HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Adult Social Care Reform, HC 368

Wednesday 5 February 2025

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Deirdre Costigan; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 49 - 117

Witnesses

I: Oonagh Smyth, CEO, Skills for Care; Emily Holzhausen CBE, Director of Policy and Public Affairs, Carers UK; and Anita Charlesworth, Senior Economic Adviser (REAL Centre Team), Health Foundation.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Oonagh Smyth, Emily Holzhausen and Anita Charlesworth.

Q49 **Chair:** Welcome to today's session of the Health and Social Care Committee on the inquiry into adult social care reform: the cost of inaction. For the record, may I ask our witnesses today to introduce themselves and what they do?

Anita Charlesworth: I am Anita Charlesworth. I am a health economist. I work for the Health Foundation. Also relevant, I am the vice chair of North-West London integrated care system. I should declare that I have recently become a trustee of Health Data Research UK.

Q50 **Chair:** And you are also a member of our independent expert panel.

Anita Charlesworth: I am indeed.

Oonagh Smyth: I am Oonagh Smyth. I am the chief executive of Skills for Care, which is the workforce development and planning body for adult social care in England.

Emily Holzhausen: I am Emily Holzhausen. I am director of policy and public affairs at Carers UK, representing families who provide unpaid care. I am also one of the three co-chairs of the Care and Support Alliance, an alliance of 60 organisations campaigning for better social care.

Q51 **Chair:** Thank you very much, all three of you, for appearing in front of the Committee today as we try to unpick all the numbers around health and social care and its contribution to our country.

Oonagh, may I start with you, and particularly the Skills for Care research that has been commissioned that found that adult social care contributes £68.1 billion to the economy? First of all, could you explain briefly how that figure was arrived at?

Oonagh Smyth: Adult social care is fundamental not only to the people it supports and the community infrastructure, but to the economy. The report and the figures that we published, as you say, stated that adult social care adds £68.1 billion to the English economy every year. That is made up of three things: the direct contributions, which are salary and profits and are just over £31 billion; just over £15 billion is indirect contributions, which are supply chain impacts; and the third element is induced contributions, which are about £22 billion—

Q52 **Chair:** How do you make those?

Oonagh Smyth: It is essentially money spent by people working in adult social care. Those three things combined make up the £68.1 billion. Adult social care has a huge workforce; almost 1.6 million people work in adult social care. More than 5% of all jobs in England are in adult social care. It is a significant sector.

Q53 **Chair:** Do you feel that there is space for that contribution to grow, given specific reforms? Have you done any work around that?

Oonagh Smyth: We have not done specific work on what it would look like if it grew, but bearing in mind that it grew about 13% in 2023-24, we can expect it to grow when we look out to the future. Just looking at demographic changes alone, and the number of people working in social care, we project that if the number of people working in social care were to grow in proportion to the changing population, we would need an extra 540,000 posts by 2040. The economic contribution will grow if we pay people more in social care. We have had the commitment around the fair pay agreement. If that is implemented and funded, we expect to see that economic contribution growing. Paying people more and also employing more people are the two real factors that will have an impact on the economic impact of adult social care.

Q54 **Chair:** Of the things that you predict might help it to grow, are there any that would help to grow the new money aspect of it? If it is primarily Treasury funding much of this stuff, they would see it as a recycling of money they already have. How would you encourage the Government to look at adult social care as an industry that grows, but where that money could also come from other sources? Would you characterise it that way?

Oonagh Smyth: That is possibly a question more for Anita than a workforce-specific question.

Q55 **Chair:** Fair enough. Anita?

Anita Charlesworth: I have thought about the question of the cost of inaction on social care from a Government economic growth agenda perspective, and how social care contributes to economic growth and therefore how lack of reform hinders economic growth. Andy Haldane, the former chief economist of the Bank of England, gave a lecture two years ago where he talked about the contribution of health to economic growth. He talked about there being two cylinders in the engine for economic growth. One is the number of people who are able to work, and the hours that they can work—in economic speak, labour supply. The second thing is the productivity of those workers. We can think about the problems in the social care sector affecting both of those.

In the labour supply, there are two key groups where failure to provide appropriate social care in ways that meet people's needs affects labour supply. One is that there are increasing numbers of younger, working-age adults using social care. When we talk about social care we tend to focus on adults, but half the budget and about a third of the recipients are younger adults. Many of them will not be able to work, but some of them could work with appropriate support. The Care Act 2014 explicitly tried to have a much wider sense of what effective social care would be that recognised a wider contribution. Progress to realise that vision has been low. That is one group.

The second group are carers who are caring for such a large number of hours that it affects their ability to work. Four in 10 working-age carers report that lack of support means that they work fewer hours than they want to. That is one of Andy Haldane's cylinders, where you can see that not providing appropriate social care potentially affects our economic growth.

The second area is around productivity. If I may, I would like to talk about this in relation to a paper that Rachel Reeves wrote back in 2018, when she talked about the importance of the everyday economy. If we think about the challenge of raising productivity and economic growth across our economy, which is absolutely fundamental, we need to ensure that we are able to develop the sectors in which we excel and that are high value-added. Those are advanced manufacturing and what they call the strategic sectors in services, life sciences, financial services and business services. It is all those things, high-paid, high-qualification and traded.

As Rachel Reeves points out, you cannot have an economy where everything is either advanced manufacturing or high-traded. What also matters in our economy is what she calls the everyday economy—the goods and services, particularly services, that we all need and use for life. They tend to be low paid and low productivity. Social care is one of the biggest sectors in the everyday economy. What matters is that in the everyday economy those sectors are as productive as they can be. In the social care sector we have seen, according to ONS data, that since late 2008 productivity has not really increased. There are challenges with measuring it. I think the adjustment for need and complexity is not where it would be, but it has not increased.

We could probably point to three things that have hindered the productivity of the social care sector and seem to me to be one of the ways in which lack of reform affects economic performance. One is our approach to the labour market and reliance on a high turnover, low-skilled workforce with very low differentials. That means there are no real incentives to train and develop your skills. Where you do, we see that people move into the NHS, which is good for them and good for the NHS, but not good for the social care sector.

The second thing is under-capitalisation in the sector and very expensive capital. I know you have had evidence from HC-One, who make this point. Because of the way we commission social care, with lots of spot purchasing and lots of uncertainty, social care providers pay a very high cost of capital. That is money that could be going into improving the sector but is going into hedge funds.

It is the same problem with children's social care. They argue—I hope that Louise Casey's review will really focus on this—that potentially, if we commissioned in a different way, we could create opportunities for the sector to have a lower cost of capital, which would benefit its ability to

improve without extra Treasury money. Obviously, access to capital matters. One of the huge issues in the social care sector is that it is almost certainly under-digitised. It has not been able to take advantage of technological innovation.

The way we commission social care is very much a commissioning model that drives out innovation. We commission tasks, which are both incredibly reductionist to human beings and make it incredibly difficult for people in the social care sector to innovate and provide care in different ways. There are some impressive innovations, but it is despite the system and not because of the system.

We need social care, because it will grow as a sector, to be as productive as possible. That does not mean flogging the workforce ever harder, which is actually what you do when you cannot be productive. It is the antithesis of productivity. We need to support the sector. Government need to play a much more effective role and have a well-designed system that is able to be productive.

As Rachel Reeves, the Resolution Foundation and the LSE have said, we also need to be realistic that an economy cannot be all high-end manufacturing and high-end services. We all need to get our hair cut, and we want to go out to dinner and have social opportunities. We want to be cared for. That is part of a well-functioning economy and society, and we will have to pay more for those things. If we have the other parts of our economy going well, and a social care sector that is able to be as productive as it possibly can be, we are in a virtuous cycle in our economy. At the moment we are in a vicious cycle, and we need to switch out of that.

I think you can see that there are lots of potential reforms, some of which would not need more money from Government, which could help the social care sector to be more effective and more productive. We also need to be realistic. We have an ageing population. We want an economy that is high performing, but that is also not reliant on people in the everyday economy having appallingly low wages so that everybody else can have a good life. We need a fairer economy. That will almost certainly mean that we have to spend more on social care, but we want to spend it on a productive social care system that supports our economy and supports individuals well.

Chair: Thank you very much. That is plenty of food for thought, and certainly a picking list of things we can recommend to Government as to what we are looking for. It is much appreciated.

Q56 **Ben Coleman:** It is great to see you all. I have had the pleasure of working with Anita on the North West London integrated board as a member. I have known Emily for many years and the work she does for carers. Oonagh, it is good to meet you properly.

