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Social care: funding and workforce

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Health and Social Care Committee

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Introduction

1. The COVID-19 pandemic has thrust the long-recognised crisis in social care funding into public consciousness. The case for reform of the system accompanied by adequate funding, whilst long supported by this and other committees, has therefore never been more urgent or more compelling.

2. Any new settlement must recognise the extraordinary sacrifices made by the social care workforce throughout the pandemic to care for elderly and vulnerable people with utmost professionalism and often at great personal risk. Often this has been in a context of hugely stretched services, sometimes in facilities which were not suitable for isolation, sometimes without adequate PPE and often until September without proper access to regular testing. For their sake as well as the for the sake of the vulnerable people they care for there is an urgent need for appropriate pay, professional career structures and parity of esteem with NHS colleagues. This will not come cheaply but is an absolute necessity in the wake of the commitment the social care workforce has shown in the biggest health crisis of our lifetimes.

3. For decades, successive governments have grappled with the problem of social care funding reform. In its 2019 position paper, Adult social care funding and eligibility: our position, the King's Fund noted that in the past 20 years there have been 12 White Papers, Green Papers and other consultations on social care in England as well as five independent reviews and commissions. Despite this, no lasting solution to the problems in social care has been implemented.[1] This cannot be allowed to continue, so we welcome the Prime Minister's commitment to "tackle the issue of social care":

> There is a growing consensus in this country on the need to tackle the issue of social care, so that everybody has dignity and security in their old age and nobody has to sell their home to pay for the cost of their care. We can do it, and we will do it.[2]

4. This inquiry is the first non-COVID related piece of work we have carried out as a Committee, reflecting the importance we attach to social care. But in the light of the substantial work that has already been done in this area, we felt that a further, in-depth inquiry risked duplication of many excellent previous reports. Instead we have chosen to hold a short, focused inquiry, looking at funding issues ahead of the Comprehensive Spending Review and workforce issues in the context of Brexit. It is not intended to be an exhaustive consideration of every issue relating to social care reform but we hope that it will provide a timely and helpful intervention.

5. The direct consequences of the failure to reform social care funding can be seen clearly in the powerful descriptions provided to us by people who need to use social care services, including those who are disabled and those who are suffering from dementia. On 9 June 2020, Anna Severwright told us of her experiences accessing social care:

1 King's Fund, Adult Social Care Funding and Eligibility
2 The Prime Minister, Hansard 15 January 2020

> As a 34-year-old who has found myself needing social care for about the last eight years, I am really grateful for the care I receive. It keeps me fed, clean and watered, but I feel that I am not able to live a normal life. I do not have enough hours to be able to go out at the weekends and in the evenings, and do a lot of the normal things that make life worth living for us. My life got split up into chunks. How long will it take me to have a shower? How long do I need to get dressed? How long for food preparation? […] I find myself in the position quite regularly where I have to think, "Well, I only have two hours left this week, so do I want to do food shopping, have another shower or go and meet up with a friend?" […] A lot of us who use social care fear our hours being cut. It makes me feel sick to think that my review is coming up because it is so out of my control, and those hours could be cut. I know many people who have had their hours cut, often by up to a third, just like that. That is a third less life that that person can effectively be getting on with and living.[3]

6. Deborah Gray, whose husband Atherton has dementia, also described the problems her family has faced in funding her husband's care:

> The impact on us all is enormous. If my husband had had a tumour or needed dialysis, the NHS would pay for his care, but because he has dementia, it does not […] Care homes recognise that dementia is a disease, and they charge us an extra 15% to look after him because he has dementia and because that involves additional needs. Consequently, when he went into a care home, we had to find £1,000 a week. That is £52,000 a year for his care. It seems like a lot of money, but I always say to my friends when I talk about it that it is extortionately expensive, but it is good value for money. It costs that much to give people good care.[4]

7. At the start of our evidence session with the Secretary of State, the Rt. Hon. Matt Hancock MP, we played Anna and Deborah's evidence to him. Commenting on that evidence, the Secretary of State said:

> They are very powerful videos, aren't they? They in a way effectively capture the challenge that we face as a society with finding long-term reform for social care, because they capture two sides of the problem: one is the high bills and the high cost, and the other is the extra demands and needs that people have over and above that for which the state provides.
>
> The current way that the social care system operates clearly has embedded in it a series of injustices that have grown up over time. One is the system of deciding which care is paid for in the social care system and which is paid for in the NHS, which, as you will know from your time in my job, is essentially decided over a number of court cases rather than anybody taking a policy decision.

3 Q26 Anna Severwright
4 Q111 Deborah Gray

> The second is the fact that many people, including some very vulnerable people, need care, and that care needs to be paid for. As we heard in the first video, some people would like to have more care than can currently be paid for. That in a way highlights the size of the challenge.[5]

8. We welcome the fact that the Secretary of State clearly acknowledged and accepted the problems experienced by Anna and by Atherton, Deborah's husband, and we take this as a strong positive indication that the Government understands the urgent need for reform.

9. The Secretary of State's comments set out how reform of social care funding has two distinct aspects, firstly an immediate, and sustained settlement to address the current funding pressures in the system, and secondly, more far reaching reform to address the historical injustices in the funding system. The need to tackle both aspects of the issue was reinforced by our witnesses from local government;[6] by Sir Andrew Dilnot, Chair of the 2011 Commission on the Funding of Care and Support; and by Lord Forsyth, Chair of the Lords Economic Affairs Committee, whose 2019 report issued a cross-party call to reform social care funding. They told us in oral evidence:

> It is a system that is grossly underfunded. It is very unfair in the way it operates, and it undervalues the people who do a magnificent job in providing social care. We felt that two things need to be done. First, we need to put right the money that was taken out of social care. The budget has fallen very considerably in real terms while demand has gone up very considerably. Secondly, we need to deal with the issue that basic care is being charged for certain types of condition and not for others, as you have just heard. If you have dementia or motor neurone disease, you get no free care. If you have cancer, you get free care. [Lord Forsyth][7]

> We have a system that does not work, does not look after the people who need it well, does not look after those who are providing the care well and does not provide an industry that is attractive to move into. Reform is due now. It has been due for many years, but now seems like a really appropriate time to act. [Sir Andrew Dilnot]

> The first thing, and the most urgent priority, is to make sure that the means-tested system is adequately funded. A whole succession of Governments have put extra bits of money in, recognising that there was not enough, but we need to do more of that now. The overall level of funding of the means-tested system is lower now than it was in 2010–11 despite there being many more people using it. The first essential step is to put more money in for the means test …. The second step is to reform the means test itself because, at the moment, there is a horrible cliff edge in the means test at £23,250. That causes a great sense of unfairness, and inefficiency, incentives to cheat and all kinds of problems. [Sir Andrew Dilnot][8]

5 Q170, Secretary of State for Health and Social Care
6 Qq160–162 LGA and ADASS
7 Q116 Lord Forsyth
8 Qq134–135 Andrew Dilnot

10. In Chapter 1 of our report we address the immediate funding issues facing social care, while Chapter 3 considers what broader reform of the funding system is required. In Chapter 2 we consider the 1.5 million committed professionals who work in the social care sector caring for the most vulnerable members of our society. Their dedication and professionalism has never been clearer than it is now, in the face of the COVID-19 pandemic. Our report therefore also makes a series of recommendations aimed at supporting the social care workforce. **The case for making a sustained investment in social care has never been stronger–the toll the pandemic has taken on this sector means that social care is no longer a hidden problem, but one that the country as a whole understands. We urge the Government to now address this crisis as a matter of urgency.**

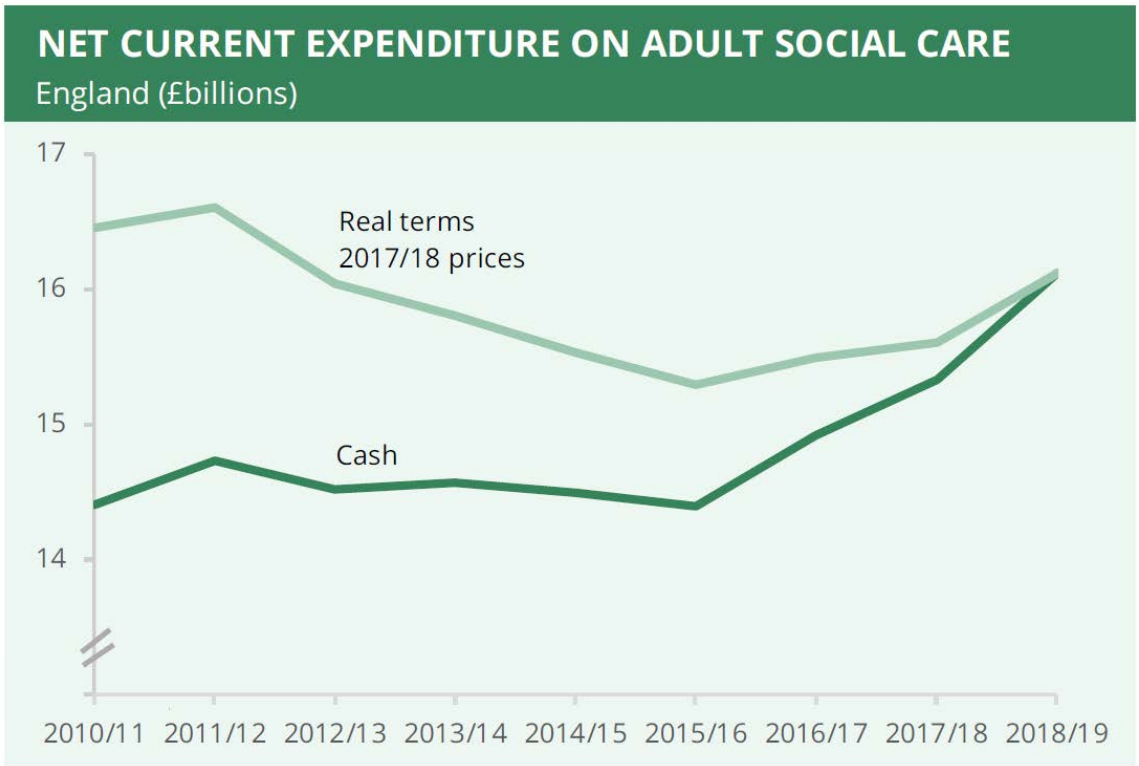
1 Current funding problems in social care

