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Wild, D. & Szczepura, A.

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Reimagining UK care homes: can their experience of COVID-19 act as a catalyst for improved education and status for its workforce?

Deidre Wild (RGN, BA, MSc, PhD)[a], Ala Szczepura (BA, DPhil)[b]

[a] Faculty of Health & Life Sciences, Coventry University, Coventry, CV1 5FB, UK

[b] Centre for Intelligent Healthcare, Faculty of Health & Life Sciences, Coventry University, Coventry, CV1 5FB, UK

Corresponding author

Dr Deidre Wild

School of Health & Life Science,

Coventry University,

Coventry, UK

deidre_wild@btinternet.com

07973 269363

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ABSTRACT

In England there are more than twice as many beds in the independent sector's care homes as in National Health Service hospitals, a fact that was recognised by the Government during the first wave of the COVID-19 pandemic with early discharge of elderly hospital patients to care homes to free up NHS beds. This took place without known COVID-19 testing status, and at the same time, with care homes' staff (nursing homes' nurses and residential homes' social care workers) having neither the specialist educational background nor on-hand medical support available to those in the NHS. Homes also experienced high staff vacancies in both nursing and social care workforces. Nevertheless, discharges went ahead, as did employment of additional freelance (Bank) staff. This influx of 'outsiders' had severe consequences with news of high death rates in care homes highlighting the need for improved education and support for care home staff. This article considers the circumstances that have to date inhibited care home staff's growth of knowledge and care practices, exposed under these unique circumstances. It offers a reasoned case for urgent reform of education and training for all care home staff and a move towards professional status for social care workers in particular, so that they can be better prepared ahead in an uncertain future.

Key Words:

Care homes; older people; COVID-19; workforce; training; professionalisation.

INTRODUCTION

The residential and nursing care home sector in the United Kingdom (UK) is worth £16.5 billion per annum (Laing Buisson, 2019). It has a complex structure with around 5,500 different suppliers in the UK operating 11,300 nursing and residential care homes for around 410,000 older people (Competition & Markets Authority 2017). The sector provides some 458,000 beds, 95% of which are delivered by independent providers (both 'for-profit' and charitable providers), the remainder being Local Authority homes. In England, the adult social care sector employs a total of 1.52 million FTE persons, greater in number than those employed in the National Health Service (NHS). The term 'care homes' encompasses residential homes staffed solely by social care workers (SCWs) and nursing homes where staff must include at least one registered nurse 24/7. Bed capacity represents more than double that available in NHS hospitals (Laing Buisson, 2019). But, 'more capacity' does not necessarily mean 'better than'.

CARE HOMES' CHALLENGES PRIOR TO COVID-19

Over recent decades, studies have identified various potential quality improvement opportunities in care homes related to: palliative care (Reid, Snowden and Kydd, 2012), culture change (Wild and Kydd, 2016a; 2016b), improved ways of working and cost effectiveness (Szczepura, Nelson, Wild, 2008), and the introduction of technology (Szczepura 2011; Szczepura, Nomura, Wild, 2020). In contrast, some other studies report a different reality with research showing care homes to be publicly and politically undervalued (Wild, Szczepura and Nelson, 2010; Robbins et al, 2013). Nelson, Wild and Szczepura (2009) conclude from their observations that, even though there is considerable

potential, UK care homes remain ‘a forgotten sector’: under-developed, under-supported, under-staffed and under-educated in meeting older people's complex needs.

Cooper et al (2017) suggest that nurses in care homes feel professionally isolated from the mainstream of nursing and that nursing degrees do not prepare them sufficiently to meet the health challenges presented by older care home residents with complex needs. Furthermore, staff shortages may be a major obstacle to staff accessing training. Interestingly, the most recent King ’s Fund social care report only mentions training in passing in terms of its link to lower staff performance (Bottery and Babalola, 2020). Stayton et al (2017) have drawn attention to a lack of nursing competencies in nursing care homes and in consultation with the care home registered nurses, established 13 key competencies via a Delphi study but as yet, it is not known how useful or widely used these are.

