ScottishCare
Voice of the independent care sector

CARE HOMES:
THEN, NOW AND THE UNCERTAIN FUTURE

CONTENTS

FOREWORD

(Care) home is where the heart is

Long before Elvis sang his 1962 song of the same title the phrase 'Home is where the heart is' had been much used by folks as diverse as Robert Burns to Anthony Burgess. It is a proverb which captures the depths of home which for thousands across Scotland today their care home has become.

I am delighted to be introducing to you this work by Becca Gatherum which paints a picture of care homes past, present and into an uncertain future. It is a work which demonstrates the dramatic and unappreciated changes which the care home sector has undergone over the last few years. It challenges myth and stereotype and calls for the development of a mature and contributive understanding of the invaluable role which care homes play in our health and social care system in Scotland. It argues forcibly for the need for us to challenge the societal and popular negativity which ignores the fact of the brilliant care and support given by tens of thousands of staff in care homes throughout Scotland today. It articulates a future which needs to become more secure for us to build on the excellence we have.

But when all that is said there is still an essential truth which makes me proud to be associated with the care home sector and that is that they are places, however different from one another they may be, where there is a vibrant and beating heart at the centre. Care homes are truly places where the heart is.

The heart is there with thousands of workers who get to know the stories and memories of residents and discover who they are and what they have been.

The heart is there as those who struggle with the distress of dementia, the pain of loss and sometimes the fear of ending are offered solace, given comfort and simply a hand to hold.

The heart is there as every moment of life is a celebration of contribution still being made, of abilities still being tapped, and of new discovery of potential and uniqueness.

The heart is there as staff, families and residents together nurture a space until it becomes a home; where the loss of another home is replaced with a commitment to make the new reality a comfortable one, a safe space and a place for re-flourishing and renewal.

For me, the proverb has become 'care home is where the heart is' for it brilliantly describes the best of care homes now and into the future. They are places of warmth, of social interaction, of clinical excellence, of compassion, chatter, laughter and tears. They are truly a home which gives sustenance physically, emotionally and spiritually.

So as you read this study and the undoubted challenges it poses; as we increasingly have to defend the uniqueness of a living in togetherness which care homes represent in an isolating world full of loneliness, let us be proud of the truth which is for so many thousands today and so many thousands in the past, that care homes truly are places where the heart is, where heart is shown, and where the heart will always be.

Dr Donald Macaskill
Chief Executive, Scottish Care

INTRODUCTION

Care home services (across both nursing and residential care settings) have a fundamentally important strategic role to play in creating a person-centred, rights-based pathway of care and support fit for Scotland's citizens in the 21st century.

Not only do these services deliver care and support to some of our most vulnerable citizens, but they also enable individuals to live full and fulfilling lives, and have a dignified, peaceful death. They are also a central support mechanism for families and play a crucial role in their local communities.

Both historical and recent development of care home services has shaped the sector in particular ways, both positively and negatively. It has led to a popular understanding of care homes that is often at odds with the reality of life and work in these services, especially as these services continue to change and develop to meet the needs and wishes of individuals and communities.

This report will seek to track the development of care homes in order to paint a descriptive picture of the reality of modern care homes, from the perspective of care home providers, managers and front-line nurses and care staff.

The following areas of care home support will therefore be explored in relation to how they have changed over time, their current status, and what this means for future care home provision:

- Popular misconceptions of care homes and what contributes to this
- The nature of care home support and how this has changed
- The changing profile of both residents and the care home workforce
- The role of regulation and inspection, both of services and the workforce
- Partnerships, relationships and the value on placed care home provision, and the people they support

We hope the resulting report and work that stems from it will be of benefit to a number of different stakeholders:

- Providers and staff within the sector
- Colleagues working across health and social care settings
- Integrated Joint Boards
- Potential recruits to the care home sector
- Individuals and their families considering a move into a care home
- National and local politicians

CONTEXT

"Standing still on the issue of the future of residential care simply is not an option. Twenty years from now, we will be in the fortuitous position of more older people living for longer, however, it is also anticipated that a smaller working-age population will be available to supply the care sector workforce that will be needed to look after them. All this in the face of anticipated tighter finances. Our expectations are changing too. As taxpayers, we expect high standards from our public services, and for those people who self-fund their care, they are entitled to expect high value for their money when it comes to the quality of care they receive and the standards of the environment in which they receive it." [1]

Douglas Hutchens & Cllr Peter Johnston – Foreword: Future of Residential Care report 2014

The report from which this quote is taken, published by the Scottish Government in 2014, represented an important output from a real effort at collaboration between a range of partners across health and social care. Borne from the recognition that care home provision, planning and regulating in Scotland had significantly changed in recent years and needed to continue to do so, the report provides a helpful marker as to where care home provision was at in 2014. Importantly, is also outlined what the range of partners involved in its publication believed the future direction of travel needed to be to secure the sector's ongoing sustainability, quality and value in the health and social care landscape.

The quote above quite succinctly sums up the range of social, political and economic factors impacting on care homes in the 21st century and which will continue to shape their reality into the future.

However, what this Scottish Care report will show is that the social, political and economic climate within which care homes exist means it is not quite as simple as saying 'this is what care homes currently do, and this is what they need to do in the future'. In fact, the complex historical development of care homes and the associated culture of care they operate within impacts directly on not only how services and their staff are valued but also on what they are able to deliver.

CONTEXT: THEN

The Future of Residential Care report also helpfully details the historical development of care homes over the last couple of centuries:

"In the late 19th century, for those who could afford to pay, the nursing reform movement led to the development of institutions which cared for people who were unable to continue to live within their own homes. These arrangements developed without significant regulatory oversight until the Nursing Homes Registration Act 1927; but real reform only came with the creation of the NHS and 1948 National Assistance Act, which placed a duty on local authorities to provide residential care for people who were unable to care for themselves for reasons of "age or infirmity" . While this duty was generally enacted through the provision of council-operated services during the 1950s through to the 1970s, the 1980s brought a new era of private provision and outsourcing, the greatest shift being from NHS continuing care provision to independent nursing homes and the development of the current care home market." [2]

Throughout much of the time period outlined here, care homes have formed part of what is termed 'institutionalised' care settings in the UK. An institution is:

"a facility or establishment in which people (such as the sick or needy) live and receive care typically in a confined setting and often without individual consent". [3]

'Insitutionalisation', in sociological terms, is defined as

" a process intended to regulate societal behaviour (i.e., supra-individual behaviour) within organizations or entire societies...

... As institutions must be considered as humanly devised contracts of social and political actors, the actual working and related performance of institutions

[1] *Full Report on the Future of Residential Care for Older People in Scotland* (Scottish Government), 2014 - https://www2.gov.scot/Resource/0044/00444581.pdf

[2] Ibid

[3] https://www.merriam-webster.com/dictionary/institution

is conducive to changes in society and its mode of governance." [4]

Care homes occupy an interesting space where they have historically represented the definition of an 'institution' but have also, through their changes, played a significant role in reflecting changing cultural and political norms regarding how we support vulnerable citizens.

Those reforms that took place at the beginning of the 19th century followed on directly from a time of the 'workhouse' system, where those with little to no money who were sick, elderly or infirm would live and work in exchange for 'relief', and charity-run voluntary hospitals existed for those with the financial means to access care. Before this time, it was the expectation that families would solely support elderly and unwell relatives. These early systems of support were grounded in an ideology whereby it was not the state's responsibility to pay for care and support and access to these services were very much determined on wealth (or lack of). They generally carried with them – particularly in terms of the workhouse – a stigmatization.

From here, there emerged the concept of a 'nursing' home - available to a wider proportion of the population than voluntary hospitals, supporting a wide range of healthcare needs, and coming at a financial cost to individuals. From the early 1900s, the quality of such facilities became of greater public concern with many deemed to be unsanitary, neglectful and contributing to additional health problems. This led to the first regulation within the care sector, through the Nursing Homes Registration Act 1947.

With the inception of the NHS and legislative changes, the role of the state in providing care services, particularly residential ones, became much more defined. Importantly however, this was borne out of issues of over-demand in existing medical settings and was not necessarily a response to a significant societal shift regarding the value of care homes:

"Concern over the well-being of individuals was only beginning to emerge and little regard was being given to those who cared for them". [5]

It is where we also see the start of the debate and practice – that remains to this day – of separating health and social care needs. It manifests into the ongoing service demarcation of hospitals, nursing homes and residential care homes, as well as raising questions of where the responsibility lies for the funding of social care as opposed to health care. However, it also marked a shift in the model of care home support since that seen in workhouses, from "t*he old master and inmate relationship*" to "*one nearly approaching that of hotel manager and his guests*", as described in a Ministry of Health report.[6]

As outlined above, changes in the market of care started with local authorities largely providing care home support, often in buildings that used to operate as workhouses. It is therefore not difficult to envisage why some of the connotations of those establishments continued to linger and colour popular perception of care home support.

Whilst the **1948 National Assistance Ac**t instilled a UK wide responsibility for government to support citizens in need of residential care, in Scotland the legislation that really influenced approaches to care and support and continues to do so to this day is the **Social Work (Scotland) Act 1968**. It required that local authorities, through social work departments, would assess individual eligibility for care services in the community, including care homes. Whilst this would level the playing field in terms of access to support for those in need, it also provided local authorities with a 'gatekeeping' role regarding eligibility criteria for support which undoubtedly would be influenced by political and economic pressures at various times.

From the 1960s to the 1980s, there began to be increasing diversification in those operating care home services, with local authorities continuing to be the largest provider but with an emergence of some private and voluntary sector homes. This trend would continue and by the 1980s, with a move away from free (for the individual) NHS continuing care as the norm to be replaced by means-tested local authority provision, a care landscape more similar to the one we know today existed with the independent sector moving into the role of major provider. We also see a growing recognition of the ageing population, interest in data relating to place of death and what role care homes play towards the end of life (which was deemed to be fairly negative in terms of how deaths were dealt with), and growing attention to the quality of life experiences of those residing in care homes.

[4] https://www.britannica.com/topic/institutionalization
[5] Sheila Peace (2003) *The Development of Residential and Nursing Care in the UK* - http://www.nurturemarketinguk.com/wp-content/uploads/The-development-of-residential-and-nursing-home-care-in-the-UK..pdf
[6] Ministry of Health (1949) Report of the Ministry for Health for the year ended 31 March 1948, cited in the above - *http://www.nurturemarketinguk.com/wp-content/uploads/The-development-of-residential-and-nursing-home-care-in-the-UK..pdf*

Care homes continued to grow in number and demand towards a peak in the 1990s. By this time, the independent sector was the largest provider of care home places, often delivering this care on behalf of public bodies. Nursing homes significantly outnumbered residential homes, reflecting the increased reliance on these services to meet the clinical needs of individuals out-with hospitals.

Since that 1990s peak, the number of care homes and of care home places have been in gradual decline. There have been a number of theories as to why this has been the case, including political changes, funding shifts, regulatory requirements such as the introduction of the National Minimum wage, and the development of a wider suite of support options for people to access. One of these contributing factors may be the predominant policy since the 1990s to the present day of supporting people to remain in their own homes for as long as possible and to shift the balance of care away from 'institutional' settings such as hospitals and care homes. This is taking us, ideologically, almost full circle in terms of a return to support at home albeit with access to more community support services now in place.

This is where, arguably, care homes have occupied an ambiguous place in that their development and operation has undoubtedly been 'institutional' over the past couple of centuries, but they would now generally see themselves as having evolved into community assets. With a policy position that infers that hospitals and care homes are not where people should be supported if at all possible, a cultural position has been created whereby living in a care home has wrongly become treated as a last resort . Hospitals aren't perceived in this way, given that they aren't defined by a particular condition age group or by policy. They remain free services at the point of use and citizens have more early and regular interaction with them - i.e. they don't represent support at a particular time of life or stage on infirmity in the way that care homes do.

2000 to 2010 saw an increased focus on the quality and scrutiny of care services and those who work in them, with the Care Commission and the Scottish Social Services Council (SSSC) both established through the **Regulation of Care Act (2001)**. Service regulation through the Care Commission (which later became the Care Inspectorate with the **Public Services Reform Act 2010**) requires all care providers to register with this public body, comply to a set of standards and be inspected against these annually, with publicly accessible reports on these inspections. The categories of registration removed any formal distinction between nursing and residential care homes but did separate them in terms of client group and needs (for example, care home for older people and care home for people with mental health problems). Whilst the intention of this is to enable more flexibility in service delivery, it doesn't acknowledge the multiple, co-existing conditions that people accessing care home support often have or the fact that they may live with these over a long period of time, including transitioning through age categories.

Through the SSSC, workforce regulation, development and planning are undertaken. Again, it requires individuals to register under certain employment categories and to adhere to codes of conduct and practice. Registration of staff in care homes for adults began with managers in 2006 with all staff requiring to be registered by 2015. The existence of such a register is intended to professionalise the social services workforce, increase accountability through individually held registrations, identify and eliminate bad practice (through the ability to remove people from the register) and ensure the workforce is sufficiently skilled and trained to deliver care (through the requirement to achieve certain levels of qualification and attainment depending on job role and service). As we will see through the report, registration has again had both benefits and challenges for the care home sector.

In terms of care home funding, between 2000 and 2010 were again a time of significant change in ways that continue to be the norm in 2018. The C**ommunity Care and Health (Scotland) Act 2002** introduced a level of public funding for care services available to all individuals, regardless of wealth, who were assessed as requiring support. Prior to this, a relatively small proportion of individuals would be supported by local authorities and anyone else accessing, for instance, a care home service would be solely responsible for the subsequent fees. This relatively small yet significant figure provided partial financial relief and signified a move towards equity of access for all. In 2002, the figures for this policy amounted to a £145 weekly payment for personal care and an additional £65 per week if nursing care was required [7]. In 2018, these figures are £174 for personal care and £79 for nursing care[8]. Whilst this amounts to a significant overall state contribution, arguably these payments have not increased in line with real-time resource increases or the increasing complexity of both nursing and personal care over this 16-year period.

Finally, but perhaps most significantly for care home funding, was the introduction of the N**ational Care Home Contract** in 2006. This has seen the annual negotiation of a set fee for care home places (nursing and residential separately) delivered by the independent sector on behalf of (and paid for) by local authorities. This has provided a considerable degree of stability in the sector and enabled a maturation of the relationship between public bodies

[7] Scottish Government (2004) *Statistics Release: Free Personal/Nursing Care Scotland 2004* - https://www.gov.scot/Resource/Doc/25725/0029168.pdf
[8] https://www2.gov.scot/Topics/Health/Support-Social-Care/Support/Adult-Social-Care/Free-Personal-Nursing-Care

and independent care home organisations beyond that of purely purchaser and provider. It has also allowed for predictability and transparency for citizens in terms of care home costs generally. However it has not been without its challenges, many of which have reached criticality in the last three years, concerning:

- Whether the model remains fit for purpose in terms of the arbitrary residential/nursing distinction;
- Whether it is sufficiently flexible to local need;
- Whether it is reflective of the range of diverse mental and physical needs of care home residents;
- Whether it adequately meets the costs associated with care home provision in 2018.

