



Select Committee on Economic Affairs

Uncorrected oral evidence: Social care funding in England

Tuesday 8 January 2019

3.40 pm

Watch the meeting

Members present: Lord Forsyth of Drumlean (The Chairman); Baroness Harding of Winscombe; Lord Lamont of Lerwick; Lord Layard; Lord Lipsey; Lord Tugendhat.

Evidence Session No. 8

Heard in Public

Questions 68 - 80

Witnesses

I: Sharon Allen OBE, Skills for Care; Guy Collis, UNISON; Professor Jill Manthorpe, NIHR Social Care Workforce Research Unit.

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Examination of witnesses

Sharon Allen OBE, Guy Collis and Professor Jill Manthorpe.

Q68 The Chairman: Professor Manthorpe, Mr Collis and Ms Allen, welcome to the Economic Affairs Committee. I am sorry that we have kept you waiting for 10 minutes; we had a bit of business to deal with following the Recess. Thank you very much for your written evidence, Mr Collis, I very much enjoyed reading it.

I shall get on with asking the first question. There have been quite a lot of warnings about social care reaching a tipping point, but on the surface the system appears to be resilient. I wondered why you thought this was. Is it simply because the number of people who may require care is being reduced in the provision? If more funding was available, how might it be prioritised?

Sharon Allen: Thank you for the opportunity to give evidence. To set some context for the responses that I will be giving, Skills for Care is the Department of Health and Social Care's delivery partner for leadership and workforce development in adult social care in England. That means that we work with 21,200 organisations providing social care to help them to get, keep and develop their workforce to try to ensure the highest quality of care in our communities. It is worth noting that 1.47 million people are providing social care in England. As you are the Economic Affairs Committee, I thought I would point out to you that social care contributes £38.5 billion to the English economy.

In answer to your question about why the tipping point has not been reached, I suggest that we are probably dealing more with a situation of whack-a-mole, by which I mean that organisations are going out of business—some because they cannot make it economically viable, others because of poor quality of care. At the same time, a lot of new businesses are trying to get into the social care sector, for a variety of reasons.

The other reason why we have not seen things fall over completely is the dedication and commitment of the 1.47 million people working in the sector. People in the sector develop long-term relationships with people they provide care and support to. During the "Beast from the East" last winter, for example, we saw social care workers working in residential care staying on for one or two nights extra, and we saw people going out on foot because they would not leave people without care and support. In a way, that commitment and dedication is to be celebrated. Unfortunately, it also masks the very real problems with the lack of funding in the sector.

The Chairman: Indeed.

Guy Collis: It depends how you define "resilient". I think you would find very few staff who worked for Allied Healthcare, for instance, over the past year who would use that term, the organisation having teetered on the brink of collapse for a number of months before ultimately a last-

ditch sale came at the end of the year. It is not the first care company to find itself in that position and it is unlikely to be the last.

The social care sector as a whole is in a state of seemingly permanent crisis at the moment. Many local authorities, which are responsible for organising care, have reached the tipping point. We saw Northamptonshire effectively declare itself bankrupt last year, and there are various reports that there are as many as 10 or 11 other local authorities, both Conservative and Labour in both the north and south of the country, with potentially very serious financial problems. Even though social care has been relatively protected compared to other council budgets—this explains why it is taking up a larger and larger share of the council funding pie—we have seen spending per head reduced substantially in recent years.

On top of that, we have had rising demand. There have been more than 30,000 extra new requests for social care in the past year. There has been research in some of the medical journals suggesting that the number of over-85s with very high care needs will almost have doubled by 2035, so there is no sign of this going away. At even the most basic level, even a cursory glance at the headlines over the festive period reveals what we in the sector are up against—as many as 90 people are dying each day waiting for social care, and there are 8,000 fewer beds than there were three years ago.

The Chairman: Why are they dying each day?

Guy Collis: They are waiting for social care. They are on lists but are unable to access the care that they need. We have also now found care companies that have started charging staff £50 if they phone in sick, and that is clearly not a good state of affairs. The former Pensions Minister, Baroness Altmann, referred yesterday to some of the elderly being treated like Amazon parcels within the system and said that there was not one part of the social care system that was not broken.

But you are right to say that it has not completely collapsed. Following on from the previous remarks, one of the reasons for that is the dedication and hard work of the vast majority of those who work in the sector. These are staff who are almost universally underpaid, largely undervalued and often exploited at work, yet they are going the extra mile. In a recent survey of our social care members we found that almost a third had visited people who they cared for in their own time, and as many as three-quarters of them had spent longer with people who they cared for than they were contractually obliged to.

The Chairman: I have had personal experience of that with a relative. I am aware that the care workers turned up to see her on Christmas Day when we were there, even though it was their time off with their own families.

Professor Jill Manthorpe: I am from the National Institute for Health Research funded health and social care workforce research unit, so this issue is very dear to our hearts.

