Communities and Local Government Committee

Oral evidence: Adult Social Care, HC 47

Monday 23 January 2017

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Watch the meeting

Members present: Mr Clive Betts (Chair); Rushanara Ali; Helen Hayes; Kevin Hollinrake; Julian Knight; David Mackintosh; Melanie Onn; Mr Mark Prisk.

Questions 287-359

Witnesses

I: Larry Gardiner, Isaac Samuels, and Anna Severwright.

II: Heather Wakefield, National Secretary for Local Government, Unison, Sharon Allen, Chief Executive, Skills for Care, and Clare Jacobs, Employment Relations Adviser, Royal College of Nursing.

Examination of witnesses

Witnesses: Larry Gardiner, Isaac Samuels and Anna Severwright.

Chair: Good afternoon and welcome to this evidence session for our Committee's inquiry on the financial sustainability of social care and the quality of care provided. You are very welcome; thank you for coming. Before I pass over to you, I ask Committee members to put on the record any interest they have with regard to this inquiry. I am a vice-president of the Local Government Association.

David Mackintosh: I am a Northamptonshire county councillor.

Q287 **Chair:** Those are our interests, which we have put on the record. Could you say who you are and whether you represent any particular organisations? I will go round the table.

Isaac Samuels: I am Isaac Samuels, and I am here as someone with a lived experience of both health and social care services.

Larry Gardiner: My name is Larry Gardiner. I don't represent any organisations, and I have a lived experience of accessing local authority services and health services. I apologise in advance: I'm as crazy as a box of frogs and have terrible memory, so you might have a few difficulties

with me. I've got something called mild cognitive impairment, which is basically a form of dementia.

Anna Severwright: My name's Anna Severwright. I'm here as someone who uses social care. No organisations.

Q288 **Chair:** Okay. Thank you for coming this afternoon. Anna, I think you came to our roundtable discussion last week, didn't you? Isaac, I think you came, as well. You didn't, Larry. Two of you have met us already in a slightly more informal setting; Larry, it is your first time.

Our intention is simply to ask some questions, because we want to give you the opportunity to tell us your experiences and the things that are important to you. This is not a cross-examination; we are not trying to trip you up in any way. We are merely trying to get things for our information, because in the end, we produce a report based on the evidence we have, and we must not forget at any stage that the people who are receiving care, or not receiving care in some cases, are the most important people in this inquiry. That is why having you before us today is really important: for us to find out what you want to say to us.

Perhaps I could ask for a bit of information to begin with. I would like the three of you to answer this, in whichever order you decide between yourselves. You get care support: some from local authority-funded care; some you probably buy yourselves; and some you get from friends and family, on an informal basis. Could you give a bit of an indication to the Committee how that split occurs—how much you get from the authority, how much you buy yourself, and how much your friends and family give you?

Isaac Samuels: I receive 17 hours of funded support from my local authority per week. It is flexible. I have a fluctuating health condition, so my support varies. Throughout the year, I might need more support at particular periods of time. Initially, I was receiving fewer hours than that. I moved, I had an assessment, and it was deemed that I would need additional hours. I'm able to use those hours flexibly. I get the right level of support, because I feel that the support from my local authority enhances what I receive from friends and family.

Larry Gardiner: I moved from one local authority to another in about 2010. I have good days and bad days. I have a condition that is degenerative and for which there is symptom progression, which is being monitored carefully. I used up all my own resources; they are completely exhausted now. I had some savings, and they are gone. I used to self-fund a service that is provided by a local organisation called YoungDementia UK. I can no longer afford to fund that, so I do not receive a service any more. I do still get the higher levels of disability living allowance. I am currently awaiting a personal independence payment migration assessment; I do not know what the outcome of that will be.

Q289 **Chair:** What about the local authority?

Larry Gardiner: I now live in Oxfordshire. I was living in Sefton in the north-west of England.

Q290 **Chair:** Do you get help from Oxfordshire?

Larry Gardiner: I get 28 hours. I was receiving agency care. They were getting me up late morning and putting me back to bed at 5 o'clock at night, so that did not work. Now I have a personal assistant and direct payments. I have a bank of PAs. It is very difficult where I live in Oxfordshire to get PAs, so I make use of several on a sessional basis. It depends on the availability of people.

Q291 **Chair:** So you get the direct payment.

Larry Gardiner: Yes.

Q292 **Chair:** And you choose how you use that?

Larry Gardiner: Well, there is a care plan, so it is within the context of a care plan. The money that I use is pretty much used to discharge the elements of the care plan. If I want to do anything different from that, I have to pay—and it is limited by my ability to pay now; I no longer have any other additional income.

Q293 **Chair:** On the care plan and the people who are employed, do you employ them yourself, or are they provided by the local authority?

Larry Gardiner: I employ a main care assistant, whose name is Ildiko. She is with me today. I had two others, Tricia and Jabu. Jabu has just got a job—she could not live on the money—and I am now looking for somebody else. There is a vacancy, if anybody is interested.

Q294 **Chair:** Does the local authority help you with the responsibilities of being an employer?

Larry Gardiner: Yes. When I was receiving a package in the north-west of England, I had to manage PAYE and national insurance. That was a very irksome and onerous task. I did not do it very well, so I often had people chasing me if I hadn't remitted something. I used to get into a bit of a muddle with it. In Oxfordshire, they have got a payroll service for my direct employee. It has been outsourced to a voluntary sector organisation. It is kind of mocked up in the area of running payroll services. They have taken over several other payroll services and have just rebranded themselves and become quite a corporate entity.

There was something else I wanted to say about that. For the sessional workers, the only time that I can really afford to pay them is if an organisation at which I volunteer is prepared to fund them. I volunteer with the Social Care Institute for Excellence co-production network. They have a policy for compensating us for our time and they also pick up expenses, which enables me to employ sessional workers. Otherwise I would be turning into a cabbage and getting square eyes and a headache every day. They get me out of the house.

Anna Severwright: I receive 23 hours of care from my local authority as a direct payment, and I employ two PAs at the moment. I make a small contribution to that myself, but the rest is funded by the local authority. I do not buy any more care than those 23 hours, and I do not really have

any informal care, because I live by myself; my family are 100 miles away, and although I have friends, I certainly would not want to be calling on them to be doing any caring responsibilities for me.

Q295 **Chair:** Do you employ your care workers directly?

Anna Severwright: Yes, I employ them myself. Like Larry, I have a payroll company that the council uses, but I have to chase them a lot. They make a lot of mistakes. I still have to pay all the tax and things. They tell me how much tax to pay, but I still have to do that. There is not much support from my local authority if I have an issue with a PA; I am kind of left to sort it all myself. It has been a steep learning curve in how to be an employer, because I had never done that before.

Q296 **Chair:** You get help from the local authority. In recent years, has the level of funding you get reduced while your needs have stayed the same, or have you found that your needs have increased and the funding has not increased to match them? Tell us your experience.

Isaac Samuels: Although I feel that my level of care and support is right for me, I am conscious that it is right because I have had to mitigate the shortfall in what the local authority provides. I use friends and family to offer that care. When I have approached the local authority, or it has been identified that I need some more support, it has not been available, and that is a really stressful process to go through, so for me it is much easier to rely on friends and family. However, that does create some challenges in itself, because people stop being friends and become advocates, and you lose all the stuff that friends and family do. It builds a false sense of relationships, which are based on me requiring care and support at particular times and them doing it because they care about me. It is not them being a friend or a brother or sister; it is them being a PA when they shouldn't have to be a PA.

Larry Gardiner: This whole area is a bit of a mess in my life, and my needs have changed over time. My local authority where I lived previously would do an annual review. They would really check to see whether there had been any improvements that had reduced the level of support required, or whether there had been any changes in circumstances that had increased the need. They did kind of titrate things upwards and downwards along the progression of my illness.

I recognise what Isaac said. First of all, friends tend to burn out if you lean on them. All the best will and love and affection cannot really make up for the fact that there are more things that need doing than there are people available to do them in my life. I now live alone. At the onset of my illness, I was in employment, I was married and I had three school-age children at home. During the progression of the symptoms, my marriage has ended and my children have grown and flown and are now scattered to the four winds. Some friends have stuck with it—and struggled, to be honest.

The other thing that has become a bit of an issue and that I have to pay attention to all the time is that it is very easy to imagine that my PAs, who

are my employees and for whom I have a duty of care—they are not my friends, but relationships of friendship and bonds of affection do grow. The carefulness has to be in not asking more from them than what they are actually paid to do. I think that people who enter this profession of providing care do so with a sense of vocation and service, and a desire to make a difference, change things and be of service, and I have to be mindful of not taking that for granted, and certainly not abusing it. It is a messy place to go, this, it really is. Families burn out; carers burn out. That was the situation that sort of precipitated me into social housing and living in sheltered housing.

Anna Severwright: I started receiving care in 2012, and I received 17 hours. I wasn't reviewed for three and a half years; I was meant to be annually reviewed, but because I was worried that they would try to cut my hours, I didn't remind them of that fact. I was reviewed last year and my hours were actually increased to 23, but in those three and a half years I had deteriorated a lot—a lot more, I think, than what the hour increase met. I could have done with a bigger increase, I felt, but I was just relieved that they weren't trying to cut any care.

Q297 **Chair:** So your needs are more than your actual funding?

Anna Severwright: Yes, I would say so.

Q298 **David Mackintosh:** Are you concerned about the sustainability of your funding?

Isaac Samuels: I am always conscious of whether my package is sustainable. We have had the Care Act, and things are supposed to be focused on wellbeing, not on crisis and delay of more care and support, but how does that really look at grassroots level? We have social workers making assumptions about the kind of care and support you need who do not necessarily meet you. There are so many changes within the social work team; how can someone ever make a fair assessment of what you need? You have somebody coming out once a year.