CONTEXT: NOW

Since the *Future of Residential Care* report was published a mere four years ago, the care landscape in Scotland has changed again in really quite significant ways.

In line with previous policy, recent legislation and planning processes have continued to seek to shift the balance of care towards more people living independently for longer in their own homes. Throughout all policy affecting health and social care in Scotland, the ambition has been to achieve more personalisation, more choice and control for individuals, better integration of services and improved efficiency through public purchasing.

The **Social Care (Self-directed Support) (Scotland) Act 2013**, enacted in 2014, represented an innovative first in legislative terms in that it sought to embed individual choice and control at the heart of care and support assessment, planning, delivery and commissioning. The Act requires local authorities to offer people four choices on how they can access their social care. Whilst there are still challenges in terms of its implementation, Self-Directed Support signals a new way of delivering services whereby the individual directs what type of care they want and when they want it, therefore requiring services to be more flexible and responsive to change. Whilst its potential hasn't yet been fully realised, this legislation has far-reaching implications for how care home services could and should be delivered in the future – for example, whether there may be a separating out of the different elements of care home support such as personal care, accommodation, nutrition and activities. Its full implementation would represent a drastic change from the relatively 'one size fits all' model available through the current National Care Home Contract.

Another ambitious and progressive piece of legislation has been the **Public Bodies (Joint Working) (Scotland) Act 2014**. This aims to, in both practical and ideological terms, achieve integration of health and social care services at a local and national level. It requires integration plans to be created and implemented by each health and social care partnership, with the engagement of other local partners including independent sector providers. These partnerships have responsibility for strategic planning and commissioning at a local level and therefore will have to address and take forward the challenges and opportunities facing the social care sector in Scotland, not least in relation to the role of care homes as part of the support landscape in local communities.

2014 also saw the introduction of the **Procurement Reform (Scotland) Act 2014**, which provides a national legislative framework for improved, sustainable procurement practice. It means that the purchasing of services will be based on principles which balance human rights, outcomes for the individual, best value and procurement regulations. This will have significant implications for the procurement of social care services where these are delivered on behalf of public bodies, including the National Care Home Contract.

Recent years have also seen a significant focus on delayed discharge (often referred to as 'bed-blocking') borne out of recognition through the **Reshaping Care for Older People Programme 2011-2021** [9]. This programme acknowledged that not only does the balance of care need to be shifted but that resource transfer to community settings must accompany this in order to ease the significant strain on resources, which will only increase with the changing demography and ageing population. It is now largely acknowledged that these delayed or failed hospital discharges often occur as a result of social care packages not being available due to the sector being under significant resource and capacity strain. More positively, the crises that frequently emerge as a result of these challenges – particularly during winter months – means that health and social care partnerships, and increasingly health services, recognise the critical role of care homes in supporting efficiency and positive outcomes for the whole health and social care system.

The significant resource and capacity strain mentioned above largely relates to the care home workforce,

[9] https://www2.gov.scot/Topics/Health/Support-Social-Care/Support/Adult-Social-Care/ReshapingCare

where recent years have seen intensifying recruitment and retention challenges and issues regarding the perceived value of social care staff. These have been recognised through the *National Health and Social Care Workforce Plan (part two)*[10], with a suite of recommendations produced including the need to make social care an attractive career option, better sharing of data for workforce planning and the development of new training and education frameworks. As the Scottish Government publication recognises, this requires effort and engagement for the recommendations to be turned into reality and will need significant involvement of care home providers themselves.

As registration of the care home workforce has progressed, it has brought with it changes to workforce regulation also. To reflect the increased complexity of care delivery, those in front line care roles must obtain an SVQ level 2 or an equivalent qualification within a defined period of time and must also complete sixty hours or ten days of documented post registration training and learning within their five-year qualification timeframe. For those in roles with additional responsibilities these requirements increase, and from 2020 new managers in care homes will be obligated to achieve qualifications at SCQF level 9 to practice.

Finally, and perhaps most recently, service regulation has been reformed through the redesign of the **National Health and Social Care Standards**[11]. Launched in 2017 and implemented from Spring 2018, these Standards form the basis on which registered services should deliver their service and against which they are scrutinised. The new version represents an entirely different approach to assessing the quality of services and applies across all health and social care settings. The Standards signify an embedding of human rights in the provision, regulation and planning of care and are experience-led, which is an extremely positive shift. Yet, as with any new legislation or policy which has such a direct link to everyday service delivery, it will take time for providers and staff to feel confident in the changes.

These policies and pieces of legislation all fit into supporting attainment of the **Scottish Government's 2020 Vision**, which is that by 2020 everyone can live a longer healthier life at home or in a homely setting, and:

- Scotland has an integrated health and social care system
- There is a focus on prevention, anticipation and supported self-management
- Where hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission [12]

In recognizing the current reality we face, '*A Route Map to the 2020 Vision for Health and Social Care'* outlines:

"Over the next 10 years, the proportion of over 75s in Scotland's population – who are the highest users of health and care services – will increase by over 25 per cent. By 2033 the number of people over 75 is likely to have increased by almost 60 per cent. over the next 20 years demography alone could increase expenditure on health and social care by over 70 per cent. These challenges will augment the specific impact of inflation on health and care services...

...There will be a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia. Estimates suggest that the number of people with dementia is set to rise from 71,000 to 127,000 within the next 20 years." [13]

Given care homes are often at the forefront of care provision for these groups, the implications of reform and advancements towards the 2020 Vision will be felt in this sector more than most.

Yet we continue to see a lack of clarity in terms of how care homes are categorised within policy. Care homes are sometimes defined as homely settings, but are also perceived to be 'institutional' environments and places where policy and practice should progress us away from in terms of resource use. This creates an unhelpful sense of confusion, by grouping them with home care services at certain points and hospitals at others. Policy should be enabling a clearer direction of travel but in reality seems to be complicating matters further.

"Optimising and joining up balanced health and care services, whether provided by NHS Scotland, local

[10] Scottish Government (2017) *National Health and Social Care Workforce Plan: Part Two* - https://www.gov.scot/publications/national-health-social-care-workforce-plan-part-2-framework-improving/
[11] Scottish Government (2017) *Health and Social Care Standards: My Support, My Life - https://scotgov.publishingthefuture.info/publication/health-and-social-care-standards-my-support-my-life*
[12] Scottish Government (2011) *2020 Vision* - https://www2.gov.scot/Topics/Health/Policy/2020-Vision
[13] Scottish Government (2013) *Route Map to the 2020 Vision for Health and Social Care - https://www2.gov.scot/Topics/Health/Policy/Quality-Strategy/route-map2020vision*

government or the third and independent sectors, is critical to realising our ambitions. Integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. The people most affected by these developments, and for whom the greatest improvements can be achieved, are older people, people who have multiple, often complex care needs, and people at the end of their lives. Too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs." [14]

Whilst inappropriate use of any service should be avoided, policy statements such as these can cause confusion when seeking to promote positive, effective and efficient resource use and exercising of individual choice and control across the health and social care system. What's more, by implying that a growing group of people with high levels of dependency can be supported at home rather than in care homes presumes that there are families and community assets both available and willing to pick up that level of advanced support and care. This isn't necessarily true, given what we know about changed family dynamics and geography as well as the existing strains on both informal carers and home care services.

WHY WE UNDERTOOK THIS RESEARCH

Outlined above are a multitude of ways in which the care home sector has changed according to evolving governance, policy and regulation, societal approaches to care of the vulnerable, the preferences of citizens, austerity and cuts in local authority expenditure. The pace of change - particularly in the last decade but especially in the last four years - has been quite astonishing. The sheer number and magnitude of the care home-related reforms that have been progressed, even if some of these feel like they haven't fully transferred from policy to practice, means it is important to engage with the care home sector to understand how these changes are being felt and how they are impacting on practice, both positively and negatively.

Much of the developments in the sector have been extremely positive in terms of the direction of travel for the future of care home provision, seeking to meaningfully embed personal choice, high quality care, competent staff and less siloed approaches as standard. However, many of the reforms are designed to incorporate the entire health and social care system and may not be fully worked through in terms of their consequences, intended or otherwise, on the care home sector specifically.

What's more, in compiling this report it became clear that there is still a dearth of information available about the care home sector and its development, both recently and over the past two centuries, and particularly from a Scottish perspective. Whilst information is out there in the form of research, legislation, policies, statistics and resources, it tends to be extremely piecemeal and often is framed within a much broader context, whether that is across different countries, subject areas or different service types. It can therefore be difficult to obtain a clear sense of what the care home sector is, what is does and how it is changing in Scotland. It is also unclear what the care home workforce is composed of and what a career in care can look like. That applies whether you are a member of the public looking for information on a service for yourself or a relative, an individual working or considering working in the sector, or someone interested in policy and development.

This was reinforced by the fact that, as the representative body for independent social care services including the vast majority of care homes, Scottish Care spends a significant proportion of our time giving presentations and sharing information about the size, scope and role of care homes to other groups and individuals, many of whom also work in the health and social care sector. We have been surprised at the number of people who have expressed astonishment over some of the factual information and statistics provided to them about care homes. Over the past few years, it has become increasingly obvious that we cannot assume people know and understand the current reality of care homes and in turn, we have to recognise that they may also hold assumptions about what these services are that are grounded in outdated or incorrect information.

In an era of promoting transparency, informed choice and flexibility in service provision it is crucial that individuals and their families have sufficient information about Scotland's care home services in order to determine

[14] Scottish Government (2016) *Health and Social Care Delivery Plan* - https://www2.gov.scot/Resource/0051/00511950.pdf

whether it may be an appropriate environment for them. Given that this form of support is often pursued at a time of crisis, it is at best unhelpful - and at worst damaging - for people to have a misguided view of care homes as places where there loved on might come to harm rather than be supported to live well. These perceptions can often be coloured by media coverage of care homes, which tends to focus on the shameful but thankfully few examples of neglect that have occurred in recent years. What's more, it is not uncommon to continue to see media portrayal of care homes as something akin to a 'prison' or places of very little activity. For instance, a 2016 episode of the popular comedy series 'Still Game' focused on the main characters, Jack and Victor, being 'enticed' into a care home only to find themselves locked in there, unable to escape and surrounded by fellow elderly people who are portrayed as bored and living in fear of the domineering staff. It is naïve to believe that such examples are simply harmless comedy moments as opposed to a means of reinforcing stereotypes amongst those unfamiliar with such environments.

For those involved in planning, commissioning and policy-making around care home services, it is equally dangerous for mistruths or lack of information to abound. If the ambitions of the 2020 Vision are to be realised, it will involve radical reform in the health and social care sector and a detailed understanding of how each part of the system can operate most effectively to meet the needs and aspirations of vulnerable citizens. If decisions are made without knowledge of what care home services deliver in 2018, the risk is that these are pursued in a way that is actually damaging to other resources and to outcomes. For instance, it is not uncommon to hear examples of local authorities proposing to reduce a certain number of care homes or care home beds in an area, without undertaking sufficient engagement or analysis into why that would be beneficial.

But the decision to undertake this research was not just about proving the quality and value of care home services in a modern Scotland, or seeking to campaign for them to continue to be used as they currently are. We believe it is equally important to unpick the challenges these services face in an honest and open way, and to consider what implications these challenges have for the future of care home provision. It is only by doing so and using what we find to engage in mature, non-precious ways with local and national partners that we can ensure that the types and quality of care available to future generations, and the employment opportunities on offer to the future social care workforce, are fit for purpose in a reformed and integrated health and social care landscape.

We therefore hope this report can shed some much-needed light on what myths and misnomers still exist about care homes, what the reality of care homes is, and what their future might be.

METHODOLOGY

As with all of Scottish Care's research reports in recent years, this report places significant emphasis on the voice of the social care workforce: providers, managers and front-line staff. In this instance, it focuses specifically on the care home workforce. We are passionately committed to utilizing this approach in our research reports because these are the individuals who work in the reality of care provision on a daily basis and are therefore often the experts in what works and what doesn't, but who don't often get the opportunity to make their voice heard in policy, research and development forums.

In order to capture a diverse range of views and experiences across the care home sector, a multi-method approach to data collection was utilized.

As part of this, three focus groups were held in Dunfermline (Fife), Livingston (West Lothian) and Montrose (Angus), providing opportunities for individuals and services who may not always have the chance to attend city-centric events to engage in the research. These locations enabled a mix of workers from urban, semi-rural and rural services to take part.

Each focus group lasted two and a half hours and was based around a semi-structured group interview process. It consisted of a mix of individual, small group and full group interactive written and discussion-based exercises. Each focus group was facilitated and scribed by two researchers.

As with previous Scottish Care focus group endeavours, this approach enabled participants to contribute and share views and experiences in a way that felt comfortable to them and allowed for a level of consistency whilst maintaining an open, participant-led session. All information collected was anonymised.

A wide range of front-line care home staff attended

the three focus groups, working in roles such as support worker, nurse, supervisor, manager and owner. This included 3 males, reflective of the fact that care homes remain a female-dominated employment sector. Participants were also reflective of a mix of life experiences and lengths of time in the care home sector, ranging from 11 months to 32 years.

Previous employment and life experiences included those who had joined the sector after raising family, those who came straight from school, people who previously had long careers in the NHS, those who had served in the military as well as those who had undertaken roles in the hospitality and retail sectors.

It was important to Scottish Care researchers to have this diversity across the focus groups, as we wanted to understand what the previous and current reality of care homes was for each participant, whether that was in less than a year or spanning a number of decades. It enabled a fuller picture to be painted of what changes have occurred in the care home sector, and when.

This data was also supplemented by an exercise undertaken at one of Scottish Care's Workforce Matters events in September 2018. The 'Kaleidoscope of Care' event exploring recruitment, retention and fair working practices in adult social care and was attended by 60 providers and stakeholders, including the Scottish Government. This exercise was also repeated at a range of Scottish Care roadshow events attended by care home providers and staff in Inverness, Dumfries and Aberdeen.

At each event, attendees were invited to contribute written information on the year they joined the social care sector and what care provision looked and felt like at that time. They were then asked to undertake the same exercise with regards to the present day. Responses were demarcated by service type and those identified as care homes were analysed and included in this research.

The data was further developed through a survey undertaken with care home services who are Scottish Care members. This comprehensive annual survey is intended to help understand the nature and extent of the current status and challenges facing the care home sector in Scotland and explores issues such as workforce challenges, including recruitment and retention, financial and operational sustainability and wider stakeholder relationships.

115 responses to the survey were collected at individual service level, which combined represent weekly support to 4,716 care home residents and the employment of 4984 members of care home staff across all areas of Scotland except Clackmannanshire, Midlothian and all islands. Respondents incorporated a mix of a care home owners (19%) and managers (81%) and the same mix of voluntary sector providers and private sector providers. Just over two thirds of responses were from nursing homes and the remainder from residential care homes, with 94% of these services supporting a mixture of publicly and privately funded individuals. Responses also demonstrate diversity in terms of service size, with 19% coming from small services (under 25 beds), 45% from medium sized homes and a further 35% from larger units (51-100 beds).

Whilst none of these methods can or were intended to be comprehensive on their own, we feel confident that the diversity of experience represented through the results of each methodology enable us to, through this report, share those voices in a way that provides a credible descriptive reality of care homes in 2018 and what the hopes, fears and anxieties of those working in this sector are for the future.

