HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Social care: funding and workforce, HC 206

Tuesday 23 June 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 49 - 101

Witnesses

I: Sue Ann Balcombe, Registered Manager, Priscilla Wakefield House Nursing Home; Marlene Kelly, Registered Manager, Auburn Mere Care Home; Mel Cairnduff, Senior Care Worker, Agincare; and Raina Summerson, Chief Executive Officer, Agincare.

II: Professor Martin Green, Chief Executive, Care England; Oonagh Smyth, Chief Executive, Skills for Care; and Jane Townson, Chief Executive, UK Homecare Association.

Examination of witnesses

Witnesses: Sue Ann Balcombe, Marlene Kelly, Mel Cairnduff and Raina Summerson.

Chair: Welcome to the House of Commons Health and Social Care Committee. This morning, we are focusing on the social care system, particularly the pressures facing the social care workforce, who have been at the forefront of all our minds during the pandemic.

We are going to hear from a wide range of witnesses, including both experts and social care staff themselves. While we are going to look at the impact of the pandemic, we also want to look at the longer-term issues facing the social care workforce and what needs to be done to resolve them.

I give a very warm welcome to the witnesses on our first panel this morning. Sue Ann Balcombe is the manager of Priscilla Wakefield House Nursing Home; Marlene Kelly is the manager of Auburn Mere Care Home; Raina Summerson is the chief executive of Agincare, which is a homecare provider; and Mel Cairnduff is a social care worker at Agincare. You are all extremely welcome. We are very grateful to you for joining us this morning.

We are going to start by talking to the two care home managers, Sue Ann and Marlene.

Q49 **Laura Trott:** Thank you so much, Marlene and Sue Ann for joining us this morning. I want to start with a question about why you both entered the social care workforce and what you most enjoy about what you do.

Sue Ann Balcombe: My background is that I am from the Caribbean, a small island called St Vincent. We did not have care homes. We have families—extended families that support each other. It is embedded in me; caring is something that I have always loved. When I migrated to the UK, being born in a British Virgin Island, Tortola, I thought the best job would be a care assistant. Swiftly after that, I became the manager of a very small unit in south-west London, and my career blossomed from there.

I enjoy being around the residents, seeing that their needs are met and making sure that every single day we bring a smile to their faces because their generation is what got us to where we are today.

Marlene Kelly: My name is Marlene Kelly and I manage a residential home based in Watford. I have been here for 13 years. From the beginning, I always knew that it was what I was going to do; I was going to work in social care. It did not feel that there was an option for me to do anything else; it was like it was set out for me.

When I originally came to this home, I thought I would stay for a short period, after working for a charity in quite a stressful position, but I love

working with older people. They have so much to offer, and the team that I manage here is incredible. It is a very worthwhile profession.

Q50 **Laura Trott:** Thank you both for sharing that. They are such incredible stories. Why do you think we have a problem with turnover and recruitment in social care in this country?

Sue Ann Balcombe: I think the recognition the NHS has as a professional body is not the same for social care. I am sorry to put it this way, but we are seen as the underdogs and the Cinderellas. I do not see that the nurses get the same respect as nurses in the NHS, yet they have a much wider range of knowledge and skills. They can manage teams and staff, and they are always the ones on the frontline making clinical judgments about any situation in a nursing home setting.

It is recognition. I am proudly wearing my CARE badge. It is something that was there but was not brought to the forefront; the pandemic has highlighted how much nursing homes and care homes do to support the community, and also to support local hospitals, and so on. It needs to be more publicised.

I will give a brief story. I was pulled over on my way to work and told I was not a key worker because they did not recognise the role of a registered manager. That is really sad. We need to get the message out that the sector does a lot to support the wider system. We need that recognition. Obviously, a badge is wonderful, but we need the recognition behind that to promote the sector as being important.

Marlene Kelly: I feel the same as Sue Ann. I do not think that the staff are given the same recognition as staff who work for the NHS. Even at the weekend, there was this amazing sign in a shop window saying 30% off for all NHS employees. That is really demoralising, because we are making the same effort and doing the same work. There are people here who worked 14-hour days and went to the shops at the end of the evening, trying to provide for their family, but were not given the opportunity to cut the line, because they did not wear an NHS badge.

With the CARE badge, I felt there was a really positive mood, but since that was announced you cannot buy those CARE badges; you cannot order them. If you go to the website to get them for a staff unit, it says they have not quite worked out how they are going to check that the applicants are the right people applying for the CARE badge so that it will not be misused. That has not been available to us since it was announced.

Q51 **Laura Trott:** You both talked about recognition. There is obviously the CARE badge and there are the teething problems that you outlined, Marlene. Are there other aspects of things that you should push? For example, the care certificate is talked about a lot. Is that something you think recognises some of the skills and qualifications that are necessary to do your types of jobs?

Sue Ann Balcombe: That is a hard question. We have the care certificate, and all our employees who are new to the sector go through the care certificate, but I do not think it is the only thing. There are other recognised qualifications or diplomas in health and social care level 2 and level 3. People go on to level 5. There is also the TNA programme, which is training as a nurse associate. If people want to get into nursing, that is a route they can take. We have done that at our care home and supported staff through that programme. The care certificate is one way in, but it is not the only one.

Marlene Kelly: There should be greater, more professional and more recognised qualifications for people working in care. I do not think people understand what the QCS levels are. I do not think they understand the care certificate particularly well. It should be more on the level of the qualifications you would get if you were working in the NHS environment or as a social worker. It should be a more professional qualification. That is certainly what the team want to work towards—having more recognised things that other people in the public would recognise.

As Sue Ann said, people do not know what a registered manager is. It is not the same as when you talk about social workers or other professions. It is just not recognised.

Q52 **Laura Trott:** I was reading that there is an 11% vacancy rate for registered managers. Do you think that part of what contributes towards that is the fact that people do not really know what the role is?

Marlene Kelly: People do not know what the role is. When you look at the content of the role, it is an amazing job. I love my job because every day is completely different, but nobody really understands. When you write down all the things a registered manager does, it is overwhelming. It is like five people moulded into one. There needs to be a bit more definition around it. It is hard to describe exactly what it involves, but it is a great job. It is about trying to get people to understand what it is.

Sue Ann Balcombe: I totally agree with Marlene. To add to that, for a lot of people who are becoming registered managers—I am obviously grooming my staff to become future managers themselves—seeing the sheer amount of responsibility scares people away. You are not just managing a service. You are managing finance; you are managing HR and recruitment; it is not a small role.

There needs to be a level of coaching and pairing people up with other registered managers who can support them through the process of their career, if that is what they want to get into, so that they do not feel alone. The job of a registered manager can be very lonely if you do not have other managers to share that responsibility with, or to count on when you need to call and say, "Oh my goodness, I'm pulling my hair out." You need a support network in order for it to work. Yes, there are a lot of registered managers who have left the sector. If one thing goes wrong, you can actually end up in prison. It is a scary job.

Q53 **Laura Trott:** We have talked about recognition, respect and the support network. How much is pay a factor in recruitment and retention of staff?

Sue Ann Balcombe: It is a big factor. I am sure that Marlene will agree. It is based, obviously, on the funding for beds, because the majority of them are funded by the local authority or CCGs. When you think about what we actually get paid per bed for the individuals we support and the level of their needs, and the responsibility health care assistants take on, the pay does not reflect the value that we give.

Our borough has just become a London living wage borough. Unfortunately, we are not able to pay a London living wage. We are only able to pay them the minimum wage. It would be something we would consider if the funding was there for that to happen. There needs to be some value attached to the role so that we can look at recognising our staff and the hard work they do.

Marlene Kelly: The home I manage is a private home, so we are able to pay the staff a higher rate than local authority funded homes. Because of that, the majority of my staff have been here 10 years. They stay if they are valued and paid well, but the difficulty is that you have to compete. We have had members of staff come for a short period and then leave because they can earn more in retail with less responsibility. Unfortunately, that is the truth, and that is when we are paying them well and retaining them. The competition is still great.

If you are more valued, it is more glamorous doing something else. People still see it as a job that anybody can walk into, and you do not need to have anything special to do the work. That is not the truth. There is masses of commitment. Most people do the job because it is their vocation. That is why they do the job, but, obviously, they have to care for their families as well.

Q54 **Laura Trott:** As you know, homes have just gone through an incredibly stressful period, and we are going to be talking about that in a bit more detail today. Can you say from your experience so far, if we have a second wave, what you would like the Government to do differently in regard to your care homes?

