Submission of evidence on the specific health needs of women in the adult social care workforce in London with a focus on home care workers

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SUMMARY:

This submission of evidence discussed what is known about specific health needs of women working in adult social care generally and home care specifically, with a focus on London. It is co-produced with the assistance of the Proud to Care Board of the Association of Directors of Adult Social Services (ADASS) London which includes home care providers, London Boroughs and other stakeholders. Their experience of London's home care workforce has informed the evidence presented here and the emphases made. The health of home care workers, the vast majority of whom are women, is not just of interest at times of pandemic; it matters in addressing staff turnover, continuity of care for their clients, sickness absences but also the long-term impact on women's later lives. The home care workforce is largely female; a Women's Health Strategy needs to address their needs and capacity to support other people in need of care and support. From the evidence, points to consider for the Women's Health Strategy include the following:

- Research is needed to see how home care occupations can be health-enhancing not health damaging. How can risks be minimised and positive aspects of the work amplified? Serious consideration should be given to the health of the social care workforce in any reform of adult social care and workforce health and wellbeing should be emphasised in this and in the proposed Women's Health Strategy.
- London's home care workforce offers much learning for other places and sectors. The majority are not UK born and are from an ethnic minority; if we get women's health right for them then we will have learned much about addressing inequalities and how to 'level up'.
- As well as addressing specific health problems, multiple problems or long-term conditions need to be recognised in any Strategy.
- Coronavirus pandemic support will need to be long-term for people who are in work, need to change their work and who may contribute to society in other ways.
- The Strategy needs to address why social care systems are so reliant on zero-hour contracts and acknowledge their health impacts so that it can support changes that are more health enhancing for women, and others.
- A Women's Health Strategy could support dementia prevention but also needs to support the largely female dementia care workforce by acknowledging its skills and needs for recognition, reward and further work-related capacity building.
- The pandemic highlights the urgency of answering questions around specific health needs and behaviours of women in adult social care from non-white ethnic backgrounds. Consultation on the 'right' questions and approaches should involve care workers, and managers.
- More specific evidence is needed on the impacts of the pandemic on the health and wellbeing of women working in adult social care generally and in home care specifically to inform any future crisis but also recovery from the pandemic.
- The impact of Long Covid on home care workers needs exploring so that effective support and readjustment can be offered. Data from Wales (linking individual health records and home care worker registration) are likely to be useful in the Covid-19 period but also subsequently for policy makers and employers.

- The Strategy must build on the evidence to best support women working in the sector to receive the Covid-19 and other vaccinations for their protection against the on-going health threats of viruses and other infections.

<u>Introduction:</u>

The Call for Evidence to inform the government's proposed Women's Health Strategy states: '*We want to understand more about women's experiences in the workplace, and opportunities for better supporting both women and employers'*. This response focuses on the home care workforce in London although many of our points are likely to have national resonance.

The adult social care workforce across England is mostly female and ageing. London's adult social care workforce is particularly diverse in terms of nationality, ethnicity and migration history and, on average, older compared to the rest of England (Skills for Care, 2020). Multiple reports have documented the physical and mental demands on people working in adult social care generally, and on people working in frontline of home care services in particular. However, the specific health needs of women of various backgrounds in the adult social care workforce – as in the rest of the labour market – must be considered in the light of recent evidence (see Manthorpe, 2020; Manthorpe and Samsi, 2020) about the impact of long-term health conditions specific to women's labour participation. The women who work across adult social care jobs in London are a vital part of local health and care systems, and this is set to remain into the future with our ageing population requiring a pro-active and rights-based approach to building a sustainable adult social care system. Home care workers support people with multiple long-term health conditions and disabilities to stay at home for longer if this is what they want. But in order to be able to do that, these workers' own health and wellbeing must be addressed by employers, and local and central government as commissioners and funders of social care. The reflects the need to consider work's impact on everyone's health in later life: 'Understanding which working conditions contribute to successful ageing is central to the design of public health policies that aim to reduce health risks over the life course' (Nilsen et al 2021).