We hope that the results will be useful to a wide range of stakeholders and that the core messages will be useful for a number of purposes – whether that is briefings for individuals and organisations with decision-making powers relating to the sector, as induction materials for new and prospective care home employees or for wider public awareness-raising around the criticality and complexity of care home support within local communities.

1970s

No individuality
Limited outcomes for acute/chronic illness
Limited career opportunities
Vocational outlook

1980s

Plenty of potential candidates
Shared rooms
Residents more able
Less legislation

1990s

Task orientiation
Residents not as stimulated
Time to do your job
Less stress

2000s

Financially viable
Person centred care starting to be embedded
Good staff retention
Employees less skilled

2010s

Overwhelming
Busy
Support not given
Impressed at how well carers knew residents

2018

"I have been amazed at the quality of care, professionalism and facilities in a sector that I hadn't really thought of before – until I joined my organisation, my exposure had been visiting elderly aunties as a child in dark, gloomy, 'smelly', 'institutions'."

CARE HOME REALITY

In seeking to provide a descriptive picture of care homes in 2018, it is important to start with some basic facts and figures about this form of care provision. It should be noted that this report will generally focus on care homes for older people and more specifically, those in the independent (private and voluntary) sector.

The sheer number of care homes and of people supported by these services are often facts that people are unfamiliar with.

At 31 March 2017 (the latest available Scottish Government data[15]), there are a total of **1,142 care homes for adults** in Scotland, three quarters of which are registered as care homes for older people.

Of these 1,142 care homes, **86% are operated by the independent sector** highlighting how important this sector is to the overall delivery of residential care. The total number of care homes has decreased by 21% over the last ten years, with these reductions predominantly taking place in the public and voluntary sectors. Care Inspectorate quarterly data from September 2018 suggests this overall figure for care homes for adults may now be 1,107 indicating a further 3% decrease in care homes over the last 18 months.[16]

These services **support 35,989 residents** any day of the year. By comparison, in 2017/18 the number of average available staffed hospital beds has been 13,246[17]. Hospitals have also experienced a reduction in bed numbers of the past ten years, decreasing by 10%, with both settings reflecting the policy drive towards supporting more people in their own homes.

32,691 of these residents are accommodated in care homes for older people, which have decreased at a much slower rate of 2% over the past decade reflecting the ongoing need for a variety of supports, including care homes, to care for the needs of an ageing population.

Indeed, the number of people supported in private sector care homes for long stay, **short stay and respite care has actually increased by 6%** over the last ten years, whilst those supported in local authority, NHS and voluntary sector care home settings have decreased in number.

This perhaps reflects the fact that despite a continuing trend of reducing care homes, those that do exist tend to be growing in size and therefore the number of residents they can accommodate has increased. As resources across the health and social care sector have become increasingly strained, it is understandable that business and planning decisions have moved towards economies of scale to enable the absorption of some of the financial and workforce challenges associated with modern care provision.

The number of people to whom care home services provide life-saving and life changing support to is reason enough why they must be understood better by policy makers, practitioners and the public. These figures obviously do not include the far greater numbers of relatives, spouses and friends who also have their lives impacted by the support their loved ones receive in care homes. These services often enable them to maintain and enhance relationships, to stay in employment and protect their own health and wellbeing.

It is also under-acknowledged that care homes for adults are significant contributors to the economy, not least through their roles as sizeable employers. Care homes in Scotland **employ 52,470 staff** with 88% of people working in independent sector services[18]. This accounts for more than a quarter of all individuals employed in social services. There are also nearly **4,500 nurses** employed in care home services with almost all of these individuals working in independent sector nursing homes. That figure amounts to 7% of all nurses working in the NHS and in social care in Scotland.

In undertaking this research, what became almost immediately apparent is the fact that, according to care home staff, myths do still very much exist about what care homes are like and what they do, with these tending to be centred around a view of care homes as places of poor care, inactivity and a 'last resort'.

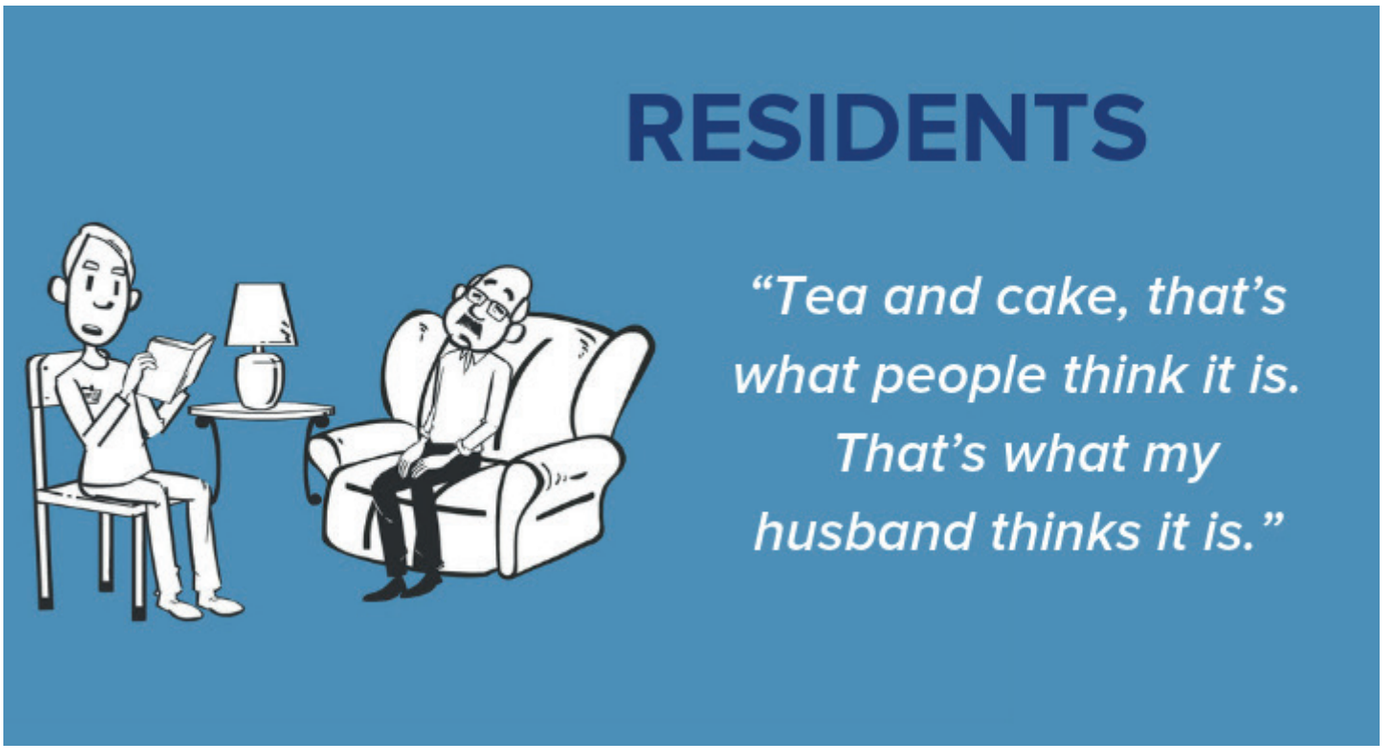
"People think it's like the workhouse – when you're in, you're not getting back out, which just isn't true."

Interestingly, that language and imagery of the 'workhouse' was used in describing what some people

[15] Scottish Government (2018) *Care Home Census for Adults in Scotland* - http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Previous-Publications/index.asp
[16] Care Inspectorate (2018) *Quarter 2 Statistical Report Tables* - http://www.careinspectorate.com/images/CI_Stats_Report_Qtr2_18_19.pdf
[17] ISD Scotland (2018) *Annual Trends in Available Beds by Health Board of Treatment and Hospital* - http://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/
[18] Scottish Social Services Council (2018) *Scottish Social Service Sector: Report on 2017 Workforce Data* - https://data.sssc.uk.com/images/WDR/WDR2017.pdf

think care homes in 2018 are like. Whilst the previous examination details the vast ways in which care homes have changed over the last two centuries, this shows that perhaps public perception hasn't advanced at the same rate. It would be interesting to further unpick this particular stereotype and to understand the factors that underpin it but in terms of research participants, they believed this image prevails because of the ideas of restriction and reluctant admission that care homes continue to be stigmatised with. This report will go on to describe the ways in which these perceptions are not actually grounded in reality. We also know that the number of residents being supported by care homes for short stays or respite care has increased by 96% since 2007. They therefore play an important role in not only supporting individuals who need care for a time-limited period but also in enabling informal carers to take a break from their caring responsibilities, as well as ensuring that individuals can be discharged from or even avoid hospital admission through the delivery of 24-hour support in a more homely setting.

The research has also confirmed what we already knew - care homes have changed beyond recognition in recent years in terms of the care they provide, the workforce they employ and the ways in which they are regulated. These three areas will be explored in more detail.



CHARACTERISTICS OF RESIDENTS

When provided with the opportunity to share if and how care staff have seen changes in the characteristics and needs of residents in recent years, one of the first topics to emerge in the research was the changing age profile of individuals in care homes.

"There's a lot of 'old' older people now. We have people of 91, 92, 97, 102 years old."

Whilst the average age of care home residents has remained fairly static over the last five years at 84, a strong theme amongst contributors was the increase they have seen in the age of residents, in terms of those living longer in services and also those being admitted into care homes later in life. Other participants detailed similar resident ages within their services, with almost all now supporting individuals in their late 90s or those well over 100. This is something that just would not have occurred in care homes even twenty years ago but serves as evidence of our ageing population in Scotland and the success of our health and care systems in enabling people to live into very old age. Whilst there has been a decrease in most age ranges entering care homes over the last decade, there have been substantial increases in both males and females over the age of 85. Since 2007, there has been a 44% increase in men over 95 living in care homes and a 15% increase of women over the age of 95.[19]

However, this does present particular modern challenges for care homes as living longer does not necessarily equate to living a healthier life. The development and

[19] Scottish Government (2018) *Care Home Census for Adults in Scotland* - http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Previous-Publications/index.asp

success of more sophisticated forms of home care supports and the skilled individuals that work in those services means that positively, more people are able to live in their own homes for a far greater period of time. But this is putting strain on home care services, then care home services when people are admitted with advanced needs.

"Residents are coming in older because they're kept at home longer."

This is likely to be one of the main factors why care home provision has experienced a downwards trend in recent times. That can be seen as a positive thing: no one should have to move to a care home if it's not what they want to do and there are other support options available. However, there will remain a proportion of individuals who either have needs so great that they require 24-hour care, who positively select to move into a care home or whose wider needs - such as social interaction and fulfilment through activities - can no longer be met sufficiently through other care provision and therefore a care home move takes place. After all, 24-hour home care would not be funded by local authorities as it would not be deemed to be resource efficient. It means that care homes are now often caring for individuals who enter these services with far greater and more complex illnesses, including palliative and end of life care needs.

"I see people coming in at an older age and nearer the end of life."

"People coming in at a greater age can mean dementia is far more advanced. When they've been in their own home they've not gone out, so their mobility is the first thing to go. They've also been used to sleeping in their armchair."

These later admissions are not necessarily negative, but they do have implications for the type and intensity of care that needs to be delivered because it often means heightened challenges relating to palliative and end of life care, dementia, frailty, mobility, nutrition, hydration and confidence to name but a few.

"We can see an increase in people's physical health and capability after they move in as we're checking fluid intake, diet, etc leading to improvement."

It means that these factors need to be taken into account when commissioning services, when undertaking workforce planning relating to staffing and skill levels, and in communication processes around a care home admission. The difference that care homes can make to older individuals' health and wellbeing must also be recognised and celebrated, rather than routinely considering these settings as a 'last resort' for our ageing citizens.

However what is a particularly striking finding is that care homes are actually experiencing a simultaneous spike in the number of younger residents they are now supporting. In this case, 'younger' tends to mean adults under the age of 65: the traditional, though arguably outdated, age marker between adults and older people in categorising service provision.

"We're getting more younger people – drink and drugs, early dementia."

Whilst the statistics don't reflect an increase in the numbers of those aged 18-64 residing in care homes, it will be interesting to monitor whether this changes in the coming years given that the majority of participants have experienced an increase in demand for their services for younger adults' support, whether they are in a position to provide it or not.

"We're getting more and more calls to take younger people."

Conditions such as early onset dementia have only begun to be widely recognised as a growing concern in relatively recent times. Additionally, there is little acknowledgement in terms of social care support planning of the prevalence of enduring mental health conditions, neurological conditions or the ongoing physical and psychological effects of substance misuse amongst adults which require intensive external support. This has led to a blurring of the lines between older people's care homes and care homes for other client groups, possibly because there has also been a reduction in residential services for younger people with complex needs. Over the last twenty years, people who would have traditionally accessed supported residential care have been able to live fulfilling lives in the community through access to multi-disciplinary health and social teams. However, due to increased demand as a result of overall population growth and less resource due to austerity, it is not always possible to support people at home in a way that is safe and meets their outcomes. This has contributed to a sense amongst some participants that their care homes services are operating as a 'last resort' for younger adults with complex 24-hour support needs, simply because they are the only viable

option. It doesn't necessarily mean that they are the wrong option, but it does point to insufficient recognition of this trend and subsequent engagement and planning to ensure that services are best equipped to meet the outcomes and needs of these residents as well as older individuals, and to ensure that they have sufficient choice in their care and support options.

"There's a gap for young people (in terms of appropriate care provision) with MS, etc – they're coming into care homes in their early 50s and there's nowhere else to provide that care."

The diversity of care home residents, particularly in terms of age range, is truly astonishing given it spans many different conditions, support needs, outcomes and life experiences.

"Our youngest is 57 and our oldest is 105."

An increase in these two extremes – those under 65 and those over 85 – has real implications for those concerned with the provision of care in a communal setting. Although this was not the experience of everybody, some participants did highlight the challenges of providing support in an inter-generational environment:

"We have a 60 year old lady who had a stroke – she sits in the lounge and the other ladies in there are in their 90s. Would I want to sit with someone 30 years older than me every day?"

It is not to say that we should in any way be 'silo-ing' individuals into particular care environments based on narrow age ranges: that would be entirely inappropriate and in no way reflective of how anyone lives their lives whether they live in a care home or not. It is also not to suggest that individuals won't enjoy and flourish in this diverse environment of different backgrounds and experiences. Indeed, some participants reflected that the client and age diversity of care homes – the cliché of no two days being the same – was what had drawn them into this career path, so this is something that could possibly be harnessed as a particular attraction in recruitment strategies. However, it does beg the question of how care homes can expect to meet the needs – clinical, social, spiritual, cultural – and outcomes of all individuals in a care home when residents have such a diverse range of interests. Does it require different facilities to be available within a care home? How can activities be made meaningful, engaging and fulfilling for all? What does this diversity mean for the staff mix?

"We've got 4 people under 65 – it's trying to find activities for them, they don't want to play dominos or do knitting. It's hard.'

