hours. We compensated care worker interviewees and said ‘thank you’ for their time by issuing each with a £20 shopping voucher.

Interviews with stakeholders followed a much looser and more iterative structure. We asked stakeholders to comment on the issues around job quality as they had emerged in the care worker interviews. We also asked them how these could be addressed and how they saw their own role in job quality improvement. These interviews also lasted between one and two hours, but interviewees were not compensated for their contribution.

All interviewees – care workers and stakeholders alike – were assured of their anonymity. No interview was recorded and interviewers took notes during the interviews. The quotations presented in the report’s main section are based on these notes. The decision not to record was made because care worker interviewees had, in pre-interview conversations, voiced disquiet over being recorded. This was rooted in worries about losing employment when speaking about their experiences of and with Covid-19 and about other matters around care work, but also in feeling that they would speak more freely when not being recorded. In order to protect care workers, but also the stakeholders who often spoke very openly and honestly about their views on the problem of decent work, neither the care workers’ employers nor the stakeholders’ institutional background are revealed anywhere in this report. This decision is also based on our explicit intent not to ‘name and shame’ individuals or institutions, but to contribute constructively to a better understanding of how the lack of decent work for care workers can be addressed and where any obstacles and challenges may be.

Care worker interviewees were found through word of mouth, personal contacts, and via social media where we ‘advertised’ the project. Some care home managers also were very helpful by linking us with members of their staff. Most interviewees were from Scotland’s central belt between Edinburgh and Glasgow and from its West coast. Interviewees were not selected because they had specific experiences with Covid-19 outbreaks in their workplaces, and not all had. For the stakeholder interviews, we contacted relevant organisations and also used our existing links to the sector. Most care worker interviewees were female, reflecting that, in 2019, 83% of the Scottish social care workforce were women. A majority (64%) of care worker interviewees had had five or more years’ experience of working in care, with 14% having more than 20 years in the sector. 36% of those we interviewed had been employed in care work for up to five years. Of those interviewed, 67% were working in the private (‘independent’) sector, 20% in the public sector, and 13% in the third sector. Overall, in 2017, 28% of the social care workforce was employed in the third sector, while 31% worked in the public sector and 41% in the private sector (Scottish Government 2016, 2020c; SSSC 2018; FWC 2019).
2. The background: Social care in Scotland

Structures and resources
The structure of Scotland’s social care is diverse and complex (see Figure 1). It is largely determined by the Scottish Government which, since enacting the legislation of the Public Bodies (Joint Working) (Scotland) Act in 2014, seeks to integrate health and social care via close cooperation between local authorities and health boards in the 31 Health and Social Care Partnerships (HSCP), covering all of Scotland’s 32 local authority areas (White & Cameron 2019; Rowland 2019).

In all but one HSCP, an Integration Joint Board (IJB) was set up and tasked with the planning of health and social care services. IJB’s memberships consist of local councillors and NHS non-executive directors, plus other members without voting rights, including professional representatives and community and staff stakeholders. IJBs receive funds from the health board and local authority which they use to commission delivery of social and health care services (HSCS Scotland 2020). Service providers range across public, private and third sectors. Health and wellbeing outcomes, set by the Scottish Government, and high-level statements of what health and social care partners are attempting to achieve through integration, seek to focus attention on the pursuit of quality improvement across health and social care.

Figure 1: The structure of social care in Scotland (OACSW 2016)
In Figure 2, the levels of funding between health care and social care and for integrated efforts in 2018 are demonstrated.

Figure 2: How NHS and social care are funded (Scottish Government 2018)

The spending figures in social care across all care recipient groups (OACSW 2016) indicate that a significant proportion, over 40%, is spent on older people's care (see Figure 3).

Figure 3: Spending in social care across care groups (OACSW 2016)
Institutional stakeholders
Care policy, standards, commissioning and regulation involve a range of bodies including the Scottish Government, the 32 Scottish local authorities and their umbrella body COSLA (Convention of Scottish Local Authorities), the 31 Health and Social Care Partnerships, Scotland Excel, the Care Inspectorate, and the Scottish Social Services Council (SSSC). The SSSC registers the whole social care workforce and ensures that basic training standards are adhered to, while the Care Inspectorate registers care homes and quality assures care provision.

Employer networks including Scottish Care (for the independent sector) and the Coalition of Care Providers Scotland (CCPS, for the third sector) are also key stakeholders, and trade unions including GMB, Unison and Unite offer support and representation to members employed in care homes.

Care as a market and its care providers
According to the Fair Work Convention, the adult social care sector in Scotland had an economic value of £3.92 billion (FWC 2019). It is, in other words, a market of considerable size and one that was, certainly before Covid-19, expected to see increases in demand as the population ages (CMA 2017).

In 2017, care homes in Scotland for older people numbered 1142, owned by a mix of private companies (60.5%), the public sector (14%), and voluntary sector organisations (25.5%) (NHS 2018). The same study indicated that private care homes had 26,053 older people as residents, an increase of 6% over the previous ten years, while the number of residents in public sector and third sector homes had reduced by 24% and 21%, respectively, over the same timeframe to 3606 and 3032, respectively. The number of homes decreased in all sectors between 2008 and 2018 (NHS 2018). A recent study on behalf of trade union GMB Scotland indicates that there is a slow withdrawal of the third sector from the market (Donaghy & Fisher 2020).

The workforce
In 2019, 202,090 full-time equivalent staff were employed in the Scottish social care sector; 83% of them were female. Pay averaged £9.79 per hour – this average includes care staff at all levels, from ancillary staff to qualified social workers (FWC 2019). This average is above the Scottish Real Living wage of £9.30 in October 2020 (to rise to £9.50 in November 2020). The UK statutory minimum wage is £8.72 in October 2020.

Figures for 2019 indicate that the overall care home workforce totalled 53,090 people working in about 1,100 establishments. With an average workforce size of less than 50, these cared for around 35,000 people across the three sectors (SSSC 2019). Overall, the social care sector was, in 2018, expected to grow by 5%, or almost 21,000 jobs, between 2019 and 2029 (Scottish Government 2020c).

Recent care reviews and ‘reset activities’
A survey of the care home workforce by Scottish Care in 2018 identified serious workforce issues. These include difficulties in recruiting into management and leadership roles; a high staff turnover of 24% per annum; an exodus from the private sector for better terms and conditions in the public sector; increasing strain created through staff covering unfilled vacancies with extra hours; and a lack of investment in people, evidenced by a significant proportion of staff not being funded to complete basic training as required by the SSSC (Scottish Care 2018). In its ‘Show You Care’ study, GMB Scotland calls for an end to low pay and poor contractual arrangements in the sector and for a new system of value and reward. It also highlights that care workers need more time to deliver dignified and compassionate care (Donaghy & Fisher 2020). Addressing recruitment issues in the sector, a COSLA review focussed on developing new workforce planning data and guidelines, promoting social care more widely as a positive career choice and developing career pathways and training (COSLA 2019).

