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Abstract

Purpose

The coronavirus pandemic has shone a light on long-standing, structural race inequality in Britain. This article reviews reflects on historic patterns of ethnic diversity among the workforce employed in services for older people to present some of the lessons that can be learned from the pandemic.

Design/methodology/approach

A historical overview was undertaken of research about ethnic diversity in the social care workforce.

Findings

Too often, the ethnic diversity of the social care workforce has been taken as evidence that structural racial inequalities do not exist. Early evidence about the impact of coronavirus on workers from black and minority ethnic groups has led to initiatives aimed at reducing risk among social care employers in the independent sector and in local government. This offers a blueprint for further initiatives aimed at reducing ethnic inequalities and promoting ethnic diversity among the workforce supporting older people.

Originality

The ethnic makeup of the workforce reflects a complex reality based on multiple factors, including historical patterns of migration and gender and ethnic inequalities in the United Kingdom (UK) labour market.

Research implications

The increasing ethnic diversity of the older population and the UK labour force highlights the importance of efforts to address what is effective in reducing ethnic inequalities and what works in improving ethnic diversity within the social care workforce and among those using social care services for older people.

Introduction

For older people's care services, the conclusions of research and policy are very consistent – diverse workforces help improve equality of access and the social care system needs to address inter- and intra-ethnic differences among everyone, including older people. While it is important to develop strategies for improving access to different services and reducing

inequalities, we also need to think about individual dimensions as people have different cultural, migration, local links, and personal beliefs and these may change across the life course. Alongside the increasing number of older people in the UK there is greater diversity among them, amplified by differences in locality, ethnic origin, and of migration history. However, the risks to the workforce during the coronavirus pandemic have drawn new attention to the ethnic diversity of the social care workforce, particularly those working with older people in care homes and elsewhere. This has been amplified by the response to the brutal killing of George Floyd in the United States which has rightly heightened the priority given to racial equality and ethnic diversity. Indeed, several years earlier McGregor's (2007) study of Zimbabwean migrants exemplified the tension between an acknowledgement of the benefits brought by having a diverse adult social care workforce while simultaneously reflecting the status of social care, which is often erroneously seen as a low status entry level job that 'anyone can do'.

Traditionally, the social care workforce has always been diverse – mainly because of the patterns of migration in the 1960s when there was a great expansion of social care, as well as growth in the number of jobs in the NHS. The profession of social work was one where people, many of them women, could undertake training and several researchers began to chart their experiences – such as in the chapter by Watt and Cook (1989) on 'Black Women in Social Services Departments'. Gail Lewis (1997) studied the entry of black women into local authority social services departments and their practice as qualified social workers in the 1980s. As part of her PhD thesis, she interviewed 10 managers (four from ethnic minorities) and 22 black female social workers employed up to and including team manager level.

There is less historic data about other parts of the social care workforce. In the home help or home care service, Hall *et al.* (2017) observe that national data on this workforce has been poor, partly because there are many home care businesses and because there is high turnover of such business and their staff. It was not until Skills for Care developed a National Minimum Data Set for Social Care for England that it became easier to analyse workforce data relating to home care and care homes (Hussein *et al.*, 2014).

While details of past workforce composition are not always clear, in the current context Skills for Care publishes annual information on the ethnic make-up of the regulated social care workforce based on returns to the Adult Social Care Workforce Data Set (ASC-WDS) (the successor to the National Minimum Data Set for Social Care). This level of detail is important as it provides details of place and practice setting. Not everyone working in adult social care is covered, for example, we have little on day services (partly because these are not regulated settings), or directly employed care workers (these are not regulated at all). Nonetheless, bearing in mind the very disparate English social care sector which has approximately 18,000 providers (Skills for Care, 2020c, p. 11), this is a very reliable resource.