The emphasis on personalisation means that no individual or group should be expected or assumed to fit into a particular model of care provision. However, it is the reality that in general terms different generations of individuals will have particular experiences, hobbies and social touch points in common. The care home reality is therefore that services and staff are challenged to understand and meet needs and expectations across an ever-widening population without always having the recognition, support and sufficient resources to enable them to fully do so.

Interestingly, the gender split of care home residents was a less frequently discussed topic yet some participants had seen some changes in this regard.

"The change in nursing homes over the past 30 years, it was all older people then (over 65), now there's younger people. Also, it was almost all women (residents), now there's lots more men."

From the available data, we know that there has been a gradual increase in the number of male care home residents across the previous ten years but that 70% of care home residents are female compared to 30% male. A handful of participants remarked on similar ratios prevailing in their services but there also being a slight increase in the number of male residents. Evidently this is still relatively minimal though, given that one group of participants in a particular area remarked on their experiences of relatives selecting certain homes for their male loved ones primarily on the basis of there being other men also living there at that time. This again raises the question of how care home environments might change in the coming years as the population ages and mortality rates continue to improve for men.

COMPLEXITY OF CARE

These changes in age profiles of care home residents and the associated needs of residents at each end of this spectrum all point to the increasing complexity of care provision. However, what this research confirms is that for all care home residents, not just those in the outlying age brackets, care needs have advanced significantly in recent years.

For instance, 65% of care home residents are now assessed as requiring nursing care: an increase from 61% in 2007. What's more, whilst 10% of residents had a physical disability or chronic illness in 2007 this figure has grown considerably to 38%.[20] In practice, what this means is that even those living in residential care homes as opposed to requiring on site nursing care are likely to have extremely high support needs, again blurring the distinction between these two types of care home.

"The work our carers are doing is mirroring the work nurses are doing."

This does not detract from the crucial clinical skills that are required in care homes and to which they are absolutely reliant on nurses for but serves to highlight that for all care home staff, their everyday working experience of providing care in 2018 is one of increased complexity and skill.

"There's a much higher level of dependency now – peg feeding, strokes..."

"Our residents are increasing in number and in medical dependency."

Therefore whilst we are seeing a less clear distinction between residential care homes and nursing homes, we may also be seeing more similarities between the types and levels of care delivered in hospital settings and those experienced in care homes. In an integrated health and social care landscape, this is an interesting reality and one that needs to be considered further as we strive towards developing a seamless continuum of care which prioritises the person rather than the setting or a uniform. The start of that discussion is in recognising the critical role care homes are now fulfilling in relieving what would previously have been additional resource pressures on health settings and in supporting better outcomes for individuals through their ability to provide on-site, homely yet complex and often clinical interventions.

"Before, anyone that needed IV antibiotics went to hospital and came back with a catheter, off their feet, with a pressure sore and a stressed family."

This relationship between care homes and other parts of the health and social care sector is also notable in terms of admissions. The simplistic 'stereotype' of a pathway into a care home is one where someone is no longer able to be supported in their own homes as their needs increase and are therefore admitted into a residential care setting. The reality now though is that that more straightforward and arguably better planned for journey is often circumvented by one or more hospital admissions and points of crisis, where decisions relating to such a significant move are borne out of situations of criticality, distress and high levels of dependency.

"Current need is primarily relating to hospital discharges and end of life care."

This trend removes any lingering preconceptions of care homes operating as 'retirement homes'. The reality is that they are often akin to hospital environments in terms of the levels of need they are supporting, whether they are categorized as nursing or residential homes.

At the other end of the spectrum though, some participants reflected on recent increased admissions from social work departments of residents with needs relating to safety as opposed to condition-specific ones.

"Recently we've been getting more admissions for adult protection issues rather than, for example, dementia."

There is not enough data to ascertain whether this is a recurring theme across the country but it is interesting in itself, given that it again points to the complexity of care and support provision required to meet such a vast array of needs and circumstances.

[20] Scottish Government (2018) *Care Home Census for Adults in Scotland* - http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Previous-Publications/index.asp

DEMENTIA

That complexity of care arises through the diversity of individuals of different ages and with different conditions being supported in care homes, but there is one condition that dominates modern day care home provision irrespective of age or other comorbidities: dementia.

The percentage of long stay residents living with dementia (either medically or non-medically diagnosed) in a care home for older people increased from 54% in 2007 to 62% in 2017 and was increasing year on year before 2007 too[21]. Participants who have worked in care homes for 30 to 40 years reflected that this is an element of care delivery that is substantially different to the time when they started their careers.

"We didn't see anyone with dementia back then, I think they were all in geriatric wards."

Even 20 years ago, whilst dementia diagnoses had increased exponentially, the approach to support was very different from today's approach. Now, regular use of anti-psychotic medication has been largely replaced by more holistic approaches to managing stress and distress and understanding the person beyond the diagnosis. Positively, participants reflected on the headway that has been made in recent years in destigmatising dementia and this has led to vast improvements in how it is recognised and treated both in health and social care and in wider society.

"I worked in a dementia unit in 1997. I had no training on dementia, it wasn't covered in my nurse training. We just managed it by medication. I didn't know about the different levels and types of dementia."

With the advances that have now been made in understanding dementia and improving dementia care, this means that care homes and their staff are not dealing with 'dementia'. Instead, they are required to understand and support numerous versions of the condition (vascular, Alzheimer's disease, Lewy Body, to name but a few) and understand how these generally manifest, how they impact each individual and how they progress. This means that the training care staff now need to undertake is far more sophisticated and advanced, their skillset needs to be different and it requires them to constantly adapt their practice to fluctuating need. They also continually have to assess whether a particular presentation, behaviour or symptom is a manifestation of someone's dementia or a distinctly different clinical or social need.

"I have 75 residents, 60 with dementia ranging from mild stage to end stage. Both of those stages are actually easier to manage, it's the middle that's very difficult. From moderate to advanced is where their personality is affected and the distressed behaviour occurs... there's not enough support given to us to provide the best dementia care. We don't get the help we need."

Support around dementia was one of the most frequently raised challenges associated with changes in residents' care needs. A number of care homes recognised the difficulties they can face in caring for a diverse population at different stages of their dementia without specialist support from the wider health and social care sector in the community.

"The one thing I find difficult is the lack of dementia support, especially at weekends. NHS 24 or social work will say 'call the police' which would just increase the problem"

It is concerning that in what is unequivocally a 24-hour, 7 days a week essential care and support service, the care home workforce is still challenged by a lack of access to critical out of hours input that can best support the needs and outcomes of an individual, avoiding an unnecessary hospital admission or emergency services involvement. Examples of care staff being advised to contact services such as the police demonstrates a continuing lack of understanding around what dementia support in care homes entails, what assistance care staff may need and how individuals living with dementia can have their needs best met. Whilst there are undoubtedly pressures on all parts of the system and resources are often thin on the ground, it would be extremely worrying to see a future trend of less specialist engagement with care homes from other professionals in an integrated care landscape, leaving these services further isolated from communities.

[21] Scottish Government (2018) *Care Home Census for Adults in Scotland* - http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Previous-Publications/index.asp

"There's more support for physical needs than mental needs – if someone is smashing the place up on a Saturday afternoon, you don't get that crisis response that you would get if someone broke a leg."

What this research as well as previous Scottish Care reports have highlighted is that care homes are as much centres for mental health support as they are for physical health needs, but that this is not sufficiently recognised.

Whilst significant progress has been made in raising awareness of dementia, this hasn't necessarily developed into a greater understanding of mental illness of older people living in care homes. Much more needs to be done to not only meet the needs of residents living with dementia but also to ensure care staff feel supported, safe and confident caring for people with a wide range of mental health conditions in sometimes challenging and distressing situations.

PALLIATIVE AND END OF LIFE CARE

The other particular area of recent care home change that stands out from the research is the increasing role of care homes in providing palliative and end of life care, both to long term residents and to those who are admitted to care homes almost entirely for this type of specialised support.

"We see much more palliative and end of life care now. Much more. And we do it well. We always have."

From April 2016 to March 2017, there were 11,296 deaths of long stay residents in care homes for older people.[22] This equates to more than a third (35%) of the entire resident population in this category of care home.

Indications are that this number will continue to increase given the changing use of care homes towards more complex support at a later stage in someone's life journey. Scottish Care's own survey data reinforces this data and future assumption as it shows that an estimated 38% of residents supported in independent sector care homes in the last year (to October 2018) have had palliative and/or end of life care needs.

This 'and/or' distinction is actually quite important given that participants noted there continues to be a level of blurring and confusion generally about what each of these terms consist of.

"People confuse the two. We had someone on palliative care for 5 years. Someone diagnosed with dementia is on to palliative care."

Marie Curie defines the two as:

"Palliative care can be defined as care for people living with a terminal illness where a cure is no longer possible. It's not just for people diagnosed with terminal cancer, but any terminal condition. It's also for people who have a complex illness and need their symptoms controlled....

...End of life care is an important part of palliative care for people who are nearing the end of life. End of life care is for people who are considered to be in the last year of life, but this timeframe can be difficult to predict." https://www.mariecurie.org.uk/help/support/diagnosed/recent-diagnosis/palliative-care-end-of-life-care [23]

Using this definition, it is easy to see how in reality the vast majority of care home residents in 2018 have palliative care needs.

"Most people coming in are needing palliative care."

Indeed, survey data tells us that whilst 41% of care home services have maintained consistent levels of palliative and end life care provision, 50% have seen increases in this form of care in the past 12 months. However, the challenge as they perceive it is that this growing

[22] Scottish Government (2018) *Care Home Census for Adults in Scotland* - http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Previous-Publications/index.asp
[23] https://www.mariecurie.org.uk/help/support/diagnosed/recent-diagnosis/palliative-care-end-of-life-care

component of care home provision is not always recognised by commissioners of services, Allied Health Professionals and other community services.

"Nursing homes are very good at palliative and end of life care – hospitals could learn a lot from nursing homes."

"We don't get recognition that it is palliative care we are delivering but hospices get loads. We do so much, but people fundraise for hospices."

Better recognition and support for good palliative and end of life care in care homes would not only promote a continuing increase in quality care and the sustainability of services, it can also improve this care across the whole health and social care system through expanding opportunities for joint learning, mentoring and training. Given that we have an ageing population and therefore more individuals and their families are likely to need support to experience a good death, there will be a growing resource demand in this area across all parts of the health and social care system. This must not, therefore, become an 'either/or' of public or professional advocating of one part of the pathway - whether that is hospital, hospice, care home or home care – over another, but about promoting and enabling the provision of high quality palliative and end of life care in all of these settings and giving individuals real choice and control over their care in the last stages of life. Services can only really flourish, innovate and develop if their value and workforce is valued, but for some reason this is not being experienced by care homes.

Perhaps that reason is the fact that care homes have only really stepped into the space of high levels of palliative and end of life care provision in the last decade or so.

"My mother died in a hospital 10 years ago but was living in a nursing home. It wasn't equipped to deal with palliative and end of life care at the time, so it's definitely a positive move now with advance care plans etc."

Popular understanding of care homes has not necessarily caught up with this reality and identified the crucial role of care homes in not only providing clinical, social and spiritual support at an often emotional and uncertain time but in enabling individuals and their families to remain to die where they are familiar and comfortable; in effect their own home. Being able to support people up to and including end of life is testament not only to the quality of care homes but to the skills and sensitive approaches of their staff.

"Palliative and end of life care is when a lot of relatives realise how good a care home is."

The mention of advance or anticipatory care plans (ACPs) was a common one throughout the research, with many reflections on how the development and implementation of these has and will continue to shape what types of support care homes deliver into the future.

"ACPs have made a massive difference. Very few of our residents go to hospital now. The GP will arrange care in the home. This is sometimes overruled by paramedics."

As use and knowledge of ACPs becomes more widespread, it is hoped that they can provide a recognised route-map for individuals as well as health and social care professionals to ensure support decisions are truly grounded in a persons' outcomes and wishes, and that care is built around that person. Part of this involves all of these professionals, including the likes of emergency service personnel, understanding what care homes contribute in this space.

"With the use of ACPs, there will be more palliative and end of life care in care homes. The elderly don't get that sort of care in hospitals."

Interestingly, care home staff spoke of already having observed a shift in how people think about different types of support and how strains on other parts of the system - such as hospitals - is leading more people towards a more positive view of care homes and the diversity of support they can offer.

"We're seeing a change in families in that they don't want their relative with, for example, dementia to go into hospital. A lot of people are coming in with bad experiences of hospitals."

Research participants were also extremely positive about the role of palliative and end of life care for care home staff in terms of providing fulfilment and showcasing the very attributes and values that make this workforce so

extraordinary.

"That's when you see that someone is working in a care home because they want to be there."

"I want to work in a hospice, that's my dream job."

The hope for the future is that a truly integrated health and social care landscape means that care homes are valued as a positive learning space and supportive environment for high quality, personalised palliative and end of life care delivery, accessible to and also supported by a wide range of health and social care professionals. They can serve as a significant step in a person's career pathway, providing them with a wealth of experience and confidence and enabling them to work across the wider system or to develop in a particular service. But we must also aspire to more health and social care professionals remarking that providing palliative and end of life care in a care home setting is their 'dream job'.

SO IS IT TEA AND CAKE?

"We had 2 people on palliative care, one with extremely challenging behaviour and the rest of the team were on the floor trying to hold everything else together."

Clearly, the reality of the myth that care homes exist to provide simple social support and to take people to the toilet could not be further from the modern day reality.