Recent data about recruitment and retention in social care, and the movements of care worker within the sector and the wider economy (Eksogen 2019; Jones 2020), highlight the complexity of service provision and commissioning, the ramifications of the dominant market dynamic, and the distinct challenges within rural and urban areas. The Fair Work Convention recommended that ‘Fair Work First’ criteria be developed and included in the commissioning of care services (FWC...
A brief examination of tenders in November 2020 on Public Contracts Scotland indicates that commissioners now seek ‘Fair Work Statements’ in the course of tendering for contracts or for entrance to frameworks and thus consider fair work practices when scoring tenders. However, despite some good practice and efforts by individual employers, the wider funding and commissioning system makes it almost impossible for providers to offer fair work (FWC 2019). Stakeholders interviewed for this project indicated that the development of a partnership approach to reviewing the national pricing framework for commissioning is underway, involving the Scottish Government, Care Scotland, Scotland Excel and others.

The Competition and Markets Authority warned in 2017 that the prevailing structure of service provision could not be sustained without additional public funding and that significant reforms were needed to enable the sector to grow to meet the expected increase in care needs (CMA 2017). COSLA’s submission to the Independent Review of Adult Social Care reinforces this point by stating that ‘it is well recognised that funding is a central determinant of the quality of care that can be provided, and that available resource has often acted as a barrier in this respect. The matter of sustainable funding for adult social care will have to be clearly addressed’ (COSLA 2020, 1).

The Fair Work Convention recommended that the Scottish Government support a new ‘sector-level body to ensure effective voice’ for care workers and to provide ‘leadership for fair work’ in the sector (FWC 2019). Discussions over such a body had begun in November 2019 with the Work in Social Care Implementation Group set up by the Scottish Government (Scottish Government 2019a). The virus pandemic interrupted the group’s deliberations.

The structure of social care had been under critical review from different quarters prior to the pandemic (e.g. MacDougall & Wood 2018; ICF Consulting 2018; Accounts Commission 2016). As existing problems were becoming more urgent to deal with during and in the wake of the first wave of Covid–19, criticism of the quality of care grew (e.g. Donaghy & Fisher 2020). For a remedy and ‘reset’ of Scotland’s social care system, some started to advocate a ‘national care service’ and the Scottish Government set up a commission, led by Derek Feeley, to report on this idea in January 2021. While some, for example the Scottish Trades Union Congress (STUC) and Scottish Labour, strongly endorse a national care service if it translates into a publicly funded system, others are more sceptical and criticised the idea as a ‘distraction’ from the fact that additional funding was needed to improve the social care system (Bol 2020).

**Advancing decent work**

This outline shows that Scotland’s social care sector has a complex infrastructure, leadership and actor landscape. We believe that fixes to only parts of that landscape or systemic aspects of it will not create sustainable improvements in decent work. Looking at this landscape – as we do in Section 5 (Analysis and implications) – through a lens of cultural, institutional, and operational ‘domains’, we hope to provide starting points for discussions of solutions revolving around the central notion of a ‘culture of care’. We believe that the promotion of such a culture of care is critical to sustainable improvements also in the other two domains, so that front line care work becomes ‘decent work’ and so that those needing care receive the best possible care.
3. Voices from the front line and their key messages

The research project set out to give care workers a voice and to use what they tell us to distil ‘key messages’ to public and policy-makers. This section then does two things. First, it offers a raw and uncut view of job quality and ‘decent work’, as told by care workers. This view captures experiences of decent work – or, in many accounts, its absence – from before Covid-19, during the peak of the pandemic in April and May 2020, and since then. Second, it presents the key messages upon which we build our implications in a later section.

Care workers’ voices are presented through excerpts from the notes we made during the interviews. These notes are presented as direct quotations. While no recordings of the interviews were made, we are confident that the excerpts are near-verbatim ‘de facto transcripts’ of what interviewees said.

The section is structured by the seven decent work factors we chose to put at the centre of our enquiry – decent pay; purpose and meaning; a safe work environment; supportive managers; feeling socially valued; job security; and terms and conditions.
Decent work factor 'decent pay'

Voices from the front line

We were underpaid and overworked, even before the crisis.

The pay should be the same as in the NHS. We are skilled people, care work is skilled work, to do it right you have to be skilled, you have to think, especially when it comes to end of life care.

They have never worked out what the job is really worth. We risk assess every day, give medication, take temperatures, support behaviour, keep people safe. This isn’t the right pay for this sector. My 19-year-old nephew earns more than me, working as a basic labourer.

This poor pay rate is an indicator of a lack of recognition and a lack of respect.

I am fine with the pay for the moment, but only because I don’t see myself in the job for very long.

Having my work described as unskilled work, it angers me, it’s complete nonsense. We are skilled, we keep up with the rules and regulations and guidelines, we are constantly learning, we’re doing our online training. We’re poorly paid, but highly skilled.

Pay is not decent at all, we’re undervalued. We have fantastic skills: I understand people, provide social care, personal care, psychological care.

Our employers were forced to give a 30p per hour increase so I was paid a living wage. It makes no difference. We were on the Scottish Living Wage anyway. The Scottish Government talked about us getting a pay rise in recognition of our work during Covid – we didn’t. That was misleading. There wasn’t a big pay rise for care workers as a result of Covid – the increase for workers was agreed back in November. What workers got was just the annual pay rise. There wasn’t anything special about it at all.

Turn this work into a profession with equal standing with the NHS. Do a proper review of jobs and pay. It should feel like a profession, a vocation, instead of people saying we wipe arses for a living.

There is no progression possible, training doesn’t get you anywhere in terms of that. People rather not take on extra responsibilities for a very minor pay increase.

Key messages

The low pay – largely unchanged despite the Covid-19 crisis and the resultant (short-term) public appreciation of the social care workforce – is not seen as reflecting skills and responsibilities. Interviewees made comparisons with jobs that are both better paid, have fewer responsibilities, and are safer. The outcomes of such comparisons may explain why recruitment into the care sector and retention of staff are so problematic.

