FOR DISSEMINATION – 17th July 2020

Public Output from the First meeting of the Workforce Advisory Group Meeting on the 8th July 2020

The Workforce Advisory Group has been formed to support the Adult Social Care Taskforce. The remit of the advisory group is:-

- Implementation of the Social Care action plan: https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan
- Implementation of the Care Homes Support Package: https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package
- Proposals as part of the overall advice to government on what should be in place in the coming months and in time for Winter

Our approach will be determined by how we define the workforce. Eg. All social care settings, including people's own homes, regardless of employer.

While all social care roles are important, the short duration of this Advisory Group will require us to focus primarily on the front-line (paid) workforce over the next 12 months in response to COIVD-19.

During the 1st Meeting of the Workforce Advisory Group on the 8th July the assembled advisory group discussed how the role of the front line care worker had changed during Covid 19, and what the impact of that change had been on the individual and the understanding of the role. The meeting took detailed feedback from all present, and the list below is indicative of the broad headings.

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

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

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

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

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

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

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

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

What has been the impact on care workers?

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

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

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

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

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

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

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

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

Membership of the Workforce Advisory Group

Health and Safety	Zameer	Bhunnoo	Health and Safety Executive
Homecare	Colin	Angel	UKHCA and co-chair
Homecare	Melanie	Weatherley	Care Associations Alliance
Individual Employer	Miro	Griffiths	National Coproduction Advisory Group
Local government	John	Sutcliffe	Local Government Association
Local government	Delyth	Curtis	Association of Directors of Adult Social Services
Nursing	Hilary	Garratt	Deputy Chief Nursing Officer
Regulation	Rob	Assall-Marsden	Care Quality Commission
Residential care	Ann	MacKay	Care England
Residential care	Vic	Rayner	NCF and co-chair
Shared Lives	Alex	Fox	Shared Lives Plus
Trades unions	Matthew	Egan	Unison
Training & skills	Oonagh	Smyth	Skills for Care
Workforce	Karolina	Gerlich	Careworkers' Charity
Public Health	Sally	Singleton	Public Health England