HOUSE OF LORDS

Public Services Committee

Corrected oral evidence: Designing a public services workforce fit for the future

Wednesday 27 April 2022

4.05 pm

Watch the meeting

Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Davies of Gower; Lord Filkin; Lord Hogan-Howe; Lord Hunt of Kings Heath; Baroness Pinnock; Lord Porter of Spalding; Baroness Sater; Lord Willis of Knaresborough.

Evidence Session No. 12 Hybrid Proceeding Questions 95 - 106

Witnesses

I: Edward Argar MP, Minister of State for Health, Department of Health and Social Care; Tom Surrey, Director, Adult Social Care, Department of Health and Social Care; Gavin Larner, Director, NHS Workforce, Department of Health and Social Care.

USE OF THE TRANSCRIPT

1. This is an uncorrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Edward Argar MP, Tom Surrey and Gavin Larner.

Q95 **The Chair:** Welcome to the second part of this session of the Public Services Select Committee in the House of Lords. In this session we are very pleased to have Edward Argar MP, who is the Minister in the Department of Health, and he has two officials with him. I welcome you and will let you give your opening statement because I know that there are issues that will take you away for a while.

Edward Argar: I am very grateful, Chair. First of all, thank you very much, if I may express my gratitude to you and the committee for your kindness just before the Easter recess when I was due to appear and I managed to have an unscheduled fight with a tree branch in my garden, which caught me square in the eye. I did not think that that would necessarily present me in my best light to the committee, so I am grateful to you for rescheduling. However, I fear that we may be slightly cursed in our attempts to do this because I am advised by our Whips that in about four minutes we are likely to have Divisions in the Commons for about an hour, dealing with your Lordships' amendments to the Elections Bill and possibly sending them back to you. I suspect that this is something that may well impact on both the committee and me at different times.

If I may, Chair, I will give an opening statement and we will see where we get to. Forgive me, I would never normally do this in a committee, but I hope you will allow me to have my phone on silent in case a Division crops up.

The Chair: Absolutely.

Edward Argar: Thank you. It is a great privilege to be here and, as I have often said, new hospitals, new technology, kit, innovation, all these things, are hugely important in our health service but none of it is of real value to the patient without the golden thread that runs through it all, which is the workforce. I talk here to a degree about the NHS workforce, because that is what I am most directly involved in, but I think it is very important we do not forget or ignore the social care workforce. They are obviously two sides of the same coin in the health and care journey that many of our fellow citizens go through.

It is also important that we seek to route our answers and responses through the eyes of the patient, of the service user. It is very easy in this place, as I have discovered in my seven or so years in it, to often talk about the systems, the strategies and a range of things like that, but it is also important that we remember what we are doing this for and the people we are doing it for, who, of course, are the patients and the service users.

I am very privileged in this role that I get to see daily the amazing impact that staff in the NHS and social care have on the lives of patients and

those in need of care. I always take these opportunities to put on record my gratitude—and I think it is a gratitude shared across both Houses—to all those who work in the health and social care workforces, particularly following the pandemic. The people working in the NHS and care system have repeatedly shown their skill and dedication, rising to the many challenges that Covid has posed, but of course they do that year in, year out irrespective of global pandemics. It is important we recognise that.

The Government's priorities for the NHS are to improve health outcomes for patients by ensuring that the NHS can tackle the elective backlog, deliver the NHS long-term plan and has the resources to continue its response to the Covid-19 pandemic. You will have also seen my Secretary of State's recent policy speech setting out his three Ps, underpinned by a fourth P—personalisation, prevention and performance and, of course, the fourth P being people—which goes to the heart of what this committee is examining. Continuing to grow and support the workforce underpins all of our ambitions.

Over the past year we have seen record numbers of staff working in the NHS and there remains strong interest in careers in healthcare. Over 30,000 nurses and midwives accepted places to study nursery and midwifery at English universities in the 2021 recruitment cycle. This is a 28% increase in those acceptances compared to the 2019 application cycle. There are currently over 72,000 people training to be nurses, so going through that pipeline, which I hope gives some indication to the committee of the homegrown workforce that will come through year on year as we work towards our target of delivering 50,000 more nurses. There are 30,000 training to become allied health professionals.

We have seen a 25% increase in medical school places, with this expansion completed in September 2020. In addition to training new staff, it is also important, of course, that we keep the experienced and skilled staff we already have in health and social care, the retention point. The NHS People Plan and People Promise published in 2020 is focused on retaining staff by helping organisations to improve their employment offer, strengthen health and well-being support for staff and has demonstrated a new commitment to tackling inequality.

I am conscious of time and I have a horrible feeling I can see out of the corner of my eye a green bell. How would you like me to proceed, Chair? As a former Whip, I suspect you will wish me to go and vote expeditiously but given that we have three or four back to back, how would you like me to approach that, Chair?

The Chair: With difficulty. You have no option. You have to go and vote and we will listen to your officials. If you can come back—

Edward Argar: If we finish earlier, shall I return and if you are still in session I will try to contribute then?

The Chair: Yes, please. Thank you very much.

Edward Argar: Thank you, Chair. My apologies to you and the committee for the vagaries of amendments.

The Chair: Okay. Welcome to the two officials. I am sorry about this. The Chamber always take precedence and certainly does in the Ministerial Code, so it is where we are. However, we will start with you and for the things that I know members want to put specifically to the Minister, we will have some quick short-fire questions when he comes back.