It is very interesting to hear how you make the link between economic

growth, caring and social care. Of course, social care provides a lifeline and is essential for unpaid carers as well. Would you like to say anything more about the impact of good social care on economic growth, particularly in the regions, and whether there are particular parts of the country that could do with an improved approach that would help to achieve more growth in a region or part of the country?

Emily Holzhausen: I will start by setting out a principle about economic growth and unpaid carers. It follows on from what Anita was saying about everyday services.

We look at childcare, for example, as a fundamental condition for parents to be able to work. That is clear. The economic links are clearly made. But we do not make the same link with social care being a fundamental condition for disabled people and their families to be able to work. When we look at the labour market statistics, we see a clear employment gap between people who are caring and people who are not caring. For people who do not have the means to purchase their own care, we start to see, as Ben said, a regional impact; for example, post-industrial areas are much more likely to have high areas of ill health and disability. We see different clusters of poverty and carer's allowance.

Coming back to the economic growth point, this is critical. In carers' work patterns, even caring for five hours a week can have an employment effect. It is differentially felt by women, which is a really important point. You have a 50:50 chance of caring by the time you are 46. It is the same chance when you are 57 and a man. There is 11 years' difference between a woman's chances of having their work impacted by caring and a man's chances. When we look at the economy, that starts to make a real difference, regionally, personally and in terms of class and opportunity, which links three of the Government's missions—health, opportunity and growth. It should link to all three.

We have done some analysis recently of carers in poverty. This is one of the costs when people fall out of work. Falling out of work is perhaps a bad term, but people get to the point when they just cannot manage juggling work and care any more, and they give up work to care. We see some of the impacts on people who then have to rely on carer's allowance, which is the lowest benefit of its kind. There are 1.2 million unpaid carers in poverty and 400,000 in deep poverty.

Q57 **Ben Coleman:** That is obviously very worrying. Is it because they prefer to care than have the person they are caring for looked after by adult social care, because they cannot get the adult social care, or for other reasons?

Emily Holzhausen: It is a combination. About 62% of people say that they have no choice about caring because no alternative care options are available. Some people wish to care, but there is also a lack of care. Some people who need care do not want to be cared for by anybody else

apart from their family. That is a factor with about a quarter of people, I think—if I have got that wrong, I will write a note to the Committee.

It is not straightforward to say that people do not have a straight choice. There are cultural responsibilities as well in all cultures about caring and gendered perspectives, which especially place duties on women to provide care. The whole intersect between carers, work and social care and disabled people and social care is under-researched. We do not see it referenced in many Government documents, and we should.

Q58 **Ben Coleman:** Thank you; that is very helpful. Anita, could I pick up a couple of things you said, although everything you are all saying is very interesting? You talked about commissioning in a different way, and you said that not all reforms need more money. Do you want to unpack that?

Anita Charlesworth: In terms of commissioning in a different way, I do not have a fully worked-up model, but I think that it is a really important issue for the Casey review to look at early, because it is about getting more value from the funding that we currently spend, and unlocking some of that. There are some examples around the country. Leeds has tried to do a lot of work on different approaches to commissioning social care.

There are a couple of things that are important to think about for commissioning in a different way. One is the duration of contracts. In other public services we recognise that if we give people contracts for longer periods of time and give people financial certainty for a period, because we are very confident that we are going to need some capacity, and you get a contract for three years, what you can do in the model for your staffing, your incentives to train and develop your staff and your ability to access capital at lower rates is very different.

There are other Government reforms, for example on the local government pension side, looking at trying to unlock some pension money for investment. That would be lower-cost capital. If we think about the way we contract for social care, with models that are attractive for longer-term patient capital, it should potentially be a lot cheaper.

The other thing is contracting for outcomes rather than contracting for activities. When you contract for activities and tasks, it is very difficult for people to innovate. That is important for things like digital and trying to think about new models. There are some examples, most obviously the Leeds one, with more outcomes-based contracting where there is more innovation and flexibility for providers to meet needs in different ways.

Q59 **Ben Coleman:** That is helpful.

Oonagh Smyth: I want to pick up on the Leeds model, which is a good example. In Leeds they are moving away from a time-and-task approach and building in integration. It is working well between health and social care, which we talk about so much. What that means is that the workforce are given more autonomy and more flexibility. We are trusting

the workforce to use their judgment more in how they support people and allowing people to be supported in the way that they need to be. From a workforce perspective, that includes things like paying for whole shifts.

One of the things that impacts on turnover in the workforce is the balance between flexibility and stability. If someone is on a zero-hours contract, they are much more likely to leave an organisation. Over 30% of our care workers are on a zero-hours contract compared with 3% of the broader population. In the first 18 months, the Leeds model resulted in 1,200 fewer adults being admitted to hospital. The length of stay for people requiring support on discharge was reduced by 17%, so there are real, preventive savings in that tertiary prevention, people going into hospital, and real impacts on the workforce. There are really good pockets and examples of good leadership and innovation. The more that we can pull those out, the better.

Q60 **Chair:** It also gives us a baseline of what we could compare. Is there anywhere else in the country we should be looking?

Oonagh Smyth: Sheffield has a similar model, and Hammersmith and Fulham in terms of the funding model there. There is so much good practice sitting across the country. It is the point that Anita made, which is that we rely on pockets of really good leadership, and what we want is for the whole system to be supporting some of this, where we see that it works.

Q61 **Ben Coleman:** Thank you. To be clear, I haven't primed Oonagh to say Hammersmith and Fulham, but I am very happy that she did.

You touched on the Government's role. Going back to economic growth, because that is what I am focusing on, do you think there is enough consideration given by the Government to the contribution of the adult social care sector when they think about economic growth alongside the debate about reforming the sector? Do you think the Government get the role of adult social care in supporting growth? If not, how could they be encouraged to do that? That is one for everybody.

Emily Holzhausen: They could do more. If we look at the "Get Britain Working" paper, for example, and people's ill health, a significant group of unpaid carers who also have ill health as a result of caring end up in that group. There is the disability employment gap as well, where people have become ill or disabled later in life. Obviously, there are key issues for people throughout their lives, so they could do more.

The DWP perhaps might understand that best because they are concerned about the benefits bill and making sure that people have the biggest opportunities. Carer's allowance is the lowest of its kind; it is only £81.90 a week for 35 hours of care. I don't think the Department for Health and Social Care has fully explored that relationship. If you put a price on carers' support, it is £152 billion a year, but that is not free care because of the negative aspects. There should be dialogue between

Treasury and the DWP. The needs of employers across the country—UK plc—need to be considered because they are losing valuable employees. Around 600 people a day give up work in order to provide care. Social care will play an important role in that.

Looking at our members who are unpaid carers, for example, 69% said that social care helped them to juggle work and care. They often provide very substantial amounts of care. Some 50% of carers who had given up work to care could not find suitable care to return to work. That pathway is incredibly difficult for people around predictability. Whatever I say for carers is true for disabled people as well, perhaps more so; 40% could not find affordable care.

We need to understand that intersect much more. A taskforce looked at it in about 2013. There was much more interest in 2009-10 around the last White Paper on social care, where I think we saw an understanding that with the ageing population, a rising state pension age and productivity issues around workers and different industries, we needed to keep people working for as long as possible. One of those things is social care.

Q62 **Ben Coleman:** Anita?

Anita Charlesworth: I don't think we have the terms of reference for the Casey review, but having productivity of the social care sector and what we need to do to support that squarely within the Casey review is important. I am hoping that that aspect of the work could be fast-tracked rather than the full 2028. That is important because the introduction of the fair pay agreement for social care is an important moment for the sector. As is often the case, the impact of that will depend on the other things that happen around it. Making sure that those wider reforms are in place is critical.

The other area where you do not see so much on the opportunity side at the moment is thinking through the impact of being a young carer. There are smaller numbers but very high impact. In a number of areas, if you have experiences in late childhood and young adulthood that affect your education, your mental health and your ability to work, that is not only wrong in and of itself—it impacts you in the moment—but it actually has what economists call a scarring effect. If you do not get a firm hold in work, with education behind you, and good wellbeing and mental health, you never reach your potential. It is a smaller number of people, but the impact on them of lack of support to have good mental health and care without affecting their education and work is something that we should be concerned about in terms of opportunity.

Chair: We are going to move to carers and the workforce. I am keen to get through all of the questions.

Q63 **Paulette Hamilton:** My question is on unpaid carers. For many years, just to preface the question, as someone who led adult social care, we could not manage the system in Birmingham, where I was the cabinet

member for adult social care, without unpaid carers. They were an army of people.