The current situation

11. Unlike the NHS, social care is not free at the point of use. Anyone with assets—including in some cases their home—worth more than £14,250, has to pay for their own social care. Local authorities fund social care for people with assets below this threshold.[9] The first part of the social care funding problem described by the Secretary of State and other witnesses, is the adequacy of local authority funding for social care.

12. Successive governments have attempted to address local authorities' need for more funding for social care through a series of different, short term grants and funding mechanisms.[10] However, despite numerous calls for this, to date there has been no long-term funding commitment for social care.[11]

13. The following graph provided by the House of Commons Library shows how funding for local authority funded social care has changed over the last ten years.[12]



Sources: MHCLG Local authority revenue expenditure and financing and HMT GDP Deflators June 2019

9 £23,250 is the upper capital limit and £14,250 is the lower capital limit. For more information see House of Commons Library, Adult Social Care: Means-test parameters since 1997

10 Department of Health and Social Care (SCF0069)

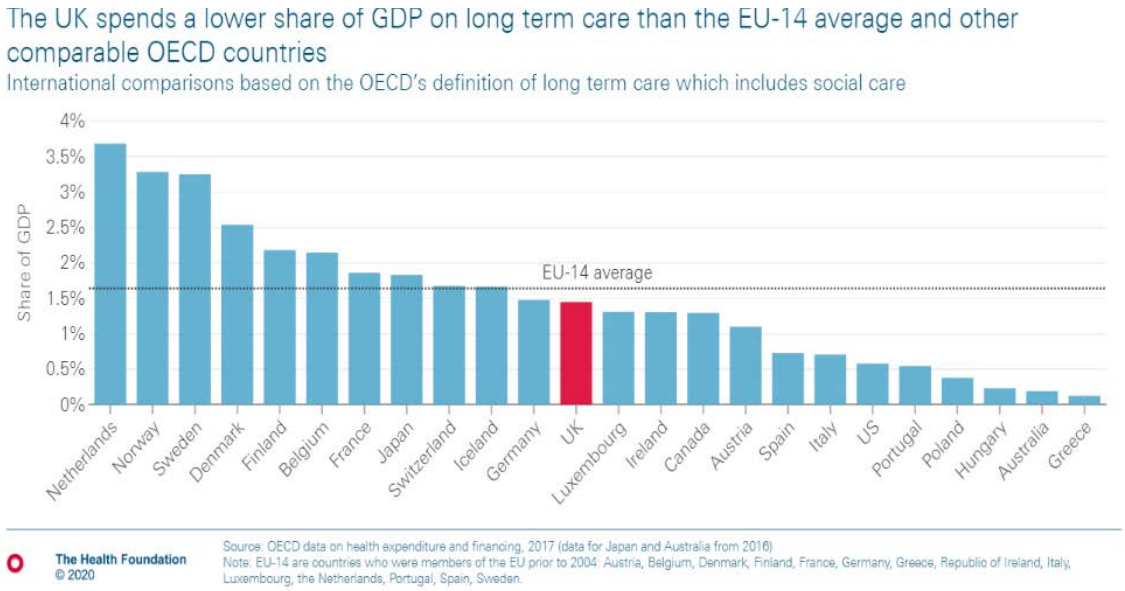
11 Several organisations have called for such a long-term commitment to be provided, including the LGA and Health for Care, a coalition of 15 NHS and healthcare organisations including NHS Confederation, NHS Providers and the Royal College of Physicians.

12 House of Commons Library, Adult Social Care Funding (England), September 2020

14. Although in absolute terms there is now more funding available, demand has grown over the same period meaning the money has had to go further.[13] The number of older people receiving publicly funded social care fell by 400,000 between 2009–10 and 2015–16.[14] Between 2015–16 and 2018–19, the older population increased by nearly 468,000, but the number of older people receiving social care fell by a further 37,000 during the same period.[15] According to the Health Foundation, taking into account an ageing population, spending per person on adult social care services has fallen in real terms by around 12% between 2010–11 and 2018–19.[16]

Comparisons with other countries

15. According to OECD data, the UK Government spends less on social care than the EU-14 average:[17]



16. While some southern European countries spend less than the UK, witnesses explained that in these countries have a long tradition culturally of family-based support and has comparatively low levels of female participation in the labour market.[18]

17. Social care funding and provision is a devolved matter; therefore, this report is concerned with social care funding in England. The Health Foundation estimate that the amount spent in England per person on social care has dropped to around £324 per person in 2017–18, less than spending on publicly funded social care in both Scotland (£446) and Wales (£424).[19]

13 King's Fund, Adult Social Care Funding and Eligibility
14 Health Foundation (SCF0044)
15 King's Fund, Social Care 360
16 Health Foundation (SCF0044)
17 The Health Foundation (SCF0113)
18 Q32 Anita Charlesworth
19 The Health Foundation (SCF0044)

18. The COVID-19 pandemic has exacerbated the financial burden on the social care sector. The LGA quantify this in their written evidence:

> Extra COVID-19 costs and losses of income incurred by councils in March, April and May, amounted to £3.2 billion. This has been met in full by the two tranches of emergency funding provided by government to councils so far. Councils could need as much as £6 billion more to cover the financial impact of coping with the coronavirus pandemic during this financial year. This figure will need to be kept under review. The MHCLG survey assumes things return to normal from July. If councils have used this assumption in their returns, then this figure could rise. Councils need an assurance that all additional costs and losses incurred as a direct result of COVID-19 will be funded by government.[20]

Interface between health and social care

19. Social care and health care are inextricably linked. Many people who need social care need it because of health problems, and people often need social care on discharge from hospital. The differences in the funding models and the delivery of social care and health care lead to difficulties and barriers when people transition between the two. These problems include hospital patients who are ready to be discharged having to wait for appropriate social care to be arranged. Not only does this result in a poor experience for individuals and their families, it also creates hospital flow and capacity issues and consequently also financial problems for the NHS. The NHS has improved its performance on delayed transfers of care, which have fallen by 24% since 2017. However, they have begun to rise again with 22% more delayed days reported in February 2020 compared to the previous year.[21]

The impact on people who need social care

20. At our first evidence session, we heard powerful evidence from Anna Severwright, a 34 year old user of social care services, who described the choices she faces on a regular basis; having to decide whether to use her allotted social care funding to have a shower, go shopping, or go out with her friends. Her story can be read at the beginning of this report.

21. We were also privileged to hear evidence from Kevin Caulfield, a Disabled person and wheelchair user with PML, a rare neurological condition. He is a disabled activist who formed the Disabled People's Commission in Hammersmith and Fulham and is now Strategic lead for co-production in that borough. He highlighted the risk of people going into debt to fund the care that they need:

> It absolutely cannot be acceptable in the 21st century that people are falling into debt to pay for the support that they need and end up in the legal system as a result. That is a fundamental issue that needs to be addressed.[22]

20 LGA (SCF0022)
21 House of Commons Library, Adult Social Care Funding (England), September 2020
22 Q109 Kevin Caulfield

22. Daphne Havercroft also shared with us the experiences of her mother Dorothy's care in the last year of her life, which she felt was driven by cost savings. After Dorothy was admitted to hospital, in common with a lot of older people, she wished to return home with a care package in place rather than move to a nursing home. However, this did not happen, despite the involvement of a total of 101 different people in trying to co-ordinate her care. Her daughter Daphne told us that her assumption was that Dorothy was not able to return home because neither the NHS nor the local authority were willing to fund the package. Instead, Dorothy remained in hospital awaiting discharge before eventually being transferred to a nursing home where she spent 6 months, and from which she had 3 emergency admissions to hospital. In Daphne's own words:

> My perception was that the priority of the hospital discharge teams and community health and social care teams was to spend as little money as possible to support an old lady to live at home safely and help her avoid repeat hospital admissions. I think their cost-saving attempts had the opposite effect. That is evident from her three emergency hospital admissions, the use of the better care fund to keep her in an appropriate residential care setting for six months and the cost of the involvement of 101 people in her case.[23]

The impacts of social care funding shortages on those who need social care were also described in the written evidence we received.[24]