Q96 **Lord Willis of Knaresborough:** Welcome. I want to look at two things. First, how are the Government intending to reduce demand and to increase capacity? Those are the two things that have a clear problem. I want to specifically talk about the 50,000 nurses and I declare my interest in working for the NMC and Health Education England *et al*. I cannot see how you are going to do this 50,000. I have looked at the stats that you have produced and I think that your update on the 50,000 nurses programme was a really useful document because it gives you a starting point on which to discuss things. In reality, if we talk from 2021 onwards rather than 2019 to 2021, because the pandemic clearly had a significant effect there, what you are talking about is going from an increase of nurses in 2021 of around 21,000 and building that up to 68,000, to 75,000 by 2024. The Minister mentioned this before he left. When you look at what is going through our universities, the actual recruitment in our universities, although it is at record numbers is not at significant record numbers to meet that demand. It could not do it.

When you look further into your stats, what you do not say is that one in four of those students going to university to learn about nursing will drop out. We also know that in the first three to five years about another one in four of those who qualify will go out. I am not accusing you of dodging this, it is a really big issue, but when you examine it more you are actually saying that international recruitment, which is the main reason we increased nursing numbers up to 2021, will increase at roughly the same level as domestic nurse supply over that period.

If you follow the logic of that through and move into five to 10 years' time, half of the NHS nursing workforce will be recruited from non-EU overseas. I am not making aspersions that they are not high-quality people, but if that is Government policy, I think you need to clearly state that that is the case. That is the one way that I can see you can get to your 50,000 by 2024. Would you like to respond to that?

Gavin Larner: Thank you very much. I am Gavin Larner on the health side and Tom is covering the social care side, so this one is largely for me although there is benefit for the social care workforce with some of the growth in the nursing workforce overall because of the dependence on nurses for their sector.

The question you worry about is one I worry about as well: are we going to hit 50,000? I think the publication set out quite clearly where we have got to so far. It is at roughly the halfway point. We are roughly ahead of where we need to be but with considerable risks attached to it, which we are monitoring closely. On the domestic student side to meet the target,

we are past the time when you can make a great deal of difference and that supply is in the bank because it takes three years to produce. That is broadly on track, although there is still a little bit of catch-up on the domestic population to get the students who went into the front line to serve during the first wave of pandemic back up to speed. There is a pretty good individualised programme of support around them, which should get the bulk of them back in and on track by the target date.

Health Education England is alive to the risks of student attrition in all this and is putting in quite a lot of work there to try to minimise the losses at that point and also crucially in the first year of practice is a vulnerable time when people move from student life into the realities of clinical practice. If you do not have the right support, you can have people dropping out. There is a lot of focused work on sustaining that bit of the domestic pipeline.

The international pipeline is going very well and, despite the pandemic and occasional flight interruptions, that has performed above expectations. While there is concern in the global picture about international markets for nurses becoming tighter as economies develop and develop their own healthcare systems and retain more of their staff, at the moment we do not see that as a significant risk for this decade. However, it is a risk for the longer term. I do not think anyone in a government department has a long-term strategy of being overall dependent on international supply.

You can do international supply quickly and at the start of a programme to get nurse supply in England back on a sustainable basis, it will naturally form quite a large component of overall growth. As successive cohorts of domestic graduates join the workforce and stay over the decade, with the proportion of domestic to international supply you should be able to depend increasingly on domestic rather than international.

Lord Willis of Knaresborough: That is not realistic, is it, Gavin?

Gavin Larner: I think it is. If we are up to 30,000 nurses a year who will graduate in 2025 and you add 30,000 a year over the decade and they do not all go, you build up a larger mass of domestic supply the longer into it you get if you can sustain that growth through the period. Then you become less dependent on international supply to do that.

Lord Willis of Knaresborough: You had only 20,000 going in in 2020-21, so you cannot get to 37,000 within the UK system.

Gavin Larner: No, I said 30,000, because that is the number of applicants we had successfully coming in last year. Obviously we will not keep all of them, but if you get a larger proportion of them staying each year, each year they are in the workforce you are in another year.

Lord Willis of Knaresborough: I accept that, yes.

Gavin Larner: There are different scenarios about how quickly you can shift that balance, but certainly I think over time if you can sustain the growth in the domestic workforce that we have at the moment, you can reduce your dependence on international.

Lord Willis of Knaresborough: Could I just—and then I will go home. To bring Tom in as well, the one area that was missing, sadly for me, from this piece of work—and as I say I am incredibly supportive of what it is trying to do, so it is not a negative sort of question, although I suppose it is—is the nursing associates, whom I have been heavily involved with. It surprised me that here you have a group of people—there are 1.3 million people working in the health and care system who are committed to working in that area—who could be recruited as nursing associates. One in three of them want to move on to be registered nurses, but the reality is that we have these very short-term schemes that say that if you apply between particular dates you can have a place within a university and a trust to train up to be a registered nurse, but if you miss those little gaps you have had it. We are talking here mostly about women, mostly about women with young families as well, who are second-opportunity people in many cases, certainly the ones that I meet.