I heard what you said earlier, Anita, but to be honest it was more the unpaid carers who kept us going than the people we actually paid for their services. The question I would like to ask Emily—Anita and Oonagh can come in—is how sustainable the current level of unpaid caring activity is for the future in the way it is going at the moment, taking into consideration what you said about cultural issues. In areas where you have large Asian communities, they predominantly look after their own. How is it sustainable for the future?

Emily Holzhausen: Thank you, Paulette, for recognising the role that families and close friends play on the whole economic side. We really value that. It is not sustainable now. As I said before, we see significant poverty impacts for families. We see health impacts. There is a poor health gap. There is a study in the US that suggests that carers have 63% increased mortality. We have work impacts. Some of our members say, "Well, we've spent all our money now. I have nothing left to pay for my own care in the future."

Carers feel very concerned. Three quarters are at breaking point and do not know how they are going to manage in the future. Of carers who have very bad mental health, about one third had had thoughts of self-harm and suicide. When we talk about sustainability, we cannot look at the current system as sustainable, even now.

I know that you know that because when we look at the survey figures last year of ADASS—the Association of Directors of Adult Social Services—on growth and demand, carers are coming now with much more complex needs. I am sure you are seeing this in Birmingham as well. They are reaching a higher level of need and are at breaking point. It is a travesty. Families need more from systems and support. Sorry, I've lost my train of thought.

Q64 **Paulette Hamilton:** That is fine. I am going to bring Anita in quickly.

Anita Charlesworth: It is important that we do not see unpaid care and the paid-for care system as direct alternatives; if we have an effective system, for most families they work in partnership. From the census data, we saw between 2011 and 2021 a growth in the number of people who are doing very high numbers of hours of high-intensity care. The numbers providing 20 to 49 hours have increased. The numbers providing 50 hours or more a week have increased. The number of carers whom local authorities are able to provide with some support has declined.

One of the concerns—and this is not because local authorities have chosen to do this—is that the model has concentrated efforts on high-need interventions. Therefore, they have had to reduce some of the lower-level interventions that probably made something sustainable for somebody. Informal carers find themselves doing more and more hours

and doing types of care that they find difficult. There are a couple of areas where we need to think about that. First, we have more younger adults who have had caring needs from childhood or young adulthood and are living much longer. They have been cared for by parents, and those parents are now becoming very elderly and are developing health issues of their own. The care that they were providing becomes unsustainable.

Many informal carers have a fellow elderly partner. It may be that they can cook a meal, but there comes a point when trying to get somebody into the bath or lifting is unsustainable, and they themselves fall. It is thinking through who is caring and how we make sure that the paid-for social care is targeted at the right things that make caring something that people can do and manage where they and their loved one want that to happen, rather than seeing them as always just alternatives. That is very important.

Q65 **Paulette Hamilton:** Thank you. Do you want to add anything, Oonagh?

Oonagh Smyth: I want to give a bit of a story about the actual impact, though Emily and Anita have covered it really well. I was speaking to a woman a few years ago whose husband had had more than 100 carers in their time. He had dementia. I say that because it is not either/or; it is both/and. Even when you have formal care, the impact on the individual family carer can be significant—the impact of the quality of care and support on people's lives.

Our lives are complex, and everybody has a slightly different sense of what they need for their own wellbeing, and that combination of formal and informal care needs to work well together. That is an important point for us to think about when we are looking at the growth that we need in the paid social care workforce. It is going to be an important element. If we cannot get that growth, it will have an impact on unpaid and family carers.

Q66 **Paulette Hamilton:** Very good point. Can I add a little bit extra? For the future, we have a risk: if we continue to rely on unpaid carers for adult social care, how are we going to quantify the risks for the future? The way social care is going is falling down, and everybody admits that. These unpaid carers cannot carry on. For the future, are you able to quantify what the major risks are? I am a person of numbers. Think about two areas where you think there will be a major risk in the future if we do not sort out those unpaid carers who are struggling, who have mental health issues and who have ended up in poverty. How are we going to work with them in the future? I hope that explains it.

Emily Holzhausen: It does. Good-quality social care is transformational for people; it really is. I know from my own family and from friends—I hear it from our members too—that it is about quality of life. It is peace of mind and then health and wellbeing, work, relationships and reducing

loneliness. It is not a "nice to have". As you said, it has an economic impact.

I think the two risk areas are to health and wellbeing. We see that clearly. The biggest growth in the numbers of unpaid carers are women over 85, who are caring over 50 hours a week. That is a lot, as you were saying, Oonagh, in terms of what people have to do. The other area is the labour market. On the cost of loss to the economy, Centrica suggested that unplanned absences cost the economy about £4.8 billion a year grossed up. They looked at their own figures. This is an issue that will also roll into things like—

Q67 **Chair:** By unplanned absences, do you mean due to caring specifically?

Emily Holzhausen: Yes, unplanned absences due to caring. Some of that will be down to social care, but, Paulette, your point is broader than that, about caring and people's lives. We need to look at the cost of people caring to business and public sector employers. The staff survey in the NHS showed that one in three of their workers is also an unpaid carer. That is down to the balance of women and age. That is why it is so high. It is really the labour market and health and wellbeing.

Q68 **Paulette Hamilton:** Thank you for that, Emily. Can I go straight to Anita and then ask the same of you, Oonagh?

Chair: Very brief answers, if possible.

Paulette Hamilton: I always do two points, so without all the explanation in between would be helpful.

Anita Charlesworth: Given our demographics, we need to make sure that people between the ages of 50 and retirement age are able to work, and work in a sustainable way. We are very focused at the moment, rightly, on the impact of their own health on their ability to work, but we also need to worry about making sure that their caring responsibilities are properly addressed. Often, the two are related, because you are caring and then you become ill. Once people leave employment between those ages, returning to employment is incredibly hard.

The other thing I talk about all the time is prevention, prevention, prevention.

Q69 **Paulette Hamilton:** Oonagh, a final word?

Oonagh Smyth: I have nothing to add.

Q70 **Dr Cooper:** We are going to stay with unpaid carers. Listening to the numbers and the census conversations, are you able to give us a number on how many unpaid carers there currently are?

Emily Holzhausen: It depends on which survey you choose because they have slightly different questions and slightly different answers. If we look at the census, it is 4.7 million in England. The census question changed and we had a drop in the number. Scotland did theirs one year

later and had an increase, and they used the same question as before. There are slight differences in the questions that you ask.

As Anita said, what we saw in the change between 2011 and 2021 was actually an increase in substantial care. That census also returned results where there was a drop in disability. We see that as a slightly different type of result. If we go to the GP patient survey, for example, they suggest it might be around 16% of the population, or between 9% and 16%, and some of our surveys return around that level when we do polling.

There could be as many as over 10 million or 8 million. The bottom line is that there are millions of people doing this, and each dataset has its own merits when looking at different interactions. There is rarely one figure. It is just taking the principle that it affects many people. It is not a static figure either.

Q71 **Dr Cooper:** No, I appreciate that. It is interesting that it is so broad. Obviously, we are calculating based on presumptions, but you look like you have a ballpark somewhere between 9% and 16% as a range that you can be relatively confident in.

Emily Holzhausen: Yes.

Q72 **Dr Cooper:** Looking at that number and then thinking about the Casey report, what are your thoughts about what social care reform should actually deliver for unpaid carers, and for society as a whole in terms of care? Is it your opinion that we should be looking to reduce the number of unpaid carers? You talk about targeted social care. I have heard that and about the right type of social care being provided, and commissioning an outcomes-based rate. I appreciate that is difficult, but laudable. Should we be looking at reducing the number of unpaid carers? You talk about the benefit for carers at the moment being low. The employment earnings limit has been announced by the DWP and there is an increase this week. Where do you sit on the spectrum of what you think should happen in this reform?

Emily Holzhausen: At the end of the day there is a choice, even if some people do not feel they have a choice about caring; young carers are a very good example. What we need to be doing is giving people the right opportunities in life to work, to connect and to be well. Families will still care. A lot of people will still choose to care. The Government's role is to support them to stay in work, to support their education and to support their wellbeing. That will be different for every family. Some families might decide to do it all themselves. Others need more support, for a whole variety of different reasons. I think that is very important.

The broader aspect is absolutely critical for us. Social care is one point there. Workplace rights are also important. The flexible working rights coming through the Employment Rights Bill are very important. In the future we would like to see paid carer's leave; turning the unpaid carer's

leave entitlement, which the last Government brought in, to paid leave is very important. We need investment in social care to reduce the health impacts of caring. We cannot leave families in poverty because they are unable to—

Q73 **Dr Cooper:** It sounds like you are talking about broader reform generally.