On the point about resilience, I want to echo the points made by my colleagues about people being resilient rather than the system. Clearly there is a great deal of resilience among care workers, many of whom work overtime but are also underpaid for the jobs that they do. We know that large numbers of them do not get paid for travel. We know that people working directly for individuals often work without contracts specifying the hours that should be worked and the wages that should be paid, and they do not have much opportunity to take sick pay or time off in lieu.

Local-authority-funded providers have been able to build some resilience by moving to self-funders, therefore making it particularly hard for people who are in receipt of local authority funding to find the care in the places and of the type that they need. That, of course, means that there are large numbers of people with unmet needs. I am sure you will have heard from Age UK, which has specified how that is affecting older people, but it clearly affects younger disabled people, and particularly their carers.

When we talk of resilience, I suppose we are talking about family carers, who are not part of the workforce in many ways but who work in association with it. They are the ones who have had to pick up a lot of the characteristics of being resilient. Many small providers have gone under as well as the larger providers that have been mentioned. It does not hit the headlines when a small local provider of home care, for instance, decides that it can no longer recruit and retain and carry out the service that it set out intending to provide.

So in many ways, the resilience of the system is a little threadbare. We certainly rely overmuch at the moment on the resilience of the people working in it.

Q69 Lord Lamont of Lerwick: Do you have any concerns about local government moving towards greater self-sufficiency? I raise that particularly because the Local Government Association pointed out that the growth in need did not correspond with the main funders of the service: namely, the business rates. Do you share that concern?

Sharon Allen: I do, in part because we know that different local authorities have different abilities to raise funding locally. We saw that with the introduction of the precept. Unfortunately, the parts of the country that are less affluent than others find it more difficult to raise the money that they need.

Social care, as I am sure you will hear said repeatedly throughout our evidence to you, is about people. It is a people business, and it is about relationships. Obviously in residential care there are the costs of buildings, meals and so on. But the biggest cost for a provider of social care—I used to be one, so I know this from first-hand experience—is your

colleagues, your staff. As colleagues have said, sadly they are not rewarded appropriately for the level of skill and commitment that we ask of them. Nevertheless, they are the most significant part of your budget. So I am concerned about that ability in all parts of the country to provide what the Care Act said was required, which was services of the same standard across the whole country.

Guy Collis: We share those concerns. Clearly, as we have already outlined, there are lots of reasons for being concerned as things currently stand.

One of the problems is the potential for this to further entrench existing inequalities. Areas that can make more money from increasing council tax are the areas where there tend to be more expensive properties. At the moment, the central government grant makes up a larger proportion of the total budget in poorer council areas, and residents in these areas tend to need their services more than residents in other places.

The Joint Select Committee report that came out last year suggested as an alternative that the current revenue streams should be kept as they are and that the extra money raised from business rate retention should be used purely for social care rather than replace the central government grants. That sounds like a more sensible way of doing things.

Professor Jill Manthorpe: There are huge variations in the proportion of recipients of social care in local authority areas. Around our coastal communities, there are very high numbers of people receiving social care. People previously migrated there because they liked where they went on honeymoon, but now it is cheaper to live in a caravan park on the coast perhaps than somewhere else.

If we contrast a London borough where there are very few care homes with the county of Kent, we are not starting off with anything like the same level playing field in provision.

Lord Lamont of Lerwick: Some people have suggested that it should be funded nationally but administered locally. Would not the need to avoid a variation in standards lead central government to impose standards everywhere and make for a much more uniform, standardised service—in other words, take away a bit of initiative from local entities?

Sharon Allen: I do not think it would, because we need standardisation. We already have that through the Care Quality Commission regulation; there are standards which all services are meant to adhere to. We do not see that consistency across the piece, unfortunately.

Local government, central government and local providers, and indeed local citizens, can work together—we see examples of this happening—to be innovative and to ensure that models are developed that meet people's needs while ensuring that there is consistency in the standard of provision.

Guy Collis: I do not have much to add to that.

Q70 Lord Lamont of Lerwick: You said at the very beginning that social care contributed £39 billion to the economy. Could you define that? What did you mean by that exactly?

Sharon Allen: We did a report on the contribution that social care makes across the UK, and I would be happy to send you a copy if that would be helpful.

Lord Lamont of Lerwick: Was this the value of the services? What was it?

Sharon Allen: No, the actual contribution: the value of the services; the value of the spending power—services are buying local services; and the contribution made by the wages. Even though, as colleagues have said, the wages are not at the level we think they should be at, most people who work in social care live and work locally, so they are contributing to their local economy by using their wages to buy locally, and when that is aggregated, that is the value. Do not ask me to explain the economics behind it, because that is not my area, but I can send you the report.

Q71 Lord Layard: I would like to pursue where we have got to so far. I do not really understand how, if the Government have essentially abolished a mechanism for aligning funding with need, you can maintain a service without essentially nationalising it. I just cannot see what direction we are heading in.

Mr Collis gave a very complex answer in which he said that some of the business rates could somehow be pre-empted, but I am not quite sure how that can do the trick, given all the other things that have to be done locally by local authorities anyway. Can we explore that a little more?

