DEPARTMENT OF SOCIAL POLICY
AND INTERVENTION

BARNETT PAPERS IN SOCIAL RESEARCH

The Job and Work Orientations of Workers in English Care Homes

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WORKING PAPER 23-01

May 2023

This research was funded by the John Fell Fund of the University of Oxford (grant number: 0010496)

The authors acknowledge their huge debt and express their gratitude to the care workers and others who generously gave their time and shared their experiences by taking part in the study.

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Executive Summary

This report presents the results of a study of workers employed in care homes in England. The empirical research, which was carried out between October 2021 and February 2022, focused on the working conditions and job attachments of paid care assistants. Empirically, the project had three components: (1) an online survey (of 86 respondents); (2) interviews with 29 care home workers and: (3) a co-production workshop with key stakeholders. In a context where relatively little is known about these workers – despite some heightened public exposure during COVID-19 – the research had three objectives. The first was to explore the nature of work within the care industry by identifying practices, constraints and norms in how paid care work is carried out in care homes from the perspective of the workers. A second aim was to research the type of attachment and ties the workers have to their work and the residents, and to see how these fit with workers' employment biographies and personal situation and backgrounds. Thirdly, the research sought to explore workers' agency in trying to improve their jobs and to explore – with the workers but also with stakeholders – the priorities for change and the conditions under which improvements could be brought about.

The following is a summary of the main findings.

- The care workers studied carried a very heavy work burden, stemming from both the demanding nature of the work and reported serial understaffing in the care homes they worked in.
- Feelings about and personal investment in work dominated respondents' accounts of their jobs. Prosocial elements emerged strongly in the sense that many workers were motivated to do the work in a general desire to help others. However, workers also derived intrinsic satisfaction from performing the tasks and activities involved and

extrinsic factors also tied them to the job – such as pay, the convenience of the work and the way it fits into their personal situation and future (career and other) plans.

- The findings make clear that the workers created meaning by invoking the relationship between their personal characteristics and the job. There is evidence of both a perceived values match and of care as embedded in people's biographies. For a significant minority of respondents, their initial introduction to care – and encouragement and confidence to enter the sector – came through either family experiences or those of friends and acquaintances. This was another way in which the personal and work worlds intersected.
- The workers perceived the work as complex and even highly-skilled. Against popular depictions of it, they saw it as involving a range of skills, requiring physical strength and expertise, cognitive skills (interpreting people's needs for example) and medical-related competences (such as dispensing medicines and undertaking medical checks).
- The respondents placed high value on the job in the sense of the work involved and were convinced that only certain people could do the work (which also acted to elevate their sense of their own value as workers). Motivation and capacity to care were prominent in their narratives around what makes a good care worker.
- The narratives contained a mix of references to the job, both negative and positive. Among the negative, understaffing and low pay were the most widely reported whereas the residents figured most strongly among the positive factors. This co-existence of strongly positive and negative views leads to considerable ambivalence and mixed feelings.
- While there might be a match between their values and what is involved in the job, some respondents saw a values mismatch between themselves and the employing organisation. Referred frequently as 'they' or 'the higher-ups', the organisation was

often criticised for perceived money-making or money-saving motivations (through savings on the volume or quality of supplies for example or though understaffing or low pay), which were seen to impact the job negatively and affect how the organisation is run and the conditions of care giving and care receiving.

- The workers generally felt misunderstood and un(der)appreciated by the public. The most common complaint was of the public not understanding the full or complete picture of what is involved in the work and the job, of dismissing it as menial and therefore not valuing care work and those who do it. The feeling was that public opinion functions with stereotypes of care as a set of very basic, routine or bodily, distasteful tasks.
- In terms of what actions respondents took to improve their situation, a mixed picture emerged. The workers certainly thought about leaving the job and seemed to engage in frequent (re)assessment to weigh up the pros and cons of leaving or staying. This mindset must be quite destabilising.
- The sense of individual(ised) workers came out strongly from the research; they have to decide for themselves what is acceptable practice and deal with their own ambivalent feelings. The main forms of resistance were quite micro in nature such as not adhering to the rules regarding sparing use of supplies for example. Far more rare were actions such as raising issues that were seen to need addressing in the workplace or even mobilising through trade unions and other collective channels.
- COVID-19 emerges as a hugely significant and mainly negative factor in regard to the experience of care workers in care homes. There was a strong sense of the pandemic as a traumatic experience for the workers, residents and families. Most people viewed staffing constraints as seriously worsening over the last years and attributed this partly

to COVID-19 as well as to more general issues of sectoral under-recruitment and under-funding that predated the pandemic.

- The participants in the stakeholder workshop had a very strong sense of what would help the workers' situation and improve the functioning and quality of care provision in England more broadly. Among the factors highlighted in this regard were: adequate pay and the need for a pay structure and a pay negotiation procedure for the care sector as a whole; the lacking or inadequate career and training structure; ineffective and stereotypical modes of recruitment (emphasising typically female values and orientations); the gender imbalance in the sector; potential exploitation of workers given their typically strong personal investments in the work; the structural and funding crisis in the sector a whole; the growing for profit share of the sector; the lack of regulation; the potential benefits of worker mobilisation on the one hand and a support architecture for paid care workers on the other. There was a strong sense that a lot of the necessary ameliorative measures are already in place but are not being used or promoted.
- These discussions and the many suggestions of workers themselves can be taken forward through necessary reforms and measures that address and improve: recruitment processes; support entry to the job and sector; on-the-job support; pay and financial benefits and recompense; general employment conditions; training, development and progression; the level of public information on care.

Broad thinking is warranted by many of the findings in this report. In effect, the treatment of care home workers reflects the low value English society places on care and those who provide and require it, as well as stemming from a sector of employment and provision that has been allowed to grow and develop without adequate regulation, quality control and funding. Fundamental changes are therefore necessary if the situation is to significantly improve.

Introduction

With funding from the University of Oxford John Fell Fund, the project sought to investigate the job- and work-related behaviour and agency of care home workers. The workers involved are those who provide direct care in care homes, usually called 'care assistants' or 'healthcare assistants'.[1] The over-arching objective of the research was to reveal, analyse and theorise the diverse concerns, priorities and work experiences of care home assistants and to harness this information to both inform policy action and academic scholarship. Methodologically, the project has three components: (1) an online survey; (2) interviews with 29 care home assistants; (3) coproduction of policy-related insights and knowledge transfer through a workshop with a range of experts.

Why study paid care home workers? One reason is because of the particularity of the sector and the kinds of employment-related and socio-political context that prevails regarding the conditions under which a functioning and sustainable care home system can be realised in England. In the UK as a whole, there are some 1.5 million paid care workers compared, for example, to fewer than half a million nurses and some 700,000 workers specifically in care homes.[2] The field is dominated by a conception of long-term care as problematic; the societal narrative sees it as being deficient and unreliable and a dominant political current of thought views the sector as unreformable, hence 'frozen' in the existing mould despite the fact that current arrangements are unable to meet demand and are arguably unsustainable even in the short term. The sector seems to be in permanent crisis. The policy response has been two-fold:

[1] Note that the literature makes a distinction between those who provide direct – that is, hands-on – care and those who provide care indirectly. The latter includes a much larger section of the working population than the former, including those involved in service occupations such as social workers, teachers, clergy and a whole range of medical and dental jobs (Duffy, et al 2013; Lightman and Kevins 2019).

[2] https://www.carehome.co.uk/advice/care-home-stats-number-of-settings-population-workforce#:~:text=The%20UK%20care%20home%20workforce%20totals%20nearly%20700%2C000%20people

a greater reliance on informal care in people's homes and in the community and, when this is no longer feasible, reliance on costly, primarily market-based care in home or institutional settings.

Care home provision in England is almost entirely for-profit and the thrust of policy is to support this form of 'privatisation' (voluntary and public provision make up at most 15% of the care home sector). Care is, in effect, a business; the expansion of private provision has been much more radical in the care sector than in the health sector. This contributes to complexity and high fragmentation - the English care home sector comprises approximately 25,000 registered providers in over 50,000 locations (Hayes et al 2019: 5). The increasing reliance on market provision has been driven substantially by the transformation of the role of the local authorities from providers of care to commissioners of care from third parties. A further sector particularity is weak regulation. Although recently extended, the Care Quality Commission's remit extends mainly to assessing generic quality and standards of care provided for residents[3] with care home providers as the main focus of responsibility and regulatory attention. This leaves working conditions to all intents and purposes under- if not un-regulated. Moreover, the workers have no professional identity - there is no requirement on them to be registered as workers with any regulatory body (unlike the other three jurisdictions in the UK), no minimum training threshold or entry point exists, and there is little organisation through professional associations and very low levels of trade union membership. A further aspect of the study's context is of a decade of austerity which is known to have impacted the sector and the workers profoundly (Burns et al 2016; Hayes et al 2019). The fact that some providers continue to make profit as the public funding for the sector overall is either kept static or decreased underlines the pressures to find cost-cutting measures regarding working conditions, the use of zero-hours

[3] Although The *Care Act (2022)* extended the Commission's remit to review and assess performance of the local authorities (as well as the integration and commissioning roles of the new integrated care systems).

contracts and lack of sick pay and other benefits for workers (Harrison 2021). Each of these contributes to a final noteworthy feature: very high staff turnover. Annual care worker turnover in England is in the region of 30% (Skills for Care 2021: 7), making it one of the most volatile employment sectors. The vacancy rate in the sector has grown over the past decade. The situation is acute in care homes in which the staff vacancy nearly doubled from 6% at the end of April, to 11.5% at the end of December 2021 (Care Quality Commission 2022). The situation is generally expected to have worsened in the interim, because of the ongoing effects of slowed recruitment and availability of migrant workers since Brexit; the mandatory COVID-19 vaccination of all care home workers which came into effect on 11 November 2021 (but was dropped on March 15 2022), and the fact that the care home and adult social care sector is in active competition for workers with the higher-paying hospitality and retail sectors.

A second set of factors that engages our interest concerns the type of work/worker involved (rather than the job or sectoral characteristics per se). Care work is often framed as 'special' - requiring more than the usual job investment or work motivations from the workers, actually a special type of worker. Care work is deeply embedded in social norms, with societal narratives depicting such work as a personal commitment on the part of workers who ideally should be of a 'caring disposition'. Moral and relational framings define the field of long-term (and other forms of) care to a degree that we would argue is unique among workers or occupations at this level. One sees in the care literature, and to some extent also in public discourse, an idealisation of care as approximating family love and commitment, emphasising (emotional) attachment, investment and selflessness (Meagher 2006).[4] With the home as the optimum care location, those whose needs cannot be met at home or by invisible carers are positioned as a problem

[4] This is reflected in how care home managers conceptualise their home's approach to delivering personalised care with notions of the care home as a family the most popular (ahead of seeing it as an institution or as a hotel) (Ettelt et al 2022). See also Dodson and Zincavage (2007).

(El-Bialy et al 2021). This serves not just to prosecute a negative discourse around the provision of care outside the home and domestic setting but to 'naturalise' caring and also to engender it (motherhood and 'daughterhood' are often the underpinning models with widespread evocation of classically feminine attributes such as the capacity for nurture and empathy) (Johnson 2015). An expansive literature has articulated the ways in which care-related and other organisations and occupations are constituted in gendered ways, and in turn create gendered—and raced, and classed—bodies (Acker 1990; Crocker 2019).

Therefore, and thirdly, the very nature of care as paid is problematic. As Harrison (2021: 1) puts it: 'the question of what constitutes care within the care industry is ill-defined'. A base complication is that paid care is never fully divorced from unpaid care and the extent to which it can be (or should be) commodified is continuously questioned (e.g., Claassen 2011). Feminist-oriented work, for example, emphasises several things: that relationships are the core underpinnings of care; that receiving and giving care are universal in and vital to human life; and that binary divisions between unpaid and paid care (or love or money) are too simplistic (Fisher and Tronto 1990; Himmelweit 1999; Sevenhuisjen 2016; Waerness 1984). Margaret Radin (1996) draws a distinction between work and labour in which work always contains a non-commodified element while labour is fully commodified.[5] Paid carers are expected to *care about* the care recipients (work) as well as to *care for* them (labour).[6] Such norms are likely to be felt more acutely in care home settings because residents are typically vulnerable (in

[5] By this she means a mixture of commodification and non-commodification as in the co-existence of commodified and non-commodified approaches to a subject/activity. She defines commodification in terms of four characteristics: objectification (the possibility of being severed, alienated from the personhood of a moral subject or group of subjects), fungibility (exchangeable and interchangeable), commensurability (the worth can be scaled or ranked in relation to any other commodity), monetisation (capable of being valued in monetary terms). For Radin the co-existence is potentially contradictory and conflicted. See also Himmelweit (1999).

[6] The first, following Himmelweit (1999: 29), is the activity of catering directly to another person's needs, both physical and emotional; the second is the desire for the other's well-being that motivates the activity.

Erikson's (2013) evocative words: they are 'places for the unloved') and the transactions are primarily conceived in monetary terms to provide a quantified and standardised amount of care.

As well as the thinking on care as a form of labour and personal service, the study is informed by Albert Hirschman's (1970) theory of exit, voice and loyalty. Hirschman's framework was developed not with care home workers in mind, but rather in a context of organisational decline focusing on 'economic operators such as business firms' and with relevance to 'a wide variety of noneconomic organizations and situations' (Hirschman 1970: 1). Exit, voice and loyalty are 'reaction modes' (ibid: 33) of response to organisational decline, and Hirschman's theory sets out to explain how these intersect in the face of such developments. Hirschman argues that exit is 'a uniquely powerful tool' (ibid: 21) of 'last resort' (ibid: 37) once other avenues have been considered. He devotes a large part of his thesis to consideration of interactions between exit and voice. The 'costs' involved in the different reaction modes are examined, and Hirschman argues that voice is comparatively costly (ibid: 40); that its utilisation is dependent on deliberations over its likelihood of being effective (factoring in past experiences (ibid: 43)), including whether those engaging in it can call on political sway (ibid: 70-71). Hirschman (1970: 37) states that the decision to exit is taken on balance 'in the light of the prospects for the effective use of voice'. Regarding the impact of exit on organisations, Hirschman (1970: 45-46) contends that the improvements that may arise in response will not make up for the loss of those most likely to act to improve things. Another important point within the framework is the argument that either exit or voice would tend to be ascendant within organisations (as opposed to both) (ibid: 76), with a few exceptions, such as in voluntary associations and political parties (ibid: 120-121). Regarding the third reaction mode, loyalty, Hirschman (1970: 98) defines this as 'the reluctance to exit in spite of disagreement with the organization of which one is a member'. Costs are important here once more, with exit costing less in circumstances

where loyalty is not present, but that for those who are loyal – who 'care' – the 'threat of exit' can be an option in advance of the difficult decision to exit (ibid: 82-83).

This report is organised into five main sections. The first presents the details of the research. The second introduces some relevant literature in order to set the context for the study. The third section – the largest in the report – presents the main results. Those of the survey and the interviews are conjoined, but the latter dominate as interviews were the primary means of evidence gathering and comprise the main bulk of the study's empirical information. Section 4 presents the policy considerations that arise from the study, and integrates results from the stakeholder workshop. A short conclusion section draws the report to a close. Two appendices accompany the text, setting out the online survey module and the interview schedule as well as the information sheet and consent form.

The Research and Methodology

As mentioned, the project used a mixed methods approach with three modes of evidence gathering: (1) an online survey; (2) interviews; (3) a coproduction workshop with a range of stakeholders. These were ordered sequentially but were designed to closely intersect.

Both the survey questions and those in the interview schedule were designed to gather evidence to consider the ties and commitments of these workers to their jobs. A primary focus was on how care home workers experience their jobs and the nature of their attachments to their jobs. Drawing from the literature on care workers in particular, we were keen to further explore issues of care workers' motivations (Dill et al 2016) and identity (Stacey 2011) and their sense of expectations of them as workers and of paid care work more generally (Meagher 2006). Among the issues considered in the online survey were the aspects of the work that gave most satisfaction, the factors that kept them in the job, the impact of COVID-19 and whether the workers planned to stay or leave their jobs. In line with the staged design of the empirical work, the content of the interview schedule drew on initial findings from the questionnaire to explore in more detail the above factors but also the everyday experience of the job, how this changed over time (if at all), respondents' biographies and values and their general opinions about care-giving and paid care work.

The details of each are as follows.

Online Survey

An online survey, taking approximately ten minutes to complete, was fielded between October 2021 and January 2022 using the Qualtrics platform. It was piloted in October 2021 with five current or former care workers or researchers with relevant experience. The survey was

advertised on both Facebook and Twitter and was widely publicised also via email notifications to relevant organisations (e.g., trade unions, care worker organisations, care-related associations, and other relevant organisations and charities). The target population was workers in care homes at either entry-level care or in support worker or assistant roles (or similar), as well as those in more senior care worker roles. This aligns with the definition of 'direct care' workers used by Skills for Care (2019: 27).

The questionnaire (a paper version of which is provided in Appendix 1) consisted of five sections. The first sought to ascertain participants' current employment situation, including length of time in current role and in adult social care work overall, while the final section focused mainly on participants' demographic characteristics. The three middle and main sections covered workers' ties to their jobs; their thoughts and decisions on moving between care jobs; their orientations towards their work and the sector more generally and the impact of COVID-19.

One hundred and three people filled out the questionnaire, of which 86 submissions were admissible. The main ground for non-admission was nature of post: those excluded were mainly care home managers or staff in care home catering roles, or people engaged in domiciliary care. Of the eligible respondents who provided their exact job title, 44 described themselves as 'care worker' or equivalent, and 9 had some version of a 'senior care worker' role.

Table 1 presents the main demographic characteristics of the sample. A first notable feature is the tendency for the respondents to be of middle to older age – while spanning the age range, the vast majority of respondents are in the 30-55 age group (reflecting the national mean age of direct care workers in adult social care of 42.6 years (Skills for Care 2021: 80)). Women

dominate (82% of respondents), which again mirrors direct care work's highly gendered and largely feminised character (some 83% women) (ibid: 17). All but one-tenth of respondents are of white ethnic background. This is a higher proportion than in the sector as a whole, with Skills for Care figures for 2021 registering 76% of direct care workers with such a background (ibid). In terms of education level, only a minority of the sample have no educational qualification while a quarter have a university degree. The average educational situation is for respondents to have obtained some qualifications after school. Table 1 also shows that respondents are drawn from a wide geographical range, spread across England. Notably, only a small fraction are based in London and other large cities, making the sample more locally based than perhaps the population of care workers as a whole.

The vast majority of respondents worked in care homes with fewer than 50 residents. This too mirrors the general pattern. A further indicator of low to medium size is the fact that half of respondents were employed in homes with 0-20 staff. Most survey respondents worked close to a full-time job (in excess of 31 hours a week). Eighty percent worked for a private organisation with the remaining 20% employed by a charitable or public organisation. Nearly 90% were on a permanent contract, which again closely corresponds with the figure of 86% for care workers overall (ibid: 47). That said, the sample also reflected a relatively low national recourse to zero hours contracts in the residential care sector (as against domiciliary care). The average hourly rate of pay for respondents at £9.48 was somewhat higher than the National Living Wage (NLW) in England (at the time of the survey) for workers aged 23 and over (£8.91).

Table 1. Survey Sample Main Demographic Characteristics*

Gender	Female Male	65 (82%) 14 (18%)
Age Group	18-29 20-44 45-54 55+	12 (15%) 27 (34%) 27 (34%) 14 (17%)
Ethnic Group	Asian/Asian British British African/Caribbean African/Caribbean Other ethnic group White British/Irish/ other white	1 (1%) 3 (4%) 1 (1%) 2 (3%) 72 (90%)
Highest Level of Qualification	University degree Further education (college) or vocational qualifications School-level qualification	18 (25%) 26 (50%) 18 (25%)
Type of Care Home	Charity/public Private	17 (20%) 68 (80%)
Average Size of Home	0-20 residents 21-50 51+	28 (32%) 40 (27%) 18 (21%)
Regional Distribution of Respondents	East Midlands East of England London North East North West South East South West West Midlands Yorkshire and Humber	16 (18%) 7 (8%) 3 (4%) 8 (9%) 6 (7%) 16 (19%) 14 (16%) 6 (7%) 10 (12%)

* Missing information is excluded from the calculations in this table.

Interviews

The second stage of fieldwork consisted of 29 interviews[7] with 'entry level' care or support worker (23), senior care worker (5), or a wellbeing worker/care worker (1). The means of interviewee recruitment varied. Ten respondents were drawn from those who had completed the online survey. A further 17 participants were recruited through social media, with all but

[7] To test the interview schedule, two pilot online interviews were conducted in November 2021 (with a former care worker and a currently-employed care worker).

one learning about the study on Facebook. Two participants were snowball referrals from existing respondents.[8]

In line with the staged design of the empirical work, the content of the interview schedule drew on initial findings from the questionnaire to explore in more detail the above factors but also the everyday experience of the job, how this changed over time (if at all), respondents' biographies and values and their general opinions about care-giving and paid care work. The interview schedule is reproduced in Appendix 2. The interviews were held online (via Microsoft Teams) or by telephone or WhatsApp, between late November 2021 and January 2022 and recorded. In advance of the interviews, participants were sent an information sheet **(**Appendix 2) and the consent form (also Appendix 2) and advised they could ask any questions and end the interview at any point. At the start of each interview, the interviewer talked through the consent form to secure participants' verbal consent. Interviews lasted approximately between 35 and 90 minutes, with the majority around one hour in duration. To compensate them for their time, respondents were given a £20 high street shopping voucher following the interview.

Table 2 below outlines respondents' main characteristics. While representativeness and generalisability are not explicit concerns in qualitative data generation, the sample (again) did share some broad similarities with the adult social care workforce in England (and also the survey population). This is the case for the gender split for example (82.7% female) and also the age make-up (although the average age of care workers in our sample (37) was a few years lower than the 43.3 average in the adult social care workforce overall). As with the

[8] In total, 85 people enquired about being interviewed including the 29 respondents. Of those, 45 did not respond to our initial replies (or follow-up requests) with further information, or stopped responding in advance of an interview being arranged. Five turned out to be ineligible, due to their role or geographical location in other parts of the UK. A further 6 interviews were arranged but the potential respondents did not present or postponed indefinitely.

questionnaire sample, those of white ethnic background were heavily represented (86.2% in the interview sample) compared with the adult care workforce overall (of whom 21% are BAME). This may be partly attributable to the regional spread of the sample: it included participants from each of England's nine regions, with the East Midlands, the South East, and the North West among the areas from which most respondents are drawn.

Table 2. Interview Sample Main Demographic Characteristics

		Care or support worker (24 participants)	Senior care worker (5 participants)
Gender*	Female	21	3
	Male	3	2
Age	Average	37	36
Ethnic group*	Albanian/Greek	1	
	Asian		1
	Black African	1	
	South African	1	
	White of whom identify specifically as White British	21 15	4 3
Highest level of qualification	Postgraduate degree	3	0
	Undergraduate degree	5	1
	Further education (college) or vocational qualifications	11	3
	School-level qualifications	2	0
Health and Social Care qualifications	None	5	0
	Care Certificate only	2	0
	In-house training/certification only	3	0
	NVQ 2	3	1
	NVQ 3	7	2
	NVQ 4	0	1
Length of time in current care home post	Mode (most common length of service category) Median (mid-point of ordered length of service) Range (shortest to longest length of tenure)	1-2 years Just under 2 years 3 months to 11 years	1-2 years/3-5 years (two participants in each category) Just over 2 years 7 months to 5 years
Length of time in adult social care work in England	Mode Median Range (shortest to longest length of service)	1-2 years 5 years Just under a year to 33 years	11-15 years/16+ years (2 in each category) 13 years Just over a year to 18 years

* The reply categories for questions on gender and ethnic group are based on participants' self-defined responses.