23. Unmet need is frequently raised as a major problem in social care.[25] Described by the LGA as 'rationing' and 'prioritisation', local authorities now restrict funding for social care to those with the most severe needs, meaning that individuals who might previously have been eligible for Government-funded care now either have to self-fund, rely on family, or go without.[26] According to the Health Foundation, over 400,000 fewer older people accessed publicly-funded social care in England in 2013–14 than in 2009–10, a 26% fall despite the rise in the population of older people over the same period.[27] There is no agreement about the overall level of unmet need, but Age UK has a widely-quoted figure of 1.4 million older people who are not getting the care and support they need, an increase of 19% in two years.[28] Sarah Pickup, Deputy Chief Executive of the LGA, gave more detail:

> A lot of unmet need is because of unmet need for care eligibility, not financial eligibility. That is the main reason, I think, for people not receiving services. They do not cross the "substantial and critical" threshold.[29]

24. Quality of care is also impacted by funding shortages. The CQC states that the majority of care remains of a high quality.[30] However, this differs between settings and ADASS found in 2019 that 66% of Directors of Adult Social Services reported quality

23 Q1 Daphne Havercroft
24 Written evidence, see, for example, Care and Support Alliance (SCF0032)
25 Written evidence, see, for example, LGA (SCF0022) Age UK (SCF0041)
26 Q152 Sarah Pickup, James Bullion
27 Health Foundation, (SCF0044)
28 Age UK, press release 2018.
29 Q161 Sarah Pickup
30 CQC, 'The state of health care and adult social care in England 2019/20', 2020

challenges due to funding pressures.[31] The CQC has also identified concerns around providers ceasing to take local authority clients or staff turnover resulting in disrupted or poor quality care.

25. As well as this, evidence from the homecare sector in particular highlighted the impact that funding shortages have on the commissioning relationship between local authorities and social care providers, particularly by creating a "pay by the minute" model which was said to have an adverse affect on social care workers' ability to provide the best possible care:

> We have seen things like pay by minute for homecare. Whoever thought that the critical role of compassion and care can be broken down into paying people by the minute? Out of good will, people are not being paid for walking up someone's garden path or waiting to get in to see the most vulnerable people… it makes you feel that no one trusts you… [Raina Summerson, Agincare Group][32]

> We need to focus on outcomes on a system-wide basis and not just reduce everything to cost and minutes. We must get away from time and task, and look at population level at outcomes and at individual level at outcomes, and then do a sensible calculation of the costs and benefits of different models. [Jane Townson, UK Homecare Association][33]

26. This was echoed in evidence from the Local Government Association who agreed that there is "a mixed picture" of social care commissioning by local authorities but suggested resource constraints mean local authorities cannot always achieve the outcomes they want:

> The resource and capacity constraints that councils have faced are not always conducive to working in the way that commissioning ideally should work, because people are worried that if they talk to providers about what they aspire to, and to people about what they aspire to, what they will aspire to will be way more than the council can afford. [Sarah Pickup][34]

Impact on the workforce

27. The funding difficulties in social care translate directly into the social care workforce; over 20% of care workers are paid only the National Living Wage, with 1 in 5 care workers under the age of 25 paid less than this, and the proportion of care workers paid on or above the Real Living Wage has decreased significantly from 25% in September 2012 to just over 10% in March 2019.[35] The issues facing the social care workforce are discussed in further detail in Chapter 2, but it is clear that fair pay for social care workers must be an integral part of our long-term funding settlement for social care.

31 ADASS, 'ADASS Budget Survey', 2019
32 Q66 Raina Summerson
33 Q81 Jane Townson
34 Q154 Sarah Pickup.
35 Skills for Care, The state of the adult social care sector and workforce in England and Pay in the adult social care sector, 2019

Impact on the care market

28. Social care is delivered by thousands of mainly private companies. Local authorities have been trying to limit how much they pay for services, but providers have been adversely affected by increasing costs, especially for staff as a result of the minimum wage. The result is an increasingly unstable market with growing numbers of providers going out of business or handing back contracts. In addition, some providers are focusing on services for people who fund their own care, and who will pay more. Care providers closing, or closing to local authority residents has a direct impact on those needing care, reducing choice, and in the most extreme cases forcing service users to move to a different care home. ADASS describes this impact:

> We have seen in the last year some 5,000 people affected by hand-backs of contracts to local authorities as a result of providers ceasing to trade. We estimate that currently perhaps a third of all providers are making a loss, and that might rise.[36]

29. Jane Townson of the UK Homecare Association explained to us the issues they face with local authorities paying providers rates that do not even cover their costs:

> We have 13 councils paying less than £15 an hour. That does not even cover the national legal minimum wage and statutory employment on-costs. We believe it should be illegal for councils to purchase care at rates as low as that. Eighteen councils have not given any inflationary uplift to cover the 6.25% increase in NMW that we had in April.[37]

30. Local authorities also argue that the lack of a long term funding settlement also prevents local authorities from commissioning effectively and shaping the care market.[38]

31. Oonagh Smyth of Skills for Care also pointed out that social care is an important part of the economy and needs to be recognised as such:

> We need to realise that the social care sector is a significant contributor to the economy. It contributes £40 billion a year, and we need to start seeing it as a significant sector, employing 1.5 million people, supporting 1 million people a year and contributing a significant amount to the economy.[39]

32. **It is clear from the evidence we have heard that funding shortfalls are having a serious negative impact on the lives of those who use the social care system, as well impacting the pay levels of the workforce and threatening the sustainability of the care market. An immediate funding increase is needed to avoid the risk of market collapse caused by providers withdrawing from offering services to council-funded clients and focusing exclusively on the self-pay market.**

36 Q153 ADASS
37 Q77 Jane Townson
38 Qq154–155 ADASS, LGA
39 Q100 Oonagh Smyth

Funding estimates for social care

33. The current level of funding for social care therefore neither meets the expectations society has for the way older and vulnerable people should be treated, nor makes provision for future pressures caused by both demography and rising wages. Calculating how much money is needed to resolve these issues is complex with different estimates put forward by a number of organisations in recent years. Written evidence to this inquiry has provided useful updates to these figures. These are set out in the table below. It should be noted that these estimates do not take into account the added costs necessitated by the COVID-19 pandemic, which have been calculated separately by ADASS at close to £6 billion.[40] The figures also relate only to funding the existing, means-tested social care funding system adequately and sustainably. They do not cover the costs of more fundamental reform to the means-test, which is discussed in more detail in Chapter 3.

Annual funding increase required	What it would cover	Source
£1.4 bn	Ensuring all care staff are paid the Real Living Wage (currently £9.30, and £10.75 in London)	Resolution Foundation
£2.1bn	Meet future demand–this is the base option where additional funding provided keeps up with underlying demand from an ageing population. [2023–24]	Health Foundation
£3.9 bn	Increase pay - delivering the planned increases in the National Living Wage for care workers with a small pay uplift of 5%, in line with the uplift given to NHS staff [2023–24]	Health Foundation
£4.4bn	Meet demand and increase care provision by 10%. This could be used to increase the amount of care people already receive or expanding care to more people. [2023–24]	Health Foundation

40 ADASS (SCF0099)

Annual funding increase required	What it would cover	Source
£5.5bn	Provide local authorities with additional funding to pay higher costs for care packages–for example to cover higher hourly rates for providing domiciliary care, or higher weekly rates for providing residential and nursing care. [2023–24]	Health Foundation
£7.7bn	Increase care provision and provide funding for higher costs for care packages. [2023–24]	Health Foundation
£7.9 billion	Address the 'provider market gap' (the difference between what providers say is the cost of delivering care and what councils pay) and 'core pressures' (inflation, demography and the National Living Wage). It is projected on the basis of maintaining 2019–20 levels of access and quality.	Local Government Association
£8bn	To restore care quality and access to 2009–10 standards, addressing the increased pressure on unpaid carers and local authorities and the unmet need that has developed since then	Lords Economic Affairs Committee
£10bn	Recover peak spending levels [2023–24]	Health Foundation
£12.2bn	Recover peak spending levels and pay increase [2023–24]	Health Foundation

34. The Health Foundation estimate that simply meeting the growing demand caused by an ageing population will cost £2.1bn per year. Delivering the planned increases in the National Living Wage for care workers with a small pay uplift of 5%, in line with the uplift given to NHS staff, will increase this figure to £3.9bn per year. In order to increase access to social care by 10% an extra £4.4bn would be needed, separate to any pay rises, but to ensure the sustainability of the care market would require an increase in the annual budget of £5.5bn per year by 2023–4. Going further, the Health Foundation estimate that a funding increase of £7.7bn would increase access to social care, and would have a potentially positive impact on workforce numbers and pay, provider sustainability,

and the quality of care. This is slightly lower than, but broadly comparable to, the estimates put forward both by the Lords Economic Affairs Committee, and by the Local Government Association.