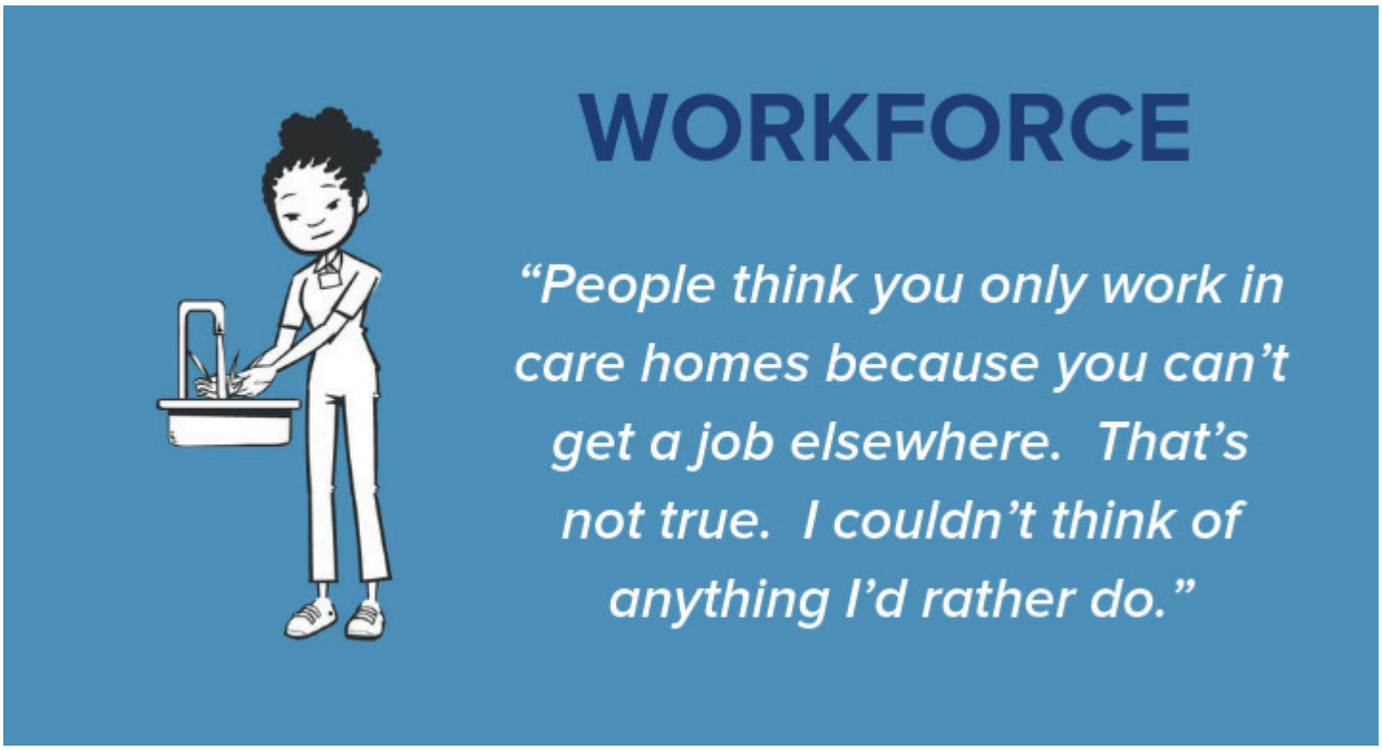
What an examination of changing care resident profiles and support needs has shown is that care homes are occupying a unique space in terms of the specialist yet generalist support they are expected to and are delivering, day in day out. They are specialist in terms of the skills, knowledge and facilities required to support individuals with conditions such as rare forms of dementia, Multiple Sclerosis, acquired brain injuries and end of life care. What's more, these conditions will very rarely exist in isolation. They are generalist because they deliver this care across an enormous span of ages, life experiences and stages of conditions.

Yet has enough consideration been given to the challenges that care homes face in doing so?

At one end of the spectrum, care homes are seeing an increase in younger adults requiring 24-hour support, presenting with a variety of complex support needs as a result of illness or injury. At the other end, there is also a growing care home population of very old individuals, also with multiple and advanced support needs, frailty challenges, and requiring palliative and end of life support.

Whilst at the same time there remains a third group of care home living with dementia. Whilst there has been a growth in the number of Dementia Units within care homes, the reality is that people are living in care homes with different forms of dementia, at different stages of progression and with needs that change on a daily if not hourly basis. Being an expert in every case is not easy.

And all these groups are supported in a homely, communal setting, providing opportunities for inter-generational engagement and a mirroring of common living dynamics in other households. However, every single person living in a care home has complex needs. This makes it extremely challenging for staff to ensure everyone's needs are best met all the time. For providers, it means ensuring that staff are not only sufficient in number but well equipped in terms of skills, confidence, training & personal attributes to manage a job which epitomizes the reality that no two days - and no two residents – are ever the same.



As care providers and staff highlight to Scottish Care on a regular basis, care services are nothing without their workforce. The people that work in care homes play a huge role in determining a service's quality, sustainability and impact on individuals' lives.

But the care home workforce is not a homogenous group and it is therefore important that we understand the reality of what the nearly 46,000 strong independent sector care home workforce looks like and is doing in 2018.

WORKFORCE PROFILE: GENDER

85% of those employed in independent sector care homes are female and this figure has remained fairly consistent over the past decade[24]. This gender mix, particularly the low numbers of men in the sector, was certainly reflected through the research.

"I have 70 staff and can count the males on one hand."

What was particularly interesting though was the trend for men who do work in care homes to undertake specific roles:

"There's not many men except in the kitchen."

"Our staff team is all female, apart from the manager."

Participants spoke of male colleagues generally occupying either practical ancillary roles such as handymen and chefs or working in management and directorial positions. It would be interesting to further examine the gender balance across all roles within the care home sector, but this research has highlighted a continuing under-representation on men in jobs with direct caring responsibilities. In reality, all caring and nursing roles require strong leadership and practical skills.

It is therefore important to understand why those already working in care homes believe this gender imbalance to be prevailing, and research participants openly shared their views and experiences on this subject.

The vast majority of the reasons given for a lack of men in care homes was the perception of care roles and their suitability for men.

[24] Scottish Social Services Council (2018) *Scottish Social Service Sector: Report on 2017 Workforce Data* - https://data.sssc.uk.com/images/WDR/WDR2017.pdf

These perceptions extended across colleagues:

"My husband is training to be a nurse and is the only male on the course. Everyone thinks he's gay because he's a man who wants to nurse!"

To care home residents:

"Residents tend to think that male carers are doctors."

And the wider public, including possible new recruits:

"We were at a job fair and it was interesting to see the people that saw the words 'care home' and walked past. Women would come over, but men didn't... 'Care' is seen as women's work."

These statements, particularly if they reflect experiences that are shared more widely across the sector, are troubling in that they indicate an enduring and substantial 'gendering' of a large and critical workforce at a time when there are already insufficient numbers to meet growing demand. They also point to an issue of public image and stereotyping of particular roles in a hierarchical way, where men working in health and social care are assumed to be in highly qualified, experienced roles such as those of doctors or to be aspiring to employment in acute settings. Wrongly, settings such as care homes are seen as either lower skilled or even unskilled and therefore a predominantly female environment. As the previous section highlighted, care homes are in fact only increasing in complexity which suggests that there may be some benefit in more public awareness campaigns for this sector in order to begin to challenge and change some of these misconceptions.

However, there are also some practical challenges at play in the reality of gender mix within care home employment. The most significant of these that emerged through the research was the issue of pay.

"There's nowhere near enough men because of the stigma, the salary... If you're the breadwinner, the only person that works in a household, it's not enough."

As a sector, we need to attract more men to work in all roles in order to secure a vibrant, sustainable future for care homes in which they can meet the needs of a wide-ranging group of individuals. The diversity of care home residents should be reflected in the diversity of the care home workforce through gender, age and life experience. This means that we need to be able to remove barriers to entry and retention in the sector created through its continuation as a low paid, low valued work environment. Whilst the sector supports the Scottish Living Wage as a first step towards improving pay and conditions in care homes, it is nowhere near enough to truly elevate the position of care homes to a more accurate one of environments of true reward: in the career options available, the difference it is possible to make to people's lives and in terms of financial recognition. It is therefore incumbent on employers but critically also the Scottish Government and Health & Social Care Partnerships who ultimately commission care home services to ensure that funding is sufficient to attract, recruit and retain the multiplicity of individuals needed in care homes into the future.

This is even more important given the changing profile of care home residents. Interestingly, some participants posited that the current gender balance in care homes is likely to be reflective of the current resident mix, which remains predominantly female. However, as already outlined, this is starting to change as men live longer and have increasingly complex support needs too. We may well see future care home services catering to a much larger proportion of male residents, which could have implications for the workforce composition. If our health and social care services are geared towards meeting not only the needs but the outcomes and personal choices of individuals, we would expect to see a growing number of men requesting support from workers of their own gender particularly in terms of intimate and personal care as well as social support. Unless we are able to recruit men to undertake such roles and make working in care homes an attractive prospect for them, how will we enable individuals to truly exercise choice and control regarding their care and support?

WORKFORCE PROFILE: AGE

Scottish Care's previous research report, '*The Experience of the Experienced*'[25], highlighted the essential contribution of care staff of all ages, including those aged over 45, as well as the real or perceived barriers to entry into care employment for various age groups. It concluded that careers in care have the potential to be rewarding and professionally fulfilling for people of all ages and backgrounds, but that we have to recognise

[25] Scottish Care (2018) *The Experience of the Experienced: Exploring employment journeys of the social care workforce* - http://www.scottishcare.org/wp-content/uploads/2018/06/SC-The-Experience-of-the-Experienced.pdf

and support the different needs of the various groups who comprise this workforce, such as older and younger workers.

Care homes are a sub sector within social care where there is quite a wide age span across employees including nearly 6,000 individuals under the age of 25. However, it is still an ageing workforce where 43% of all workers are over the age of 45. This includes approximately 6,000 workers aged 55 and over.[26]

It was therefore important to provide participants with the opportunity to reflect on any changes they had observed regarding the ages and experiences of their colleagues and to share their views on the mix required to provide quality care to current and future care home residents.

"We're now taking much more younger carers than before. Maybe younger people apply now?"

Some participants had experienced an increase in the number of those under the age of 25 applying for care home posts. This is not to say that there are necessarily more people applying, and may in fact point to a shortage of older individuals seeking to work in care homes. Interestingly though, some care staff described care work as increasingly a 'young person's game' as a result of the growing physicality of the role:

"We went from not having to hoist anybody to 4-5 hoists – it's time consuming. I've had to put an extra staff member on in the evening."

Indeed, amongst the research participants were older individuals who had taken on different roles within the care home. This was as a result of their own physical health constraints which limited their ability to undertake some of the tasks associated with delivering complex care to often frail individuals with mobility challenges, including moving and handling. This has considerable implications for the sector when considering the future workforce of care homes and how these services will be staffed if existing older workers reach physical burnout or face health and age-related limitations within their roles. It is a concern for both care staff and nursing staff in care homes.

Where people did notice a divergence in the experience of younger and older workers was in terms of retention within a care home service:

"Young people don't always know what to expect. There's more turnaround. They don't always give themselves enough time. I always say take a month."

With regards to younger recruits, participants identified a common theme of lack of knowledge of care home work as an often intimidating and sometimes overwhelming factor, with realities such as intimate care, complexity of support and emotional toll recognised as challenges for people without experience of care – professionally or personally - to grapple with. This can lead to a quick succession of new care staff leaving, often for good. It points to an ongoing challenge for the care home sector in terms of being able to provide relatively intensive support and mentoring to individuals in the first weeks and months of employment. This is particularly difficult to do when care homes are already short-staffed and facing high levels of demand but if done successfully, it could lead to momentous shifts in the number of people, young and older, choosing not to leave within the first six months or year of employment. There will always be people who, rightly, recognise they are not best suited for working in care homes but we cannot afford to continue to lose those who could be supported to flourish.

"We've just taken on 5 'older' ladies from a local factory that closed down. They've got families. They're more likely to stay."

Conversely, some care staff pointed to a different outlook amongst older recruits into care homes when faced with the reality of this line of work. Whilst this certainly involves a degree of generalisation, it is interesting to note the perception of family and other responsibilities as a significant reason why older individuals may choose to persevere with care home employment even when dealing with initial challenges to their preconceptions. It also highlights the importance of care homes to their local communities in terms of supporting employment and growth when other local services are under threat. However, these become meaningless if care home pay, terms and conditions are not also geared towards ensuring individuals with other caring and financial responsibilities are afforded sufficient flexibility and reward to make entering and staying in the sector an attractive option.

"In hospital, you get paid unsocial hours, nightshift, sick pay, almost double pay at weekends – you get none of this in care homes. It puts a lot of people off, especially when you're getting older and you're paying into a pension etc."

[26] Scottish Social Services Council (2018) *Scottish Social Service Sector: Report on 2017 Workforce Data* - https://data.sssc.uk.com/images/WDR/WDR2017.pdf

It is therefore absolutely critical that, for a vibrant and effective health and social care sector where staff feel valued and motivated in all roles, there is more workforce equity across and between the different component parts whether that is hospitals, care homes or home care services.

But do each of these age groups bring particular challenges or opportunities to the care home sector? This was a theme that emerged especially in relation to younger colleagues and one that participants felt particularly passionate about. A small number expressed concerns about the suitability of young people in terms of their attitude and experience but most other care workers challenged this strongly:

"You have to give people a chance. My daughter started in care at 18... It's good to have fresh ideas."

Indeed, participants detailed ways in which young people have contributed significantly and positively to care home practice and development:

"We took someone on at 16, they've done their SVQ2 and will work towards SVQ3. They've whistleblown on poor practice among colleagues twice their age."

It was also extremely helpful to have participation from young care home staff in the research, including those who had joined the sector straight from school and those who have been working in the sector for only a short period of time. Their reflections on this experience were extremely powerful:

"It feels like a family. It has made me feel valued and like I have a purpose."

This shows that care home work can not only be extremely beneficial to the diversity and quality of a service through the attributes that each member of staff brings to a care home and its residents, but in providing a workplace for young people where they can build skills, confidence, and a career. Participants spoke of the recruitment of young care staff as an 'investment': providing the opportunity to mould people into the care home workers we want and need for the future through their values, skillset, ideas, approach and motivation. In plugging existing vacancies within care homes, we must not lose sight of the importance of this developmental approach or deter people from viewing care as a career as opposed to a job through an outlook of short-termism and common reality of 'fire-fighting'.

Finally on the subject of age, an extremely interesting point was raised in relation to the role and influence of the Scottish Living Wage:

"For 17-19 year olds, it's very good – their friends won't be earning £8.75 an hour – but it creates issues with them being on the same as someone who's been there for a long time."

This suggests that the introduction of this minimum pay level for caring roles may have particular benefits for young people, hence why some services have seen more younger people taking up such posts. However, this initial pay advantage over peers in other sectors is generally minimal or removed entirely by the time someone is in their early 20s.

"Pay at every level in McDonalds is better – I could be on less than my son if he's working there."

If we are to truly recognise and value care home work as important and worthwhile, politicians and policy makers must stop viewing the Scottish Living Wage as a panacea when the reality tells us otherwise. Instead, it seems to be helping recruitment of an important yet relatively small proportion of the workforce often without enabling services to provide the support that is needed alongside the employment of such individuals, leading to young people leaving and a subsequent failure of this investment. Additionally, it leads to a levelling out across the sector which appears to disregard experience, skills and knowledge for those who don't necessarily want to progress to more senior roles. It also creates challenges in the wider workplace in terms of pay differentials since these are not recognised in Scottish Living Wage funding allocations. What's more, in being funded for those in direct caring roles only, it doesn't acknowledge the importance of those in domestic and ancillary roles who are equally critical to care home environments. The reality for providers in trying to manage this as retention challenges intensify is that 47% believe their organisation to be less sustainable as a direct result of the Scottish Living Wage.

When both young and older people are considering their career options, it should not be the case that roles in sectors with far less expectation, qualification and registration requirements and regulation outstrip such a vital sector in terms of financial reward.

RECRUITMENT & RETENTION

"I am amazed at the quality of care but the recruitment and retention challenges, even for a well-funded charity, are some that I haven't seen in other sectors and I've worked in all aspects of the public and charity sectors."

The recruitment and retention challenges being faced by the care home sector are so significant that they pervade every aspect of care home reality detailed in this report.

77% of care home services surveyed have current vacancies, indicating that less than a quarter of care homes are able to operate with a full complement of staff. On top of this, 41% have found recruitment of care staff even more problematic than it was in 2017, with nearly a fifth having experienced difficulties recruiting managers and a third struggling to bring in new domestic and ancillary staff. In terms of nurses, these challenges are even more profound with 60% of services finding it difficult to attract nurses.