Detailed data collection means we are now more informed about regional and local variations in the social care workforce composition. For example, the Health Foundation (2020b) reports that London workforce profile is very different from the rest of England – with workers from an ethnic minority group representing 54% of the food production, process and sales workforce (including all food retail and processing) and 48% of the health and social care sector. In contrast, outside London, the sector with the greatest share of

ethnic minority workers is health and social care at 13%, followed by food production, processing, and sales at 11%. However, specific to social care in London, the city had a significantly more diverse care workforce than the rest of England in 2018/19 in terms of both ethnicity (67% being black and minority ethnic relative to the England average of 21%) and nationality (25% non-EU (non-British) and 14% EU, relative to the corresponding England averages of 10% and 8%) (Health Foundation, 2020a). Added to this distinctive profile is the greater proportion of London's social care staff being on zero-hours contracts, probably connected to the greater proportion of them working in home care rather than care home services.

Accurate, consistent, detailed data are key to establish which groups are over- and under-represented in the social care workforce and what is meant, for instance, by ethnicity and nationality. For example, analysis revealed that more social care workers were recent migrants to the UK rather than people from Black British backgrounds who were UK citizens (Hussein *et al.*, 2014). In the context that immigration is not a 'devolved matter' across the UK, employers need to continue to monitor migration status. Indeed many employers were not necessarily aware of the precise status of their staff not subject to immigration rules, such as the number of years they had been living in the UK, until the Windrush scandal and recent Brexit related changes. For example, employers now need to understand the implications of 'settled' and 'pre-settled' status for citizens of the European Union and their families.

Other policies and requirements affect social care employment. For instance, the Equality Act 2010 can be used to recruit people from a specific ethnic background where it is important for the service or its users. There are examples where this is used to improve outreach to people who are not accessing or aware of services (Moriarty *et al.*, 2015). This is not just about workers being bilingual or even trilingual but also about their deeper understanding of a particular culture, as noted in one account of a service for Latino people with dementia in Los Angeles where Latino workers understood the best ways to disseminate information in the community and knew how to avoid culturally specific terms like 'burden' (Moriarty, 2002). Unfortunately, organisations providing outreach often operate on a shoestring budget and have to concentrate their priorities on funding services rather than being able to commission external evaluations. This means that much of the evidence about these services comes from descriptive accounts and individual case studies which are often excluded from reviews seeking to establish 'what works?'

Training and learning

There is a substantial UK social work literature about training in what has been termed anti-oppressiveness, anti-discrimination, and anti-racism, although most of this relates to social work students, rather than practitioners. In older people's care services, such as care homes, we found that social care managers were often expected to be able to 'manage' diversity in the workplace and did not receive training in how to deal with any difficulties (Manthorpe *et al.*, 2018). There seems to be more in the UK context from social work professional websites; while this is not training but more related to peer support it can be very helpful - see British Association of Social Workers (2020) and Skills for Care (2020a) websites. Reid (2020) has outlined some of the steps that social work leaders and

organisations need to take to tackle racism within their organisations and his advice has a wider relevance for all older people's organisations.

There is a much larger North American literature about what they term cultural competence that is strong in their service traditions but of course reflects a different context – as the recent Black Lives Matter protests demonstrate. A review we undertook for Age UK (Moriarty and Manthorpe, 2012) highlighted some of the reasons why older people from black and minority ethnic groups might not access mainstream services. Examples such as the Pepper Pot Centre (2020) or Meri Aydian (2020) show how services can be developed to support different communities. The factors required to ensure mental health provision adequately serves minority communities seem to be related to values of being non-discriminatory and culturally sensitive but also need expression in the composition of the workforce at all levels and monitoring of what is happening. This may be easier in some parts of the country than others, for example, there appear to be more resources to support diverse communities in urban as opposed to rural areas (Manthorpe *et al.*, 2010; Manthorpe *et al.*, 2012).

Managers of older people's services also need to consider the needs of service users who do not speak English as a first language, especially as language barriers may contribute to additional distress. Cooper *et al.* (2018) found that the criteria for selecting a care home needed to include whether the prospective resident's English language abilities were declining, or were likely to decline. They also suggested that dementia-friendly translation services could help reduce the distress of residents with dementia from minority ethnic groups with whom staff cannot easily communicate.

