Centre for Care

Policy tensions and synergies on the long-term care workforce: The case of the United Kingdom

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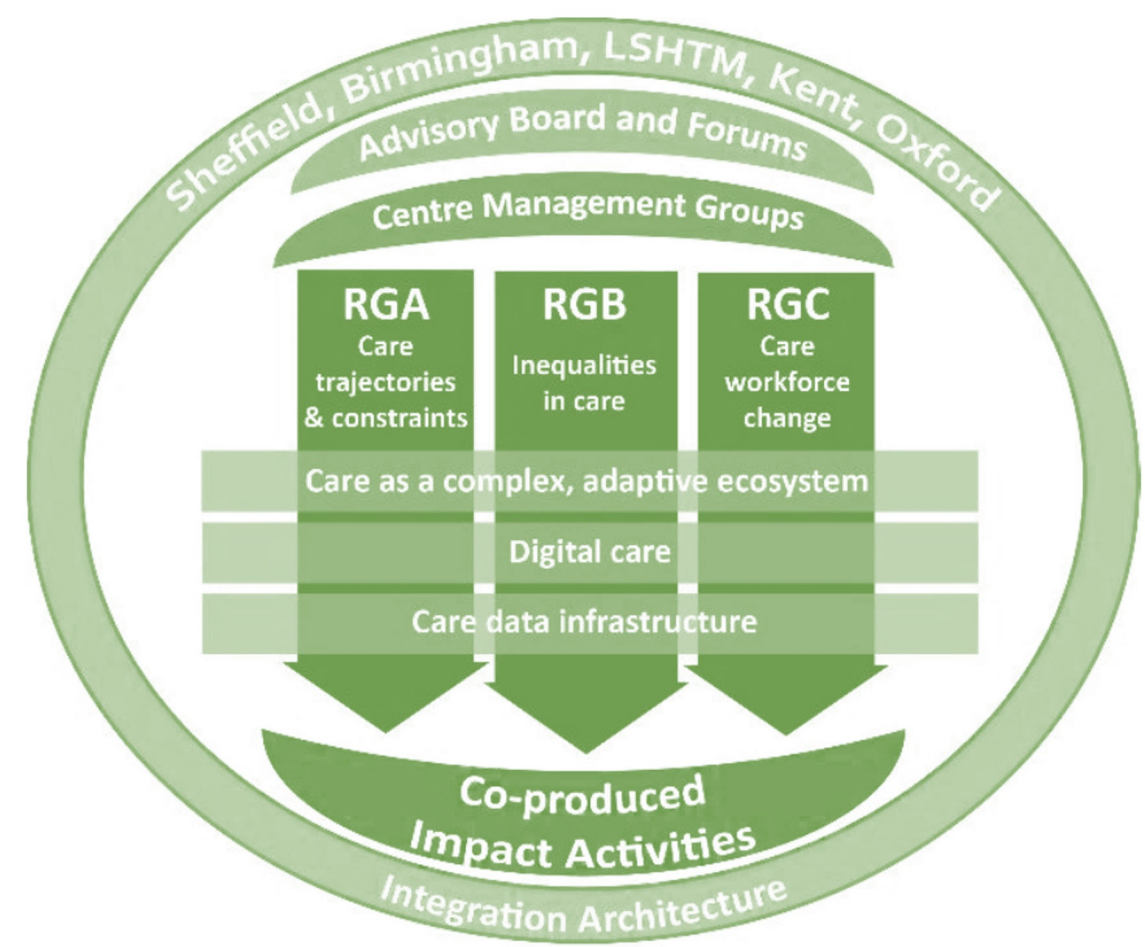
Centre for Care – Research Group on Care Workforce Change



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RG on Care Workforce Change:

- LSHTM (lead)
- University of Kent
- University of Sheffield

Care Workforce Change Team

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The long-term care workforce

- Large, majority female, older workforce,
- Diverse occupations from regulated professions to direct care roles.

Direct roles:

- Poor terms and conditions: zero-hours contracts, only statutory leaves, benefits and pensions
- Poverty (Allen et al 2022),
- Recruitment and retention challenges, high level of turnover (Skills for Care 2023),
- Migrant workers seen as the solution to challenges until recently.