I think that if we could have a guarantee, first, that once you become a registered nursing associate you have an automatic right to access a graduate nursing programme and, secondly, having gone through that graduate nursing programme—which is only 18 months afterwards—you have a right to a position as a registered nurse within the NHS, you suddenly are making the best use of a workforce and the best use of the investment that you are making in those people. Would you take that away and could the committee have a response to that? I think that that would be a powerful way of bringing Tom's workforce into play and give it a real sort of golden ceiling rather than the glass ceiling that currently exists.

Gavin Larner: I am a huge fan of nursing associates as well, and that sounds like a very interesting proposition. I will certainly take that back and discuss it with Health Education England colleagues and come back to you on that.

Lord Willis of Knaresborough: Thanks very much.

Tom Surrey: Thank you, Chair. I am Tom Surrey. I am the director of social care policy in the Department of Health and Social Care. I thought I should say a little bit about nursing in the social care sector as well, where approximately 10% of the numbers of nurses in the country are working in social care sector, about 34,000.

When we published our White Paper on social care in December last year, we made a number of commitments on helping to boost the number of nurses working in social care and make their careers more attractive for them. That started prior to the White Paper when we appointed Deborah Sturdy as the first chief nurse for social care and she has been doing a huge amount of work with her profession to boost the profile of nursing

within social care. We have also made a commitment to match the continuing professional development for nurses in the social care sector going forward. They receive the same offer as their colleagues working within the NHS in their own professional development.

We believe that the combination of raising the visibility and the prestige through Deborah's appointment and others and the work that she has been doing through the nursing award scheme and so on, and also the commitment that we are making to their own professional development, will help make nursing in the social care sector a more attractive career.

Lord Willis of Knaresborough: The NA route is perfect for that.

Tom Surrey: I was going to go on to say that, like Gavin, I am a great fan of nursing associates and we will take that away and look at it.

Specifically one of the things that we announced in the integration White Paper that the Secretary of State published recently was that we would be looking at the delegation framework and the nursing task delegation framework. Deborah is leading that work for us over the coming months to look at exactly where the boundaries between nursing and social care are and how we can encourage more innovation and flexibility and make sure that more elements of the workforce, including nursing associates, can play a role in the social care setting as well.

It is all work in hand but, as Gavin said, we will look to respond to your prompts about the roles of nursing associates and that career route in a collective way across both health and social care.

Q97 **Lord Hunt of Kings Heath:** I should declare an interest because I am a member of the board of the GMC. The issue about associates applies to doctors and the programme for physician associates and anaesthetist associates is waiting for regulations to go through to enable the next stage. As part of your workforce planning, are you building in assessments about how the numbers could be stepped up and the potential that might have for some of the challenges around medical workforce recruitment?

Gavin Larner: I think for both the non-medical and medical workforces the question of skill mix and how you can use roles like physician associates and anaesthetics associates and nursing associates as ways of building different clinical teams that can meet patient needs professionally is an important dimension to workforce strategy. You can do a sort of crude supply and demand about the conventional workforce and say that there is a gap of X and one of the principal ways you can narrow that gap is by redesigning the shape of the clinical teams.

In the medical profession and the nursing profession there was a degree of initial suspicion about these groups, about whether they were safe and were intruding on professional boundaries, but when they work with them they see the value and the way that you can spread the right work around the team more appropriately. I think as NHS England and HEE get to grips with it, once they have done the projections bit into what you do

about the future mismatch between supply and demand, productivity is one of the key bits of that. Skill mix, including physician associates for medicine, is an important dimension of that alongside all the other things you might do.

It is frustrating that we cannot get the legislation in on physician associates, before you ask me, at the pace that we would all like to and we are in constant dialogue with the GMC on that. I think there is a government bit of that about us making sure that our policymakers and our lawyers are cracking on at full pace—it is complicated—but also a GMC bit about whether at the same time as we are doing that it can crack on with getting ready to regulate the profession. Then there is an exciting bit about prescribing in these groups where you have to be careful, because medicines are dangerous things, but properly done I think it will be a huge benefit if physician associates can get into a place where they can start to do some of the work that doctors are doing at the moment, not just for professionals but for patients.

Q98 **Lord Bichard:** Excuse me if I get this wrong because I do not have the level of expertise and knowledge that Lords Hunt and Willis have, but is there not an issue of pay here? If you are a nurse in the NHS system, do you not get paid more than if you are a nurse in social care? Therefore, is there not a danger that, the more successful Gavin is, the more problems Tom has? I wish in a merged department you were not sitting with this large chasm between you, but I can understand why. Do you not need to address the parity of pay as well as the parity of training and development and all the other things you have talked about?

Tom Surrey: I will respond and then maybe Gavin can say something as well.

Lord Bichard: I would like you to respond first, Tom.

Tom Surrey: Yes, certainly. For the nursing profession, pay rates are not very dissimilar between the NHS and social care. There are wider issues around pay in social care, which we may come on to, or not, as the session progresses, but for nursing they are not that different on average. There are always exceptions, I am sure.

The Chair: They do not have access to the pension fund, do they?

Tom Surrey: No, they do not.

The Chair: That is a big issue.

Tom Surrey: Although, anecdotally, a number of nurses who work in social care—I would not want to put a number on it, but certainly some of those nurses—have previously been employed by the NHS and may in some cases be claiming their pension while also working in social care.

Lord Bichard: Can I just interrupt you? The jobs points really matter, do they not? If you are not earning a great deal, an additional point or two on the grade and the possibility of some sort of pension will be very

convincing reasons why you should not walk across the hall and go into the NHS system. Why is it not possible to get parity of pay and package, not just pay?