35. **The crisis in social care funding has been brought into sharp focus by the COVID-19 pandemic, and this must now be addressed by Government as a matter of the utmost urgency. The funding increase we are calling for is significant at a time when public finances are likely to be stretched, but the pandemic has made it clear that doing nothing is no longer an option. Providing adequate funding for social care will also help the NHS, and may itself have positive economic and long-term social impacts, given that social care is an important part of the economy.**

36. **We believe the starting point must be an increase in annual funding of £3.9bn by 2023–24 to meet demographic changes and planned increases in the National Living Wage. However such an increase alone will not address shortfalls in the quality of care currently provided, reverse the decline in access or stop the market retreating to providing only for self-payers. Further funding to address these issues is therefore also required as a matter of urgency.**

37. **Alongside such a long term funding settlement we strongly believe the government should publish a 10 year plan for the social care sector as it has done for the NHS. The two systems are increasingly linked and it makes no sense to put in place long term plans for one without the other. Failure to do so is also likely to inhibit reform and lead to higher costs as workforce shortages become more pronounced with higher dependency on agency staff. Reducing the 30% turnover rates typical in the sector will also require a long term, strategic approach to social care pay and conditions.**

2 The social care workforce

38. The social care sector employs around 1.49 million people in England across 18,500 organisations. Although social care is a devolved issue, some care staff work across England's borders, and for all recommendations in this chapter, consideration should be given to ensuring, where possibly, a consistency of approach between the four nations. Nonetheless, the workforce is under significant pressure, with 122,000 vacancies, a turnover rate of 30.8%, and a quarter of staff employed on zero hours contracts.[41] As the UK population ages, demand for social care is rising, calling into question the long-term sustainability of the social care workforce. Estimates suggest that if the adult social care workforce is to grow proportionally to the number of people aged over 65, 580,000 more social care jobs will be required by 2035. If it is to grow proportionally to the number of people aged over 75, this figure would rise to 800,000 jobs.[42]

39. Social care workers have been on the frontline during the coronavirus pandemic. It is not yet clear what the long-term impact of the crisis will be on the workforce, but it appears that existing pressures have left the sector ill-equipped to respond, with severe consequences for both social care staff and the people they care for. ONS data has shown that social care workers died at double the rate of healthcare workers during the peak of the pandemic, and that 19,394 care home residents have died of COVID-19 to date.[43,44]

40. We have heard from several social care workers who described how difficult it has been working during the pandemic. One social care worker who wished to remain anonymous told us:

> It's actually been horrible because you don't know exactly what will become of you, you don't know what you are carrying within yourself, you don't know how long you can sustain without being infected. […] It's scary. You just live day by day and you just see how much your body is telling you. Most of the time I try as much as possible when I am [home] from work to […] stay away from [my children] which is […] not too nice.[45]

41. Mel Cairnduff, a senior care worker in Dorset, described feeling even less valued by members of the public during the pandemic:

> We get tutted at because we are in uniform out in the street. People tell us that we should not have our uniforms on, but they do not understand what a domiciliary care worker does. We go to people's houses. We work in our uniforms and we keep those uniforms on throughout the day in everybody's house.[46]

41 Skills for Care (SCF0067)
42 *Ibid.*
43 *Ibid.*
44 Office for National Statistics, Deaths involving COVID-19 in the care sector, England and Wales, July 2020
45 Transcripts of interviews with care home managers (SCF0112)
46 Q57 Mel Cairnduff

42. The challenges faced by social care staff during the pandemic were exacerbated by difficulties in providing them with sufficient personal protective equipment (PPE), as well as routine coronavirus testing. We heard that PPE was a significant challenge for care homes well into the pandemic. In mid-May Professor Martin Green, Chief Executive of Care England, stated "even now, we are still in a position where people are not getting enough PPE."[47] This was echoed in evidence from social care workers and providers: Raina Summerson describes having "a tremendous challenge getting PPE" while one social care worker suggested they were not provided with PPE until lockdown was eased in June.[48,49]

43. We welcome the Government's focus on the provision of PPE to health and social care staff and we were reassured to hear from Lord Deighton that between June and December the UK is expected to secure 2.5 billion items of PPE for the health and social care sector.[50] **It is vital that the supply of PPE to social care providers is protected in the event of any future surges of coronavirus so that providers can be confident in their access to PPE.**

44. The testing of social care staff for coronavirus was also raised in oral evidence sessions. Professor Green was clear in his evidence that social care needs regular testing of staff and residents, stating "it has to be done two or three times a week if possible, so that we can really get on top of this."[51] This was echoed by other witnesses including Adelina Comas-Herrera of the London School of Economics, Vic Rayner of the National Care Forum, and James Bullion, President of ADASS. Despite this, in mid-May James Bullion, President of the Association of Directors of Adult Social Services (ADASS), stated that "we are nowhere near the level of testing required."[52] One care worker described having their first coronavirus test on 20th June, while another described facing challenging behaviour from service users early on in the pandemic when there were no testing kits and therefore no way for staff to reassure worried service users that they were COVID-negative.[53,54]

45. The roll-out of routine testing to care homes is a positive development and a major step forward in improving the resilience of the sector to a second wave. However we were concerned to hear reports that test turnaround times for asymptomatic staff have been lengthening given the vital importance of quarantining anyone with the virus before they can infect vulnerable residents.[55] ***The Government must ensure that standards for weekly testing for care home staff are maintained including rapid turnaround times and that regular data is published on the number of tests delivered to social care staff and residents. In addition, the Government should consider extending routine testing beyond care homes to other care settings, particularly domiciliary care and consider including a named key relative in routine testing.***

47 Q478 Professor Martin Green
48 Q63 Raina Summerson
49 Transcripts of interviews with care home managers (SCF0112)
50 Q553 [Lord Deighton]
51 Q468 [Professor Martin Green]
52 Q474 [James Bullion]
53 Transcripts of interviews with care home managers (SCF0112)
54 Transcripts of interviews with care home managers (SCF0112)
55 Helen Whately, 1 September 2020, vol 679

Recognition of social care workers

46. Despite their place on the frontline facing these challenges, the care workers we heard from also told us that they felt a lack of recognition during the pandemic. In the early days of the pandemic, social care workers saw the recognition that was given to NHS staff and described feeling left out by comparison:

> I do not think that the staff are given the same recognition as staff who work for the NHS. Even at the weekend, there was this amazing sign in a shop window saying 30% off for all NHS employees. That is really demoralising, because we are making the same effort and doing the same work. There are people here who worked 14-hour days and went to the shops at the end of the evening, trying to provide for their family, but were not given the opportunity to cut the line, because they did not wear an NHS badge.[56]

47. The emphasis on NHS workers was later expanded to include 'key workers' but the social care workers we heard from did not feel more recognition as a result of that change:

> I know they say "key workers", but, if the care element—social care—was part of that and we were looked at as key workers, there would be an element of understanding our role and supporting us as well.[57]

48. There have been efforts by the Government to improve the recognition of social care, including the CARE badge promoted by the Department of Health and Social Care. That has been appreciated by some of the social care workers we heard from although we remain concerned that the badges have only been distributed to a small portion of the workforce. We would also encourage the Department to work with devolved governments to see if the scheme could be rolled out across the UK. But despite this welcome initiative, poor recognition remains an issue for the sector, with social care workers feeling unvalued. Social care workers we spoke to suggested that this was a key factor behind the high turnover and vacancy rates in the social care workforce.[58]

49. **Improving the level of recognition afforded to social care workers must be a key focus for the Government to safeguard the future of the social care workforce. Not to do so would be to fail the many thousands of care workers who have worked so tirelessly during the coronavirus pandemic. Building on initial steps such as the CARE badge and recruitment campaigns for social care, there are a number of practical changes which the Government must make to improve the level of recognition felt by social care professionals and to support the future sustainability of the workforce. These are detailed below and in our recommendations.**

56 Q50 Marlene Kelly
57 Q67 Sue Ann Balcombe
58 Q50 Sue Ann Balcombe, Marlene Kelly

Pay and conditions

50. We have heard from several witnesses that pay is a key issue for the social care workforce. They told us that this is a significant determinant of high turnover and vacancy rates and gives a perception of social care as low-skilled work. As Anita Charlesworth of the Health Foundation told us, "Social care work at the moment is highly skilled work, but it is not recognised in pay on average." The average wage for social care is just 2% above the national living wage.[59]

51. There was a high degree of consensus in the written evidence we received that low pay is a significant factor undermining the resilience of the social care workforce. Pay in social care is uncompetitive, not just compared to health but also to sectors such as retail. This devalues social care workers who are often highly skilled; is a factor in high turnover rates and high numbers of vacancies; and as a result undermines the quality and long-term sustainability of social care.[60,61,62,63,64] Marlene Kelly, a registered manager of a care home, described the benefits of being able to provide competitive pay, as well as the impact of low pay:

> The majority of my staff have been here 10 years. They stay if they are valued and paid well, but the difficulty is that you have to compete. We have had members of staff come for a short period and then leave because they can earn more in retail with less responsibility. Unfortunately, that is the truth, and that is when we are paying them well and retaining them. The competition is still great.[65]

52. We recognise that things have improved in the last five years with the increase in the Minimum Wage from £6.70 per hour in 2015 to £8.20 per hour today and the introduction of the National Living Wage now set at £8.72. However the Department of Health and Social Care acknowledged the ongoing impact of low pay in its evidence to this inquiry, in particular on the recruitment and retention of staff in social care.[66] The Department has committed to ensure that pay is "factored into forward looking work to strengthen the sector moving forwards": we await more detail about what this will involve.