Dean Mitchell, Getty Images via BBC news

Research Group on Care Workforce Change

Overarching aim:

To understand care workforce change occurring at all levels of the care ecosystem.

Research focus:

Policy and system change (macro level)

The impact on the organisation, regulation & delivery of care work

Work practices (meso level)

Continuity and change in workforce innovation

Care workers (micro level)

Care workers' responses to change

Inquiry 1: The drivers and implications of care workforce change

Aim

To understand the policy drivers of social care workforce change and some of their implications for the workforce in the UK.

Research questions:

1. What key policy reforms have been driving workforce change in the UK's four home nations?
2. What intended and unintended consequences have these policy reforms had for the social care workforce?
3. What are the synergies and tensions between the workforce effects of different policy reforms?
4. How can policy reforms interact with other macro level drivers and shape workforce change in the long-term future?

Research methods

- Literature review
- Stakeholder consultation: interviews, roundtable discussions, prioritisation workshop (e.g., Cowan et al., 2021) and foresight exercise (e.g., West Midlands ADASS, 2023).
- The same group of 28 stakeholders at all stages.
- Stakeholders from a wide range of organisations: trade unions, older people's charities, commissioners, sector organisations (SCIE, Skills for Care, Scottish Care, Health Education Scotland) and researchers from Universities and think tanks in the UK's four nations. Informed consent was secured. Emerging findings from the literature review were discussed with the Centre for Care's Voice Forum.
- All stages of consultation were recorded and transcribed. Comments from online whiteboards and chat were gathered and analysed along with the transcripts. Transcripts were analysed along the research questions.

Research methods

Identifying key policy reforms (RQ1)

The policy context

- Long-term care (LTC) is referred to as social care
- Long-term care, vocational education and health are devolved policy areas - different approaches and divergent reforms in the four nations: England, Wales, Scotland and Northern Ireland
- Regulation and enforcement by public bodies at national level
- Decentralised system: funding through local authorities
- Mixed economy of LTC: local authorities commission but do not typically provide publicly funded services.
- Fees paid to service providers affect the pay of all workers.

Key policy reforms: literature review

Social care policy reforms	Intersecting drivers of change
Personalisation	Social care funding (reforms)
Professionalisation of the workforce	Policies affecting the flows of migrant workers
Integration of social care with health	Digitalisation

Stakeholders' comments on policy reforms

- Workforce change is primarily shaped by government underfunding of social care
- Policy reforms are often 'intentions'
- Complexity of adult social care not reflected in policy reforms
- Devolution – different reforms in the UK's four nations
- Disagreements among stakeholders about the future:
  - Professionalisation (registration, training, pay uplift)
  - National Care Service

Drivers of workforce change - after roundtable discussions

Social care policy reforms	Intersecting drivers of change
Personalisation	Social care funding (reforms)
Professionalisation	Policies affecting the flows of migrant workers
Integration with Health	Digitialisation
National Care Service (plan in Scotland and Wales)	Regular uplift of minimum wage
The introduction of real living wage (Wales)	Workforce plans in the NHS
'Ethical commissioning' (Scotland)	Changing trends among informal carers
	Devolution of social care as a policy area
	Fair Work Convention (Scotland)

Workforce effects of key policy reforms (RQ2)

Key policy reforms: personalisation

- A way of thinking about public services and the people who use them, rather than a set of policy prescriptions (Needham, 2011)
- Scotland, Wales and Northern Ireland: self-directed support, to differentiate their approach from what is seen as the more market focused approach in England (Pearson et al., 2018).
- Personalisation is at the centre of The Care Act (2014)
- House of Lords Adult Social Care Committee called for the implementation of personalisation (2022)
- Mechanism: individualised funding, requiring local authorities to give all eligible users a personal budget.
- Direct payment spend as a proportion of total care spend is less than 10 per cent in all of the four nations of the UK (Atkins et al., 2021).
- Personalisation means different things to different groups of people drawing on social care – different expectations towards the workforce

Workforce effects of personalisation

- The language of personalisation has fundamentally changed the narrative about social care, but the impact on the workforce is less clear.
- Difficulties with the implementation of the Care Act (2014) at local authorities: skill mix of staff, high workloads and a lack of staff continuity (Needham et al, 2020).
- *The system does not enable "frontline workers to be personalised in the way they deliver [care and support]. Often, frontline care workers are not listened to." (Roundtable 2)*
- The Personal Assistant workforce emerged as a result of the personalisation agenda. There is a growing body of literature describing that PAs often have the worst pay and employment conditions (e.g., Cominetti, 2023) but they are often more satisfied with their jobs than other direct care workers (Woolham et al., 2019).