Tom Surrey: I will come on to the pay point. I think the other thing that Deborah, as the chief nurse for social care, would say if she were here is that the roles are very different in many ways and they attract different people who look for different things in jobs. A nurse in a nursing home has incredibly high levels of personal responsibility for all the residents in there. They tend to operate in a much more independent and unsupervised environment. They tend to have much more freedom and flexibility in shift patterns and working patterns. There is a difference in the nature of the roles that attract different people and they are both incredibly valuable and to be celebrated, but they are different. That is the first point I would make.

On pay more generally, the underlying position there is that nurses working in social care are not employed by the NHS. They are not public sector employees. They are employed in most cases by private businesses or in some cases charities or not-for-profit. Ultimately their pay is a matter for their employer. We are working to address, through our White Paper, many of the things that you also mentioned around training and development, esteem and parity of value that we place on them when we talk about them and the offer that we can make through our continuing professional development, but ultimately the issue of pay is for the employers in both cases.

Q99 **The Chair:** We end up with the really challenging problem of how you get equity with two such very different systems. It seems to me that the only way social care will meet some of the aspirations that we all have for it is if the link with the NHS becomes greater. At the moment, it is the lowest-paid people who end up as care workers but they need to be able to up their skills to do what Lord Willis talked about, and that is reduce demand. How are you going to address that? I know through work that my husband does that one organisation, a not-for-profit, has now trained its care workers to do things like every day they test the urine of the people they see. That saves them being taken into the NHS, into the hospital, when they then end up much more ill for a much longer time. But there is no way in which that can be acknowledged through the funding of the NHS, so the company has to take that on with no support. Are you talking about things like this to shift the whole basis of the workforce to reduce the number needing acute care?

Gavin Larner: I think that the issues of the disparities between the two sectors are very clearly in Ministers' minds and have been made particularly salient by the pandemic and the experience of the two sectors through that. The integration White Paper is an expression of very serious ministerial attention to what good should look like in the context of the resources available to the public sector to deal with it. Within that, there are genuine structural differences between the two sectors as well as similarities and quite strong cultural differences as well, which partially the ICB model is trying to grapple with at that level.

I think that the integration White Paper that was recently published starts to get to grips with that and particularly at ICB level about how—places like Leeds are already looking at this—you plan across your NHS economy, your local government economy and other big public sector players and do this in a joined-up way. There are things like the Leeds Health and Care Academy, which are fantastic in bringing people from the different tribes into the same place to learn not about how to treat a patient or how to be a service user but how to treat a citizen. But you also raise some quite big structural, cross-government questions about the weight of public investment in different sectors, which, without a Minister by my side, I might sidestep, if that is okay.

Tom Surrey: Perhaps I could say a little bit about what we are doing to address those things and what we included in the social care White Paper. The Chair is absolutely right that particularly care workers do difficult and skilled jobs, but it is also the case that many of them are paid at or just about the minimum wage as things stand. It is also about the skills that they have and the recognition of those skills.

We are doing some things to enable exactly that kind of integrated approach to workforce planning at a local system level. As things currently stand, only around 46% of care workers have a relevant qualification in provision of care work. When we published the White Paper in December, we announced that we would be investing up to £500 million over the next three years in the social care workforce. An important element of that is the development that is under way with care providers in the sector, colleagues in HEE and Skills for Care around a knowledge and skills framework, which for the first time brings some consistency to the skills that care workers have.

We also aim to invest in the care certificate, which is the basic qualification, and indeed to make that portable so it is recognised across care providers. We very much hope that that investment will lay the foundations for a more integrated workforce planning approach and the role, as Gavin was talking about earlier, around the delegation framework that I also mentioned for the tasks such as the one that the Chair mentioned. It is making sure that those can be carried out efficiently and safely by care workers and that they have a way of acknowledging that they have those skills and sharing through a digital portal that those skills are recognised by other employers, be they in the public, the private or the voluntary sector.

Lord Willis of Knaresborough: I recommended in my *Shape of Caring* report exactly that for the skills passport. You build up a skills portfolio, which is transferrable to both public and private sectors. Is that dead just because I have left?

Tom Surrey: No. Indeed, far from it. We were grateful for the recommendation and are taking it forward exactly to make the skills passport and portability within the care sector. Through the work on the integration White Paper and through the ICSs, I am sure we will continue to look at how that translates across both the NHS and social care.

Q100 **Lord Porter of Spalding:** I have a retention question but, before we get there, I do not mind getting into this bun-fight. We all agree that we talk about care as if it is a low-skill, low-ability job, but we all acknowledge it is not really. It is a highly skilled and socially valuable job and we do not pay people enough money to do it. Now we will make them even better qualified so we cannot pay them quite a lot more than they are worth then. Is that what we are saying? If the extra qualifications do not come with a bigger pay cheque, what is the point in somebody getting the extra qualifications? I cannot get my head around that.