Guy Collis: I think you are right. I was just offering what the Joint Select Committee had suggested as an alternative.

The Institute for Fiscal Studies does not think that replacing central government grants with locally raised revenues will be enough to cover the various shortfalls, so you are right that this will not be a magic wand that suddenly solves all the problems.

Lord Layard: Sorry, what will not be a magic wand?

Guy Collis: Moving to local government having greater self-sufficiency.

Lord Layard: Does that mean that you would all favour some sort of integrated national funding system that did not depend on local revenue?

Guy Collis: Building on previous comments, we would favour ensuring that there are at least minimum standards, which are enforced. When you are dealing with a low-paid sector of the economy, an area of the economy that is massively underinvested in, the first move is to ensure that the bottom line is covered and that there is no abuse at the bottom, whether of the people receiving the services or of those delivering them.

That is what we have tried to do with the ethical care charter at UNISON, which is designed to be a minimum set of guarantees. It would end rushed care visits, but it would also ensure that staff were paid for their travel time. I am not saying that this is the be all and end all, but it would at least take out some of the regional variation at the bottom end of the spectrum if all the councils abided by these kinds of basic requirements.

Lord Layard: If they do not have the money, they cannot maintain the standards, can they? I do not see how imposing more and more standards is an answer if people do not have the money to supply them.

Sharon Allen: I agree with you that there is certainly insufficient money in the system. My organisation's remit, as I outlined at the beginning, is to ensure the quality and capacity of the workforce. It is not necessarily my place to determine how that money should be raised, but I do know that if we want a skilled, confident and sustainable workforce, that has to be paid for. How that money is raised, I think, is the responsibility of both central and local government—as well as us as citizens, obviously.

When this question comes up, it always reminds me of the conversation that I had with one of my previous board members, who needs care and support and uses her own funds to employ her own care and support team. She asked me, "Sharon, why is it okay for me to be ill but not okay for me to need care and support?" I could not answer her and I still cannot.

The Chairman: That does not answer Lord Layard's question. There have been a number of reports on this subject, yet we have had differing evidence. We heard from Sarah Pickup from the Local Government Association, who argued for not having a national system. We heard from Natasha Curry from the Nuffield Trust, who said, "I think the funding piece has to sit at the national level if we are to have true risk pooling, but local authorities can still have autonomy to administer the system", like the NHS. Then we had Andrew Dilnot, who said that it was pure chance that it should be the responsibility of local authorities.

You are all taking a slightly different line and not really addressing Lord Layard's point.

Lord Lamont of Lerwick: What about the individual contributing something as well? Is there not a sharing of risk or a sharing of responsibility as well?

Professor Jill Manthorpe: We mentioned the immense role of self-funders, how unevenly self-funders were distributed between local authorities, and indeed the power of local authorities to move them around. This really differentiates the world of finance, in that the domination of private patients in hospitals or in NHS communities is not the same in the NHS.

We anticipate that self-funding may grow. We have never had too much detail on what self-funding extends to and how many people are employed in that sector, although we know that it is very large and increasing, so it is very difficult for a local authority to make predictions about self-funding. It still has residual duties to people who are self-funders—if, for example, they lack decision-making capacity, there are suggestions of abuse or exploitation on either side, or they need services in relation to mental health assessments, and so on.

Regardless of payment status, local authorities have responsibilities to local citizens who are packaged up as social care. We tend to think mainly of people being in care homes and home care, but there are other services as well. In particular, there are roles relating to housing, homelessness and so forth.

So where the workforce is paid from and where the accountability is, whether it is local or national, matters. In the end, for the workforce and for the sustainability of the organisation—private or not-for-profit—that is employing them, these matters and the proper mechanisms for funding this care need to be sorted out and debated within local communities and by politicians. Much of it is about social security money, which also has an enormous role in paying for care, even for self-funders, who get quite an amount of social security-type money as well.

The Chairman: Lord Layard, did you want to pursue this self-funding point or are you happy?

Q72 **Lord Layard:** I wondered if we could have a bigger comment on the issue of whether the self-funders are being forced to subsidise the non-self-funders. Is that really a sustainable or equitable long-term situation?

Professor Jill Manthorpe: Clearly the Competition and Markets Authority, and indeed everyone under the sun, have recognised that if you or I are paying for a room in a care home that takes local authority residents, our private payments, if we are paying out of our own resources, will cross-subsidise people.

Of great risk to the sector at the moment are the number of homes that are clearly unable to manage to take local authority-funded residents, not because of any stigma but just because the sums do not stack up. We have seen very large numbers of homes make hard decisions about that.

I do not think we have a two-tier system here—other countries do—in relation to the quality of care that you get if you move into a care home if you are a self-funder or a local authority-funded person, but we run the risk of one group of people being seen as silver-service customers while others are paid for on the rates.

The Chairman: But there is a two-tier system in that self-funders are paying more than they would otherwise need to.