Sue Ann Balcombe: We need to be treated on a par with NHS staff. One of the biggest problems in this pandemic is that we did not have access to testing. People were doing guesswork when it came to deaths of residents. We were not even able to say, hand on heart, that they died from Covid-19. That is where the difference would be if we had another wave. It is important that we are seen as equals and not as lesser, and that we have the same access as our NHS counterparts or colleagues.

Marlene Kelly: I hope that during the process people have learned something. One of the major challenges for me was that it felt like every department was working independently. They were not working together. I hope they would be able to do that better next time. There were points

when I was receiving three calls a week from three different departments asking me the same 10 questions. When you are dealing with multiple deaths, your focus needs to be on the people you are supporting.

It was such an incredible waste of time, and it was not a priority for us. It seemed like no one was talking to anybody. In one call, I would say, "You know, I answered these questions this morning to another department," and they would say, "I'm sorry but we've been asked to do this."

Q55 **Laura Trott:** How was your support from local authorities? How did you feel that that connection worked?

Marlene Kelly: For me, I felt that Hertfordshire did a good job with us because we were not bombarded with information, but I felt that they could have worked better with Public Health England and with CQC. There could have been a greater conversation between those departments.

What really made a difference—I do not know what it is like in other areas—was that the Hertfordshire Providers Association filtered all the masses of information that registered managers were receiving in their inboxes into one daily email. Sometimes I was reading that email at 12 o'clock at night, but they had done that piece of work for us. It would have taken hours. They were telling us every day what we absolutely needed to know. It is a big providers association, but a small department in the scale of things, and it was doing a really good job.

Laura Trott: Thank you both, Marlene and Sue Ann, for all you have done.

Chair: I am now going to move on to Mel and Raina, who work in the homecare sector, which is another part of the social care sector that is sometimes overlooked but is incredibly important.

Q56 **Paul Bristow:** Mel and Raina, thank you for what you have done, not just during this difficult time for our country but before that too. Thank you for the contribution you have made to people's lives.

Some of the questions I am going to ask are quite similar to Laura's, but I will take a different stance on some of them. Could both of you tell me what first attracted you to careers in social care?

Mel Cairnduff: I was 16 when I had my first job in a care home. I went to college and did a YTS course—I'm showing my age here—and progressed from there. I took a break when I had my children, and then 20 years ago I started working as a domiciliary care worker, which fitted in around the family and still fits in around the family.

Raina Summerson: I started in care at about 18. I started working at a hospital in a joint project between the hospital and the council as a care worker. Then I joined a local agency when I moved area. I trained as a social worker. Then I was a regulator for five years and have been with Agincare for 16 years. Care is something that attracted me. I wanted to make a difference. I like the quality side of it. I like direct care giving and

I wanted to make a difference. Because I chose something I naturally loved, it has given me a great career and one that I am keen to support others in.

Q57 **Paul Bristow:** Mel, do you feel valued for what you do?

Mel Cairnduff: No. I feel valued by the company that I work for. I do not feel valued by members of the public, especially since Covid. It has been tough. We get tutted at because we are in uniform out in the street. People tell us that we should not have our uniforms on, but they do not understand what a domiciliary care worker does. We go to people's houses. We work in our uniforms and we keep those uniforms on throughout the day in everybody's house. We cannot change as you can in a home. You can get changed when you go into the home and you can get changed when you leave the home, but you cannot do that when doing domiciliary care. It has been tough, but it is the nature of the job. I do not do it to be valued by members of the public; I do it to be valued by the people I look after.

Q58 **Paul Bristow:** Raina, do you think that Mel's experiences are typical?

Raina Summerson: Yes, it is the same issue for us. We have care homes in our group as well. We have about 55 locations across the country, and it is a mix of services. What Marlene and Sue Ann talked about in terms of the lack of parity with NHS team members definitely comes out as lack of recognition and lack of value. Even in our own group, our homecare teams, our living care teams and even our support delivery teams have felt very differently from our care home teams. The focus was secondary for care homes and there was a better understanding of what was going on. Obviously, that was in the media and there was heightened public awareness of that, but in homecare, as Mel says, the awareness is so little that they face even less recognition.

They are making judgments on the next step, on their own in people's homes, maybe with one other person there. They are making absolutely critical decisions. They do risk assessments; they are negotiating and using communication. They increasingly have to do medical tasks. That has been very evident through Covid. We have had GPs not visiting people in care homes or in people's own homes, so they have to make critical judgments about people's medical condition. They are being asked to support nursing tasks that would previously have been done by primary care.

Alongside that, they were not getting recognition for what they were doing, and that has had an impact on morale. The clapping for carers and some of the aspects of key worker recognition were great, but we heard similar stories to Marlene and Sue Ann. We had people being told that they were not important and that they were not key workers. We had a registered manager told that, even if she was a registered manager and a key worker, all she did was sit in an office all day. There is complete lack

of understanding about the critical role that our frontline workforce play every day.

Q59 **Paul Bristow:** Building on that, Raina, we have heard a lot about social care not being thought of in quite the same way as the NHS. When people talk about social care, you quite rightly say that they talk about care homes. When we talk about homecare, do you think that that is even more of a challenge? Is there a divide between what people think about social care in care homes and those who provide homecare?

Raina Summerson: Absolutely. Care homes are a more mature market. They were regulated slightly earlier in a different way. People associate them with beds. They think of a care home in their locality and what it is like to drive past it. Maybe they knew someone in it. It is bed-placed care, and they can relate to that.

In the last 10 or 15 years, I have been working with local government and trying to contribute to central Government strategy. There is still a fundamental lack of understanding about what homecare does. It is not just about what people like Mel do every day; it is about the scale of the work and how it is paid for. It is how basic pay rates are constructed, the on-costs, wages, training and support. That feeds the end result.

We have a lack of central Government understanding about homecare. We then have a lack of local government and commissioning understanding about what homecare does and the challenges in it. That drives behaviours and practices that lead to people like Mel feeling undervalued when they are doing a critical role that we need more people to join. We need to retain people in that. Homecare is absolutely way down the list. If you start to talk to people about live-in care, which is a form of domiciliary care, people do not understand that either.

Q60 **Paul Bristow:** A lot of people would claim that domiciliary care is a low-skilled job. Would you agree with them?

Mel Cairnduff: No, not at all. We administer controlled drugs. Nurses do that. I am not a trained nurse, but I have training so that I can do that. We do wound care. There are so many things that we do that nurses used to do. They have passed it on to carers to do, yet we do not get recognised. As you say, we are classed as unskilled. We are not unskilled at all.

Q61 **Paul Bristow:** I can see that the Chair has unmuted, so I think he is about to tell me to wind up.

I heard anecdotally that a lot of your clients were reluctant to see domiciliary care workers during Covid because of the fear of catching Covid, and then their needs were left unmet. Do you think that was typical or that it was a feature? I would like to ask about your experience of testing and PPE. Do you think there was enough access to testing in your profession, and did you have enough PPE?

Mel Cairnduff: We eventually got enough PPE. At the start of it all, I think Raina struggled to get it, but we were well covered with what we had out in the community. As for testing, I have not been offered a test through the company I work for, but I have been tested myself through the King's College app that I use every day on my phone.

Q62 **Paul Bristow:** Did you find the experience of clients not wanting to see you?

Mel Cairnduff: No. None of our clients stopped. We have not ceased seeing anybody at all through Covid. In fact, we have probably seen them more.

Q63 **Paul Bristow:** To end on a quick positive, would you advise others to pursue a career in social care?

Mel Cairnduff: I would, yes. I love doing what I do, so, yes, I would.

Raina Summerson: On PPE and testing, we had a tremendous challenge getting PPE. It has cost a huge amount and we are still sitting here not knowing whether those costs will continue to be met. The guidance has been coming out thick and fast, so we are adapting to that.

Testing has been similarly difficult. It is easier in care homes, but only recently. There is still an issue of reliability and access for all our social care workforce when they need it.

Q64 **Chair:** Could I follow up on Paul's question to Mel? Mel, you said you would encourage your friends to pursue a career in social care. Could you elaborate? You have told us a bit about the grief you get, which will have shocked a lot of members of the Committee; it certainly shocked me. When, as we all hope, the pubs open on 4 July, if you were sitting there with a friend, what would you say were the magical moments when you are with your clients that you take home and treasure?

Melanie Cairnduff: It is the way we make them feel. I go to work, and I have to be happy and cheery for them. I might not feel happy and cheery inside; I might have had a blazing row with my husband beforehand.

It is what I do for them. It is not what I do for the company I work for or for myself. It is seeing the people we look after smile every day, or when you are leaving they have a little grin on their face and they say thank you. That is what I do my job for. That is what I would say to anybody who wants to go into care. You have to not do it for the money. Obviously, the money helps because we all have bills to pay, but you have to do it because you want to make somebody else happy. You want to make them have the best life they possibly can.