We have had, in my opinion, far too long with the National Health Service taking the resources at the back end of people's need and care services not getting them at the front end of people's need to reduce the demand for the acute stuff. We have always had the ability in this country to love everything the health service does and not care much about what makes people get into the health world to need care. We will never square that circle. Until we have a Minister sitting in the middle who believes, "I am the Care Minister, and we also do acute stuff if we have to", it will not change. That relationship, as much as we might badge it up as one team is not; it will always be two teams. It will always keep pulling in different directions. When we hit the Sunday papers to see who gets the money, it will be the National Health Service every day over care. If we do not start spending the appropriate amount on care, we will keep spending more and more money on the health service. I cannot see that circle squaring.

The question I was supposed to ask you is about retention. Currently, we have some numbers here and in my head I have not squared where they have come from. About 17% of both your workforces are thinking about getting out. I do not know whether that is true or not. If it is true, do we measure that every year? Is 17% higher or lower than it has been historically over the last five or 10 years? If that is what people say, do we measure what they say and then what they do if 17% might say they are leaving but only 8% do?

Tom Surrey: The 17% is a specific NHS figure, so I will turn to Gavin. Then I can say something about retention in social care as well.

Gavin Larner: There has been a pattern of retention, which I will try to describe. The first point to make is in healthcare, while we worry about retention, rightly, relative to other sectors and other bits of the public sector and private sector it is good. The kinds of people who go into these jobs are driven by a sense of purpose, which makes them more sticky than perhaps in other industries. We have a head start relative to other industries, but given how much we need them, having a leaky bucket is not helpful.

In December 2016, we had a leaving rate of about 11% for nurses. Before the pandemic started, we had got that to about 10%. During the pandemic, people stayed put, so we had a benefit from that. It fell to 9%. Now, as we come into a different phase of the pandemic, leaving rates are starting to creep back to pre-pandemic levels.

It is quite difficult to pin down single factors that drive this because retention is multifactorial in whether people feel fulfilled in their jobs, whether they can do the work that they want to do, how they are treated at work, their pay, the terms and conditions, what the local labour market is like, whether there is somewhere else better to go, the culture of the organisation they work in and whether the leadership sends out the right signals. Pre-pandemic, our primary focus was on things like bullying, harassment, workplace culture and particularly flexible working and how people who do shift-based work designed for a different era have different lives with caring responsibilities and different expectations about work. We still focus on how we can provide a more modern working life for people. With the impact of the pandemic on people's exhaustion and mental health, increasingly we do not just look at that flexibility piece but more at health and well-being and whether people have the energy and their heads up to do these difficult jobs.

The policy response is, therefore, quite broadly spread. The people plan that NHS England published in 2020 looks at good employment cultures, good leadership, health and well-being, flexible working and action on the toxic elements of racism, bullying, harassment and so on. Secondly, the supply strategy stuff we were talking about before and having more people to do the job is an important part of retention. When people feel that they have the team around them to provide the kind of care they want, they avoid burnout. That supply piece and the 50,000 target are important.

We monitor leaving rates closely and they are published in official statistics regularly. We watch that closely and we continue to try to think about, out of all those different interventions I have described, whether there are five high-impact actions where we need to focus our attention or whether there is a broad-based approach for different people in different places.

Tom Surrey: In social care we see higher levels of staff turnover, significantly higher in some cases. In 2021 it was around 28.5% turnover across all roles. That is higher for those directly providing care, perhaps up as much as 34% or so turnover. The majority of that turnover, however, is churn within the system. As I said, there are around 18,000 individual organisations and employers and people move between those employers quite a lot.

Probably a number of factors drive that, some of which I have already talked about. The lack of training and qualification, some of the terms and conditions, career perception and public perception of the roles they do are all cited by people during exit interviews and surveys of reasons that they leave. Pay is one of those, but the latest data I have seen published by Skills for Care rather than official statistics—and pre-pandemic so a little bit out of date now—suggest that pay is only a factor for 2% to 3% of those who explain why they have moved roles.

We know that around 25% of the care provider market has staff turnover rates of less than 10%. We also know from those organisations that the

organisation culture, the value and the empowerment of individuals in their roles, rather than just the direct impact of pay, enables them to retain the staff that they have. Then, as I said earlier, some of the questions around qualification, recognition and so on will be important in that retention rate.

The other thing that Gavin has spoken about that is particularly the case coming out of the pandemic is the well-being of the workforce. The Minister put on the record our thanks and gratitude. I have met many care workers over the last two years and have heard amazing stories, as I am sure all of you have, about the sacrifices and the commitments that they have made, especially over the two years, but that takes a toll. That is also why, as part of our White Paper and that £500 million investment, we are investing in services to support their well-being, particularly recognising that in such a diverse sector as the care sector, with all those small employers, in many cases, the Government can do something to provide well-being services, support services and employee support services that are accessible to all care workers. Some of those small businesses may not have the overhead or the scale to do so.

Q101 **Lord Hogan-Howe:** I have a quick question on the turnover point. Most organisations would say 8% to 12% is quite a healthy turnover. For health, at 9% on average—I am sure geographically it changes—is it an issue? I take the 30%-odd point, but you also said that churn was a significant portion of it. I do not know what normal turnover beyond that is. Churn is not necessarily a big issue. Is it such a big problem?

Gavin Larner: The view of the Minister is that we still need to grow the workforce before we can relax on that front because people are stretched across the amount of work that needs to be done to meet patient need. Movement within healthcare is fine. It is healthy that people move around different places. Indeed, movement between our two sectors is good, but losing them overall at a time when staff feel that there are not enough of them to provide the care they want to without working really hard, is a problem for us on retention. There is a good question about what is the right vacancy rate to have in any workforce but at the moment we have not got to the point where we think we are there and there is more work to be done.