Regarding health and social care qualifications, most respondents held a relevant qualification: one a Business and Technology Education Council (BTEC) qualification, and 14 National Vocational Qualification (NVQ) (three others were working towards an NVQ qualification). Five others had either the Care Certificate (some of those with NVQs also had this qualification) or in-house training or qualifications.

For the entry level workers, hourly pay averaged £9.37, which was less than 50p above the NLW. Six respondents were paid at the NLW rate of £8.91 (which is the lowest amount legally permissible for employees to be paid to work), and a further six received hourly pay within 50p of the NLW. The disconnection between experience and pay level was borne out time and again. For example, a worker with 33 years of experience in adult social care employment (including 11 in his current post) earned £9.40 per hour.

Although the sample contains a number of workers who were relatively new to adult social care work (eight had been working in the sector for two years or less), only one participant had been in her current post for three months (although she had been in adult social care work for over six years) and another for 7-8 months. Both had longer histories in care work though, with this and other evidence illustrating 'churn' in the sector.

As with the questionnaire sample, the overwhelming majority of interview participants were on permanent contracts (86.2%) with two of the remaining four on bank contracts that have no limit to their duration (but no guarantee of hours either). This is in line with sector practices (89% permanent). All but one of the participants worked in what Skills for Care (2021: 35) describe as the 'independent' sector, that is private or charitable care providers. And as can be

seen from Table 2 there were no age differences between care and support workers and their more senior colleagues.

Data Analysis

The survey data was analysed using SPSS to undertake descriptive analysis, including correlations, as the sample size (of 86) was too small to allow for more causal analysis.

The interview narratives were analysed manually in a series of steps. First, the replies to each question were analysed through content analytic coding. The coding schema included deductive codes based on broad areas of initial interest, including the organisation of work, care practices and commitments, and relationships. In a second step, emergent themes were derived from inductive, cross-question coding and evidence juxtaposition. Thirdly, the evidence was carefully examined for the selection of appropriate quotes.

In the presentation of the empirical evidence, both the interview evidence and that from the survey are presented in an integrated fashion, although the main emphasis is on the qualitative information from the interviews (mainly because of its richness and depth).

Stakeholder Workshop

The third stage of participant engagement took the form of an online workshop with a number of stakeholders held on July 1st 2022. Three people attended: a representative of a care home owners organisation, an expert researcher in health and social care and a representative of an NGO involved in analysis and advocacy in issues core to the study. The purpose of this workshop was to gain attendees' insights on some of the key policy-related points from the survey and interviews. The specific focus was on identifying problems – with the survey and

interview findings as prompts – and gaining participant views of and suggestions for potential solutions.

Ethics

The study received ethical approval from a subcommittee of the University of Oxford Central University Research Ethics Committee (reference number C1A_20_017). In addition to the steps taken regarding informed consent at each stage, every effort will be made throughout the analysis to protect participants' identities. The original recordings were destroyed once the interviews had been transcribed and checked for accuracy.

The Care Sector in England

The care sector is a very particular locus of service provision and employment in the English context (as some of the contextualisation details of the samples in the previous section has adverted to). For information on the sector, we draw especially from the information and analysis provided by Skills for Care, a registered charity focused on workforce development and relevant planning for adult social care in England. The data used from this source mainly relate to the year 2020/2021, to reflect the situation when the study was carried out (Skills for Care 2020a; Skills for Care 2021).

Care workers and conditions of employment

The conditions of care work, in both its paid and unpaid forms, are the subject of much current interest and concern nationally and internationally (International Labor Organization 2018; Hayes et al 2019; Eurofound 2020; OECD 2020). The literature provides overwhelming evidence of paid care work's lack of status and under-valuing in the UK, and beyond. These issues have been interpreted by UK policy makers especially in terms of retention and recruitment, a problematic that is rooted in the perspective of the industry and employers rather than coming from the perspective of the workers. The problems then are seen to cohere around workforce sustainability, and in particular the recruitment and retention of sufficient numbers of good quality staff now and in the future (in an idealised future where demand for care and the need for care workers is somehow matched).

Adult social care in England is a highly gendered sector dominated by women who comprise 82% of the overall adult social care workforce (Skills for Care 2021). As well as being gender differentiated, it is also marked by ethnic and age-related divisions, leading academic literature to position care work at the intersections between gender, migration, race and ethnicity,

underscoring the over-representation of workers (women) from migrant and minority backgrounds in paid and unpaid care work (Hochschild 2001; Yeates 2012). This is borne out in the paid care work sector in England, with Black, Asian and Minority Ethnic (BAME) workers being over-represented in comparison to their distribution in the population as a whole (Skills for Care 2021). There are wide regional variations in this, however, with BAME workers comprising 4% of the adult social care workforce in the north-east compared to 67% in London (ibid: 81). The age characteristics of the workforce are striking also. Some of the notable age-related features include: the average age of a new start in care work (35.6 years (Skills for Care 2020a: 55)); the high numbers of workers close to retirement age with over a quarter of the workforce over 55 (Skills for Care 2021: 79)), and the under-representation of young people (ibid).

Although there is a lack of data on care workers' overall levels of education (and socio-economic backgrounds), formal qualifications are not necessary for entry to the sector. Despite this, and care work's administrative and rhetorical categorisation as 'unskilled' (Trades Union Congress 2020: 6; Migration Advisory Committee 2021: 38), accounts based on the realities of the work find it to be skilled, demanding work (Hayes 2017; Hayes et al 2019). The one-dimensional representation of the work is reflected in the sector's flat organisational structure, with entry-level care workers comprising a large percentage of the workforce, and those in 'regulated professional' roles accounting for only approximately 5% of staff (Skills for Care 2021: 36). Another important structural factor is that adult social care is made up of thousands of providers: in fact, there are an estimated 17,700 'whole PAYE- or VAT-registered organisations (enterprises) involved in providing or organising adult social care' (Skills For Care 2021: 30). This feature is central to the sector's variation and fragmentation, and has

significance also for political mobilisation prospects in the sector, including unionisation and collective bargaining, and progression/career advancement for workers.

'Working conditions' encompass a range of indicators, the field being an exemplar of why perspectives on it should incorporate multiple interlinking and cumulative factors. Overall the sector and the conditions have been said not to be 'professional' in the sense that care workers 'are not recruited or trained as professionals, and are not, on the whole, respected as professionals' (Hayes et al 2019: 1). The headline measure is pay, and in this regard (as with many others), adult social care fares extremely badly with very low pay endemic and normalised. Alongside real-term declines in pay generally in the UK economy (prior to the pandemic anyway), the number of adult social care workers paid in line with the legal minimum wage has risen over time (Skills for Care 2021), with the sector classed as low-paid by the Low Pay Commission continuously since 1998 (Skills for Care 2020a: 93). Alongside hospitality and retail, the levels of remuneration in adult social care are consistently among the lowest of any sector (Hay 2015; Hussein 2017), and there is research evidence of problems with underpayment of legal minima (Hussein 2017; Dromey and Hochlaf 2018: 9-10).

Beyond basic pay, other forms of remuneration have been reported as insufficient including: inadequate sick pay coverage (Hayes et al 2019); scarce antisocial hours' payments; and limited or minimal increments tied to gaining promotion (Kingsmill 2014: 30) or qualifications (Atkinson and Lucas 2013: 168). The gendered nature of care work also manifests in, inter alia, a gender pay gap and associated limited pension coverage. The matter of a care wage penalty has been explored in cross-national research by Lightman 2021 and she found this to be present in 12 quite different countries ('care regimes'). The cumulative effects of being an immigrant, a woman and a care worker are found to result in a 42% wage penalty in comparison to a

comparable male, non-immigrant, non care worker. The devaluation of care work is a widespread phenomenon. Adult social care also does poorly on other measures that suggest worker insecurity, including the use of zero-hours contracts (Dromey and Hochlaf 2018: 10).

When it comes to terms and conditions of employment, temporary or agency work is not commonplace, and 89% of the workforce hold permanent contracts (Skills for Care 2021: 16). And yet about a quarter of these workers are on zero-hours contracts, raising questions about the meaningfulness of calling these workers permanent workers.

Another area in which adult social care fares poorly is in training, with over half of the workforce holding 'no relevant social care qualifications' (Skills for Care 2020a: 98). Induction and training provision in the early employment period has been reported as patchy and not standardised (Hayes et al 2019: 20-22). A key reason for unevenness and variability is that training is the responsibility of providers, whose offer varies:

> 'The key training requirement for social care workers in England is an adequate induction, although the definition of adequacy is largely at the discretion of the provider. This minimum level of induction, which may or may not involve formal training or the award of the Care Certificate, contrasts with requirements for qualifications and post registration training and learning (PRTL) that exist in the other countries of the UK' (ibid: 34).

An important dimension of training in adult social care is the hurdles that hinder access to it, including lengthy hours of work, contractual insecurity and lack of paid time to undertake training (Hayes et al 2019: 12). Other issues include workers' concerns that they are not given

the 'specialist training' to care for people with particular needs, and that the task boundaries of their work are unclear in part due to a lack of appropriate training (Dromey and Hochlaf 2018: 12). As the authors of a recent report for the All-Party Parliamentary Group on Social Care (2019: 31) comment:

> 'With such messy, inconsistent provision, the importance of good training can get lost, but 'high quality learning experiences have the potential to transform caring relationships''.

The sector also struggles with worker progression. This is one of a number of ways in which the structure and organisation of social care work compares poorly with the NHS equivalent, the latter including clear, standardised progression routes and pay banding.

Care workers are quite routinely exposed to conditions that pose considerable risks to their physical and mental health and wellbeing. Such risks come from the body work involved, with lifting and moving a routine part of the work, the pressures of care work and the demanding and frequently grave situations workers regularly face (Hayes et al 2019), including dealing with the decline and death of people they have cared for (Vandrevala et al 2017). The exhaustion and strain associated with care work prior to the COVID-19 pandemic (Clarke 2015: 200) has been intensified by worker burnout as the pandemic has progressed (Health and Social Care Committee 2021; UNISON 2021a). The pandemic brought new risks to care work, with the dangers greater than in other employment sectors, as reflected, for example, in the comparatively high death rate for care workers during the initial, Spring 2020 wave (ONS 2020 cited in Daly 2020: 986). The risk factors in care work associated with COVID-19 included the necessary physical closeness and body work involved in care; the fact that care workers could

not ‘work from home’; the long and extra hours required (Health and Social Care Committee 2021). It is also the case that the policy response, especially during the initial period of the pandemic in the first half of 2020, exacerbated rather than mitigated risk to care workers and care home residents in various ways (Daly 2020; Nyashanu et al 2022; Health and Social Care, and Science and Technology Committees 2021). In addition, the pandemic accentuated other inadequacies, including those already mentioned with regard to sick pay (Hayes et al 2020: 2; Health and Social Care Committee 2020: 20), training (Work Foundation 2021: 13) and health and safety, all of which were further compromised by the halting of Care Quality Commission inspections (Hayes et al 2020: 2-3).

A final area of significance to working conditions is worker organisation and the involvement of trade unions and collective bargaining. Against a backdrop of falling trade union membership in the UK economy as a whole, workers in sectors such as social care are most unlikely to be in a union (Dromey and Hochlaf 2018: 24). There are gender differences here also. A recent World Health Organisation (2019) report highlights how within health and social care men are more likely to be unionised as a result of the vertical segregation that increases their chances of being in professional, higher status roles. Figures on trade union membership in the sector are difficult to locate, but research for the Institute for Public Policy Research published in 2018 estimated that just one in five care workers (19.8 per cent) and senior care workers (20.6 per cent) were members of a trade union or a staff association. This is below the average for the whole economy (20.6 per cent), and the contrast with the NHS is especially stark: four in five nurses (82.6 per cent) were at that stage members of a trade union or a staff association (Dromey and Hochlaf 2018: 24).

Labour shortage, and issues around recruitment, retention and turnover

These deficiencies in working conditions are closely linked to serious ongoing problems in maintaining sufficient workforce numbers. Figures for 2020/2021 estimated that there are 105,000 vacancies in adult social care on any given day (Skills for Care 2021: 67-68) (with Dromey and Hochlaf 2018: 3, 12-17) projecting this to rise to 400,000 by 2028 (although this was a pre-pandemic estimate)). This is equivalent to 6.8% of posts (rising to 7.6% for care workers (Skills for Care 2021: 68)), and significantly higher than the 2.1% figure for the UK economy overall (ibid: 68). In 2020/2021, annual turnover rates stood at 35% for care workers, which means that more than a third of workers left their roles within that year (Skills for Care 2021: 13). There is some evidence that a significant portion of the turnover is intra-sectoral, with many care workers moving jobs for better or more suitable conditions, for example rather than leaving the sector. Many of the new starters are from within the sector (66%) (Skills for Care 2020a: 59)). However turnover is especially high for those in the first year of their jobs, and around half of care workers have thought about leaving their post (Dromey and Hochlaf 2018: 13).

In addition to indicating work ties or commitments of some care workers, the turnover situation highlights the sector's difficulties in attracting people external to the sector. Other structural features, such as the sector's flatness (Dromey and Hochlaf 2018: 12) (the ratio of more senior roles to entry-level roles is low (Hayes et al 2019: 27)) and lack of consistent, standardised progression routes (Dromey and Hochlaf 2018: 12; Hayes et al 2019: 27; Health and Social Care Committee 2020: 23) and the relative paucity of incremental pay for length of service (ASHE 2021 cited in Migration Advisory Committee 2021: 36), are likely to influence such movement between care providers. Research shows that one of the knock-on effects of raising the level of the National Living Wage has been to narrow the (admittedly already slight)

earnings gaps between newer and more experienced care workers (All-Party Parliamentary Group on Social Care 2019: 18). Again, however, the problems with staffing numbers are not uniform across the sector with mixed experiences on the part of individual providers.

Significant concern has been expressed across the social care sector about the strain caused by the staffing situation. In July 2021, Jane Towson, the Chief Executive of the UK Homecare Association, wrote: 'Many employers say they have never experienced such difficulty in retention and recruitment and fear for the well-being and safety of older and disabled people' (Towson 2021). The Nuffield Trust estimated that over 50,000 fewer workers were employed in adult social care in October 2021 than in the previous April (Palmer 2021). The problems with staffing were apparent long before the first COVID-19 outbreak, but, by mid-2021, matters took on a greater degree of seriousness and urgency. Beyond the debates about a post- Brexit policy and the ethical quandaries over mandatory vaccination of care workers (Hunt 2021), both sets of associated policies (in the former case, specifically the end of freedom of movement for workers between EU countries and the UK) have had immediate ramifications for social care workforce numbers. Following a call from the Migration Advisory Committee (2021: 38), care workers and home care workers were made eligible for the Health and Care Worker Visa. This temporary policy was announced in late December 2021 to take effect in early 2022 (UK Government 2021c). The latest available figures suggest that 56,900 visas were granted for care workers and senior care workers under this initiative in 2022 (Department of Health and Social Care 2023). It is planned to extend it through a £15 million regional fund for the 2023 to 2024 financial year, along with a programme of engagement, guidance and support products for the sector. There are large questions as to how successful this may be in addressing the deep-rooted, long-standing workforce issues though, with the visa only being offered for one year, and the minimum salary threshold of £20,480 (ibid) too high for many care positions.

The high numbers of people with unmet care needs (estimated to be approximately 2.6 million people aged 50 and above in England in 2022 or who are waiting for care assessments or reviews (almost 300,000 (Albert 2021)) are a result of a confluence of factors including staffing shortages. Understanding the problem in a wider context, the factors that the King's Fund (2021) pinpoints as causal in current policy around access to care include: an overly-stringent means test; catastrophic costs; unmet need; patchy care quality; poor workforce pay and conditions; a fragile provider market; disjointed care; and a 'postcode lottery' of access.[9]

For those in receipt of care, staffing shortages have clear and serious implications for care quality in many settings (UNISON 2021a), including their safety and well-being.

Reform Agenda on Workforce

Looking at the field as a whole, there are many proposals in play and some significant reform plans.

The 2018 National Audit Office report was scathing of the Department of Health and Social Care's strategy and planning with regard to the social care workforce. Its recommendations for reform included the creation of 'robust' workforce strategies at both national and regional levels, and planning that is reflective of changes such as around integration of health and social (National Audit Office 2018: 11-12, 43-45). The call for a national workforce strategy for social care is echoed elsewhere (All-Party Parliamentary Group on Social Care 2019: 11, 52; Dromey and Hochlaf 2018: 29-35; Social Care Institute for Excellence 2020: 17-18; Dunn et al, 2021: 38; Health and Social Care Committee 2021: 41). Another national-level policy proposed is the

[9] https://www.kingsfund.org.uk/publications/radically-realistic-vision-adult-social-care

establishment of a system of registration for care workers in England (it already exists in other UK nations) (Dromey and Hochlaf 2018: 4-5; All-Party Parliamentary Group on Social Care 2019: 56; Health and Social Care Committee 2020: 23). This was also a recommendation of a Europe-wide report on the social services workforce (Baltruks et al 2017: 60). Some recommend going beyond such strategies to forming national care services akin to those for health as is underway in Scotland (Scottish Government 2021: 45-53). The 2019 All-Party Parliamentary Group on Social Care (2019: 59) also called for a 'universal training framework' as a way to address the inconsistencies arising from the current fragmented and uneven arrangements, and other bodies call for action on training and progression (Health and Social Care Committee 2020: 36; Work Foundation 2021: 13-14). Another line of recommended reform is collective bargaining. This appears far less frequently in reform proposals but has been called for by some as a vehicle for improving conditions and standards (Dromey and Hochlaf 2018; Hayes 2017). It could be argued that to-date in England there has been an absence of positive, affirming policy towards the adult social care workforce, in contrast to measures such as bonus pay awards in other UK nations, and the Welsh Government's efforts to curb zero-hours contracts in homecare (Dromey and Hochlaf 2018:11).

In the context of the lack of workforce strategy (in a further contrast with the NHS which has its NHS People Plan of July 2020 (Health and Social Care Committee 2021: 41-48) from central government and the Department of Health and Social Care, leaders in adult social care came together in 2021 to set out what the priorities should be for a workforce strategy (Social Care Leaders 2021). This ambitious document includes obvious areas for enhancement such as pay, training and progression, but also looks to wider questions around planning, prevention and integration (alongside other services), and moves to improve the status and recognition of care work (Social Care Leaders 2021).

Set against the context of these calls for a clearer workforce strategy, in December 2021 the Conservative government under Boris Johnson published a white paper, *People at the Heart of Care* (UK Government 2021b). This followed on from the publication in September 2021 of *Build Back Better* (UK Government 2021a), the government's plan for health and social care, including funding and eligibility reform in adult social care. The December white paper includes the government's '10-year vision for adult social care', but the workforce measures only refer to workforce development funding – of £500 million – to cover the next three years, and other policy interventions only cover this shorter period also. Whilst there are some promising policies included, such as the pilot of Freedom to Speak Up Guardians and measures to improve mental health and wellbeing support, huge questions remain. In particular, the amount of funding allocated to workforce development (Bottery 2021; Women's Budget Group 2021) appears paltry given the task at hand. Furthermore, while these funds do address the quality of care work and have the potential to improve the demand-side offer, the proposed reforms do not sufficiently address major issues like very low pay. In fact, the white paper relies on the assumption that care work is work of low value in that the government's raising of legal minimum pay rates in 2022 being the pay reform heralded within it.

This sets the context within which workers approach and experience their work as paid carers.

Evidence Analysis

This section presents the main results of the empirical research with the care workers. It concentrates on the results of the interviews but also gives details where appropriate of the survey responses. As befits a short survey, the latter were less extensive in comparison to the former. The 11 sub-sections here consider in turn job satisfaction and the meaning of the job and the work, relationships with colleagues and employers, work motivations, employment conditions, raising concerns and complaints, care work and workers' biographies and expectations, staying and leaving the job, effects of the COVID-19 pandemic, opinions on the qualities of (good) care workers, care work in public opinion, workers' suggestions for change.

Job Satisfaction and Meaning

When asked to assess the working conditions overall, the online survey population divided roughly evenly into those who were positive and negative, with around 38% in each grouping and the remaining 23% expressing neutral attitudes. Regarding the positive factors, the interview respondents spoke of liking or loving the work or the job and of it being rewarding. This finding was reproduced in the survey data - over a half of respondents expressed high levels of satisfaction (with some 26% neutral) and over 73% of respondents agreeing that they like their job.

This chimes with much existing research on care work, which consistently finds evidence of care workers enjoying their work and gaining satisfaction from it (Stacey 2005; Johnson 2015). In terms of particular aspects experienced as positive, satisfaction could be interpreted as connected to both the intrinsic (the tasks, the 'doing') and prosocial (the relational, and

particularly the rewards of the relational)[10] elements of care work. More specifically, the people workers care for were prominent in responses.

The rewards of working with residents, and of helping them, was a strong motivation for workers, some of whom invoked metaphors of family to describe the relationships with residents. Not only did some workers speak of residents as family, but they interpreted the work of caring for them in the way that they would for their actual family:

> I always do my job with a mind view of …I want to look after people the way I'd want someone to look after my mum, or my loved ones.

This highlights the enduring normative pull and expectations associated with unpaid care and family-related norms within the sphere of paid care work.

In a context of the above-mentioned positive elements which largely derived from the intrinsic, prosocial and relational elements of care work, a notable feature was the scarcity of positive comment about working conditions.

Turning to the negative side, the stress of care work was the most commonly-mentioned factor, with people describing it as 'draining', 'tiring', or 'exhausting'. These words all hint at the intensity and complexity (both of which have positive connotations also) of care work. One is on one's feet constantly and a mental adjustment is frequently required in moving from resident

[10] Prosocial motivations derive from the desire to protect and promote the welfare of others which in a work setting may mean that the worker performs a work task because it is a means of helping others (Dill et al 2016: 99).

to resident. This complexity was often placed in a context of relative ignorance on the part of the public of what is involved (to be covered in greater detail in section 3.10 below):

> Like… people think it's just doing people's shopping and stuff.

Some participants mentioned both positive and negative factors, but there is a sense from the accounts that the direction of travel over time was towards the latter:

> There has been more bad than good recently.

> It's very tough and stressful at the moment, so it's not as enjoyable as it has been.

Neither of these quotes attributed these developments to anything in particular, but others more pointedly referred to the impact of COVID-19 in increasing stress levels. For example:

> It has gotten a lot harder since the pandemic started. It has been a lot more stricter and the work we've been doing is a lot more heavier, I think.