Professor Jill Manthorpe: Yes, but in the dark of the night when a person is dying and someone is holding their hand, the integrity of the staff means that they do not make those differentiations.

The Chairman: I am not suggesting that, but it is not particularly fair to the people who are self-funders.

Professor Jill Manthorpe: No, it is taxation by other means.

The Chairman: Indeed.

Q73 **Baroness Harding of Winscombe:** I declare my interest as the chair of NHS Improvement.

To what extent are local authority commissioning practices affecting the provision of care?

Guy Collis: Again, it comes back to the underfunding issue. As a result, dysfunctional commissioning practices have become depressingly widespread among local authorities. We have seen that price is by far the dominant factor in commissioning decisions. Very few councils are paying the rate to providers that is expected if we are to see safe, high-quality care delivered and staff paid properly. Recent research from the United Kingdom Homecare Association said that only one in seven councils was paying the correct rate.

It is unsurprising, therefore, particularly in home care, that so many councils are seeing providers returning their contracts; I think that as many as one-third have seen contracts returned. The King's Fund recently did some work on home care, which also found that commissioners themselves were frustrated by the so-called time and task approach to commissioning in which providers are paid per hour for what they are doing but there is no real means of assessing the outcomes at the end of it. So there is a link between the price paid by councils and the quality of care that is delivered.

We have done work in the past, as have some of the disability charities, on the expansion in 15-minute or even shorter care visits that are being done. The most recent UNISON survey on this suggested that around half our members said they did not have time to provide dignified and compassionate care, which is really alarming, while 40% said they had had to leave the vulnerable or elderly when they were upset or distressed, which is no way to run a social care system.

The models used by local authorities in this way embed insecurity and uncertainty into the system, because the providers are given no certainty over the hours that they are going to receive, which in turn ends up being passed on to the workforce, often in the shape of zero-hours contracts. The Skills for Care work has shown that around a quarter of the entire social care workforce are on zero-hours contracts, but in home care it is much closer to half.

Another big problem is the alarming number of care workers who are not even receiving the national minimum wage—not the national living wage, and certainly not a real living wage, but the national minimum wage. Various estimates over a number of years have put the figure at anywhere between 150,000 to 200,000 staff who have not received the minimum wage, largely as a result of the failure to receive travel time, as has already been mentioned. These are really big problems in the system.

Baroness Harding of Winscombe: Is it just a question of funding, or do we need different, tighter regulatory oversight of the commissioning practices?

Sharon Allen: I do not think it is just about funding. It is always about getting the balance right in focusing on the need to modernise services in order to make sure that services are genuinely meeting individuals' needs and the needs of local communities, so we all have a responsibility to look continually at what is being provided.

There was a lot of disappointment when the regulator's—the CQC's—oversight of local authority commissioning was taken away. Whether reintroducing it will help I am not sure, to be honest, because local authority commissioners are in a very difficult position. You have already heard about the level of reduction in budgets. They are desperately trying to provide services for their local communities within sufficient funds.

Baroness Harding of Winscombe: That is what I am pushing on: if you just gave them more money, would all of this sort itself out, or is the moral hazard still there, and do we have the right regulatory oversight framework?

Sharon Allen: It depends on how much more money you gave them. Some people would say that they have already money, and others would say yes, but not enough, and, actually, giving a little bit does not answer the problem.

Turning your question around, more regulatory oversight without properly funding the social care system will not help either. What do we do? We just keep finding that things are not working because there is not enough money in the system, so we go round in a circle.

It would be better if both the commissioning and the provision of social care were part of a system that was held to the same standards. Again going back to my experience as a provider, I wish we could have a system whereby providers, citizens and commissioners worked together, rather than the more adversarial position that unfortunately we keep hearing about, but when things are tight, people get pushed back into corners.

Professor Jill Manthorpe: It is also important to consider commissioners and professional staff as members of the workforce. We tend to think of commissioners as Daleks, or something, but these are

people among whom there is high turnover. It is very stressful and, as was summed up in the Local Government and Social Care Ombudsman's recent report, *Under Pressure*, the pressure is not only on front-line staff but on management.

The number of cases coming under the Care Act through to the ombudsman but also to the courts shows that the pressures are system-wide and not staff fault. There has been a tendency occasionally to say, "If only the staff were better", but almost everybody now, including the National Audit Office, is saying that it is not the staff, it is the system. *Under Pressure* is a great compilation of the impact on the individuals but also on the staff who are delivering the bad news about not being eligible, what has to be charged and how people's budgets are being cut. It is a very telling contribution to our debates.

Q74 Baroness Harding of Winscombe: A final follow-up question from me. Would you like joint commissioning locally with local NHS organisations?

Sharon Allen: Yes.

Baroness Harding of Winscombe: Could you explain why? You gave a straight answer to a straight question, which is rare in this place.