I had a reviewing officer who came out, and it was my social worker who stopped the process. The reviewing officer was making lots of assumptions and ticking lots of boxes about the care I needed, not based on what was known by the social worker. You have processes that are not joined up, and I worry about presenting a picture of what somebody needs to a panel that makes a decision, when that information is not accurate. For me, it is always really important that I have support in articulating, because I am not always able to articulate the challenges I have around my social care.

Also, this is based on what other people say. I never imagined that I would be a care co-ordinator, but it is really important that I ensure that all the consultants and the people involved in my care have a way of feeding in. It is not joined up at all. You have a reviewing officer who comes around once a year and asks you a set of questions, which are basic functioning questions that are closed and don't give you a snapshot of someone's life. If you have a fluctuating health condition, as I do, it may not be accurate to put things in that kind of way. I am always

conscious when I have these reviews that I have the right support, that the people who should be there are there, and that they are done at a time when I am able to articulate, or have that support.

I also mindful that I have recently been in the process of having health professionals and a care professional—an OT—making a recommendation, and the panel, who have never met me, made a decision to provide something that is £500 cheaper. I now have to trial a product that is not going to work and is wasting my time and the professionals' time just to please a panel. It has all been a game of aligning what you need with the people who can support you in that, and sometimes your voice gets lost within that. I am really mindful that most of my peers have either had a dramatic funding cut or have lost their services, so I am conscious that I also have to be mindful that that is possible.

Larry Gardiner: Unfortunately, I echo some of those remarks. There is a protocol and a process for moving from one local authority to another, so it should be quite a slick procedure, but I don't think my local authority kept to that when I arrived where I live now. It decided eventually that it would do another assessment. It sent somebody to carry out that assessment who had a gizmo and was just ticking boxes on an electronic form and asking me questions and then providing her own answers.

The care assistant who was present with me at that time, a young man, was driven to use some colloquial English, along the lines of, "Oi, mate, I need a little word with you." He took the social worker aside and an altercation ensued. My personal assistant was getting really upset by the behaviour of the social worker, so eventually I said, "I think you should leave; maybe send somebody else." That was the best I could think of at the time, and I only really did that because I felt I was pushed into it.

The result was that nobody came near nor by for a very long time, and I struggled for a while to function without support. The person who had been working for me provided his services voluntarily for a period, because there was no cover and he wouldn't leave me, which I don't think should have happened. It shouldn't be this difficult.

I didn't know what to do next. I asked for help. I phoned up people; they have a central point of contact. I asked for advice, and they said, "Why don't you try to find an advocacy service?" They signposted me. I didn't really know what an advocacy service was at that time, but I approached them and found an advocate who ensured that the process that should have been followed was followed, and who helped me to articulate what I thought had gone wrong with the first visit from the social worker.

I made a mistake: the manager of the social work service doing the assessment asked me if I wanted to make a complaint. That was a really big mistake because it wasn't possible to talk to anybody after that. They kind of closed ranks, and there was a process that went through that didn't really resolve anything. It wasn't until that process was finished that they would get on and do my assessment, which I think was wrong as well.

sOn the sustainability of this for local authorities, I suppose, in a way, what doesn't kill you makes you stronger. Since those experiences, I have decided to take more of a hand in things myself. Every time I look over my shoulder, I see somebody else struggling with the same issues, so I trained and became a citizen lay advocate and worked for the advocacy service that had helped me, and subsequently became a trustee. I stepped back from that role after three years as a trustee, and I'm now on their advisory panel. In that capacity, I met the cabinet member in the local authority who is responsible for adult services. Reading between the lines and paraphrasing a lot of what has been said in those conversations, my local authority will only fund something for which there is a statutory duty. Anything that falls outside those quite narrow parameters is now unfunded. Services that I was receiving now no longer exist.

I live in sheltered housing, for which there was a visiting service. Originally, the building was built as sheltered housing; it had amenities, a warden's flat and—sorry, I'm struggling with this. The warden's flat was converted into another room. We have a lounge and a kitchen, which are no longer used because we don't have staff. We had a bath with an electric bath hoist, which nobody can operate because nobody has been trained and nobody is insured. So I live in a building with lots of amenity, but with no service—with no actual, tangible support for residents—and the result of that has been that, in the last year, I have lost five of my neighbours. Now, old people die and sick people die; it is expected that people in sheltered housing will die, but there are 20 units where I live and, in the space of a year, I have lost Kath, Michael, John and Chris. There's another one; there are five of them, but I can't remember the other name—Dorothy. To lose 25% of my neighbours in one year is absolutely unprecedented. I am not a doctor or anything else, but I knew these people very well. They were my neighbours, and I spent a lot of my time—probably most of my time—among my neighbours. Some of those deaths were expected and anticipated, and some of them probably were a release, but there were others that I think were premature, unexpected, and for which there should be an investigation, and there hasn't been.

Chair: It is obviously extremely upsetting to have gone through that experience. Anna.

Anna Severwright: Yes, I am concerned about the sustainability of both my care and social care in general. I know that in my local authority, which is Leicester, they have already had to make £100 million of cuts and they have to make another £55 million. Obviously, that creates a lot of pressure. Like Isaac, I know people who have had their care either stopped completely or drastically reduced, and I consider myself quite fortunate.

My main worry is not about whether my quality of life will improve, but that if my condition gets worse—I don't know what is going to happen in the future—the care won't increase to even be dignified. I know of local authorities where, if you need assistance going to the toilet at night-time, it is now legally acceptable for them to just say, "Well, use incontinence

pads," even if you are not incontinent, because you can't have a night-time carer. I don't need that, fortunately, at the moment, but that is a fear for me: if one day I needed that support, would it actually be provided in my own home, or would I end up having to go into some sort of institution—I don't know what the right word is. That is my main concern.

Q299 **Mr Prisk:** Could I look at some of the aspects beyond the immediate and very important central personal care questions? To be fair, Mr Gardiner has been very full in his answers, so others may want to lead on this one. Does the money you currently get really enable you to fund activities beyond personal care—volunteering, a social life or something of that nature—and, if it does not, what impact is that having on you? We are aware of the wellbeing rules and requirements under the Care Act. They are all very well, but what if the money doesn't enable you to do that? I am just trying to explore the issues beyond the most core issues of personal care, looking at volunteering, learning and education and that sort of thing.

Anna Severwright: I would say it does not promote my wellbeing. Certainly, the assessment that I have had has been focused on practical things. I am very grateful to social care; it keeps me clean and fed, and my flat clean and tidy—the practical needs are met—but my wellbeing was not really raised in those assessments. I had to say, "I would like to do this," or "I would like to do that." Then I stopped, because I felt like I was asking for too much; that was the kind of reaction that I got. I had to limit it in some way.

I get six hours a week for socialisation, whatever that means. That has to include my food shopping; my hospital appointments, which average one a week; going to church and going swimming if I want to. None of those things can be done separately. They don't get covered otherwise. By the time you have done that, there is no socialisation left. There is certainly no flexibility if a friend suddenly rings up and says, "Do you want to go here?" "Sorry, I've used my hours."

You try to get on, don't you, and to make the most of the situation? I find myself having to make choices sometimes. There will be times when I think, "I want to go here, so I won't have a shower or cook a meal that day with my PA. I'll use the time to do the socialisation aspect." Otherwise, you become extremely isolated, and that is quite depressing. It is hard not to feel—I am a 31-year-old, and my friends who were in university with me are all out doing all these things. My life looks extremely different from theirs. It is a lot emptier, in a way. Yes, the practical things get done, and I am looked after well, but it does not feel fulfilling, and if I ask for more of those sorts of thing, there is no funding there. They have to meet these other needs, which are prioritised over what you want to do in your life. That is my experience.

Q300 **Mr Prisk:** Thank you. Is that something you share as well, Mr Samuels?

Isaac Samuels: My experience and that of my peers is that there has definitely been an agenda by local authorities to use the words "wellbeing"

and "socialisation". However, the reality is that no one's packages have been amended to include any social aspect, so after you have done everything you need to do which is practically based, there isn't any money or support available. We have care plans that talk about wellbeing, prevention and social aspects, but in reality, people are not able to do any of that, because they are not even able to access their basic needs.

For me, there is a real disparity between what a local authority says they are doing and what people actually experience. The language being used at the moment is "wellbeing" and "outcome-focused". That does not mean anything to people if they have to wake up every day, consider what their challenges are on that day and then make decisions such as "If I use two hours' support here, I won't be able to do what my friends and family want me to do or attend family events," or "I need to go to the hospital four times this week, so that means next week I'll have to have four hours' less support." That is the reality for me and for lots of my peers.

I get really upset when people say, "Would you like to do something around social inclusion?" I have never felt as isolated as I do. I live in my own home; my own home is becoming more like an institution. I have support, but there are periods of time when I feel really isolated and need that additional support, but it is not available. For me, it has been really detrimental, and it has had a massive impact on my mental ill health. I think lots of people with care and support needs often struggle with it.

The practical stuff is amazing—I am grateful to live in a country where we have that system—but sometimes I feel like the product of a system that is just about functioning: dress, wash, eat, but nothing about wellbeing or relationships. The hardest thing is, being somebody who has hopes, dreams and aspirations, you have to sometimes say to yourself and the people around you, "That's not possible," or, "It's going to take me longer," or, "I need to do it in a different way." I feel that all my milestones have been slightly delayed because I have had to think about doing them in a different way or there has not been the support.