Many interviewees indicated that they saw care work as a vocation and called for it to be considered as such. This not only came with calls for more societal appreciation but also explains why so many care workers remain in their jobs – they understand how important their work is and they value its purpose and meaning, despite poor pay and poor public recognition. A further important key message was the call to undertake a thorough review and re-evaluation of care work roles with the aim of establishing a fair pay structure. In this respect, a last key message around pay is that care workers consider that they deserve equal standing with NHS health care workers.
Decent work factor ‘purpose and meaning’

Voices from the front line

Meaning and purpose has always been there – it’s a major motivator to help people have a nice life and to look after them. During Covid, we felt that our work was very important, and meaning and purpose became even stronger. It was really difficult when people were dying, we wanted that they passed away peacefully and not in pain. Helping as many people as we could to recover became a powerful purpose – this also gave us hope.

You give your all to service users to keep them safe and doing well. So, a sense of meaning and purpose is always high.

This was always very important – giving people a good life keeping them happy, keeping them safe. It’s important to think you’re making a difference to someone’s life, and care work does that.

I did a few 14 hour shifts during Covid, I needed to do them, needed to help. We weren’t forced, we wanted to help. Although my son said to me ‘don’t go back to work, mum, don’t go back to your work’ and I said ‘no I can’t, I have to help them, we have to keep going’.

Care plans have barely any space for proper activities with those who receive care. It’s all about basic tasks, if I want to provide ‘invisible’ support, it’s in my time and with my creativity that that happens, but this is where humanity begins and ends in care.

The satisfaction of caring for others, making people comfortable, creating a nice home environment for them, making their days, lots of job satisfaction comes from this and keeps you going when other aspects of the work aren’t so good.

Yes, my work always has a sense of purpose and meaning but the recent experience has had a bad impact on my mental health. I’ve been traumatised, crying, not sleeping. I can’t switch off. I keep running and re-running it in my head.

Just knowing that you’re enriching someone’s life is a reward. And people saying ‘you’ve done a good job’. I get a lot of respect from the client and the family.

Key messages

A key message taken from our interviews is that the strong sense of purpose and meaning underlines the need for care work to be viewed, publicly, as a vocation. Recognition for this would be an important part of changing societal attitudes towards care work and is vitally linked to other decent work factors, including pay, and also to the persistent problems of recruitment and retention. Another message is that the care workforce would not ‘do the job’ were it not for their intrinsic motivation. However, this motivation should not be exploited by governments or care providers – as any resource, it can be depleted.
Voices from the front line

My job is emotionally and physically stressful. And this stress never gets addressed by management until its bursting out at the seams, or until staff are all ill, or until I stand in the office crying. But for mental health support, you go to the manager’s office and they might listen to you for 20 minutes and then give you a leaflet and say ‘call this number, they’ll help you’. They don’t want to sit down with you, they don’t want to hear about your stress. There is not much care for the carers.

When people died, they were taken away by guys in private ambulances who turned up in full PPE – they had full hazmat suits, they were completely kitted out for the private ambulances; and they were looking at us wearing bin bags.

Lone working with challenging service users must end. Lone working exists only to cut costs and that is why assessments for care plans are so faulty. Playing down the risks allows putting down the wage bill.

The GP who refused to enter the care home to look after Corona-ill patients when we had the first cases, he only now [July 2020] started visiting the home again. For 102 days he didn’t come into the home, only phone consultations, and you could never get through, so we called NHS24, and you could never speak to anyone. Now he comes back to the home, with PPE for himself.

Loads of people earning measly wages came into work every day with that fear, that pressure, and were traumatised by the scale of the deaths.

The phones didn’t stop ringing and we couldn’t let relatives in to be with their loved ones when they died, I had one resident who was dying and I was holding his hand while he was dying while his daughter was at the window, too scared to come in, she was frightened, but I was fucking frightened, too.

We didn’t get any telephone numbers and we don’t have an employee assistance programme. We talk to each other, to pals, to other care workers – I don’t think anyone understands what we’ve been through unless they’ve been through it themselves.

I had panic attacks and I was told I was mentally unstable and should get to my GP. There’s no employee assistance. Covid has highlighted what you really need in a manager. But they never asked us if we were alright.

I remember a sense of panic and fear among colleagues and I argued with my boss that they needed a protocol, but it was so hard to know what was right. The Council had the say over all of this, and the Council did not speak to us, they’re not good at looking after their staff, lots of staff are off ill with stress.

At this point before lockdown, there was no PPE at all in the home, only the normal gloves and aprons. The GP advised staff, by telephone, that when they were caring for residents with Corona, often seriously ill and coughing heavily, that they should gurgle with saltwater after they’d finish with the personal care. Within two weeks, many of our residents and the staff became ill and those who passed away died a terrible death.

One supplier, who would always supply us with aprons and gloves, a private company, told us he could no longer give us anything as he had been told only to supply the NHS.

The airplane that landed in Prestwick with PPE was seen as a relief for the care homes – but all supplies went straight to the NHS.
Covid made a big difference re health and safety. Most managers were either working from home or were ill themselves and care workers, coming into the office to look at plans and to pick up materials, felt left alone, we felt helpless.

I work in a third sector care home. We were, also during Covid, well-equipped with PPE. But in all private care homes I had worked before, there was always a shortage and they wanted us to use as few gloves and aprons and so on as possible. Private care homes don’t bother with that stuff, hygiene for carers. And that’s always been more or less accepted by staff.

---

**Key messages**

Interviewees described general concerns about health and safety but focussed, understandably, on how they experienced Covid-19. In the interviews, they spoke often about the care home residents and their health and not so much about their own health and safety, unless prompted. But clearly, we heard that many care workers’ mental health suffered greatly during the pandemic and how care workers were at higher risk of falling ill with Covid-19 than the average population, including health care workers.

Amongst the key messages is that there needs to be a credible effort made to provide mental health support to care workers – and not do so only in crisis times as being a carer is emotionally stressful also in ‘normal’ times. The absence of such access is likely to lead to the deterioration of care workers’ job quality as they are exposed to high levels of stress and anxiety. Also, more support regarding physical health was demanded, especially under the impressions of the Covid-19 crisis. In other words, the provision of good employee assistance and access to counselling and the recognition and management of physical and mental stresses are critical for the future of care work.

A further key message is that in order to guarantee a safe work environment during crises such as Covid-19, clear guidelines need to be in place and understood by managers and care staff alike. Contradictory guidance sows confusion which is likely to endanger physical and mental health of care workers and those they care for.

Finally, it seems that staffing levels do not always reflect the needs of a service user. That means that care workers are likely to be overworked and, specifically when working in care-at-home services, can feel unsafe when lone-working with service users with challenging behaviours. A method to calculate ‘safe staffing’ should be introduced into social care.
Decent work factor ‘supportive managers’

Voices from the front line

The manager never left, she was there all day every day, checking staff were alright, staying out front all day with staff; she listened and was calm. Above her I’ve not seen any support, there didn’t seem to be anyone.