> **What this means for a Women's Health Strategy**
> *The health of home care workers, the vast majority of whom are women, is not just of interest at times of pandemic; it matters in addressing staff turnover, sickness absences but also the long-term impact on women's later lives. The home care workforce is largely female; a Women's Health Strategy needs to address their needs and capacity to support other people in need of care and support.*

This submission of evidence argues that health factors and long-term health conditions specific to women working in adult social care generally - and home care in particular - must be considered in any Women's Health Strategy to build a resilient adult social care system and to promote women's health overall. This requires responses that are local and tailored to the demographics of the home care workforce, which in London as elsewhere is mostly female, ageing and diverse in background. More evidence is needed to understand and develop interventions that will support the health of women working in the wider adult social care workforce as well as in home care in London. This is a matter of discharging the legal public duty to treat people equally, as well as to protect, respect and fulfil the human rights to health and to employment.

What this means for a Women's Health Strategy

Research is needed to see how home care occupations can be health-enhancing not health damaging. How can risks be minimised and positive aspects of the work amplified? Serious consideration should be given to the health of the social care workforce in any reform of adult social care so that workforce health and wellbeing are emphasised in this and in a Women's Health Strategy.

Overview of the adult social care workforce in London:

- **Number of workers:** The adult social care workforce in England comprises 1,650,000 jobs across residential, day, domiciliary/home care and community care settings (but excluding hospitals). In London alone there are 237,000 adult social care workforce jobs, higher than other regions in England.
- **Gender:** The adult social care workforce is mostly female, with 82% of all jobs taken up by women. This applies also to London, with an 81% female workforce.
- **Age:** The average age of the social care workforce across England is 44 years, with an ageing trend becoming more evident over the past years (in 2012/13 the mean age was 42.5). Around a quarter of the workforce is aged 55+ years. In London, the average age across all job roles in adult social care is higher than the national average, at 45.9 years.
- **Employment status:** Just over half (56%) social care jobs are full-time (national average 50%) but 42% of staff are on zero-hours contracts (nationally 26%).
- **Diversity:** London's adult social care workforce is more diverse than the rest of the country: 66% of all adult social care workers in London have a minority ethnic background, whilst the national average lies at 21%. In London, 59% are non-UK born (compared to 22% nationally) and 37% are non-British nationals (compared to 16% nationally). The main countries from which migrant care workers in London come are Nigeria, Romania, India, Ghana and Jamaica. The large majority of the adult social workforce (98%) has no declared disabilities and this applies to London too.
- **Home care/Domiciliary care:** A large share of the adult social care workforce is employed in home care or domiciliary care (care at home) with overall 715,000 jobs, of whom 635,000 are engaged in direct care. Home care also comprises the largest share of the adult social care workforce in London with 130,000 jobs out of which 116,000 are involved in direct care provision.

The adult social care workforce in London (Skills for Care, 2020)		
Marker	**England**	**London**
Jobs across adult social care	1,650,000	237,000
Proportion of females in adult social care workforce	82%	81%
Average age of adult social care workers	44 years	45.9 years
Proportion with a minority ethnic background in adult social care workforce	21%	59%
Proportion with non-British citizenship in adult social care workforce	16%	37%
Proportion who are not UK-born in adult social care workforce	22%	59%
Top 5 nationalities of non-British adult social care workforce	Romania, Poland, Nigeria, Philippines, India	Nigeria, Romania, Ghana. Jamaica, India

> **What this means for a Women's Health Strategy?**
> *London's home care workforce offers much learning for other places and sectors. The majority are not UK born and are from an ethnic minority; if we get women's health right for them then we will have learned much about addressing inequalities and how to 'level up'.*

<u>Evidence of long-term health conditions in women on labour participation:</u>

Manthorpe (2020) recently conducted a rapid review of evidence on long-term health conditions in women and how these may affect labour market participation, either through women experiencing one or more of these conditions or having to care for affected family members. In this review, she concluded:

> There is a pressing need for employers, health services and the government policy makers to not only consider the impact of long-term health conditions and make adjustments for individuals but also to change work environments, attitudes and practices.