Emily Holzhausen: Yes. It has to be broader.

Q74 **Dr Cooper:** I understand that. Oonagh or Anita, is there anything you wish to add?

Anita Charlesworth: There are two things. This issue of more and more of the formal social care system being devoted to very high packages of care has reduced the amount of lower level interventions, both earlier interventions and lower levels of support. That is a completely understandable change when there is funding constraint, but what that may well affect is the sustainability of the informal care.

It is unlikely that most people who care will elect no care at all, but there is an extent to which doing 50 hours a week of care can be seen genuinely as a choice—for some people it will—and many people are doing very high intensity both in terms of hours and types of tasks that, if they had appropriate support, would free them to have more of the time and relationship that they want to have and that they, as the person's loved one, uniquely bring. That is something I hope the Casey review will look at, and how it can be done.

The other thing is that the Care Act included provisions to support informal carers. The extent to which local authorities have been able to implement that in the spirit in which it was intended is limited. If you were looking at somewhere you want to focus early, it is on young carers. If we were prioritising, and inevitably we will have to prioritise, to what extent could we do that, especially with outreach? Often, if you are a young person and you are trying to finish school and look after your parent, the idea that you have time to devote to trying to interact with a public system to get what you are entitled to is not very realistic. How we reach out with multi-agency activity to make sure that young carers in particular are getting the support they need is something very important to think through.

Q75 **Dr Cooper:** The question is very substantive, but it sounds like you are all talking about a case for reform, whereby unpaid and paid are on a spectrum and are both vital, but it is the thing that if you are the unpaid carer there is choice to have good quality of life alongside caring for your family to the extent that you are able to. That sounds like it would be the best return on investment for the country as a whole as well.

Anita Charlesworth: Yes.

Q76 **Gregory Stafford:** My questions follow on from the ones we have just

had. You have talked very eloquently and passionately about the effect that this is going to have on carers. I am afraid I am going to be a bit more hard-nosed in my questions and get down to the money side of it. Have you done any assessment of what is more cost-effective to the economy as a whole? Is it having unpaid carers with the support packages that you are talking about versus having fewer unpaid carers and having professional social care pick up that cost?

Anita Charlesworth: I have not seen any modelling like that. It would be an excellent thing to suggest that the Casey review does, to set out that business case. It is important, though, that the business case is not just an immediate short-term one. Some of the things that we are talking about here are quite important. If you just have a short-term problem, you might say, "Let's ask people to bear a bit of a heavy load," but we are on the cusp of profound demographic change. There are major changes as well in our economy linked to that demography, with fewer young people and a desire to reduce the amount of inward migration.

We need to increase our employment rate. If we have highly skilled people in occupations where at the moment employers cannot find people, and they are having to leave the labour market 15 years early to do unsustainable levels of caring hours, over the long term that is what my granny would have called "penny wise and pound poor". It is important that we look at this as a one-off opportunity for long-term reform and what is in the long-term interests of our economy.

Q77 **Gregory Stafford:** That is very helpful. Are there any other thoughts? I know there are no studies, but what is your personal and experiential view on that?

Emily Holzhausen: We hear a lot from our members that some of them have more income and cash but cannot find care. Investment in the workforce is absolutely critical. It is no good if you cannot buy it and it is not the right kind of quality. As Oonagh said, it is the task-based approach. There are stories from our members, too, about being exhausted by different people coming into the house. The sustainability of packages and relationships is so important for the person they care for and for them. When they get poor-quality care, they refuse it. They do not buy it and they do not use it. That puts them in a very difficult position.

There is an economic value around the disability movement and having choice not to be cared for by parents, brothers and sisters and families. They have fought very hard for the right to live their lives as they wish to. Equally, not all carers want to care for relatives, and some should not be caring for relatives where perhaps they have gone from previously abusive relationships. There is a finer point to this around rights as well as your economic question.

Q78 **Gregory Stafford:** I accept that.

Oonagh Smyth: The only thing I would add is that as we start to look out longer term, which is one of the benefits of a long-term review with the Casey review, we need as a society to think about the role of prevention. If we prevent need by preventing ill health, or we reduce the draw on social care by primary prevention or new models of care, there is a real impact on the workforce.

If we do not do that, we have some choices to make. We can grow the workforce from a formal workforce perspective and meet the changing needs. We can not meet changing and growing needs and/or we can rely more on unpaid carers. They are the choices that we have to grapple with as a society when we start to look at what social care is in the future. We were looking at a 15-year horizon, but it is happening now. The long-term view, with immediate, medium and long-term action, is really important; we have a limited number of choices, but we have to make them.

Q79 **Gregory Stafford:** From the financial perspective, there are various figures, but around £180 billion is contributed by unpaid carers to the economy. I think your suggestion is that, if they do not want to care, we should build up the professional care system in order to replace them. If we did that and we saw a reduction in unpaid carers, what do you think would happen to that £180 billion? Would it get redistributed in the economy or would it just be lost?

Emily Holzhausen: I don't think we will see a reduction in what people do. There was a small study done when Scotland brought in free personal care and how families reacted to that. They did not actually reduce the amount of care. It changed from very fundamental care tasks, very task-oriented, to things that you would consider part of family relationships. It was the social stuff. If you only have three hours in the day, you have to get the most demanding tasks done and you do not have time for socials. We know how much loneliness and isolation affects disabled and older people, and how there are clear health benefits to making sure that people are not lonely. Quality of life makes a difference.

There are no other countries around the world where we see a reduction in care. If we look at the movements, for example, in Germany and Japan, investment in care was largely driven by the labour market, perhaps not largely driven, but a factor for it was definitely labour market participation—women in particular participating in the labour market with the ageing population. We still expect to see an increase in what people do. It is just the level of care that people have to provide that is the critical issue.

Q80 **Chair:** Did the Japanese model work?

Emily Holzhausen: They are into a super-ageing society. Every country still has shortages of social care and challenges around those areas. The Nuffield Trust has done some very good investigations into both of those

systems. If you want more information, I am sure they would be more than happy to supply it to you.

Q81 **Gregory Stafford:** Anita, do you want to come in on that?

Anita Charlesworth: One of the things that is important to say is that a lot of the estimates of the economic value of care are based on how much it would cost if it was done by paid staff. If we shifted the boundary between informal and formal care, we would be bringing into GDP things that at the moment are not in GDP. That is just an artefact of the fact that GDP is an imperfect measure of what we do.

The question is whether that would be a better economy, which worked better to meet the needs and desires of its population. There is no modelling study, but if you follow this through—it seems really important now—we are going to have more older people who need care. We are going to have more younger people who need care. We need to do lots of prevention to make that as minimal as possible, but there is no escaping that demography. We are not running that well for anybody at the moment. We need a fundamental change because the problem is not going away. Ignoring it just makes it harder to fix, not less. Part of the reason why we have not had reform is that each year when we do not reform, the costs go up and the challenge from where we are to where we want to be gets bigger and bigger.

Q82 **Jen Craft:** Thank you for being here today. A few of you mentioned the poorer health outcomes for unpaid carers. I am interested to drill down into those a little bit more. What is it that causes poorer health outcomes for unpaid carers?

Emily Holzhausen: On the poorer health outcomes we are talking about, if we look at the GP patient survey, they have higher percentages for mental ill health and musculoskeletal issues—from moving people around, where they strain—and blood pressure is higher. That goes without saying. They often put themselves at the back of the queue. Their primary concern is the person they care for. Mental health and wellbeing are challenges, with stress and lack of time off.

If you ask carers with substantial care what they would really like, at the top of the list comes a good night's sleep and then breaks, and to be valued and recognised. They are quite fundamental things that perhaps other people do not understand. Imagine somebody in their eighties looking after a partner with dementia and having to get up several times in the night. Some working people do that and go to work the next day. That is why they usually display those additional areas.

When people have pre-existing conditions—perhaps arthritis—and they are doing a very physical job of caring, those conditions are then exacerbated. A particular worry is that 44% have put off health treatment as a result of caring. That is from our members who are providing very substantial care. We know that 70% have cancelled appointments, scans

or treatments. It is a bigger number because they have had to shift things around due to caring. Their ability to look after themselves is hugely reduced.

I will not go into the link between poverty and ill health, but of course that is another factor in their ability to take time. They are time poor. They often have very physical caring roles, and some people talk about it being endless and without a break. Those are the different reasons.