Lord Hogan-Howe: I can see that when you are trying to grow, you would like to reduce your churn and turnover as much as possible. I get that. However, there will always be people retiring and there will always be people leaving for different jobs.

Gavin Larner: It is natural.

Lord Hogan-Howe: It is just a query: is that the issue? On the numbers you have mentioned, it does not sound like it.

Gavin Larner: It is still one significant part of our supply problem. We can do better to retain some of the people that we are losing. As you say, some of them are natural departures—what people do with their lives,

retirement and so on—but there are things we can do, because we have not got the employment culture right and we have not got the flexible practices right, to make sure that we hang on to good people who cost a lot to train. The public have invested in them and we need to make sure that we keep them happy so that we make the most of that investment for patients.

Lord Hogan-Howe: For some of them, it is good they move on anyway.

Q102 **Lord Bichard:** I am not sure whether to address this question to Tom, Gavin, Lord Willis or the empty chair, but bear with me for a minute because it will take me 10 seconds to get to the punchline. When you articulated the differences between a nurse working in adult social care and one working in health earlier in this discussion, you seemed to me to itemise reasons why they should be paid more rather than less. You identified the greater responsibilities and the need for them to use their initiative more than if they were in health. Our response to that is to do something about the qualifications, because only 46% of them have qualifications, and we will issue a care certificate.

At the end of that process, which will take a while, we will end up with them still carrying the burden that you described and still not getting the same level of pay. I accept your point that the level of pay may not be massive but I also feel, as I said earlier, that a small amount is quite persuasive for some people. I wonder how many people are moving from health to social care. I suspect not that many.

The point of my question is that in doing what you are doing, which is to increase access to higher levels of qualification, are you not in danger of excluding some of the people who we want, with the skills that they have through lived experience, to work in the care sector? Is this not to some extent what happened with nursing 30 or 40 years ago, when we made it a graduate qualification to be a nurse? We are now saying that some of the nurses do not have the people skills that we would like them to have. Are we not in danger of taking social care down the same route and ending up excluding some of the very people that we would like to have working there?

Tom Surrey: If the Minister is content to let me respond to the question—

Edward Argar: Yes, there is always a risk that I may, in appearing suddenly, find I completely contradict anything my officials have said.

Gavin Larner: In which case we were wrong.

Tom Surrey: The first thing to have clarity on is that when we are talking about the social care workforce we are talking about an incredibly large workforce, approximately 1.6 million people in the country, 1.2 million of whom are involved in the provision of direct care to individuals. It is that large number, many of whom are not qualified. We think around 34,000 of those people are nurses, just to clarify and differentiate

between the nurses in the social care system and the wider social care workforce.

One of the things that we are very interested in is people who have come into that workforce for exactly the reasons you describe, their lived experience, their personal experience and their commitment to provision of care. Many of them may have found that they have cared for their own relatives prior to, or at the same time indeed, as working in the care sector. We are looking to enable them to have a professional framework, not a graduate framework but a recognition of the value of the work they do through things like a care certificate and the passport, as previously mentioned.

It is a slightly different question to that of nursing itself. It is not intended in any way to be a barrier to entry. As I said, with 54% of that workforce not yet having any qualification, it is about offering them visible recognition and a way to record the skills that they use every day, to make sure that they are recognised for that.

Lord Bichard: I could flip the coin there and ask: could you not be more imaginative? You talked about the people who are already in the workforce and the need to give them greater qualifications. Could you not flip the coin and say that we need to be doing more to get people from the community working in care homes? We heard in previous hearings about attempts to set up local talent pools so that people who expressed an interest in volunteering initially might understand more about not just care homes but other aspects of public services. You then have a pool of people who you can bring in and further develop. Are we being creative and imaginative enough in developing that kind of activity? *[Interruption.]*

The Chair: We are voting already. I shall suspend the meeting while the bells are ringing.

The committee suspended for a Division in the House.

The Chair: I will ask Lord Hogan-Howe to ask his question.

Q103 **Lord Hogan-Howe:** This is a very good question. In a way it sums up everything we have explored, perhaps for the Minister's benefit, over the last hour. I think we have looked at the problems. The question here is: how does the Department of Health and Social Care plan to achieve parity and better integration between the health and the social care workforce?

Edward Argar: I am going for that. It is a very good question. Quite rightly, my Lord, it goes to the nub of what I touched on just before I departed the room rapidly to vote, which was about the social care workforce and the NHS basically being two sides of the same coin. A lot of what we are seeing reported at the moment, for example, about challenges around accident and emergency units and ambulance handovers, is reflective of both parts of that system seeing challenges, discharges being a key part of it.

Hopefully, and I say this slightly at risk because I do not know what my officials have said to you for the past 50 minutes, one of the points that we have made is the desire to have a greater opportunity to move between those workforces, the ability for those in social care to continue to learn, develop their qualifications and move into healthcare, but equally a recognition that social care in and of itself should be a valuable and rewarding career.

The challenge remains—and it would be remiss of me not to say it remains—that in one part of that workforce, the health workforce, you have in the nature of it a much greater degree of central control and uniformity of approach to career progression, the ways in which different specialisms develop, and the pay and reward package that goes with it through national pay deals and similar. In the nature of the evolution of social care in this country, it is to a very large degree dependent upon local arrangements, private businesses and the arrangements that are put in place through those.