In terms of retention, survey data estimates show that nearly a quarter of all care staff turn over each year. In terms of support workers specifically, 44% of those who left a care home employer in the last year did so in under one year of being recruited. These figures demonstrate momentous challenges for the financial health and overall sustainability of care homes who are constantly having to undertake recruitment processes and investing in staff who then leave. This has led to 56% of care homes relying on the use of agency staff at least occasionally if not frequently to plug care worker gaps. This figure rises to 64% for the occasional or frequent use of agency nurses.

These workforce challenges are so all-encompassing and have such an impact on all other aspects of care home provision, it is almost impossible to consider them in isolation. However, there are some particular insights shared by research participants that are important to consider when providing a detailed sense of 2018 care home reality.

"We had 32 applicants for a current vacancy and I emailed them all, less than 10 have got back to me and today we had no shows at interview."

The issue does not seem to lie in the number of people applying for posts in care homes. Or perhaps it does, given that numerous participants shared their frustration at applicant numbers not correlating with the numbers who go on to appear at interview and genuinely want to work in a service. Most put this down to an issue of Job Centre requirements for individuals to apply for a certain number of jobs. This is time-consuming for already stretched providers and managers, particularly when it does not translate into a successful recruitment process. As has been suggested in Scottish Care's previous reports such as '*The 4Rs*'[27], more work needs to be undertaken with Job Centres and other local partners to meaningfully, and accurately, promote careers in care with a range of different groups in communities.

What's more, there remain no guarantees that someone who has the necessary practical skills will actually be suited for the job.

"You can interview really well and it backfires – it wouldn't be the first time that's happened. I've had someone who ticked all the boxes and they were horrendous."

Working in a sector that is premised on relationships and requires many 'softer' skills, as well as a multitude of practical and intellectual abilities plus certain qualification attainments, really does ask a lot of new recruits for limited financial reward. This can mean that employers have to assess whether certain attributes can be developed in individuals. However it is not always possible to fully determine someone's suitability until they are working in a role, following induction processes and other investments of time and resource.

Participants were also experiencing challenges in recruiting specific categories of care home worker, especially those in senior care and supervisory roles.

"Recruitment is very difficult, especially for seniors & deputies."

"Whereas we used to see a massive response to job ads, we're seeing a massive drop off in numbers applying. Especially for senior care positions."

[27] Scottish Care (2018) *The 4 Rs: The Open Doors of Recruitment & Retention in Social Care* - http://www.scottishcare.org/wp-content/uploads/2018/03/The-4Rs-Report.pdf

Whilst some services are managing to overcome this problem by promoting from within the organisation, most services seem to have developed particular issues in filling these posts. Given leadership and experience are so important in the learning environment of care homes, it is concerning that at a time of significant change in the sector, there is a growing shortage of individuals able to support this. The survey data tells us that the most prominent reasons for shortcomings in potential recruits for such posts relate to a lack of skills, qualifications, experience in the sector and a lack of applicants due to low pay. This suggests more collaborative work needs to be undertaken between care home providers, front line staff and the SSSC to further explore how the requirements now needed for these roles can serve to improve quality of care without acting as barriers to recruitment and retention.

Finally, the biggest risk of ongoing recruitment and retention issues is that it becomes a vicious cycle of losing existing staff due to burnout in short term efforts to plug vacancies.

"The salary is terrible and the business element where you do more for less has made a dangerous mix of unmotivated staff, who are overworked and low paid."

"I often feel stressed. I work 12 hour shifts which gives me a better work/life balance but I am also 'on call' and live fearing a call due to staff constraints."

Whilst this statement may sound like a broken record, we need to urgently consider how as a health and social care sector we can break this cycle. We must overhaul perceptions, practice and policy affecting the current and future care home workforce because recruitment and retention challenges are moving us dangerously closer towards the sector shuddering to a halt.

CAREER ATTRACTIVENESS, PATHWAYS AND PROGRESSION

"A carers job used to be a quick fix – 'I'll just go be a carer'."

One of the most significant topics of discussion when considering existing care home myths was the subject of how people perceive a career in care homes. Participants recognised that working in these settings is frequently misconstrued as unskilled, unattractive and a 'last resort' job.

"The culture now is that people often come into care because it's perceived as 'easy' – to get into and to do."

This sense that people can fall back on a job in a care home when they have exhausted other options is adding to the lack of value placed on social care employment and is also unhelpful for those who do enter the sector and experience the reality of high demand and expectations on them.

"I was dismissed as 'just' a carer. It was years ago... but it made me feel this small."

The notion of care homes and older people's care in general being low down in a perceived hierarchy of health and social care employment is one experienced not only by care staff but by nurses in the sector too.

"Even when I was training as a nurse, I was seen as 'lesser' because I wanted to work in geriatrics."

Again, this was a view shared by both those entering the sector and those already working in it:

"Nurses in care homes can be treated as second class, as not 'real' nurses... by NHS nurses yes, but also by ambulance crews coming in."

Participants detailed instances where the 'taboo' around care home work remained evident in their interactions with others, reinforcing the findings of Scottish Care's

'*Voices from the Nursing Front Line*' report[28]. With regards to nurses, however, these negative attitudes seemed to exist more strongly amongst other nurses and health professionals rather than the wider public. Perhaps this points to the fact that a lot of people simply don't know that so many nurses work in care home settings. It is, however, concerning that other colleagues hold these views and treat care home nurses as less skilled, ambitious and capable than their NHS counterparts, not least because it undermines their professionalism. In some cases, it may even lead to decisions being made that are not in the best interests of care home residents, for instance whether an individual needs to be admitted to hospital or whether they can be supported appropriately with the skills and support of care home nurses.

On the other hand, some nurses interviewed as part of this research explained how working in both hospital and care settings, and therefore having seen different elements of the nurse role, had created or reinforced their passion for practicing in care homes. Both these negative and positive experiences highlight the importance of providing more opportunities for cross-sector and inter-sector learning and shadowing so that more people truly understand what nursing in a care home entails and can therefore make informed career decisions and judgements.

Positively, participants shared the view that despite the various workforce challenges impacting on the care home sector in 2018, opportunities for career progression and personal development continue to exist and to be taken up.

"I have progressed quickly within the home... The work is challenging, varied and enjoyable. The providers have recognised my ability and are supporting me to progress."

It is extremely encouraging to hear that providers are valuing their staff in this way and recognising inherent talents that can be developed to not only retain good staff and also to support service innovation and improvement.

"I think career progression is much better now. It's been good for me anyway"

What is important to recognise about career progression in many care homes is that opportunities exist to develop not only in terms of seniority but also to undertake lateral moves.

"You can progress if you want to, without needing to move on from the home."

With the diversity of residents as outlined previously, staff working in care homes often have the chance to gain enhanced knowledge and skills relating to a wide range of conditions and client groups. This is a crucial aspect of staff retention in order to keep high quality employees engaged and motivated in their roles. However, the experience and competency that staff have in both general and specialist areas is not something that is recognised, utllised or valued widely enough within the health and social care sector. In considering the future of care in an integrated landscape, this could be hugely beneficial for all care homes no matter size or location.

"There can be good career progression, if you want it"

'If you want it' or phrases to that effect were amongst the most frequent utterances on the subject of career progression, highlighting the importance of avoiding assumptions on individuals' career pathways in care homes. Aligned to the issue of an undervaluing of care work, there can be an issue of presuming that care and nursing roles in care homes are simply stepping stones to careers elsewhere or in positions of more seniority. The reality, in fact, is that many people working in care homes are fulfilled in their roles and should be supported to move and develop in ways that suit their own career ambitions within the care home sector, rather than limiting this to a view of upwards or outwards progression.

"I always said I just wanted to be a carer. Now I'm a senior, I'm questioning it. But I do want to learn. "

The distinction between learning and progression is therefore an important one. Yes, opportunities absolutely can exist in care home settings to develop and diversify in a person's career. However, what absolutely everyone who works in a care home will explain (and did so through this research) is that they learn every single day: whether that is facing a new condition to support, tracking the development of an illness, administering a different medication or simply speaking to a resident about their life experience. It is important, therefore, that providers, commissioners, regulators and policy makers recognise this difference and support both areas to be protected

[28] Scottish Care (2016) *Voices from the Nursing Front Line* - http://www.scottishcare.org/wp-content/uploads/2016/11/SC-Voices-from-the-Nursing-Front-Line-.pdf

and promoted as a unique selling point of care home work.

"Now I'm older, [career progression] is not as important as when I was younger. Now it's about caring for people."

"I want to treat my residents as I would my parents & stick to my principles."

Part of this recognition must also take the form of allowing people to 'just care'. This is in no way a derogatory statement but is in fact a phrase emphasised by participants in various ways to underline the importance of, in a climate of ever-increasing demand and lessening time, being able to apply their values and qualities to their work. These are the very things that give people the passion and the drive to succeed in care home employment and to make a meaningful difference to residents' lives in a way that goes beyond keeping people 'safe' but enables them to experience compassion and love from the staff that support them.

"People actually do care. We cry when people die, it's not just a job. You can become so involved with that person, the family can actually become jealous of you."

"To this day I miss John, and that was 20 years ago that I nursed and cared for him."

DO PEOPLE ONLY WORK IN CARE HOMES BECAUSE THEY CAN'T GET A JOB ELSEWHERE?

"People need to remember that what we do is 'care' – everybody who works in a care homes cares. That's why it's called that. We invest a lot of our own lives, this is not a job."

In the same way that care homes support a diverse range of individuals, they also employ a wide range of people of different ages, gender, background and life experience.

They offer not just jobs but a career and even a purpose to people leaving school, people who pursuing a change in career through choice or necessity, those re-entering the workplace after having their own families, and everyone else in between.

But that absolutely does not mean this should be misconstrued as a simple career option. Care homes demand a lot of their workforce as a direct result of the nature of the work: physically, emotionally and intellectually. In the same way that we revere people who choose careers in medicine, law or education, we must start recognising the criticality, commitment and rarity of those who are cut out for jobs in this sector. It is not a job anyone can do, whether they want to do it or not.

One of the oldest and most common concerns that exists regarding care homes is about the quality of services, whether that relates to the care and support delivered or the people who provide it. This is not surprising given that these services support some of the most vulnerable citizens in our society. Any example of harmful practice by an individual or organisation should be identified and dealt with robustly. In recent years, such incidents tend to draw media interest and reporting which unfortunately can colour public perception of all care homes in a negative way.

The reality is that, according to Care Inspectorate data, 82% of care home services for older people were graded good, very good or excellent as of September 2018[29]. Whilst there is always room for improvement, this shows that the vast majority of care homes are providing high quality care and support. There is not an equivalent quality grading structure for NHS establishments.

As has already been tracked in this report, there has been an increase in regulation and scrutiny and its robustness over recent decades; the care home sector and its workforce has never been so highly regulated. These processes increase accountability and public assurance that services are delivering care in a way that protects individuals' safety, human rights, dignity and wellbeing, and these were reflected on positively by research participants. However, unprecedented levels of regulation from a number of different bodies also brings a degree of challenge for providers and staff.

"It feels that we are bombarded with information, expectation and scrutiny."

OUTCOMES

One notable change in the care home sector in recent years has been an increased focus on individual outcomes, personal choice and control and the promotion of a human-rights based approach to all aspects of care provision. Participants deemed this to be an extremely positive direction of travel.

"There's more choice, dignity and respect – individuals are valued."

"After 19 years, my role has more impact on the care I provide and on the sector."

This is not to say that many care homes were not already operating in a way that aimed to protect the best interests of residents but the new Health and Social Care Standards and the SSSC Codes of Practice have helped

[29] Care Inspectorate (2018) *Quarter 2 Statistical Report Tables* - http://www.careinspectorate.com/images/CI_Stats_Report_Qtr2_18_19.pdf

to ensure it is the norm. This has also enabled care home staff to identify ways in which their practice can continually be adapted and improved as the preferences of individual residents change.

"Before, every resident had to be up, washed, dressed and in the sitting room but not now. We have a rolling breakfast for 2 and a half hours – people can have breakfast in bed, in their jammies..."

However as expectations are raised around supporting people to have their personal preferences met in all aspects of their daily care home life, this is not without its difficulties. It is not always easy to combine some aspects of individual control with providing intensive support to people who remain frail, unwell or experiencing physical or mental challenges and achieving this for all people at all times in a communal living environment.

"Personalised outcomes are really going to get us thinking differently – we're not geared up for it at the moment. We're staffed around tasks."

This should not be a reason not to aspire to this but it does have implications for the care home workforce and how the sector is funded. Many research participants spoke of previously having time to spend with residents but that this has been eroded by managing competing priorities with constrained resources. We therefore seem to be seeking, in terms of social care policy and regulation, to return to some of the values and approaches that existed in years gone by without sufficient cognisance of the modern reality of care homes. Residents have higher support needs, staff are under significant strain and care is not suitably planned for or funded in a way that enables wider needs and preferences to be consistently met. Instead, care homes and their staff are often having to strive for this by going above what they are resourced to do, which is not sustainable or fair on either services or residents.

It is also critical that all parts of the health and social care sector are working towards the same ambitions regarding rights, choice and personalised outcomes. However, participants indicated we may still have a way to go before this is a consistent reality.

"I don't think a lot of residents really get a choice about where they go – they are forced because they are 'blocking' a hospital bed, families decide, care homes have waiting lists and they have to go to the first care home available. They're not seen as 'people', they're seen as 'bed blockers'."

"In hospitals, they move dementia residents to 4 or 5 wards and they do it during the night. No wonder they are confused."

This does not mean pointing the finger at any particular part of the system but rather recognising that we cannot solely scrutinise services such as care homes without applying the same expectations to all services involved in the support planning, assessment and provision to an individual. Someone can move into a care home and have their human rights and outcomes met there, but if the process by which they came to be in that service means that their rights and choices have been compromised, that is not a model that should be accepted even if it is the result of strain on all parts of the sector. It also puts more pressure on those care homes who are often supporting people who have been admitted at a period of significant distress and without those support decisions being sufficiently planned, understood and agreed. We must all work towards enabling meaningful choice and the best outcomes for individuals within care homes as well as in the services that support residents - before and during their care home residency.

Care home staff have also noticed a positive shift in terms of outcomes through the types of compassionate care they are supported to deliver.

"To me, 'overstepping the mark' is not giving someone a cuddle, bringing in a DVD for them or buying them a chocolate bar. Care is about building relationships, this is their home."

Care staff are very clear that the unique strength of social care is the 'social' aspect of it: the connections that care staff can build with the individuals they support and help them to feel 'well' in more ways than meeting their clinical needs. However, there remains a bigger job in informing the general public and policy makers about how important care homes are in providing this type of support, alongside extremely complex care interventions.

"The inspector commented how good it was to see staff giving residents a cuddle. Years ago that wouldn't have been the case."

It is encouraging to see regulatory bodies recognising and supporting this more. In protecting this 'social' element to care home provision it is critical that regulatory practice is sufficiently balanced to ensure safety and quality but to also give care home staff the time, flexibility and individual discretion to deliver person-centred care.

"You can't get all the paperwork done in time. It's far greater than with nursing care plans in the NHS."

"I wanted to make a difference and I'm back to sitting behind a desk."