53. The provider market in social care, however, means that increased funding for local authorities to commission social care services does not guarantee that wages will be increased, and one-off funding settlements do not ensure sustainable pay increases over the long term. For this reason, both the Local Government Association (LGA) and ADASS advocate structural reform of pay in the social care sector. In evidence to this inquiry, the LGA called for an integrated approach to pay across NHS and social care, whereby social care workers in lower bands are paid according to equivalent NHS Agenda for Change rates.[67] Similarly, James Bullion of ADASS called for a 'National Care Wage' of £10.90 per hour, linked to the pay of a band 3 NHS healthcare assistant.[68]

59 Q29 Anita Charlesworth
60 Skills for Care (SCF0067)
61 Local Government Association (SCF0022)
62 Care England (SCF0023)
63 Trades Union Congress (SCF0072)
64 King's Fund (SCF0064)
65 Q53 Marlene Kelly
66 Department of Health and Social Care (SCF0069)
67 Local Government Association (SCF0022)
68 Q156 James Bullion

54. **We welcome the Government's commitment to bringing forward a long-term solution to low pay in social care. It is essential that this solution provides a sustainable basis for continued rises in pay above and beyond increases to the National Minimum Wage and in line with increases given to NHS staff. Evidence from the Health Foundation and others demonstrates that this must be supported by investment: the Health Foundation estimates that to increase the average pay in social care to just 5% above the National Living Wage, while meeting future demand, would cost an extra £3.9bn per year by 2023–24.**[69]

55. ***The Government must use the forthcoming Spending Review to ensure that there is a sustainable funding settlement to provide for competitive pay for social care workers which ensures parity with NHS staff and is reflective of the skilled nature of social care work. Parity could be achieved by linking social care pay to equivalent bands of the NHS Agenda for Change contract and introducing meaningful pay progression.***

56. Working conditions are also an issue for the social care workforce. Many organisations have highlighted that a quarter of workers in social care are employed on zero hours contracts, which the Health Foundation, UNISON and other organisations have pointed to as a further reason for high turnover.[70,71,72,73] In particular, the proliferation of zero hours contracts was suggested to have left the social care workforce particularly vulnerable during the coronavirus pandemic. The Health Foundation explained to us that:

> In the short-term, the social care workforce has been disproportionately affected. The high proportion of people on zero hours contracts means that incomes are precarious as a result of the need to self-isolate due to COVID-19 and may dissuade people from self-isolating, which is vital to controlling the spread of COVID-19.[74]

57. The need to improve working conditions for social care workers was also highlighted in evidence from the Nuffield Trust and the Trades Union Congress.[75,76] One social worker summed up the anxiety they felt over the impact that sickness absence during coronavirus could potentially have on their life and livelihood:

> At the end of the day, with sickness you just find yourself thinking what can I do? I can't really stay out of work because if I stay out I'm just going to be paid statutory sick pay […] That doesn't pay your bills, that doesn't pay anything. And you find yourself struggling.[77]

69 Health Foundation (SCF0044)
70 *Ibid.*
71 UNISON (SCF0030)
72 Nuffield Trust (SCF0056)
73 Adam Smith Institute (SCF0004)
74 Health Foundation (SCF0044)
75 Nuffield Trust (SCF0056)
76 Trades Union Congress (SCF0072)
77 Transcripts of interviews with care home managers (SCF0112)

58. ***Inadequate employment conditions undermine the sustainability of the social care workforce and have been brought into sharp relief by the coronavirus pandemic. As well as addressing issues of pay within the social care sector, we recommend that the Government bring forward proposals to support the improvement of employment conditions in the sector, including reducing the over-reliance on zero hours contracts and improving the provision of sick pay.***

Training, career development and professionalisation

59. The majority of the evidence we received highlighted the lack of a defined career path for social care workers as a significant problem for both the recruitment and retention of social care staff. For example, in oral evidence to the Committee, Professor Martin Green stated that the graduate entry scheme for social care, now run by Skills for Care, is not as well funded and therefore smaller than both of its predecessor schemes and the NHS graduate scheme.[78] In addition, Bupa Care Services, the National Care Forum and the Nuffield Trust also highlighted the lack of an effective training pathway and pipeline of supply as another serious concern.[79,80,81]

60. As an example of how training pathways could be improved, Professor Tine Rostgaard from Roskilde University provided us with a best practice example of training from the Danish social care system, where a more integrated approach is taken and the workforce is highly professionalised.

Box 1: <The Danish social care training system>

In Denmark there is an integrated training system for health and social care staff which provides degree-level qualifications to social and healthcare helpers and social and healthcare assistants. This training involves placements in both healthcare and social care settings including hospitals, residential care homes and home care, providing a multidisciplinary grounding for future helpers and assistants, fostering mutual understanding between health and social care and providing flexibility for future health and social care staff.

Social and healthcare assistants in particular are analogous to advanced practitioners in England: Professor Rostgaard described how many assistants have increasingly taken on some of the tasks and responsibilities of nurses, which has helped to create both a sense of pride in the profession, and a clear career progression for social care staff.

Source: <Q21 [Professor Rostgaard]>

61. Professor Green, Oonagh Smyth (Skills for Care) and Jane Townson (UK Homecare Association) emphasised the unique skills of care and therefore did not necessarily support a completely integrated training structure. Nonetheless there was a consensus that parity in terms of training and some level of integration would be beneficial. Professor Green in particular highlighted the disparity between the amount of public money spent on social care training compared to training in the NHS, and called for "a much more integrated career pathway, and proper escalators for care roles as well as health roles."[82]

78 Q95 Professor Green
79 Bupa Care Services (SCF0035)
80 National Care Forum (SCF0075)
81 Nuffield Trust (SCF0056)
82 Q83 Professor Green, Oonagh Smyth, Jane Townson

62. **The Secretary of State has committed to increasing the alignment between the training of NHS and social care staff and his stated ambition being to make it easier for a registered nurse, for example, to move between the NHS and social care is an important one.[83] We await more detail about how this increased alignment will be achieved. It is important that this increase in alignment of training is not focused solely on nurses and other social care workers with a registered qualification, or allowing care staff to more easily move to higher paying roles in the NHS. Establishing a clear career path with substantial training opportunities, more effectively aligned with the NHS is vital for all entrants to the social care workforce.**

63. As well as weakening recruitment into social care professions, the absence of a defined career development and training pathway for social care workers also harms retention. Several social care workers raised this in evidence to us. Marlene Kelly told us that her team want to work towards professional qualifications more in line with NHS qualifications, while another social worker, who wished to remain anonymous, called for more integrated training in line with the teaching care homes pilot run by Care England and the Department of Health and Social Care. Another care worker anonymously described social care as "a career [at] a standstill," with too little opportunities for training and progression.[84,85,86]

64. We recognise that many social care employers do invest in training for their own staff, as Oonagh Smyth pointed out to us, and these employers have lower turnover rates.[87] Indeed, Mel Cairnduff described the training she has been on to administer controlled drugs and told us specifically that she feels valued by her company.[88] Yet despite the efforts of some employers, the absence of an effective career pathway and universally recognised qualifications for social care workers limits progression and recognition, and as a result harms retention.

65. One particular aspect of progression and recognition which was raised by several of our witnesses is the development of clinical skills in social care, whereby social care workers are able to take on some clinical tasks such as administering medication and caring for wounds.[89] These opportunities were seen by social care workers as a positive step forward for both the advancement of their own skills, and for improving the recognition of their work by the NHS and the wider public. Despite the many difficulties faced by social care workers during the coronavirus pandemic, the opportunity to work autonomously using these skills was felt to be particularly important, and witnesses warned about the damage that could be done if that autonomy is not preserved. Marlene Kelly told us that:

> If at the end of it, those responsibilities are taken back from the team—"You can no longer change a pressure dressing," or "You are not qualified to do this or not responsible enough to do that,"—they are going to be really demoralised.

83 Q178 Secretary of State for Health and Social Care
84 Q50 Marlene Kelly
85 Transcripts of interviews with care home managers (SCF0112)
86 Transcripts of interviews with care home managers (SCF0112)
87 Q75,Q93 Oonagh Smyth
88 Q57, Q60 Mel Cairnduff
89 Q60 Mel Cairnduff

This was echoed by Raina Summerson who said:

> There is a danger that people have had a brief look at what it is like to get some acknowledgment, and if it is taken away that is going to have a more detrimental effect than before.[90]

Professor Green agreed:

> Likewise, there are some of the ways in which care staff have stepped up and delivered services that used to be delivered by a whole raft of other parts of the system. We could consolidate that, acknowledge it and make it part of the funding process. There are lots of things that have been positive. What we must not do is slip back to the previous point.[91]

66. The evidence we received was consistent in recommending that professionalisation, training, registration and regulation of social care workers should be the ultimate goal of reform in the care sector and that it should be accompanied by more consistent routes into the profession and increased professional development after qualification.[92,93,94] Our evidence also pointed towards an immediate focus on the development of more consistent and recognised training pathways for existing staff.[95,96]

67. **As part of its long-term proposals for the future of social care, we recommend that the Government work with Skills for Care and the social care sector to bring forward a plan to streamline the training of social care workers in order to improve routes of entry to the profession and improve career progression for existing social care workers. The plan should include proposals to improve alignment with training for NHS staff and to improve the professional recognition of social care staff. We further recommend that the workforce development fund be expanded to implement the plan, ensuring that all staff are able to access funding for training and career development.**[97]

Immigration

68. Around 17% of the current social care workforce originates from outside of the UK, a proportion which rises to 40% in London.[98,99] A large body of the written evidence we received expressed concern about the impact of the Government's Immigration Bill on the social care sector, given that the average salary in social care will fall below the Government's proposed salary threshold. Social care workers without a recognised qualification are not identified under the Government's new health and care visa, and are not covered by other arrangements such as the Shortage Occupation List.[100] This has opened up a gap in the Government's stated commitment to treat the two sectors with parity of esteem.[101]