Q301 **Mr Prisk:** Can I look at this issue of care plans? I think that both Mr Gardiner and Mr Samuels have mentioned it. One of the things that we have been exploring is how realistic it is that people have a real choice in the nature of the support they get. While there are well-intentioned aims set out in all sorts of legislation that we get involved in, the reality on the ground, which many of us see as constituency MPs, is very different. I am interested to hear from you how, in practical terms, you are able to exercise that choice—that control, if you like—over the support you get.

Anna Severwright: I think that choice is not true choice. There are choices, as long as it fits within the system or within their boxes. I feel like my life is a unique journey that doesn't fit into any boxes, and nobody else has ever done it before, so my care needs to be truly unique. I would like it to be that somebody comes out and says, "So what is your life about?" and then, "How do we fit the care to that?" and not, "Okay, this is what we do." Often—usually—they are used to working with more elderly people and certainly, with some of the questions I have asked it is, "Oh, I'll have

to go and find out." It is as though I have asked to go to the moon and back; actually, it is just what I consider a perfectly normal thing for a 31-year-old to want to do. I have almost stopped asking questions, and now just do stuff, because if I ask they either say, "We don't know," or, "I don't know if you can do that." I just think, "I'm just going to do it," until someone tells me—"You can't do that anymore"—to stop.

One thing I would say is that, in Leicester, I asked a couple of times whether there was any involvement of social care users in the planning of the services. Nobody has been able to tell me that there is any; they have all just said, "I don't know," "I'll find out," and, "No, there isn't anything." If services were co-produced with the people using them, you would get better value for money because they would actually be providing the service people want. People know what they need to stay well and to stay part of society. That would help, as well as individuals' choice over their care, in planning the services.

Q302 **Mr Prisk:** Thank you. Mr Gardiner?

Larry Gardiner: I am at least 30 or 35 years older than my colleagues. I think that social care was designed for people of my age and older, largely. It is clear, from what I hear and what I know—these young people are the same age as my own children and I know, from the lives that my own children are able to lead, that the system that we have is not currently configured to meet the needs of younger people with impairments, long-term illnesses and disabilities.

I didn't expect to get ill. I worked and enjoyed working. My care package is simply written to keep me hydrated—fed and watered—and hygienic. It doesn't go beyond that and it hasn't been reviewed for a long time, so the intention of Parliament in more recent legislation wasn't included in my care package. I still work as a volunteer and I pretty much work every day, but what is written in my care package doesn't cater for that, so I largely volunteer in organisations where they are able to pick up some care costs and then I can employ my sessional care workers to accompany me. Particular difficulties that I have are to do with memory, orientation and organisation. I get lost really easily and tend to ramble a lot, so please jump in if I am doing that.

Q303 **Mr Prisk:** Don't worry. I think we are all used to each another doing that, so I wouldn't worry too much.

Larry Gardiner: The difference is that my brain cells are dying at faster rates than for people with an age-related memory or cognition problem, and the progression is faster—faster than I anticipated and faster than I have been able to plan for.

There was a reference to continence aids. I had three episodes of acute surgical treatment, which resulted in the re-plumbing of my insides. I used continence promotion supplies for a very long time. I manage to cope without them providing I manage my life so that I don't hit an emergency, so I am never far from a toilet, and I know where they all are.

A particular thing—around eating—happened when services were removed from where I live. You will probably have heard from other witnesses that cooking and catering for one is difficult to manage, and buying food in small enough quantities is also difficult. When there is a mobility impairment, getting to places where you can do that is a problem. In my care plan there is no provision for help with shopping or with keeping my environment clean. That is not written into my care plan. When I had agency carers, they were just 15-minute flying visits to get me up, make a cup of tea and park me in front of the telly, then to hoover me up, dust me down and pop me into bed. Having direct payments has enable me to negotiate with my personal assistant. What I will tell you about all of them is that they do far more than they really should be doing, and I could not cope without their good will.

Isaac Samuels: I do think that receiving a direct payment offers me a certain amount of choice. For me, everything that I spend in terms of my care is driven by my needs. However, it is really interesting that the choices that I have are limited and that the local authority does not support me to be a good employer or with different options. If I relied on the local authority—I tend to rely on people who have access services and third sector organisations to support me when I have had challenges, and it has not been the local authority. So I think there is choice, but it is limited. I am grateful that I receive this direct payment because it is the way that I can get the services and the support that I need. I am just conscious that every year, to be a good employer, you have to increase the wages of your staff, who are entitled to certain things, such as a pension and all those kind of things. That is not funded, so for me, I am conscious that although I have choice about who I can choose, am I able to be a good employer? That is challenging at times because my choice is limited. Am I able to access different services? I think that is really challenging because the local authority is not providing some of the stuff that makes that possible, such as advocacy or independent support. User-led organisations have been a real asset to me and my support networks.

What is really interesting about choice is that most of us don't have to explain why we choose something. In adult social care, you are told that you have choices but you have to explain them. In any other part of my life, if I make a choice—I don't have to explain why I have chosen a cappuccino versus coffee. In adult social care you have to justify your choices, and often people like myself who have mental health challenges are deemed as people not able to make choices. I think that with the right support anybody can make the right choices; you just may need additional support.

Anna Severwright: May I add something? You said "can make the right choices"; actually, I should be able to make the choice I want whether it is deemed right or not—to a degree. I understand that the authority can't assist me in doing something that will actually cause me harm but, actually, at my last assessment I was discussing the care plan and the lady said, "Well, as long as you don't want to go to raves." Honestly, at that moment I thought, "If I want to go to a rave, why shouldn't I go to a

rave?" I have never really wanted to go to a rave, but how is it for her to say that that would not be an appropriate way to spend my socialisation—six hours? I think as adults with capacity we should be able to make "bad" choices as well as good choices—make choices we want.

Isaac Samuels: I agree—it is the right choice for the individual. I often think that we make choices based on the service. So I sometimes feel like I have to spin a yarn to actually get a package; and if you really make choices that are based on my hopes, dreams and aspirations, will you really be supporting that? I think that things like positive risk-taking conversations don't happen. Thinking outside the box rarely happens. So I think there's a process and you are part of a process and you learn to have choices within that process, because it's easier than talking about choices that may need some education, or maybe support staff or the local authority to have a different understanding.

Q304 **Rushanara Ali:** You have all mentioned the fact that you live independently—a mixture of independent and sheltered. Can you tell us whether you were able to make that choice and what obstacles you faced when you were trying to do that?

Isaac Samuels: I live in a wonderful community. Many people can't say they live in a really nice community. I live somewhere where I feel really connected to my neighbours. They really understand my social care and health challenges. It is really interesting: I feel that I am absolutely tied to where I live because I wouldn't be able to move anywhere else and have what I have; because it's taken me many years to build up what I need in practical terms. I have challenges sometimes around remembering to lock the door, so I have a mechanism that was provided that solves all those problems. All the technology that I have invested in and acquired over the years, to meet my needs, has been refreshing. I am worried that if I went somewhere else I would have to start again. I have had adaptations to my home, which makes it more complicated, as someone who lives in social housing, to move; because where would I move to? Would it be somewhere without those adaptations? There are few properties that are adapted. Also, for me it is really important that in my current home I have access to the services. I moved three years ago and it was really telling: the Care Act says that your care and support needs should be portable; however, I know that where I am you get funded for particular things and somewhere else you don't get funded. So it doesn't make it really easy to move around.

Q305 **Rushanara Ali:** Did you have access to the disabled facilities grant? What was your experience?

Isaac Samuels: I have had access to a DFG twice—in my old property and this property—and I would say that I have always struggled. The DFG has been a process that hasn't been person-centred, hasn't been about my needs, has meant a very costly adaptation that hasn't met my needs and hasn't been transparent. The thing that really annoys me about a disabled facilities grant is the amount of money that is spent, and the quality of service. I do not know anyone with a long-term health condition or care

and support needs who wants to make their home into an institution. I just think value for money is not there and there is a lot of profiteering via organisations and companies that have provided these services. I would like someone to say to me, "Well actually, if you had this money, what would you want to meet your needs?" That has never happened.

Q306 **Rushanara Ali:** You have all talked about the problems of gaps between services. In relation to that, can you say a bit more about housing versus the grant, healthcare and benefits? What was your experience of all those things in getting the solution you wanted?

Isaac Samuels: I can reflect on a pilot, "the right to control", which looked at people holistically and where you could access a number of different budgets. When I got my first disabled facilities grant, it was adult social care and housing, and everyone worked together. The process was frustrating because it was a pilot and no one knew how to do it. That pilot ended and the thing I am conscious of is that I never woke up with social care needs and decided I wanted to be a care co-ordinator, but I found myself having to be the person who pulls all the professionals together, the person who does all the research, the person who understands value for money, the person who is able to make a complaint. Where do I start just living my life? This is something that is supposed to help me, not make more work for me. I really struggle with the fact that housing talks a different language. No one wants to take responsibility; no one wants to be transparent.

Talking about public money spent on adaptations, I asked for a builder to give me a quote, which was a lot less than was spent on the adaptation and I could probably have got a better spec. The really challenging thing is that after the first year, it goes to the local authority or whoever your housing provider is if you don't own your own home to maintain it. They don't take responsibility so you end up spending a fortune on all the snagging issues.

Larry Gardiner: I had a disabled facilities grant award and I owned my own home at that time, when there was an unfortunate conjunction of things happening. I was assessed under the independent living fund and an award was decided, but unfortunately the independent living fund was scrapped shortly after the award was decided, so it was decided but never made.

I continued to use my own resources—savings and whatever I could scrape together—to self-fund the element of my care that couldn't be funded in any other way. The disabled facilities grant was about providing a downstairs bathroom in my home, because I was having to shuffle my bum up and down the stairs to get to the bathroom, which would take about half an hour in the middle of the night. I had some mishaps doing this. It was not ideal.