Long-term health conditions are generally defined as health problems which persists for longer than 12 months. Conditions that disproportionately affect women compared to men include musculoskeletal conditions, osteoarthritis, arthritis, multiple sclerosis or urinary incontinence. High physical workloads do not just lead to sickness among women, they also lead to problems in later life (Gnudi, et al 2009). Other points relevant to women are the risks of damage to the pelvic floor following childbirth and the new pilot women's pelvic health clinics in maternity services are a welcome effort at prevention. There is also evidence that women experience mental health problems and other long-term health conditions, such as asthma, differently to men. The symptoms of the menopause can adversely affect many women for several years (4-8 years). These and other conditions can lead to prolonged and/or more common sickness absences from work, women having to cut down on working hours or having to leave the labour market altogether. Long-term health conditions become more prevalent with older age. In the light of the adult social care workforce being mostly female and older, there is a need to consider the impact of long-term health conditions on female social care workers as well as how their work can impact on their health and wellbeing. According to the OECD (2019), across the European Union one in six long-term care workers report having at least one health problem caused or amplified by their work. In the UK the most commonly reported causes of injury and ill health among home care workers are moving and handling, and dealing with what is called challenging behaviour (other terms include unmet need or distressed behaviour) (Health and Safety Executive 2020).

> **What this means for a Women's Health Strategy**
> *As well as addressing specific health problems, multiple problems or long-term conditions need to be recognised in any Strategy. Not all home care work is physically demanding but much is and some attention to assistive technology or equipment might enable women to work in the sector or stay there longer. We have few examples of what would effectively help home care employers to offer work to people with disabilities or to keep people in the sector if they develop health problems. Home care managers are in short supply and the sector needs to retain this group and to grow new managers and administrators by highlighting the potential for women of progression and a long-term career in the sector.*

Health of the adult social care workforce generally and of home care workers in particular

The adult social care sector is mistakenly often seen as a low skilled and low status employment sector and these perceptions can affect the health and wellbeing of the women working in it. The adult social care sector experienced high turnover rates and vacancies for many years, even before the Covid-19 pandemic (Bottery and Ward 2021). Around 30% of care workers left their jobs in adult social care within a 12-months timeframe between 2019/20 across England, whilst in London this rate was slightly lower at 29%. The national mean rate for vacancies in the sector is at 4.4%, whilst this was higher in London at 6.4% in this period. Work in the sector is generally not paid well (Cominetti *et al* 2020), although many important tasks are undertaken by staff (Rubery, 2007) with high physical and emotional demands. Overall financial pressures on the sector may mean that there is limited opportunity for supervision or management support (D'Astous *et al* 2019) or for occupational health support, redeployment or compassionate leave. In the context of the Covid-19 pandemic, Age UK (2020) argued:

> Evidence from previous pandemics suggests that health and social care workers have an increased risk of adverse mental health outcomes, including Post Traumatic Stress Disorder

and Depression, so it is vital that this is not ignored. Especially as we know that as a professional group, lower paid health and social care staff already have higher rates of pre-existing mental health conditions. (page 12)

What this means for a Women's Health Strategy

Coronavirus pandemic support will need to be long-term. While trauma may be experienced by few there will be many who worked under pressure. Vacancy problems might be solved by new recruits but they will need to be supported and their health and wellbeing fostered. While this applies to frontline staff the importance of support for managers and supervisors who are mostly female in home care must be part of Covid-19 rebuilding.

Conditions of employment differ from contract type. People in the frontline of care, most of whom are women, on zero-hour contracts and many Personal Assistants (directly employed care workers – Woolham *et al* 2020) do not have the same benefits and protection when it comes to employment terms and conditions such as sick pay or rights to furlough compared to their colleagues with regular contracts. Such employment-related job insecurity as zero hours contracts can add further stressors to home care workers and is associated with mental health problems such as anxiety and depression, despite the positive relationships that many home care workers build up with service users (Ravalier *et al* 2017; Ravalier *et al* 2019). For women who are single parents income insecurity may be particularly difficult in terms of access to support with school meals and so on. We know little of the access of home care workers to good advice on welfare benefits and debt counselling and this could be addressed.

What this means for a Women's Health Strategy

The Strategy needs to address why social care systems are so reliant on zero hour contracts and support changes that are more health enhancing for women, and others.

Manthorpe and Samsi (2020) recently highlighted the role of women in the care of people with dementia, a neurodegenerative condition that affects more women than men. Caring for people with dementia, especially at the later stages, can be physically as well as mentally demanding. Manthorpe and Samsi (2020) argued that any adult social workforce strategy must include a gendered analysis of people working in dementia care and the impact on female workers financially, physically and mentally.