Changing data collection, monitoring, and reporting on race and ethnicity

At one level, routine recording of service users' ethnicity has taken place in councils with social services responsibilities for a long time (Butt *et al.*, 1994). However, it was not recorded systematically – for instance, when 'white' was assumed to be the default identity, the ethnicity category tended to be left blank. This problem still appears to exist as data on ethnicity often seems to have a higher proportion of missing values. A 'prefer not to say' category would be helpful in ensuring that, if ethnicity data is missing, it is because a person has chosen not to share it, not that it has not been recorded.

There is much potential to make better use of routinely collected data to investigate disparities, service trends and workforce profiles. Using the Office for National Statistics (ONS) (2020) harmonised ethnicity standards enables organisations to see how the profile of both older people and carers using their service and the workforce reflects the demographic profile of the local population. For example, if the numbers of people from a mixed heritage in touch with adult social care services in a small London borough are greater than in a much larger and similarly ethnically diverse urban area in another part of the country, what are the reasons why this is happening?

Increasing integration between the NHS and social care may mean that social care gets to hear more about NHS developments around monitoring. The NHS Workforce Race Equality Standard (WRES) (NHS England, 2020a) was developed by the NHS Equality and Diversity Council in 2014 as part of its action to ensure employees from black and minority ethnic

backgrounds had equal access to career opportunities and received fair treatment at work. In 2015 the WRES was mandated through the NHS standard contract, starting in 2015/16, and from 2017, independent healthcare providers were also instructed to publish their WRES data. Currently, the WRES is required on the grounds that a motivated, included, and valued workforce helps deliver high quality care, increased satisfaction, and better safety for patients. The annual report (NHS England, 2020b) provides interesting examples of how NHS employers are putting the Standard into practice which may be very transferable to social care employers, such as changes in Board composition and in processes related to disciplinary action.

Improving data collection and monitoring

Other data in addition to ethnicity need to be collected to help workforces support and reflect the communities they serve. A care home that is providing support to Sikh or Hindu Asian Indians who came to the UK via Uganda will likely be different from one that is going to specialise in the care of Bangladeshi or Pakistani Muslims so information about religion and national identity (Office for National Statistics, 2020) can help workers to provide better support for older people.

Data collection is also needed to inform workforce progression and leadership. Analysis of the 36 biggest care home and home care providers who provide publicly available information on their Board members observes that only 5.4% come from a Black and Asian Minority Ethnic (BAME) background. Thus only 14 of 258 Board positions were from a BAME background (Bains, 2020). Other parts of the economy may be in advance of social care in terms of acting upon the Race Charter. Inspired by the findings of the McGregor-Smith (2017) review of race in the workplace, Business in the Community (2019), an organisation dedicated to responsible business, surveyed its membership. This found that employees from black, Asian and minority ethnic backgrounds were under-employed, under-promoted and under-represented at senior levels in public and private workplaces and advocated a senior Race Champion role be established by employers to monitor data, act on bullying and address diversity in the workforce. Beech *et al.*'s (2017) report on the 'management pipeline' notes the key role of Board and HR staff in speaking up and addressing barriers to achieving diverse workplaces. However, it does not include case studies or observations on the social care sector. Like many management reports, social care is invisible whereas 'health' is prominent in industry comparisons.

Learning from COVID-19

The increased risk to people from black and minority ethnic groups emerged during the first UK wave and is currently the subject of several ongoing inquiries, including one by the Equality and Human Rights Commission (2020). According to Public Health England (2020), the risk of dying among people diagnosed with COVID-19 is very much age-related but also higher in men than women; higher in those living in more deprived areas in England than those living in the least deprived; and higher among people from Black, Asian, and Minority Ethnic (BAME) groups than in White ethnic groups. This pattern is also reflected in death rates among those living in care homes. The Care Quality Commission (2020) has reported that 54% of deaths amongst Black people and 49% of deaths amongst Asian people were

related to COVID-19 compared to 44% of deaths of White people and 41% for people from mixed or multiple ethnic groups.