The specification of the amenity that was to be provided would be funded, but what would not be funded were other things, such as alterations in the house to make that possible, and I was asked to fund that from my

own resources, which I continued to deplete in paying for my care. So in the end, we did not take up the disabled facilities grant.

The amount of unfunded care got to the point where my marriage ended, and I became homeless for a while. I lived in a garage with an up-and-over door with my belongings, which were stashed there. How I came to live where I currently live—there was no choice at all. It was the only thing available.

Older people are disproportionately affected by lack of choice, especially if they go into social housing. There was a very long period of delay before it was recognised that the local authority where I lived were going to accept that they needed to house me.

Q307 **Rushanara Ali:** How long did it take?

Larry Gardiner: Three years. I lived in Ruskin College in student accommodation, and I did a course and got a qualification out of it. Living in student accommodation was infinitely preferable to living in an up-and-over garage, notwithstanding the noise and all kinds of wild carryings on, which I no longer have the energy for—or the inclination, actually.

Anna Severwright: I purchased my flat when I was a lot less disabled and probably did not really fully envisage ever becoming as disabled as I am now, but thankfully it is a ground-floor flat and my wheelchair can get around. I had an OT come out and provide me with some equipment. She basically just came out and said, "Well, we'll give you a perching stool and some rails." I didn't have the leg strength to stay on the perching stool, because they are sloped—I don't know why—so that was a useless waste of their money and my time.

I did then go on the waiting list for a DFG, because my shower was over my bath and I couldn't get into it. It took just over three years to get the DFG to get a wet room. That was three years without being able to have a shower, which felt pretty horrible at the time. I agree totally with Isaac: there was no choice in that process about anything. I kept asking, "What tiles will they be? What floor will it be?" You get no information at all. I really had to fight just to get told anything and to be able to make any kind of choices so it didn't look like a hospital wet room—because that was my real worry. Because of the DFG, I am not allowed to move for 10 years. I had to sign to say that I would stay in that property for 10 years, which I think is quite a long time, as a relatively young person—well, at any age, to be honest—to commit to staying in one place.

Q308 **Rushanara Ali:** So if you moved in that time, you would not get any further—

Anna Severwright: I would have to pay back the cost of the adaptations.

Q309 **Rushanara Ali:** Do you know what the cost of the adaptations was?

Anna Severwright: Not off the top of my head. Quite a few thousand, I think.

Chair: Thank you all very much for coming to give evidence to us this afternoon. We have really learned quite a lot about the practical challenges that face people who go for help for their social care needs—and beyond their social care needs to just their wellbeing, which ought to be addressed and often is not. That has been really helpful to us. Thank you for coming and sharing some very personal experiences with us. We appreciate that. We will go on to our next witnesses now; you are very welcome to stay and listen to them if you would like to.

Examination of witnesses

Witnesses: Heather Wakefield, Sharon Allen and Clare Jacobs.

Chair: I thank the second panel of the afternoon very much for coming. Before we hand over to you, we asked Committee members to declare their relevant interests at the beginning of the first panel session, but one or two members who are now present were not present at that time, so I ask for additional declarations.

Melanie Onn: I used to work for Unison.

Helen Hayes: Apologies for my lateness, Chair. I employ a councillor in my staff team.

Kevin Hollinrake: I repeat both of Helen's points.

Q310 **Chair:** Thank you for that. To the panel, could you say who you are and the organisation that you represent?

Clare Jacobs: I am Clare Jacobs and I am an employment relations adviser for the Royal College of Nursing.

Heather Wakefield: I am Heather Wakefield and I am the head of local government at Unison.

Sharon Allen: I am Sharon Allen and I am the chief executive of Skills for Care.

Q311 **Chair:** Thank you for coming. The first really big question is with regard to the social care workforce. We know the number of people likely to need social care is going to go up. Is the workforce currently expanding at the same rate, both with regard to the number of people needing care and the complexities of their particular care needs? Also, do you see problems in the future about the care workforce growing at a rate commensurate with the demands that are likely to be placed upon it?

Sharon Allen: I will start with that, because my organisation collects and analyses the data on the workforce. Between 2009 and 2015, the workforce grew by about 240,000 jobs—about 18%—which is about the same rate of growth as the population aged over 65. The projections are that we will need approximately another 275,000 people to join the workforce by 2025. We currently employ 1.43 million people doing 1.55

million jobs. By 2025, that should be around 1.83 million. Of course, some of that is dependent on advances in technology and, potentially, robotics. However, I suggest that we will always need people to provide person-centred care, as we heard articulated by the previous witnesses.

Heather Wakefield: We know that 40% of 85-year-olds and over are not getting enough help as it is. It is not simply a question of the number of staff to the number of people; it is about the quantity and the quality of care that they might get. There is a huge deficit at the moment and, as we know, a very high turnover of staff. With Brexit on the horizon, in some parts of the country there will be a particular issue if migrant workers, on whom we are dependent in some places in social care, are in some way forced out of care occupations. Some 6% of social care workers in England are EEA migrants—about 84,000—and 90% of those don't have UK citizenship. There is a particular issue around that, which will add to the pressures that Sharon has already described.

Clare Jacobs: RCN members tell us that social care is understaffed where they are working, and that staff often lack the right skill mix, as Heather just alluded to, and the right equipment to ensure that quality of care. They also report high levels of unmet need, which is creating greater pressure on the NHS. One of the stark figures for me is that district and community nursing has reduced by about 50% over the last six years. That will have a significant impact on the provision of nursing and healthcare in the community. As far as we are aware, there are about 50,000 nurses working in social care and the figure hasn't changed much over the last few years—it hasn't increased.

Q312 **Chair:** Right. I suppose this is a very simple question—a naive one. If all the extra care workers are there, what's the problem? Why is everyone complaining?

Sharon Allen: They are not all there; that's the problem. The jobs are there but they are not all filled. We have 90,000 vacancies on any one day in adult social care. We have a recruitment and retention challenge and, in large part, we would suggest that that is because of the status and profile of adult social care. Many people, if they have not had personal experience of the sector, do not know what it is. If you compare that with the health sector, when people talk about working in health most people have some kind of idea what that means. It is different in social care and, unfortunately, the media portrayal of our sector is very negative also.

I am absolutely no apologist for poor practice, and I want the brightest light shone on that. The trouble is that that is not what happens most of the time, day and night, with dedicated people—as you have heard—going above and beyond what they are paid to do. But we do have a challenge with the level of vacancies and, as Heather said, with the number of EU non-British nationals in the sector, if they are not able to stay.

Q313 **Chair:** We will come on to pay and conditions in a minute. Is there anything else to add at this point?

Heather Wakefield: I would like to say that there was no mention in your questions about the impact of privatisation. As we know, in the early 1990s, 95% of home care was provided by local authorities. It is now less than 10%, and we have some local authorities with multiple providers. There are eight local authorities with more than 100 home care providers. The employment picture and the attractiveness, or non-attractiveness, of the job have been significantly affected by privatisation, and there has been a toxic mix of cuts combined with privatisation that has impacted on the quality of the work—you said you were going to come on to the pay and conditions, so I won't mention them now.

In terms of its attractiveness as a job, it has become very poor quality employment in very many providers. I think that privatisation has to be looked at in that context, also because it means that a huge amount of public money is not being put to public use. It is being lost in profit margins, commissioning costs and, in some cases, extremely inflated salaries and so on for large company executives. It has had a direct impact, I think, on the care labour market.

Q314 **Mr Prisk:** We are obviously alert to the challenges within the workforce that you have just described. What difference does the new national living wage make?

Sharon Allen: It is too early to say, to be honest with you, in terms of being able to give you any evidence about trends. Anecdotally, what we are hearing from employers is that it is very difficult for them. It is a complex sector we are talking about. We always have to remember that there is a very private part of this sector, with self-funders purchasing their own care and support, that nobody knows very much about, but in the local authority commissioned sector many providers are reporting that their local authority has not been able to increase the commissions they are paying to accommodate the national living wage. They are also concerned about the impact in terms of a differentiation. Everybody supports raising up the pay of the lowest-paid workers. People would like to pay their staff more but they can only afford to pay what is in the commission, and then the differential to then move up to being a team leader, a senior or a registered manager becomes less attractive because the national living wage is driving up the entry pay.

Q315 **Mr Prisk:** Briefly, from an employer's point of view, however, if fulfilled financially, I am assuming that you would say that one of the critical issues about attracting the extra people you need, as you have just described to us, is a wage that is attractive and competitive.

Sharon Allen: Absolutely. On the other hand, what it does, because it is effectively the new minimum wage, is mean that we are just competing with the same people that we were competing with previously. In some cases, that has got more difficult with some retail providers, for example, saying that they are going to pay above and beyond the national living wage. As I say, most of the employers I talk to would dearly love to do the same; they just can't make the budgets stack up.

Heather Wakefield: It is probably not widely acknowledged, but in fact the national living wage is now the bottom rate of local government pay. I am talking about all local government workers directly employed. So the social care market is in competition with the local government labour market, too, for staff, and of course other major employers, for whom the national living wage is now the bottom rate.

I think that needs to be recognised because, while of course as Unison, we welcome the increase represented by the national living wage over the national minimum wage, it does mean that, as Sharon said, there is an equalisation, if you like, within the labour market across a much broader range of employers now.

That will make it harder for the care sector to attract staff because, as we often hear, people will leave because, they say, "I can go and be a supermarket checkout worker or I can work in a call centre." It is perhaps not as interesting or fulfilling, but it is certainly not as stressful, physically demanding or emotionally demanding. I think that will increasingly happen and the care sector will be under increasing pressure.