Q65 **Chair:** That is a lovely answer. We heard a bit from you, Marlene, about why you love your job. Could I ask Sue Ann the same question? What is the magic in your job and the moments that you most treasure?

Sue Ann Balcombe: It is knowing what the impact of what we do has on the individuals we support. It is exactly what you said, Mel. I was nodding my head all the way throughout your talk. It is about making them smile and knowing what that one moment in time is for that individual. It swells your heart and you leave work knowing that you have done your best.

Registered managers working in care homes often do not have a lot of physical contact, especially when the size of the care home increases. I have a very large one; it is 117 beds. It is knowing the colleagues I work with. I have similar trust in them, and I know that they are in it for the right reasons as well. As Mel said, you have to have that in your heart. Nobody can make you a carer. That is the important thing. You have to have it in you.

Chair: That is wonderful. Thank you.

Q66 **Barbara Keeley:** I want to follow up what we have been hearing about lack of parity of esteem with the NHS. We have heard from Mel about care staff not being valued and about people being tutted at in the street. I am appalled at that, because you are doing such a valuable job.

What difference has the Covid pandemic made to how people feel about the job? I understand the issues about low pay and that sometimes the terms and conditions make it difficult. Care staff have really stepped up in the pandemic. They have been dealing with incredibly difficult issues—multiple deaths in some cases, as well as infection control. They should feel proud.

What could we do to improve that? What could we do to make sure that they can feel proud in their job? That is for Sue Ann and Marlene, or anybody else on the panel who wants to contribute.

Marlene Kelly: Recognition goes a long way—being acknowledged for what you have done in the way you have just said that; for some of my staff to hear that they are being recognised at this level would mean something to them. They were responsible for a lot of tasks during the pandemic that they were not seen as being capable of before. They were given those responsibilities. There were things we did years ago that were taken away from us and given to district nurses or doctors. Then those responsibilities were given back to us and we were entrusted with them. They did a brilliant job with those. This is a residential home; I am not a nurse, but we supported 10 people to die here beautifully, well supported, with amazing end-of-life care.

If at the end of it, those responsibilities are taken back from the team—"You can no longer change a pressure dressing," or "You are not qualified to do this or not responsible enough to do that,"—they are going to be really demoralised. They are going to feel that when something bad happened they were trusted with everything, and then once things moved on all those things were taken back from them. That is going to have a great effect on them. They need to be acknowledged, encouraged and supported to do the things they know they are capable of.

Raina Summerson: Marlene is absolutely right. There is a danger that people have had a brief look at what it is like to get some acknowledgment, and if it is taken away that is going to have a more detrimental effect than before. The key issue is trust, as Marlene said, particularly driving homecare behaviour. In commissioning behaviours and the way that care is bought by local authorities and CCGs, there is often an underpinning lack of trust in partnership. If a provider is made to feel that there is a lack of trust in partnership, it filters down to the workforce feeling there is a lack of trust in partnership.

We have seen things like pay by minute for homecare. Whoever thought that the critical role of compassion and care can be broken down into paying people by the minute? Out of good will, people are not being paid for walking up someone's garden path or waiting to get in to see the most vulnerable people, because criteria levels are such that we do not deliver to people for whom it is a nice to have. As Mel said, they need their visits. If you are not trusted, that is what a pay by minute call does to you as a team member. It makes you feel that no one trusts you to make that judgment. Some of that has been taken away during Covid. We have gone on to planned care. Our team members have been left to trust by necessity. They have got on with it because they are very capable. They care, they are resilient, they are adaptable and they are hugely skilled. They have got on with it.

If we go back to some of the commissioning practices like pay by the minute, it is going to completely demoralise our homecare workforce and make them feel, as Marlene says, "Oh, you were useful for that period, but now we will go back to pushing you to the sidelines and not trusting you, your judgment or your timekeeping, and thinking that you and your provider are just out to scam us." It will put people off. Those are the fundamentals. Commissioning and purchasing behaviours drive how our workforce feel at the end of the day.

Q67 **Barbara Keeley:** Thank you. Please pass on, at least from me and I am sure from every Committee member, how valuable we think the job is that your staff are doing. I thank Mel and everybody who works in the sector. It is a very valuable job.

Sue Ann Balcombe: I want to add one thing, if I may. The media have a part to play in relation to recognition. I used to clap every Thursday, and all you hear is, "Let's clap for the NHS." The staff felt, "Where are our voices in all of this?"

If there was recognition, it should be that we are publicising care as such, and not just the NHS. I know they say "key workers", but, if the care element—social care—was part of that and we were looked at as key workers, there would be an element of understanding our role and supporting us as well. I think the media have a large part to play in recognition.

Barbara Keeley: Thank you.

Chair: Thank you, Barbara. I am sure we absolutely echo the incredible admiration for the work that everyone in the social care sector does. That is indeed one of the reasons why we are having this session this morning.

Q68 **Dean Russell:** I will not elaborate too much on what Barbara just said in her excellent comments, but I absolutely thank you for all the work you do. I have a family member who has somebody come in to care for them on a regular basis, and it makes such a difference to their life and wellbeing.

My question is about practical steps in terms of moving forward. We have heard, quite rightly, the challenges around the roles and around the visibility of care workers and so on. Looking ahead, what are the practical things that could be changed to make you feel more comfortable in your role, or happier in your role from a wider perspective, and could encourage more people to take on this job, which you have just described as being amazing in many ways? What are the barriers and what practical steps can be taken?

Mel Cairnduff: Practical steps? I do not know what I think. We need things to be set out more so that carers know what they are coming into. We see a lot of new carers who, in six months' time, will not be doing the job because they did not realise what domiciliary care workers do. To make it more practical, you need a real understanding of what the job is. Does that make sense?

Q69 **Dean Russell:** Yes, absolutely. We talk about salary and so on, and that will always be a challenge.

Mel Cairnduff: That will always be an issue.

Q70 **Dean Russell:** Are there any other things outside that? I often look at the private sector in roles where they have additional holiday or sabbatical time, if you have been in a role for four or five years. Are there other practical steps like that which would wrap around the role and the job that you think would be more appealing?

Raina Summerson: It is beyond pay. We cannot take away the fact that the system needs to be funded better. If we try to do care on the cheap, we are not going to get a workforce who feel valued or who deliver their best. Everybody expects a high-quality, responsive and reliable service without fundamentally having the structure to pay for it.

Again, look at the NHS. They have a long-term plan. They have long-term funding. Their team members know what that is. They might not always be happy with it, but it is there and it is collective. Obviously, there are issues with the fact that we have a dispersed independent sector market providing a lot of care now, but we need to move on. Whatever people's feelings were about the original outsourcing of homecare, it is in the independent sector and we are providing a critical infrastructure service and workforce. It needs to be recognised as such. It needs to be mapped as such. There needs to be some standardisation, but not too much

because some of the greatest innovation and responsiveness comes at a local level, working with local authorities and local needs.

As Mel, Marlene and Sue Ann said, some of it is not bells and whistles. It is recognition. It is awareness. It is feeling that you are not in something that people value so little that they only pay for contact time and they only pay by the minute. Those things are absolutely fundamental. Yes, they are attached to pay and terms. With things like sabbaticals and extra holidays, different providers do different things anyway. A lot of the homecare frontline workforce work an average of 25 to 27 hours a week. A lot of people fit that work around their life.

I would not say that they are drivers. Mel and I spoke with a few other team members to make sure that we were representing their views today. There is that trust, recognition and having a structure where you are not rushing to give sensitive care to people at the highest criteria levels now. They are rushing in and rushing out. We are asking people to be emotionally invested.

You have heard Mel, Marlene and Sue Ann say how emotionally invested people are in social care. That means they are emotionally affected. They are the ones who have to shut the door and walk away up the garden path, leaving people when they know they did not really get the time they needed. They may have missed out on the preventive services that were there 10 or 15 years ago. That affects their morale and job satisfaction, and that affects retention. No matter what training or pay you give them, if that is their experience every day, it is not going to change. We are not going to change the experience of the workforce.

Q71 **Rosie Cooper:** I thank every member for their comments. You have told us of the highs and lows of working in the sector. Raina, you have probably partially answered this, but I would like to be a little more succinct. We can have all the badges in the world. We can have all the thanks in the world, but do you agree that the core of it is that, without parity and a proper financial base, nothing is going to change? The message to the powers that be has to be, "Stop talking and work out a proper financial settlement, and then we can get on with the details." All of it is talk unless it is underpinned by real money.