To have a supportive manager is important, they should understand where you’re coming from, should listen, there should be confidentiality and trust. Everybody should be entitled to say what they think about the workplace and also speak out on behalf of the residents.

The manager was fabulous. She was great for supporting us, but who was supporting her?

We could always get a hold of someone, but during the pandemic they kept us really well informed and contacted us personally every day to see how we were.

Every day we got emails from management, with information on how to get PPE, how to wear it, what we needed to wear. They gave us all the updates on what was happening, any new guidance and any regulations. We were told where everyone was. We had a contact during office hours and an on-call contact from 5pm through to the next morning. Every single day. We also got a text every day from our team leader checking in that we were ok and to see if we needed anything. They were really quite good. I felt aware of everything that was going on.

Managers didn’t really have a clue. They didn’t really keep us in the loop – maybe they weren’t in the loop themselves.

We were told about a member of staff testing positive while we were serving up food – they didn’t even call a meeting to explain what would happen next. No support for mental health, no idea about the Social Care Fund – I had to tell them about that. HR didn’t help, they were on holiday.

The managers were badly affected. So desperate for staff they phoned up absent staff and pressurised them to come in, even if they said they were sick. This was not entirely down to manager though – the problem was higher up. We had no control over what was being decided. There was no clarity and conflicting guidance coming in from the Government, SSSC, the Health and Social Care Partnership, the management in our own organisation.

We are spoken down to as if we don’t matter. The managers were faceless throughout the outbreak.

Something needs to change about the quality of managers. Maybe they struggle to get good people. Having a good manager makes all the difference. Having a bad one is demoralising and puts staff at a low ebb.

Key messages
An important message coming through from interviews is that care workers expect strong and consistent support from their managers. However, at least in the experience of our interviewees, this expectation was not met during the Covid-19 outbreaks in care homes. While care workers expressed understanding for the difficult and challenging context their managers found themselves thrust into by Covid-19, their views on supportive managers present a picture of inconsistency and variability ranging from faceless to excellent, from unapproachable to concerned and supportive. A further key message is that the quality and consistency of management needs to be reviewed and form part of the creation of a proper career structure, with training, progression and professional status for care home managers. Demonstrating that all decent work factors are interrelated and interdependent, interviewees told us that they often received conflicting guidance on Covid-19 – from their own managers, but also from regulatory bodies and other institutions. This had a negative impact on their health and safety and on the quality of care they could offer. From this derives a last key message – the avoidance of confusion arising out of conflicting guidance is the task of managers and they need to be enabled to take on this task.
Decent work factor ‘feeling socially valued’

Voices from the front line

I don’t think society values care workers though, or the people we look after – they don’t treat them with the respect and support they deserve.

Older service users who had verbal skills were much more appreciative and grateful than usual, I heard them say ‘thank you’ so much more than usual.

My family are proud of me for the work I do. I don’t wear a uniform so nobody has come up to me in the street to thank me or anything.

I was working all hours so didn’t come into contact with many people, but people at my wife’s work, and neighbours, would pass on their respect. I heard nothing from managers. Residents families would also say ‘thanks’.

Social care is very hard and difficult, people forget about us and only focus on doctors and nurses. It was all about save our NHS – how about us?

We’re not valued at work – we’re just a number. We dealt with huge stress, but all we got was a sticker saying ‘Everyday hero’ from the company. The owner never came to thank us. Twelve staff have left since Covid.

When people say ‘caring is just about wiping people’s bottoms’, that angers me.

After the local paper covered the Covid deaths in our home, the comments on Facebook were horrible. They said it was the staff’s fault.

We felt all attention was on the NHS and while the 8 o’clock clap was a nice gesture it took a while for people to remember us and for me to realise that it was about us too – it seemed to be for the NHS and the care workers an afterthought, we were second class. I felt more included in it as time went on. It was good that people realised that care workers are key workers.

Everybody is out clapping for the NHS. I’m thankful to the NHS that they looked after my ill work colleagues. But they were not overwhelmed because they didn’t take anybody from the care homes.

The clap, well, it was not really for us, it was for the NHS. We didn’t get the support, we didn’t get what the NHS got, we only had aprons and the masks, in hospitals they have much better stuff.

You’re clapping now, but as soon as this is over, you’ll forget us.

I think there’s a lot more public support for us, perceptions have improved. We were always the poor cousins and second rate. Covid has highlighted what goes on, what we were doing in the crisis.

At first, we felt good, but after a while we felt we were blamed for spreading it. We were shouted at for going to the shops in our uniforms. People said it was ‘just our job’ and why should we be singled out for any special praise. That’s not fair, people were sick and dying and care staff didn’t have, and weren’t given, the equipment to help these people.
I was turned away from special shopping hours and was told ‘you’re only a carer’. It happened so many times during the pandemic. I didn’t work for the NHS so I was told to get back to the end of the queue. All the discounts, meals being sent? Well, I didn’t get any.

The NHS and the government failed us. I only hope that they make use of the big new hospital, it took only two weeks to build it – when they wanted it done, they got it done no matter how expensive it was. I hope they use it for our residents when the next wave comes.

I felt that we were abandoned, neglected, written off, ‘it’s only about old people’, you know. It’s shameful.

There’s only a certain level of things that nurses can do in care homes – we tried to access health services but the door was shut in your face. We were crying out for help but they were saying ‘we can’t take them because they have Covid symptoms’.

We got a lot of help from our Health and Social Care Partnership; the Local Authority Social Work Teams were very supportive and they are still supportive. The regional teams from our own organisation and the Care Inspectorate also gave us help and support. We got direct medical help as well from the HSCP – they gave us NHS nurse practitioners; they were sent into our home. I’m hearing that was pretty unusual but we’re a small locality and we all know each other by name so they all helped. So, the people who died didn’t die in pain or distress or discomfort. And 15 residents recovered.

Key messages
Care workers feel most appreciated by the people they care for and by their families – and this is most important for them. However, a key message is that they feel that the importance of their work is in stark mismatch with how they are seen more widely. Many feel forgotten and think that they are seen, by public and politicians, as a ‘poor relation’ and an ‘afterthought’ to the NHS. Many felt that this is rooted in attitudes towards older people and that valuing older people more would lead to valuing those who provide care for them more. This leads to a further message related to resourcing – it must be accepted that good care comes at a cost regarding infrastructure and the people who provide the care.
Decent work factor ‘job security’

Voices from the front line

Job security is good in the care sector if you have a proper contract.

There will always be a need for care work, and right now they need us more than ever. Normally we have a new staff intake every three months, but the last two haven’t happened.