90 Q66 Marlene Kelly, Raina Summerson
91 Q99 Professor Green
92 Q95 Professor Green, Oonagh Smyth, Jane Townson
93 National Care Forum (SCF0075)
94 GMB (SCF0060)
95 Q95 Jane Townson, Oonagh Smyth
96 Nuffield Trust (SCF0056)
97 Q91 Oonagh Smyth
98 Q100 Oonagh Smyth
99 Health Foundation (SCF0044)
100 Q100 Oonagh Smyth
101 Q174 Secretary of State for Health and Social Care

69. Professor Martin Green stated the proposals in the Immigration Bill would have "a significant effect" on social care and called for a transition plan while domestic supply is improved; Oonagh Smyth argued that these changes would introduce further "fragility" into the sector, while employers such as Bupa Care Services called the current plans "a source of serious concern."[102,103,104]

70. The Government's proposed changes to immigration rules are also a cause of concern for social workers, who felt that the definition of social care as 'low-skilled' for the purposes of immigration policy does not reflect the level of skill they are required to have, and undermines the professional recognition of social care workers. As one care worker who spoke to us anonymously said:

> I think especially the Immigration Bill that was recently published. I think that's what makes a lot of carers, like myself, really upset because I looked at the list on the Immigration Bill of those that were considered skilled workers […] but to my great dismay I realised that carers were not among it.[105]

71. Over-relying on recruitment from overseas is not beneficial for the long-term sustainability of the social care workforce. However, it is vital that the domestic supply of social care workers is sufficient and consistent enough to make up for any shortfall in international supply when the new immigration rules come into force. It has been suggested that high levels of unemployment caused by the pandemic may provide a short-term source of labour.[106] In that respect, we welcome the figures shared by the Secretary of State which suggest that the vacancy rate in social care has fallen from 7.8% last year to 6.6% currently.[107] Nevertheless, the evidence we received was clear that planned changes to the immigration system run the risk of having a negative impact on the social care workforce, and it is not clear, despite short term reductions in vacancies, that there is a sustainable future pipeline of domestic supply.

72. ***The Government must ensure that transitional arrangements are in place to ensure that social care workers can continue to be recruited from overseas for as long as it takes to build sufficient resilience in the domestic supply of social care workers. We agree with the Migration Advisory Committee (MAC) that building this resilience will depend on improving pay and other workforce issues in social care.***

73. ***We are concerned that lower qualified social care workers and those without qualifications at all are not eligible for the new NHS visa, not least because it undermines parity of esteem between the health and social care sectors. The Government should accept the MAC's recent recommendation to add senior social care workers to the shortage occupation list. We welcome the MAC's plans to conduct further research on the social care workforce: this research should consider the impact of new immigration rules on the ability of care providers to recruit to less senior roles.***

102 Q79 Professor Green
103 Q100 Oonagh Smyth
104 Bupa Care Services (SCF0035)
105 Transcripts of interviews with care home managers (SCF0112)
106 Q74 Oonagh Smyth
107 Q174 Secretary of State

3 Longer term reform of social care funding

74. Unlike the NHS, social care in England is not free for all those who need it. People who have savings over a modest threshold, or who own their own property, will need to use their savings and potentially sell their home to fund their care. According to the Alzheimer's Society, the total cost of care for people living with dementia is typically £100,000, but that cost can rise to as much as £500,000. Two-thirds of this cost is currently being paid by people with dementia and their families, either in unpaid care or in paying for private social care. The risk of that level of cost is high; one in ten over 65s will pay more than £100,000 for their care.[108] In addition, the means-tested system has also led to a situation where the care home market relies on significant cross subsidy between care-home residents paying for themselves and those who are funded by their local authority. On average, a self-funder's care home place costs around 40 per cent more than one paid for by the local authority.[109]

The impact on people who need social care

75. During the course of this inquiry, we were given vivid descriptions of the impact the current social care funding system by from people who use social care, and their families.

Unfair distinction

76. Deborah's husband Atherton, who worked for the NHS as a doctor, was diagnosed with dementia in his 60s. She described the profound unfairness faced by those who are diagnosed with this devastating illness, and can find themselves without any financial support:

> My husband was a doctor in the NHS. He was really proud to be a doctor in the NHS. He spent his whole life paying his national insurance, in the knowledge that when it was his turn the NHS would take care of him, but it hasn't.
>
> He was a poet. He had vigorous interests in astronomy, the arts and philosophy. Now, he is unable to utter a couple of words at a time. He has seizures and falls. He is doubly incontinent. He doesn't recognise his own children.
>
> Dementia is not just a matter of ageing. Liver failure is not like that. Cancer is not like that. It is the unfairness of the treatment of somebody with dementia that makes me really angry. It is like picking up a random card from a pack and saying, "Oh, you've got this particular one. Tough. That's the disease the NHS isn't going to pay for."[110]

108 Alzheimer's Society (SCF0034)
109 King's Fund, Adult Social Care Funding and Eligibility
110 Q111 Deborah Gray

77. Deborah's words were echoed by Lord Forsyth, Chair of the cross-party Lords Economic Affairs Committee whose report on the funding of social care was published last year:

> We need to deal with the issue that basic care is being charged for certain types of condition and not for others, as you have just heard. If you have dementia or motor neurone disease, you get no free care. If you have cancer, you get free care.
>
> I believe in the principles of the health service, which are that you should be able to get care according to need regardless of ability to pay. I do not understand how it can be right that someone with motor neurone disease is not treated in exactly the same way as someone with cancer … The false distinction, and the hardship and stress it causes to families, is something I find intolerable.[111]

Choosing your care according to price

78. Pamela King described the experience of supporting her sister, Diana, to make arrangements to pay for the long term care she needed after suffering a stroke. She told us how, as a self-funder, her sister's choice of care provider was restricted by what she could afford–a dilemma not faced by people accessing NHS services:

> I found from experience that the cheapest home I could find in our Leicestershire area was £650 a week. Hers is currently £712. There are many more at £800 or £1,000 a week. The one she wanted to go to, and asked to go to, was between £1,000 and £1,100 a week. I had to say to her, "I'm sorry, but you can't."[112]

Demeaning financial assessment

79. Drawing on his experiences, Kevin Caulfield also told us that he felt it was demeaning to be subject to a financial assessment at a very vulnerable time in your life:

> The financial assessment process is often demeaning. It comes at a point in people's lives when they need support and peace and tranquility. Instead, what happens is that you move further and further away from that. Overnight, my life changed in terms of me needing state support to live independently. I cannot survive without that support, but then you start on a whole process of taking you further away in terms of the additional burdens that are placed on you as an individual to navigate the system and deal with the assessment and charging process.
>
> It reinforces the sense of you being other and different. The underlying message is of being a burden and expensive. These are all negative messages. If we are really interested in developing a national care and support service

111 Q119 Lord Forsyth
112 Q107 Pamela King

> that meets people's needs, those things have to be taken into consideration. They are all issues that disabled people have been raising for 20 years or more. They are not new.[113]

Difficulty of navigating the system

80. Our witnesses with experience of the social care system also described the huge difficulties they face, as self-funders, in arranging care for their loved ones at a very stressful time in their lives, with very little support or guidance. Deborah described the system she had to navigate, without any signposting, as a 'quagmire', and told us that information was 'confusing, hard to find, and contradictory' and that a lack of information made it impossible to plan ahead.[114] Several years after her husband Atherton started needing care, Deborah discovered a day care centre which would have been very helpful to her husband, seven minutes away from their home, but the confusion and lack of signposting meant they had missed out on it for several years.[115] Pamela described having to help her sister choose care from a directory provided by social services but which had no prices in it, "because the prices change all the time".[116]

Risk of having to move to a cheaper home

81. During our inquiry we heard that the way the funding system currently works subjects care users to the risk of great uncertainty and upheaval as their savings are spent and they approach the £23,500 threshold to become eligible for local authority funding. Pamela King told us:

> She hadn't got any property and she was renting, and all the money she had was in pension pots, but they said that because she had more than £23,250, she would have to pay for her own care. She was paying in full for her own care until very recently, but I was advised not to find somewhere too expensive because when the time came that we needed to get social services to pay any difference, if we had chosen somewhere too expensive, they would probably ask me to move her out into a cheaper home.[117]

82. Pamela told us of the huge anxiety she and her sister then faced as her sister's money ran down towards the £23,250 threshold, and the risk that the local authority would move her to a cheaper care home. The local authority initially asked Pamela and her brother, both pensioners, to pay the top-up fee of £109 per week to enable their sister to stay in the care home which she had chosen and where she was settled. As they couldn't afford it, they had to go through a further local authority process of a review board to determine whether Diana would have to move.[118]

113 Q109 Kevin Caulfield
114 Qq111–112 Deborah Gray
115 Qq111–112 Deborah Gray
116 Q103 Pamela King
117 Q103 Pamela King
118 Q107 Pamela King

No incentive to plan for the future

83. It is not just older people who are adversely affected. We also heard that, for younger adults with lifelong care needs, the current funding system leaves them with no incentive to save or to buy their own home. Anna Severwright described the situation she faces as a young person with ongoing care needs:

> I have had genuine conversations with my family that at some point I will probably inherit half a house. That money will go completely. I would become completely a self-funder, and that money will be spent on social care. Some people might think that is right and some people might think it is wrong; I don't know. If I was not having social care and I inherited half a house, I could think about investing that money and doing all sorts with it. Obviously, if I spend it very quickly—I don't know on what—it would not go on social care. For me, there is some sense of inequity. Perhaps the only thing that could come in, if we are still going to contribute to care, is some sort of cap, so that once I have spent £40,000 in my lifetime on care, any money I then save, inherit or earn would be mine and would not be touched for social care.[119]

Written evidence to the inquiry backed up the impacts described by the service users we spoke to.[120]

Impact on the care market

84. Sir Andrew Dilnot told us that the current funding system also had a negative impact on the care market:

> At the moment, the funding model means that if you have to buy social care, as Pamela, Kevin and Deborah all do, it is a bit like being in a shop with no prices. Although you know how much the price is per week or per month, you have no idea how long it will carry on, so you do not know what the overall cost will be. That makes it very difficult as a provider to invest and innovate. Forgive me for being an economist for a moment. Instead of there being a nice downward sloping demand curve, there is, effectively, a flat demand curve at whatever the cost of the minimum level of provision will be. That makes it very hard to innovate or invest. I would emphasise that the funding model not only creates fear, unfairness and anxiety for individual consumers, but also makes it a very difficult market in which to be a provider and contributes to the low and very consistent level of wages.[121]

85. As we set out in Chapter 1, the warnings about the future viability of the care market were expressed clearly and unequivocally by our witnesses representing local government.

119 Q45 Anna Severwright

120 See, for example, Motor Neurone Disease (MND) Association (SCF0100); Independent Age (SCF0043); Alzheimer's Society (SCF0034)

121 Q142, Sir Andrew Dilnot

The options for reform

The Japanese system

86. We were privileged to take evidence from Yasu Shiozaki, who previously served for three years as Minister for Health, Labour and Welfare in the Cabinet of Japan. Minister Shiozaki described the Japanese reforms that were introduced in 2000 to address difficulties in providing and funding social care for their rapidly ageing population.

Box 2: <social care funding in Japan>

Japan introduced a new long-term social care system in 2000, to meet the challenges caused by a rapidly ageing population and decreasing capacity for families to take care of older relatives.

The system provides universal comprehensive social care packages for those who need them, which are co-ordinated by care managers. As well as increasing access to social care, the introduction of this system has resulted in a very active competitive market for care providers, who compete on quality and reputation rather than price, with prices set nationally.

Service users pay a co-payment of between 10% and 30% of the total care cost. Those in residential care pay 'hotel costs' (accommodation and food) but these contributions are means-tested and capped for those on low incomes. The system is funded through general taxation and through 'premiums' paid by all people over 40 at a rate of 1% of income.

87. Minster Shiozaki told us that these reforms have had a positive impact on the care provider market in Japan, expanding the number and variety of affordable care services. It has resulted in people who use care, and their families, having a choice, and has delivered greater efficiency, variety and flexibility of services. Of equal importance, it has mitigated the financial burden arising from out-of-pocket payments by each household. As a result, the burden on family carers—particularly women—has decreased. Finally, the improved access to affordable social are has brought about a reduction of hospitalisation without due clinical need.[122]

88. Minister Shiozaki told us that, in common with many social care systems, financial sustainability is always a big challenge. Japan is also facing workforce problems, with a shortage of social care workers which they plan to tackle by growing their international recruitment of care workers. While accepting that 'nobody loves being taxed', Minister Shiozaki said that the public insurance scheme for elderly care has now been accepted as an indispensable part of the social infrastructure.[123]

89. **The current system is unfair, confusing, demeaning, and frightening for the most vulnerable people in our society, and their families. It is therefore essential that the Government tackle the problems in the care sector as a priority. The success of the reforms in Japan has demonstrated that it is possible for a Government to grasp the nettle and take decisions on social care which, though they may be initially difficult, lead to positive and lasting change which is widely accepted by society.**

122 Q126 Minister Shiozaki
123 Q127 Minister Shiozaki

Options for reform—free personal care and a cap on care costs

90. In this section we consider the options for long-term sustainable reform of the funding of social care. We were grateful to Lord Forsyth, Chair of the Lords Economic Affairs Committee, whose in-depth inquiry into social care funding reported in July 2019; and to Sir Andrew Dilnot, Chair of the Government's Commission on the Funding of Care and Support, which reported in 2011 who gave evidence on their proposals for a long-term solution.

Lord's Economic Affairs Committee's report on social care funding

91. Lord Forsyth's Committee recommended the introduction of free personal care, with an estimated cost of £7bn:

> The Government should introduce a basic entitlement to publicly funded personal care[124] for individuals with substantial and critical levels of need. Accommodation costs and the costs of other help and support should still be incurred by the individual.[125]

92. In Scotland, where free personal care is in place, a limit of £180 per week is placed on funding for personal care, with a further £81 for people needing nursing care. If care costs more than that, the person's savings or assets would be used to pay the difference. The Health Foundation estimate that free personal care allowances currently only meet around 25% of the weekly cost of a residential care home. The Health Foundation's estimate of introducing a version of the Scottish system in England is £5bn.

93. Free personal care was also a key recommendation of the report on the Long Term Funding of Adult Social Care published by our predecessor Health and Social Care Committee, working jointly with the Housing, Communities and Local Government Committee, published in 2018.[126]

Sir Andrew Dilnot's Review

94. Sir Andrew Dilnot's review recommended the introduction of a **lifetime cap on care costs**. Under this policy a person with savings and assets would be expected to make a contribution, but only up to a certain maximum, after which the state would fund care. In common with proposals for free personal care, under a lifetime cap policy, people would still be expected to pay their basic living costs. This reduces the incentive to move to into residential care, as there is increasing evidence in favour of supporting people to receive care in their own homes, where this is feasible.[127]

124 Personal care means essential help with basic activities of daily living, such as washing and bathing, dressing, continence, mobility and help with eating and drinking. It does not include other areas where support might be needed, such as assistance with housework, laundry or shopping.

125 House of Lords Economic Affairs Committee, Social care funding: time to end a national scandal, HL 392, paragraph 135

126 Health and Social Care Committee and Housing, Communities and Local Government Committee, Long Term Funding of Adult Social Care, 2018

127 House of Commons Library, Social Care: Government reviews and policy proposals for paying for care since 1997 (England) October 2017

95. A cap on care costs was accepted in principle by the Government, and the Care Act 2014 includes provisions to implement such a measure. The Commission recommended a cap of £35,000 for over 65s, with lower caps for those under 65. The Government, however, opted for a less generous cap of £75,000. Despite the passage of the Care Act 2014 and widespread acceptance of the policy, its implementation was delayed in 2015 and has never been reinstated.[128]

96. In evidence to us, Sir Andrew reiterated his recommendation that the cap should be set at £46,000 and that the charge for general living allowances should be set at £8,000 per year. The Health Foundation estimate that implementing a cap on care costs set at this level would cost £3.1 billion in 2023–24.[129]

Weighing up the options

97. Anita Charlesworth of the Health Foundation gave the following explanation of the differences between free personal care and a cap:

> The key differences between the cap on care costs and free personal care are that neither pay for the full cost of care; both require individuals to contribute. Free personal care… helps individuals from the beginning when they move into a care home, but if individuals need to stay there for a long time or they have very high needs, they are not protected against very high costs. A cap on care costs means that individuals contribute at the beginning, but they are protected from very high costs. That shifts the balance of state spending to those in greatest need. In the end, it is a judgment call between those two things as to which unfairness you think is greater.[130]

98. Lord Forsyth told us that his Committee came to the conclusion that free personal care was the best way to reform care because it would align social care funding with the principles of the NHS—having care delivered free at point of use without a means test—and would take away the complexity and worry currently faced by social care users and their families:

> We came to the conclusion that the difference in cost between having free personal care—the basics like washing, cleaning, continence and feeding—as they have in Scotland, and the Dilnot proposals did not represent a very substantial increase in funding. It just meant that it was simple and was aligned with the principles of the health service.
>
> I did not think shopping, cleaning and things of that kind should be covered, but very basic services—help for people who are doubly incontinent, with the changing of beds, and help with feeding. All of those basic things should be provided free according to need. People should not have the complexity and worry that arises as they run out of money. They see their savings run down

128 House of Commons Library, Social Care: Government reviews and policy proposals for paying for care since 1997 (England) October 2017

129 If pay is to be increased in line with the National Living Wage uplift modelled by the Health Foundation, as per the Committee's earlier recommendation, this figure of £3.1bn is a slight underestimate of the total required to implement the cap on care costs.