Key policy reforms: professionalisation

Scotland, Wales and Northern Ireland:

- A combination of compulsory registration, minimum level of training/certification, national induction framework and continuous development
- Some form of pay uplift

England:

- Care Certificate: 12-week induction training. Not a legal requirement on employers, not a qualification.
- Proposals for career path and skills passport (DHSC, 2023)
- General Election (July 2024) manifesto promise to establish a National Care Service (career path, pay bands, improved terms).
- Previously committed funding for workforce development cut (August 2024)

Caveat: PAs not covered by any of these practices in any of the four nations

Workforce effects of professionalisation

Early days, more data and independent evaluation needed.

Unintended consequences

- Older care workers and those working part-time have left LTC jobs to avoid compulsory training and registration (Scotland and Wales) (stakeholder consultation).
- Training and registration potentially increases existing inequalities among care workers: who has time to train, who can afford to pay for training/miss out on work? (stakeholder consultation)

Key policy reforms: integration with Health

- Integration has been a policy goal for several decades (England). Most recent reform: introduction of Integrated Care Systems (Health and Care Act 2022)
- Different taxonomies of integrated care (Goodwin et al., 2014; Reed et al., 2021), different aims of initiatives in practice (Uribe et al., 2023)
- Policy-makers focus on structural change rather than on culture, norms, systems and processes (Reed et al., 2021: 3)
- Social care perceived as an add-on to health care services - lack of "parity of esteem" between the two systems (Quilter-Pinner and Hochlaf, 2019) and the two workforces (stakeholder consultation).
- Integrated workforce is an aspect of measuring the depth of integration (Wodchis et al., 2020).
- Difficult to share staff across organisations that follow different approaches to pay, holiday and pensions (Reed et al., 2021; stakeholder consultations)
- Lack of resources, infrastructure and staff to meaningfully integrate services (Miller et al., 2020; Reed et al., 2021; stakeholder consultation).

Workforce effects of integration with Health

- Integration is hard to measure and evaluate – we have limited data on its impact. Data from case studies of local integration initiatives with supportive workforce policies (Goodwin et al., 2013; Reed et al., 2021; Uribe et al., 2023; Wodchis et al., 2015)
- New approaches to staffing (Uribe et al., 2023): expanding the roles of providers; adding new roles and finding new ways of working for existing providers.
- Most common new roles: care co-ordinator or case manager, responsible for supporting service users (and informal carers), co-ordinating medical and social care services (Wodchis et al., 2015).
- Health care staff are concerned about role substitution, deprofessionalisation and loss of specialist skills (Tracy et al., 2020)
- Integration could lead to shifting the specialisation and professional identity of staff, functions, cultures and organisations – this may have costs and disadvantages (Reed et al., 2021)

Policy tensions and synergies (RQ3)

Policy synergies: personalisation and professionalisation

The training aspect of professionalisation is relevant here.

There is evidence that training around person-centred care can be really beneficial. (Roundtable 1)

'Person-centred care' is included in the standards of the Care Certificate.

- There is a particularly strong focus on care planning and it is emphasised that a person-centred care plan is a legal document.
- It is the responsibility of the care worker to make every effort to communicate and find out what the person they are supporting wants, rather than making decisions for them.

Policy tensions: Personalisation and professionalisation

- Compulsory registration limits the pool of potential care workers

  On what basis could you say to a working age adult with a disability, 'you can only employ someone from a register?' I mean, how could that ever make any sense? (Interview, pt 16)

- Individuals drawing on care argued to want 'soft skills' rather than technical skills, and they prefer to train their support workers (Farquharson, 2020).