While we are talking about the national living wage, I would like to mention the fact that the estimate was that about a quarter of a million care workers were not being paid the national minimum wage. I think we can safely say that that is at least true for the higher national living wage.

That is because an awful lot of local authorities are still commissioning care without ensuring that travel time between visits is paid for. As a consequence, there are still many, many care workers who are not receiving the national living wage once their earnings are averaged out to take into account unpaid travel time.

We have done research as Unison that showed that 58% of workers in our survey were not receiving pay for travel time. When you look at local authorities' contracting practice, in our first survey, which was 2015, less than 25% of local authorities included travel time in their contracts. In our more recent survey in 2016, that is up to 35% including travel time.

That is actually a requirement of the Care Act. It is in the guidelines emanating from the Care Act that—at that time—the national minimum wage, now the living wage, and travel time should be paid. Of course, it is because local authorities have had their budgets cut by an average of 37%, with another £6 billion to be cut from local government by 2020.

As Sharon has said, it is not that local authorities do not want to commission for high-quality employment or that providers do not want to pay their staff well; it is becoming impossible. The social care precept has mostly not even covered the cost of the increase from the national minimum wage to the national living wage, let alone given commissioners more money to improve the quality of care or the amount of care.

Clare Jacobs: We think the national living wage could impact on staff retention. However, it's not enough to be commensurate with the skills

and responsibilities required by these people who are giving this care. We also think it's undermined by the fact that, even after the raise to it, workers are still dependent on benefits, even when they work full-time.

My colleagues have talked about the loss of pay differentials. So, a senior carer will get 20p an hour more than a care assistant and yet they are taking on greater responsibilities, particularly in terms of management and supervision. The age differential is also undermining it, so that those under 25—many of those are carers—receive less pay for doing exactly the same job.

Also, it still does not go far enough to recognise the skills and the investment that is required in training to take on those roles. What we'd like to see is the real living wage as the absolute minimum for anybody who's working social care, rather than the living wage.

Q316 **Mr Prisk:** Sorry, you want to see the real living wage, as opposed to the national living wage?

Clare Jacobs: Yes.

Q317 **Mr Prisk:** But you would like it applied across the picture?

Clare Jacobs: Yes—as the absolute minimum.

Q318 **Mr Prisk:** Right, but that would replicate exactly the problems we've just heard about from your two colleagues, which is that if it's applied across all local government—

Clare Jacobs: Sorry. I was referring to social care.

Q319 **Mr Prisk:** So that would only apply to social care?

Clare Jacobs: Well, that's the area that the RCN has coverage over, if you like, and healthcare.

Q320 **Mr Prisk:** Fine. Thank you. Ms Wakefield has given quite detailed views about the application of contact time. I'm keen to hear your view on this particular issue as to how widespread the practice is.

Sharon Allen: I can't actually give you evidence on that, because that's not something that my organisation collects through the national minimum data set. The data set is a minimum data set and that is not one of the things that we collect.

Anecdotally, however, I would say that it's quite a mixed picture. We talk to many, many employers and also to people who receive care and support, and they're also represented on the board of my organisation. I think that commissioning practice is quite varied across the piece and some commissioners are only paying for time spent with somebody. It's very difficult to see how people think that can work, because people are going in to visit somebody in their own home, and they then have to go and visit somebody else. Who pays for that? You can't ask the worker to do that.

There has been a lot of work done to try to address the issue around what people have tagged as 15-minute visits. I might be unpopular with my colleagues when I say that in some cases those short visits are appropriate, if you are only going in to do something like reminding someone to take their medication.

For me, the critical issue is about having a proper assessment—again, as we heard very eloquently from our previous colleagues—with the person about what their needs are and then putting the appropriate package of support in to meet those defined needs, getting away from the time and task approach.

Q321 **Chair:** Heather Wakefield, regarding the local authorities that include the travelling time as part of the commissioning arrangements with a private provider, do you publish the list of the authorities concerned?

Heather Wakefield: We did a freedom of information request. We can make it available to the Committee.

Q322 **Chair:** Would you? That would be really helpful to the Committee.

Heather Wakefield: Yes, but according to our last survey 93% of councils don't make payment for travel time, which is a contractual requirement. And absolutely none in Wales, if you're interested in Wales. On top of that, almost 80% of councils don't monitor contracts for payment of the national minimum wage—or now, the living wage—once they've been let.

Chair: If we could have that information that would be really helpful to us.

Heather Wakefield: Yes. We will let you have all of that.

Q323 **Helen Hayes:** I have a follow-up question before I move on to my proper questions. I will declare an interest: I was a local authority member at the time that that local authority—Southwark—introduced and adopted the Unison ethical care charter, which I know is about more than just pay. Pay is an important part of it—pay at the independently set living wage—but there are also terms and conditions, training and qualifications for care workers. I just wondered whether you have any experience beyond my experience in Southwark of the roll-out of that as a different way of approaching the need to improve both pay and quality of provision in social care, and how that is perhaps being impacted by some of the even more severe pressures on local authority funding that we are now seeing.

Heather Wakefield: Are you talking about training or the ethical care charter?

Helen Hayes: The ethical care charter.

Heather Wakefield: We now have 25 or 26—we are not quite sure—local authorities as commissioners that have signed up to the ethical care charter. For people who don't know, the thinking behind it was very much that in order to achieve quality care we need quality employment. No one

would argue with that, probably. It has three standards, the first one of which includes statutory sick pay, because so many home care workers don't even get statutory sick pay, and goes up to the third level, where the living wage is required. It is very much tied to, also, the elimination of commissioning of 15-minute visits, which is now the norm.

Our aim is very much to get the best possible use of public money but to provide dignity and person-centred care. We care as much about the care as about the workforce. You can't separate them. It has had quite a significant impact. I think within the LGA, and within local government now, the ethical care charter has become a kind of accepted standard. I think we also have six independent providers who have signed up to it. It doesn't sound like a lot, but there are more and more as the weeks and months go by, and I think it has been very important in generating a debate about the need to do something about zero hours, travel time and low pay and poor conditions.

Obviously, we would like every local authority to sign up to it. It was certainly very much reflected in an important piece of research. I have forgotten the name of the woman: Camilla—

Sharon Allen: Cavendish.

Heather Wakefield: Thank you, Sharon—the Camilla Cavendish report. It has also been, I think, reflected to some extent in the thinking behind the Care Act. I think it has had an impact beyond just individual local authorities.

Q324 **Helen Hayes:** Thank you. What is it about the social care sector that makes zero-hours contracts so prevalent?

Heather Wakefield: Certainly in home care, I think it is partly to do with the organisation of the work and the fact that there are often "split shifts", with breaks between visits, but also this really comes back to commissioning practice again and the fact that most outsourcing of social care has been based on framework agreements and spot contracts rather than on the requisite number of hours and the specific care required—often through e-auctions and all kinds of terrible things that are so far removed from the needs of the kinds of people we heard from today that you couldn't believe it.

I think that often because carers are stood down for parts of the day and so on, people think that it is okay to appoint them on zero-hours contracts, which means that they don't have to pay for stand-down time or things like that. We have had members who have lost mortgages because of zero-hours contracts, because if they speak up they are then not given work, so they don't get an income. We had a member who lived on porridge for a couple of weeks because she just didn't get the work. It has a massive impact on people's financial and working lives. It also quite often means that there is not continuity of care for care users and so on. I would argue that that is a bad practice altogether in the care sector.

Sharon Allen: We know from the dataset and the state of social care report that we produce based on that dataset that 50% of domiciliary care workers are on zero-hours contracts. It is obviously different in different parts of the sector; in residential care it is only about 8%, although that still sounds quite high to me. I echo what Heather said about the impact of that. There are occasionally people who say that it suits them to have that flexibility. I think the issue is whether people are offered a genuine choice about a zero-hours contract, and whether it is a constrained approach—for example, if they are not allowed to work for somebody else or they are really limited. Obviously, it is a very difficult working environment for the colleagues. We argue that, to provide genuinely person-centred care and support, you have to treat your workforce in a person-centred way as well. This doesn't do that.

Clare Jacobs: I wholeheartedly agree with what Heather and Sharon have said. I just add that, particularly in residential care, often the flexibility of agency work is chosen because the substantive contract is not very attractive. You can get paid more for being an agency nurse, and you are not tied in to long 12-hour shifts or 40-hour weeks; you can actually flex your work as you may need to for your own care responsibilities or your own responsibilities outside work. However, that is not to dismiss what Sharon and Heather have just said about zero-hours contracts.

Q325 **Kevin Hollinrake:** Sharon, you mentioned employers treating the workforce properly. Do you feel this is a universal phenomenon in social care? Are there examples of good employers that are treating their workforce properly, and what proportion is that?

Sharon Allen: To answer the first part of your question, there are definitely many very good employers in social care. If we look at the CQC findings about the numbers of social care providers providing good and outstanding care, I think it is about 73% now. I suggest they would not be able to do that if they were not investing in their workforce and providing them with training opportunities and the right kind of culture. I think it is the minority that are not treating their staff well. The problem is that that impacts on all of the other things about recruitment, retention and the quality of care that people provide. There are some outstanding employers out there.

Q326 **Helen Hayes:** Some of the problems in accessing support services to help direct payment users with their employment responsibilities were very well expressed by the previous panel. We heard each of those panel members say how much they value the independence that direct payments afford, but also that when they ran into difficulties they were kind of cut adrift to deal with those employer responsibilities on their own. How widely available are support services to help direct payment users with their responsibilities, and in your experience where they are available are they widely used?