Does the NHS really recognise caring? You can get flagged on your patient record whether you are an unpaid carer or not. There are some positive health measures that you can introduce like health checks, but the NHS could do a lot more for unpaid carers.

Q83 **Jen Craft:** Are we able to quantify the cost of increased unmet health needs on unpaid carers, or is it perhaps too vast and wide?

Emily Holzhausen: Yes, we are able to. There are very few studies that have been introduced. Control samples are incredibly difficult when we look at these sorts of situations. The best you can do is carer versus non-carer, but there are studies to show, for example, that breaks reduce cortisol levels, which are directly related to a different health area. Again, breaks make a huge difference to people. They are in very short supply; 54% of carers have not had a day off in the last year when they are providing very substantial care.

Anita Charlesworth: There is a study by a team at the LSE—Nicola Brimblecombe, who submitted some written evidence to you—that looked at the costs for young people aged 16 to 25 who were caring. She found an overall cost of £1 billion; about a quarter of that was NHS costs. I will share the link for the study.

Q84 **Jen Craft:** I am picking up from what you are saying that one of the things that might be helpful is resetting the relationship between formal care and unpaid carers, perhaps unpaid carers having a better seat at the table or more parity of esteem. What would that look like to you, and how would it work in practice? Is there anything practical, and not small, that can be done to reset that?

Emily Holzhausen: Yes. If you ask them, they have a very clear idea about what that is. It is being valued and recognised. It is being treated as a partner in care, but also having choices and people not making an assumption that you would do that. Paulette mentioned cultural differences; it is important that there is not an assumption that different cultures look after relatives, but to introduce help and support that is acceptable and helps people who need it.

Part of the reason why the relationship is difficult at the moment is that social care is underfunded. The Care Act is a good piece of legislation. It is really great, providing adults with good rights and entitlements, but local authorities cannot deliver it in the way that it was intended because of a shortage of funding, so we are left in the situation where carers are

ignored. If we look at hospital discharge, for example, we have measured the rights and entitlements for carers with substantial caring responsibilities. Only 14% at the point of hospital discharge received the right amount of help and support to help them care safely and well. Hospital discharge is a highly pressurised environment. The relationship between carers and services would change.

I think that the NHS needs to do more, when we are looking at the 10-year plan, to recognise and support carers. That will automatically help to reduce the health and wellbeing impacts, as well as help social care. Often, we look at social care helping health, but we should be looking at it the other way as well, at how the NHS can support social care.

Q85 **Jen Craft:** With the NHS supporting social care—you mentioned health checks for carers as a potential idea—is there something around that which is more treating the symptoms of a social care system that is not working? Is there something that can be done to redress that balance, rather than treating mental ill health, musculoskeletal issues and all the kinds of things that we know are risk factors? Is there more on the prevention side?

Emily Holzhausen: Definitely. People often come to their rights and entitlements too late. It is about income maximisation. It is about activating your rights. For example, what rights do you have in the workplace? Can you activate them as well? It also comes down to the kinds of good-quality support that you can rely on.

Good news travels well. If you have a good experience, you share it. If you have a poor experience, it helps to put people off care, or certain paths. We have not talked much about workforce strategy, but that—

Q86 **Chair:** We're about to.

Emily Holzhausen: Excellent—I won't talk about that then. It is some of the aspirations to reduce the number of times that you have to repeat information; services linking up; simple uses of digital; and making sure that carers know about their entitlements quickly. On the back of an application for carer's allowance, for example, you could encourage them to register with their GP as an unpaid carer and link with their local authority to find out what local support is available so that people do not fall through the net.

The Health Foundation did a very good piece of work with a network data lab, looking at the overlap between GP lists and local authority lists. There was a very small level of overlap of unpaid carers. GPs tend to do older carers. Local authorities tend to do younger people. There is a missed opportunity to get services linked up to the person. There is a bit more on data linkages that has been done.

Chair: We need to move on.

Q87 **Josh Fenton-Glynn:** I am going to move us on to workforce strategies,

which you just trailed. In that last answer you gave a statistic that I think I saw four of our members writing down. I want to check on that. Did you say that 14% of people who are discharged from hospital have the care packages they need? Is that correct?

Emily Holzhausen: Yes, I said 14% of carers said that they did not have the support and information to care safely and well for the person being discharged from hospital.

Q88 **Josh Fenton-Glynn:** So 14% of carers didn't have?

Emily Holzhausen: Sorry; only 14% had. I beg your pardon.

Anita Charlesworth: And 86% did not.

Emily Holzhausen: I cannot say that categorically.

Q89 **Josh Fenton-Glynn:** To clarify the statistic, because it is the kind of thing that may end up in the report, that is carers feeling they have support, so people may be getting the care package, but the carers do not feel they have the support or an idea of what care they—

Emily Holzhausen: Yes. That 14% were getting the right care package and the right level of information and advice. That is 14%. About 56% disagreed with the statement that they were getting the right level of support and care. We have a large number of people who are managing at the point of hospital discharge without the right care and without the right information and advice.

Q90 **Josh Fenton-Glynn:** I would love it if you could send us some further information as to what the 86% looks like, just so that we can get an idea of where we are not getting the care right and what that means in terms of hospital discharge.

Emily Holzhausen: I will clarify that, of course.

Q91 **Josh Fenton-Glynn:** I am going to move on to the workforce. Skills for Care did a brilliant state of care report last year, which I have brought up at this Committee a few times. One of the things that came out of that was the 8.3% vacancy rate in social care: 131,000 vacancies in adult social care. What is driving those vacancies?

Oonagh Smyth: It is probably important to start with the impact of the high vacancy rate.

Q92 **Josh Fenton-Glynn:** That is my next question.

Oonagh Smyth: What drives the vacancy rate is two things: attraction and retention. Some of the vacancy rate is positive. Some vacancies are good. It might be growth and additional needs being met, but our report shows that the vacancy rate in adult social care for the full year that we have the data, up until March 2024, is about three times the national vacancy rate. While some vacancies are good, it is still much higher than the general economy.

There are probably two questions. First, what stops people coming into social care in the first place in terms of roles? We know from our data that the biggest indicator of whether a provider is going to be able to fill vacancies is the ability to compete in the local labour market. That includes pay, but it is not just pay. It is how we talk about social care. It is how we value social care. It is differentiating social care roles from other similarly paid roles. We need to tell a different story about social care as a society and as a sector.

We are starting to do that. One of the questions that Ben asked earlier was, "Do the Government view adult social care as part of the growth agenda?" The Secretary of State says that the Department for Health and Social Care is a growth Department. We are saying more and more, and the sector is saying more and more that we can do more to talk about social care in a positive way.

There is a high vacancy rate of about 131,000 vacancies on any one day. Let's start talking about that as 131,000 opportunities to work in excellent roles where we can give purpose and flexibility. They also need to be good-quality roles. There is an element of competition in the local labour market and a view of adult social care that could be linked to the fact that as a society the people we support are not always valued. Older people and disabled people are not always valued in society, so is that one of the reasons that social care is not valued? We need to tell that story more.

Even when we get people in—we recruit a lot of people every year; there are more than 300,000 new starters in social care—we have a bit of a leaky bucket. We do not keep them. Although turnover reduced in the year 2023-24, most of that is down to international recruitment because international recruits are less likely to leave their roles in a year. We did some analysis of our data, which we collect from the adult social care workforce dataset, covering just over half of the sector, looking at the factors that influenced turnover. If five conditions are in place, turnover halves: if somebody is on higher pay; if they are not on a zero-hours contract; if they are able to work full time; and if they have access to training and a relevant qualification, turnover goes from 40% to 20%.

If you add to that the impact of culture and leadership, which we know is important, we see three things we need to do to keep people. One is to focus on quality of role, which includes terms and conditions, stability in role and a lot of the things that the reform agenda should pick up in terms of the fair pay agreement, the Employment Rights Bill and some of the labour market conditions. Another thing is whether we train people, and there is quality of role and training people, where the skills agenda is incredibly important. Then there is organisational culture and leadership. They are the three factors that will impact the most on whether we can keep people in role.

Q93 **Josh Fenton-Glynn:** That is reasonable. I used to be a cabinet member

for social care—like many on this Committee, I am a recovering local council cabinet member. We tended to find that people would come in from retail and leave to the NHS. We talked about the 8.3% vacancy rate in social care. I think it is 2.3% in the NHS. What do we do to make social care a bit stickier? You talked about the training. We gave people brilliant training, and then they would go and be HCAs on the NHS pay band.