Despite the negative factors brought on by the pandemic, participants did hint at positive effects of COVID-19 too (to be considered in greater detail in section 3.8 below). Although not linked to the pandemic, this quote from a migrant care worker who began working in the English care sector six months before the first UK wave, demonstrates her personal, enduring commitment:

> I am there to support a person in need, to care, to love, to protect, to encourage … this is what I…I am motivated and wanted to...to carry on doing my best.

How did the workers make their work meaningful?

When asked an open-ended question about meaningful or satisfying aspects, well over two-thirds (23) of interviewees invoked the residents, mentioning such factors as the meaning or satisfaction derived from interactions and relationships with residents, from residents' reactions to them and from doing particular tasks or activities well for residents as part of their care. Four framed this in a general sense of the relationships being meaningful, but many highlighted specific sources for such feelings.

Workers feel satisfaction when residents show their appreciation for the work that they do in the form of 'thank yous' or other words or gestures indicating appreciation – what Johnson (2015: 117) calls a 'moral currency'. This can include appreciation expressed by a resident's family members, drawing attention to the wider community involved in care home work. One respondent referred to the 'bond habits' between her and residents, seeing it expressed in the excitement on the faces of residents when they meet. Four other interviewees referenced seeing reactions such as smiles or 'that little grip of your hand' as bringing meaning or satisfaction. Notably, it was the 'small' or 'little' things that frequently conferred meaning and satisfaction.

Respondents sometimes valued the existential state of simply being in the company of residents, and interactions with them such as sitting with them, talking with them, or having a cup of tea together. However, some referred to such opportunities being less common than in the past:

> So, it's nice to have that one-to-one interaction because it's becoming less and less possible. I mean, even at half past seven at night… we do a 12-hour shift… so half past

> seven at night, our manager might come round and say, 'Why are you not walking down the corridors?' But there'll be two or three residents in the dining room, and they'll be watching TV and we sit, and we chat, and they chat. But they don't count that as work.

Although this interview – and one other – mentioned that the chances to have such interactions were decreasing, the idea of the relational aspects of work taking less priority or not being classed as 'work' is not new. In her mid-1990s ethnography of a New York care home, Nancy Foner (1995) found much evidence of this, with particular focus on how care work's bureaucratic elements took precedence over its relational aspects. This is another indicator of how time-pushed care workers are. Personal contact mattered to all, either those who had been in care work for a period of time and noticed a negative trend, or newer workers' preconceptions and hopes around what care work might be for them and how it might enable them to contribute to a general good (and find meaning or satisfaction for themselves). Returning to the more generic notion of 'being there' for residents, three interviewees made reference to the particular meaning they took from performing this role during the coronavirus pandemic when residents were cut off from family and others in their lives.

Although these relational aspects were prominent in respondents' accounts, people also referred to the meaning and satisfaction they derived from other areas, including some more task-based or intrinsic elements. Four mentioned how satisfying assisting with personal care is, while for another four helping to ensure residents are well-fed and have enough to drink are especially meaningful. Some respondents raised the issue of end-of-life care in this context, describing the meaningfulness they draw from caring at the end stages of life. One particular respondent articulated this clearly in terms of the process of biographical change, and also the satisfaction that she finds:

> I've been there for about 14 months but you do see people decline and so to be there in those stages when you've looked after someone is… you know, it's sad, but it is quite satisfying that you've helped them through that. Even at the end of their life, it is upsetting, but you do feel that you've contributed something to their life and have helped in a very important life event. Yeah, I do find that satisfying.

A final theme on intrinsic work satisfaction - present in the accounts of four workers and alluded to by others – was when they had observed (and contributed to) positive change in residents' behaviour, even if that was sometimes only narrowly within the context of their interactions with residents. This included recovery over time from traumatic episodes, or residents' achievements that may have been unexpected or not foreseen by staff. Workers derived meaning from the personal nature of relationships with residents, with a number referring to the trust they had built with certain people. This came in different ways: in the residents seeking out those workers at particular times, or those workers being able to help calm residents down when others might not be able to do so.

When asked about how meaningful relationships were with residents, only positive responses were forthcoming. Some placed great emphasis on the meaning derived in this context describing the relationships as 'very meaningful' or meaning 'a lot'. Other phrases used included residents 'being everything' or of the 'utmost importance' within the work. Although this question was asked separately for residents, colleagues and organisations, some workers connected their relationships with these different actors; one mentioned the notion of being 'all in it together' when asked about both residents and colleagues (in the context of the pandemic).

The following respondent too, brought her relationships with residents (and their families) and with colleagues together into an inclusive formulation:

> It's the relationships that make it, to be honest. It's the relationships that get me to go to work. You know, it's the bond that you build with the residents, the bond that you build with the families and the staff as well.

Relationships with Colleagues and Employers

The responses to a question on relationships with colleagues were not as unanimously positive as those for residents, but on balance they were considerably more positive than negative. Only one participant responded in a negative way stating that her relationships with colleagues were not so important to her. Over a third of the interview sample (11 participants) gave answers that were composed only of positive remarks about their relationships with colleagues, or the meaning they derive from those. Some made differentiations between particular colleagues when replying. In the online survey nearly 80% of respondents viewed their relationships with colleagues either very positively or positively. When the interviewees expanded on why they found relationships with colleagues meaningful, the sense of shared experiences emerged as important, and in particular the bonding and solidarity that results from finding positive meaning and satisfaction in the face of common adverse experiences. Six participants spoke of this, referring to adversities such as the pressure of the work, the exhaustion, and the short-staffing, while a further two mentioned the coronavirus pandemic and coming together to work with colleagues in that particularly acute time of challenge and adversity. Other interviewees discussed the meaning in relationships with colleagues that develops as a result of the trust necessary to perform care work, and another emphasised the importance of good relations between workers, and a harmonious working environment, for the residents especially.

In contrast to relationships with residents and colleagues, there was very little evidence of meaningful relationships with the employing organisations. Two-thirds of the interviewees gave negative responses to this question with ten explicitly stating that their relationships with their employers are not meaningful. Interestingly, the two workers who spoke unambiguously positively about the organisations they work for were both senior care workers.

There was some patterning in the reasons workers gave for why their relationships with their employers lacked meaning. One reason was a felt distance between them and those higher up in the company, with one suggesting this contributed to making care workers' jobs harder as more senior staff lack knowledge of developments 'on the ground'. There was a strong sense from some respondents that they did not actually know the employer at all – this was especially the case for those who worked in the larger homes who tended to use the term 'the company' or even the othering 'they'. One respondent put it well when she referred to distance and some remoteness leading to a lack of meaningful relationships with those higher up. The reason she would not approach more senior staff with worries or concerns was because she did not have a meaningful relationship with them, in the sense of feeling she could approach them to raise experienced difficulties.

A second contributory factor derived from the effects of hierarchy and especially the perceived lack of credit and value the organisation gives to the workers. This is how one respondent saw things:

> What I despise about our company is when you get people from higher up … you know, coming into the home. I mean they come in with such an attitude, do you know what I mean? They rarely greet you and you almost know that they're hierarchy.

There were many examples of how workers felt they were not valued by the organisations they worked for. Some expressed this in terms of 'being just a number'. Some of the responses are very interesting in the context of the nature and definitions of care. One argued that she and her colleagues were 'caring for the residents but not the company [they] work for', and that the company did not care about the residents or, by implication, about the workers either. The lack of reciprocity in the organisation also diminished a connection just as that with the residents was bolstered by feeling appreciated.

> Because I know I'm not meaningful to them. I'm meaningful to the residents. So, they're meaningful to me.

A third very significant factor was lack of value alignment with the employer. When asked whether their values match those of the organisation they work for, just under half of the interviewees (13 participants) said that they did. Of those seeing a match between personal and organisational value sets, good feedback and person-centredness were considered important.

Five stated explicitly that their respective values did not align and the remaining interviewees gave more ambivalent responses. Singled out for criticism by the group as a whole was the importance of money or the profit-motive of their employers. The latter was seen to manifest in saving money or cost-cutting, on reducing care quality for residents, and, to a lesser extent, diminishing job quality through under-staffing especially. As an example of the former, one

interviewee recounted how she and other colleagues interpreted a demonstration about the amount of liquid incontinence pads can hold in order to show they could hold more and be changed less often than was the case at the time (and thus save money because too much was being spent on them).

> They're not providing a service. They're making a profit. They have to make a profit. And they come to us and say, 'These are our values, blah, blah, we care so much'. They're not. They're in it for the money, basically. They'll shut down if they don't make money. … I mean, they talk about values and integrity. They talk about being the best care home in the country. They talk about all these things. But actually, when it comes down to it, all they really want is results and to make money.

> I think the trouble with the organisation is I don't really know what they value.

There were a number of relevant points involved in the impact of the profit motive on lack of investment. The matter of minimal training for staff was raised in this context, and seen to be connected to both care quality and job quality. It has a negative influence on the former according to one respondent as staff are insufficiently trained to support people. Complex needs and dementia were mentioned in this context. Furthermore, this aspect inhibits staff and their prospects for both learning and progressing. A second point made by the same respondent is especially important to the debates on staffing, and particularly the area of staff retention. She argued that many workers in care were doing it as a last resort because they cannot find other work. But rather than argue that they are not suited to care, she put forward an alternative view:

> I just feel if they were encouraged and supported a bit more into their roles and offered the training, they would probably stick with it. Especially if the training came with a pay scale and progression, they would see a better future for themselves.

This might seem like a rudimentary point, but, in the context of retention and recruitment, improvements to job quality or demand-side factors such as these would likely contribute to benefits in terms of the size, nature and quality of the workforce.

Some respondents used the lack of value alignment with employers to set up an opposition between them and employers in which they were 'the better people'. For example:

> No, mine [values] are more…. mine are higher. Yes.

A final barrier for participants developing meaningful relationships with organisations they work for was the way the institutions were run, and the negative effects of this on how staff were treated and services delivered (and the impact of that on the quality of care). People gave examples of how in the past they had felt pushed away from previous care jobs due to the culture or the way services were run. In the latter case this could refer to either their own treatment and/or that of colleagues or the treatment of residents. For one respondent her employer's lack of support and confrontational stance over her own mental health difficulties had prompted her to re-evaluate how her employer saw her (lack of value, care) and seek to move on.

Stone (2000) and others would say that all of this is inherent in care work as a clash of private and public values. The practices in the care homes that workers are criticising are neoliberal management practices. Joan Tronto (2010: 165) also makes a relevant point to the effect that

when care givers find themselves saying that they care despite the pressures and requirements of the organisation the institution has a diminished capacity to provide good care.

Work Motivations

When asked about their own motivations, many espoused prosocial or caring motivations – they are suitable for the work because they are caring people. Describing their caring orientation came easily to some:

> I just love working with either the elderly or children. I'm quite maternal, I think. And because my kids are all grown up. I mean, when I first started, they were all in their teens, late teens, so I suppose it's sort of like trying to fulfil that maternal instinct in me. Still trying to take care of people and look after them and be there for them really.

Hence for some such as this respondent, the work is self- or identity-affirming, an expression of themselves.

Prosocial motivations can also have a political underpinning, extending beyond working with particular individuals. In this connotation, people evoked more macro aspirations regarding change, for example to advocate for those they care for or others and to be a 'voice for the voiceless'.

> Just, yeah, being able to help someone that can't do something. Someone that's vulnerable. Someone that, through no fault of their own, isn't in this world as we are.

> You know, yeah it's … helping people have access to things. And yes, it's that drive for equality and justice.
>
> So, that's partly why I wanted to do it … not just go 'I have expertise because I've got a certain qualification' but I've actually lived and worked with these people. I understand the challenges they're up against.
>
> I don't think even research has realised just how much power there is between a carer and a vulnerable person. It's almost too much. And it shouldn't be the case.

Some workers linked their caring motivations and interest in care work to particular biographical experiences. For example, a 22-year-old living in the north-west who had been an unpaid carer for her grandmother was motivated to take up paid care employment as 'it's no different to what I do for my grandma anyway'. For another observing her grandfather's experience of dementia influenced her desire to help others. For still another there was a seeming inevitability that she would take up care work based on the work experiences of family members:

> I think it's always something that I thought I'd get into with my mum and my grandma doing it… like I say, it's always something that has interested me.

One respondent learned about care through a friend rather than family. This was a 20-year old woman new to care who spoke of spending time with a friend who worked in care and developing and taking an interest in the work via that avenue. And, while she was not confident that she could do the work, when she lost her cleaning job in a pub during the lockdown and

the opportunity for care work presented itself, she took it. These examples all provide insight into the ways in which the care workforce is reproduced along class, gender and even family lines (Stacey 2011).

Private life and personal biography and identity are a root of prosocial motivations. But the latter do not by any means fully encompass the range of respondents' job motivations. Alongside them are both intrinsic motivations and extrinsic motivations.

Intrinsic motivations or attachments (which may be easily confused with prosocial motivations) inhere in a sense of satisfaction in actually performing the work to a valued standard (in the case of the present research a 'professional standard'). Somewhat against the claim by England et al (2012) that motivations for care work are based on either love or money, our respondents find much in the doing of the work that is inherently rewarding for them. For example, four interview respondents mentioned the satisfaction they take from assisting with personal care, while a further four spoke of the rewards from helping to ensure residents are well-fed and have enough to drink.

> Even just the basic thing of getting someone washed and dressed who needs help… Even something like that. I'm satisfied in the small things that I do, and that definitely has helped me to enjoy my job more.

> Like yesterday for the one that passed away ... being able to get them prepared for the funeral directors and dressing them nice for their families, for them to go and visit them in the funeral home.

A further four interviewees raised the issue of end-of-life care, and the meaning they draw from the complex caring involved for another person at that stage of life. Intrinsic reward can also be obtained from observing (and feeling they have contributed to) positive change in residents' behaviour, such as adjustment to the kind of (regimented) living involved in being a care home resident or recovery from traumatic episodes. Responding appropriately to situations in which trust is placed in the worker by residents was another dimension.

A third type of motivation – extrinsic motivation which values such factors as the pay and the propinquity to home or the potential career prospects – was hugely important to these workers also, almost all of whom were on a low income. The extrinsic factors most widely mentioned by the interviewees included: how paid care work fits in with unpaid caring responsibilities; the opportunities care work provides to gain experience towards other employment; and the local (and easily obtainable) nature of care work. When the motivation lens is applied to their current job, for some the pull of their current post lay in better hours, aspects enabling better work-family life, and offering 'exact hours, a contract and then at least you know there is a job security'. The latter was valued especially by those who had previously worked in domiciliary care.

This picture of complex motivations was reproduced also in the responses to the survey, especially in replies to question of what keeps them in the job. The following table shows the respective importance attributed to different factors.

Table 3. Survey Responses to a Question on the Relative Importance of Factors Keeping Them in the Job

	Very important	Important	Neutral	Low importance	No importance
Working conditions overall	31%	44%	23%	0%	2%
Job satisfaction	45%	48%	5%	1%	1%
Pay levels	32%	43%	23%	1%	1%
Relations with residents	61%	35%	4%	0%	1%
Relations with colleagues	46%	47%	6%	1%	0%
Loyalty to residents	59%	34%	5%	2%	0%
Gaining experience towards a different career	27%	27%	29%	6%	11%
Convenience in terms of location	30%	39%	21%	6%	4%
Lack of other work options locally	11%	23%	36%	13%	17%
Familiarity	44%	32%	22%	1%	1%

Again, we see an intersection of what might be termed socio-emotional factors (loyalty to residents, relationships with residents and with colleagues) and practical/material factors (pay level, convenience of location, familiarity). Understood in a broad way, both were of a generally similar level of importance, suggesting not just complex ties to work but some moral tensions, especially in situations where workers are trying to cope with limited resources (including fellow workers).

The interview accounts help to clarify further the nature of the residents as a pull factor. First, when an open-ended question of what keeps them in their job was asked, over two-thirds of interview participants (21) spontaneously mentioned the residents as important to their remaining in their jobs. There were two aspects here: the attachments, bond or relations with residents and the appreciation or thanks they get from them. One worker spoke of how happy

the residents are to see her, and their displays of affection as something that contrasts with other types of job, remarking:

> You don't get that working in a corporate job. You don't get that back. But you do in care.

This contrast is important in terms of recognising some of the unique rewards of working in caring occupations, and again hints at the association between this work and the assumed reciprocity and other features of unpaid care work. A point made about caring as naturally remunerated through residents' gratitude seems apposite (Johnson 2015). The second factor – regarding gratitude – assumes relevance and import especially in a general context of difficult work where positive achievements are hard to identify and in the more specific context where the workers feel they are not rewarded or appreciated by their employers. There are strong echoes of Hirschman's concept of loyalty.

Ties to residents also have the effect of tying workers to their current job. Six workers explicitly mentioned thoughts about what would happen should they leave, with two framing the scenario in terms of the impact on themselves through missing the residents and cutting the ties that bind them. One respondent spoke with a strong sense of caring motivation and awareness of the importance of care continuity when expressing concern for residents in the event of her moving on:

> I think the residents is what makes me stay because I just don't want them to be put with staff that are there for a week and then leave. It's not nice is it? It is a new face, every

> day, every week, every month even so who are doing such personal things and helping you so much.

Another said:

> I think it's hard to say goodbye to a job role like care, because you say goodbye to the residents.

Beyond these points related to residents and to relationships with and felt responsibility towards them, five of the interviewees mentioned their colleagues as important to their remaining in their jobs. Again this included feelings of responsibility towards others, and the importance of getting on well with colleagues.

Employment Conditions

As outlined in section 2 above, the employment conditions in the paid care sector are generally poor and this study confirms that.

The two most commonly mentioned aspects that workers would improve if they could were pay levels and staffing (each raised by 11 interviewees). There can be no doubts about workers' dissatisfaction with levels of pay, with significant numbers indicating that the pay should be higher in light of what they have to do in the job. The workers make comparisons with other work and when they did the low wages in care work relative to what they see as other comparable sectors – e.g., work in retail – were 'a bit of a kicker'. Again the comparative worth element came up. But so too did the practical elements like working longer hours, working at short notice, working without breaks and at high risk during COVID-19.

The lack of pay increments – manifested by the wide use of minimum pay rates – also means that workers are not rewarded for extra responsibility. This also helps explain why they did not go for promotion (with only a quarter of the interviewees replying positively when asked a question of whether they have plans to go for promotion) or avail of the structured training and progression opportunities provided in-house by the large providers.

Speaking of the pay levels associated with career progression, one respondent said:

> The progression involves you working for five years or six years or seven years in other senior roles at about 20p above minimum wage, or 50p above minimum wage.

One point to note is that, while most found it easy to articulate their negative views on pay, a small few were hesitant in doing so. One interviewee, for example, broached the subject as follows:

> Right, ok, this is gonna sound totally selfish of me but I'm gonna say it. We…we are worth so much more than minimum wage.

Another respondent's hesitant enquiry as to whether she could mention pay when asked the question of what aspects of the job she would improve indicates that she felt she needed permission. These responses hint at the internalisation of normative constructs about care work not being something that is done for money and of hesitancy of workers to frame it in those terms (England 2005).

The significance of under-staffing could not be exaggerated. It manifested in such everyday work experience as less support than needed in doing the job and in managing the experiences associated with it (e.g., in coping with physical decline and death); many short-term and even last-minute changes of working conditions; long working hours; difficulty of scheduling time off and holidays.

> I'm going to tell you, you literally have to radio a staff member for a toilet break and still wait another 10, 15 minutes depending on the situation in the house before you could actually go to the toilet.

> You know, sometimes I finish a shift, I don't even know what my name is. My head's in that much of a spin because you've dealt with so much from other people that you do forget yourself.

Those with a longer career can trace an arc of change in terms of struggling now to fulfil the basic tasks of physical care in comparison to formerly when they saw themselves as being able to work on creative activities and attend to the mental and social well-being of residents.

The resulting situation is one where 'everybody gets some care but most people don't get enough care'. Time rationing leads to care time poverty, not least because the residents' time tends to be on a different clock to that of the organisation's usually very tight time metric to complete tasks that are set out in each resident's care plan'.[11] This faces the workers with a moral dilemma:

[11] Tronto (2010: 164) makes an interesting point here that commodification of care can lead to thinking of care as a scarce resource which in turn leads to a zero-sum calculation.

> I try to listen to the residents and be there emotionally for them and … sometimes I have feedback from seniors who said maybe I'm a bit slow. But that's because I take the time with people and I always complete all my tasks on time. So, I found that a bit offensive because it's all about rushing, doing stuff quickly and I don't think that makes a good care worker.

> And it's like … you can't enjoy time with your clients. You can't enjoy the activities with your clients because you're already thinking 'right, well in 15 minutes this needs to be done and in another 15 that'.

The 'care encounter' (Harrison 2021) is impoverished in other ways as well. Some of the workers had real fears, mainly for the wellbeing of the residents but also that they themselves might make a mistake. The words of one respondent evoke the fears for residents: they are rendered vulnerable she said 'by being left with a stranger who's paid £9 something an hour in a building all night that has no CCTV, no check-ins, no drop-ins'. The responses confirm the difficulties for night staff and convey a sense that the staffing constraints and time pressures were worse for them – some spoke of having responsibility for 12 residents' rooms on their own. A further consequence was that the night workers especially almost universally felt anxious because basic safety standards and procedures could not be adhered to in situations of staffing constraint and time and other pressures. One respondent described an extreme case of being forced to break the law, in that short staffing meant that only one person was available to sign off on the medication rather than the required two.

Understaffing – which seems to have become system-wide since the pandemic – also leads to staff being asked to work overtime or to come in to work at short notice. This is often on top of long shifts during unsociable hours. A number of respondents complained about frequent short-notice requests from employers (on employer-originated apps that employees are compelled to sign up to) to cover for staff shortages when on time off. One respondent said that 'the industry guilt trips you'.

Staffing is prominent in respondents' opinion on what would improve their situation. Most of the mentions of staffing related to staffing levels, and workers wanting to see higher staffing levels so as to improve their experiences of work generally, and also enhance residents' care quality. This would allow people to be 'treated with dignity' and help to reduce the difficult dilemmas around resident care faced by workers when staffing numbers are low. One respondent lamented the lack of contingency planning in her workplace for when staffing was low, and said that she and her care worker colleagues were called upon to cover non-care related, administrative tasks, which added to the pressure they felt. Some mention was also made of the need to address staffing shortages to prevent staff from 'getting ill and burning out' and of attention needing to be paid to the skillset of bank and agency staff who are brought in to cover staff shortages as at times they are unable to provide adequate support due to lack of training.

Another aspect seen to be helpful was to improve training, with five mentioning this (although one worker – with over 30 years in the sector - would like it to be cut as he felt much of the essential training was unnecessary and repetitive). A further five workers were keen to see improvements to the physical infrastructure or the supplies to meet residents' needs. There was some sense that residents deserved better food and more plentiful supplies of products such as

pads and wipes. Mention was also made of poor staff facilities and how these were emblematic of a wider lack of worth or value bestowed upon care workers. Beyond those mentioned, a number of other improvements were discussed including shorter hours for workers, greater emotional support, better management and improved benefits (including more generous breaks) (see also section 3.11 below).

Note that the lack of training was not just about difficulties in doing the job but actually depriving workers of skills. These workers were at best standing still in terms of skill and human capital development, or even being 'deskilled' (especially as other employment sectors move forward with skills training).