Participants shared a view that whilst regulation looked very different in the past and may have been insufficient in a number of ways, more recent forms of scrutinising the quality of a service and its staff have swung to the other extreme whereby documentation of care is, from the perspective of care staff, taking precedent over the time needed to deliver care well.

This points to the ongoing importance of a collaborative relationship between regulatory bodies and providers to ensure that positive outcomes are being achieved for care home residents through the right balance of delivering personalised support, evidential paperwork and workforce needs.

"When you walk in, you can tell if residents are happy – that's so much more important."

SERVICE REGULATION

"I think it's really important that care homes are inspected regularly and unannounced."

It is worthwhile noting that almost all research participants felt that service regulation and inspection through the Care Inspectorate is a really important aspect of assessing and improving care quality. If the belief still exists that care homes are places of neglect and poor care, the fact that care staff value scrutiny as a way of inspecting practice and welcome greater transparency, flies in the face of such myths.

"Families tell us they've seen our Care Inspectorate reports before choosing the home for their family member. This would never have been able to happen before."

"I find [the Care Inspectorate] extremely helpful and find the inspection process a vital part of our business as it gives us an opportunity to see possible strengths, weaknesses and developments."

This is further reinforced by our current research survey where we discover that 63% of services believe their relationship with the Care Inspectorate to be a positive one, and 78% feel well informed on changes to regulation and inspection.

This is particularly important given the considerable changes that have taken place in the last 12 months around standards and inspection methodology. The new Health & Social Care Standards represent a markedly different way of providing and assessing quality care through a foundation of human rights and individual experience. They have been introduced in the first instance in care homes for adults at what is already challenging and busy time for the sector with a lot of other reforms also taking place. There was therefore a risk that the optimism for this new approach could be subsumed by anxieties about how it would work in practice. However, it is encouraging that most services do not seem to be overly worried and indeed almost a third feel confident about the new inspection process and methodology.

This confidence may correlate to the services who have experienced or heard about experiences of the new inspection process in action. Whilst 78% of care homes have not yet been inspected according to the changes, those who had – both through the research groups and the survey – were overwhelmingly positive about that experience.

"I do like the new inspection process. They're out speaking more to residents and staff. The feedback is also better - very constructive as opposed to destructive."

"I've been inspected on the new framework and it's better. It's more focused on outcomes and less based on paperwork. More in discussion, asking people what their experience is."

People spoke about the new process being much more engaging from the perspective of staff, residents and relatives. In turn, this seems to be leading to care staff feeling more confident about building relationships not only with a service but with inspectors and feeling empowered to be proud of the work they do.

"She's not out to catch you. Our new inspector very much isn't like that."

"You should tell your staff, 'don't hide'. They're not trying to catch you out."

This is certainly a substantial change in attitude compared to data collected by Scottish Care in previous years about inspection experiences, where care homes spoke of feeling as if inspections were premised on finding fault and could often feel oppositional.

Undoubtedly, there will continue to be a contingent of care home services who remain nervous and unsure about whether the new inspection process will signify a meaningful progression towards trust and improvement-based relationships rather than an 'us and them' dynamic.

"The Care Inspectorate are certainly working in a more collaborative way and we appreciate that. Our inspector is approachable and helpful but one still can't get past the feeling that we could be open to scrutiny that would make all the good work we do slip under the weight of audits and procedures etc."

It is only through time and consistent positive experiences that more care home providers will feel like a partner in service regulation rather than merely a recipient of it. Positive experiences do not have to mean high grades if these are not merited, but a genuine desire to support services to improve and for regulation to be proportionate and grounded substantially in the happiness and wellbeing of residents rather than in documentation and tick box exercises.

One way that regulation absolutely needs to continue developing for care homes is through the consistency of relationships with inspection staff. The most common theme that surfaced regarding regulation was this very issue, with almost all responses centred on the importance of these relationships and around a quarter of these specifically mentioning consistency as a key element.

"We never get the same inspector so they don't know what we've updated or what's been recommended by the last one. There's no consistency."

"For a few years we had a different inspector every year so although grades were good, it was difficult to move the grades forward as improvement could not be evidenced."

Within the focus groups, staff detailed having had three different inspectors in the space of three years and even four inspectors within two years. This was described as 'unnerving'. In a sector where so much relies on relationships, it is crucial that this also extends to regulation if we are to support the development and innovation of a care home sector towards one that is fit for the future. Where this stability does exist, it undoubtedly reaps benefits not only for services but crucially for the individuals they support.

"We have had a consistent Care Inspector for a few years and he has learned about deaf service users with additional disabilities - which is what our service is all about."

On the other hand, if regulatory practice is not based in genuine understanding of individual services and the sector in general, then it risks alienating providers who do want to develop their services but cannot do so because of unreasonable pressures and asks placed upon them.

"Lack of consistency in inspections, coupled with unrealistic expectations, impact on the organisation's ability to affect change within the constraints of the 'real world'."

"In some ways I would like to say positive. However, the lack of consistency as well as their inability or unwillingness to accept that we are operating under conditions of extreme prejudice & unprecedented financial stress make it difficult to give more than a neutral position."

There is so much potential within the new Health & Social Care Standards, the revised inspection methodology

and the development of more positive links between care homes and the body that regulates them, to truly innovate and continually improve the care home sector for current and future needs. However, this involves working through the many challenges that face the sector together, and will require brave steps on both parts because at the moment, consistency of care – a key inspection success criteria - is becoming an impossible ask of many care home providers. It means recognising that care homes are currently operating in a climate that does not facilitate positive change easily and needs both providers and critically, regulators, to be asking difficult questions as to why this is the case.

WORKFORCE REGULATION

As has been confirmed in previous Scottish Care reports, care home staff are also very supportive of workforce regulation through the Scottish Social Services Council (SSSC).

"Registration is a good thing, I agree with its purpose. Before, you could've been hiring anyone."

Research participants attributed this support to the improvements registration of the workforce has made in minimising poor practice, through the existence of the SSSC Register. Both care home employers and workers felt strongly that individuals who do not have the values and skills required to deliver high quality care in the sector need to be identified and prevented from moving around care services which previously, may not have known their practice background. Other supportive feedback related to increased accountability for individuals and a greater sense of professionalism within the workforce.

Whilst many understood and supported the sense of individual responsibility associated with registration, some did comment on the issue of registration fees as another barrier to entering – and remaining - in the sector for some individuals. From an employers' perspective, this was also recognised as problematic when it resulted in individuals being suspended or removed from the Register as a result of fees not being paid.

"Notifying if someone is off the register has a massive impact on a small service. The individual gets notified but not the service until someone is taken off."

In a sector that is already challenged by severe workforce shortages, it is easy to see how even one individual facing registration difficulties and unable to work at short notice without the prior knowledge of their employing service, can detrimentally affect care home provision, particularly for smaller or rural homes.

Interestingly, only a third of organisations surveyed indicated that they had a positive relationship with the SSSC. Instead, 64% of services determined this relationship to be 'neutral'. Upon further exploration, the predominant reason for this is a lack of regular contact or engagement with this regulatory body. Those that had had reason to contact the SSSC had generally had positive experiences, but the sense was that this tended to be provider-led rather than regulator-led and was generally to resolve a specific query or concern. However, providers did express a desire for more engagement with the workforce regulator going forward.

"The SSSC have been to a branch meeting and supported us on the Steps to Leadership programme. We'd always love more involvement."

This relationship is always going to differ from the one that providers have with the Care Inspectorate given there is not a face to face scrutiny process associated with workforce regulation. However, sanctions still apply if individuals and organisations do not meet registration expectations and requirements. It is not only beneficial but crucial that we continue to work towards a closer relationship in order that there can be ongoing two-way comprehension of the care home workforce, the skills and developments required and the challenges this workforce face.

"[The SSSC] has very little understanding of the workforce and therefore builds processes which have little connection to the real lives of staff."

Providers' ultimate frustration with both regulatory bodies is not necessarily the sense of expectation for continual improvement that they place on services and individuals, but how this can often feel detached from the reality of the real issues that care homes are up against, such as the under-resourcing of services and having a low paid workforce.

QUALIFICATIONS

"A very demanding/inflexible approach. SSSC are trying to impose professional standards on a group of workers who have not been granted any professional kudos. It is unfair to ask a care worker, who receives minimum pay, and whose educational attainment (SVQ 2 minimum) is not as valued, to meet the same standards as a nurse or doctor or teacher. A huge strain is placed on any individual care business who does not have a huge administration team to monitor and manage staff's SVQ registration and it is disingenuous to state that this is their own responsibility. It shows a lack of understanding of the socio-economic and educational status of much of the care workforce. In reality, many staff need their employer to help guide them through their responsibilities."

This frustration is currently being felt most strongly in relation to the SVQ model of qualification attainment required by the SSSC as part of the registration process. Understandably, care home providers are concerned when they experience paper based requirements serving to drive people out of the sector rather than confirming and recognising their skills and knowledge. Quite a few research participants shared examples of colleagues who had taken this unfortunate decision.

"One member of staff has gone into the kitchen when there was a vacancy there to avoid doing an SVQ."

This pattern is not necessarily borne from people's ability - or lack of - to actually complete an SVQ but instead from the fact that it marks a significant recent change in terms of obligations for care workers and for some, is seen as an undermining of the many years of experience they may have in care homes.

"Everyone in a caring role needs to have at least an SVQ2. That's different. No one ever needed a qualification before, it was notable if someone chose to do an SVQ. Now everyone needs to, but in most places people need to pay for it themselves."

The issue of payment for these qualifications was found to be hugely significant for what remains a low paid workforce. Whilst 52% of organisations told us they fully fund staff qualifications, the remainder are either only partly funded, not funded or operate under a payback scheme to their employer over a period of time.

However, others were positive in relation to how undertaking the SVQ had highlighted the extent of their knowledge and capabilities which made the slightly daunting prospect of doing it worthwhile.

"You don't realise how much work is involved but you also don't realise how knowledgeable you are until you have to write it all down."

"It's how you practice, not how you write things down."

This shows how important it is for vocational qualifications such as SVQs to strike the right balance between ensuring competency and capability but doing so in a way that boosts confidence and reinforces existing skills rather than seeming to be a monumental task for individuals who may not consider their skillset to include academic levels of writing and study. SVQs can be a hugely valuable form of accreditation within the care home sector but it is the current lack of flexibility and choice around them that is having a detrimental effect.

What stands out most from feedback on the reality of qualifications for the care home workforce is the range of opinion that exists on how fit for purpose the current model is in terms of timescales for attainment.

"5 years is too long to get qualifications – people can just leave after that."

"You only get 9 months to do SVQ3. There should be the same timescales for all."

"SVQ level 2 should be done in the first year, although not in the first few months. This would help people to stay, showing investment in them straight away."

"SVQs seem easier to get now – that's worrying. They're rushed through and not as in depth as they used to be."

"We've got a group of 10 fairly new staff and they all want to do it but the SVQ provider is saying that they can't put them all through."

We do not have the answer to what the correct timescales are for obtaining social care qualifications: what would suit some people would undoubtedly not work for others. Yet what this does highlight is that the time is now for further engagement with care home staff regarding how the qualification system can be improved and made most meaningful, both to ensure and enhance the high levels of skill and knowledge now required of workers but also to act as an incentive rather than a barrier. After all, the strongest message from care home staff on this subject was that staff came into the sector to care, not to enter a scholastic environment and this must be protected.

TRAINING, LEARNING & PRTL

A workforce that requires qualifications to practice and which delivers highly complex care is inevitably required to also undertake a significant amount of training. However, participants told us that it is a common misconception that care homes are poor learning environments and an 'easy' place to work in.

"I didn't think you had to do all that training."

The reality is that care homes are likely to be amongst the most varied and changeable environments to work in across all sectors. As a result, there is an obligation on services and staff to remain up to date with best practice alongside continuously extending their practical knowledge about different conditions and individuals.

"There's so much more training we must do now. It used to only be some mandatory training, moving & handling, that sort of thing. There's so many more topics now."

As was outlined earlier, even broad areas of learning such as dementia now have far more components to them. For example, a care home can be supporting individuals ranging from their mid-50s to those over 100; all with conditions such as brain injuries, strokes, dementia, degenerative diseases, physical and mental health challenges; some with high levels of mobility and others at end of life; whose nutritional, activity, social, hydration, medication and spiritual needs must all be assessed, met and documented. We therefore begin to comprehend the level and intensity of training and learning that is required by each member of staff in a care home to do this well.

What's more, care home staff are also now obligated through their registration to undertake a minimum of ten days of post registration training and learning (PRTL) depending on their role. As participants told us, this increased and ever-increasing level of expectation regarding training and learning is having an impact on the sustainability of the care home workforce.

"PRTL has taken its toll."

"We lost a couple of staff when PRTL came in. With SVQ, registration, they'd had enough and left. Lots of people get their documentation returned [by the SSSC] to write more. It's insulting."

Where this impact is most felt is in the ability to sustain a healthy work/life balance, given current staff shortages and the existing level of demands on time within an everyday care home shift.

"I'm trying to give staff time in the working day to do training and learning. I don't want them spending 2 hours at night having to do that, but it's hard."

Whilst some managers told of trying to protect time for their staff to accumulate such development hours during their shifts, it appears to be becoming increasingly challenging for them to maintain this level of support. Others longed to be able to do this but found it to be impossible to implement within their services.

The majority of care homes (58%) attribute this challenge to an insufficiency of resource within existing care home funding frameworks to allow for training, learning and development needs. Again, the issue of the Scottish Living Wage emerges here since many care homes have had to eat into training and learning budgets to cover the costs of implementing pay differentials which are not sufficiently funded through the Scottish Living Wage commitment.

"With the new wage structure we struggle to build in training and development within the constraints of our budget."

Positively, a number of participants noted that more opportunities for shared training are opening up across the sector with NHS, Local Authorities, third sector or fellow independent sector counterparts. This is not only widening access to free courses or reducing the cost to individual organisations for training, but it also enables more cross-sector informal learning and networking to take place which is arguably equally beneficial in an integrated landscape. However, it appears this has not had the full desired effect yet given that some providers perceive there to be at worst, a prejudice against the independent sector and at best, a lack of awareness of the training challenges this sector faces.

"There is no funding and when courses are advertised by the statutory sector with access for care providers, the places have usually already been offered internally, followed by the voluntary sector then released to the private sector. Additionally, we operate on a staffing knife edge at the best of times. We have no backfill capability due to the staffing crisis. Our only option for backfill is to employ agency staff which is extremely expensive."

Worryingly though, it is the care home workforce who suffer the consequences of this lack of investment in their development, which frequently impacts on their work/life balance and will do nothing to ease the challenge of workforce retention and staff burnout if it is not addressed.

"I've got to babysit my grandchildren etc, I can't always use my days off."

"Care staff are predominantly female. They have family commitments outside their work place. They do not have time to give up days for training and small care homes do not have the resources to pay for both the training and their attendance while having to also pay for extra cover for their shift."

We as a sector and as a society are currently failing to adequately value and respect what is a predominantly older, female workforce in how we upskill our care home staff. As the needs of Scotland's older people continue to advance in number and complexity and we become even more reliant on an ageing workforce to support them, we must think very carefully about what this means for care homes and the people they support now, and into the future.