Oonagh Smyth: The Health Foundation did some research that showed that, as a sector, when people join us in social care, they are likely to join us either from another social care organisation, because about two thirds of people will be moving around the sector, but they are more likely to join from hospitality and retail and more likely to leave for another caring profession, which includes children's care and the NHS. An element of that is pay. A health care assistant with two years' qualification will get about £1.45 an hour more than somebody working in social care. There is an element of movement between social care and health that we will want to see, because—

Q94 **Josh Fenton-Glynn:** But it is only going one way at the moment.

Oonagh Smyth: That is the point. We need to be getting more people into social care, and it needs to be two-way. We have to embrace the fact that, in social care, we have a lot to teach as well as a lot to learn. In social care we see people's needs through the lens of their whole life, not through the lens of a disease but through the lens of a health need. The benefits of people spending some time in social care are absolutely massive when we look at the prevention and personalisation agenda.

What we have to do at system level, at the ICB level, is to make sure that when we are looking at one workforce it is not just a one-way draw, but that we are, where possible, aligning terms and conditions and making the roles in social care as attractive as in health, and sometimes making the most of the transition between the two so that it is not just one way.

Q95 **Josh Fenton-Glynn:** Going to the question that I trailed earlier, thinking about the impact that it has, the ADASS survey at the start of last year, from January to March, said that there were 161,000 unfilled hours in social care. What impact does that vacancy rate and the turnover have on the workers and on the people receiving care?

Oonagh Smyth: We have started to see a reduction in the vacancy rates since the 2023-24 data. In 2023-24, it was 8.3%. It has now stabilised at around 7%. It was dramatically reducing with international recruitment, and now it has stabilised at around 7%. I make that point.

There are two impacts. There is the impact on people drawing on care and support. If we cannot fill vacancies we cannot meet need, or we are providing support but not enough support. I spoke to one young woman who got social care support who said that she often had to choose whether she had a shower or saw her friends because she could not do

both. She could not fill the hours. She could not recruit enough personal assistant support. It was not that the funding was not there; it was that she could not get people to fill the roles.

I spoke to a young man, a care worker, who got quite upset, saying he was going to leave his role. It was not because he did not love it—he did love it. That was what was driving him to leave; he said he was going away at the end of the day feeling, "I'm not able to actually give the support that my values are driving me to, and it means I'm having to make people choose to eat or be supported to see friends or family. I am finding it hard to support people to make that choice. What I am doing is working more hours and not getting paid for those hours. I'm having to cover other people's shifts and I'm not able to bring my best self to work."

We want people with the right values to work in social care. It is clear that that has an impact both on the quality of care and on the workforce. Our data shows that when you have a higher vacancy rate, you see a reduction in CQC ratings. There is a direct impact in terms of workforce and quality.

Q96 **Josh Fenton-Glynn:** There is obviously the issue about caring; Emily talked about the person who had had 100 carers. With the movement in social care, what is the impact on patients of having multiple carers and the lack of retention on those who are cared for?

Oonagh Smyth: In the example I used, the impact on the person being supported was not being able to build a relationship. Continuity of care really impacts on your quality of life. This can be deeply personal support in your private home. The best social care support, as Emily said, is absolutely transformational. There is a real personal relationship between the person providing the support and the people drawing on care and support. These are deeply skilled roles in terms of communication and the ability to build relationships and communicate. When you are not able to do that because you have multiple different carers, it becomes more transactional and affects the ability to spot signs.

I spoke to a carer who was supporting somebody who went into hospital. The doctor said, "Oh, this person isn't eating. That's a symptom of their dementia." The carer was able to say, "Absolutely not. I've been supporting this woman for two years and she has a really healthy appetite. There is something else going on here." Of course, if you did not have that relationship, you would not know that. There is all of that intangible as well as the tangible impact in terms of increased recruitment costs—just under £4,000 every time we recruit—and the additional training costs. There is that real personal impact as well.

Anita Charlesworth: Could I make one point that I think is important to add to that? I agree with everything that has been said. Alongside the importance of the relationship between the care worker and the person receiving care, many people who need social care need other health

services as well. We are trying to build integrated teams and care around them. We are finding that very hard.

One of the things that is important is that, when we want to build an integrated team, we often do lots on structures and funding flows, but all the evidence is that a team is a collection of people who have relationships of trust. When you turn over a lot of staff, it is very hard to make integrated team working operate as effectively as it can. The relationships are multi-professional, as well as between the individual and the carer. High turnover is a challenge in both areas.

Q97 **Josh Fenton-Glynn:** It almost seems that when you leave hospital, multi-disciplinary teams stop being a key cornerstone to good healthcare, which is a pity. I assume that the high turnover also impacts the relationship between the care staff and the family carers. Does it also have an impact on the wellbeing of those who are cared for?

Oonagh Smyth: Social care is so relational. It really is, at every single point and in every single aspect, with the people we support, with the families and with other professionals, as well as with our managers and leaders. If we see higher turnover in a service of registered managers, we see higher turnover overall. The staffing relationships have a massive impact. If our registered managers leave, we see an impact on the CQC ratings. You just cannot underestimate the impact of that churn.

Q98 **Josh Fenton-Glynn:** Picking up on that, obviously in our heads when we talk about this we mainly think about residential care, but I imagine there is a very similar picture in care homes.

Oonagh Smyth: It is across all of it.

Q99 **Josh Fenton-Glynn:** My final question is looking at what good examples of retention are. When I ran a care service in Calderdale, we had a small care company—the Equal Care Co-Op—which gave more power to the staff. They also paid slightly higher. They had good retention and some positive stories. Could you leave us with a couple of positive stories?

Oonagh Smyth: About 16% of our providers have a turnover rate of less than 10%. That used to be—

Q100 **Josh Fenton-Glynn:** Is that 16% have a turnover—

Oonagh Smyth: Yes, 16% have a turnover rate of less than 10%. It used to be that about a quarter of our providers had a turnover of less than 10%. It is getting harder to maintain. We did some research called "The Secrets of Success". We asked the providers with the lowest turnover, "What do you do differently?" What they said is backed up by our data. They did not mention pay, although our data would say that pay does have an impact. They said, "We say, 'Thank you'. We give people autonomy in their decision making as much as possible. We develop them and we really focus on culture and leadership."

I went to visit a service in Harrogate called Vida Healthcare. They have a very low turnover rate of about 3%. When I asked them what they did, they said exactly the same. They focus on the quality of roles. They focus on training and development. They focus on culture and leadership. They are the things that make an impact. Obviously, some of that is easier to provide in different service models and different funding models, but they are the three things that make an impact.

Q101 **Andrew George:** Anita, when you commented earlier you said that the current situation is having appallingly low wages so that everyone else can have a good life. I want to address the cold health economics, not the soft argumentation that justifies why we should pay care workers more. If, for the sake of argument, we were to model an increase in care worker wages by, let's say, 50%—quite a dramatic increase, which one might argue is socially justifiable—how could we build a case in terms of productivity addressing retention levels, pay progression, productivity, standards and so on? Is there a way in which you, from your experience and knowledge in this area, believe that such a case could be made, where we could persuade the political classes to look at the cold arithmetic of how we justify doing that?

Anita Charlesworth: There are two things that we need to think through on pay. One is the starting level of pay. There is an issue that it is not without consequence for the state to pay providers such low amounts that providers then pay their workers such low amounts. What happens is that many of those workers then end up on other forms of state support like universal credit. Many of the people who work in social care are pushed into poverty and are reliant on that support. That is not without consequence, and we need to think about it.

We also need to think about the extent to which there is progression in pay. Starting salary matters, but progression in pay is important for two things. One is for retention. Oonagh set out the important economic case on retention. The other thing that having progression does is to create an incentive for someone in social care to develop their skills, engage in training and, through that, to be able to take on more tasks, be more autonomous, deliver more skilled activities and be more productive.

There are different sorts of training that we can think about. If we want a higher-paid workforce, one of the interesting questions—we are doing work on this and, again, it would be interesting to look at it more systematically in the Casey review—is to what extent we can use technology and advances in technology to support social care workers so that more of their time is freed to do the care where human care really matters, so that they are more productive and we can afford that higher pay.

That is where a stand-alone social care case, with lower retention and higher productivity, gets you. What the global economics would suggest—not unique to social care—is that, in sectors where quality is so bound up with human touch, there is a limit to how far machines can replace

humans. We need to make sure that we are able to attract and retain people with the right values and the right skills. This is a really important part of our society and our economy. The productivity gains in the wider economy enable us to have an everyday economy, as Rachel Reeves called it, that is well paid.