Raising One's Voice and Being Heard

Voice – in the sense of bringing their situation to the notice of those who have power and requesting or demanding change - is an important mechanism whereby workers can act to change their job situation and conditions. It is one of the three options suggested by Hirschman (1970). It can be an expression of workers' political agency. The official situation is that the Public Interest Disclosure Act 1998 provides statutory protection for care workers if they suffer a workplace reprisal for a raising a concern they believe to be genuine. In addition, the Care Quality Commission (CQC) provides guidance for how employees can raise issues which includes information on how to 'whistleblow', usually understood as raising matters to do with malpractice or wrong-doing.[12] Interestingly, a half of all CQC physical inspections during the COVID-19 period up to June 2020 were informed by information from whistleblowers.[13]

[12] https://www.cqc.org.uk/contact-us/report-concern/report-concern-if-you-are-member-staff
[13] https://www.cqc.org.uk/sites/default/files/CM072004_Item4_ETReportJJuly2020%20.pdf

There is no mention of 'whistleblowing' by the respondents and all the evidence suggests a very careful process around raising voice. There was some prioritisation if not hierarchicalisation among different issues that might be voiced. Essentially, the issues were seen to be of two broad types: issues to do with service quality and those to do with the well-being/welfare of staff. The former had a much higher currency than the latter. When asked if issues raised about service/care quality get acted upon, the most common response was a straightforward 'yes', with 11 interview respondents stating this to be the case. Action depended especially on the seriousness of the issue – and especially whether it is pertinent to the homes' legal obligations to protect residents' welfare. Hence, more serious issues around safeguarding were likely to be addressed, but less acute matters – likely everyday supplies – were not acted upon at times. One respondent saw a pattern of things being allowed to continue despite being raised and only to get acted upon when something bad happens or they come to a head. Note here that the workers are acting as advocates for residents (Johnson 2015). Whether action followed was also related to the matter of with whom the matter was raised. This does not necessarily go as expected in that action often follows by raising a matter with the immediate supervisor rather than, say, someone further up the hierarchy.

Seven respondents were explicit that if they raised issues about the service/care quality, they were not acted upon. One such respondent had only been in her current post for three months, but her impression was that things would not be addressed. Another, also relatively new to her job but 17 years in the sector, said she was exhausted from fighting to make things better, so much so that she was at the time of interview reluctant to or felt unable to expend the energy on working to change things (and was keeping her head down and getting on with things for now). One gets a strong sense of feelings of powerlessness:

> Nothing changes. Nothing changes. Even if you were to raise something which I have done in the past, I don't feel anything changes.

One worker revealed her strategy of combativeness about this, and said that in effect she would not take no for an answer if things she raised were not addressed:

> I nag, I nag, I nag. And I will go right to the top if I have to if I think something has to be done and it doesn't get done. I don't give up.

Compared with issues around service/care quality, action was less likely in response to issues raised about working conditions. Some saw the likelihood of action as depending on the issue involved, with some of some of the answers again based on hypotheticals or worker perceptions of what might result. Some respondents formed their responses on their experience though, with six stating that when they did raise, or had raised, issues they did not get acted upon with one offering the despairing comment that 'no one cares'. Three participants mentioned the poor state of facilities for staff – particularly staffrooms or space for staff during breaks – as being issues that have been raised and not addressed. This, allied with worker accounts of not being able to take breaks during shifts (and in any case only being allowed very short breaks – such as 20 minutes in an eight-hour shift), suggests an undervaluing of care workers regarding both the lack of priority given to their own time, and the space in which they spend it.

Of those who said issues raised about working conditions do get acted upon, this was for some dependent on the issue in question. Two workers said that issues around shift changes and suitability would be acted upon, but that pay would not. One respondent, a senior care worker and also a union representative in her workplace, recounted some success in ensuring that

workers across all levels of service would get sick pay. Notwithstanding that, she lamented the lack of possibility for change on the more fundamental pay levels, including the lack of increments for long-serving workers like herself. It seems that more day-to-day working issues – like shift and hours changes for example - are more likely to see some action. All of this suggests that these organisations are not institutions conducive to the care of the workers.

Note that workers did not withdraw their emotional labour or care orientation in situations like this - which Johnson (2015) also found this in her study of a private residential home in England.

In response to a question about impediments to voice, a slight majority of respondents said there were things that put them off raising issues. For eight of these it was the futility of it that deterred, they felt their views would not be listened to. One strategy to be heard was to use intermediate channels: for example, in one workplace an interviewee explained that they inform the nurses of any issues wanting them to pass on the information to management because 'the nurses tend to get listened to more than us'. Again, as well as indicating a relatively lowly place in the hierarchy, this hints at lack of voice or relative powerlessness for care workers. Another worker who questioned the point of raising issues brought up hierarchy when arguing that those higher up in organisations did not care about the day-to-day workings of care settings, and so, if she speaks to her manager about things and they are passed higher up the chain, the chances of things getting done diminish. This was again a matter of respondents' relatively negative feelings about the employing organisations.

Four other workers who said that there were things that put them off specifically referred to negative consequences in the event that they did speak out. Two of these feared that they would be treated differently as a result, and one said - matter-of-factly - that the prospect of losing her

job put her off raising matters. For another respondent the off-putting factor was her lack of trust in the management, including managements' perceived lack of discretion and the lack of understanding that had been shown her when she raised a personal issue in the past. Two participants said that whether they are put off or not depends on the issue in question.

For 10 respondents there was nothing that would put them off reporting issues. Two of these were senior staff. One interviewee said that 'it should put me off, but it doesn't'. Her reasoning evidenced what might be regarded as her own value system in her persistence in raising things that she considers need to be raised and pursuing them even when – as has happened in the past – she is disciplined as a result. A further two of the 10 respondents in this grouping displayed an almost nihilistic attitude by stating that they did not care if they were sacked as a result of speaking out.

The evidence suggests that workers do not enlist 'outside' help in that there was no case of their raising matters with a trade union for example or with a care workers' association. Only about a quarter of the interviewees were members of trade unions and only a fraction of these were active. One respondent was associated with a care workers' organisation. Among the barriers to trade union membership mentioned were the costs of affiliation but also the cultural distance and lack of information on what trade unions either do in general or might do for them. The main option they saw themselves as having was to leave the job and/or the sector (to be discussed further in section 3.7 below).

Overall, it appears that the majority of respondents would be prepared to speak up but there was some hierarchy involved here in that they were more prepared to speak up on issues to do with client safety or quality of service than about their own well-being or working conditions or

those of their colleagues. It also seems to be the case that the former issues are more likely to be acted on by management than are those relating to staff welfare.

Care Work as Embedded in Workers' Biographies and Expectations

Participants commonly discussed their prosocial or caring motivations in response to a question on what drew them to adult social care work in the first place, with over a third doing so. Caring as an activity and value can be naturalised, part of who they are:

> I've always had a sort of caring nature.

> It [care work] suits me in my personality and what I can give.

This naturalisation, and disposition to care, was not universal, however; nor did it necessarily lead them directly to care home work (in the sense of actively searching after work that fits with their values). For a significant subsection of respondents – at least a third – it had been a personal connection or experience of unpaid care that sparked their interest and engendered confidence regarding care work. Such influences stemmed from people in their lives having connections to care in some way with family or personal experience of caring dominating.

Three participants' mothers had worked in care; in another case a sister did so; and another respondent adverted to family members having worked in the broader health and social care sector as doctors and nurses. The following shows some elements of the process or thinking involved:

> It runs in the family. My mum has always worked in care. It's just one of those things, you know, it just… I did health and social care at college and then after doing that, I was just, 'Yes, well I may as well go into working in care'.

The inevitability of this trajectory endured: this 31-year-old female had worked in care continuously since she was 18. For another her mother actively encouraged her to take up care work saying how it would benefit her, and still another gained motivation from the admiration she felt for her mother 'making a difference' to people's lives during hard times.

Five participants referred to family members needing or receiving care as influencing them in taking up care work. They had observed different aspects of care and felt they too wanted to help, or thought it was something they could do as a means of employment. One, a 28-year old woman who had been in care work for around a year, had been motivated by the experience of living through her grandfather's dementia diagnosis and eventual death:

> It was the watching the man that I'd knew for nearly twenty-five years become someone completely different. But it also it sounds a bit strange to say it but like, it fascinated me as well, because it's so… it's like so strange to watch it happen. But I … basically it was wanting to help people really, and if I could, you know, ease someone's distress or make them a bit happier while I could do. That's what kind of drew me.

This quote makes clear that it can be a combination or set of factors that leads to care work. There is sometimes a conjuncture of factors. Two respondents had previous connections to care or interest in it, but got into it at a time when they were unemployed, and in the case of one, 'struggling' to get work.

> I needed a job, I knew from all them previous conversations [with my friend who is in care] that it's something I could do …

A further four participants mentioned their own direct involvement in providing unpaid care to family members as important in their becoming paid care workers. Again care for a grandparent was the root experience here although one participant had additionally cared for her ex-husband for 14 years. Her words about her grandmother convey the motivations involved:

> You go and do something that …you know you're gonna be good at and you know you're gonna enjoy it … cos I loved that period of my life while I was looking after my grandmother, I really did enjoy it.

It is interesting to observe an undertow of confidence here – personal experience of or exposure to care can both give confidence around the capacity to do the work and also instil a sense of its value and meaning. Some of this should be set in a context of lack of choice or other options for the workers involved, many of whom either have little work experience or few marketable skills. Another influential factor is the gender construction of care as women's work and the ways in which both paid and unpaid care work continue to be overwhelmingly the domain of working-class women.

It might be expected that workers with some previous experience, motivation or interest would be more likely to thrive in care work, or at least remain in it for a longer period of time than those with no obvious prior involvement. The study evidence does not necessarily support this and indeed provides examples of those without any prior experience or connection to care work

relishing it once they started and growing into it. One such respondent (with five years' service) remained in care work as she enjoyed it so much, and another – who had worked in the sector for six years – 'became emotionally invested', and this contributed to sustaining her and motivating her to continue. For both these workers, the local convenience of care work was key to their taking it up. This was also the case for a further respondent who, although he had no prior experience, walked into a local care looking for work on one occasion when he was unemployed (and had been for a number of years). He was still employed in the sector 34 years later.

When asked about what they hoped to get out of care work, responses largely fell into three sets: hopes around helping people, hopes around career and progression, and hopes that were not specifically tied to care work. In the first grouping, the desire to help people was mentioned by about a third of participants (9), sometimes framed in terms of 'making a difference' to the lives of people receiving care. For most of these workers, the feelings element of helping people in the course of care work was prominent. The preconception that care work allows or enables workers to find satisfaction or fulfilment is undoubtedly an important element. The second, slightly smaller grouping (7 participants), spoke of hopes they held of building a career in care work, or of progressing in it. Two particular respondents mentioned the security and durability of care work – despite its association with poor conditions and precarious work – as a draw and something they hoped to gain, with one arguing that 'it's a very secure career to have… we'll always need care workers'. Making up a somewhat different sub-group, three participants spoke of their generic hopes when starting out in care work in the sense of gaining employment and a wage.

A question on whether the reality of care work matches the initial expectations yielded two robust findings. The first is that for the majority of respondents the reality is different to that imagined or desired, and the second is that real-life experience is more negative (considerably so in many cases).

In regard to the first, the main substance of the responses related to respondents' expectations – which as outlined already were dominated by interpersonal and relational orientations - that were generally seen not to be fulfilled. In a few cases people queried whether they had come into the job or sector with expectations that were too high or ambitious but, more widely, the sense was that it is the job and the work rather than expectations or commitments that are the source of any mismatch.

> The thought of having a career in care for the rest of my life, I could literally cry now. I could not do that. I look at women that I work with that are 60-years-old plus. There's a lady, last night, she's 62 and I could not do it. I could not do it.

In regard to the nature of the mismatch, the root is not so much a feeling of intrinsic disappointment but rather of what might be called 'externally generated' pressure caused by staffing and resource shortages which make the work less satisfying or rewarding. This is an overwhelming finding. Workers' strong orientation towards the residents remained for many or had not in itself dimmed. Workers did not withdraw their caring orientation but saw it as an entity for the residents rather than the employer. However even the prosocial motivation was quite diminished by poor job conditions, especially staffing and resource constraints. Some people took the poor conditions personally, interpreting it as lack of value and/or respect for them.

Is what we are seeing a process of disillusionment? In some narratives there was a sense of people feeling they were waking up to the real world but also an almost inevitable diminution of passion that comes with time in a job. One interpretation was of a sense of commitment being eroded over time, almost inevitably. One person put it as follows: 'there is a shelf life to care …There's only so much emotion that they can drain from you and there's only so much care that you've got in yourself'. The 'they' references here refer to employers. This is of particular significance in a sector like care work which relies so much on personal commitment and a caring orientation from the workers.

Poor conditions lead to a situation where people reduce their aspirations for their work situation from: 'Did I spend enough time with that resident?' to 'Did I get the basic work done?' A consequence in its extreme form is where: 'people become a nuisance'. One interviewee summed it up in the following terms:

> For every reward, one reward, there's nine times where you feel rushed, and you feel you haven't done a good job, or you haven't done everything you've wanted to do.

In order to deepen understanding of attitude and motivation progression over time, a specific question was asked about whether their motivations had changed. Answers here were more evenly divided between affirmative and negative replies. Those who said their motivation had remained the same or similar drew attention to how they still wanted to offer care and do the best they can. For a small few the motivation had got stronger and their caring orientation had been strengthened by the 'hard' experience of being at the social care coalface with a greater appreciation developing over time of the responsibility involved in 'looking after someone's

mum or dad' or indeed the responsibility of being someone's family substitute. Interestingly though, as respondents started to consider the question in more detail their initial answers seemed to undergo a change, especially among those who had initially said their motivations remained unchanged. When they reflected, there was a sense that initial passion and enthusiasm had dimmed over time, that they had drawn or reined in their passion by, for example, concentrating on their relationship with a few residents or being careful about engaging with difficult job-related issues. This 'self protection' was sometimes occasioned by what they saw happening around them and sometimes due to their own getting older. As one respondent put it: 'I suppose my motivation is still there but it has dwindled a bit over the years with the situations that I have come into contact with'.

Those who were explicit about motivational changes spoke of being ground down by resource shortages – 'having to fight against the bureaucracy of time and money', 'putting out fires' and how underappreciated they are by the company, being given 'monkey nuts for what we do'. The latter respondent said the care industry demands that you keep trying and noted how care workers have to go above and beyond to be celebrated but the industry does not give anything back.

But there was a different register here too – people who retained some of the original motivation (principally expressed as wanting to provide care) but said that this motivation was now the only thing keeping them in the job, whereas previously they would have had several motivations (such as wanting a career in the field for example or in care management). Such aspirations seem to have fallen away when they saw how the care home was run and recognised weaknesses in the care sector as a whole. There was only one counter case of someone who had realised that they wanted to progress in the industry to become a senior carer.

When asked a specific question, the vast majority of interviewees confirmed in their replies that their opinions of care work had changed, although a few were ambivalent ('yes and no') and another few said it had not changed.

A widespread sense here was of scales falling from the eyes. Echoing responses to the last question, one can almost sense workers realising and experiencing how much work is actually involved and how physically and emotionally demanding care work is. Dementia care was frequently used as an example here – the difficulty of getting such patients 'settled' for the day or night for example. But mentioned also was the actual and potential physical harm that workers are subjected to (one mentions 'getting the odd thump' when on the dementia unit but another speaks of being violently hit, slapped, kicked, bit on a daily basis). Caring for patients with (varying degrees of) dementia underlines the degree of responsibility involved. This dovetailed with a voiced realisation of the job as involving emotional support for residents (and colleagues) as well as physical tasks.

In general, personal experiences and biography featured heavily in people's replies to this question. Lack of reward (as in a relatively flat pay scale and few if any promotion channels) was quite widely referred to. One interviewee gave the example of being offered 50p an hour extra for a more senior position (which, unlike the more junior positions does not include a paid break, and so was calculated by the respondent to mean in practice less money per hour for more responsibility). Over time workers come to be aware of the stress of the job and they look at their initial assumptions with questioning eyes. One respondent – who chose care as a profession having seen and admired her mother and grandmother as care assistants – reflected that they too must have been constantly stressed and how she had never noticed that. In some

cases a change in opinion of care work was a strategic orientation - one described how one has to learn to say 'I'm ok … no I can't do that' in response to requests to work, although this (experienced) care assistant also recognised that this can occasion feelings of guilt and even of employers 'guilt tripping you'.

Two other nuances in the replies here merit mention. The first is of (employer) promises unkept (as regards being transitioned to another rotation if it gets too much, for example, or briefing and debriefing in the case of traumatic or emotionally demanding experiences). There were some (romantic) references here to a past where local authority-run homes were more widespread and the pay and conditions better. There was a relatively ready critique made of the perceived domination of the profit motive in privately-owned care homes – 'they tend to be more about profit than they do about caring'. This can be quite a profound critique – for those who saw their job in terms of providing care and well-being in a system that is seen to work against that made for some sense of anomie. A second current in the replies here was of the realisation of how care work is viewed more widely, in particular the fact that it is not universally respected and little understood (to be covered in section 3.9 below). This is another form of lack of recognition also (in addition to meagre material reward). So one finds two intersecting trends here: the realisation of the difficulty of the work and the realisation that they are not considered or rewarded as skilled workers.

Staying and Leaving: Future Plans

Existing evidence demonstrates the 'churn' within care work with workers moving horizontally between posts throughout their time in the sector, and a majority of new starters being people with previous experience in care work (Skills for Care 2020a: 59). The evidence from the

present study conjures up the care home (as environment, job and work) as a magnetic field, with push and pull factors operating.

While respondents voiced a very strong set of attachments to their job centring upon the work and relationships with residents, this did not stop them from thinking of leaving or planning to do so. When asked explicitly, only nine interviewees were definite about staying in their job. The remainder had thought about exiting (and seemingly talked about it also), although only a minority of respondents had decided exit intentions. Exit then seems to be carefully chosen, although it was frequently seen as an option. The most common response was for people to say they were thinking about exit within a time line and planned to review their situation within a few months or years. It seemed as if there was a tipping point, comprising either a particular timeframe they were giving themselves to decide, and/or a criteria set or event to be reached or met that would precipitate a change. The respondents were notably in assessment mode, which must be a source of (ontological) insecurity for them. For some the plan was to complete or continue with their current education process for example (in the case of 7 interviewees) and then leave. But for others assessment meant weighing up the pros and cons of leaving. The cons would almost always include the residents and their welfare as well as the familiarity of the job whereas the pros centred upon their sense of dissatisfaction with the pay and conditions on the one hand and their worries about the impact of the work on their own health and welfare.

Ambivalence and mixed feelings about the work and the job were commonplace. This was a robust finding from both the survey and the interviews.

The answers to a question on what are the first things that come to mind when they think about their jobs revealed real ambivalence: ‘hard work, rewarding, stressful’; ‘rewarding but it is

tiring and quite emotional at times'; 'well I enjoy working, I love the residents and I like helping people but it is not easy you know'. This tends to confirm one of Stacey's (2005) conclusions from her study of domiciliary care workers in the US: that paid care workers have a conflicted, often contradictory, relationship to their labour and are forced to wrestle with conflicting norms and values. Stacey (2005) also suggested that care workers' everyday work lives are likely to be characterised by elements of cognitive dissonance and/contradictory feelings/experiences. The finding of ambivalence also jells with the love *and* money (emphasis in the original) perspective identified by England (2005) which argues against an oppositional dichotomy between the realms of relationality and self-interested economic action.

When asked how they felt about their future in adult social care work more broadly, just over half of interviewees indicated that they planned to stay in the sector, at least in the medium term. And about a quarter were explicit about their plan to stop working in adult social care completely; the remaining quarter were less clear. The 'remainers' grouping included some who indicated their hope to progress or gain promotion within care work, and others who hoped to continue working in the sector but in a more specific role, such as occupational therapy or counselling. Three of those planning to stay were older workers nearing retirement (two of the three aged over 55). Three participants in this grouping stated that, while they plan to remain in adult social care work, they intended to move on from their current job.

The factors influencing thoughts, feelings and plans around whether to leave or stay in adult social care work (and jobs) varied, but there were some discernible patterns. For those who planned to stay in care work, some stated that they were happy in their role and happy to continue doing the work. One, for example, said that she had considered leaving a few months ago, but that her employer had listened to her concerns and changed her shift pattern to improve

her work-life balance particularly around caring for her children. A 19-year-old was very keen to stay for as long as possible, but had concerns about the levels of pay and rising cost of living. Some may stay but not in care home work particularly. One respondent, for example, hoped to progress to working as an occupational therapist. She wanted a better work/life balance and a better salary, and her attachment was to the work and supporting the elderly and people with disabilities rather than her employer or social care itself (she was attracted by better conditions in the NHS). Of the three participants intending to stay until they retire, one merely stated that he could not wait to reach that point; another said she was keen to work until then partly to keep her mind and body active; and the third hoped she would be able to work until her retirement but voiced concerns about the cumulative toll on her body due to the physical nature of her work.

Of the participants who intended to leave care work, some were motivated by better pay and conditions elsewhere, with one mentioning being able to work less and have more time with his family should she move. Two of the younger care workers, one in her early twenties and another in her early thirties, with three and five years of care work experience respectively, were keen to leave as soon as possible. For the latter, there was an urgency and lamentation in her desire to leave:

> It’s really sad to say but I can’t wait to be out. I can’t wait. As soon as I can put my notice in, I don’t want to be in care anymore.

> I'm not as happy as I used to be in my job anymore … It's just, I don't think care works for me anymore.

One of the reasons the latter respondent planned to leave was the lack of progression, particularly within her place of work, but for her there was also a general sense of the work being repetitive and not offering new challenges.