Sharon Allen: One of the roles my organisation fulfils is to support the implementation of the Department of Health's PA framework. As part of that work, we have done research over the past five years with local

authorities about the support that they provide for individual employers and their PAs, which has shown that, year on year, the level of support available has increased. Some of that is delivered directly by local authorities themselves; some is contracted out to user-led organisations and direct payment support organisations. Skills for Care also provides information and advice for individual employers.

One of the challenges—I think one of the previous witnesses said this—is that people generally choose to take up a direct payment or individual budget so that they can personalise their care, not to become an employer. Sometimes people do not realise they are an employer, and then find they have fallen foul of HMRC or something like that. We need to do more to raise awareness of what people are taking on, and then to point them to the support that is available for them.

Through the research we have found that there are about 300 organisations around the country—I am talking about England only—excluding local authorities, that provide support for people who are choosing to employ their own care and support staff. I think that there are about 65,000 people who are doing that, and of course we are going to see an increase with the advent of personal health budgets.

Q327 **Melanie Onn:** Do you think there is anything we can do to improve the vacancy rates and turnover in social care?

Sharon Allen: Yes—we have to believe that, don't we? One of the most important things we can do is to address the image, the profile and the status. Some of that is about the way we talk about things. I am often frustrated to hear people conflate low pay with low skill and low value. Most people working in adult social care are undertaking very skilled roles and they need high skills and personal attributes and high levels of resilience to be able to do what they do. The fact that it is not fantastically paid is not in any relation. There is a much better story that we need to tell collectively. Good news, unfortunately, does not tend to make the news, so we have a job of work on to promote that.

It is also about explaining more fully to people what social care is, the huge range of jobs that we have available in the sector and that people can come into this sector from most other sectors and bring skills and talents that they can transfer into providing social care. We do a lot of work with Jobcentre Plus to make sure that their advisers know about the range of roles available. I was at a roundtable this morning with a group of employers talking about what more we can do to encourage disabled people to come and work in the sector. There is some really valuable thinking around people's lived experience making them great people who could come and fill some of those 90,000 vacancies. There is some work to do to raise awareness across the piece.

We need to scotch some of the myths. There are still people who think that regulated services cannot employ 16 and 17-year-olds; they absolutely can. Young people are interested in this sector, particularly when they hear about it from an "I Care" ambassador—somebody already

working in the sector who goes and talks about it, warts and all; someone who is doing it now, rather than somebody like me, who used to do it a long time ago and is now far too old to interest a young person.

I do think there are things that we can do. Obviously, raising the pay would be helpful, but we have to be realistic about where we are and so look at other things we can do to make it a more attractive career opportunity.

Heather Wakefield: It would also make a big difference if there was a career structure within care, which there isn't really. You may become a supervisor or manager, but there is very little opportunity for real career progression. The fragmentation of care exacerbates that problem. There is nothing like the equivalent of the NHS knowledge and skills framework, opportunities to move around between employers and so on. The provision of training is something that we would say would make a huge difference.

We did our own survey, which more than 1,000 home care workers responded to. It showed, for instance, that more than a quarter of them had no dementia training and nearly 60% had no training in catheters, which they have to deal with. There isn't a sense that it is a job you can go into and really develop your skills. People do it by looking at a video or just learning on the job—God forbid—with many of these things.

I think having some knowledge and training framework across the sector would really help, but at the moment more than 70% of local authorities do not include any element for training in the price they pay for commissioned services. I was a member of the Low Pay Commission for a long time. We visited an awful lot of care providers and that was one of the things that people mentioned most. People who had been in the sector for a long time—small local providers with real commitment—were really upset that they were unable to do it. I think the fact that five large multinationals provide 20% of the care and are also involved in sectors other than care—I wouldn't go as far as to say they are only in it for the money, but the money, the profit, is very important to them, and that has a huge downward effect on the whole notion of staff development. It's really doing it at a bargain-basement price.

Clare Jacobs: It is really important, as Heather and Sharon have said, that we articulate the competencies, the knowledge and skill sets that are required to work in this area and then that those skills are properly rewarded and properly valued through fairer pay, terms and working conditions. We know from KPMG talking about payment of the real living wage that recruitment and retention and productivity and staff engagement are improved by doing that, so there is some benefit to rewarding people properly for what they are doing.

To pick up the point that Heather made about training, the reality is that most social care is provided by smaller providers, which on the basis of economies of scale just do not have the resources to put in a training and development package or to employ people to do training and development. You have lots and lots of small providers, and it is not

something that is centrally funded or provided, so there is a huge training and development gap in the market, as I see it, which is not picked up.

Q328 **Kevin Hollinrake:** Heather Wakefield, to go back to your point, you mentioned the word "profit". Profit and good practice are not mutually exclusive, are they? You may have some examples of employers who don't believe in best practice or good practice, but can you not think of some employers who are private sector businesses and do believe in training and developing their people, with Investors in People and that kind of thing? Can you not point to some examples like that?

Heather Wakefield: Of course. This is not an ideological point. We know that a lot of the larger private social care providers have profit margins of 10% to 12%. That is an awful lot of money that is not going into services. Of course we know of some good private employers, but our experience of the large multinationals, the big players in the game, which, as I said, account for getting on for a quarter of the market, is not of that. They are incredibly removed from the service, from the frontline. They often have interests—look at residential care in particular. That is now dominated by a number of hedge funds, which have made some very dubious financial decisions about the future of their business. The very existence of the staff and staff needs and therefore user needs is a very long way removed from their major preoccupation, which is about making money.

I personally think there is some conflict in this sector between privatisation—private provision—and what should be the primary motive or driver, which is to care for people.

Q329 **Kevin Hollinrake:** Referring to the previous point, I think Sharon Allen said she felt that there was poor practice in terms of workplace welfare by a minority. Are you saying in your view that it is a majority?

Heather Wakefield: Yes, I think those findings are interesting. We have done some research—with *Community Care* magazine looking at the relationship between inspection results in residential care and the provision of training, good supervision and so on. There was a direct correlation between whether the provider was in the private sector or in the voluntary sector and the quality of care, the provision of training and supervision, and the involvement of staff in decision making. Yes, of course, I find those findings quite surprising—that such a large proportion of providers are providing good care, although I accept that most of them want to do that—and it does not correlate with a lot of the experiences we have at Unison. Perhaps because we are a trade union we see some of the very worst examples. I don't know, but for instance, we are in the process of taking an awful lot of employment tribunal cases for people employed by a large private provider. They were receiving about £3.85 or £3.95 an hour.

Q330 **Kevin Hollinrake:** Would you go as far as saying that the majority of private sector employers in this sector look after employees badly?

Heather Wakefield: I would not go that far, no. I could not possibly make that claim because I don't know them all and we don't know the

employment practices of all of them, but I think there is a toxic mix of huge, huge cuts to local government budgets—some councils have lost almost 60% of their funding since 2010—and privatisation. Those two things together are an absolutely toxic mix. I think the fact that more than 90% of the workforce are women—

Q331 **Kevin Hollinrake:** Toxic mix sounds like you are implying they treat them badly.

Heather Wakefield: By virtue of the fact that the national living wage now is the going rate of pay for women predominantly, who are often doing what were once district nursing jobs—administering medicines, stoma care, catheterisation and a lot of personal care—on significantly reduced rates of pay. I think that is very significant too. I hasten to suggest that if we were talking about refuse collectors or a predominantly male job, the downward push on pay and conditions would not have happened. I used to work for NUPE, the National Union—

Q332 **Kevin Hollinrake:** So you are saying it has happened because it is mainly women in the sector, and privatisation.

Heather Wakefield: I think it is a combination of the gendered nature of the workforce, privatisation and the swathing cuts that have been inflicted upon local governments since 2010. You simply could not make that equation add up, because there is not enough money in the system, and there are now so many providers. It is a very fragmented sector. You can have local authorities with 10, 20 or 30 providers, and it is hard to co-ordinate it. It is an absolute mess, to be honest.

Sharon Allen: What Heather says about the fragmented nature of the sector is absolutely right. There are about 19,300 organisations providing adult social care in England. Most of them are small organisations. The figures I was citing earlier are from the Care Quality Commission's report. You cannot get an outstanding rating if you are not able to demonstrate that you are well led, and I think you would be highly unlikely to get a good rating if you were not demonstrating that you were well led.

I do not deny for one moment that there are some serious issues in our sector. I think I have a different view of it because we work with providers across the piece. I have some private sector providers sitting on the Skills for Care board who are brilliant, who invest in their staff and whose cultures are the sort of thing we would all love to work in. What we need to do is find the ones who are not doing that and encourage them to step up or step out.

Q333 **Mr Prisk:** Following on briefly from that, and principally coming back to Ms Wakefield's remarks, as we have heard from all three of you, the need to recruit more people into the sector is paramount, and we have had a discussion about the living wage. But all I am hearing at the moment, principally from Ms Wakefield, is that the private sector is bad. My concern would be that that sends the worst possible message. I have had a constituent say to me, "I wouldn't go into the health care sector, because what I understand to be the case is that all these private sector

people are bad. They are only in it for the money"—to pick up the phrase you used—"and privatisation is something to be condemned in principle." My question to you is: do you not accept that there is a risk that simply saying that the private sector of itself—I know there are rogues and they need to be dealt with—is why the sector is in bad shape is going to put off people who might otherwise come into the sector and work there?