Sharon Allen: I thought I would try it. I would like to see it, because we have seen some examples of it happening in particular aspects of local provision and it can be very effective. One example is Stockton and Hartlepool, where there is an integrated discharge team working with multidisciplinary teams to enable people to get out of hospital, which is obviously very topical. We also, of course, need to stop people having to go in in the first place.

If we joined up the money and the approaches in such a way that neither party dominates, so in a true partnership, that could only be of assistance locally and provide better outcomes for citizens. We have seen this with the introduction of personal health budgets and direct payments. People do not fit our neat little boxes. Some people have health care needs and social care needs and they need resources from both parts of the system to work together, rather than in a fragmented way that means that they can sometimes fall through the middle.

Professor Jill Manthorpe: I think many of us will have seen joint commissioning at various times. It goes in and out of fashion and in waves and people's job titles change a lot, but joint commissioning needs to be properly done. We still have immense concerns about younger people with learning disabilities and profound multiple needs, whether related to autism or a whole range of other things.

Joint commissioning needs to prove that it can be better than the sum of its parts. We only need to look at the outturns from the Winterbourne View scandal and how they have fed into the system—and it is supposed to be joint commissioning—to see that they have been a little slow to happen. I am sure you will have heard of Bethany's dad and a whole host

of people talking about things that are apparently joint but where there seem to be system failures.

So rather than saying that joint commissioning will solve everything, perhaps we need to make a smart investment by asking, "Will it work?", and suggesting areas where it really must make a difference, such as young people detained in secure or semi-secure settings, which are very expensive but where there are clearly massive quality of life and human rights issues for those young people at the time.

- Q75 **The Chairman:** Following up on the point about the money, when Mr MacBeath, the director of adult care services for Hertfordshire, gave evidence to the Committee, he said that in his budget there was £23 million of short-term funding, because the Government produce packages of funding—"We have provided an extra £100 million here", or whatever. He made the point that they would "like to spend the money on things like pay rises or more long-term care packages, but because it is all short-term funding and it might disappear it would probably be imprudent to invest in those initiatives".

This is a problem not about the quantity of the money but about the certainty of the money. I am happy with a yes or no answer, but do you agree with that view?

Guy Collis: That rings true. It is another way in which those in the system cannot plan in the way they would like to, because they are operating almost on a month-by-month basis rather than there being any ability to plan for the years ahead.

The Chairman: So you cannot increase the wages of the care workers, because you can see these extra cases coming down the line and you are not sure that you will have the money to deal with them. Is that the kind of issue?

Sharon Allen: Also, if the funding is time-limited, what are you going to do when that additional pot of money has run out? You still have all your staff and their contracts, and you will find yourself in a very difficult position. The sector has been asking for a long time for properly sustainable funding, which means both the quantum of money and its security for the long term, because then you can do longer-term planning.

Professor Jill Manthorpe: In particular, if you have only short-term money, you spend money on agency and locum workers, and it denudes the sector's workforce of people who want sustainable careers if they think it is a role for agency or short-term working.

The Chairman: And it is more expensive.

Professor Jill Manthorpe: Much.

- Q76 **Lord Tugendhat:** I think the answer to this question is really very clear, but why in your view are there such high vacancy and turnover rates in social care and what can be done to reduce them?

Sharon Allen: One thing that my organisation, Skills for Care, does is collect workforce data. We produce a number of reports, which I am very happy to send copies of to the Committee if that would be helpful. Sadly, we have seen turnover rates increase every year since we started collecting the data 10 years ago, and they now stand at an average of 30% across all roles and all providers. In some sectors, such as domiciliary care, it is higher for some roles; for some roles, such as nurses in social care, it is much higher—nearer 40%.

That is not only unsustainable but a real quality issue, because, as we have said, social care is about relationships. As those of you who have experience of it know, it is about people coming in to provide some of the most intimate care. Who wants that to be provided by someone different every day, week and year? We want continuity, but we do not have it.

The reasons why we do not have it are multiple. If it was one simple thing, if it was just about money, that would make it easy, in a way. So it absolutely is about money. We do not pay people well enough. If you are a social care worker, you are likely to be earning about £15,700 a year. If you are a healthcare assistant working in a team, likely to be working in a hospital setting with supervision, you are going to be earning something like £17,600 a year. We need to look at parity for our colleagues working across social care and health. We do not value the skills of the workforce highly enough.

It is not just about money, though; it is about the intrinsic value of the work. I often describe people working in the health service as almost having that Ready Brek glow around them. Everybody loves the NHS—I love the NHS—and we are all very grateful to people who work in it. We need that same level of esteem and value for our social care colleagues, because they are out in our communities every day and every night supporting people to have a life. Yet when you meet them, and I know you are going to meet some later, I would be surprised if you do not hear the word “just” mentioned quite a lot—“I am just a care worker”, “I just do this”—because other people do not value them, which plays into the way people see the role.

I do not know how many of you are parents, but when I speak at events, which I do a lot, I often ask the audience, “Who here has children?” Most people have. “Who here would encourage your children to seek a career in social care?” Most hands go down. We need to change that. We need to make it something that people aspire to go into, because once they go into it and stay in it they love it. It is hugely rewarding and fulfilling, and it needs to be recognised and rewarded.