Raina Summerson: Absolutely. Funding is critical because funding, or the lack of it, drives the central Government agenda, which drives the local government agenda, which drives the commissioning practices that have the impacts we talked about. We need proper long-term reform of social care. How are we going to pay for it? What, as a society, are we prepared to pay for? At the moment, there is disparity not only between the NHS and social care but between expectations about what social care should deliver and how it should behave—the standards—and what people are paying for it. Funding has to be the key behind it all.

Q72 **Rosie Cooper:** I do not believe that the problem we have is the solution. The problem is who is going to pay for it. That is the only question to be

decided. The rest of it will come. Do you agree with that?

Raina Summerson: I think that is the basis of the reform. Reform and funding has to drive everything else that comes out.

Chair: Thank you. We have lots more time to talk about funding issues. We are now going to move to our second panel, but I want to take this opportunity to thank the panellists we have had this morning. I do not think any of them has spoken to a House of Commons Committee before. I am sure that is quite a daunting thing. All of us on our side of the fence think that one of the most magical things about our job is to be able to talk to people like you, in the way you have been talking this morning.

Sue Ann, Marlene, Raina and Mel, thank you very much indeed for sparing your time. Thank you too for all the brilliant work you do. Thank you to your colleagues as well from all of us in the House of Commons.

Examination of witnesses

Witnesses: Professor Green, Oonagh Smyth and Jane Townson.

Chair: Before I introduce our second panel, Paul Bristow has a brief declaration.

Paul Bristow: My wife owns a communication consultancy with clients in the social care sector. That includes Skills for Care, who are giving evidence today.

Q73 **Chair:** Thank you, Paul. We are going to go on until 11.25 with this panel. We have to stop sharply then, but we will have a one-minute suspension at 11 o'clock for the victims of the Reading terrorist attack. I will need to interrupt for one minute at 11 o'clock.

A very warm welcome to the panellists in the second half of the session. I welcome back Professor Martin Green, who is the chief executive of Care England, which represents a large number of social care organisations, including a lot of care homes. Oonagh Smyth is the chief executive of Skills for Care, the body responsible for co-ordinating the training and career development of people working in the social care sector. Jane Townson is chief executive of the UK Homecare Association, representing all the organisations who do what Raina was talking about this morning in the first panel. You are all extremely welcome.

Oonagh, thank you for joining us this morning. What is your reaction to some of the stories that we have been hearing this morning? Mel was saying she was tut-tutted for wearing her uniform. Sue Ann said they were not really valued for the work that they do. What is your reaction to those?

Oonagh Smyth: It was great to hear from our frontline registered managers. What we have seen, and what I have certainly reflected on, is that there is absolutely no doubt that social care is at the absolute heart of all our communities. We heard from Mel that care staff want to support people to live their best lives. Raina described it as a critical role of

compassion and care. We know that every single year people who work in social care support 1 million adults, including young adults, to live their lives, whether that is in care homes or in their own home.

We know that they are not valued as much as they should be. We know that has an impact on entry rates. We had 122,000 vacancies a day before Covid, which means that this impacts on employers who are expending a lot of energy finding new people. It also impacts on continuity of care for the people who access support. I do not think we can lose the opportunity in social care being prominent in public consciousness. We have to take this opportunity for the adult social care workforce, to make sure that it is valued, trusted and recognised. The crisis has brought adult social care to public attention.

We might have some examples of the public not treating our care staff in the way that we would want them to be treated, but my hope is that the majority of the public will have seen and understood the value of the adult social care workforce in a way that they might not have done before.

Q74 **Chair:** I want to ask you about some of those numbers. You said there are 122,000 vacancies in the sector. We heard from the Health Foundation that the sector is going to need an extra 140,000 recruits by the end of the Parliament. You said it was an extra 580,000 by 2035. Have those numbers changed at all with coronavirus?

Oonagh Smyth: The projections have not changed yet. The vacancy rate has reduced slightly since Covid because unemployment has risen and we have seen new people come into the workforce. That is wonderful and we hope they realise what an amazing job it can be. We hope they stay. What we know is that we do not know what to expect. We do not know how many of those people will stay and whether the vacancy rate, the daily rate of 122,000, will keep reducing.

The other thing that we know is that, during Covid, the absence rate has trebled. While we have new people coming into the sector there is also a greater demand on people. Our very experienced staff, like the ones you heard from this morning, are going over and above. I spoke to a registered manager who had not had a day off in seven weeks because she was trying to hold her service together and support her team.

We might expect an influx of new staff, which is wonderful, but potentially we might lose some very experienced and values-driven staff if, at the end of this, they suffer from PTSD or burn out. That is my concern. We heard from the Royal College of GPs that they are expecting more people in general to suffer from PTSD as a result of Covid. Considering that our care staff are on the frontline, and trying to manage their own service as well as family issues, the way we all do, my concern is that the vacancy rate, particularly among experienced staff, will increase.

Q75 **Chair:** I understand there has been turnover because of Covid, new people coming in and people going off sick. One of the very striking things in your evidence was that you said the turnover rate for the sector in normal times is about 30%, which is double the national average. In the homecare sector, it goes up to 43%. In parts of the social care sector, organisations are losing nearly half their staff every year. Why is that?

Oonagh Smyth: It is a combination of things. We heard about them this morning. There is an element around pay, and I do not think we can get away from that. There is a conversation that we need to have around a sustainable future for social care. We know that some employers do it well; a small percentage of employers have a much lower turnover rate. Part of it is values-based recruitment. It is not just about numbers. It is about the right people. We heard that this morning; it is a real calling and a vocation.

There is an element around how we recruit. Again, we heard very strongly this morning that people do not feel valued or recognised. We need to address that, as well as development and career progression. Employers who pay more have lower turnover rates. Employers who invest in and support their teams to get qualifications have lower turnover rates. For me, the combination of pay, recognition, development and support are the key issues that impact on turnover.

Q76 **Chair:** Jane Townson, could you comment on that? Turnover of 43% in the homecare sector must be a nightmare for your members to cope with. Do you recognise that picture? What do you think the main reasons are?

Jane Townson: First of all, it is important to say that much of the turnover happens in the first six months. That is true across care homes as well. There is a very substantial number of people who have been in the sector for a very long time.

As Oonagh said, the pay is a key factor. I ask you to imagine a clinical commissioning group saying to an NHS trust, "We are only going to pay nurses for every minute that they are by a patient's bedside. We are going to electronically tag them to find out when they are there, but we are not going to pay them when they move from one patient's bed to the next. We are not going to pay them when they are training. We are not going to pay them when they are supervised. We are not going to pay them when they are doing their CPD." Can you imagine the outcry in the NHS under those conditions? And on top of that, the NHS trust would have to pay for all of those additional things by some miracle.

That is what homecare providers have to do and are expected to do every day. It is the lack of trust that Raina talked about: measuring care by the minute and paying for care by the minute. Councils buy care by the minute, which means that providers end up having to employ by the minute. Nobody wants to do that, but it is the system that is wrong.

It is the feeling that Mel and Raina talked about of not being able to meet people's needs. People want to remain well and independent at home. They want to live the best life they can, and we can support them to do that and save money for the health and care system. We know we can prevent admissions to care homes. We can prevent admissions to hospital. The number of people being admitted to hospital through malnutrition has increased fivefold in the last decade. That could all be avoided.

Q77 **Chair:** I completely understand and hear what you say about payment by the minute. It is something we need to talk to Ministers about. When I was Health Secretary, I was told that 15-minute visits had been abolished, but it feels like they have not. That is definitely something we need to look into as a Committee.

Let me ask you about the level of pay. In the evidence from Skills for Care, they said the average pay was £8.10 an hour. Sue Ann Balcombe talked very powerfully in the earlier part of the session about the importance of pay. It is not the only factor. It is not the reason you come to work, but none the less it matters. What do you think pay would need to rise to if we were to get a level of pay sufficient to bring down that high turnover?

Jane Townson: The first point is that we see a big difference between the self-funded part of the market, which is about 30% of the total, and the rest, the 70% in the state-funded part. Some local authority commissioners are trying to get pay up. We have seen levels at about £12.25 an hour.

In my previous role, when I was a provider CEO, I had a letter from a member of the public. He said, "I would willingly work in care, but I am a married man with two children. I need to earn at least £2,500 a month," which is not a lot by any standards. "I would need at least £12 an hour and 40 hours a week."