We operate with minimum requirements staff-wise, so my job is safe as they’d struggle with any less.

It’s quite secure, relatively safe, because no-one wants to do it. There are thousands of vacancies and loads of people start and leave very quickly after. These are not good reasons for job security.

Some people who didn’t turn up for work lost their jobs. Staff were sacked because they were too scared to come in during the pandemic. They are still desperate for staff now that the first wave is over.

We were worried about losing our residents to Covid and then we wouldn’t be needed. New people won’t want to come to our home and we would lose our jobs.

I am on a zero hours contract despite all this. I feel strongly there will always be a need for this work and yet as a relief worker my hours are back to fluctuating like mad. Now I’m making way for all the contracted people who stayed off throughout the pandemic to come back. My hours dropped back to zero in July. I have no income.

There is no job security in this care home and a terrible shift pattern.

In the private care home, where I used to work, very few carers were on permanent contracts and when the care home closed the management had very little interest in what would happen to us.

As a bank worker, I get enough hours. But I think if I didn’t pick up the shifts that they want me to do, I would no longer be asked and be off their list. When I was shielding, because of my husband, there was no problem though.

Key messages

Many of our interviewees told us that they saw no reason to worry about losing their job. There were different reasons for thinking this – they could be referred to as ‘positive’ and ‘negative’ job security. For example, some interviewees said that they felt their job was secure because of the pandemic as colleagues had quit the sector for good, describing the pandemic and how it affected care homes as ‘the last straw’. Also, interviewees said that they expected that many people would no longer consider working in care because of the pandemic. Finally, we were told that care homes often operate with the minimum number of staff and have always found it hard to recruit so that they are unlikely to make care workers redundant.

The key message regarding job security was that the care sector should offer more ‘positive’ job security. This would mean permanent contracts being the rule and a reduction of zero-hour contracts and of the number of bank and agency staff. Also, where bank workers are used there should be no implicit or explicit pressure on them to accept all offered hours and to work regular shift patterns as if they were permanent staff. Lastly, bank staff should not be used, during a crisis such as Covid-19, to simply ‘fill in’ for regular staff and then receive few or no hours once permanent staff return after the crisis. This exposed bank staff to disproportionate health risks while leaving them without any of the benefits which permanent staff are entitled to.
Decent work factor ‘terms and conditions’

Voices from the front line

We’ve had problems with paid holidays in the past – where the employers tried to get away with the minimum, and not take account of our regular earnings when calculating it. When we’re sick after a few days we get a months’ full pay then a months’ half pay, then SSP. Nothing was said about the Covid fund. Staff took annual leave to self-isolate for fear of not being paid.

Relief workers don’t get any sick pay.

I’m on zero hours – I’m not entitled to sick pay or leave. I don’t blame properly contracted staff for staying off – they were shielding, or keeping their families safe, or isolating or sick. But us on zero hours contracts – if we didn’t work, we got nothing. We risked our lives for everyone, put ourselves in danger while everyone was at home. Otherwise we’d have got no wages, never mind leave or sick pay.

No annual leave was allowed during the pandemic. Bank staff don’t get paid sick leave – even during Covid-19 and even if we were off sick, we would have nothing and we get no help. I would’ve got nothing – not even Statutory Sick Pay; no pay at all. There was only Statutory Sick Pay for the ones who had a contract. Thankfully I didn’t get ill so was able to do 13 hour shifts every day without a break to cover the massive absences.

Until recently the home was asking carers to work late to early shift, until that was found to be illegal.

Sick pay was improved for some but not all. Off with Covid: full pay. Anything else: SSP. Anyone with a positive diagnosis: off sick and full pay. Everyone else who was off to self-isolate or due to Covid got SSP from Day 1 instead of Day 3.

The management didn’t know about the Social Care Fund. I had to tell them about it. But that’s a temporary improvement and only for corona. For anything else, we still don’t get paid for the first week off sick. When I had to self-isolate, they tried to make me take it as annual leave.

We get ill a lot, despite all we do for infection control, even in normal times. But for me, it’s only SSP.

I worked far longer hours and got less hourly pay when I worked in a private care home. No one in their right mind wants to work in private sector care homes.

Key messages

Care workers’ terms and conditions show much variation; and we heard in the interviews that for care workers in the private sector these can be inferior to those in the public and third sectors. Our interviewees often connected the absence of sick pay beyond the statutory minimum with the low recognition of their work and understand it to suggest that ‘anybody can do care work’.

One key message is that bank workers need a more equal standing with their colleagues on permanent contracts. This includes sick pay – and a beginning was made with the Social Care Fund, available only in relation to Covid-19 and not any other illness. A further key message was that sole reliance on Statutory Sick Pay is inappropriate for workers who are, by the nature of their work, exposed to elevated physical and mental health risks even in ‘normal times’. Another message is that managers should be better informed about care staff’s legal entitlements and be more proactive in helping them towards these.
4. Stakeholder views

While this project has at its heart care workers’ voices, what the other stakeholder interviewees told us was also important to inform our analysis and the implications we draw. These ten interviewees included individuals from local government, regulators, trade unions, Health and Social Care Partnerships, and industry umbrella organisations. In the interviews, we presented stakeholders with findings from the care worker interviews and asked them to comment. Then, in asking about the extent to which their organisations were involved in assuring decent work for care workers, we sought their views on where more should be done and by whom, and what the main obstacles to improvements were. Three themes emerged from these interviews – ‘responsibilities, resources and remits’, ‘social care and the NHS’ and ‘trust’. They are discussed in turn.

**Theme 1: Responsibilities, resources and remits**

Many of the interviews suggested that the core responsibility for assuring decent work for the social care workforce was ‘in someone else’s court’. Most interviewees referred to ‘the Government’ as holding the key levers for decent work change in their hand, rather than employers or their umbrella organisations, local authorities or Health and Social Care Partnerships, or trade unions. At the same time, many described the Scottish Government as struggling to understand social care, while some interviewees said that to them the Scottish Government seemed less than keen on assuming responsibility for change in the social care sector because solutions to decent work and other problems are costly and complicated. In that sense, the September 2020 announcement of the Scottish Government’s ‘Feeley Review’ on the question of whether a ‘national care service’ should be introduced was met with scepticism by some stakeholders who saw the review as a government attempt of ‘stakeholder management’. Others were more positive and hoped for a breakthrough from it. Some provider representatives felt that the criticism directed at them by trade unions was misdirected and that the Scottish Government should be in the ‘crosshairs’ instead, given that it makes the decisions over funding and policy. Provider representatives welcomed moves towards sectoral bargaining – but suggested that unless the Scottish Government increased its funding for the whole social care sector most providers would be unlikely to join collective bargaining agreements due to worries over financing pay rises.