That matters for the regional picture. Sir Chris Whitty, in one of his chief medical officer reports two years ago, did a really fascinating report about ageing society and demographic shift, and how people are moving around the country. This is something that we have not thought about enough with the link to our economy.

We have older people with higher care needs moving to rural and coastal areas. They have less of the high-end strategic sector economy anyway. If we have all the everyday services that they rely on as rock-bottom, low-paid economy, we will increase our disparities and we will not have people in those areas to do those jobs. Those wages will need to be competitive. We need to make sure as much as possible that we reap the benefit of that in the productivity of the social care sector, but actually we are going to have to pay more.

Oonagh Smyth: We have done some modelling that I can send to the Committee. In July last year the sector led a workforce strategy for social care, and some of the recommendations in that are already being developed by Government in this space—the fair pay agreement and the care workforce pathway, building the career structure. In the workforce strategy, which has an economic case attached to it, we modelled various scenarios, including an increase in base pay, keeping differentials, aligning with NHS Agenda for Change, and paying real living wage. We modelled both the costs and some of the impacts of that. I do not have the figures in front of me, but I will send a note to the Committee.

Q102 **Andrew George:** That would be helpful. I am sure that all MPs have met the proprietors of care homes or domiciliary services, when there was a recent increase in the minimum wage, and been told bluntly without any shame that that will be a challenge, and that it is the biggest problem they currently face in maintaining the viability of their business. There is strong resistance among them to increasing wages. Of course, they do not care two hoots—I am not saying that they do not care, but in terms of their viability they would not be impressed to be told that it will cut the universal credit budget for the Government. That is obviously not their concern. How do we get the health economics to work in a more virtuous way so that we can improve the wages of care workers, and justify that in a wider sense, so that we are not putting those important businesses out of business, and so that we make a strong case for an upward spiral to pull people into better careers and career structures?

Anita Charlesworth: This is where having a hard look at reforming the way we commission and contract is important. If we can move to a system that buys either outcomes or capacity with more certainty of income, actually you transfer some of the risk away from the provider.

Alongside hourly pay there are zero-hours contracts, and the guaranteed hours matters, where there are some issues.

There are issues and questions to ask, because at the moment there is quite an interesting difference. In the NHS, providers are not allowed to compete on price. You have to compete on quality. It all got mucked up with covid, but theoretically, pre-covid, we had a system where you set a tariff—a fair rate for the job nationally—and adjusted it for different costs in different parts of the country. For a hip replacement, there is a price nationally and then you adjust it for local differences, so you cannot have a race to the bottom on price. You have to compete on quality.

In social care, people are pushed to compete on price. All the evidence is now that the rates we pay are below the cost of delivering a decent quality of care with decent terms and conditions. The question is whether we need to have competition on quality rather than price. That would give transparency about what extra burdens are being passed to local government, when other parts of central Government make decisions about social care. Everyone passes the buck, and it is so opaque that it is difficult to understand at the moment.

Q103 **Chair:** Are you suggesting copying the model over?

Anita Charlesworth: You would not directly copy it, but, essentially, the basic idea would be to set tariffs. I would argue that you could set tariffs, as well, for outcomes or programmes of care, so that, again, you get away from the task and essentially allow people to compete on quality. That is the model and the basic principles that we have in healthcare. They are quite important principles in services where quality is so important, and is difficult to observe, and where the tendency is therefore to compete on what you can see.

Q104 **Andrew George:** That is really helpful. Finally, on the disaggregation of residential and domiciliary care, what has happened, in view of what you just described, about care workers' conditions of employment with regard to travel time and travel recompense, and having sufficient time to care when they get to a home? This has always been a contentious issue in the past. How have those issues been properly addressed? Can they be addressed in the fair pay agreement negotiations?

Oonagh Smyth: The fair pay agreement is the opportunity for us to have the conversation about pay. It is really important that we all engage with that. We will have some choices to make. Providers have been very clear that for the fair pay agreement we have to look at funding. We have choices to make about what the policy intention is. The Low Pay Commission estimates that about 15% of care workers are paid below the national living wage, because things like travel time are not taken into account, so even just enforcing the national living wage would have an impact on that 15%.

Q105 **Andrew George:** What proportion of providers are not covering the

travel time? Do you know? Are there any figures on that?

Oonagh Smyth: No, other than that Low Pay Commission figure. We can see a difference in other terms and conditions, like zero-hours contracts, which are much more common in home care than in residential care, because of the model and how it is commissioned; 47% or so of the workforce in home care are on a zero-hours contract, so we can see an impact from some of that. Some of it is because we are trying to balance people's real desires to have care and support tailored around their needs. A lot of people want to be supported in the mornings, before 8 o'clock, for example, and there is a time during the day when fewer people want to be supported. Trying to get the balance between the commissioning model, the workforce and people's needs is the conversation that we need to have.

Andrew George: Thank you.

Q106 **Danny Beales:** I am going to ask a few questions about measuring the costs and data, following on from colleagues' questions. In previous answers, Oonagh, you talked about having modelled the impacts of different pay levels, following Anita's point about the indirect costs to the Treasury of low pay in the sector. Did your modelling also include impacts on the Treasury, in terms of benefits, UC or other social entitlements reducing with increasing pay, or is it just from direct modelling of the impact of the pay on the sector?

Oonagh Smyth: Let me send a note to the Committee. I don't want to say something and then have to say it was wrong.

Q107 **Danny Beales:** That would be helpful. On that point, Anita, are you aware of any evidence that models the cost to the Treasury of low pay and poor conditions in the social care sector?

Anita Charlesworth: We have some figures, if I can find them, for the proportion of the workforce on universal credit. If I cannot find it quickly—I know we have some data around that—I can send it through.

Q108 **Danny Beales:** If you can follow up, that will be really helpful. As you say it is key data, and there is a risk of robbing Peter to pay Paul; we think we are making a saving to the Treasury, but ultimately the Treasury is paying—

Anita Charlesworth: Let me send you a follow-up note on that.

Q109 **Danny Beales:** That would be helpful. I was also interested, Anita, in your point about regional economic development. Do you have any further evidence about the potential regenerative benefits, and benefits to the Treasury, of growth in the sector, and growth in the quality of pay and conditions in the sector, and what that might mean for regional and local economies?

Anita Charlesworth: The New Economics Foundation did a study in the west midlands, which looked at the regional impact on social care. If I

send you a note on universal credit, I can also send you the link to that work, which is very relevant to that. Do you have regional breakdowns in your data?

Oonagh Smyth: Yes, we do, and the economic report that I will send to the Committee showed that in some regions, like the midlands, for example, social care makes up a higher proportion of the workforce and the economy, so we model some of that out regionally.

Q110 **Danny Beales:** Really helpful. Thank you. Lastly, Oonagh, one of the first things you said to the Committee, which was quite stark, was some clear evidence of the benefit to the economy of social care, around indirect and induced values. I want to understand a bit more: do you have any sense of how, relatively, that compares with other sectors, so that if, from a Treasury perspective, you were looking at where you invest, you would have a sense that if we invested in childcare there would be a greater, lesser or equal indirect or induced benefit in terms of employee spend or the other costs you talked about?

Oonagh Smyth: This is the point I was making: as a sector we can do more to support DHSC and MHCLG to help people understand more about social care, both what it delivers for people's lives and for the workforce. A lot of people do not know that social care employs more people than the NHS, construction, transport, or food and drink. There is a story to be told, and we need help in the telling. Given the scale of that workforce, comparatively speaking, the scale of impact on the economy is obviously significant.

Anita Charlesworth: Can I add a couple of things to think through? It is a good question, and I do not have the direct answer, but one of the things people talk about that is quite important is that if you put more money into someone who is working in the everyday economy—they are by and large low paid—they will spend it all locally.

The other thing is that in the sectors where the state has such an influence on pay, there is the direct observed effect of low pay, through being on universal credit; but, in many families where someone is working in social care, their children are the children who are the child poverty statistics that other parts of Government are thinking about how to deal with. The consequences of low pay are quite important overall; but there are parts of the country where that is a much bigger share of the workforce. Concentration really matters, and having large numbers of people in low-paid and insecure work, with children in poverty, is a real problem for those communities.

Q111 **Danny Beales:** Thank you. Some of the witnesses in our earlier sessions talked about the benefits of social care reform for other public sector areas of the economy. Policing and housing were talked about, as well as the discharge issue and the health service more broadly. Is there anywhere particularly, outside social care, where you think we should look for possible benefits of social care reform?