Unison (2016) states that a lack of funding has reduced opportunities for education and training and created more pressure on workload and a decline in standards of care, as some £1.95.bn. was cut from UK social care budgets between 2005-2015. Several authors have blamed cuts in Government funding to social services (Hayes et al, 2019) for making care homes’ adherence to the important lynchpin Regulation 18: Staffing (Care Quality Commission 2019) impossible to attain:

> *'To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise'*

(Health and Social Care Act 2008 [Regulated Activities] Regulations 2014:

(Regulation18 Care Quality Commission 2019)

Significantly, the Regulation gives no guidance as to how to calculate 'sufficient' or to define 'suitably qualified' and given the reality of present work conditions in care homes, neither calculation is likely to fully meet the complex care needs of residents. Three contributory factors can be identified as having had a detrimental impact upon care. These are SCW staff numbers, nursing staff levels, and SCWs' pay and conditions. Bottery and Babalola, (2020) record care homes' increased difficulty in filling SCWs' posts for residential care in England reporting an estimated 122,000 vacant posts (an increase to 7.8 per cent in 2019/20 from 5.5 per cent in 2012/13), combined with 30.8 per cent annual turnover. Second, in terms of nursing staff availability, Skills for Care Data Analysis Team, (2020) shows that between 2012/13 and 2020, the number of registered nurses in nursing homes has reduced by 5,500 or 30% with a vacancy rate of 12%. Likely reasons for this could include the return home of nurses to Europe post Brexit and to other parts of the globe (Leone, 2020). In the longer term, a projected decrease in the size of the UK working age population available to enter or complete nursing degrees is also likely to have an impact (UK Parliament, 2021). There is also the possibility that some nurses find the pace and conditions of nursing older people unattractive (Kydd and Wild, 2013). Third, in terms of pay and conditions in the residential care sector, the pay for SCW staff is low at just above the minimum wage, with holidays and sick leave often not funded (Hayes et al, 2019). Employing Bank or Agency staff to fill gaps in the care homes' workforce has been a quick fix solution, especially during the pandemic. However, although these workers may have higher rates of pay per hour, they have no tenure of employment if working on zero-hours contracts, i.e. only paid for the hours that

the home requires their services. As their working life can entail working in different care homes, this has implications for cross infection between homes with these free-lance staff identified as potential carriers (ONS 2020a).

Other ongoing issues that have proved difficult to resolve for care homes' staff are the pre-COVID-19 poor relationships and lack of collaboration with NHS health professionals. Care homes staff vary in their tendency towards reactive ways of working and resistance to change. However General Practitioners found that being engaged in a co-ordinated multifaceted approach with relationships focussed upon supporting the care homes was essential to the successful management of their patients and motivating staff (Roche and Wyatt, 2017). Lack of professionalisation and registration opportunities; lack of security concerning income; long shifts; and poor quality and lack of appropriate training have also been identified as issues (Hayes et al, 2019). Because the SCW workforce has a low union membership, the opportunity for collective bargaining to seek resolution for the above issues is inhibited (Unison, 2016, Dromey, 2018). As similar unresolved issues were found in an earlier study by the present authors (Wild, Szczepura, Nelson, 2010), it seems reasonable to assume that over the last decade little has changed except what was of concern then has now become critical. This is reinforced by the most recent King's Fund 'Social care 360' report which concludes that the social care sector has been fragile for several years, and that tackling the underlying problems exposed by front-line participation in the present pandemic will be at least as important a challenge as the COVID-19 pandemic itself (Bottery and Babalola, 2020).