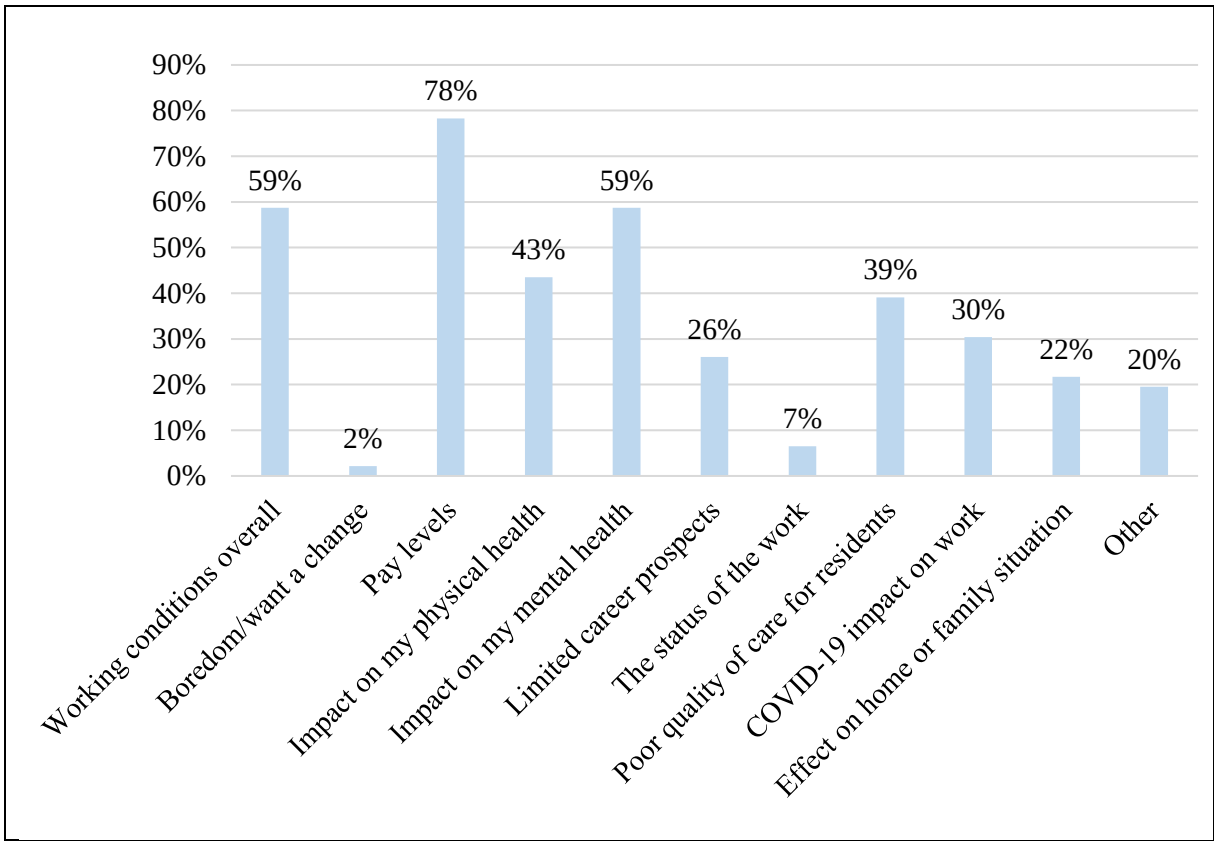
Two of the other participants who were pessimistic about their future in care work were longer-serving workers: one is 34 years old and had been in care work since she was 17, and the second was 38 years old at the time of interview and had close to 16 years' experience. For both there was a sense of the work taking its toll on different aspects of their work and non-work lives over time, and of despondency with the direction of care work and the way that it has impacted their lives. Both mentioned barriers to progression, with one previously having been a manager but not wanting to return to that level because of the stress and her disillusionment with the 'care industry' and the way it is run. For the other there was no obvious progression from her senior role within her area of interest.

The intensity of the work is very draining. Some of the narratives conveyed a sense of constantly dealing with crisis in people's lives, moving from one crisis to another, and the impact on respondents' non-work life, such as the inability to get a proper holiday over a period of time and the effect this and the work generally has on relationships outside of work. There was a strong sense of pessimism about the care home situation, getting worse rather than better.

The evidence confirms that a majority of workers had thought about leaving their job. In the online survey, three-quarters of respondents said they had considered leaving their current job and only a quarter felt positively about their future in their current job. Negative feelings about the future of care home work more broadly were also widespread (nearly 60% were negative or very negative about it). Three factors most affect considerations around leaving for the

survey respondents: pay (by far the most important), working conditions generally and effect on mental (and less so physical) health (see Table 4). Other factors mentioned (in an open-ended question) that might prompt exit were poor quality of care for residents, the lack of career prospects, the impact of COVID-19 and the effect on home or family situation.

Table 4. Survey Responses to a Question on What Have Been the Most Important Issues When You Have Considered Leaving your Current Job? (N=46)



This sense of depletion and of the need for some 'care for self' was made much worse by COVID-19. The mental health effects of the pandemic on workers emerged from the survey as one of the single most important effect (see below).

Only a minority (a quarter) of interview respondents had plans to go for promotion or to work in a different care job (or setting). Some did have other plans though. One respondent for

example hoped to set up and run her own care service in the future and so aimed to acquire as much experience as possible. Additionally, at the time of interview, another respondent was about to move to work in a different care service where she was due to start in a senior role (but did not want to go any further and take on the 'hassle of management'), and yet another was being trained for a more senior role within her workplace. One other participant expressed interest in going for promotion, but said she would need to overcome the barrier of her own anxiety before she felt able to do that. When people were reluctant to go for promotion it was most commonly because the rewards (especially pay levels) do not match the level of responsibility and stress involved.

> It's too stressful. There's too much pressure. There's too much responsibility. There's too much expected of you for very little pay and very little support and recognition.

A second barrier mentioned was they might be in the firing line for poor treatment by employers. One long-serving worker said he had been offered promotion on numerous occasions, but that it was 'not worth it', citing extra training and unspecified responsibility for scant extra reward.

It is clear that workers frequently thought about leaving their current job, with only two exceptions. In terms of factors prompting thoughts of leaving, the pandemic dominated. Of the five workers who mentioned this, two spoke of their fears of taking the virus home to family members. For two others, it was the procedures for COVID-19 that were at issue, involving extra work for example, or in one case an employer not adhering to the guidelines and acting in a way that she deemed to be unsafe.

More enduring complaints also emerged here. Four workers gave pay as a reason they were thinking of leaving with one saying that when she was doing 24 hours a week the financial gain (and her household had her partner's income as well as income from Universal Credit) was so minimal as to make her think it was barely worthwhile. Another four workers blamed treatment from management or their employers, with examples including lack of communication, negative comments from management and lack of support (including around sickness absences). Sometimes there was a cumulation of factors:

> There were lots of other reasons why I wanted to leave, like the lack of support being another one. Only having one supervision in a year, I don't think's good enough. We're not debriefed after a resident has died. Sometimes you just find out because their room's empty, for example. I don't think that's … that's not good.

This quote again highlights the gravity of situations that care workers are faced with, and which they were increasingly faced with during the height of the pandemic in 2020, and underlines the importance of proper support for staff on a human level, but also because of the way it discourages people from working in care.

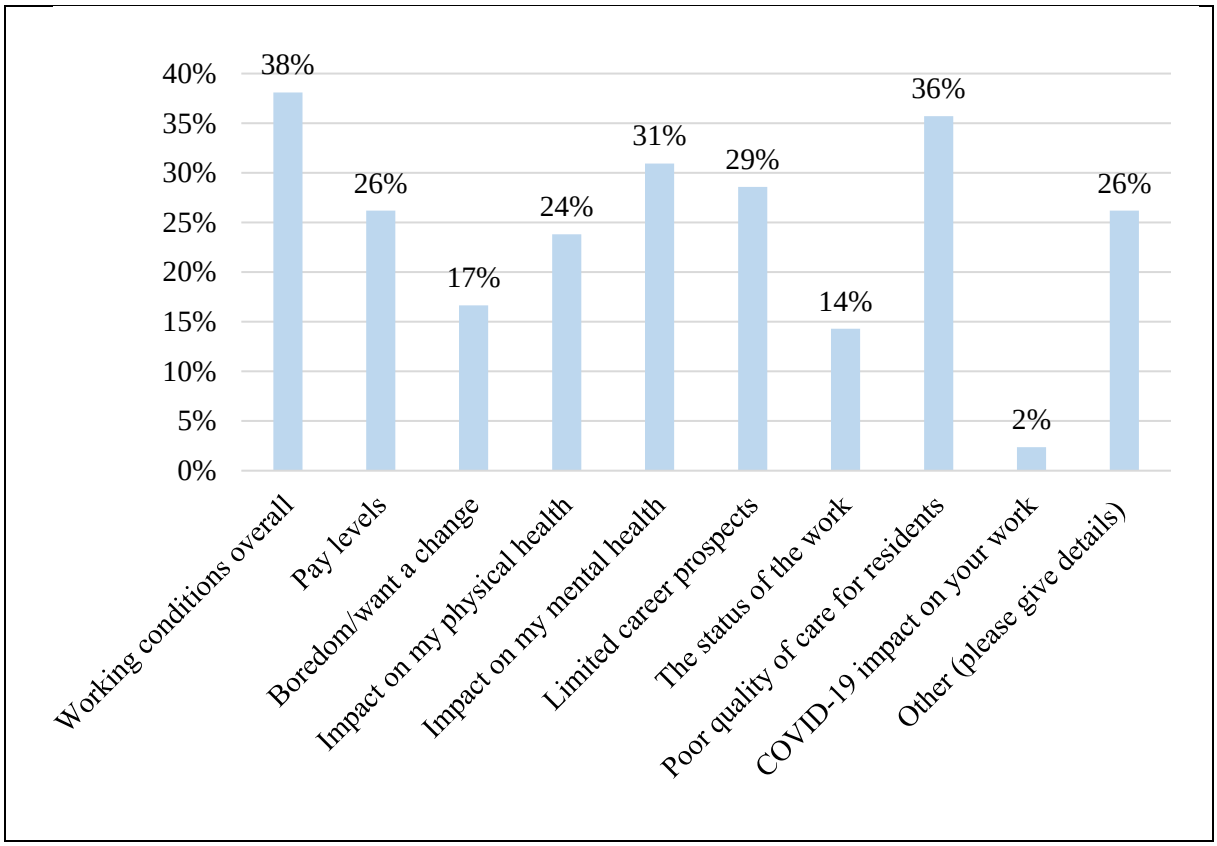
Do they actually move jobs? To answer this question, it is helpful to look at their work histories (gathered through a set of interview questions around their career in care work).

Twenty-two out of 29 interviewees had had more than one job in adult social care. Of the 7 who had had no job other than the present one, two and a half-years was the longest any of them had been in the job. This as well as other evidence suggests that people stay on average around two

years in the care assistant job. Between them the 29 respondents had held over 80 jobs in the sector.

Table 5 shows the relative importance of different reasons for leaving previous jobs given by the respondents to the survey.

Table 5. Survey Responses to a Question on the Reasons People Left Their Previous Adult Social Care Jobs? (N=42)



Comparing Tables 4 and 5 shows that the hierarchy of priorities regarding thoughts of leaving the current job is generally reflected in previous care home job exits, apart from two factors. First, pay was less prominent as a reason for changing in the past. This might reflect the greater availability of better-paying work today (especially during recovery from the pandemic) and recent labour market demands in the service sector which further confirmed care work as relatively low paid. Second, the quality of care for residents is higher on the list of reasons for

having left a previous job (as against a consideration for thinking about leaving the current one), underlining this as a value commitment among care workers. The evidence from other questions emphasises the importance of other work as more attractive and of family/personal circumstances as of continuing influence on why care workers might leave their jobs.

The interview evidence gives more detail, especially on issues to do with the quality of care for residents which was the most common reason for interviewees leaving previous care jobs. The bundle of relevant factors mentioned here can be grouped around issues with management or the way services are run (services in a wide sense, including both the treatment and conditions for staff and for residents). Six workers cited such reasons, and these included general comments about workplaces being poorly run, lack of support from management or poor treatment, particularly of workers. Examples of poor management included workers saying that the organisation of time was so bad that they were forced to work excessive hours and eventually to leave the post. Another notable pattern in the responses was safeguarding issues being such a source of concern and contention that they can lead to workers leaving posts. Four respondents said they had left previous care jobs after reporting safeguarding issues, with their departure being fuelled by either their dissatisfaction with the way their employer responded or of them being pushed out by employers following making such interventions. The reported responses from management suggest a lack of care shown towards workers and care home residents alike.

In addition to the above, other reported examples of lack of support from employers include unreasonable responses to events in workers' personal lives. Three such instances were given, and again could be bracketed under examples of lack of support for workers or poor working conditions. They are also important in the context of the notion of reciprocity (or lack of it

between worker and employer). One 34-year old woman with 8 years of experience in the care sector had left a previous care job due to her employer's response when she fell ill during her pregnancy. Prior to her returning to work, her employer informed her that she would not be coming back in a senior role as planned and for which she had prepared. She challenged this and her employer apologised, but the episode had put her off the organisation and so she left. Another respondent, a senior care worker with 18 year in the sector, had resigned from a previous job due to a lack of support when she told them she would not be working for a while as she would be caring for her terminally-ill grandmother. The third respondent had left a previous role when she was told that she could not take 'holidays' – the reasoning being that someone else was on holiday – when her brother died, including time to attend his funeral. All three of these examples convey a lack of 'care' for care workers, which is all the more stark in a sector in which care is so constitutive. Two other workers cited the working environment or culture in previous jobs as being factors in their departures from them.

Effects of the COVID-19 Pandemic

The evidence from the online survey makes it very clear that COVID-19, which as investigated mainly refers to the years of onset and recurrent infection (2020 and 2021), is seen to have exacerbated the conditions in the job and the sector. Among the most severe effects identified were on workloads, morale levels, workers' physical but especially mental health, and on-the job support. Notably, relations with colleagues and residents were much less likely than the above factors to have been negatively (or positively) affected by COVID-19. About a fifth of respondents actually thought that their relations with residents had improved during the pandemic. When asked about how COVID-19 might affect them staying in their job, 52% of survey respondents said it made them more likely to leave, 34% said it did not change their orientation and about 14% said it made them more likely to stay.

The pandemic featured throughout the interviews also. As with the survey respondents, it was front and centre as a factor that was seen to have changed the jobs of interviewees, with a majority seeing it as highly influential. Among the factors mentioned were exhaustion/burnout in terms of the degree of effort involved, the relative isolation of working under lockdown and the general lack of follow-up or recognition in terms of an improvement in conditions. The matter of the mandatory vaccine decree for the sector which came into effect in November 2021 was also the subject of comment, with the more negative workers questioning whether this spells recognition of punishment. Broader sectoral pressures were also alluded to, and indeed the broader context was depicted by some to be one of declining volume and quality of supportive health and other services and a greater 'individualisation' of provision (interpreted as lack of community services and support). One respondent concluded that the system does not work. More generally though, the pandemic loomed large in people's analysis of their current situation.

Comments were not all framed negatively though. Some valued a perceived strengthening of the familial bonds with residents. This was contextualised in terms of residents having reduced contact with those outside of the home during the period of lockdown (from March 2020 to July 2020 and then intermittently to mid to late 2021), including their own families, and thereby a deepening reliance on those paid to care for them (to which most respondents seem to have responded). The survey respondents also mentioned some tendency for relations with residents and colleagues to have improved during the COVID-19 period. Again, this can act as a motivation to workers, the evidence showing a sense of the pandemic acting to renew and deepen (some) workers' commitment to those for whom they care. Indeed in a few cases, the

pandemic had spurred respondents into care work or to return to it. However, the negative factors and experiences overshadowed this.

In response to a specific question on whether the pandemic had changed their thoughts about care work, the interview population divided between those answering yes (the majority) and no (about a third). People understood the question and the pandemic in different ways though. An over-arching interpretation was of how the pandemic affected the care home; a second framing was of how the company/provider behaved and responded and; thirdly, people recounted their own personal experience of COVID-19 (and living with the fear of catching it and of passing it on to residents).

In the first vein, interview respondents experienced professional traumas. One told of losing 15 residents in the first wave of the pandemic, leaving one corridor of the home more or less empty; others cited even higher numbers of losses (16 or even 17 residents lost).

> Every single day that you went in, someone was ill, or someone was dying or there was an ambulance ... it's just constant grieving - for those people whom you have known and cared for 2 or 3 years.

Becoming relatively desensitised to death was mentioned as a consequence of the high mortality rate in care homes by one respondent – the result being for her that she had to act more 'technically' as compared with more personal engagement in the past. Among other consequences mentioned were mental health issues (on the part of residents but also staff). There was also sense in which the pandemic forced people to act up to the responsibility of

caring for people who were not only vulnerable but were without family or other supports in a period of great fear.

In regard to how the company or care home responded, one respondent voiced a sense of being 'left on our own'. In general, criticism was specifically directed at the managers and the 'higher ups' in the company rather than colleagues. Reference was made not just to lack of equipment but to lacking physical presence of managers. The staff vacancies associated with COVID-19 were also discussed and the added work (but also protection) associated with new rules and regulations was mentioned by a few respondents. The latter was not a uniformly negative observation, however.

When it came to their own experiences of COVID-19, those who focused on this conveyed a real fear of passing COVID-19 on to the residents (rather than self-care for example) and stressed the pains they took to return as soon as possible to the care home. There was a felt responsibility to be present.

> I went there every day because, you know, these grandparents, these residents, apart from being taken away from their houses and from their families, now they have been totally disconnected. They are not able at their age to have a video conversation ... technology is too much for them. And they needed support. No one else came. They were locked in the house. No visitor, no going out.

Opinions on Core Qualities of (Good) Care Workers

When asked for their opinions on what makes a good care worker, over half (19 interviews) spoke of the importance of care. There were two main emphases here: being caring (as part of

a person's nature or disposition), caring as an action or activity (something a person does ('you have to care') and something one has to be willing to do. Seven participants' answers included points within the first category, and six answered in the second vein.

In the first set of replies, comments included variations on the notion that caring has to be part of or something within a person's nature or character, with the following view as exemplary of this:

> I don't think it's something that you can be taught to do. I think it has to be in you.

The replies here should be seen in the context of normative expectations of how care workers should care.

One interviewee spoke of the importance of willingness to care in order to be a good care worker. Her reasoning was as follows:

> Do you know what? You've got to want to care. You've got to want to get someone clean. You've got to want to do nice things for someone. It's pointless if you don't want to do any of that because they will tell, they will pick up on it. You've got to want to help someone and want to make their life better. Want to make their life easier. Want to stop them crying or resolve their issues or help them. You've got to want to. You've got to want to care.

This interviewee too raised the idea that being a care worker is more than a job. Three others voiced such sentiments, which again highlights the question of boundaries between the work of

care and workers' non-work lives. One respondent gave the example of 9-5 workers who do a shift and then go home and switch off and forget about their work, and argued that this type of 'mindset' was not conducive to being a good care worker.

Over a third of interviewees (10) mentioned that good care workers have to prioritise others, usually explicitly identified as residents, and this included points about being (other or) person-centred and some about being selfless. The idea of person-centredness or of prioritising the residents was encapsulated by a quote from one person who argued that an important aspect of being a good care worker is:

> Treating people how they want to be treated, not just how you think they should be treated.

The idea of being other- or person-centred raises questions around the role of the self. Very few workers discussed self-care, and when they talked about looking after themselves it was framed in an individualistic way as their own responsibility. In fact, only one respondent's reply, a Senior Care Worker, could be explicitly classed as referring to self-care, and this is very much in the vein of it being the responsibility of care workers to look after themselves:

> You have to be able to look after yourself as well. A lot of carers I see burning themselves out. And like, you can't look after other people unless you look after yourself.

The quality of resilience is implied here. For example, one interviewee commented that good care workers need to be physically and mentally fit, and able to cope with rudeness, insults and

physical and verbal aggression from residents. Three other participants also named resilience as something that good care workers need to have.

Of other qualities that make care workers good at what they do – some of which could also be classed as skills – patience was the most frequently mentioned (13 respondents). Nine mentioned empathy, and five brought up compassion. Of the responses relating more clearly to skills, six participants mentioned organisation or time management skills, and five mentioned team working skills. Others less frequently raised included listening skills and advocacy skills.

When asked if care work requires particular characteristics, almost everyone replied in the affirmative. Most commonly mentioned were skills involved in the use of equipment or manual handling. Organisation and time management skills featured also. Another set of answers bracketed together interpersonal skills such as listening, observation, communication and emotional skills. One migrant worker lamented the fact that care work is classed as unskilled in England and linked this to the undervaluing of care workers. She gave the example of doing care plans on a daily basis as something that requires considerable skill (and also highlighted the other administrative (and skilled) work involved). Three workers touched on the importance of training in care work, and one highlighted the importance of having an ability to learn.

The main type of specialist knowledge referred to was medical knowledge, including of conditions such as diabetes and dementia and some other complex conditions and end-of-life care. In some senses this might reflect growing complexity as people's needs have become more complex and nursing tasks previously delivered in hospital or under NHS oversight are now delivered by care homes and in other care settings. Hence, the interpretation and meeting of high-level need calls for greater knowledge and skill deployment in the care home setting.

One specifically connected this to part of the process involved in assisting residents with taking their medication. A range of personal characteristics were mentioned, including the capacity for compassion, empathy or understanding, hard work and dedication, physical fitness, and, less often, endurance and/or resilience.

When asked whether care work calls on particular values, there was near unanimity that it does, with the only participant answering in the negative here proceeding to discuss how care workers are not valued, which is a different matter. Respondents knew what these values were and could readily talk about them. There was some crossover here with responses to questions about the personal characteristics involved in care work, with honesty, for example, regarded as both a value and a personal characteristic. One of the more common responses was that in care work the necessary values are everyday, normal, decent or human values, and no different to those called upon in everyday life. Two people even called them 'family' values, in one case likening them to mothering.

Although not a straightforward distinction, other responses can be broadly categorised as values that relate to what care workers do, and how they do it. Of the former, participants raised 'encouraging', 'doing one's best', 'listening and observing' (as action that are value-driven or related). Working in an empathetic, understanding or compassionate way was mentioned by four workers, and the values of honesty and patience were each mentioned by three participants. Working with integrity or respect were mentioned twice each, with an additional participant specifically mentioning respect for colleagues (when a broad assumption would be that such values would primarily be directed towards residents). Values mentioned that are less commonly connected with care work include courage, sacrifice of self (part of broader values this participant defined as 'love') and open-mindedness. In regard to open-mindedness the

participant who mentioned it argued that it was not just about acceptance, but also the willingness to support a range of people with diverse values and orientations.

When asked a question on whether care assistant is a job anyone can do, there was a resounding negative response, suggesting that care workers do not think their work can be done by everyone, with over two-thirds (20 participants) answering in the negative. Of the six who were of the view that anyone can do the job, all but one qualified their answer in some way (and even the one who firmly said anyone can do it spoke of people with certain qualities who are or would not be good care workers).

The qualifications within the answers of those who said that anyone could do the job reveal an important distinction made by interviewees between, on the one hand, getting into care work and doing it, and on the other, doing it properly or well, managing the job and staying in it for a period of time. One respondent's affirmative answer exemplifies this type of construction:

> Anybody can do it but doing it properly is a different thing.

Although the question was framed as a binary, some of the replies connote possibility and conditionality. Respondents made a distinction between theory and practice – saying that while perhaps anyone could do it in theory, in practice many could not deal with the nature and demands of the job.

> So, can anyone do it? Not well. Could anyone do it? Yes.

Of the significant majority who said that care work is not a job that anyone can do, some too made similar differentiations between getting into the job or the sector and doing it and doing it well. Here participants placed great emphasis on the way in which workers do their jobs. This distinction was clearly articulated by one respondent:

> I think this is what I mean, is that anybody can technically go into a job and get paid minimum wage and, you know, wipe a few bums and I just sort of think, anyone can wipe a bum and put someone to bed. But can you do that in a way that makes that person feel seen? And respected. And valued. That is the question that I would want to ask. Not can you do it.

This split is central to the ongoing issues in care work regarding the labour shortage and workforce sustainability, and the challenges of improving the situation with care worker numbers while also ensuring that those recruited are people who can do the job in a particular way, at least in time.

One of the other responses to this question from a participant who argued that not everyone can do care work is of relevance here. The notion of whether someone 'can' do the job is not straightforward as an important element is whether or not the person stays in the job (with the reasons for not staying myriad). Rather than not being caring enough, one respondent reasoned that some people care too much and therefore struggle to cope with situations around serious illness and death.