There is lack of security of income, too. A large number of care workers, nearly 60% in homecare, are on zero-hour contracts. You are probably aware that the United Kingdom Homecare Association calculates a minimum price for homecare to be compliant with the national legal minimum wage of £8.72, plus compliance with the care regulations. This year, it has been calculated at £20.69 an hour.

We have done data collection from 139 of the 152 local authorities. Currently, the median is only £17.20. We have 13 councils paying less than £15 an hour. That does not even cover the national legal minimum wage and statutory employment on-costs. We believe it should be illegal for councils to purchase care at rates as low as that. Eighteen councils have not given any inflationary uplift to cover the 6.25% increase in NMW that we had in April.

When employers are paid by the minute, on fee rates lower than £15 an hour, how can they possibly reward their staff properly for the skill, dedication and compassion that you have heard about this morning?

Q78 **Chair:** Thank you. Let me bring in Professor Martin Green. What is your reaction to some of the evidence that we have heard so far this morning from people on the frontline?

Professor Green: Chair, what we saw this morning was the professionalism, the dedication and the commitment of people on the frontline. All the people who gave evidence this morning were fantastic ambassadors for social care. They also underlined the complexity of the role that they perform. When we look at, for example, comparisons between social care and the NHS, we see that social care is supporting exactly the same people, but what we do not see is the same recognition in terms of public recognition or things like pay, conditions and training. I am constantly amazed at how we talk endlessly about an integrated system of health and social care, yet all the architecture around the workforce for health and social care is separate.

We have workforce strategies in the NHS. We are waiting for one in social care. We have Health Education England with a budget of £4.7 billion; £100,000 a minute is spent on training in the NHS. Compare that with Oonagh's budget of about £21 million for Skills for Care.

One of the things that has come out is the concept of an hourly rate. We need to move away from that. These are consummate professionals. They should be on proper terms, conditions and salaries. It should not be about a paid job; it should be about a salaried profession. We have to move social care into that space.

Q79 **Chair:** Thank you. I want to ask about something we have not yet touched on, but which is very important—the forthcoming changes in immigration policy. At the moment, the average annual salary for a senior care worker is £23,700 in local authority-run homes. It is £17,600 in the independent sector, but the threshold in the new immigration policy below which you cannot bring anyone in from overseas is £25,600. How is that threshold going to affect your members in the sector?

Professor Green: It is going to have a significant effect. One of the things the Government need to understand is that we all want a home-grown workforce. What we want to do is to aspire to a situation where registered managers are paid significantly more than they are currently paid.

We have some reliance on overseas staff. What the Government have failed to understand is that they have not got their strategy right to make sure that we have enough people in the pipeline from in-country staff. It would have been much more sensible if they had had a transition plan that said, "We are going to enable you to bring some staff in from overseas until we have our workforce strategy and social care right, and

until we have enough people in social care from the indigenous group of people who live here currently."

Q80 **Chair:** The Government say that you should just increase your salaries to the threshold level as a way of both increasing the stock of people applying from inside the UK and allowing you to bring people from overseas. What is your reaction to that?

Professor Green: My reaction is that it is not commissioned in that way. Dr Townson gave a very eloquent overview of the appalling way in which services are funded. We could, and we want to, increase our salaries. We want professional salaries with proper training and development moneys. We would like to be far north of £25,000.

When we heard this morning from colleagues who are managing care services, we saw how complex that role is. It is certainly a role that is significantly above a £25,000 role. We have to get the commissioners of service to understand that. We have to have a long-term strategy on social care funding, as I think Dr Townson said, so that we can benchmark ourselves as a profession rather than just as a job.

Q81 **Chair:** What you are saying is that there should be a 10-year plan to go alongside the NHS's 10-year plan and a long-term funding settlement.

Professor Green: Absolutely. There is endless talk about integration. Why don't we have a 10-year integrated plan? I would like some baseline skills and competency frameworks so that people can seamlessly move across the system from the NHS to social care, as citizens do. Citizens are not in a silo where they are dealing one minute with the NHS and the next minute with social care. They are interdependent systems.

One of the things that we need to understand is that, as demographic change hits us, we are going to need, first of all, more people to support people. Our current system, with its straitjackets, is not going to allow that. We have to get much more flexible in how we deploy staff. We have to get more staff who are able to move across the systems, just as citizens do.

Jane Townson: We need to focus on outcomes on a system-wide basis and not just reduce everything to cost and minutes. We must get away from time and task, and look at population level at outcomes and at individual level at outcomes, and then do a sensible calculation of the costs and benefits of different models. We do not even have a social care strategy, never mind a workforce strategy. We have no idea whether we are heading for a more institutional approach. At the moment, that is what it would appear to be, because all the money is going into acute hospitals and care homes relative to homecare and other community support.

Citizens want to stay at home. They do not want to go into institutions. They want to stay in their community, surrounded by the people they love. We already support more than twice as many people at home as are

supported in care homes, and about eight times more than in hospitals, but for 4% of the budget that is spent on the NHS. We need to stop looking at costs and start looking at value. We need to invest.

Chair: Thank you. We had a very interesting piece of evidence from a Danish expert, who talked about the deinstitutionalisation strategy that they had in Denmark and which echoes some of those thoughts.

Q82 **Taiwo Owatemi:** We heard earlier from the previous panel about the negative perception of the social care sector and the lack of understanding the public have about social carers and the roles of carers. How do you think this negative perception can be addressed? Do you think the pandemic has had a positive or negative effect on how the public view the social care sector?

Oonagh Smyth: I agree that the perception of social care staff during the pandemic and public awareness has never been higher. Sometimes, we lack understanding of the diversity of social care and the diversity of people who are supported. Sometimes, there is an assumption that social care is only care homes. Care homes are a really important part of social care, but social care is much wider. I think we could do more on that.

The national recruitment campaign has been quite helpful in helping people to understand what skills and roles in care could look like. The more we can do that, the more we can draw attention to how skilled and important those roles are in our communities. I think that would be much more helpful. The pandemic is an opportunity to do that.

Jane Townson: I agree that the pandemic has given voice to care workers and made their work more visible. The media play a key role. Some have been fantastic, but we have been told that we cannot get homecare stories past editors unless we have dead bodies or businesses closing. We are trying to stop that. In homecare, we have been very successful at keeping people safe. Our largest member cares for 28,500 people. They have had 135 deaths. Yes, each one of those is a person and we are traumatised by every one of them, but it is less than 0.5% and, therefore, it is not news.

We have been very successful at keeping people safe and well at home. Nobody wants to hear the good news. We really value the fact that you are listening to us today because we have an opportunity to get some of the positive points across.

Professor Green: One of the things we should acknowledge—Jane mentioned it—is the amount of focus on the NHS in the media. I was preparing for something recently and I looked at my Sky box and I saw, "Inside the Ambulance", "GPs: Behind Closed Doors", "The Surgery" and "Hospital". That was all on one evening. All those media are designed to give people an impression of the NHS. We need the media to be more balanced. We need to see some of the social care success stories

championed in the media as well. There is a role for the media in that too.

Q83 **Taiwo Owatemi:** I agree that the media have a role to play. Following on from the previous question, you spoke earlier about integrated care. Do you believe that England should have a fully integrated care model similar to Denmark's, in which training, pay structure and career structure are integrated? How do you think we can address the lack of workforce parity that we have with the NHS?

Professor Green: I want an integrated system, but what I don't want is an integrated structure. Far too much of the integration debate is all about organisations. People talk about the NHS, local authorities and care providers. I think that misses the point. True integration is about the experience of the person who uses the service. There are lots of good examples. The airline industry is one where you can have lots of different players on the field, but they are all clear about what they are there to do, which is to deliver a good outcome for the person who uses the service.

We have to look at how we—shall we say?—reapportion some of the money in training and development. At the moment, we have significant amounts—£100,000 a minute, as I mentioned earlier—for training in the NHS but we have very small amounts for social care. If we had a much more integrated career pathway, and proper escalators for care roles as well as health roles, we could see a much more integrated approach. I think that would deliver better outcomes for citizens. That is our focus. It is about the outcomes we deliver to citizens. To talk about organisations is to miss the point.

Oonagh Smyth: I agree with Professor Green. It is about integration of experience so that the individual does not feel the baton change between health and social care but that they are getting one experience.

We should never lose the value of social care in and of itself. It has value in and of itself, as well as in its interaction with health. The focus on the individual comes from making sure that there is a similar level of infrastructure with social care and health. We often find that the debate about integration can be quite health-led because there is not the same infrastructure in social care. In countries where they have integrated structures, they still have similar issues around parity. I do not think the structure changes it. It is a wider conversation than that.