Heather Wakefield: I didn't say that. I said that privatisation has been a bad thing. There is a difference. The process of creating a market in social care, the fragmentation that has resulted and the fact that there are large providers who are primarily in it to make money—they run multinational corporations; they are not in it for the good of the users or, necessarily, the workforce—is a bad thing. *[Interruption.]* No, let me finish. I did not say that all private provision or all private providers are bad. I am saying that the process of privatisation combined with swingeing cuts has been a disaster for the social care market., I have met private providers—particularly when I was on the Low Pay Commission—who were in tears. There are small private providers who had been in the market for a long time who can no longer exist on the rates local authorities are paying them because of the cuts. I know there are very good private providers, but that would not change my view that the process of privatisation that began in the late 1980s, and the way in which care has been privatised—the commissioning practice and the outsourcing practice—have been a disaster for the sector and the workforce.

Q334 **Mr Prisk:** So you do not resile from the argument that people shouldn't work for these companies because they are bad employers and are only interested in the money.

Heather Wakefield: I did not say that at all. I think it can be an incredibly rewarding job. We have lots of members in Unison who work in social care and what we know from all the research is that most of the women who work in social care, particularly in home care, are people who want to make a difference to people's lives. They are often people who haven't been through higher education or they might not have qualifications, perhaps not even qualifications sufficient to allow them to become nurses. They are people who want to make a difference to people's lives and they are very committed and go that extra mile.

Were it not for the fact, I would venture to say, that they are predominantly women who have this commitment to people, our care sector would be in a much greater state of crisis than it is now. We all know that they put in lots of unpaid hours because they care for the clients they work for, often to disastrous effect because they sometimes gets disciplined by their employers for doing it. All kinds of allegations are then made about them but that is another story. People want to care; people want to help people, therefore, they have no choice but to work for the private sector. We certainly don't go round saying, "Don't work in the care sector because it is predominantly privatised." In fact, we say quite the opposite. What we do know is that it is not a very good deal for employees.

Q335 **Chair:** If I could just interrupt to get some factual issues. Does anyone have information to show in real terms how the pay of care workers, particularly those caring for people in their own homes, has changed, not just since 2010, but in the past 10 to 15 years? Is that evidence and information there for us to have?

Sharon Allen: Maybe not quite as long as that but certainly since we started collecting the national minimum dataset for social care. We can provide that data to you. We produce a report every year and we have that information.

Q336 **Chair:** That would be helpful. Any information that anyone else could find would be very helpful to try to get the facts of the situation. In the end, that is what we have to try to pin our report down to.

Clare Jacobs: It might not be just around the changes to pay but it is around loss of education and training or lack of—

Q337 **Chair:** Any factual information would be helpful.

Heather Wakefield: Could I throw into the pot the fact, of course, that most care workers now do not have access to a pension? When they were employed by local authorities they had access to the local government pension scheme. That is one of the very big differences. Very, very few care workers now have access to a decent pension scheme.

Q338 **Melanie Onn:** We have heard about the reliance on women in the social care sector. How about EU nationals and other foreign nationals to fill vacancies? What are the percentages? I think, Heather, you touched on it. Have we got some hard facts and figures?

Sharon Allen: We have. We know that actually it has gone up slightly. There are 90,000 EU non-British nationals working in adult social care. One of the interesting things to pull out of that is how that impacts regionally. In the north-west and north-east, there are quite small percentages. Not surprisingly, in the south-east and particularly London it really shoots up.

We need to look at that in terms of areas of low or no unemployment and think about what that is going to do to how we recruit and retain people, if people are not allowed to stay or are fearful that they will not be allowed to stay. We are hearing anecdotally from employers that some of their EU non-British staff are asking whether they are going to be able to stay in their jobs and are worried about what they are going to do. Some people are leaving because of the uncertainty and insecurity.

Frankly, that is not something that we can afford to happen. If they are good workers, we want to keep all the good workers. It is also, as you would expect, differentiated by job grade. The highest proportion is in nurses working in social care. As has been said, there are about 50,000 nurses working in social care.

Interestingly and worryingly, that is also the group of professionals that has the highest turnover rate of 36%. We have a real problem recruiting

and retaining nurses, which in turn has a massive impact on the quality of provision. Residential nursing care is the part of the sector that achieves the poorest outcome ratings from the regulator.

Q339 **Melanie Onn:** It is interesting that you should say there is higher turnover in the nursing element. From what we were saying before about adding prestige to the sector, if having the qualifications, training and career progression and the higher salary that goes with the nursing qualifications as well—

Sharon Allen: But it doesn't.

Q340 **Melanie Onn:** Okay. So for their higher nursing qualifications as opposed to care qualifications there is no pay increase.

Sharon Allen: There is but they don't get paid the same as they would if they were working in the NHS and they don't get the NHS pension and all the other things that go with working in the NHS.

Q341 **Melanie Onn:** No, but in the care sector there is a differential between nursing qualified and care qualified?

Sharon Allen: Yes.

Clare Jacobs: To add to the point that Sharon was making, we do not believe that international nurses are a substitute for a stable, home-grown, sufficiently trained workforce.

Q342 **Melanie Onn:** Does the bursary impact on that?

Clare Jacobs: It does. My understanding, although the figures are not yet in for the end of January, is that applications for nurse training or nurse education have gone down. As I said, the closing date for the end of January has not gone yet, but we are expecting significant shortfalls again around nurses who have education.

Q343 **Rushanara Ali:** You have already expressed your concern about training and the skills gap among people working in the sector. What would it take, in terms of costs, to raise the bar in investment and training in this field? If you have not done the number crunching, it would be really helpful to have it. I imagine my colleagues will be keen to consider recommending that to Government, but some serious work on it would be a big help. I am not saying that that means we will get our wish list, but it would be helpful to understand it.

My second question is this. A lot of the concern and publicity has been about pressure on the national health service. I suppose what we are interested in is understanding better where the pressure is for those working in the care sector. Again, what complexity of needs are they dealing with? What are the risks with that? In your view—again, this links back to training, but also potentially to other things—what needs to be done to mitigate those risks?

Sharon Allen: I will start with the training issue. It is fair to point out to you that the Department of Health invests in the qualifications of the social

care workforce. They provide something called the workforce development fund, which Skills for Care administers to the sector. As you would expect me to say, that fund is heavily over-subscribed.

The reason why I went, "Ooh!" when you asked what it would really cost is that because it is an independent sector, we do not have information about what employers put in themselves. Some organisations are very good at investing in the learning and development of their staff. They use the workforce development fund as it should be used—to contribute towards the cost of qualifications—and they invest themselves, because they have seen the merits of that. There are other organisations, like the ones Heather has been talking about, that do not invest in their workforce. We know that 52% of the workforce—remember, it is a very big workforce of 1.43 million people—have a level 2 or above diploma. That has increased over the last seven years or so from around 47%. It is going up, but too slowly, I would suggest. It would be great to have further investment in the qualifications of the workforce.

In terms of the skill mix, there are some really interesting things happening with social care workers working alongside other professionals. There are areas where people are trying out working under the supervision of a nurse, doing things that people might traditionally have seen as nursing roles. There are all sorts of issues to do with that, as you might expect, but enabling the care workforce to provide that kind of support is part of their profile too.

Q344 **Rushanara Ali:** Is there something that could be done to address the information gap to work out the actual difference required, in terms of making up for investment? Could we put pressure on private companies that are doing very well and are profitable to play a bigger role in building a training fund and working with the Government to co-finance, so that we can target both public and sector pressure to meet the gap? But if we do not know what is needed, perhaps that is an area for research and evidence gathering that could be done with partner organisations. Would that be something that you could lead, perhaps, or initiate with potential like-minded partners or others who have that expertise?

Sharon Allen: If somebody was willing to fund that kind of research, yes, absolutely.

Clare Jacobs: As Sharon said, it is something that, if there was funding, the RCN would certainly be interested in shaping. I think that nursing has unique knowledge, skills and professional accountability to assess clients adequately, and manage and evaluate their care. Careworkers play a really important role in providing personal care, but at the end of the day they mustn't be used as substitute nurses.

Effectively, careworkers are an unregistered workforce, who aren't regulated. We welcome the approach now of nursing associates, which I think is a new opportunity to fill some of the gaps in the system, if you like. But those people still need to be trained up to a level and they don't substitute sufficient nurse leadership and nurse skills.

Similarly, the sector is developing associate practitioners already. While there are pilots going on with regard to nurse associates, actually many providers—I would guess there are around 500-odd associate practitioners in the system already, trained up by employers, and they are doing the same job that a nurse associate would do. However, they will only have had three months' training to do that, rather than two years for a foundation degree, and they won't be registered.

So one important thing is to have those national standards that people need to adhere to, which are properly audited and assessed against. That is key, rather than there being lots of little pockets of local training opportunities, which may or may not fill the requirements and needs of the client group.

Of course, those associate practitioners are also paid a lot less than nurse associates would be paid. So again, you're already starting with a system where people are doing the same job but are on a different level of pay with a different level of training.

Q345 **Rushanara Ali:** Thank you. I will go back to Heather Wakefield and your points about big providers. Basically, given the problems in the market and some of the failures, have you got some reflections on what could be done by way of improving regulation? I know it's a word that some of my colleagues might not like the sound of, but what can be done to strengthen the framework, so that there is a climate in which good practice—you and Sharon both said that there are lots of great providers in the private sector— can be encouraged and incentivised? Have you got some reflections, given the number of tribunals you're dealing with?

Related to that point, there have been a number of high-profile programmes on employees who are poorly trained or inadequate, which is shocking. Obviously that's damaged the reputation of the care sector, which is really unhelpful but understandable.

Then you look at parallels in other sectors. In the private sector, there has been the BHS scandal, or the SportsDirect scandal. From your observations and from a union perspective, are you concerned that there is a major accident waiting to happen, alongside what's happened so far?

Heather Wakefield: I am surprised that there haven't been more accidents. I think that there haven't been more accidents because care employees frequently go that extra mile, unpaid and in their own time, to ensure that those accidents don't happen. I think that's the main reason why they haven't happened.