Health and social care workers overall are at additional risk of contracting COVID-19 because of their increased exposure to coronavirus (Parliamentary Office of Science and Technology, 2020). The additional impact on workers from black and minority ethnic groups was highlighted in a survey conducted by the Runnymede Trust (Haque *et al.*, 2020). They were more likely to be 'over-exposed and under-protected' from coronavirus as a result of their key worker employment, need to use public transport more; more often living in overcrowded and multigenerational households; and not having appropriate PPE (personal protective equipment) at work. Among workers in healthcare settings, racial insults have been identified as an additional stress for workers during the pandemic (Mollica and Fernando, 2020) so this is another factor that organisations need to consider in terms of supporting people from black and minority ethnic groups in their workforce.

In response, many organisations have developed tailored COVID-19 risk assessments aimed at better protecting people from minority ethnic groups. The most recent (December 2020) government guidance (Department of Health and Social Care, 2020) sets out both a risk reduction framework covering the assessment and efforts needed to reduce the risk to the care workforce and an individual risk management process. It notes that people from a black, Asian or minority ethnic background who were diagnosed with Covid-19 had up to two times an increased risk of death than white ethnic groups. However, it also points out that this does not account for the effect of occupation, comorbidities or obesity, which may be associated with risk of acquiring and/or dying from Covid-19 drawing on a report from Public Health England (2020) cited earlier. Specific to care homes, earlier guidance on Supporting Risk Assessments of BAME Staff at Risk of COVID-19 in Adult Social Care was produced by the Greater Manchester Health and Social Care Partnership (GMHSC) (2020). When published, the findings of Skills for Care's (2020b) survey conducted in Summer 2020 seeking the experiences of social care workers from a black and minority ethnic groups during the first wave of the pandemic will provide further information. Skills for Care's series of webinars and peer coaching for staff about Covid-19 is ongoing at the time of writing.

At strategic level, a Black, Asian and Minority Ethnic Communities Advisory Group was established to make recommendations to feed into the work of the Social Care Sector COVID-19 Support Taskforce that finished in August 2020. This created a report and 10 recommendations covering measures to promote equality and inclusivity across the social care workforce (Social Care Sector COVID-19 Support Taskforce BAME Communities Advisory Group, 2020). It conducted an online survey in August 2020 that attracted 142 workforce respondents, finding:

- Respondents reported a lot of support and trust in employers and provider organisations. People were less positive about the information supplied by government about COVID-19.

- Respondents felt that Government information lacked clarity. Some felt that their teams or employers did not understand the risk to BAME groups, the intricacies within 'BAME' or in some cases did not believe the compounded risks they faced from existing inequalities.

- Most respondents felt that the government should work closer with care providers and local authorities. Others stated that there should be collaboration with community groups or faith leaders.

- There were strong responses for better support around PPE (personal protective equipment), better guidance for BAME people working in social care and people who use services and for better use and knowledge of risk assessments'.

(page 15)

Conclusion

Diversity in ageing and social care often focuses on people using social care services. Attention is being given to how social care services can respond to greater diversity in the UK older population. By contrast, it has taken the severe toll in lives taken by the coronavirus pandemic to highlight the ethnic diversity of the social care workforce and then to see this amplified by renewed attention to overall inequalities in the context of Black Lives Matter. For social care providers and employers, there are questions related to coronavirus risks and workforce practices that these developments have moved centre stage. There are leadership activities and employer initiatives to learn from taking place in other sectors, notably the NHS. Moves to encourage greater NHS and social care joint working can help transfer learning and good practice.

For administrative and data handlers, including researchers, there are strong pressures to collect, analyse and address health and care inequalities. For larger social care providers this may not be so challenging but social care for older people is mostly provided by small and medium enterprises for whom data collection is not so easy. Stark illustrations of this emerged in the coronavirus pandemic when so few care homes proved to have computer tablets available to residents to talk to relatives.

For general workforce stakeholders, there are long-standing recruitment and retention challenges in social care. These tend to dominate discussion and over-shadow work or career progression, management development and leadership. Diversity in these important parts of the sector tends therefore to be similarly marginalised. Again, the NHS, teaching, and children's social care may have evidence about what works in these areas and can give some realistic estimates of costs.

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