Guy Collis: I agree with everything that has been said. To give a one-sentence answer to your question, pay is too low and there is not enough training and development, but these also play into the wider problems of poor morale among the workforce and the perception that social care is in some way low-status work. The findings that Skills for Care has produced are confirmed by what we find in UNISON surveys: half our care members say they are currently thinking about leaving their jobs, and,

unsurprisingly, for three-quarters of them that is based on their low pay. However, more than half also cite the lack of time that they get to spend with the people that they are caring for as a big reason for wanting to leave, so it is not just about whether they are going to be able to put food on the table.

The low pay sends out a feeling that care workers do not deserve to be respected and valued for the work that they do. It is leading to many care workers who would like to continue working in social care feeling that they have to vote with their feet and leave the sector. So you find many care homes facing recruitment crises because there are other local employers, such as discount supermarkets, moving in and hoovering up their staff.

The lack of funding also affects access to training, which is demotivating for staff if they are not getting the training they want and need. It also has a potentially damaging impact on the quality of care that staff are able to deliver. In this area there is almost a vicious circle: employers know that there is a high turnover of staff, so they lack an incentive to invest in training. If you know that a third of your workforce will leave every year, why would you spend that money training them up when they are just going to go? In turn, the staff are not being trained well enough, lose motivation and leave the sector. It is becoming a self-perpetuating problem with no sign of it being solved at the moment.

There is another issue: vacancies. There has been no national workforce strategy for social care for a long while, or one for the NHS. The National Audit Office raised concerns about this recently. The Government produced a draft health and care workforce strategy in December 2017, but tellingly it included only five pages on social care out of 142. I know that Skills for Care has done its own exercise on what this should look like in future, but this is clearly something that we need a lot more action on.

The Chairman: Sorry to ask a daft bloody question, but what would a workforce strategy say?

Guy Collis: It would look to be much more long-term. In relation to the questions that you posed before, it would look at trying to give councils, and in turn providers, more certainty so that they could plan properly for the numbers of staff they needed. It would include things like the immigration system, so that they knew what numbers are staff they could expect to access from other countries and what they could not. It would just put everything on a more secure, more certain footing.

Lord Tugendhat: Of course I understand your point about low pay and so forth, but when you say there is a high turnover and the work is highly rewarding, is there not a slight dichotomy there? If something is highly rewarding in the way that you say, there would not be a high turnover, notwithstanding the other conditions.

Sharon Allen: I would have to disagree, I am sorry to say. You might find something marvellously fulfilling, but if it does not pay enough to put a roof over your head and food on the table for your children and something else will, you will do what pays you more money.

What I am trying to say is that we have a high turnover—30% is just not sustainable, and that is an average—but we also have people who have been in the sector for a long time. We find that people come into the sector and possibly do not really understand what the role entails; we are asking people to provide care and support to people with a range of multiple needs, so it is a very demanding role. Once people have got past probably the first 12 months and develop close relationships, they tend to stay, but we need to do something about the high turnover rates.

To add to the point about the workforce strategy, the Department of Health and Social Care has been working with a range of colleagues, including all of us, to develop a workforce strategy that we believe will be a chapter in the social care Green Paper, when that appears. It will address many of the issues that we have talked about, such as recruitment and retention, learning and development, leadership, digital capabilities—all those sorts of things. My colleague is quite right, though: there has not been one for a long time.

Lord Tugendhat: In terms of the high turnover, is there any dichotomy—or any difference, perhaps—between male and female social care workers and between British-born and non-British-born?

Professor Jill Manthorpe: That is an interesting matrix to address. Men are concentrated in social care in certain sectors and certain roles, so there are gendered differences. They are particularly to be found in more professional roles and in some areas of work, such as work with people with learning disabilities and disability. There are very few men, by comparison, in something like the traditional home care service, and very few men on the front line of residential care, although they will be found in the domestic staff—the gardeners and so on. We must always remember that they, too, are people who work in the social care workforce.

We find that men often come in later in life following another job. Here is the opportunity for social care in the Green Paper, and in the imaginings and vision that it will have for how to sustain a workforce, by drawing on examples such as the NHS's work with former service personnel, Stepping up to Public Health. If you have left the services—for a variety of reasons, which are many and multiple—you may have a career in the health service as a paramedic, a chaplain or whatever.

Equally, why does social care, which could be very helpful in this respect, not have the abilities that the health service has to see a new pool of labour and draw on it? We have mentioned recruitment and retention; we also need in social care to be able to re-engage with people, many of whom leave for a break, to have kids or because they are emotionally

exhausted. That goes to the point about not being well paid but being highly motivated; sometimes you are emotionally exhausted.