If this future prospect isn't reason enough to effect meaningful change, then the benefits of proper investment and support for training and learning speak for themselves:

"I have so much more confidence, in myself and in my job, because I've done lots of training."

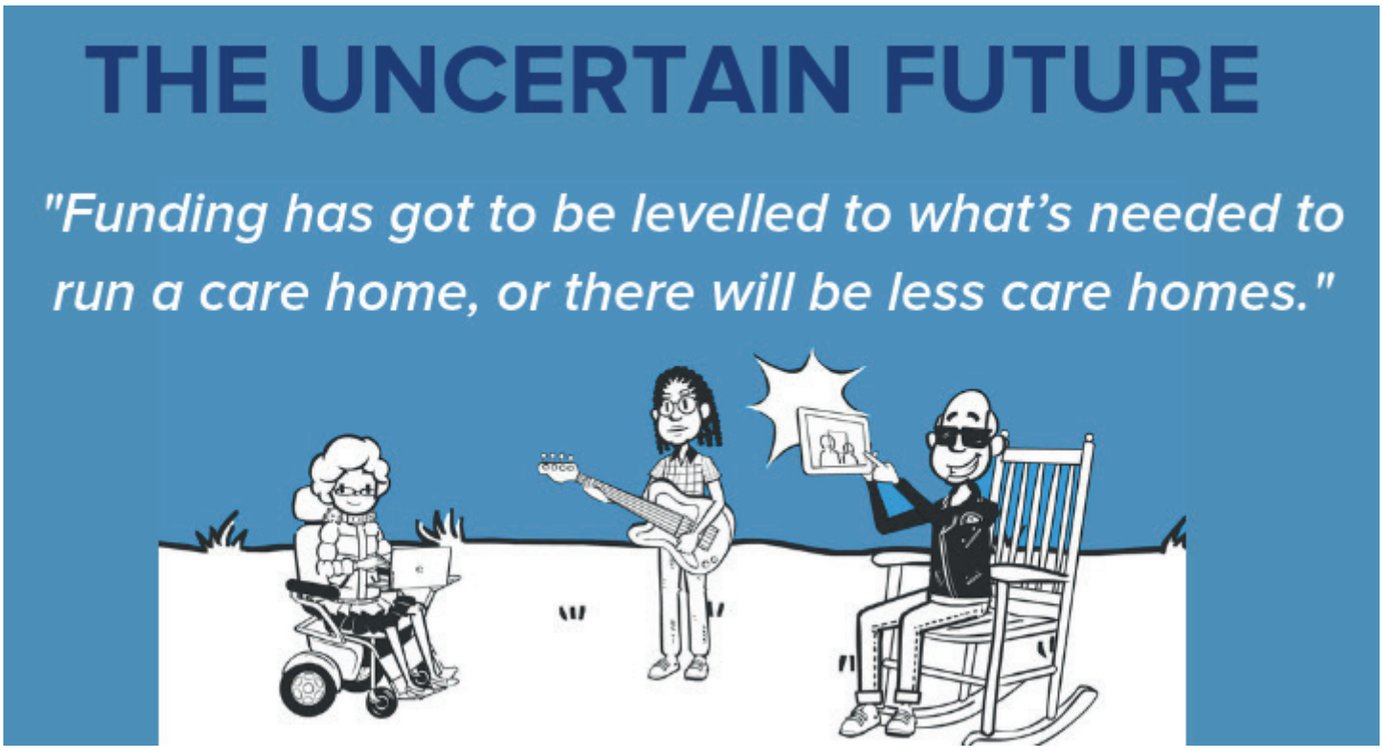
A workforce full of individuals who have this confidence, motivation and passion for their roles must surely be what we all want, what we must strive for and what we must facilitate through the reform of funding and support mechanisms.

ARE CARE HOMES CENTRES WHERE POOR PRACTICE IS COMMONPLACE?

"Care homes will hopefully continue to develop as centres of excellence for care of the elderly and be a hub for the community to visit and interact with."

The evidence speaks for itself in busting the misconception that care homes equate to poor care. The reality is that care homes, by a huge majority, are places of exceptional support and where staff strive every day to improve the experiences and lives of the people they support. And it is not done behind closed doors. Care homes welcome scrutiny, want to be transparent and want to work with others to continue to improve.

Yet what stands out from an examination of modern day regulation is a growing need for proportionality and flexibility, without compromising quality of care. Growing expectations of what can be delivered need to be balanced against the existing challenges relating to funding, resource and workforce shortages.



This research has provided a descriptive account of the origins of care homes up to and including the current reality. It has highlighted significant changes in resident needs, the care home workforce, and how the sector is regulated.

It builds on a series of research projects undertaken by Scottish Care that have sought to examine the reality of social care services and workforce requirements across Scotland and explain why less people are choosing to work in social care, and more people are leaving. Our reports have shown the impact on care homes and their workforce of delivering palliative and end of life care and have examined the mental health needs of older people and of social care staff. They have also highlighted the recruitment and retention challenges within the sector and detailed the employment journeys of what is a predominantly older and female workforce.

This research pulls many of these themes together and describes care homes in a way that removes any semblance of doubt as to how they have changed, what they offer and why they are a vital component of health and social care in 2018.

But what it has also uncovered is that we now need to be asking why.

- Why have care homes developed in the way they have to the position they occupy in the present day?
- Why are we making particular changes in the sector?
- Why are making decisions at a local and national level without early and meaningful consultation with care homes?
- **Why is that that the future remains uncertain for care homes, rather than one which is planned, progressive, strategic and innovative?**

We need to ask these questions and genuinely interrogate both our actions and inactions because we are at an absolutely critical point in the history of care homes and social care more generally. Care homes will not continue to change and evolve to meet the needs of some our most vulnerable citizens – young and old – without being at the heart of strategic change.

They can either serve as a fantastic, innovative exemplar of an integrated approach to health and social care that values both the people that require support and the people that deliver it. Or they can decline in number and quality to a point of near eradication in the next ten years because their contributive reality was not acknowledged and supported to be both sustainable and fit for purpose. If that happens, we need to have a very clear plan for the hundreds of thousands of people and services that rely on them for care, support and employment.

As with all previous Scottish Care reports, this research seeks to provide a solutions-focused approach to how we address what are diverse and complex challenges facing care homes.

Care homes as a key component in integrated service provision

This report has detailed the development of care homes across the decades and has indicated that at all times they have played a critical role in the health and social care economy of Scotland. This has been substantially articulated in the Scottish Government priorities to enable people to live for as long as possible as independently as possible 'in their own home or in a homely setting.' Such an aspiration is one which the majority can assent to and agree with. However, there are growing concerns that the ability of citizens to choose the 'homely setting', i.e. the care home, as a place of independence and personal fulfilment is being marginalised if not dismissed. An examination of a number of recent Integration Strategic Board Plans both indicate on the one hand a belief that care homes are 'institutions' and should be categorised alongside the acute hospital sector and on the other, evidence a desire to withdraw public funding from care home placements. This is dangerous on two counts. The first is that any reading of this report will show that a mature understanding of modern care homes would see them a key contributor to the care of some of our most vulnerable citizens in very 'non-institutional' settings. This is especially true for those living with advanced dementia and reaching end stage of life from a number of conditions including frailty. Secondly the desire to withdraw from funding care home places is acting against the principles of the Self-directed Support Act. Regardless of the individual wishes and outcomes desired by citizens, a decision has been taken to limit finance for a service option and as a result, fails to develop the care home market to enable choice as the SDS Act requires. One might conclude that this risks becoming discriminatory treatment given the age and needs of those using care home provision.

Work on understanding resident needs

All stakeholders concerned with social care, whether at policy or practice level, should seek to work with urgency and in a collaborative manner to ensure that decisions currently being made are fully cognisant of the distinctive, unique and complimentary contribution of care homes, not least in supporting advanced dementia and palliative and end of life care needs of an increasingly ageing population.

For the future, how do we retain what is clearly fantastic about these settings in meeting resident needs whilst supporting them to manage such complexity? We can have exceptional care homes that deliver high quality multi-generational support and are vibrant and attractive community hubs, care settings and workplaces as a result of this. Alternatively, we can have a sector effectively crippled and crumbling under the weight of providing care to a vast range of people with insufficient external support.

Work which is currently underway in partnership between Scottish Care, COSLA, the Care Inspectorate and the Scottish Government will go some way to developing tools to address the issues of capability and staffing required to properly recognise and support the dependencies, needs and outcomes of residents.

However further work needs to be undertaken as a matter of some urgency to address the fragmented practice around initial assessment, including clinical assessment, which is currently failing to adequately address the dramatic changes in clinical and nursing needs of those presenting as requiring residential and nursing care home support.

In addition, action must surely be taken to ensure that those who require their personal outcomes to be met through care home provision are enabled to be in receipt of the whole range of choices and options open to other citizens who might be able to be supported and cared for at home. The historical stress upon maintenance and safety for a vulnerable older age care home population fails to adequately recognise and resource the capabilities and potential of older people. Specifically, there is a real urgency to address the fact that very few of those 32,691 older people in care homes today are in receipt of packages of care and support, of individual budgets and choice in terms of the Self-directed Support Act. The step-change SDS offers all citizens around control and choice cannot continue to be ignored by assessors and commissioners of care home provision. It is an individual right which could be transformative in terms of the control and choice of individual residents in care homes.

The need to transform workforce support

We are at a critical juncture and a unique point in social care history, whereby care is more professional and skilled than ever before yet appears to be less attractive as a career.

We therefore have to seriously consider what we want the care home workforce to look like in the future.

We can have a valued, competent and confident care home workforce who want to work in the sector, who serve as ambassadors to other young, middle-aged and older recruits and who are rewarded appropriately for their vast array of professional and personal competencies.

Or we can devalue, depersonalise and demoralise the workforce by treating them as 'lesser': to health colleagues, to other sectors, to male-dominated careers,

and to our society. If we do, we simply won't have care services for our most vulnerable citizens. And as a result, our health services will also be decimated due to the interdependencies between the two sectors. They cannot exist without each other and neither can survive into the future without an integrated, stable and valued health and social care workforce.

There is a real urgency upon us all to recognise the genderised nature of care and the associated reward for the role which this report has articulated. In so doing we have to ensure that we do not consider that the Scottish Living Wage intervention, however implemented, should be the ceiling of our ambitions as a society. The continued under-valuing of care as a career cannot realistically continue for much longer without the clear cracks in the ability to recruit and retain a care home workforce being unrepairable. Yet again Scottish Care is calling for a Social Care Commission to thoroughly explore the whole funding of social care and for the purposes of this report to explore the establishment of a Pay and Reward Commission for the social care workforce as a whole, and for care home staff in particular.

We recognise the considerable work to address the challenges around nurse recruitment and retention in care homes, to create positive pathways and transfer between the NHS acute sector and care homes, to improve the student experience and to create care homes as a primary setting for nurse training, mentoring and leadership development. We acknowledge the potential in new nursing roles such as the Advanced Nurse Practitioner and in attracting new nurses into the care home sector. These are new developments and it is hoped that they will bear fruit. However, this report clearly articulates that there is some distance to go before we can ensure that there is a level of respect and professionalism shown not solely to nurses but to other care home professionals by their colleagues in the acute and community NHS. These negative attitudes and stereotypes need to be challenged and addressed.

Some of the most substantial concerns for the future of care home provision in relation to the workforce relate to the increased role of workforce regulation and registration. Yet again we would state our support for a proportionate system of regulation which grants public assurance. However more work urgently needs to be undertaken to ensure that we can create a more flexible system around initial registration so that this does not put off new recruits. Post registration training and learning (PRTL) must also be more cognisant and appreciative of previous experience, other academic and workplace qualifications and skills.

In addition, along with earlier reports this study has highlighted the real concerns around our present qualification system which appears to many to be unaffordable, inflexible and unappreciative of the prior skills and experience of an older workforce. Scottish Care would like to work collaboratively with the workforce regulator and the further education sector in Scotland to address some of these immediate and real concerns. Person-led and person-centred care must go hand in hand with personalised learning, qualification expectations and relationships.

Develop proportionate and flexible scrutiny underpinned by a robust resourcing model

The new model of scrutiny and inspection offers real potential to embed the principles of the new National Health & Social Care Standards into practice. They are being introduced at a time of real fiscal and resource challenge for the care home sector in Scotland. It will be critically important that this introduction is fully appreciative of the contextual resource pressures under which the sector is working. A one size fits all approach is outdated and incompatible with current care home and workforce needs.

In the same manner as much has been made about changing public expectations through 'realistic medicine', there needs to be an honest, non-partisan debate with the general public about what are realistic expectations of a resource-stretched care home sector.

All of this will not be possible without a robust model to adequately resource the care home sector into the future. The recent desire by some Integrated Joint Boards to make necessary savings by deciding not to purchase care home placements is short sighted and dangerous. It fails to appreciate the invaluable role of care homes, acts against citizen choice, and effectively is likely to be costlier as individuals require more expensive acute services but at a later stage in their life. It is incumbent upon us all not just to continue the work on cost-modelling which both COSLA, the Integrated Joint Boards and Scottish Care has been progressing, but also to have a serious societal debate about the extent to which the public purse is willing and able to continue to pay and resource high quality care home provision.

The need for greater public awareness and understanding of care homes

None of these findings point to something we didn't already know, to at least some degree. They are the 2018 reality of challenge, change, complexity and real care that working in the sector grapple with on a daily basis. Yet they remain removed from the popular rhetoric around care homes which in no way bears resemblance to the words contained in this report. Instead, we continue to hear public and politician alike characterizing care homes

implicitly or explicitly as the last places on earth you would want to be supported in, as workplaces lacking in ambition, skill and motivation, and as environments where regulation exists to uncover the poor practice and neglect that must exist.

We continue to see planning and development processes for health and social care taking place at national and local levels which largely exclude care homes, despite them being centres of excellence, innovation and ambition; all the attributes required to ensure Scottish Government's health and social care reform processes are successful. Unfortunately, there continue to be an absence of meaningful shared decision making.

We need to acknowledge care homes as critical to health and social care and to our communities and have to ask ourselves the hard questions as to how they can be funded, valued and supported in a sustainable way. We also have to face the difficult truth that we are all ageing and at some point we may, through illness or injury, require 24-hour support in a way that our loved ones can't provide and in an environment that is tailored to provide this.

For this very reason, we should be actively and positively shaping the future support available to our loved ones, our communities and eventually, ourselves. The reality is that care homes remain essential components of the health and care landscape. Without them, hospitals and community supports would face unprecedented and impossible demand. They cannot continue to be treated as surplus to requirements - they are critical to it. Sadly, their potential is not being fully realised.

We have the opportunity to make the future far more certain, but it will require radical change grounded in an informed reality, with shared decision making and all the 'why's' explored. It is no longer 'them and us' in terms of care homes and wider society. It is 'us'. If that future is a bleak one, we all have to take responsibility.

THANK YOU

Scottish Care wishes to extend our most sincere thanks to all individuals and care homes who shared their experiences with us in such an honest and open way. At a time when resources are strained, it is even more appreciated that people gave up their time to take part in this research either through participating in focus groups, attending Scottish Care events or completing surveys. We also wish to thank the Local Integration Leads who were so helpful in setting up the focus groups.

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