CARE HOMES PARTICIPATION AS CARE FACILITIES FOR COVID-19 PATIENTS

It can be argued that COVID-19 has brought care homes' standards of care to the forefront with a new call for inclusion and change. Initially, care homes appeared to be overlooked by Government in terms of front-line participation against the COVID-19 pandemic. But, as the level of the infection rapidly escalated throughout the land, Government attention turned towards the voluntary and independent sector and its potential to receive early hospital discharges if they had surplus beds. In general, Oliver (2020a) describes care homes' staff, existing residents and their relatives as ill prepared for the high numbers of resident deaths from COVID-19 that quickly began to emerge. He notes that with little time to prepare staff for the use of on-site specialist equipment or the procedural knowledge underpinning it, and with an inadequate stock of personal protective equipment (PPE), care home staff and residents quickly became vulnerable to the infection. Staff sick leave tripled to 8% (Bottery, 2020). No stranger to staff shortages in normal times; care home managers sought to employ more bank staff to increase pairs of hands. ONS (2020a) figures, drew attention to residents being 1.58 times more likely and staff 1.88 times more likely, to be infected in homes that used agency or bank staff most or all days, compared with those who did not use them at all. The emotional distress of losing a high number of residents who staff had known for a number of years and relatives being 'shut out' as their ill residents were 'shut in' had a significant psychological impact (Gordon 2020). Reliable hard data for care homes are thin (Hanratty et al, (2020) and at that time, it was not known if either the older people discharged from hospital to care homes or the bank staff working across multiple sites had been tested for the virus or not before entering the care homes but as the infection is asymptomatic for the first 7-10 days, there was every opportunity for them to spread the

virus unknowingly to the *in situ* care homes' residents and staff. McCullough (2020) has accused the Government of a lack of foresight and falling short in following Covid-19 ethical guidelines for adult social care, published in March 2020 (Department of Health and Social Care, 2020)

Results from the first Vivaldi study, a large scale Office of National Statistics' survey which looked at coronavirus (COVID-19) infections in 9,081 care homes providing care for dementia patients and the elderly in England between May 2020-June 2020 (ONS, 2020a) showed that homes that employed bank staff or had staff that worked across multiple sites had higher levels of COVID-19 infection. Deaths attributed to COVID-19 in care homes' staff was 29.3 of all deaths for care homes staff with men being more likely to die from the virus than women (ONS, 2020b). Despite the hard work of care staff to protect their residents (QNI, 2020), seven local authorities had to adopt emergency powers to backpedal on their legal duty to provide care given the competing factors of high demand and high staff shortages (Kings Fund, 2020).

While acknowledging with hindsight that some mistakes were made concerning care homes, in preparation for a second surge of the virus thought was given to how to do things differently. The Department of Health and Social Care sought to approve 500 "hot home" facilities by December 2020, mostly wings of care homes that use separate staff and separate entrances, to release hospital beds while preventing the virus from spreading. To date, 136 have been recruited, largely because care homes are unable to get liability cover (Booth and Campbell, 2021).

REIMAGINING SOCIAL AND HEALTH CARE: WAYS FORWARD

It seems that it has taken a pandemic to shine a sympathetic spotlight upon the present strengths and limitations of the care home sector. Despite past inertia, there now is Government recognition post the first wave of COVID-19 of the need to recognise the SCWs and safeguard the future workforce:

> '*Improving the level of recognition afforded to social care workers must be a key focus for the Government to safeguard the future of the social care workforce. Not to do so would be to fail the many thousands of care workers who have worked so tirelessly during the coronavirus pandemic….. there are a number of practical changes which the Government must make to improve the level of recognition felt by social care professionals and to support the future sustainability of the workforce*
>
> (Government UK, Parliamentary Business, 2020)

Registration for SCWs could act as the first step towards formal role professionalisation (Hayes et al, 2019). An upgrade in remuneration in line with the recent NHS nursing care assistants' (NCA) pay rise would help the SCWs' role be seen as a more attractive option and lessen the cross sector drain of SCWs into the higher paid NHS NCA posts, although this will require an increase to Adult Social Care budgets. Extending learning of digital skills for all staff enables online more flexible ways learning (Griffiths et al, 2019; Wild and Kydd, 2016a and 2016b). Apprenticeship schemes that facilitate practical learning within the homes could also be promoted for SCWs (Royal College of Nursing, 2019; Health Education England, 2015) as providing career progression up to post-graduate level to place the SCW on a par with the NHS NCA. Encouraging union membership to represent SCWs in their bid for improvement to current conditions (such as no paid leave of absence due to sickness or paid annual leave) could galvanise a sense of professional status. Although it may seem obvious that nothing can change without adequate investment from the public purse, it will be of interest to observe if the projected rise in unemployment due to COVID-19 lockdown