We have yet to learn about social care staff's work managing death. Everyone in social care dies; that is what you learn quickly. In care homes now, going to a funeral is a very regular occurrence, because people are moving into social care much later in life. The support in the health service or our own employers in relation to encountering death and distress is just not there in social care, so people leave to protect themselves from these very human emotional activities that can lead to stress and distress. While they may get a lot of personal accomplishment in their work, they are at high risk of burnout. They make what I think is the right decision that burnout is not good for a care worker. If you cannot empathise with the individual, you are treating them as a non-human.

On the point about the different statistics and whether men or women stay in, it all depends where they are staying and how long they are coming through for.

On the point about whether people are UK citizens, EU citizens or here on a more temporary basis, we may wish to address that separately, but data has been collected by Skills for Care and other agencies charting those differences, and it is interesting.

Lord Tugendhat: That is a very interesting set of answers to my question. What about the British-born and immigrants? Is there a difference in the turnover rate?

Professor Jill Manthorpe: I do not think there is, no.

Lord Tugendhat: Do we know whether there is?

Professor Jill Manthorpe: Yes, there is data examining the national minimum dataset for social care, and data has been collected on people's migrant status and can compare turnover. I could send you material on that. It depends what work we are talking about, because of the variations between someone who is, say, a senior occupational therapist or senior care worker and someone who is a more domestic carer. They are very different. In the health service, we would talk much more separately, differentiating consultants, midwives, physios and healthcare assistants. Lumping everyone together in the same box is a little risky.

Q77 **Lord Layard:** Did I understand you correctly that there is an average—again, I do not know over which categories—of something like £15,000 for those working in care, and that for a similar bundle of people in the health service it is something like £17,500? That is an extraordinary difference. Does that lead to a difference in the turnover rates?

It would be very interesting if you could say anything about how this problem is handled in other countries, whether there are turnover rates like this in other countries or whether this sector is more highly rewarded and therefore has more normal turnover rates. These turnover rates are

quite extraordinary.

Sharon Allen: You heard the figures I gave for salary levels correctly. It is important also to explain that in adult social care in England, the vast majority of people working in the sector are in direct care-providing roles, so they do not need any qualifications to join the sector, and neither are they professionally regulated, whereas in the health service, the inverse is true: most people in the health service come in through a professional route, and the healthcare assistant role, which is the role I was making a comparison with, is relatively small as a proportion of health colleagues.

I made the point about parity because it is really important, not just in relation to salary but in relation to the whole reward package. There is also the NHS pension. People working in the NHS have access to a card that they can take to retail outlets which says that they work in the NHS and gives them a discount. They have better access to learning and development.

Addressing the salary issue would, I suggest, be a starting point for parity for people who we are asking to go out into the community on their own, unsupervised, to provide high-quality care to our families.

Lord Layard: And the turnover rate in the NHS is correspondingly lower?

Sharon Allen: I believe it is.

Lord Layard: And in other countries?

Sharon Allen: I do not know so much about that. Do you know, Jill?

Professor Jill Manthorpe: It depends which countries we mean, of course. I suppose that our nearest comparators are Australia and Canada. It is difficult to make comparisons between many countries, because their definition of health and social care varies. In many parts of Scandinavia, for example, municipalities will do much more of what would be community nursing, but for us community nursing is now done by social care.

So, yes, there are trends in which, in many countries, direct-care providing that is not medically oriented is not as high status as clinical training, particularly in the western world.

Q78 **Baroness Harding of Winscombe:** I want to ask another follow-up question about retention and reasons for leaving.

Do any of your three organisations have any hard data based on exit surveys of why staff leave? We have heard lots of different hypotheses. In my experience, in front-line unregulated environments such as call centres and supermarkets—the sorts of roles which, I would hazard a guess, a lot of care workers are switching between—these retention rates are not that unusual, but that the reasons why people leave can vary hugely, based on how well they are managed and their conditions.

Do you have any such data, because it would be helpful in understanding

what is not working for people? I do not like leaping to the conclusion that the reason is either money or a lack of support for stress. The data ought to be able to help us.

Sharon Allen: We do not have data on the reasons why people leave, although we have very rich data on the number of people and the roles that they are leaving.

We do have a report, which we published last year, called *Secrets of Success*. We went to organisations with retention rates of 90%, or thereabouts, because obviously there are very high turnover rates and some organisations that are very good at keeping hold of people. What are they doing that others could learn from? Again, there were a range of reasons why people stay with those organisations, including but not just pay. It was about culture, investment in learning and development opportunities and encouraging people to come forward with ideas.

Employers tell us that exit information is incredibly difficult to get from people, because they do not have to give a huge amount of notice and they are not massively motivated to give exit feedback. Organisations try to get it, but we do not have a huge amount of it. I know that you, Guy, have some from the surveys you have done.

Guy Collis: Yes. Ours is less hard data and more anecdotal. It is about the kinds of reasons why staff might consider leaving at the moment. That does not mean that they have left. We can certainly forward our most recent report, *Care in Need*, which came out in November, which we can send to the Committee.