  There's a shift that takes away from the training, from medical skills towards soft skills, what the person wants. (Roundtable 1)

- Different needs and wants of different individuals, e.g., those with complex medical needs v those who do not need specialist support.

Policy synergies: personalisation and integration

We expected synergies, because:

- Personalisation emphasizes the co-ordination of health and social care services – seamless service (Allen et al. 2023; Needham et al., 2023)
- Care Act 2014: personalisation and integration are to be pursued simultaneously
- A fundamental objective of integrated care is to deliver person-centred joined up care (SCIE, 2019)

Policy tensions: personalisation and integration

However, we have found many tensions:

- in England the policy focus is on systems integration rather than on service integration (Allen et al., 2023; stakeholder consultation).
- Allen et al (2023) found barriers despite joint working and co-location: unwillingness to share data and a sense that health tried to dominate joint working.
- Scotland: self-directed support ‘overshadowed‘ by the integration agenda (Pearson et al., 2018)
- Social care has a weaker voice and representation in Integrated Care Systems than the NHS (stakeholder consultation)

Potential synergies

Professionalisation and integration of health and social care
Specialist training for home care workers in nursing skills enables, or would enable them to provide increasingly medical care to individuals in their own homes (stakeholder dialogue, roundtable 1)

Digitalisation and integration of health and social care
ICT has been argued to support the ‘joining up’ of services prone to working in silos (Baines et al., 2014)

Long-term workforce change (RQ4)

Reminder: Foresight methodology

Scenarios:

- Imaginative but realistic descriptions of potential futures and how they are shaped by their contextual dynamics.
- Not predictive – they help explore a range of potential future outcomes.

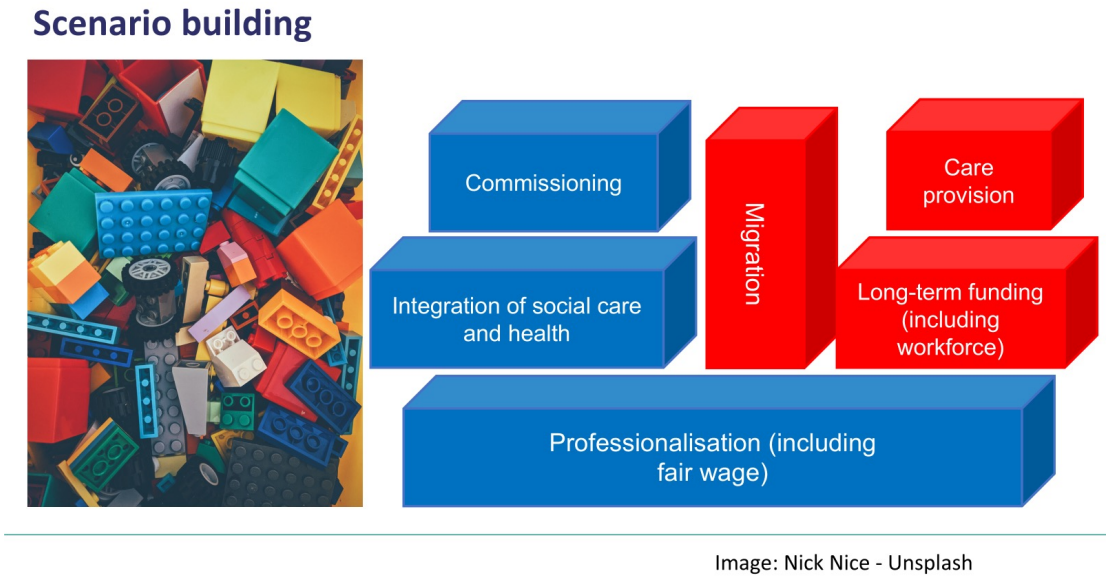

Image: Nick Nice - Unsplash

Developing scenarios

The UK social care workforce in 2035

- Use the **building blocks** to develop your scenario. You don't have to use all the six blocks.
- You can use one **wild card**: an unforeseen or uncertain factor that could potentially disrupt or significantly impact a scenario. It could be a policy, or an emerging macro-level trend or development.
- When developing your scenario, think about
  - the policy aspiration,
  - the contextual environment,
  - impact.