The reason I highlight that is because, of course, those arrangements then are reflected in the pay, the offer, the career progression and similar. Hopefully, Tom has highlighted in previous answers particularly the *People at the Heart of Care* White Paper, which seeks to set out the next steps on how we can further develop that parity of esteem, parity of opportunity, and the opportunities to grow both within and through movement out of and into that workforce. The reason it is a good question is because there is no simple answer, I am afraid, to that. I hope that gives some answer but come back on me if you wish, my Lord.

Lord Hogan-Howe: I am no expert in this area, and you have people around you who clearly are far better informed. I suppose what you are arguing for is consistency, more national consistency in local arrangements, which matches over to the health side. The question is: how do you achieve that unless you have—nobody here would allow me to say this—a national social care system or you have national pay arrangements or national accreditation? How do you get that national bit in?

Edward Argar: I would not say consistency and uniformity lead inexorably to that policy conclusion of a national care service.

Lord Hogan-Howe: You have not said "national" or "consistent" but something that reinforces each other, given you have a split between the two.

Edward Argar: I think, at the heart of what we are doing here, we can move further down that road. You will have seen the recent legislation, which we sent you, you sent us and we sent back again, around health and social care in the Health and Care Bill. Although the debate was about the metering amendment, those debates in both Houses widened to the broader approach to social care. Similarly, there were measures in that legislation around integration. With that, we take another large step forward in integration with the integrated care partnerships and the

integrated care boards. We would expect to see social care, through the local authority, represented on the ICBs, but we would also expect to see some of those organisations delivering it, rather than simply the local authority, represented on the integrated care partnership because that experience is valuable. We are doing a lot more to achieve a greater alignment and a consistency there.

However, we come back in this space, in policy and also in workforce and the model we work with, to the point that we have seen the two parts of the system evolve very differently. Prior to 1946 and the implementation of the legislation in 1948, essentially both elements were delivered on a place-based, local model and they were very patchy, hence the impetus that was growing in the 1930s but came to a head during the Second World War for a national health service. From that point you have seen a bifurcation in the sense that you have the national, almost vertical approach within health services, and you have continued to have that local, place-based approach to social care services with local communities essentially making provision within the locality, obviously with national inspections. You see them going in different directions. I think no Government has ever wished to reverse either of those positions and push it all into national or back down to local.

What we have sought to do with the legislation that we have just put through both Houses is move it a step further forward, so that the NHS has the flexibility to adopt more of a place-based approach and social care gets, through the integration White Paper and beyond, a broader national framework. That is almost the philosophical policy perspective.

Coming to the workforce element, I think there will always be a difference in approach because of that fundamental difference in how the two systems have evolved and how they are structured. However, with the integration White Paper and the White Paper on the social care workforce, which I think was last December, we have shown how we are working to build on that parity of esteem, the opportunities for skills and the opportunities for different types of entry into both workforces.

There is something Ministers can do, all of us in both this place and in our House. It is very easy to talk about the NHS and say, "We pay tribute to our NHS and the people who work in it." It is really important that we mention social care as well. I know it was seen slightly as a gimmick at the time when Jeremy Hunt changed the name of the department, but I think it is extremely important that that message is sent.

Hopefully in that I have not contradicted anything Tom has said, but if I have I am sure those reading the transcript will have a lot of fun with it.

Lord Hogan-Howe: Giving something that I do have some experience of, you have a national pay scale for police, although it has geographical differences for London and the surrounding area. As far as pay matters, and you give a very good explanation of the history and why we have what we have, why could we not have some national approach to that?

Edward Argar: The reason I mentioned the history at some length is because it is relevant to how the sector has evolved. I think that there are roughly 2.5 million people in the workforce, depending on how you define it, the vast bulk of whom are employed in private businesses that are contracted by local authorities or others. For policing, essentially, yes, there is a national arrangement but they are all public servants in public bodies, the police, be it Leicestershire Police in my patch, the Met or wherever. Therefore, you can strike a national policing deal with regional variation, weighting or however that works. Similarly, when you have that vertical approach in the NHS we strike national pay deals with the unions, representative bodies and others.

The structure of social care in this country is made up of a lot of small to medium—with some very large—private businesses, each contracting with their employees and I think you would find it extremely difficult to square their ability to run their businesses in an appropriate way with a national mandated pay structure that would, essentially, be their single biggest expenditure. I think in the nature of the structure of the social care market, it would not be operable unless you went down the route—which I hasten to add I would not advocate—of a nationalised care service.

Q104 **Lord Willis of Knaresborough:** Following on from that, Minister, we have seen a different way of delivering this already. If you look at what is happening with some of the mayoral systems—particularly in London but I think Manchester is a good example—you see a greater integration between health and social care because it is a single budget. The budget from the local authority, and indeed from the Department of Health and Department of Social Security, is bringing that resource together in a place-based system where you have, in many ways, a policy that is regional and approved by national government but in fact is then delivered, because you have the resource, within private and public sector organisations. You do not necessarily need to have privatisation or have it be publicly owned because you control the purse strings. I think that is a really interesting way of dealing with it. Gavin and Tom mentioned Leeds earlier and it is an extremely interesting model of bringing their health and social care together.