For some interviewees, many problems around job quality stem from care home managers who are not sufficiently skilled or overworked, possibly both. For example, interviewees said that there is too little time available to dedicate to annual personal reviews with staff or to hold meetings where staff voice can be integrated into care provision itself and also inform a better work environment. Moreover, care home managers were considered to be not well paid in comparison to similar roles in the NHS and with respect to their responsibilities, whilst their jobs were carrying a societal stigma. Again, the ball was seen in the Government’s court as it could introduce, analogous to the Safer Staffing Act (Scottish Government 2019b), a ‘Safer Supervision Act’ that recognises the importance of staff supervision and the duties of home managers to their staff, plus the resources needed to ‘get it right’.

Concerning Care Inspectorate and Scottish Social Services Council, it seems that each is regarded, by stakeholders, as a central actor in the provision of decent work; a role, it appears, that neither of them has a key focus on as per their official remits. Furthermore, the resourcing of these bodies was seen as insufficient even to address their existing, and in some interviewees’ views, too limited remits. However, for many stakeholder interviewees it is really these two organisations’ remits that need to be more focused on job quality if the existing regulatory regime is to be used for job quality improvements. Given that interviewees were all of the view that improvements of the quality of care are inextricably linked to job quality, the expansion of the regulators’ remits was deemed as one approach to dealing with job quality issues. The same might be true for HCPSs – they do not, generally speaking, have systems in place to continuously scrutinise job quality at individual care homes. While regular meetings between HSCPs and care home managers are focussed on care quality, during the Covid-19 crisis the focus on PPE provision also contributed to the health and safety of the care workforce. It seems that HSCPs have a
significant degree of discretion in how far they want to get involved in the process of job quality improvement – some use this discretion, some do not.

Another element of the theme of ‘resources’ pertains to the commissioning system and how social care is funded in Scotland. All interviewees agreed that the resourcing of the social care sector is at the heart of the problem. This includes how the commissioning system works as it results in local authorities ‘squeezing’ third and private sector providers to deliver too much, and a consequence of this is that providers reduce pay and other terms and conditions. While in particular local authority interviewees were of the view that they afforded ‘decent work’ to their social care workers and were ‘leaders of the whole system’, they were aware of the ‘uncomfortable truth’ of how commissioning creates a two-tier workforce of people doing the same work, but in different and often worse conditions.

Theme 2: Social care and the NHS
Interviewees agreed that the relationship between health care and social care is problematic and needs addressing. For many, social care had been an afterthought for too long in funding decisions with regards to the NHS – this relates, in particular, to differences in pay for care staff but also for managers. Even in the current reform debate, some interviewees said, too much emphasis was still on health care. Furthermore, some stakeholder interviewees said that the limited understanding of the social care sector on the side of NHS and the Scottish Government was contributing to the government being reluctant to take on a large reform push in social care.

Professionalisation of social care was mentioned by some interviewees, but others said that social care was so much more about ‘caring’ than health care professions that an academisation of social care along the lines of, for example, the nursing profession would not be desirable. Many interviewees said that the integration of health and social care has worked mainly to the benefit of the NHS. In the concrete context of Covid–19, some said that it allowed hospitals to more quickly ‘empty beds’ into the social care sector and that, as consequence, care homes were more exposed to the risk of Covid–19 whilst having fewer resources to deal with it. The high number of deaths related to Covid–19 in care homes, in turn, made it easy to apportion ‘blame’ to these care homes and further contributed to the negative image of social care so that retention and recruitment continue to be challenging.

Some interviewees said that the integration of health and social care has not led to an approach to workforce planning in the social care sector which compares well with that used in the NHS. The consequence is understaffing. These problems were attributed, by some interviewees, to a misunderstanding of social care as only an ‘add-on to health care’. This misunderstanding continues amongst government officials, but also within the NHS itself and is reflected in what one stakeholder described as a ‘divided language’.

Theme 3: Trust
Trust between organisations from the three different sectors – private, third, and public – and from different levels – local and national – was deemed by all interviewees to be an important ingredient for running a social care system which offers high quality care to its users and a ‘decent work environment’ to its workforce. However, it seems this trust is not always as strong as it might need to be. Covid–19 may have had an impact on trust in positive ways. For example, some interviewees said that some private and third sector care home providers, in particular smaller ones, worked more closely with their relevant HSCP to make sure that all care homes had enough PPE. Before the crisis the impression was that smaller private care homes were worried about opening up to their HSCP about any potential problems. The hope is that this trust remains a resource for the future so that more cooperation when it comes to training of staff but also, maybe, for staff services can be brought about. This would be, as stakeholders said, specifically important for mental health support which smaller care providers are less likely to offer ‘in–house’ than local authorities or large providers from the private and third sectors.

Interviewees from HSCPs and providers spoke positively about trust between them and the trade unions – for example, where trade unions successfully put pressure on, and worked with, HSCPs
to provide care homes with sufficient PPE and to put further health and safety measures in place, care providers and HSCPs were able to rely on a workforce that felt assured that their workplaces were as safe as possible.

Among the three trade unions which represent social care workers – GMB, Unite and Unison – seem to exist differences with regards to strategies for job quality improvement and in the social care sector overall. Unions representing mostly public sector workers were perceived, by some interviewees, as less confrontational and keener on a ‘social partnership’ approach than those representing third and private sector care workers. That could suggest that there is not sufficient cooperation and possibly even insufficient trust between the unions. Interviewees also said that the sectoral split means that trade unions mainly representing public sector workers have relatively little interest in job quality improvements reaching the private and third sectors where fewer workers are organised in trade unions.

With trade unions, local authorities, private and third sector employers or their umbrella organisations not being part of the Feeley Review’s ‘panel of experts’, some stakeholder interviewees worry that the Scottish Government will not be able to adequately address the wider social care crisis nor the job quality issue. Also, the worry is that the review will mark the start of a top-down approach to social care reform and one in which crucial stakeholders are ignored or overlooked. Lastly, there is a worry that the true purpose of the review is to manage the public debate rather than the issues facing the social care sector.
5. Analysis and implications

From the interviews with care workers we have learnt about the urgency of change. It certainly seems as if decent work is in short supply in Scotland’s care home sector, and that decent work matters not only for those working in care homes, but also for those receiving care. The interviews also allowed us to take away a number of clear key messages to those in positions of power to make the overdue changes. These messages are in Section 3, the core part of this report, to read and act upon. In the stakeholder interviews, we heard that ‘decent work’ is an objective that is shared by all, in principle, and that there ought to be common ground for working together towards it. But we also understood that in order for the professed shared interest in seeing decent work become a reality for care workers, leadership and a willingness to take responsibility for the situation as it is and for driving change are required. Also, significant additional resources will be needed. Given that despite the shared interest to improve job quality the qualitative shift towards ‘more decent work’ for care workers has not occurred – Covid-19 served to highlighted this – the only diagnosis is that there must be a collective failure to act upon on what has been long known about the social care crisis in Scotland.