Jane Townson: We need to start with the needs of our people. The needs are not all the same. If you are a young person with a physical disability but full mental capacity, your needs are going to be different from those of a 98-year-old person with advanced dementia and frailty in a care home, or a middle-aged person with mental health issues resulting in self-neglect and their physical health suffering as a result.

We need to look at the skills and competencies that care workers need to support those different types of people. As Oonagh said, some of those will be very much social needs and others will be very much health needs. We have not even talked about digital yet. That is a huge emerging area where we need to get the workforce to the right level of skill and competency too.

I totally agree with Martin that we need to focus on the people receiving care, and work in multidisciplinary teams on the ground. In the best areas that is already happening, with good communication between those teams, and then the organisational form is irrelevant.

In my previous role, we had a collaboration with Yeovil District Hospital. Their staff worked on our nursing home floor from 8 o'clock in the morning until 8 o'clock at night seven days a week. Apart from the difference in uniform, you would not have known that they were in different organisations, because the focus was on the people. You can train the whole multidisciplinary team around different cohorts of need.

Q84 **Taiwo Owatemi:** Jane, how do you think the current issues in the social care workforce undermined the sector's preparedness for coronavirus?

Jane Townson: Quite a lot of emergency planning went into the preparation for Brexit, but nobody had planned at local level, I believe, for a pandemic of this nature. We have learned a huge amount through this. In particular, personal protective equipment was quite a contentious issue. Normally, independent providers have their own suppliers, but the suppliers were telling providers that the supplies were being diverted to the NHS supply chain. That is vehemently denied by the Government, but that was the experience on the ground.

Testing has not been available, and still is not, for homecare. We are at the bottom of the pile, after care homes and the NHS. We have also been at the bottom of the pile for guidance. We have had to push really hard to get domiciliary care the recognition that it deserves in central Government and in local government, too.

I do not believe that the planning was adequate. We have managed, but we have been lucky in homecare in that we have managed to avoid too much catastrophe. Somebody asked earlier about cancelled calls. That has been an issue. Both citizens and councils have cancelled care calls. At times, it has been as high as 10% of the total. We have been worried all along about people needing support and care and not getting it, and their health needs not being met as a result. There is a huge amount that we need to learn that we have not got right.

Q85 **Dr Evans:** My question is to Professor Green and then to Jane Townson. We have touched a little bit on the structure, but it is a very dangerous thing for a politician to do blue-sky thinking.

I would like you to answer this question. Should we carry on with the same system, with the changes you have talked about for an outcomes

focus, or if I gave you a blank piece of paper how would you design care as a broad structure? We have care homes; we have domiciliary; we have different nations across the world that have emphasis on state versus the family and the individual. Do you think what we are doing is right and it needs tinkering with, or should we be doing something completely different?

Professor Green: The reality is that we have the system we have, and if we did something completely different we would have to start from year zero. We would have to do what Jane and Oonagh suggested, which is to start with people's needs. It would be a very broad system because it would take into account things like housing and access to a range of other issues like transport. If you think about the prevention agenda, you would put in services much sooner.

Our entire system at the moment works on the basis of crisis intervention. Despite all the rhetoric and the stuff around prevention, it is very difficult, for example, to get domiciliary care in your home when you are at the point when it would be most effective. What usually happens is that people wait for a crisis and then, of course, services go in. If we were starting from year zero, we would completely change the approach. We would have a much more integrated approach in communities as well, so there would be a lot more of that.

We would also put much more power in the hands of particular citizens, so they would decide what was the intervention that made the most difference for them. Many years ago, in a previous role in the 1990s, I did some reviews of very expensive care packages in Lambeth. One of the things that was startling was that when I spoke to the people who were receiving them—incidentally, nobody else had spoken to them—and asked them what they thought of them, the majority said, "Well, I don't really want this. What I want is," and then they gave me a list.

What was interesting was that the list was about things that were much cheaper but actually made a difference to their lives. It was about support for carers. It was about interventions. It was about the flexibility of services. Rather than getting an assessment that said, "You will have your domiciliary care worker coming in for 30 minutes every morning at 9 o'clock," people wanted to be able to say, "Well, on Wednesday I want to meet friends, so I'd like a domiciliary care worker in for an hour and a half to help me prepare for that."

One of our challenges is that often services are very much about the structure of the service and not about the outcome for the individual. The challenge around flexibility is a really big one. What happens is that services try to squeeze service users into them rather than responding to what service users need. The flexibility issue would be high on service users' criteria of the things that are important to them.

Dr Evans: Jane, do you have a comment? Then I have a quick follow-up question.

Jane Townson: If I were in charge, I would do things very differently. We know from scientific evidence that the social determinants of health play the biggest role in people's long-term health, not acute healthcare. I would therefore view community-based support as preventive and part of public health, and invest in keeping people physically active, making sure that they have enough food and ensuring that they are connected to their communities so that they have a sense of purpose. I would make sure that they have adequate housing and that they have work. All of those things will lead to a healthy economy. We cannot afford to skimp on them.

Martin talked about putting people at the centre. I have often observed that the self-funded part of the homecare market points the way to how we could do things. In that part of the market, people are the commissioners. In my world, I would probably abandon local authority commissioning—sorry, local authority friends—and I would stop the micro-managing that goes on and allow people like Mel, Marlene and all the people we heard from this morning to work with the people they are supporting, to agree and decide what can be offered within the budget.

It is unrealistic to believe that the state can pay for everything, but what we are missing out on is the preventive work and the lower level of need that does not necessarily cost very much in proportion to the amount that results in acute care if you do not do it. We need to look at the cost of not doing things rather than the costs of per-minute homecare.

Q86 **Dr Evans:** From the GP side of things, I have dealt with lots of relatives, families and individuals. Where do you see the line drawn between what we need to do for the public and relatives on education, regarding whether we move more towards, "It's the state's responsibility," or "It's the individual and the family's responsibility"?

We heard last week that in Denmark, as a society, they have decided that it will be taken on by the state. In India and the subcontinent, it is very much the individual, and elderly relatives live with the family. We, effectively, want to do both, as well as have our working lives. Do you have an opinion on how the public's culture might want to change in terms of the perception of providing care?

Jane Townson: We need to learn from other countries, where they have managed to do better than we have so far. In countries like Japan and Germany, they manage to engage the public in meaningful conversation about the benefits to them. One of the things that people fear is that they will have to leave their own home but they will not have enough money to pay for care. In those other countries, they managed to address those fears and explained that the measures they were putting in place would give people more certainty for the future. That does not have to be about the state paying everything. It could be that there are ways for them to save, perhaps to have tax relief on paying for their own homecare.

We need to get rid of some of the perverse incentives in the system. At the moment, because property assets are put against the cost of care, local authorities would be inclined to move people into care homes because it means that the local authority will not have to pay, although it would not necessarily be the right time for the person to do that and they could have been cared for at home. There is quite a lot of dissatisfaction already among the public. It is about showing them what solutions we could come up with that are of benefit to them. It is not all about paying more tax. It is, "What's in it for me?" That is the bit we are not doing.

Professor Green: I agree with some of that. One of the challenges is about having an adult conversation about what the citizen should expect to deliver and what the state is going to deliver. Of course, if we had a conversation, Luke, exactly as you said at the start, we would also have a conversation about what bits of healthcare are free as opposed to what bits of social care are free.

If you look at who uses social care, pretty much nobody is using social care for any reason other than that they have a health condition. One of the other issues that would be interesting to unpick is the amount of ageism in our health system. We have seen it graphically brought to the fore during the Covid-19 pandemic, where we saw really bad behaviour from the NHS around, for example, retreating from care homes so that they were left very much on their own.

Interestingly, the responsibility for the health needs of every person in a care home should be with the NHS. How many of them got a shielding letter? My research tells me very few, and that was because, once you move into care services, people in the NHS seem to think that that is their job done and they have handed it over to somebody else. One of the challenges is that, if we are going to have a public debate about what people pay for and what they do not, it has to be a whole system debate, not separating out particular bits. Actually, nobody is in care for just one reason; there is a multiplicity of reasons, some of which are health related and some of which are social related.

Chair: Could I ask our witnesses to turn down the volume of their speakers? We are getting a bit of echo.

Q87 **Dr Davies:** My question relates to care homes and the impact of Covid, which has clearly been a massive concern, and the access to testing now. How often are members of staff being given access to antigen tests? How is the rollout of antibody testing going?

Professor Green: It is patchy. The first thing to say is that, if testing is to be effective, there is going to have to be a rolling programme of continuous testing. That needs to be for both staff and residents.