What this means for a Women's Health Strategy

Care work is skilled and supports families as well as service users. Dementia care is often seen as non-gendered but the main dementia workforce is the home care workforce; and this is female. A Women's Health Strategy could support dementia prevention but also needs to support the dementia care workforce by acknowledging its skills and needs for recognition, reward and further work-related capacity building.

Home care tasks come with particular challenges, sometimes hazardous working conditions as a United States (US) survey found (Quinn et al. 2016). Beyond the homes of their service users, some care workers are often under extreme time pressure when travelling between the homes of service users to meet their appointment times adding to their stress. In London, home care workers may be particularly affected by heavy traffic and complicated commutes between homes. This can compound levels of physical and mental stress. A US study of home care workers (called aides) working in urban areas found that their travel to work had proved particularly challenging during the pandemic and concluded:

> … safe transportation during a public health crisis is a complex issue that was not always resolved by offering vouchers for ride-sharing services during the pandemic because of delays and unreliability of these services as an alternative to public transportation. Agencies may consider increased flexibility or overlap between aides in scheduling to allow for delays in transportation. Agencies may also need increased state-level funding to provide aides with improved methods for safe transportation. Access to reliable transportation to and from work is critical for ensuring safety for both aides and their clients, particularly to minimize risk and potential exposure from public transportation (Bandini et al 2021).

What this means for a Women's Health Strategy

Travel between service users' homes can be difficult whether this time is paid or not and this question of payment contributes to job uncertainty and inequalities. It affects women in particular. Access to safe transport and journeys is a particular concern for London's home care workforce, particularly those who have no transport of their own. Car parking near clients' homes remains a problem for many. Work by local resilience bodies with home care managers to plan for crises or disaster needs to acknowledge that many women do not have access to private transport and new arrangements for social care should address the payment of travel time for home care workers.

Once at the home of a service user, there may be shortages of equipment, such as baths, lifts or hoists and protective equipment, to undertake their care work safely (Quinn et al. 2016) or there may be delays in getting it to the service user. Prior to Covid-19, Quinn et al. (2016) found home care workers in the US faced health hazards, such as musculoskeletal injuries, blood-borne pathogen exposures, and psychosocial stress. Only recently in the UK has there been any broad interest in infection control in social care and mostly this has focused on care homes. Any Strategy must also recognise other hazardous working conditions of many home care workers, who generally work on their own in often less than ideal environments. Delays in getting equipment to service users to help with mobility for example, also affect those providing home care who may have to manage lifting or turning – and risk musculo-skeletal damage.

What this means for a Women's Health Strategy

We know little of infections that affect home care workers beyond Covid-19 and how these risks can best be managed in ways that respect care users' homes and routines. Delays in getting equipment and other facilities do not simply affect care users and their families but can impact on care workers' health. Such points need to be addressed in a Strategy that is trying to prevent health problems.

Home care workers generally work on their own. They may be more vulnerable to becoming victims of violence or abuse, especially when working alone. A large survey of 1214 directly employed care workers in the US (Hanson et al 2015) found high numbers were experiencing workplace violence or sexual harassment (such as verbal aggression, workplace aggression, workplace violence, sexual harassment, or sexual violence) and that this was associated with greater stress, depression, and sleep problems, controlling for age and education. Another reported that US home care workers suffered nearly four times the rate of injury at work as the general US workforce (Hansell et al 2018) and noted that, while staff were aware of reporting procedures, they did not often choose to take this path for a variety of reasons. A recent review (Clari et al 2020) concluded that such problems were likely to be under-reported by staff and that employers had a role in helping their staff reducing the risks, de-escalating a situation, encouraging reporting and providing care for those affected. They also observed that gender-based violence is a global public health issue; making this aspect of home care work relevant to any Women's Health Strategy.

What this means for a Women's Health Strategy

The needs of home care workers for safety at work must be considered with them and their managers, and UK evidence of measures to improve this would be welcome. These need to be acceptable interventions.