Perhaps things will be different with the current reviews and debates, pushed by the terrible consequences of Covid-19 on care home residents and staff. We have put together our ‘implications for change’, in this chapter, in the hope that this will be the case. We do not present quick fix ‘solutions’ or ready-to-implement policy ideas in this section. Rather we aim to demonstrate how all decent work factors are interconnected and inter-dependent and to encourage all stakeholders to embrace the concept of culture change, and foster a ‘culture of care.’

### Addressing the ‘decent work’ factors

Regarding **decent pay**, a full review of roles and a pay structure which reflects skills and training is important for improvements in pay and should also serve as a basis for the public recognition of care as a valued career, a vocation, and a skilled profession.

Pay and pay structures cannot be decoupled from how services are commissioned. The cost reduction incentive for local authorities to use private and third sector providers through commissioning is obvious. However, it seems as if the national pricing framework, and its role in commissioning processes, is out of step with real costs of delivery, making it difficult to operate a ‘decent work environment’. In the absence of sectoral wage bargaining, the hard bargains between local authorities and private and third sector providers appear to squeeze job quality of front line employees. As care workers in private and third sectors have little voice through, for example, trade unions and therefore do not benefit from the strength of a collective bargaining voice as do public sector employees.

While Scotland is comparatively progressive in providing the Real Living Wage for its social care workforce – £9.30 per hour in Oct 2020 (rising to £9.50 in November 2020) – this still does not meet the need and demand for fair and decent pay in the social care sector as it does not follow from any job evaluation process, but instead is a worthy attempt to reduce in-work poverty. Thus, a systematic review of roles and a pay structure is required.

Given that the pandemic has afforded society the opportunity to consider which work is really valuable in times of crisis, a new pay system could also include the concept of a ‘social value premium’. The idea of ‘social value’ refers to how, for example, highly paid jobs do not necessarily create social value but may, in fact, destroy more than they create. In other words, ‘pay’ and ‘value’ are not the same (e.g. Lawlor et al. 2019). An implication of this realisation could result in the calculation that decent pay for care workers should equal a wage which is commensurate with skills, responsibilities, tasks and competencies, plus a social value premium that accounts for the social value of the work care workers do. No doubt, this will have significant implications for the

---

**Decent pay for care workers should equal a wage which is commensurate with skills, responsibilities, tasks and competencies, plus a social value premium**
cost of social care and will necessarily have not only government and other stakeholders face the ‘test’ whether their rhetoric matches their willingness to act, but also society more generally. After all, additional taxation, maybe in the form of a ‘social care tax’, or shifting spending from elsewhere towards social care would be a necessary (but not sufficient) foundation for a ‘culture of care’ in Scotland.

To us it seems that the inconsistency of the quality of managerial support for care staff could be addressed by a stronger public recognition of excellent practices and making ‘care home management’ into something akin to a profession itself. Existing systems to develop and support care home managers need to be reviewed and improved. This must involve employers and their representative bodies and other top-level stakeholders. In a fragmented sector such as the social care sector, cooperation between private, third sector and public providers seems crucial with regards to assuring capable management and its ability to actively work towards decent work. In particular small care providers could benefit from systematic inclusion in CPD programmes for managers currently open to employees in the public sector. Such cooperation will require trust between the sectors. These changes are necessary, as to us it seems that supportive and supported managers are crucial for decent work.

**A safe work environment** appears closely intertwined with the quality of managerial support. Managers need to be enabled to provide support, but it seems that problems in this area are linked to the undervaluation of what it means to be a carer and to the lack of support for managers. Issues raised by interviewees demonstrate in what ways inconsistent managerial quality impacts job quality and care quality. For example, during the Covid-19 crisis, the many ever-changing and inconsistent guidelines on safety, infection control and PPE use provided to care homes by the Scottish Government, HSCPs, SSSC, and their own employers left care home managers struggling to make sense of it all, did not help managers or staff to feel safe, and suggest a lack of clarity around leadership, roles and responsibilities in the social care infrastructure.

Just like the conflicting guidelines, the glaring health and safety failures described by care workers during the first wave of Covid-19 may also have many parents: chronic under-resourcing, a dysfunctional commissioning system which reduces costs by squeezing providers, and low investment in people may be some of them.

To address reported risks of deteriorating mental health among care home staff, a concerted effort is needed to ensure that there is sufficient employee assistance for staff to access aftercare and treatment for trauma – and this needs to happen now. For this aspect alone, a safe work environment is the most immediate and pressing challenge.

**Job security** is currently not sufficient to make the care sector an attractive one to join, if the nature of some work contracts combines with low pay and the absence of sick pay beyond the statutory requirements. An improvement of the terms and conditions needs to include those of bank staff – as the Covid-19 crisis has demonstrated, they are an important reserve but need to be given higher guarantees regarding their income and their employment protection. There seems to be a paradox at work in the care sector – job security has become higher thanks to Covid-19 as, while care workers may have gained some public appreciation, the sector itself has become more unattractive for new recruits and to those already in it due to care home deaths and the higher mortality rate amongst care workers. Because of this we make a distinction between ‘negative’ and ‘positive’ job security. Negative job security is based on the care sector being unattractive to join so that care workers even on comparatively precarious contracts feel they have job security. Positive job security is about secure employment contracts and about terms and conditions that make care work an attractive option.
Feeling socially valued is important to care workers – even though many have stated that it is more important for them to be appreciated by care service users rather than by ‘the public’. Feeling socially valued and seeing meaning and purpose in one’s work appear to be two sides of the same coin in many ways. We saw that there is immense commitment, personal pride and engagement in care from a great majority of the workforce. This was especially clear during the pandemic despite care home workers feeling under-resourced, under-paid and under-valued. Care workers have a strong sense of meaning and purpose and remain in their work often despite other decent work factors being woefully underdeveloped. However, those needing care and those employing care workers cannot endlessly depend on this as a resource to keep the sector afloat. Public recognition, decent pay, job security, supportive and capable managers, and acceptable terms and conditions are needed, too.