There is one programme going on in Hampshire at the moment where you can get test results within about 20 minutes. We need that testing rolled out, because that will help us not only to be able to test staff and

residents but to be able to test relatives who might want to visit. We have to get testing as part of an ongoing programme. It is not a once-in-a-lifetime activity; it is something that needs to happen regularly.

Some of the testing regimes have been too complex. There are too many organisations involved and too many websites that people need to go to. Some websites are specialist websites for care providers. Others are for general public access, and so on. We need a much clearer centralised, consistent and regular approach to testing.

Q88 **Dr Davies:** Clearly, that is pretty urgent as we fight the pandemic. We need to roll it out and there needs to be leadership to make it happen.

Professor Green: Yes, very much so; and it needs to be now.

Q89 **Dr Davies:** Yes. To what extent are you aware of cases having come into care homes because of lack of access to testing, whether for staff or for residents?

Professor Green: At the start of the pandemic, we saw people being discharged from hospital without tests. Of course, that is a major challenge because you might be bringing the pandemic into the care home. One of the things we should acknowledge is that residents of care homes are all people with several underlying health conditions. They are in the highest category of risk, and part of the problem at the start of the pandemic was that there was no acknowledgment of that, despite what the chief medical officer said about three weeks ago—that they knew that people in care homes were at the highest risk. That did not translate at the start of the pandemic into a consistent approach to how they supported care homes, particularly the way in which primary care withdrew and some of the challenges around that.

We have learned some really tough lessons from this. To go back to a point I made on an earlier question, we need to stop focusing on organisations. All the focus was on the NHS as an organisation. It should have been on the most vulnerable citizens and how we protect them, whether through social care or the NHS or, in the best of all worlds, a combination of both working together to ensure that people have the highest level of protection.

Q90 **Dr Davies:** Jane Townson, do you have any perspective on these issues?

Jane Townson: Yes. Testing has never been seen as a priority for homecare, right from the beginning. Although it has not been reported, we also had people discharged from hospital to homecare without testing. Because testing capacity has been limited, homecare has been at the bottom of the priority list. People receiving homecare were never even on the list. At one stage, care workers were told that they could all have tests, but the practicalities of accessing them meant that it was at very low levels.

You mentioned antibody testing. None of that has been available for homecare. The pilots were all directed at care homes. Exactly the same number of people work in homecare as in care homes. It is 685,000 people nationally, which is half the workforce, but they have been largely ignored.

Chair: We are getting very close to 11 o'clock. Barbara, Paul and Dean want to ask questions, so we have lots to talk about after 11 o'clock. I am going to suspend the hearing now until one minute past 11 in memory of the victims of the Reading terrorist attack.

The Committee observed a minute's silence.

Chair: Barbara Keeley has the next question.

Q91 **Barbara Keeley:** I have a couple of questions. Oonagh, we have heard a lot this morning about the lack of parity of esteem for care staff compared with the NHS. We have also heard about how care staff have stepped up during the pandemic, delivering end-of-life care in care homes and doing tasks previously done by district nurses in homecare. Professor Green touched on this earlier, but can you tell us how much is currently spent per head on training for care staff and how that compares with training for NHS staff?

Oonagh Smyth: It is quite difficult to do the comparison with health staff. As Martin Green said, the total amount, if you divide for social care staff per head the £11 million invested in the workforce development fund, gives about £7.72 per head for social care staff.

Q92 **Barbara Keeley:** That is a staggeringly low amount. What on earth could be delivered for £7.72 per head?

Oonagh Smyth: What came up quite a lot this morning was the sense of the need for more development and a clearer career progression for our care staff, not least because the roles are quite complex and very skilled. It will not surprise anybody to know that from the Skills for Carers perspective, as a workforce and skills body, we advocate better development of the social care workforce and more opportunities for career development. Given that we will need approximately 580,000 additional care workers between now and 2035, it is important that we start to invest in that and think about that now.

Q93 **Barbara Keeley:** That is a staggering figure that you just quoted. I do not think many people would understand how little is spent on care staff, when we are entrusting them during this difficult time with the tasks that I have just outlined. They are entrusted with end-of-life care for large numbers sometimes in care homes, when district nurses have stepped back and they are taking on those nursing roles in homecare. It seems unbelievably small.

Oonagh Smyth: It is probably important to point out that that is the amount spent from public money or from the Department. Employers

also invest in developing their own staff. We do not know what that figure is.

Q94 **Barbara Keeley:** But we can compare it with the public spend, which runs to billions; I think it is nearly £5 billion, as Professor Green told us earlier. On this issue, would registration or regulation of care workers help with the standing of working in care? We think it is very important, as we have covered this morning, to raise that standing. Martin Green talked about a professional salaried career in care. Would those be important aspects, do you think?

Oonagh Smyth: Skills for Care definitely supports increasing the value, status, recognition and trust in the adult social care workforce. Employers definitely tell us that they see benefits of registration as a way to achieve that. A recent study with our equivalent in Northern Ireland said that care workers feel that registration gives them more confidence. People are asking whether we should start with registered managers, as we heard this morning. I certainly think there are a lot of employers who would see the benefits of registration in having a defined workforce so that we can increase their recognition and value.

Q95 **Barbara Keeley:** Do Professor Green or Jane Townson want to comment?

Professor Green: It would be great if we had a proper approach to registering the social care workforce. I lament the demise of things like the graduate entry scheme into social care. There is a really good one in the NHS. We had an excellent one, which was part of the skills academy for social care, which then merged into Skills for Care. Again, we lost some of the funding for that. I want to nurture our next generation of managers.

We saw fantastic people in the first evidence session who are managing and delivering social care. We have to start really attracting people to build careers in social care. I would love to see the reinstatement of the scheme. We have a scheme, but it is a very small scheme compared with the NHS.

Jane Townson: As far as homecare is concerned, we believe that the long-term goal should be registration, but if that is done in the absence of the other measures that we have talked about this morning—adequate funding, a workforce strategy, clarity about skills and competence for different roles, and clarity about the training and national accreditation of training—it would be like putting an Elastoplast on your knee when you have a fractured neck or femur. It would be absolutely pointless, and you could end up spending a lot of money and time without getting the benefits that we need long term from developing the workforce in the way that we have described.

Oonagh Smyth: Jane is right. That is not where you would start. It might be where you would end. We need a package of interventions that

improve value, recognition and support for the adult social care sector. Registration is not where you would begin.

Q96 **Barbara Keeley:** Care providers have taken on additional responsibilities and still have to take extra precautions for infection control, and are spending much more on PPE in a lot of cases. This is a question for both Professor Green and Jane Townson. By how much do you estimate those extra measures are increasing costs? Are care providers receiving funding from councils to cover those costs at the moment?

Professor Green: Certainly we are talking of hundreds of millions of extra pounds spent on this. I commend the Government on some levels. They have put enormous amounts of money into social care, but they have put it in the wrong place. Social care providers have not seen the £4 billion that has been invested. Local authorities in many areas have not transferred that money. We have the infection control fund, and now we have seen endless amounts of bureaucracy associated with it. That is causing some serious issues. We heard that from our first group of evidence-givers this morning.

In terms of where the other money has gone, it has not reached the frontline of care. There are some tough questions that need to be asked, first of all, to local authorities as to where that money has gone; and, secondly, why the Government constantly obsess with putting money through a flawed mechanism. Local authorities are not a good way to deliver money to the frontline of care. After this pandemic, we need a long, hard look at what is local and why some things are seen as local; and about the performance of some local authorities in relation to how they have supported care providers.

Jane Townson: In April, we did a piece of analysis through an independent consultancy. They helped us to calculate that the additional costs of Covid-19 for homecare worked out at £3.95 an hour extra. I spoke earlier about our UKHCA minimum of £20.69 an hour, so that is on top of that. We are only seeing £17.20 median coming through.

On the additional funding for Covid-19, in the Public Accounts Committee yesterday Katherine Francis stated that only £500 million of the £1.6 billion that was given by central Government to local government has been spent, according to the records that are being sent back to central Government. It is an absolute travesty. We have one week until the end of June, and our providers have no idea whether the extra funding for Covid is still coming. It is driven mainly by PPE costs because we have to use face masks and eye protection that we do not normally use, and the unit costs of those items have gone through the roof.

Q97 **Paul Bristow:** At the risk of the witnesses repeating themselves, I want to clarify some of the things Jane said. Professor Green might want to comment as well. Jane, would you say that local authorities are not effective commissioners of homecare services?

Jane Townson: We have to see it in the context of central Government funding for local authorities, which has been cut dramatically over the last 10 years. They are trying to make their budget fit. They cannot do what the NHS does, which is spend with impunity. They have to balance their budget. What they have done to try to do that is to commoditise care. They treat care workers like commodities to be passed from one provider to another, through contracts beginning and ending. They also treat clients in that way, because people bid for work through procurement portals.