Oonagh Smyth: When we looked at the workforce strategy, we suggested that we need to focus more on getting more younger people into social care. The younger generation is under-represented in the numbers, and so are men. There is a real opportunity, given that it is a sector that will need to grow—we can say that about all roles—with 540,000 additional posts by 2040.

There is an opportunity for us to appeal to a new generation of people who would not necessarily think about social care. They might be out of work, long-term unemployed or leaving one sector for another: "There is an opportunity in a sector that can give you real purpose." We hear from younger people particularly, when they are coming into the labour market, "I want a job that gives me flexibility and purpose." I can give you that in bucketloads in social care.

We also need to make sure that they are good-quality roles. Interestingly, although we have high turnover in social care, it is lower than in similarly lower-paid roles, because when people get into social care they get so much from it. There is a real opportunity, when we are thinking about getting people into work and back to work, to make a case for social care's potential; even if people do not stay forever, or do not build their whole life in social care, there are skills to learn. You can come into social care without any qualifications and we will train you. You will learn some amazing transferable skills. There is an opportunity, when we look at getting people into the labour market.

Emily Holzhausen: In the context of public services and where there is positive impact, there is people's ability to build up pensions over time. Also, as I said before, one in three NHS workers is an unpaid carer, so all the labour market issues that we talked about there can be applied to the social care sector. We do not know the exact proportion. A very old study suggested it was similar. You could probably add that to your list as well.

Q112 **Chair:** Are there studies that back that up, or are we just looking at something general and broad? We want to try to drill down into actual numbers if they exist.

Emily Holzhausen: Yes. The Pensions Policy Institute looked at unpaid carers as being under-pensioned, and the disparity between the two. The social care workforce survey, I think, had an identifier question to see whether people were unpaid carers as well. You could ask the Department of Health and Social Care for the data if they have it. They might not have that analysis. I don't know.

Oonagh Smyth: There is another point, which is possibly less around public services and more about the equalities agenda. Social care is an equalities issue. There is an equalities lens, because we support two of the groups in society that are likely to be most discriminated against—older people and working-age adults—with our staff being disproportionately female, and people from ethnic minorities. There is real potential for social care to be a really diverse sector, and to fly the

flag as the most inclusive and diverse sector you can work in. We also need to make sure that it is inclusive, but there is another lens in terms of equalities and equity that is important.

Q113 **Danny Beales:** Thank you. As the kinds of questions we are getting to, evidencing and demonstrating data around some of these issues has been a challenge. In the cold light of day, Treasury colleagues are making somewhat harsh decisions about investment, and it can be a barrier. I understand that client-level data has been rolled out. There is hope that data in the sector is improving and has improved. I want to get your sense of the impact of that, what additional insights it has given you in addressing some of these questions, and where you think there might still be limitations in data collection.

Oonagh Smyth: Shall I start? I think we will all have a view on that. The workforce data that we use comes from the adult social care workforce dataset, which covers 650,000 staff working in social care. It is commissioned by DHSC and helps us understand the care provider and workforce issues—pay, vacancy rates, sickness. We are lucky in that it is high-quality data, and we have had it for more than a decade, so we can see the trends as well as the immediate impacts. With the ability to combine that with local intelligence, we can properly analyse it and understand what it is telling us.

I was thinking about the question in terms of gaps. We do the projection based on the growth in the workforce. The figure of 540,000 additional roles that we are going to need in social care by 2040 is based just on the ageing population. We do not have the equivalent for working-age adults, so that modelling could be much better if we knew what we were expecting in terms of children who are being supported now coming into social care. That, combined with good national system-level and local workforce planning, would be incredibly helpful, not just so that we can plan for the numbers in the labour market, but because our needs are changing.

We expect that by 2040 there will be a 43% increase in the number of people with dementia. The support, workforce training and skills that we need are going to be very different. One of the recommendations from the sector in the workforce strategy was a statutory requirement to do workforce planning, so that we could do it at system and local level.

It would be helpful to see where people go when they leave adult social care. That is something for us to think about—people moving between the NHS and adult social care. The Health Foundation research is really helpful. Is there a way we can track that movement, linking workforce data with client data so that we can get a sense of the impact of funding source on workforce, and see whether it makes an impact?

Q114 **Danny Beales:** Is that possible now with client-level data, or do there need to be evolutions, and additional data collection, to enable that?

Oonagh Smyth: I think it is possible, but it is not happening currently. The only other thing is that we are adding questions to our dataset, the better to understand how many people are performing delegated healthcare tasks. That is an increasing policy area between health and social care. We hope to be able to look at what those tasks are, and at pay, training and qualifications, because we know that care workers are doing more and more delegated healthcare tasks. Getting a better understanding of that should help with the data as well.

Q115 **Danny Beales:** Anita, do you want to come in?

Anita Charlesworth: Yes. There are three things that I think are important. One is that we have a better understanding of the self-pay market alongside the publicly funded provision. There have been a lot of studies trying to understand what reduced public support has meant in terms of, say, use of the NHS; but unless you can understand whether someone had no care or had to have different, privately funded, care, it is difficult, and the research is very limited. If the Treasury, from a public policy point of view, wants to understand where it would be best to put our funding, they need to understand the whole picture of the consequences of reduced funding in some areas.

Linked to that, the other thing that is very difficult is that we often have information on the workforce and information on the people. Linking those two is important. The other bit we want is what the model of care is. A lot of what we want to understand, and a lot of your questions, which are really good, are about how we can do things differently to get better outcomes and better value for money. For that, we need to understand what the model of care is, who it did and did not work for, and its consequences. That is important.

The final point is that it is great to know about a point in time, and if you are delivering a service you need to know now, but if you are doing policy and planning you need to be able to follow things over time. The wonderful Sure Start is the great example: it was only by doing a long-term evaluation that we were able to understand the effects. Some people will not use social care for very long, but many people will need care and support very long term. Understanding the dynamics of that is important to inform policy. We need to be able to follow people over time.

Danny Beales: Thank you.

Emily Holzhausen: In terms of data, local authorities had their hands slightly tied. There are not very many local data sources that you can use to look at unpaid carers and their journeys. I don't know if you would agree with that, with your experience. We have the census and other national datasets. The GP patient survey is very important. We do not have formal measures of carers' experiences of hospital discharge—talking not about the patient's experience but their own: "How was it for

you, and did you get the right support?" When you decouple those questions, you get different answers.

Those data linkages are all important. There are a smaller number of questions on client-level data for unpaid carers, but I am interested to see what happens in the 10-year plan and where local authorities might be able to improve their administrative data. All you need is an identifier question: "Are you also an unpaid carer?" Then, if you have the right permissions, you can start to link datasets.

Q116 **Danny Beales:** We may have up to three years until the Casey commission completes its work. Advising Baroness Casey and the Government now, what studies and research could the Government commission to help inform and build an evidence base for reform? Are there particular things that you think are vital now for the commission, to inform the review?

Chair: You each get up to two.

Oonagh Smyth: I would first make the point that even within those three years things will happen that will have an impact, particularly on the workforce, like the fair pay agreement and the Employment Rights Bill. It is not that there is nothing between now and then. There will be quite a lot that will impact on the workforce.

Of the two things that we could do with knowing a bit more about, one would be to put more focus on retention. We often have a focus on attraction. I am keen to keep focusing on how to keep the people with the good values and the skills that we need in the sector. There is a big piece around skills and training in social care. We have seen a 75% reduction in the number of apprenticeships in social care since 2016, so the way the new skills reforms and skills agenda works for social care will be important. That will happen much more immediately; it is happening now, in terms of the policy thinking.

Q117 **Chair:** Emily.

Emily Holzhausen: I would look at the economic impact of social care, taking perspectives: labour market, employers, carers' own perspectives, young carers of course, and people coming in with education opportunities. I would look more closely into the link between positive social care and carers' health and wellbeing. The economic impact would have a link to poverty prevention. I am kind of boiling the ocean with that one.

Anita Charlesworth: Because I think this needs to be about the future, I would like the commission to do some work on the productivity potential of the sector going forward. I would also like to see good subnational analysis, because that is important. Social care is locally provided; it is a local labour market, so coming at it just through a national lens you could find that things do not work in areas. I would do those two—and everything that has been said.

Oonagh Smyth: In the meantime—taking the workforce strategy as an example—we will all be getting on with implementing that and making the change we can make in our own spaces. That is important.

Chair: Perfectly timed. Thank you very much, all three. That brings us to the end of our session.