The ability to mentally and emotionally cope with care work was mentioned as a prerequisite by six of interviewees who were of the opinion that not everybody could do the work. As with

issues of resilience and self-care, this raises questions around individual versus collective support structures, including self-care techniques and strategies, and the amount of support provided by supervisors and management, and the sector overall. Also in this group four participants argued that care work could only be done by a certain type of person, by which they meant a person with a particular mindset. Two respondents argued that this was true for other jobs, with certain people being suited to certain jobs. Other respondents mentioned workers leaving as evidence that not everyone can do the job. Some pointed to aspects of care work, such as assisting with personal care, that not everyone can do, while others suggested that people who lack certain qualities, such as patience, cannot do care work.

Care Work in Public Opinion

Responses to a question on how the public views care work show some complexity but the most prominent view was that the public holds negative, or predominantly negative, views of care workers (and the answers to this question overwhelmingly incorporated references to care work also). Some people also felt that public opinion of care work and workers had improved because of the pandemic and that public opinion was divided.

The single most commonly-mentioned factor in regard to public perceptions was that they do not understand the full or complete picture of what care workers do, or of what the work entails. Of the negative views of care workers, a prominent interpretation was of the public seeing care workers as being situated at the bottom of a hierarchy.

> We are seen as in the bracket of like cleaners, carers. You just fall into that bottom category and that is what's really sad.

> Being a healthcare assistant in England… it means being a slave with no value, with no dignity where you don't matter. You don't exist as a human being.

One respondent commented on the working-class connotations of care work and the snobbery of some towards it (with one even regarding the 'higher-ups' in the care home she worked for as possessing an attitude of snobbery). In the view of a migrant care worker, many English people consider the work to be beneath them, work one would not do unless one had to (or had little or no choice, like some migrant workers).

Other common negative perceptions of care workers revolve around two tropes that point to stigma and relative ignorance. The first trope is that what care workers do is wipe people's bottoms with the implication that this defines the job: seven workers specifically mentioned this perception, and an additional person referred to the stigma of the 'dirty' work involved in care. The other trope is that care work is defined by cups of tea. Respondents made the point that these partial views of what they do predominate:

> You know to some people I suppose it's … you make them a cup of tea, make sure they've got a cardigan on and give them a dinner and you sit there chatting to them all afternoon having a hunky dory time in front of the telly. No we don't ... we don't stop. I am on my feet constantly.

Respondents expressed frustration at what they saw as incomplete and ill-informed perspectives on them and their work.

Thinking through the origins of such perceptions, some respondents blamed what they saw as one-sided portrayals of care work in the news and media, with the suggestion that those characterisations are overwhelmingly negative or exaggerated in the direction of the negative. In a few cases reference was made to the pandemic as confirming this – the underlying reference here being to the generally poor treatment of care homes (and their residents and staff) vis-à-vis health care and hospitals. The omission of care workers from the praise directed towards key workers was mentioned here as was the tokenism of the CARE badge[14] (which she contrasted with the presumably preferable wage increases given to supermarket workers as key workers). There was also the fact of the hidden or confidential nature of what happens in care settings. One respondent's narrative adverted to her friends not seeing past the dirty work of care, and of them being 'freaked out' when she or another friend talked about it.

Returning to the commonly-made point about the public holding ill-informed views of care workers (or especially of care work and what it involves), these views were seen by respondents to have significance for the image of care work in the context of workforce problems and issues with sustainability.

Not only do some of these views have implications for recruitment (they put people off from entering care work) and retention (when they turn off new recruits phased or overwhelmed by being unprepared or unwilling to deal with the aspects of care work), they are also important to overall perceptions of care work, and public and political opinion. These questions are important to making the case for improving the recognition and rewards of care work and are tied in with the formal and informal classification of care work as unskilled. Although the term

[14] This is a badge, emblazoned with the word 'Care' that Matt Hancock, then Minister for Health and Social Care, relaunched in April 2020 as the Covid-19 pandemic, and shortages of PPE equipment, gripped the UK.

she used was 'underskilled', a female care worker expressed her frustration and dissatisfaction with such framings or designations of care work:

> I don't think it's an underskilled role, myself. There is a lot that goes into it. There's a lot of physical factors to the role, there's a lot of emotional challenges. There's a lot of paperwork to do. There are lots of things to remember and there is quite a lot of pressure and responsibility in that role, as a carer. But that responsibility is not recognised, and I think that we are generally viewed as the underskilled workers when we work in care.

Respondents' accounts specifically referenced tasks that involve skills and the responsibilities that come with them. A less widely-mentioned dimension was of what care workers go through and how the gravity of that is deserving of greater recognition and should be factored into how workers are valued and rewarded. One spoke candidly of the impact on her when someone whom she had supported died, and also described the emotional difficulty of the worrying situation her partner experienced during the pandemic when numerous residents died in the care home she worked in.

Another external aspect with potentially negative effect is high expectations of care workers on the part of the public. With only five exceptions, our respondents regarded the expectations placed on them as unrealistic. This was mainly to do with the volume of what they are expected to do, with some also commenting on the nature of the work. In terms of workload, important themes included workers lacking the time to get all that is expected of them done, and of the commonly cited under-staffing inhibiting workers' ability to meet expectations.

The single most widely-mentioned actors in the context of unrealistic expectations were residents' families, with six participants identifying them as a source of such views. One respondent attributed a causal role to company marketing material, including the (presumably positive) information given to residents' families. Two participants commented on the expectations created by the cost of care, and how the high costs bring expectations that certain levels of care will be forthcoming in return. One spoke of a particularly demanding family member:

> Some of the relatives of the residents think that we've only got their resident to care for. 'I want a daily update, I want you to ring me every day ... I want a daily update' ... when we've got 29 other residents. And then she'll come in for a visit, a particular family member and she will find fault, 'Where's her blanket? Where's her cushion? Why is this here? Why is she …?'… and she will literally find fault over the slightest little nothing thing.

The second most commonly-mentioned actors with unrealistic expectations were employers. As outlined earlier, respondents feel very strongly that they were expected to work under poor conditions with frequent shift-related changes and additional requests at short notice. Understaffing was again front and centre here. Notably residents were not among those cited to have high or unrealistic expectations - only one respondent mentioned residents as having expectations that were unrealistic, and another touched upon societal expectations of care workers being so high. One respondent discussed care packages in this context, with the ways that these plans are tailored to individuals leading to a lack of 'slack' with regard to staffing. This point opens up considerations beyond individual employers or providers to include the commissioning of care, and the wider structures around how it is funded and delivered.

In terms of further explanations for expectations being unrealistic, workers mentioned specific factors about the nature of the work, or the environment, which are very closely connected to the way employers run their organisations/services, and the wider delivery model of social care. Ten workers highlighted insufficient staffing as a contributing factor with one saying she and colleagues are 'expected to do three people's job for one person'. Another observed that if other departments in the home are short on staff, care workers were expected to step in and assist, whereas the same was not true if they were short on care staff.

These overly high expectations lead to workers rushing in order to get things done, which further compromises safety and care quality. It also leads to dilemmas for workers caught between assisting residents with complex needs requiring high levels of care and attention. One respondent spoke of how her workload had increased over time, which, combined with decreasing staff numbers, had created a current situation of unrealistic expectations. Another factor mentioned as a general driver of change is the medicalisation of care work with one respondent noting that the tasks they are increasingly expected to carry out are more akin to those of nurses. In addition to the intensification of work while on shift, two others mentioned the expectations to work long hours and overtime (again as a result of low staffing levels). One bemoaned the toll care work took on her, including the lack of time it left her for relationships beyond her working life. One interviewee shared her experience of constant requests to work on her days off, and how this impinged on non-work life:

> You're expected, even if you're contracted for, like I said, 22 hours, your phone will ping on your days off. On days off, your phone will ping constantly. 'Can you come

> in? Can you come in? We've got nobody'. And people are expected to drop their life at home and come into work.

One respondent said that she had learnt to say no to these requests unless she wanted to work more, and she was very conscious of looking after herself; perhaps crucially, she had a comfortable household income due her husband's earnings as a teacher. Others in her workplace did not feel they had this 'freedom', leading to feelings of burnout in this respondent's view. She lamented the lack of 'caring values' on the part of her employer:

> This is these companies. This is why I don't like them because they burn people out and they don't even care that they're burnt out.

Workers' Suggestions for Change

Interviewees had some very important and interesting suggestions about what needs to be addressed, in response to a question asking 'If you could improve any aspect of your job what would it be?'

The two most commonly-mentioned aspects were pay levels and staffing (with each raised by 11 participants). A number of different arguments were advanced for why pay should be higher. One clear set of references was to the nature of the work. Comparisons with other workers underline a sense of lack of recognition if not grievance, with one pointing out that the earnings for stacking shelves in supermarkets were higher. Other references were made to the relative importance or worth of the work to society:

> I think higher pay, pay that reflects what we do. The physical and emotional aspects of it and you know, it does contribute to society.

Other aspects of pay mentioned as needing improving were the rates for working antisocial hours, and better sick pay (most workers only received the statutory minimum when off sick).

While most respondents raised the matter of pay without reservation, a small few broached the subject carefully as if they wondered if they dare raise it. These responses hint at the internalisation of normative constructs about care work not being something that is done for money (England 2005).

Most of the mentions of staffing related to staffing levels, with workers wanting higher staffing levels to improve their experiences of work generally, and also to enhance residents' quality of care. One respondent framed the end goal or aim as allowing residents to be 'treated with dignity'. In reply to this question some respondents lamented the lack of contingency planning in their workplaces for when staffing was low, and the knock-on consequences whereby workers were called upon to cover non-care related, administrative tasks, which added to the pressure they feel. Time shortages were another consequence. Concern was also raised about staffing shortages as leading to workers 'getting ill and burning out'. Beyond the numbers of staff, one respondent called for attention to be paid to the skillset and training of bank and agency staff as at times they are unable to provide adequate support due to lack of training. Reference was also made to the 'right people' to be employed more often.

At root of a number of stated improvements is needed improvement in management practices. This could be a matter of how staff are treated but it could also relate to supplies, equipment, facilities and the perceived sparing attitudes regarding food and supplies.

Another aspect that a number of workers would improve is training, with five mentioning this. While most called for an increase in training and an improvement of training access (through technology for example), one worker would like it to be cut as he felt much of the essential training was unnecessary and repetitive (although this is perhaps in part a reflection of his 30+ years of service as a care worker). Others mentioned improvements around progression and career as being welcome.

Five workers said they would be keen to see improvements to the physical infrastructure or the supplies given to or used with residents. Mention was also made, albeit by only two respondents, of residents deserving better food and more plentiful supplies of products such as pads and wipes.

Interestingly, few called for improvements in facilities for staff (other than the above). However, rather than a statement about need, this was more a function of putting their own situation second to that of the residents. The mention of a greater user voice was notable also, albeit only suggested by one respondent who brought up the matter of power distribution in care homes (and the relative disempowerment of residents).

Beyond those mentioned, a number of other improvements were discussed including shorter hours for workers, greater emotional support, and better benefits (including more generous breaks).

The interview transcripts were also analysed to identify suggestions for improvement or action that came out of other questions that were not specifically enquiring about change. These overlap only slightly with those factors just discussed. Hence in what follows, we emphasise suggestions that have not been covered already, even if they were made by only one or a small number of respondents. In all, these can be organised into seven themes.

Recruitment, including advertisement, targeting, framing

- More accurate representation of what the work is actually like in recruitment materials.

Pay and conditions

- Put in place a WageStream tool so that workers can get some of their pay in advance should they wish to;
- Introduction of an interest-free loan scheme;
- Increase recompense for unsociable hours, including public holidays;
- Introduction of a pay scale;
- Better pay for staff in senior roles to recompense the extra work involved and also so entry-level workers can see progression as worthwhile;
- Put in place a sick pay scheme rather than relying on Statutory Sick Pay;
- Improve the effectiveness of breaks (including as part of greater acknowledgement of physical demands of the work) and the ability to actually take break allocation;
- Ensure better staff facilities, including washing up facilities (which would also be an expression of greater valuing of care workers), and staff-only bathrooms and places where staff can eat separately from residents;
- Deploy a floating member of staff in every building or service unit;

- Improve regulation and enforcement of minimum legal staff requirements.

On-the-job support, including for example, mental health, physical health, and emotional support and guidance

- Improve emotional support, for example a debrief after a resident has died;
- Make mentoring available as routine;
- Put in place better support for senior workers when they take on that role, including with paperwork.

Ways/mechanisms to enable workers' views to be heard more/given more prominence/have more influence

- Encourage and enable more sector-wide trade union involvement (that should be free or where the costs are not a barrier); automatic enrolment into a union; more 'aggressive' work from unions with regard to the conditions of workers in care homes;
- Allocate specific times/opportunities for workers to raise issues/concerns with more senior staff (not necessarily in large meetings).

Improve and increase supplies

- Increase the supplies of pads and wipes and other goods necessary for care;
- Increase budget for residents' food, and improve the standard/quality;
- Install 24hr CCTV in accommodation for the safety of those being supported.

Improvements around training, development and progression

- Put in place bespoke training for senior staff/managers;

- Establish better, standardised training for new entrants, with greater depth and keeping training practical as far as possible;
- Allocate paid time to do training, including on NVQs;
- Invest more in staff more broadly, including more encouragement and support to take up training;
- Improve progression, including options to shift sectors (into health for example).

These and other themes will be revisited in the next two sections which report on the workshop and give an overview of the findings and recommendations, respectively.

Analysis of Stakeholder Workshop[15]

The third empirical part of the project was a policy-focused workshop held on July 1st 2022, to present the findings to a range of stakeholders for discussion and also to solicit expert views of the current policy landscape and possible solutions. Despite a wide set of invitations, only three people attended on the day. Those present included two researchers, one from a research organisation and the other from an NGO, and a representative of an organisation for care home owners.

The following were the main points of discussion elicited by review of the main findings (which had been circulated in advance of the event).

One subject of discussion was how to ensure that workers are not exploited in light of their strongly personal and prosocial work attachments and motivations. Among the possible solutions suggested here was better support for workers. In this context, the importance of collegial relations and ways of working were highlighted as very important. The example was given of the importance of staff rooms and having a place and allocated time where workers can meet on their own – such as for lunch for example. The availability of such a 'space' would also help workers to debrief, something they rarely have the chance to do because of the pressurised nature of their work.

Discussion focused on more macro changes as well, such as greater recognition of the value of care and caring (and especially the more social aspects) and also actions to reduce the feminisation of the sector. The job placement services were criticised in the latter respect as

[15] The assistance of Mariela Neagu in organising the workshop and undertaking a preliminary analysis of the results is gratefully acknowledged.

operating to stereotypes of women (especially mothers and mothering) in prioritising the ideal values and persons most suitable for care work.

The modes of recruitment into the sector were also seen as relevant in this context, especially the use of campaigns around values-based recruitment which seek to promote the work and the sector by appealing to people who feel that their values and 'caring nature' align with an (idealised) version of social care. This approach has been popular in England for nearly a decade. Promoted especially by the Skills for Care organisation which is concerned with the workforce development and planning for adult social care in England, it is represented as a strategy to employers for greater efficiency in staff hiring and retention (Skills for Care 2020b).[16] Mention was also made of another current – even newer - strategy. This is one where employees act as recruiters for their employers, identifying and recommending friends, family and acquaintances whom they think would be suitable, using an App called 'Care Friends'[17] which is purchased by the employer. Staff are given bonuses in the form of points on a loyalty scheme, which increases in generosity depending on whether the referral results in recruitment and retention. This again uses a values-based logic in that employees are asked to recruit people for whom the work is perceived to fit with their life and their caring nature. The discussion identified three main risks with both of these approaches. One is of furthering a transactional approach, a monetising of care and caring motivations. A second is the danger of bringing in the same kind of person already populating the sector (female, caring orientation) which risks homogeneity and is not conducive to sustainability. The point was made that there is insufficient recruitment of men, a greater presence of whom would diversify the sector. Thirdly, there is the danger that the job and the sector cannot live up to or satisfy the recruited workers' expectations.

[16] See https://www.skillsforcare.org.uk/Documents/About/Evaluating-our-impact/Guide-for-how-employers-can-use-values-based-recruitment.pdf
[17] https://carefriends.co.uk/

The wide evidence in the current study of dissatisfaction and dashed hopes does not bode well in this regard. It was also pointed out that some of the working conditions – such as zero hours contracts - do not facilitate the staffing continuity and relationship building which are so important for care work. Policy makers were also critiqued as not fully appreciating or grasping the importance of the relational elements of the work. The feeling was that they tend not to see such elements as connecting to the quality of care and resist making the connection between wage rates and value.

Another topic to emerge from the discussion was the nature of the crisis facing the industry. The funding crisis was adverted to here in addition to the recruitment crisis. The ongoing cost of living increases were seen to be another debilitating factor, affecting both workers and care home owners. In regard to the latter, the situation of the many small, family-run homes was seen to be especially precarious. The opinion was expressed that the sector as a whole would be impoverished without the long experience of care provision which these homes have accumulated and the often higher quality care provided in smaller settings. The relative rapidity in the change of ownership in the sector was also adverted to. One participant recalled how less than 30 years ago 95% of institution-based care was provided by local authorities whereas today circa 84% of care beds in England are provided within the private sector. Among other things, this means that there is a wide range of care providers in the country, hence posing challenges for regulation. Accompanying the privatisation has been a financialisation of care homes – the observation was made that about 25% of the sector is now run by multi-chain providers. Although most are profit driven, the non-profit charities must also break even and cover their costs. The view was expressed that profit is not necessarily a negative factor if the surplus is reinvested in the home. This is important also in a context where many care homes are not purpose built and so require continual upgrading and structural changes.

In relation to workers' costs and crisis of living, mention was made of the need for and work done by the Care Workers' Charity, in terms of supporting – sometimes financially – care workers.

The situation in England regarding pay increase was seen as bleak. For example, the 2021 White Paper on social care made no mention of pay. The participants interpreted government intention as to introduce a training and skills framework first and to embed that over the remaining years of the current Parliament (officially to December 2024). It was pointed out that circa £460 million extra funding was given to local authorities in 2021, which the authorities could use as they wished. The discussion suggested that a considerable number chose to increase payment for commissioned care. While this was welcomed by participants, it was also seen to act to further inequality and fuel competition within the sector. In the current plans for a workforce strategy by the Department of Health and Social Care, a basket of different initiatives is suggested (such as telephone helplines for example) but participants felt it was not clear how these are to be implemented and whether the whole package would be sufficient to meet the needs of care workers. It was pointed out that there is nothing in the White Paper about career development of care workers, such as, for example, providing support to those who want to become senior care workers or those who are already senior care workers and who want to progress, or even switch to health care.

Mention was made of the research exercise underway to determine the cost of care in England. It is a condition of government funding to the local authorities for 2022-2023 that they

undertake such an exercise.[18] It is officially presented as an exercise pertinent to establishing fair and sustainable funding to providers.

A good practice example discussed was the setting up of Social Care Fair Work Forum in Wales[19], dating from 2019, and a similar forum announced for Northern Ireland.[20] National-level bodies, these are tripartite in nature and use the principles of collective bargaining to deliberate on and establish a set of priorities for the sector and make recommendations for how those priorities should be achieved. As well as seeking to improve the conditions, they are intended to give care workers a voice. A further good practice example mentioned was Scotland's increase of the minimum wage for social care staff to £10.50 an hour from April 2022, significant not least because of its equivalent to Agenda for Change Band 3 for the NHS.[21] It was thought that this could set an example for England which has not taken similar action. The point was made that England is less state interventionist and more market-determined as compared with Scotland.

It was pointed out that it is almost impossible to disentangle poor pay and conditions from the reduced funding of the sector. Funding has been greatly cut back – despite local authorities' efforts to prioritise social care – with the result that in 2020 the funding level was equivalent to what it was in 2011 and 2012. The scale of the 'drop' is magnified by increases in the cost of living, and the costs of running a business. One consequence is that the care providers need to make some savings and many of those savings have come at the cost of frontline care workers. Salaries have not gone up in line with inflation and care providers have little leeway to invest

[18] https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023/market-sustainability-and-fair-cost-of-care-fund-purpose-and-conditions-2022-to-2023
[19] See https://gov.wales/social-care-fair-work-forum
[20] https://www.health-ni.gov.uk/news/fair-work-forum-planned-social-care
[21] https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates/agenda-change-pay-rates

in the sector and the monies from the new social insurance levy for health and social care introduced in April 2022 were planned to come through only in 2025. In any case the levy was ended in November 2022.

Domiciliary care was considered to be in an even worse situation than care homes. Shared care protocols are effectively nursing tasks which have been disconnected from the district nursing service and put into domiciliary care with no increase in the recompense for care workers delivering those tasks (who are in effect pseudo-nurses). It was said that they get paid at least £2 (per hour) less and are not eligible for the NHS pension.

Discussion also reflected on the Care Certificate which is the basic qualification for paid care work. Introduced for some seven years or so, it is not mandatory but is a structure for care providers to use should they wish to. The quality of what or how it is delivered was said by participants to vary however. The comment was made that there seems to be a general trend to move away from training rotas or training programmes with many people now receiving some training on the job. Some local authorities provide free training online, purchased from organisations like Grey Matter Learning. It is said to be cheaper although the opinion was expressed that face to face learning is the most impactful form of training and learning. Another training opportunity is provided through Skills for Care, the workforce development fund. This, supported by the Department for Health and Social Care provides an opportunity for care providers to defray some of the costs of training. It was said that only about half of the providers participate. Participants suggested that it appears to be standard practice for care providers to ask care staff to do their training in their own time as opposed to providing study time. The view was also expressed that the Care Certificate as a tool to justify skills in care may also have

unintended consequences in that training, especially when mandatory, might incentivise some more experienced care workers to leave the profession earlier than planned.

The possibility of setting up a college of care so that care can be a regulated profession was also raised and discussed. Participants wondered whether that was the only route to getting institutionalised recognition of the importance, skills and value of the care work and then possibly leading to a new structure of pay that recognises the skills and the services that care workers provide.

In terms of career structure, it was pointed out that the existence of some 17,500 care providers with different terms and conditions, may stymie a clear career path or structure. The participants saw it as a real challenge to create the cohesive training strategy which all providers should adhere to rather than opt in to. Difficulties from the demand side were also raised. For example, a significant minority of care workers have low literacy levels and many do not have English as their first language. At the present time, social care in England has a hands-off approach regarding qualifications and training whereas Wales and Scotland have gone down a different route with mandatory registration and training.

Another suggestion made was for a code of conduct for the industry. Such codes have been mooted for other low paid workers, such as factory workers and women workers in general. The suggestion made was for an agreed tripartite Code of Conduct for care workers and staff in care homes which would make clear what the provision was, what the expectation was and what the minimum standards were for workers as well as for residents and their families. The example was given of food. Night shift care home workers need to bring their own food with them and if they forget or do not have any, then they may not eat for 12 hours. Food may also

be an issue for residents. One participant mentioned visiting care homes where residents did not get any food after 4pm. A framework which informed everyone of the expectations and amenities and which allowed those affected to make suggestions of what would be included, would be a way at the very local level of amplifying worker voice and making clear the expectations and responsibilities for providers and workers.