redundancies has a positive impact upon the uptake of employment opportunities in the independent sector by drawing in wider and more varied experience to SCW posts. This could have the potential to bring new skills such as computer literacy to the sector and support future introduction of assistive technologies, telecare and integrated care records.

Society also should take stock of its tendency to seek to apportion blame and create scapegoats when catastrophes arise (Douglas, 2002). Oliver (2020a) recalls, that although initially media attention was seen to take little interest in the participation of care homes' staff and despite them becoming part of the frontline with admissions of potential COVIS-19 hospital discharges. This changed to what Oliver described as an unfair media focus upon the supposed abandoning of care home residents to preventable deaths. He lays emphasis upon the efforts of those working in health and social care long before the pandemic in trying to draw attention to the crisis of underfunding; lack of care home capacity and staff and inconsistent support from local NHS services also overstretched but the media showed little interest. Bowman (2020) in a positive vein, recently suggests the need to convene a Royal Commission to review all resources (public and private) for older people and to consider how these could be sensibly and most effectively utilised. He advocates:

> *'..a resilient national model of provision in which roles and responsibilities are clear. No arms' length quango bodies, but a proper Government care home commission providing the sort of coherent policy, practice and resource support, as well as the governance needed'* (Bowman, 2020)

In March 2020, at the start of the pandemic, the national 'framework for enhanced health in care homes' (NHS England, 2016) was updated to the NHS England and NHS Improvement briefing 'A Framework for Enhanced Care 2020/21, Version 2 (2020). In this new briefing,

the focus has retained local rather than national training schemes for both health and social carers but makes no mention of national standardisation. The emphasis is upon the spread of the Vanguard care model with its community-based integration of NHS with social care and in brief, mentions giving support and training to care homes. It is perhaps worth noting that the present consultation document on how Integrated Care Systems can be embedded in legislation or guidance largely ignores the care home sector and the opportunity for "training and education, together with a nationally agreed set of competencies and standards" (Szczepura, Wild et al, 2021). It may be that questions are being raised over public accountability and short-term investment. Furthermore, it is also possible that some larger private equity-owned care home groups are less interested in collaborating with the NHS than charitable providers in the independent sector. (Centre for Health and the Public Interest 2019).

CONCLUSIONS AND RECOMMENDATIONS

The evidence indicates that care homes were struggling to provide a quality service for some time before the COVID-19 pandemic, so the question is - will the latter prove to be the right stepping-stone to take forwards real reform or just empty rhetoric? Care homes' SCWs and nurses were seen to willingly commit to a partnership that extended the capacity of the NHS during the first wave of the crisis and evoked (with some exceptions), meaningful and supportive relationships between NHS health and care homes' nurses and SWC staff. In this climate of growing mutual respect, certainly the time seem right to totally integrate health and social care into one seamless funded service for older people. This would offer opportunities for economies of scale and a merged extension of digital care into this important sector (Castle-Clarke and Imison, 2016). In doing so, it would give meaning to the

rights of older people in care homes to have full access to all NHS and Social Services expertise from under one funding umbrella

However, in this call for the integration of health and social care we suggest that the SCWs' aspirations of better pay, conditions and professionalisation can no longer can be ignored because without their contribution to the health and wellbeing of a large number of vulnerable older people, the alternative of languishing in expensive hospital beds is neither capacity feasible nor is it desirable for the wellbeing of older people. Nurses working in care homes also should be valued for their contribution to care and encouraged to undertake leadership training to support their development as the future's change agents.

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Dr Deidre Wild and Professor Ala Szczepura contributed equally to the writing of this article.

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