There should be some national or UK-wide—however you construe it—standards of care and related employment training standards for the sector, which all providers should have to comply with. Having said that, the money would have to follow those standards. At the moment, more than 70% of local authorities, who are the commissioners of social care, do not include anything in their budgets for training because they can't because of cuts to their budgets. Having some standards and some

regulation around those standards would make a huge difference. I suspect Sharon has more to say.

Q346 **Rushanara Ali:** You mentioned smaller private providers versus the large ones that are very profitable and successful. Just as in any other sector, presumably you would expect to look at how appropriate the regulatory burden is and so on, although this is a much more complex area that requires good standards across as a minimum.

You mentioned earlier that there are some companies doing very well, thank you very much. How does that square with your point about local authority commissioning? If they are doing very well and they are not investing in training and development for their staff and there are still issues about the kind of service they are providing, leaving aside those that are doing a good job, what should be done in those cases that you mentioned?

Heather Wakefield: Certainly some of the ones that are doing well are cross-subsidising. You will have read, no doubt, and the Committee will know that a number of providers, particularly in residential care, are keeping going because they cross-subsidise from self-funders.

Prior to the introduction of the national living wage, a much larger number of providers were doing quite well. The national living wage has created an issue. We know now that some major providers are exiting the market. MiHomecare, part of Mitie, a multinational that provides everything from cleaning to IT services to goodness knows what else, has exited the home care market because they say the national living wage means they presumably cannot make the profit they were previously making. We know that for different but related reasons in residential care there are major providers, too, who are talking of exiting the market.

Some are doing well because of cross-subsidy. Others are doing well because previously they were really rubbish employers who did not pay travel time, sick pay or anything else but now they have to pay the national living wage. However, I would like to make a point there about enforcement. We are still very unhappy about the level of enforcement of the national living wage. My colleague, Matthew, has been doing some work with what was BIS around enforcement of the national living wage and looking at how payslips need to be changed to reflect all that.

Q347 **Rushanara Ali:** You mentioned the point about pensions. Does that apply across the field, including the bigger, profitable companies? They are just not providing a pension.

Heather Wakefield: No, and that is one of the really big differences in the price. It is one of the things that privatisation—or outsourcing, not to use the "private" word—has directly led to. Pensions have been taken out of the equation as has occupational sick pay.

Q348 **Rushanara Ali:** I have one brief question about sheltered housing, which has been in decline. Has anyone done any work on what is likely to happen in the light of some of the changes in housing association

financing around sheltered housing? If not, is anyone planning to, to your knowledge? Obviously, that applies to local authority housing, too.

Sharon Allen: Yes, I that think the three big specialist housing providers—Housing 21, Anchor and Habinteg—are doing some work now looking at the impact of the changes, particularly around the local housing allowance cap for supported and sheltered housing. There are very real concerns about the impact of that on the future of supported housing. Of course, all these things have a knock-on effect, don't they? If people can't get supported housing, their needs might increase; they might then need social care but be unable to get it, and so on.

Q349 **Kevin Hollinrake:** On the standards point, the Committee watched a "Dispatches" programme, which showed some clearly inappropriate standards of care in, I think, Haringey. Do you think that the people responsible for commissioning it—in other words, the local authorities—should do more to put simple audits in place? Presumably, if they are commissioning the care, they know there is a standard of care they would expect. Is it not incumbent on local authorities to make sure that that standard of care is being delivered?

Sharon Allen: I think we need to look at how we are assured about the quality of care. I would say that the first line of responsibility lies with the provider—the organisation that is providing social care. They should be doing it because it is the right thing to do. We do have very clear standards: we have the standards that the Care Quality Commission inspects against.

Talking about burdens, one of the things that employers talk to us about a lot is the duplication of inspection they go through. They have the service regulator going in, and then they might have the local authority going in to look at sort of the same thing, but asking for the same information in a different way. They have environmental health going in. They have the fire service going in. They have all sorts of people going in, so what we need to do is determine who we think should be inspecting the standards, doing it once and finding a way for everybody to be confident in that happening, and happening well. But the first line of accountability, in my view, has to sit with the provider. I used to be a provider, and I think it is your responsibility, if you are running services.

Q350 **Kevin Hollinrake:** I 100% support that, but it is about what is inspected rather than what is expected a lot of the time, isn't it? From your list there, there are plenty of opportunities to put in good practice, to make sure that inspections are happening so that you can get the delivery—the service—you might expect, rather than some of the examples of inferior service we spoke about earlier. There are opportunities to do that, wouldn't you agree?

Sharon Allen: There are, but I do not think it is co-ordinated well enough. Probably some of the really good services are being inspected goodness knows how many times, and being told they are good, and then we have those that feature on "Panorama" and "Dispatches", where people

should have been in there much more quickly, sorting out what was happening.

Heather Wakefield: I might take a slightly different view. I think that local authorities have a duty to care for their local residents. We are talking about huge amounts of public money, and we know that 70-odd per cent. of them, from our latest survey, do not monitor contracts once they have been let to ensure payment of the national living wage and so on—or, indeed, for the quality of care, which is much more worrying. They have a responsibility, as people who are administering and dishing out public money, to ensure that that money is used in the public interest.

Q351 **Kevin Hollinrake:** I think we have covered a lot of the ground on the reasons for the shortage of nurses in social care. If there was an integrated health and social care system, would that improve matters? Would that mean that it was a more rewarding and attractive occupation to be in?

Clare Jacobs: It has its challenges. We welcome integration—it seems to be the way forward—but there are challenges with nurse leadership and nurse involvement in the planning for integration, which are fundamental to taking that forward. The differentiation around different standards, pay rates, terms and conditions and so on will also create challenges. Having a two-tier workforce is not conducive to taking integration forward. The equivalent of a care home manager in the health service will be earning a lot more, and the equivalent of a nurse—

Q352 **Kevin Hollinrake:** Is it impossible to bring the two things together, because of the differentials in pay and conditions?

Clare Jacobs: It is not impossible, but it is one of the fundamental concerns we have. Those things need to be looked at and considered, particularly the pensions issue that Heather talked about.

Q353 **Kevin Hollinrake:** There will be pensions—private employers are required to provide a pension scheme for their employees—but it is a different type of pension scheme.

Clare Jacobs: Indeed. It is very significantly different and does not provide nearly the same sort of platform. They are paid less, they have far less pension entitlement and their possibility for career progression and enhancing their skill development is a lot less. There are minimal training and professional development opportunities. Role development, advanced skills development and things that we have talked about, like occupational sick pay and holiday pay and so on, are all very much at the minimums. It is just the whole package.

Our members tell us that the biggest issue is enhanced pay for working shifts or difficult-to-cover shifts, such as bank holidays, Saturday and Sunday nights. Invariably, that area of work is not covered very well, or there are gaps, and staff cannot be attracted to work on those shifts because there is no enhanced payment.

Q354 **Kevin Hollinrake:** Very quickly—finally, Chair—you mentioned that an

international workforce is no substitute for a UK workforce.

Clare Jacobs: A stable, home-grown workforce.

Kevin Hollinrake: Why is that?

Clare Jacobs: Because of the stability of the market. We should be growing and developing our own market, or our own labour workforce. That is because we have had to rely significantly on overseas nursing staff to fill those gaps, because of our own shortages.

Q355 **Kevin Hollinrake:** Are you saying that care is not as good from the international—

Clare Jacobs: No, not in the slightest. They are underpinning our system.

Q356 **Kevin Hollinrake:** Why does it matter, then? If they are just as good, why does it matter? We will always have immigration in the country.

Clare Jacobs: Because there have been significant issues with the immigration of nurses over the last year or so, including being able to get them in the country and their anxiety about staying, with Brexit and so on. It is important that we have enough numbers of our own without having to rely on overseas nurses.

Q357 **Kevin Hollinrake:** So if we had not had Brexit, that wouldn't have been an issue.

Clare Jacobs: Well, it was already an issue before that with regards to non-EU nurses.

Melanie Onn: Are you saying that you don't want British nurses?

Kevin Hollinrake: No, not at all.

Clare Jacobs: I think we have to be careful where we recruit nurses from, so we are not draining their nursing workforce.

Q358 **Chair:** Finally, let me raise one individual instance, triggered by the fact that you raised the issue of local authorities and commissioning, and what they can and should require providers to do. I had a constituent who raised a really bad issue with me. He believed that his mother had been abused by a care worker. The local authority rightly undertook a safeguarding adults investigation and concluded, following two case conferences, that there had been emotional and verbal abuse of this elderly lady, who has since died. One individual was found guilty of engaging in that abuse. The recommendation was that he should not work with vulnerable adults or children again. Comfort Care, which is a major provider of care, has simply ignored that, and that individual is out working now with vulnerable adults by himself. Is that in any way acceptable?

All witnesses: No.

Sharon Allen: No, and I suppose there was no criminal investigation, was there?

Q359 **Chair:** The police have been encouraged to look at that, but at this stage, they are waiting for everything else to be finished before they do so. Meanwhile this person is working. The initial recommendation, even while the investigation was taking place, was that he should only work with supervision. That was ignored and then, following the proper investigation and the conferences that were held, it was recommended that this individual should no longer work with vulnerable adults or children. The company has said, "No, we have no problems with him, he can carry on."

Clare Jacobs: And that is precisely why the RCN is calling for the workforce to be regulated—so that people can be held to account.

Sharon Allen: A register.

Clare Jacobs: Exactly.

Chair: And perhaps local authorities can look at whether they have the right, in their commissioning of providers, to decide in those sorts of areas that this kind of practice cannot continue.

Thank you very much for coming and for giving so much evidence today, and for responding combatively to some of the questioning.