Mention was also made of the possibility of setting up some kind of multi-stakeholder initiative that included government and trade unions and representation from the care providers and care workers, at national level. There are models of this from the 1990s when the government supported the establishment of the ethical trading initiative which was a multi stakeholder forum that had a great impact on supply chains.[22]

The challenge of getting care on the political agenda was another important topic raised and discussed. In this regard reference was made to mobilisation in the sector. Some examples were given. In addition to the Care Workers Charity (which is grant giving), there is also the National Association of Care and Support Workers, a voluntary organisation which, founded in 2016, promotes itself as a support and representative organisation for the social care workforce. There is also the Care Workers' Union (CWU), an advocacy organisation looking to support people who are paid less than a minimum wage in home care. There are also Facebook groups of care workers which may involve as many as 40,000 people. It is interesting in this context to consider the relative isolation of respondents in the present study. It may be that people do not have the information or think that being part of an organisation is not for them or they may fear retribution in their workplace if they become active in representative organisations.

[22] https://www.ethicaltrade.org/

It was suggested that English society has to decide on the value it places on – and wishes to see its government place on - care. The view was expressed that it might help to consider and value social care as an important part of the economy, to establish, for example, its net contribution for the English economy (De Henau and Himmelweit 2021).

The point was also made that the move towards integrated care systems – which were established on a statutory basis across England on July 1st 2022[23] - can play a role in helping to transform work and conditions and pay at local level and then if we can build and evidence base to show that the initiatives are working and scale up nationwide.

By way of overview, there was a strong sense that a lot of the ameliorative measures are already in place but are not being used or promoted.

[23] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

Overview and Policy Recommendations

Overview of Main Findings

A number of main conclusions can be drawn from the research.

First, the care home workers studied carried a very heavy work burden. This was because the work is very demanding but it is also due to serial understaffing in the care homes the carers worked in.

Second, feelings about and personal investments in work dominated respondents' accounts of their jobs. When their work motivations were examined, prosocial elements emerged strongly in the sense that many workers were motivated to do the work in a desire to help others. Given this, the workers tend to feel they are a natural match for the job and part of the meaning they derived from the job comes from 'giving' to the residents. However, prosocial motivations were not the only reason why the respondents did care work. They derived intrinsic satisfaction from performing the tasks and activities involved and extrinsic factors also tied them to the job – such as pay, the convenience of the work and the way it fits into their personal situation and future (career and other) plans. The job security aspect was also important to people. The point was made that care work is a job one chooses to leave rather than a job from which one is sacked (especially given widespread labour shortages).

Third, the findings make clear that the workers created meaning for themselves through their own personal characteristics and identity and how these are seen to mesh with the actual work and relationships involved in care work. There is certainly a strong sense of a (prosocial) values match but care work is also embedded in people's biographies, in the most extreme cases almost foretold for people by virtue of their backgrounds (and sometimes lack of other possibilities or

options). For a significant minority of respondents, their initial introduction to care – and encouragement and confidence to enter the sector – came through either family experiences or those of friends and acquaintances. This was another way in which the personal and work worlds intersected.

Fourth, the workers understood the work as complex and even highly-skilled. They saw it as involving a range of skills, requiring physical strength and expertise, cognitive skills (interpreting people's needs for example) and medical-related competences (such as dispensing medicines and undertaking medical checks).

Fifth, the respondents placed high value on the job in the sense of the work involved and were convinced that only certain people could do the work (which also acted to elevate their sense of their own importance and value). Motivation and capacity to care were prominent in their narratives around what makes a good care worker.

Sixth, the narratives contained a mix of references to the job, both negative and positive. Among the negative, understaffing and low pay were the most widely reported whereas the residents figured most strongly among the positive factors. This co-existence leads to considerable ambivalence. The workers have to live with very mixed feelings about the job, and about staying in it or leaving. In essence, they have to manage the normative pull of their concern for and relationships with the residents and the push or negative factors associated with poor job conditions and lack of public esteem for what they do. When they felt negative, they tended to think of and make plans to leave; when they felt more positive, they shelved the decision for future review.

Seventh, while there might be a match between their values and what is actually involved in the job, some respondents saw a values mismatch between themselves and the employing organisation. Referred frequently as 'they' or 'the higher-ups', the organisation was often criticised for perceived money-making or money-saving motivations (through savings on the volume or quality of supplies for example or though understaffing or low pay), which were seen to negatively impact on the job and affect how the organisation is run and the conditions of care giving and care receiving. Relatively negative views of the employing organisation also stem from and affect workers' willingness to raise work-related issues or problems, in other words for them to have 'voice'. Only about half of the interview respondents felt they could raise and be heard on issues regarding the quality of care and residents' well-being. This set of findings suggests that workers have limited 'voice'.

Eighth, the respondents felt misunderstood and un(der)appreciated by the public. The most common complaint was of the public not understanding the full or complete picture of what is involved in the work and the job, of dismissing it as menial and therefore not valuing care work and those who do it. The feeling was that public opinion functions with stereotypes of care as a set of very basic or routine tasks. Workers, on the other hand, saw the work as complex and involving a particular set of skills. The respondents questioned whether their own expectations of care were realistic (in the sense especially of the actual constraints of the job). When offered the opportunity in the interviews to reflect on their experience over time, there was a strong sense of scales falling from their eyes about what is involved in the work and what it is like to be a care worker.

Ninth, in terms of what actions people took to improve their situation, a mixed picture emerged. The workers certainly thought about leaving both the job and the sector with only about a

quarter of the interviewees fully committed to staying. They seemed to engage in a frequent if not continual (re)assessment process, wherein they weigh up the pros and cons of leaving or staying. This is a mindset that must be quite destabilising. While some feel that there is a 'shelf life to care' (in the sense of burn-out and exhaustion), a decision to leave also needs to be weighed up carefully, not just because of the importance of the residents to them and the consequences for the residents of their decision to leave but also because they are important earners in their (typically low-income) families who may not have many other options and so cannot afford to act impulsively.

Tenth, it is striking how individualised the workers were and how circumscribed was their resistance agency. The main forms of resistance could be described as micro rather than macro (although not inconsequential). The acts of resistance included not adhering to the rules regarding sparing use of supplies for example. Actions such as raising issues that were seen to need redressing in the workplace or even mobilising through trade unions and other collective channels were far rarer. The interviewees had only a one-in-four likelihood of trade union membership and they tended to lack support networks beyond their colleagues (although carer support organisations exist). Ultimately, leaving the job was their only recourse and constituted a political act as it was often motivated by dissatisfaction with the way the home was being run and residents being treated.

Eleventh, COVID-19 emerges as a hugely significant and mainly negative factor in regard to the experience of care assistants in care homes. There was a strong sense of the pandemic as a traumatic experience for the workers, residents and families. Most people viewed staffing constraints as seriously worsening over the last years and attributed this partly to COVID-19 but also to more general issues of sectoral under-recruitment and under-funding that had

predated the pandemic. The mental health effects of COVID-19 on workers emerged from the survey as one of the single largest negative impacts of COVID-19 (along with the workload and morale of colleagues).

Twelfth, the participants in the stakeholder workshop had a very strong sense of what would help the workers' situation and serve to improve the functioning and quality of care provision in England more broadly. Among the factors highlighted in this regard were: adequate pay and the need for a pay structure and a pay negotiation procedure for the care sector as a whole; the lacking or inadequate career and training structure; ineffective and stereotypical modes of recruitment (emphasising typically female values and orientations); the gender imbalance in the sector; potential exploitation of workers given their typically strong personal investments in the work; the structural and funding crisis in the sector a whole; the growing for profit share of the sector; the lack of regulation; the potential benefits of worker mobilisation on the one hand and a support architecture for paid care workers on the other. There was a strong sense that a lot of the necessary ameliorative measures are already in place but are not being used or promoted.

Thinking Critically about Policy Change

As outlined in sub-sections 2.3 and 3.11 above as well as in section 4, there are many suggestions for change from both workers and policy experts. And, of course, there are opportunities for change in the policy landscape in England and beyond. A new *Health and Care Act (2022)* has been passed into law for example, following a White Paper in 2021 (*People at the Heart of Care*). However it must also be said that other developments temper expectations. In particular, the cancelling in 2022 after just six months of the new health and social care levy which was due to raise significant amounts of funding for the social care as well as health sectors suggests lacking political will.

And yet there is political mobilisation in the field of social care. The pandemic and the vulnerabilities of those receiving care as well as the situation of workers and care homes more broadly revealed by it have led to a greater public visibility of each, although not in equal measure. As mentioned, a new representative organisation – the Care Workers Union – has been set up recently and other unions are also active. For example, Care Workers for Change associated with UNISON are mobilising for decent jobs, quality standards as in a national framework for care, with pay and training linked to standards and fair funding.[24] Operating more in the field of support and advocacy is a number of care worker organisations, such as Care and Support Workers Organise (an organisation, mainly of care workers, campaigning for change in the sector) and the Care Workers' Charity (which provides some material and other forms of support to care workers as well as advocating for change). The Relatives and Residents Association, a voice for those receiving care, has been an active critic of many care home-related policies as has the COVID-19 Bereaved Families for Justice Group. And there are campaigning organisations which focus either directly on social care – such as the Care and Support Alliance and Think Local Act Personal – or advocate for older populations more generally such as Age UK. But throughout, the voices of the owners and managers of care homes have been loudest. Their interests and voice have been mobilised through a number of associations and groupings, many of which speak for a relatively small number of mainly commercial providers. The organisations include Care England, the Care Provider Alliance, the National Care Forum.

There is also significant research and analysis underway in the field of social care. The Economic and Social Research Council has, for example, committed up to £10 million in

[24] https://www.unison.org.uk/our-campaigns/care-workers-change/

funding for a Centre for Care at the University of Sheffield (with a range of university and other partners) and some £15 million funding has led to IMPACT ('Improving Adult Care Together') - the UK centre for implementing evidence in adult social care (based at the University of Birmingham and jointly funded by the Economic and Social Research Council and the Health Foundation).

Against this backdrop, this report identifies a range of needed improvements and reform. They derive from the voices of the respondents and the broader insights of the research but draw also from proposals made by other researchers, research projects and organisations working in the field. Research and policy undertaken outside of the UK also inform the discussion.

a) Recruitment (including processes, advertisement, targeting, framing)

The relative homogeneity of the workforce, especially in terms of age, gender and social background, is something that needs to be a consideration for active change. There are many merits of having a diverse workforce; indeed, one might argue that it is essential for sustainability reasons. Diversity encompasses gender, migration and ethnicity background. To achieve diversity, special outreach measures or campaigns are likely to be needed. Some examples exist, including the Men into Care programme organised by Skills for Care to attract more men into the long-term care workforce and the Norwegian 'Men in Health Care' recruitment programme which was set up to recruit (unemployed) men aged 26-55 to the health and care sector.[25] Students have also been targeted as potential care workers for example, in an effort not just to increase the workforce but to change the age and generational composition. Belgium, Portugal and the UK have all tried to increase the share of students entering the long-term care sector – for example, using image campaigns to help make the sector more attractive

[25] http://norden.diva-portal.org/smash/get/diva2:747320/FULLTEXT02.pdf

among young workers and students (OECD 2020). An over-arching idea or plan here is one suggested by the Work Foundation (2021: 17): that care providers should create work experience opportunities to develop a pipeline of talent for the sector.

Whatever their focus, advertisements and out-reach as well as other parts of the recruitment process should provide accurate and realistic representations of what the work involves, including the variety and demands of the work. This was deemed very important by the study respondents. So too was the important of proper induction. The research reported here (as well as other research) has shown that workers get little induction to the sector and that many are thrown in at the deep end, most typically after a short informal shadowing experience and induction session. The importance of an organised sector-wide induction programme is to be emphasised. It should be noted in this context that the government has stated its intention to ensure induction training is of consistent standard no matter who it is for and also better, standardised training for new entrants, with greater depth and keeping it practical as far as possible. It has also committed to funding for Care Certificates, alongside significant work to create a delivery standard recognised across the sector (UK Government 2021b).

b) On-the-job conditions and support

Initiatives set out in the 2021 White Paper, *People at the Heart of Care*, in regard to on-the-job support are welcome. Among the services mentioned are counselling (one-to-one therapeutic sessions, offering tailored mental health and wellbeing support to care workers; peer support (group mental health and wellbeing sessions for care workers, with facilitated peer support, including online events led by leaders in the sector); a bespoke support helpline; mental health training, coaching; a workplace wellbeing fund (to enable employers and local organisations to access funding for a range of holistic interventions to support staff wellbeing).

The study reveals several relevant insights. One is the need for a mentoring scheme which all workers in the sector (not just those who are new) have the possibility of accessing (as recommended by the Women's Budget Group 2020: 5). Relatedly, it also seems vital that there is some form of regular 'checking in' with new workers – especially young workers and those new to the sector – to ascertain how they are placed and their experiences, offer encouragement, and provide the opportunity to discuss issues/concerns and respond to questions.

There is also the matter of the staff complement on shift and of the skill levels of those on shift ('hire and deploy the right people') and contingency plans in place for situations of shortfall. Respondents expressed both negative experiences and strong feelings on this issue, and the evidence suggests that it has been a factor in workers leaving particular jobs or thinking about leaving. A relevant recommendation in this regard is for 'a method to calculate 'safe staffing' to be introduced (Pautz et al 2020: 18). The suggestion was also made by the respondents for a floating member of staff to be deployed on/in floors/departments/buildings.

The importance of ongoing support for staff to deal with the emotional aspects of the work, including deaths of residents, is also to be emphasised. Some relevant good practices or suggestions here include the Social Care Institute for Excellence 'scorecard' approach within organisations to monitor both negative factors including sickness absence due to mental ill health, and positive factors including the extent to which workers feel in control of their workload, or well-supported by their line manager (Health and Social Care Committee 2021: 19). Another, related suggestion is for providers to conduct regular workforce wellbeing surveys and to use this to shape both a general wellbeing strategy as well as a strategy on mental health support and staff training (Work Foundation 2021). Support or helpline services for all

staff (not just those working for particular providers) is another suggested improvement from the present study.

It also emerges that workers have insufficient support in the face of victimisation for raising issues or drawing attention to problematic practices. The White paper proposed 'Freedom to Speak up Guardians' to be introduced on a pilot basis, in collaboration with the National Guardian Office, to explore ways in which Freedom to Speak up Guardians can be introduced in the social care sector, providing a route for workers to raise concerns, and escalate issues around their wellbeing and quality of care, and support providers with their employees' concerns. In the latest government policy document these plans appear to have been shelved, however (Department of Health and Social Care 2023).

Another finding suggested by the research is the need for better support for senior staff when they take on the role, including support with paperwork and other work associated with the volume and complexity of reporting and record-keeping. The research showed that care workers perceive senior roles as under-supported and rewarded and that this puts them off seeking promotion and wishing to progress (and ultimately weakens job retention and workforce vitality).

The Work Foundation has made a helpful recommendation suggesting that care providers should consult with their workforce to understand the rewards and benefits they would value most and use this information to develop a package of benefits that reflects staff preferences' (Work Foundation 2021: 17). It also highlighted that greater effort is needed from those higher up in organisations to show respect to care workers, to take an interest in them and their work,

and to show appreciation for what they do (and acknowledge their fundamental importance and contribution to the workings of homes, and recognise how hard the job of a care worker is).

Efforts should be made to try to avoid expanding the role of care worker through adding additional tasks such as laundry and kitchen work (especially in cases where it has been done by designated staff in the past). Such role expansion diminishes the skilled nature of the care assistant role and adds to expectations and uncertainty around the appropriate task assignment and occupational role for workers (and also potentially has implications for care continuity and quality by taking care workers away from care and support work). The findings of the research also show that staff have less time for activities with those in receipt of care than they used to and there is evidence also of workers finding the job repetitive. More could be done to enhance the variety within jobs/on the job as well as between jobs.

c) Pay and financial benefits/recompense

One of the strongest findings from the research and other sources is that care workers do not receive adequate compensation for the activities they engage in.

There is, first, the matter of the process to establish and legitimate appropriate and fair pay scales. One relevant suggestion here is for the Department of Health and Social Care to set up a national social care board to ensure that the social care sector pay is fair and properly monitored (Alzheimer's Society 2021: 11). In this, consideration should be given to how NHS and social care sector pay-scales could be more closely aligned. This echoes a suggestion by the Social Care Leaders group – representing a wide range of sectoral interests[26] - which has

[26] Including the Association of Directors of Adult Social Services (ADASS), Care Provider Alliance (CPA), Care and Support Alliance (CSA), Local Government Association (LGA), Skills for Care, Social Care Institute for Excellence (SCIE) and Think Local Act Personal (TLAP).

called on government to set up an independent review of both pay levels and the mechanisms for setting pay in the sector (Social Care Leaders 2021: 3). The Women's Budget Group echoes this call but also goes beyond it, making the case for measures that guarantee care workers employment for the hours they are willing to work at wages comparable with those working in similar jobs for the NHS, while urgently developing their training on a par with public health care workers. They recommend the establishment of a national body in England, in line with the other countries in the UK, to develop and oversee this (Women's Budget Group 2021). The Scottish government has recommended a national job evaluation exercise for work in social care, to establish a fair and equitable assessment of terms and conditions for different roles. This should take account of skills, qualifications, responsibilities and contribution (Scottish Government 2021: 104).

In terms of actual pay rates, the Trade Union Congress (TUC) argued in 2020 for bringing in pay scale/banding (that is complementary at least to wages in other sectors) and setting a minimum hourly wage (at the recommended rate of £10 in 2020 – when the national living wage was £8.72). In addition to this, the TUC has called for an end to zero-hour contracts, better sick pay and towards what they term 'a real valuing of care skills' (TUC 2020: 8).

There are a number of other considerations that need to be borne in mind regarding wage rates and pay of care workers also. These include the introduction of incremental pay for length of service as part of broader measures to incentivise longer service and also progression in the sector. There is also the matter of rewarding extra responsibilities or more difficult types of caring activities (e.g., dementia, night work).

Social security coverage is another issue. The lack of a bespoke pension scheme in the sector is notable, separating care workers from those in the NHS for example. Improved sick pay accessibility and conditions that recognises the particularities of care work would also significantly benefit the respondents in this study and many others. 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' (Pautz et al 2020).

Other aspects that come out of the present study and are pertinent to remuneration include the additional costs that care workers bear (for example replacing clothing damaged during work) and how these should be compensated and compensation for unsociable hours, including public holidays.

d) Wider employment conditions

One question that continues to be relevant is how care workers can be recognised and compensated for what they contribute and specifically the conditions they endured during the COVID-19 pandemic. There have been few if any moves in England to this end.

Putting in place better conditions for the future may be one way of recognising the pandemic contribution at the same time as better protecting care workers. In this regard, measures to improve the work-life balance of care workers would constitute a significant contribution, given what the study reveals about the ways in which the work-life balance of care home workers is undermined. One example is of 'phone pinging' on days off with requests from employers or managers to come in and work. This is clearly counter to work-life balance and worker autonomy. Another measure that would help to improve work-life balance is better job security

in the care sector. This would mean permanent contracts being the rule and a reduction of zero-hour contracts and of the number of bank and agency staff.

The conditions of bank and agency staff also need attention, including the matter of whether they are subjected to pressure to accept the offered hours and to work regular shift patterns as if they were permanent staff. Research suggests that bank and agency staff were used during the pandemic to 'fill in' for regular staff and then received few or no hours once permanent staff returned after the crisis. This exposed bank staff to disproportionate health risks whilst leaving them without any of the benefits to which permanent staff are entitled (Pautz et al 2020: 22).

The regulation of working time and conditions also needs to receive attention. The length of shifts is one important matter – there is strong evidence that they are too long. This is at root associated with workload levels which the study has shown to be very heavy. In addition, better on-the-job breaks (including as part of a greater acknowledgement of physical demands of the work) and the ability to take full break allocation (or some way of claiming that back or being compensated for missing out on it) are basic employment conditions which are frequently denied care workers. Building time for paperwork into shifts would also help since, under existing arrangements, workers often have to stay on to fill in the paperwork after their shift has officially ended, which means they are doing it in their unpaid time. Fair procedures around when workers can take holidays, including acknowledgement of times when they have assisted in taking on extra work/shifts and even times when they may have had to cancel holidays/leave (more balance/reciprocation in this area). are also needed.

In addition, every effort should be made to make sure care workers know their employment-related rights.

e) Training, development and progression

Paid care work is in England underdeveloped as a profession or occupation. Training and accreditation are key to both crating and rectifying this. Kessler and colleagues (2020) have proposed the creation of a new National Care Career Service (NCCS) that would include the appointment of local Career Coaches and Advisors. As envisaged, the NCCS would provide careers information, advice and guidance including for those nearing retirement. It would also help staff navigate their careers including between occupations and agencies, but also support new models of care and ways of working, for example by identifying the competences required to work in multi-disciplinary teams (Kessler et al 2020: 11).

The results of this and other research make clear that greater effort has to be devoted towards recognising care work as part of a valued occupation and career. One relevant proposal in this regard is from the Alzheimer's Society which calls on the government to develop a ten-year social care People Plan underpinned by efforts to 'retain-attract-train and progress the social care workforce' (Alzheimer's Society 2021: 11). The Health and Social Care Committee has also recommended that adult social care have its own People Plan, which would include parallel commitments to those for the NHS on diversity and inclusion (Health and Social Care Committee 2021: 26).[27] The meshing of local and national workforce strategies has also been recommended (NAO 2018; Social Care Leaders 2021). In terms of the process of developing a successful national workforce strategy, coproduction with service workers and those who use

[27] The NHS People Plan is its workforce strategy organised around four pillars: health and wellbeing, belonging (with a focus on discrimination), new ways of working/delivering care, growing (recruitment and retention) – https://www.england.nhs.uk/ournhspeople/.

the service is an important principle (Social Care Leaders 2021: 9). Building funding for training into service contracts has also been recommended, in the long-term goal of establishing a 'Continuing Professional Development Framework' (Work Foundation 2021: 17).

Greater 'investment' in staff more broadly is also needed, including more encouragement and support to take up training. The planned new skills passport will help to address issues of portability of staff training and development. It is intended that this will be embedded as a function in the new digital care hub for the workforce. The intention is to provide a permanent and verifiable record of skills, behaviours and achievements that can be shared with new or potential employers.

Among a series of other recommendations already issued the following seem very important:

- To make training programmes more attractive, the return to training in terms of salaries and career progression also needs to improve (OECD 2020: 88).
- There should be allocated, paid time to do training, including on vocational qualifications.
- Staff should be given a minimum learning entitlement throughout their careers. There should also be a guarantee that all staff be supported to obtain a minimum level of functional and digital skills (Kessler et al 2020: 11).
- The training for conditions such as dementia, which in some cases workers see as inadequate, and is undoubtedly variable depending on employer, should be improved. Training for safeguarding issues is also essential. In addition, the OECD (2020) has pointed out that workers in long-term care do not always have enough training on geriatric conditions, interpersonal skills, care after hospital discharges, and management of emergencies or bereavement.