Developing scenarios: fortunately/unfortunately

Fortunately, technology enabled self-care has become affordable to many, and the shortage of care workers became less critical.

Unfortunately, the digital divide meant that many people still couldn't access technology.

Fortunately, …

Unfortunately, …

Scenario 1: System change focused on the workforce

Summary

- Social care is transformed through sufficient and consistent public funding.
- Care workers are highly respected. Their pay is at parity with the NHS and their wellbeing is supported.
- The use of technology, including AI creates new jobs and supports care staff working in people's homes.
- Care jobs are available to asylum seekers waiting for decisions about their claims.
- There is close co-operation but not full integration with the NHS.

Requirements

- Increased public funding
- New public discourse: social care is part of the critical national infrastructure, with funding perceived as social investment.
- Public debate takes place before the system of social care is transformed, e.g. citizens' assemblies.

Scenario 1: Impact

Workforce impact

- Improved job quality for care workers.
- Improved well-being of care workers.
- Recruitment and retention is less challenging.
- The care workforce is more sustainable.

Broader impact

- Improved quality of care.
- As most care workers and informal carers are women, the transformation leads to reduced gender inequality.
- To compensate for the increased demand on public finances, steps taken to increase revenue (taxation or social care insurance payment).

Scenario 2: System change focused on commissioning

Summary

- The system of social care is transformed through fully implementing The Care Act 2014.
- People purchase their own support using personal budgets to achieve the outcomes that are important to them.
- Providers creatively fit personal budgets around people's needs. Care and support are person-centred and 'right sized.'
- Local Authority commissioners and care providers work in partnerships, based on trust.

Requirements

- The Social Care Future vision is adopted.
- The Care Act 2014 is fully implemented (direct payments, personal budgets, information and advice).
- Culture change in commissioning: care providers are viewed as 'extensions' of local authority social services.
- Good quality data on local care needs and the labour market are used to plan how support is delivered.

Scenario 2: Impact

Workforce impact

- Care workers' wellbeing is improved.
- Their pay may be improved, but at a minimum, their travel time is paid and only those work on zero hours contracts who want to do so.
- Migrant home care workers need more advanced level English language skills to negotiate with the people they support.

Broader impact

- The quality of care is improved.
- People with a care need/informal carers put more time and effort into managing their individual budgets and negotiating their support with providers.

Scenario 3: Workforce change and the legalisation of assisted dying

Summary

- Assisted dying is legal and culturally accepted in the UK.
- Care workers who support people at the end of their lives are dealing with ethical challenges and complex expectations as part of their everyday work.
- In preparation for implementing the legislation, high quality training and development around assisted dying have been designed and delivered to care workers.
- There is easily accessible occupational and mental health support (e.g., counselling) for care workers.

Requirements

- Broad cultural acceptance of assisted dying.
- Organisations, including the NHS shape their culture and develop new practices around assisted dying.
- Investment in training and professional support for care workers.

Scenario 3: Impact

Workforce impact

- Major impact on palliative care teams, multidisciplinary teams, hospice staff, and home care workers supporting people at the end of their lives.
- To avoid working in end of life care, some care workers will shift to supporting younger adults living with disabilities, but care workers will not leave the social care sector in large numbers.

Broader impact

- Legalising assisted dying could open up a tiered social care system, where less affluent people would choose assisted dying to avoid care costs.
- Some care providers may want to move towards providing services for younger people living with disabilities, to avoid dealing with the consequences of the new law.

Discussion and conclusions

- Perceptions of different functions of LTC, e.g., health enhancement, safety and comfort for the individual, supporting independence.
- Unintended consequences: implementing professionalization during ‘workforce crisis’
- Networked’ organisations in LTC - focus on workforce development and job quality are steps towards the standard employment relationship (Rubery and Unwin 2011) - compensating for the effects of outsourcing in public services.
- Difficulties in achieving recognition of the long-term care workforce. Can recognition be based on the ethic of care - responsibility for another person’s life?
- What about care workers’ autonomy?
- Policy conflict between professionalisation and personalisation. Trade-offs? Different approaches in for different groups of individuals drawing on care?

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