There is an opportunity at this point – while there is some public appreciation for care home workers and also the sense of ‘vocation’ growing among many front line workers – of reorienting care work as a profession and rewarding career choice that enjoys an esteem similar to that of nursing and has comparable opportunities for training, development, and progression alongside comparable pay structures based on a thorough analysis of skills, competencies, and responsibilities. This would help overcome the existing negative reputation of care workers and the social care sector, described earlier through the voices of care workers themselves.

Working towards a ‘culture change’ for decent work

The implications we draw regarding the seven decent work factors, stemming from interviews with care workers and stakeholders, are not clear-cut policy prescriptions. However, we think that they could be starting points for discussing new or different ways of doing things. These could be costed to show what a society that cares needs to be willing to pay to live up to its professed desire to afford high job quality to care workers and high-quality care to those who need it. We have not done so in this report, also in order not to risk that discussions about change are too much dominated by cost aspects. Rather, we want to emphasise that putting these changes into place would also require a much-needed culture change. In the following, we propose to think about this change in terms of a new ‘culture of care’ for Scotland and to look at this change through the lens of operational, institutional and national ‘domains’. These are briefly discussed in turn.

In the operational domain, there appears to be little in the way of motivation to effect job quality improvements or develop a coherent cross-sectoral approach. Delivery standards are driven by a national framework which is unconnected to cost and resourcing, where competition determines quality of care, where doing more for less is the norm – and job quality is one of the casualties. Staff on the front line describe this as a ‘race to the bottom’, where despite a strong cross-sectoral sense of meaning and purpose, a lack of recognition, fairness and ‘care for care workers’ is leading to disillusionment.

At the time of writing this report, operational change is being discussed through the lens of a ‘national care service’ – the Scottish Government set up the Feeley Review in September 2020 to develop ideas on what form such a national care service could take (Scottish Government 2020b). While the different potential forms of such a service are not yet clear, we are not convinced that this is the answer to the job quality question. If a national care service were to extend health and social care integration to the health and social care workforce then it might contribute to a solution.

In the institutional domain, the range and number of stakeholders driving policy and standards, including the Scottish Government, NHS, local authorities, HSCPs, Care Inspectorate and the SSSC contribute to a specific institutional-level culture. In this domain, it seems as if variable standards in job quality have become accepted between the private, public and third sectors. Moreover, it has become a domain in which present levels of resourcing and the structure of commissioning do not enable the quality of care which public and policy makers profess they wish to see. The institutional domain with regard to care homes is further characterised by a highly detrimental culture
of ‘referring on’ the responsibility for progressing job quality among stakeholders. There is no combined leadership for a decent work agenda, and there is no single stakeholder willing to take leadership and responsibility so that, ultimately, no-one ‘owns’ the agenda of job quality improvement. The integration of health and social care as a Scottish Government strategy has not been helped by this prevailing culture of deflection of responsibility and has done little to overcome it.

Regarding change in this domain, the ‘poor relation’ status of social care, in particular that of care homes, needs undoing. The relationship between NHS and social care needs to be revisited. Also, decent work improvements for the care sector require a dedicated and specified ‘regime’ for job quality improvement which is embedded in all institutions. We think that each different part of the social care sector requires such a dedicated regime as each appears to be too complex to allow a ‘one solution fits all’ approach.

As we see it, culture change in the national domain is missing from the debate. It could be a critical aspect of any attempt to progress job quality. Currently, this domain is characterised by the relatively low status of social care work. The reputation and experience of job quality in the sector and its appeal to potential employees has been a concern and subject of attention for some time (Simmons & Macer 2019). Reports from various perspectives agree on similar and familiar job quality concerns (PCW 2018; Eksogen 2019; CCPS 2019) around pay, recruiting and retaining, job quality, manager quality, and wellbeing. Linked to this is, we propose, the fact that the national domain is also characterised by not valuing those needing care as they are seen as ‘unproductive’ and as a ‘burden’. Certainly, the care workers we interviewed felt that the people they support, just like themselves, had been forgotten – by public and policy-makers – before the Covid-19 crisis and were only an afterthought during the crisis. They also felt that younger generations are pitted against older generations in competition over scarce resources. These impressions are supported by evidence. Explorations of attitudes on older people in the UK demonstrate widespread ageist views which see older people being widely mocked, patronised and demonised by the rest of society and seen as a burden (e.g. Centre for Aging Better 2020; Swift et al 2016). The first consequence of such attitudes is minimal resourcing in terms of quality of care and job quality. A second consequence is higher resourcing for health care services, predominantly those aspects geared towards ‘productive’ generations (Taylor 2011; RSPH 2018). A third consequence is a general worsening of health outcomes for older people (Chang 2020). In a way, therefore, the undervaluing of care workers and of those needing care, in particular older people, are two sides of the same coin. A culture change requires challenging such attitudes towards older people as they hinder the development of a better social care system and progress towards decent work.

One way of approaching this challenge is, we propose, to address first the undervaluing of care work. The recognition of care work through the various mechanisms outlined earlier might help leave behind a culture of not valuing those cared for, and to end the anomaly that care work is, simultaneously, low-paid and publicly undervalued while performed by a workforce with high levels of dedication to the job. To do so, introducing the concept of ‘social value’ into pay structures could be a significant step to a redesign of the social care sector into one offering respected employment.
Conclusion

As reviews into social care, high level strategic ones and local operational ones in individual care homes, are conducted, it is right to hope that real change towards ‘more decent work’ stemming from the Covid-19 crisis will come. Given the importance of care work in an ageing society, there needs to be more care for care workers. To drive change, the lack of job quality in a sector employing a substantial workforce delivering socially immensely valuable services, while suffering from a lack of resourcing and a huge cultural deficit in terms of its societal status, reputation and recognition must be acknowledged.

A ‘whole sector approach’ to culture change, and embedding a culture of care through addressing challenges within national, institutional and operational domains, may be effective. Understanding these challenges will help inform action to change, but all discussions about change and all decisions to proceed with it need to include the care workers’ voice. This report has certainly tried to amplify this voice and used it to present some ideas for debate.

The following issues might be relevant for future research, conducted with the objective of creating a culture of care in Scotland:

• Generate a thorough understanding of the origins of our present (lack of a) culture of care and an exploration of required (policy) shifts and desirable core values;
• Identify and cost the benefits of a culture of care and engage citizens and stakeholders in this discussion;
• Discuss the shape, use and acceptability of a social care tax for Scotland if coupled to the proposition of a culture of care;
• Develop an approach of how social value can be incorporated into job evaluation as one determinant of pay in social care;
• Analyse and learn from the successes and failures of health and social care integration with respect to job quality in social care;
• Analyse and tackle the challenges of workforce planning and of attracting people into care work;
• Outline the values, competencies, and training needs for ‘decent work’ care home management.
References