Professor Jill Manthorpe: Of course, when we talk about leaving, we need to break it down into the people who leave that job with that employer and people who leave the sector, and those who come back. I am sure that the care providers you talk to will talk about the immense and immediate pressure of a new supermarket opening not too far down the road. That will be an immense, immediate pressure, but they may come back.

One of the issues is not only retention but allowing the doors to remain open. You will also hear from many providers who talk about “find a friend” and how they monetise that. They know that people who are likely to work can be recruited as friends and family, and they have set up reward systems for that. We need to think about exit from the sector and turn and churn, and why that is.

The National Care Forum provides quite a large amount of data on the successful employers, who appear to have much higher retention rates than their competitors down the road. It tries to explain in some detail the reasons for that: cultures of care, management style and so on.

Q79 **Lord Lamont of Lerwick:** Could I ask you about training and development? Some people have argued that what has happened with nursing, which has become more professional and the qualifications have become more elaborate, should happen with social care. People have

pointed out that Health Education England's budget was £6 billion; the Skills for Care and Development budget in your sector was less than £100 million—

Sharon Allen: It is significantly less.

Lord Lamont of Lerwick: —significantly less—and 70% of local authorities make no provision for training in their contracts with providers. That is quite dramatic. However, we have had witnesses who have gone the other way and said, "No, no, it's not necessary to go down the path that nursing has gone down". Indeed, Warwick Lightfoot from Policy Exchange, who has experience of social care, said that he had seen many environments and situations where untrained people were giving wonderful care and he did not think it was necessary for them to have qualifications.

Sharon Allen: On the funding issue, I would point you to the National Audit Office report that was produced a year or so ago, which made a comparison between the amount of funding that goes through Health Education England and the amount of funding that comes to Skills for Care. Funding that comes to Skills for Care from the department is more in the region of £24 million, half of which is money that we disburse to the sector to support people gaining qualifications. That is a contribution to employers to support their colleagues in getting a diploma at level 2 or above.

We would not support degree-level entry requirements for social care. What we would say is that people need to be supported to gain their qualifications, because it is a skilled job, as I have said a number of times. I am not averse to there not necessarily being an entry requirement. One of the things that we promote is what we call values-based recruitment; we want people who have the right hearts and minds and who understand that the most important person is the person they are providing care and support to. However, we then need to support them in learning the skills and having the confidence and the qualifications.

Going back to the point about esteem, one of the other areas that we have not talked much about is professional regulation. In the other parts of the UK, the social care workforce is professionally regulated. In England, the only roles in social care that are professionally regulated are nurses, social workers and occupational therapists, and between them they make up fewer than 100,000 of the 1.7 million workforce. So it is about getting the balance right. It is not about not having any qualifications, but we do not want to make it so difficult that we exacerbate the recruitment issues that we already have.

Professor Jill Manthorpe: There is an appropriate comparison to be made perhaps with childminders and nannies, who are required to have minimum qualifications such as a first aid certificate. I think everyone with children would be very pleased that the nanny or childminder

dealing with their child had such a certificate. I am rather horrified to learn that you did not need it for yourself or your grandparent or parent.

When we talk about training, we are not talking about three-year degree-level training; we are talking about some very basic things. In social care in particular, where most people self-manage—we manage all our ailments, even our flu, with the help of medication or something—and where people are PEG-fed or on oxygen or life-support systems, as they are very often nowadays, a situation that is covered by the medical phrase “multimorbidity”, which sounds ghastly but means that we have a lot of things wrong with us, that is where we perhaps want people with a bit more training than a first aid certificate. If I am having a PEG feed, which is what people on personal budgets and personal health budgets do, I do not want someone who says, “I don’t believe in training for this. I once met someone who knew someone who said something”, or, “I saw it on a video from America”. I want someone to do my PEG feed right. I want them to look after my feet correctly if I have diabetes, not get out the kitchen scissors or something like that.

This is important work for people whose needs are so very high. When we are considering the eligibility criteria for moving into publicly funded social care, and for people who are in care homes that have many of the same patient profiles as long-stay wards or hospices, we need people who have had training in order to have quality and safety.

Guy Collis: I agree with everything that has been said there. The point about watching videos is not even a throwaway remark; some of our members have reported that that has been the extent of the training they have received before starting on some of these jobs, which is really worrying.

On the point about professional registration, almost all the care members who responded to our surveys said they would like England to go down the route that has been pursued in the devolved nations of having professional registration for care workers.

Baroness Harding of Winscombe: Is there any evidence that professional registration in the devolved nations has delivered benefits?

Guy Collis: It has not come in yet. It is on the way.

Q80 The Chairman: We have another session with some practitioners, and I am conscious that we have run out of time. This has been a most interesting session.

There was one last question, which there is not time to deal with now. It was about your experiences of how the public understand navigating the social care system, and I suspect that that would have taken at least another 10 minutes, so if you would not mind writing to us that would be helpful.

Thank you again, particularly you, Mr Collis, for your excellent paper, which I enjoyed reading on Sunday afternoon. We hope that we will be

able to make an impact when our report is published in due course.