The Covid-19 pandemic has had a further devastating impact on the health and wellbeing of adult social care workers – mostly female: They suffered the highest mortality rate of all sectors, with women from minority ethnic backgrounds disproportionately affected (Office of National Statistics 2020). However, the health needs of women in social care with a minority background are generally under-researched.

What this means for a Women's Health Strategy

The pandemic highlights the urgency of answering questions around specific health needs of women in adult social care from non-white ethnic backgrounds. Consultation on the 'right' questions should involve care workers, and managers.

A small survey for The Health Foundation (2020) found that the level of stress in adult social care workers had increased for 80% of them, with reports that their job has left them more 'tense, uneasy and worried' since the beginning of the pandemic. Other evidence (Queen's Nursing Institute, 2020) showed the adverse impact of Covid-19 on the physical and mental wellbeing of care workers in care homes, with 54% of their respondents feeling worse than before the pandemic. Increases in depression and anxiety between the first and second wave of the pandemic in the UK show the importance of mental health support and access to early help for those on the frontline of care (McFadden *et al* 2021a).

The home care sector received comparatively little attention compared to care homes during the pandemic. The Bureau of Investigative Journalism (2021) reported a sharp rise in deaths of people receiving care at home and changes in the way care was provided and accepted. Whilst many home care workers left their jobs altogether, perhaps to care for their own families, others tried to juggle their work and with fewer colleagues. A study from Ireland (Bedenik,2020) provided evidence of the levels of mental and physical exhaustion in home care workers during the pandemic and, from the

UK, McFadden et al (2021b) found mental wellbeing and work-related quality of life among social care staff and social workers had worsened by the second wave of the pandemic. From Wales we will shortly have substantial evidence of the impact of Covid-19 on home care workers since the registration of this workforce in Wales has enabled linkage of anonymised registration data with routine health care data (Lugg-Widger *et al* 2021).

> **What this means for a Women's Health Strategy**
> *More specific evidence is needed on the impacts of the pandemic on the health and wellbeing of women working in adult social care generally and in home care specifically to inform any future crisis but also recovery from the pandemic. The impact of Long Covid on home care workers needs exploring so that effective support and readjustment can be offered. Data from Wales about the health status of home care workers are likely to be useful in the Covid-19 period but also subsequently for policy makers and employers.*

Various vaccinations have been developed, produced and tested to protect against Covid-19. In London the uptake of the vaccination amongst the home care workforce is at around 63% (mid-June 2021). Whilst this represents good progress in getting this workforce vaccinated, evidence (Lancet, 2021) suggests that there is a gender divide in terms of accessibility to the vaccine, which sees women disadvantaged. Working conditions and other responsibilities, such as childcare and home-making, make it difficult for some women to get the vaccine. Furthermore, there is evidence that people with an ethnic minority background are at a disadvantage when it comes to accessing the vaccine and suggest the importance of building up and sustaining trust to reduce hesitancy and to promote vaccine accessibility among groups with social disadvantage (Razai et al 2021). In home care vaccine take up looks set to be a remaining topic as we all learn to live with Covid-19.

> **What this means for a Women's Health Strategy**
> *There must be greater understanding around the hurdles for women working in home care to access vaccination schemes, foremost the Covid-19 vaccine. Based on this knowledge women in the sector must be better supported to access the vaccine without additional stressors on their daily routines and a greater understanding of individual circumstances.*

According to Skills for Care (2020), a positive workplace culture can have a positive impact on the overall health and wellbeing of social care workers. This can reduce sickness leave and lower turnover rates. However, any strategies to address positive workplace cultures in social care and support programmes for staff must recognise the evidence on specific long-term health conditions in women and how these conditions can employment cultures. Manager and peer support are essential and effective in coping with work pressures according to a study of home care workers supporting people living with dementia (Yeh et al 2019). This called for the development of models of effective support to alleviate home care staff's practical, emotional, and interpersonal pressures and noted that due to the isolating nature of home care work, managers may not recognise early signs of their staff finding stress unmanageable and miss the opportunity to mitigate these negative effects.

Conclusion

The Covid-19 pandemic has shone a light on the risks faced by home care workers and their resilience. We need more knowledge on the specific needs of this workforce to inform future policies on women's health. London's home care workforce – both the frontline of care but also managers – has substantial diversity and skills and its women need a Strategy that is relevant and supportive.

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