I think that is such an incredibly wrong-headed way of going about the health and wellbeing of our nation. I want us to think more about the impact on our economy of our health and our wellbeing, and to invest properly so that we come away from time and task, paying by the minute and treating care workers and their clients like commodities.

Professor Green: I absolutely agree with what Jane said. One of the problems has been, for example, that Governments are absolutely steadfast about not saying that they will ring-fence certain things for social care. There is a vastly disproportionate amount of money between health and social care. I made the point earlier about the health status of most of the people in social care. We need to see some transfer of money across the system.

There are some big issues that we need to look at. First of all, we need to look at commissioning. As Jane says, it is not fit for purpose. It is all about transactions; it is not about outcomes. It is not about showing that we are delivering things that help and support people. There is no incentivising people to make sure that they are as independent as possible. In fact, we have a deficit model; you get more money depending on people's dependency, and not independence. We need to look at that. We need root and branch reform.

There is an obsession in politics with localism. That is all well and good, but it needs to be justified. The notion that somehow Covid is different in Halifax from how it is in Hertfordshire is ridiculous. If there is to be localism, I want justification for why localities are doing things differently. It should be based in the demographics, in the social make-up of their citizens and so on. We have left far too much to laissez-faire approaches to localism.

Q98 **Paul Bristow:** Jane Townson, you said earlier that some councils are charging as low as around £15 an hour, which suggests that they are commissioning on price rather than value. At £15 an hour, obviously some providers are taking it up and are providing a service for that low cost. What is the consequence of that?

Jane Townson: It is important to recognise that councils are monopsony purchasers, and they effectively coerce providers into bidding at those rates. Providers cannot collude with each other, and they fear that if they

were to bid higher, at the UKHCA minimum price, nobody would win any contracts.

That is not the right answer. The workforce and the people who receive care are the ones who suffer. People talk endlessly about the workforce, but we never see anything addressed. I tell the Care Quality Commission all the time that the biggest driver for quality in homecare is the commissioning practice.

We have worked out that the national minimum wage of £8.72 an hour, plus statutory employment on-costs—pension, national insurance, sick pay and holiday pay—comes to £14.89. Some councils are still purchasing care at £14.41 an hour, and we are condoning that. Central Government are condoning that; local government is condoning that. How can that be right? It is not even a legal level.

Professor Green: Jane is right. We should have some oversight of commissioning; the Care Quality Commission or somebody should be overseeing commissioning. Commissioning is one of the biggest influences on quality and outcomes.

Chair: I had many battles on that, Martin, when I was Health Secretary and I am afraid I failed miserably, but I could not agree with you more.

Q99 **Dean Russell:** This question is for Jane and Martin. We have talked a lot about the bureaucracy, the challenges, localisation and all of those things. It seems to me that during the Covid crisis one of the things that has shone through is the fact that getting rid of a lot of red tape has made an awful lot of difference. The idea of a single-patient view in the approach of how we look at health, social care and all of those things is really important.

I am interested to get your views on this. If you had the choice now to say, "Look, from now on we are going to cut two or three bits of red tape that have been around for a long time," what would they be?

Professor Green: I am preparing something that I will send to your Chair and Committee. It is about all the things that have changed in Covid that we must not let slip back. One of the things that has been brilliant, despite the fact that there have been challenges around testing and so on, is the discharge from hospital process. It used to be endlessly complex, with arguments between the NHS and social care about who was going to pay for what. We have managed to get through that, and now people are just being discharged. There is an agreement that they will be assessed after discharge, so it is a discharge to assess process. That can be so powerful in terms of how we deal with things like winter pressures.

One of the biggest challenges in social care, particularly residential care, will be occupancy levels. I have put forward some proposals that the NHS might like to guarantee occupancy levels in care homes. This would enable them to have access to some beds. When we get past the

pandemic, we will see a huge backlog in elective surgery. What we could then see is people having their surgery and going straight into a care home for convalescence, reablement or the time before they go home, getting some treatment and support in that service. That would kill two birds with one stone. It would make hospitals have a much clearer pathway, and it would give care homes money that would sustain them through the blip that the pandemic has delivered around occupancy. Occupancy is very much pivotal to the sustainability agenda.

There are some important things that have happened in this pandemic. Likewise, there are some of the ways in which care staff have stepped up and delivered services that used to be delivered by a whole raft of other parts of the system. We could consolidate that, acknowledge it and make it part of the funding process. There are lots of things that have been positive. What we must not do is slip back to the previous point.

Jane made a point earlier about technology. We have seen the use of technology. We have seen, for example, GPs doing what might be described as virtual ward rounds. We have seen technology being used as a fantastic support; for example, we have loads of care homes on NHSmail. That is a good way of transferring information so that people know who they are dealing with when there is a transfer from one system to the next. There are some really good things, and we must all now use our particular positions in the system to make sure that we do not slip back to where we were and that we use this as our platform for change.

Chair: I am sorry to move everyone along, but we have oral questions at 11.30. Laura Trott has some final questions for the panel.

Q100 **Laura Trott:** Oonagh, you mentioned an important statistic earlier, which was that we will need an extra half a million jobs in the care sector by 2035. What do we need to start doing now to prepare for that number of people coming into the workforce?

Oonagh Smyth: It is everything that we have spoken about today. We need to change the narrative around care and help people see what a valuable and rewarding role it is. We need to think clearly about career progression and the steps we can take, and how we can start that now with people coming through the education system. We need a long-term, sustainable plan for the social care workforce.

We need to be cognisant of some of the impacts of Covid on the existing workforce, because that figure was calculated before Covid. We do not know whether it has increased and whether we are going to lose experienced staff. We know that care workers have been much more likely than the general population to die during Covid. That is bound to have an impact. We need to start planning for some of that now.

We need to realise that the social care sector is a significant contributor to the economy. It contributes £40 billion a year, and we need to start seeing it as a significant sector, employing 1.5 million people, supporting

1 million people a year and contributing a significant amount to the economy.

Q101 **Laura Trott:** What would the immigration system that supports that number of new staff look like for you?

Oonagh Smyth: Around 17% of the current workforce are not British. Within the current rules the average salary is going to be lower than the threshold in the new immigration rules, and care workers are not classed as a shortage occupation because they do not meet the qualification threshold.

My concern is that social care and providers are going to have to navigate the uncertainty of Covid in an already fragile state without a long-term plan or a long-term funding settlement. If there is an additional limitation around ability to recruit from outside the UK, I worry about the fragility. There is a lot that is unknown with Covid. Having some flexibility in the social care sector would be helpful; 85% of organisations in our sector are small and medium enterprises with fewer than 50 staff. If they find it more difficult to recruit, it will be a significant challenge for the sector. A little bit more flexibility would be welcome.

Jane Townson: They could start by putting care workers on the shortage occupation list.

Professor Green: One of the things about social care is that we are a 24/7, 365-day service. One of the things we could do is to attract people who are currently not in the workforce and who have the great values that would support social care. They might have, for example, other caring responsibilities. If we could make sure that they are enabled to work—maybe not full time; it might be very part time—they would bring a contribution.

We also have to look at the diversity of the workforce. We support people from every walk of life and from every minority community. We need to reflect that in our social care workforce. There are some big issues around how we make sure that the flexibility of the social care workforce is appropriate to the diversity of the people it serves, and that we make sure that we offer and give opportunities to lots of people who are currently a bit excluded from the workforce.

Jane Townson: In homecare, the structure of the system means that we cannot use the workforce that we have efficiently because the volume is fragmented across numerous small providers. You often get five different care organisations all in the same street, in the same town at the same time. There needs to be a think about how the market is shaped going forward to make the best use of the workforce we have.

Laura Trott: That is very helpful; thank you.

Chair: Thank you all. That brings this morning's session to a close. We have had a fascinating and very important session. It feels like a session

where we have been shining a spotlight on an area that is not talked about nearly as much as it should be, but where there are some very profound issues that have come to light during coronavirus. As Professor Green has just said, we need to put things right for the long-term future, as well as just fixing the short-term pandemic issues.

On behalf of this House of Commons Select Committee, I want to say a very big thank you to Martin, Oonagh and Jane for their very powerful evidence this morning. We will, of course, reflect very closely on what you have said in the report that we are hoping to publish around September time. It will be very helpful for us in that respect.

Thank you too to the technical team in the House of Commons for making this morning happen. Thank you to Laura Daniels and all the Select Committee Clerks for their work in preparing for this morning's session.