I think that the more we encourage, and you encourage as a Minister in the department, place-based delivery of national and regional policy, the better it is. The police come into that as well because we stopped thinking of things in silos and started bringing them together.

Edward Argar: If I may, Madam Chair, my Lord, you are absolutely right. I have seen both, in a sense, because before I was at the Department of Health I was a Justice Minister for 15 months and one of the places I went to visit was Greater Manchester to meet Bev Hughes, who is the deputy mayor covering that. We talked in that context about the opportunities that were available with recognition of a national framework. Any Government of any party would wish to be able to set certain national priorities and protect value for money, but equally how you could, within that, come up with place-based tailoring and flexibility.

That is one of the themes. Before I was in Parliament I was a city councillor in Westminster and I saw the London model under mayors of both political persuasions. Again, that gave me the idea. That is one of the things that sat behind my thinking around integrated care systems.

I seek to be, in this place, not revolutionary but evolutionary. I tend to find that you have more chance of things sticking and making a difference that way. Therefore, with the integrated care systems we have tried to build on exactly what you are saying. There will be a framework there of national objectives and national priorities, of course there will, but the goal is to empower each ICS to set themselves up within that broad framework to reflect their local area in the partnerships, the local determinants of health and what they actually need. In my conversations with ICS chairs I have been very clear that we want to empower them, "Here are the bits that you have to do. Beyond that, form your partnerships with your local authority and social care providers and work together."

I remember when I was a councillor we used to rely on Section 75 of the 2006 legislation on pooled budgeting and being able to work together as a local authority with social care and the NHS. It works but essentially it has been outgrown, hence why we are tweaking it with this that has just passed through. I found, doing that, that what was far more effective was less the formal structures and processes and more the ability to be flexible, relationships between different parts of the system and the understanding of that local system.

The one caveat I will add, which we made clear during the passage of the legislation, is that we would not envisage that as being an opportunity, for example, in health to move away from nationally negotiated and agreed terms and conditions of pay—

Lord Willis of Knaresborough: You do not need to.

Edward Argar: But it gives flexibility in ways of working and how social care and healthcare can be better integrated and talk to each other more. That is a very long way of saying that I think your examples are very good ones, but they will not necessarily work everywhere. There will be other models that work in different parts of the country, be it in a large rural county, a suburban area or an outer London borough. There will be different models but that is the whole purpose. I think, to be fair, your Lordships were kind about that element of my legislation when it went through your Lordships' House in the Health and Care Bill. There were other bits I think you were less keen on. That ability to be permissive rather than prescriptive was at the heart of it.

The Chair: We have overrun, which was inevitable today given what has been going on, but it is not fair of us. I know what your diary will be like.

Edward Argar: I am at your disposal, Chair. I may regret saying that.

Q105 **Lord Willis of Knaresborough:** May I ask another question, very

briefly? It is just a very quick one. The Department of Education was in before us and I was struck by the excellent Minister, who said that he is going to argue very strongly to the Chancellor that in fact a starting salary for a graduate teacher should be £30,000. At the moment, the starting salary for a graduate nurse—they came in in 2013—is £25,655. Would it not be excellent if you could say, "I am going to match the Department for Education and say that a starting salary for a graduate nurse should be £30,000, in line with teachers"?

Edward Argar: I knew I might regret offering to stay a little bit longer and take your question, my Lord. You are absolutely right, my colleague Robin is an excellent Minister and an excellent colleague, but I am afraid you will not tempt me to nudge the Chancellor in a public committee hearing.

I will make two serious points. One is that I think what he is talking about is reflective of the direction of travel that was set out in our manifesto in a manifesto commitment and, one hopes, secured a degree of collective agreement at that point. Therefore, I am not going to make policy in that way on the hoof. All I will say is that it is important that we always continue to reflect on the levels of pay for all those in the health and care system to ensure that the package of pay and other benefits and factors remains an attractive one.

I suspect that my colleagues have covered this. As well as working hard to recruit more to grow the workforce both internationally and domestically, the crucial element is that we maintain or improve retention rates because if we fail to do that, in a sense it is the leaky bucket approach. We are putting a lot of effort into filling it to the top but we are not keeping those experienced, long-standing workers within it. We always continue to look at pay and terms and conditions throughout one's career in this space, including starting salaries. In a very charming way you seek to tempt me, my Lord, but I fear I will not be tempted to comment in that way.

Lord Willis of Knaresborough: It was worth a try.

Q106 **The Chair:** I am very sorry that we have not had more time. I wanted to put to you things such as that I gather about 90% of training money is spent on initial training. It does not leave much for that—

Edward Argar: Continuing professional development.

The Chair: Which is what you have all said is going to be absolutely critical for retention. That is one of the things that we will be thinking about and looking at. It is not just in health; that is also true in education and, I think, in policing too.

Edward Argar: It may not be as optimal as being able to ask in an oral session with the to and fro, but would it be helpful if your clerk perhaps let me know any subsequent questions or particular questions you would like me to answer and I write to the committee as swiftly as possible so

that at least you have written responses to some of those areas you would like to explore?

The Chair: Very much indeed, thank you, and thank you for coping with the rather disjointed session.

Edward Argar: Thank you for your indulgence.

The Chair: It is nobody's fault; it is just the way Parliament works. We are very grateful to you for coming on. With that, I formally end this session.