- Specialisation where appropriate in specific areas such as supporting people with learning disabilities, autism, dementia and so forth would be another improvement (Social Care Leaders 2021).

f) Workers representation and voice

Greater input from trade unions and other representative organisations is needed as well as some kind of sector-wide initiatives for improving care worker conditions that do not involve much cost to the individual worker, or require much in the way of bureaucracy. Even if not in the guise of mobilisation, some kind of sector-wide/specific service for advice on conditions and treatment in employment would make a significant contribution to improving workers' lives. At care home level, there could be standardised and specific times/opportunities/procedures for care workers to raise issues with more senior staff as part of broader efforts to listen to and involve care workers in decisions. This is also a call made by other research: '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' (Pautz et al 2020: 5).

g) Public opinion and information

One of the strongest findings from the research being reported here is a sense of relative ignorance among the public of what the job involves. And yet it is essential – for the good of society as a whole not to mention the well-being of all those involved in care - for care and care work to be viewed by the public as a positive contribution to society. Some suggestions for how this might be brought about include information campaigns such as such as Every Australian Counts and Caring Across Generations (Social Care Leaders 2021: 3). Tangible action by

government to show that it values and recognises the work care workers do would go a considerable distance to placing value on care, care workers and those who receive care. As part of this there should be a challenge to the notion of care work as being 'unskilled' including in official contexts, such as in migration rules and conditions.

h) An overarching vision

As an overarching vision, England and the UK more widely might use the International Labour Organization's (ILO) (2018) idea of decent care work. The Organization's decent work agenda, which dates from 1999, is based on four normative pillars: job creation, rights at work, social protection, social dialogue. The Organization defines decent work as 'productive work for women and men in conditions of freedom, equity, security and human dignity.[28] The decent work concept is a rights-based approach that concerns itself with pay rates, security of work, social protection, working conditions, access to labour rights and the promotion of social dialogue encompassing the actions of governments, employers and trade unions. Built into the ILO's concerns are the gendered asymmetries characterising care. It therefore links poor treatment of care to the pre-dominance of women and the strong links between paid and unpaid care. Developing the UN's extant 3 Rs framework on unpaid work (recognise, reduce and redistribute)[29] as a strategy to achieve women's economic empowerment, the Organization highlights a strategy of action focused on 5 Rs:

- Recognise
- Reduce
- Redistribute
- Reward

[28] https://international-partnerships.ec.europa.eu/policies/sustainable-growth-and-jobs/employment-and-decent-work_en

[29] https://www2.unwomen.org/-/media/hlp%20wee/attachments/reports-toolkits/hlp-wee-report-2016-09-call-to-action-en.pdf?la=en&vs=1028

- Represent.

The first three Rs – recognise, reduce and redistribute – relate to unpaid work while 'reward' and 'represent' mainly pertain to paid care and paid care workers. To respond on all counts, 15 policy measures are deemed to be necessary in a policy package that specifically encompasses macro-economic policies, care-related policies, social protection, labour, and migration policies. Hence, the position taken by the ILO is that policy should strive to give care work recognition and value, to reduce its volume as unpaid work, to redistribute it among institutional spheres and between individuals, and to appropriately reward those who do it – especially paid carers - and enable them to be politically represented.

Thinking in such broad terms is warranted by many of the findings in this report. In effect, the treatment of care home workers reflects the low value English society places on care and those who provide and require it as well as stemming from a sector of employment and provision that has been allowed to grow and develop without adequate regulation, quality control and funding.

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Appendix 1

The Online Questionnaire and Supporting Material

Information Sheet and Consent Form

If you are a worker in a care home, you are invited to participate in a research study by the University of Oxford. We are interested in the views of people in direct care positions, such as Care Worker or Care Support Worker or Care Assistant. If this applies to you, we would love to hear from you. This page has information about the study and contact details if you have any questions. It explains why the research is being done and what it will involve, which will help you to decide if you wish to take part.

The purpose of this study is:

- to learn about the experiences of care home workers, their conditions of work, and how they feel about certain aspects of their jobs.
- to improve understanding of why care home workers do what they do, what keeps them in their jobs, and what makes them leave or consider leaving.

These are issues of great importance with ongoing difficulties in the sector around recruitment and retention of staff, and the findings of the study will shape policy recommendations.

Taking part in the study is voluntary, and all questions are optional. Even if you are only comfortable answering some of them, it will still help us gain a better picture of working in a care home. We do not see any risk to you from completing the questionnaire. The benefits of your participation are for society as a whole to learn about the conditions of care home work. All information collected during the course of the research will be kept strictly confidential. Data will be deleted after the research is completed. If you provide any personal details you will not be identified at any stage of the study.

On a technical note, personal data including special category data collected during this research project is used lawfully as research carried out in the public interest. Use of personal data including special category data is proportionate, respects the essence of data protection, and provides suitable measures to safeguard participants' rights and interests in full compliance with the General Data Protection Regulation and the Data Protection Act 2018.

If you have any questions about the study, please contact either of the study's research team by email:

Dr Duncan Fisher (Researcher): duncan.fisher@spi.ox.ac.uk

Professor Mary Daly: mary.daly@spi.ox.ac.uk

Survey Questionnaire

The questionnaire should take about 10 minutes to fill in.
If you would like to take part based on this information, please type yes in the box below, and then click the arrow to begin. If you do not wish to participate, please close and exit. Thank you for your interest in the study.
(Space to fill in)
ARROW MOVES ON TO NEW PAGE/SECTION

Please provide your job title from your current care home position.
(Space to fill in answer)

Question 1: What type of care home do you work in?
Care home without nursing (residential)
Care home with nursing
Care home that includes residential and nursing care
Other (please give details) (Space to fill answer)

Question 2: What type of organisation do you work for?
Private
Charity/voluntary sector
Local authority or NHS
Other (please give details) (Space to fill answer)
Don't know

Question 3: What is the approximate number of residents in the home?
0-20
21-50
51+
Don't know

Question 4: What is the approximate number of care staff working in the home?
0-20
21-50
51+
Don't know

Question 5: In which region of England is the home located?
East Midlands
East of England
London
North East
North West
South East

South West
West Midlands
Yorkshire and the Humber

Question 6: How many hours per week are you contracted to work?
0
1-15
16-30
31-40
41+

Question 7: What type of contract do you have?
Temporary
Fixed-term
Permanent
Other (please give details) (Space to fill answer)
Don't know

Question 8: How much do you earn in your current care home position (please enter figures for either per year or per hour)?
Per year (Space to fill answer)
Per hour (Space to fill answer)

Question 9: How long have you been in your current care home job?
0-3 months
4-6 months
7 months-1 year
1-2 years
3-5 years
6-10 years
11+ years

Question 10: How long have you worked in adult social care in England (including in your current care home job)?
0-3 months
4-6 months
7 months-1 year
1-2 years
3-5 years
6-10 years
11-15 years
16+ years

Question 11: Could you tell us up to three most important reasons you took up adult social care work?
(Space to fill answer)
ARROW MOVES ON TO NEW PAGE/SECTION

Question 12: How do you view the following in your current job? Likert scale of answers: Very negatively, negatively, neutral, positively, very positively
Working conditions overall
Job satisfaction
Pay levels
Number of working hours
Training provided
On the job support
Impact on my physical health
Impact on my mental health
Relations with residents
Relations with colleagues

Question 13: To what extent do you agree or disagree with the following statements? Likert scale of answers: Strongly disagree, disagree, neutral, agree, strongly agree
I like my job
I feel valued
I consider my work to be very important
The residents matter to me
I feel part of a team
My job is more to me than just a way to earn money

Question 14: How often are the following true? Likert scale of answers: Never, rarely, sometimes, often, always
You have a say in improving your organisation's ways of working
If you raise concerns about care quality they are acted upon
If you raise concerns about your working conditions they are acted upon
You are able to take your allocated break time during your shift
You have enough time within your contracted hours to get all your work done
You have the feeling of doing useful work
You are treated fairly in your workplace
Your supervisors/managers are understanding of your needs as a care worker

Question 15: Thinking about what keeps you in your job, please rate how important each of the following is to you. Likert scale of answers: Not important, low importance, neutral, important, very important
Working conditions overall
Job satisfaction
Pay levels

Relations with residents
Relations with colleagues
Loyalty to residents
The fact that I know it and am familiar with it
Gaining experience towards a different career
The convenience (in terms of getting to work)
Lack of other work options locally
ARROW MOVES ON TO NEW PAGE/SECTION

Question 16: Have you considered leaving your current care home position?
Yes
No

If you answered yes to Question 16, please continue from Question 17. If you answered no to Question 16, please go to Question 18.
Question 17: What have been the most important issues when you have considered leaving your current job? Please select all that apply.
Working conditions overall
Boredom/want a change
Pay levels
Impact on my physical health
Impact on my mental health
Limited career prospects
The status of the work
Poor quality of care for residents
COVID-19 impact on work
Effect on home or family situation
Other (please give details) (Space to fill answer)

Question 18: Is this your first adult social care job in England?
Yes
No

If you answered yes to Question 18, please go to Question 21. If you answered no to Question 18, please continue from Question 19.
Question 19: What were the reasons you left previous adult social care jobs? Please select all that apply.
Working conditions overall
Pay levels
Boredom/want a change
Impact on my physical health
Impact on my mental health
Limited career prospects
The status of the work

Poor quality of care for residents
COVID-19 impact on your work
Other (please give details) (Space to fill answer)

Question 20: Are there other reasons you have left adult social care jobs? Please select all that apply.
Home or family situation
Childcare/family caring responsibilities
Visa/migration status issues
Relocating within the UK
Leaving the UK
Change in financial situation
Attraction of other work
Other (please give details) (Space to fill answer
Question 21: How do you feel about your future in your current care home job?
Very negatively, negatively, neutral, positively, very positively

Question 22: How do you feel about the future of care home work and adult social care work more generally?
Very negatively, negatively, neutral, positively, very positively

Question 23: Please name up to three things that would most improve your working situation.
(Space to fill answer)
ARROW MOVES ON TO NEW PAGE/SECTION
Question 24: During COVID-19, how did the situation change in terms of the following aspects of your work? Likert scale of answers: Got much worse, got worse, unchanged, improved, improved greatly
Working conditions overall
Job satisfaction
Pay levels
On the job support
Your work-related physical health
Your work-related mental health
Relations with residents
Relations with colleagues
Workload/volume of work (as opposed to working hours)
Morale levels in your workplace

Question 25: Has the COVID-19 pandemic made you more or less likely to stay in your care home job?
Far more likely to leave, more likely to leave, unchanged, more likely to stay, far more likely to stay

Question 26: What is your view of the government's introduction of mandatory COVID-19 vaccination for care home workers?
Strongly disagree, disagree, neutral, agree, strongly agree
ARROW MOVES ON TO NEW PAGE/SECTION

Question 27: In what age group are you?
16-17
18-29
30-44
45-54
55-64
65+
Prefer not to say

Question 28: What is your gender?
Male
Female
Non-binary/third gender
Prefer not to say

Question 29: What is your ethnic group?
Asian/Asian British
Black/African/Caribbean/Black British
Mixed/multiple ethnic groups
White British/Irish or other White background
Other ethnic group
Prefer not to say

Question 30: What is your highest completed level of education or training (in any subject)? Please select the level of your highest qualification.
School-level qualification
Further education (college) level qualification
Undergraduate degree
Postgraduate degree
I don’t have any qualifications
Don’t know
Prefer not to say

Question 31: Please list up to three health and social care qualifications you hold.
(Space to fill answer)

If you have anything to add in relation to the questionnaire or the answers you have given, please do so here.
(Space to fill answer)

If you would be willing to speak to us further, and possibly take part in an interview, please leave your name and email address here (this information will only be used to contact you, and will stored separately from your questionnaire responses and subsequently deleted).
(Space to fill answer)

We thank you for your time spent taking this survey.
Your response has been recorded.

Appendix 2

Interview Schedule and Supporting Material

Call for Interview Participants (circulated through the internet)

Care home workers' attitudes to work in COVID-19 times

We are seeking the views of care home workers for this research study by the University of Oxford. We are interested in the experiences and opinions of people in direct care positions, such as Care Worker, Care Support Worker or Care Assistant, or Senior Care Worker. If this is the work you do, we would love to hear from you. If this does not apply to you, but you know people who work in these roles, we would be grateful if you could make them aware of this call and share it across your networks. Participation will involve a recorded online or telephone interview of an hour to an hour-and-a-half in length. The interview will be based around the experiences of social care workers, including their working conditions and work motivations. Participants will be given a £20 high street shopping voucher once the interview has been completed to compensate them for their time.

The aim of the study is to improve understanding of why care workers do the work they do, what keeps them in their jobs, and what makes them leave or consider leaving. These are issues of great importance with serious, ongoing problems in the sector recruiting and retaining staff, and the findings of the study will shape policy recommendations. As our societies learn to live with COVID-19, we have to find new ways to organise care for our most vulnerable members, and to better reward and acknowledge the work done by care workers. The information we gather will be used to develop policy insights and practical guidelines aimed at improving the sector and the conditions of workers.

If you have any questions about the study, or would like to be interviewed, please contact members of the study's research team:

Professor Mary Daly: mary.daly@spi.ox.ac.uk

Dr Duncan Fisher (Researcher): duncan.fisher@spi.ox.ac.uk

E-mail Inviting Survey Respondents to Take Part in the Interview

Dear (insert name if have it, or if not put in 'care worker'?)

Thank you for taking the time to fill out our recent online questionnaire about your attitudes to the care work you do. We are contacting you because you left your contact details and indicated that you would be willing to speak to us further, and possibly take part in an interview. We are now at that stage and would like to confirm if you would be available to do a recorded online or telephone interview at a time convenient to yourself.

Attached to this email is an information sheet about what this would involve. The main things to emphasise are that your participation is entirely voluntary and that your details will be kept confidential and your identity not revealed at any stage of the write-up of the study. The information sheet includes more detail on the purpose of the study and how the research findings will be used. Should you take part, you will be sent a £20 high street shopping voucher once the interview has been completed to compensate you for your time.

Please have a read of the information sheet attached and feel free to ask any questions about the study or what taking part involves. Please let us know if you would be able to take part, and we could then look to arrange a suitable time.

Thank you for your time and best wishes,

Interview Information Sheet

Care home workers' attitudes to work in COVID-19 times

This is a research project carried out by Professor Mary Daly and Dr Duncan Fisher of the University of Oxford's Department of Social Policy and Intervention.

Mary Daly mary.daly@spi.ox.ac.uk
Duncan Fisher duncan.fisher@spi.ox.ac.uk

Invitation paragraph

You are being invited to take part in the research study. This statement outlines why the research is being done and what it will involve, which will help you to make an informed choice as to whether you wish to participate. Please take time to read the information carefully and discuss it with others if you need to so as to make a decision about participating. Please get in touch if anything is unclear or if you would like more information.

Thank you for reading this.

What is the purpose of the study?

The purpose of the study is to learn about the experiences of care home workers in England, with a focus on their work motivations and what connects them to the work. The aim of the study overall is to improve understanding of why care workers do the work they do, what keeps them in their jobs, and what makes them leave or consider leaving. These are issues of great importance with serious, ongoing problems in the sector regarding recruiting and retaining staff. As well as providing needed knowledge, the findings of the study will shape policy recommendations. As our societies learn to live with COVID-19, we have to find new ways to organise care for our most vulnerable members, and to better reward and acknowledge the work done by care workers. The information we gather will be used to develop policy insights and practical guidelines aimed at improving the sector and the conditions of workers.

Why have I been chosen?

Participants have been chosen due to their status as currently employed care home and supported living direct care workers in England. We aim to interview up to 25 people in these positions.

Do I have to take part?

Taking part in the research is entirely voluntary and it is up to you to decide whether or not you do so. If you do participate you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

Participation will involve a recorded online or telephone interview of an hour to an hour-and-a-half in length. The interview will be based around your experiences as a social care worker, including your working conditions and work motivations.

You will be given a £20 shopping voucher once the interview has been completed to compensate you for your time.

Will my taking part in this study be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential.

On a technical note and to ensure that you are fully informed, personal data collected during this research project will be used lawfully as research carried out in the public interest. Use of personal data including will be proportionate, will respect the essence of data protection, and will ensure that suitable measures are taken to safeguard participants' rights and interests in full compliance with the General Data Protection Regulation and the Data Protection Act 2018.

Your name will be not be used in the writing up or presentation of the study. The organisation you work for, or the location of your work will not be made public in the writing up or presentation of the study results. The interview data will be securely stored during the research and then destroyed, including the interview recording.

In the event of disclosure of a potential safeguarding issue by you during the interview, the researcher will seek further advice and potentially disclose this information to the relevant local authority, so please be aware of this.

What will happen to the results of the research study?

The results will be used in a project report and set of guidance for employers and national policy makers, and as evidence in academic journal articles. A one-page summary of the study will be created, which will be available to participants and others electronically. In addition, once completed the other outputs can be sent to participants on request.

Who has reviewed the study?

The project has been reviewed and approved by the Ethics Committee of the Department of social Policy and Intervention of the University of Oxford. The ethics approval is available on request.

Consent Form

Interview consent form

Care home workers' attitudes to work in COVID-19 times

Names of researchers:
Professor Mary Daly mary.daly@spi.ox.ac.uk
Duncan Fisher (Researcher) duncan.fisher@spi.ox.ac.uk

1. I confirm that I have read and understand the Interview information sheet for the study and have had the opportunity to raise any questions I have.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I understand the interview will be recorded.

4. I understand that I will not be identified at any stage of the study.

5. I agree / do not agree (delete as applicable) to take part in the above study.

Name of Participant Date Signature

Researcher Date Signature

Interview Schedule

Section A: Opening section

I would like to start by asking you some background details about your current job, and your experience of care work.

Q1: What is your current post (e.g., job title)?

Q2: What type of care service is it that you work in?

Q3: What type of organisation do you work for (prompt: e.g., private/commercial, charity)?

Q4: Which local authority area is the care home located in?
And which region of England is this?

Q5: What is your employment status (prompt: permanent, temporary)?

Q6: How long have you been in your current job?

Q7: How many years have you been in adult social care work?

Q8: How many jobs have you had in adult social care work?

Q9: Do you have caring responsibilities yourself?
If so, can you briefly explain?

Section B: Let's turn now to your current job

Q10: When you think of your job what are the first things that come to mind?

Q11: Can you tell me how you got your current job (prompt: how did you hear about it and apply?)?

Q12: What motivated you to take up your current job?

Q13: What induction (prompt: introduction to the job and organisation you work for, including training, procedures) did you receive in your current job?
How good was it for what you needed?

Q14: Did you work shadow or do observation shifts?
If so, how many times and how good were they for what you needed?

Q15: In general, how would you rate the training you received in the initial period in your job?

Q16: In general, how would you rate the training you get (if any) on an ongoing basis?

Q17: What areas would you say you are undertrained in (if any)?

Q18: Do you receive any formal on-the-job support (prompt: formal procedures for emotional support, guidance, supervision and development)?
If so, what is it and how helpful is it?

Q19: Who do you turn to for informal job-related support, if anyone?

Q20: Do you and your colleagues have a Facebook or WhatsApp group?
How does that help?

Section C: Let's turn now to adult social care work more generally

Q21: What drew you to adult social care work in the first place?

Q22: What influenced you to take up care work?
Can you explain further?

Q23: What did you hope to get out of care work?

Q24: How has your experience matched up with what you hoped to get out of social care work?

Q25: Has your opinion of care work changed over time?
If so, in what way?

Q26: How about your motivations: have they changed?
If so, in what way?

Q27: Has the COVID-19 pandemic changed your thoughts about care work in any particular way?
If so, how?

Q28: Are there particular aspects of your work that you find meaningful or satisfying?
If so, what and why?

Q29: How meaningful are the following relationships to you and why:
Residents?
Colleagues?
The organisation you work for?

Q30: How do you feel about your future in adult social care work?

Q31: How long do you plan to stay in your job?
And in care work overall?

Q32: Do you have any plans to go for promotion in your job or work in a different care job?
Why/why not?
If so, what are your plans and how achievable is this for you?

Section D: Characteristics, skills and values

Q33: In your view, what makes a good care worker?

Q34: Does care work require particular:
Skills?
Knowledge?
Personal characteristics?

Q35: Is it a job that anyone can do?
Why/Why not?

Q36: When you have done something well in your job, how do you know?
What guides you in this?

Q37: Is it a line of work that calls on particular values?
If so, what are the values and do you call on in them in your job?

Q38: Do you think your values match those of the organisation you work for?
Please explain how they do/do not match up.

Q39: Can you give an example of your values matching/not matching with those of your employer?
If so, how did/do you respond?

Q40: How do you think the public views care workers?

Q41: And how do they view care work?

Q42: Are the expectations of care workers realistic do you think?
How/how not?

Q43: Why do you do care work over other types of work?

Section E: Reasons for remaining in the job/line of work

Q44: What are the most important things that keep you in your job?

Q45: Are there reasons why you do care work in a care home as against other types of care?

If so, what?

Q46: Some people say that care work is a public service. What do you think?
And why?

Q47: Do you have a sense of connection to other workers across adult social care?

Section F: Voice and reacting to negatives at work

Q48: If you raise issues about the service/care quality, do they get acted upon?

Q49: If you raise issues about your working conditions, do they get acted upon?

Q50: Can you give an example of when you raised an issue, and it did or did not get acted upon?

Q51: Is there anything that puts you off raising issues or speaking out?

Q52: Is there anything that would make it more likely, or encourage you, to raise issues or speak out?

Q53: What do you think is/would be the most effective way you could act to improve things at work?

Q54: And what about group/colleague action in this context?

Q55: Does the possibility of being able to raise issues to improve things influence your thoughts on whether to remain in your job?

Q56: Does your employer encourage you to raise issues about working conditions, and care/service quality?
If so, in what way?

Q57: Are you in a trade union, or any other workers' organisations, or have you been in any in the past?
If so, what does/did your involvement consist of?
And what did you want to achieve?

Q58: What do you think about the role for trade unions in your line of work generally?

Q59: Are you involved in any other organisation associated with your job/line of work?
If yes, what?

Q60: Whose responsibility is it to improve the situation of care workers (prompt: employers, local councils, the CQC, the Government)?

Q61: Have you ever been involved in any actions/campaigns/cases?
If so, what?
If no, why not?

Section G: Thoughts about leaving/actual leaving
Will have already established if this is first adult social care post. If not relevant skip to Q67.

Q62: When you left a previous/previous adult social care job(s) before, what caused you to leave?

Q63: Was it a difficult decision?

Q64: What finally convinced you to leave?

Q65: When you left that job, did your employer make any efforts to get you to stay?
If so, what did your employer do?
Q66: Have you ever left the social care sector specifically to work in another sector?
Why/why not?

And what brought you back?
Q67: Have you thought about leaving your current job?
If so, for what reasons?
Which job did you think of moving to (if any)?
What are the pros and cons of the decisions here?

Q68: Why have you not left?

Q69: How much do you know about other potential work options available to you?

Q70: If you could improve any aspects of your job, what would they be?

Section H: Background details
I am going to close by checking some background details – please feel free not to answer any of these.
Q71: How old are you?

Q72: What is your gender?

Q73: How would you describe your ethnic group?

Q74: What is your hourly rate of pay currently?

Q75: Are there other sources of income in your household?

If so, what are they and how much do they amount to?

Q76: How would you describe your financial circumstances (prompt: struggling, comfortable, well-off)?

Q77: What is your highest level of qualification?

Q78: What health and social care qualifications do you hold if any?

Thank you very much