130 Q37 Anita Charlesworth

> to the last £14,250, and even then they are asked to make a contribution. If they cannot afford to pay, "Couldn't you get some of your relatives to pay?" It is a most debilitating system and difficult to defend.[131]

99. Andrew Dilnot set out to us the arguments in favour of a cap:

> If your costs are more than £200 a week—say, the £712 a week that Pamela was paying in the care home for her sister, or the £1,000 a week that is needed for Atherton's care costs—free personal care does not help you very much. It pays for the first slice, but it still leaves you exposed to the much higher costs. I think a cap is the most efficient way of spending money to help the people who are in the greatest need. It takes away the fear that otherwise people face.
>
> In social care, free personal care would help everybody who had social care needs, but the people it would help the most would be the people with low needs, all of whose costs would be met, whereas somebody like Atherton, or Pamela's sister Diana, would still be left exposed to very substantial costs. It seems to me that, when we introduce a social insurance system, the people we want to help most are the people who face the highest needs and the greatest category of problems.[132]

100. A decision on free personal care and a lifetime cap on care costs is not a binary choice. Both could be introduced, giving individuals a social care service where basic care is free at the point of delivery, as is the case with the NHS, as well as introducing a protection against unaffordable costs. The Lords Committee report acknowledged that if free personal care was introduced, some people who need long-term care for many years, particularly in residential and nursing homes, might still face catastrophic accommodation costs. It therefore recommended that "to avoid catastrophic accommodation costs, the Government should also explore a cap".[133] The Health Foundation, arguing for the introduction of a cap first, also says that following that, free personal care could be introduced as a next step.[134] Sir Andrew Dilnot was also supportive of free personal care being introduced as well as a cap, if funding allowed.[135]

101. **The Lords Economic Affairs Committee's report makes a persuasive case for the introduction of free personal care. This would cost around £5bn per year, which is only a small fraction of what is currently spent on NHS care. It would also simplify the current confusing arrangements for people who need care, and would put social care on a more equal footing with the NHS by ensuring that all basic care needs are met free at the point of need. Free personal care was also recommended by a joint report of the Health and Social Care Committee and Housing, Communities and Local Government Committee in 2018.**

131 Q120 Lord Forsyth
132 Q140 Sir Andrew Dilnot
133 House of Lords Economic Affairs Committee, Social care funding: time to end a national scandal, HL 392, paragraph 135
134 Health Foundation (SCF0044)
135 Oral evidence, Sir Andrew Dilnot

102. **We also strongly endorse a lifetime cap on care costs which could be implemented swiftly under the provisions of the Care Act 2014. Such a change would focuses resources on the most severely affected people, protecting those with very high care needs–and remove the injustice which sees the NHS cover certain types of extreme care costs but the social care system not cover others, including those with dementia, motor neurone disease or many other neurological conditions. Any reform package must therefore introduce a cap on care costs to protect people against catastrophic costs. We believe this should be set at the level specified in Sir Andrew Dilnot's original report, namely £46,000 which will cost around £3.1bn by 2023–24.**

Overall conclusion

103. **The COVID-19 pandemic has had devastating consequences both for vulnerable people using social care, and for the committed professional workforce that provide that care. These challenges have been exacerbated by long-standing funding and workforce issues which need to be recognised by the government in a social care reform package that must be brought forward before the end of this financial year.**

104. **We believe that the starting point for the social care funding increase must be an additional £7bn per year by 2023–24 to cover demographic changes, uplift staff pay in line with the National Minimum Wage and to protect people who face catastrophic social care costs. This represents a 34% increase from the 2023–24 £20.4bn adult social care baseline projected budget at today's prices. In this report we have not examined how such an increase could be funded but we recognise the challenges involved and the need for innovative thinking to address them.**

105. **But we are clear that this is only a starting point. It will not provide any improvement in access to care, which is urgently needed and would be improved through introducing free personal care as recommended by previous select committee reports from both the Lords and the Commons, which we continue to endorse as worthy of consideration. The full cost of adequately funding social care is therefore likely to be substantially higher than £7bn, potentially running to tens of billions of pounds. We recognise these are substantial increases at a time of severe financial pressure but the evidence we have heard both from those who use social care, and frontline social care workers suggests that the gravity of the crisis now facing the social care sector requires a bold response if we are to recognise the sacrifices made recently by the social care workforce and—most importantly—look after vulnerable people in our society with the dignity and respect they deserve.**

Conclusions and recommendations

Introduction

1. The case for making a sustained investment in social care has never been stronger– the toll the pandemic has taken on this sector means that social care is no longer a hidden problem, but one that the country as a whole understands. We urge the Government to now address this crisis as a matter of urgency. (Paragraph 10)

Current funding problems in social care

2. It is clear from the evidence we have heard that funding shortfalls are having a serious negative impact on the lives of those who use the social care system, as well impacting the pay levels of the workforce and threatening the sustainability of the care market. An immediate funding increase is needed to avoid the risk of market collapse caused by providers withdrawing from offering services to council-funded clients and focusing exclusively on the self-pay market. (Paragraph 32)

3. The crisis in social care funding has been brought into sharp focus by the COVID-19 pandemic, and this must now be addressed by Government as a matter of the utmost urgency. The funding increase we are calling for is significant at a time when public finances are likely to be stretched, but the pandemic has made it clear that doing nothing is no longer an option. Providing adequate funding for social care will also help the NHS, and may itself have positive economic and long-term social impacts, given that social care is an important part of the economy. (Paragraph 35)

4. We believe the starting point must be an increase in annual funding of £3.9 bn by 2023–24 to meet demographic changes and planned increases in the National Living Wage. However such an increase alone will not address shortfalls in the quality of care currently provided, reverse the decline in access or stop the market retreating to providing only for self-payers. Further funding to address these issues is therefore also required as a matter of urgency. (Paragraph 36)

5. Alongside such a long term funding settlement we strongly believe the government should publish a 10 year plan for the social care sector as it has done for the NHS. The two systems are increasingly linked and it makes no sense to put in place long term plans for one without the other. Failure to do so is also likely to inhibit reform and lead to higher costs as workforce shortages become more pronounced with higher dependency on agency staff. Reducing the 30% turnover rates typical in the sector will also require a long term, strategic approach to social care pay and conditions. (Paragraph 37)

The social care workforce

6. It is vital that the supply of PPE to social care providers is protected in the event of any future surges of coronavirus so that providers can be confident in their access to PPE. (Paragraph 43)

7. *The Government must ensure that standards for weekly testing for care home staff are maintained including rapid turnaround times and that regular data is published on the number of tests delivered to social care staff and residents. In addition, the Government should consider extending routine testing beyond care homes to other care settings, particularly domiciliary care and consider including a named key relative in routine testing.* (Paragraph 45)

8. Improving the level of recognition afforded to social care workers must be a key focus for the Government to safeguard the future of the social care workforce. Not to do so would be to fail the many thousands of care workers who have worked so tirelessly during the coronavirus pandemic. Building on initial steps such as the CARE badge and recruitment campaigns for social care, there are a number of practical changes which the Government must make to improve the level of recognition felt by social care professionals and to support the future sustainability of the workforce. These are detailed below and in our recommendations. (Paragraph 49)

9. We welcome the Government's commitment to bringing forward a long-term solution to low pay in social care. It is essential that this solution provides a sustainable basis for continued rises in pay above and beyond increases to the National Minimum Wage and in line with increases given to NHS staff. Evidence from the Health Foundation and others demonstrates that this must be supported by investment: the Health Foundation estimates that to increase the average pay in social care to just 5% above the National Living Wage, while meeting future demand, would cost an extra £3.9bn per year by 2023–24. (Paragraph 54)

10. *The Government must use the forthcoming Spending Review to ensure that there is a sustainable funding settlement to provide for competitive pay for social care workers which ensures parity with NHS staff and is reflective of the skilled nature of social care work. Parity could be achieved by linking social care pay to equivalent bands of the NHS Agenda for Change contract and introducing meaningful pay progression.* (Paragraph 55)

11. *Inadequate employment conditions undermine the sustainability of the social care workforce and have been brought into sharp relief by the coronavirus pandemic. As well as addressing issues of pay within the social care sector, we recommend that the Government bring forward proposals to support the improvement of employment conditions in the sector, including reducing the over-reliance on zero hours contracts and improving the provision of sick pay.* (Paragraph 58)

12. The Secretary of State has committed to increasing the alignment between the training of NHS and social care staff and his stated ambition being to make it easier for a registered nurse, for example, to move between the NHS and social care is an important one. We await more detail about how this increased alignment will be achieved. It is important that this increase in alignment of training is not focused solely on nurses and other social care workers with a registered qualification, or allowing care staff to more easily move to higher paying roles in the NHS. Establishing a clear career path with substantial training opportunities, more effectively aligned with the NHS is vital for all entrants to the social care workforce. (Paragraph 62)

13. As part of its long-term proposals for the future of social care, we recommend that the Government work with Skills for Care and the social care sector to bring forward a plan to streamline the training of social care workers in order to improve routes of entry to the profession and improve career progression for existing social care workers. The plan should include proposals to improve alignment with training for NHS staff and to improve the professional recognition of social care staff. We further recommend that the workforce development fund be expanded to implement the plan, ensuring that all staff are able to access funding for training and career development. (Paragraph 67)

14. *The Government must ensure that transitional arrangements are in place to ensure that social care workers can continue to be recruited from overseas for as long as it takes to build sufficient resilience in the domestic supply of social care workers. We agree with the Migration Advisory Committee (MAC) that building this resilience will depend on improving pay and other workforce issues in social care.* (Paragraph 72)

15. *We are concerned that lower qualified social care workers and those without qualifications at all are not eligible for the new NHS visa, not least because it undermines parity of esteem between the health and social care sectors. The Government should accept the MAC's recent recommendation to add senior social care workers to the shortage occupation list. We welcome the MAC's plans to conduct further research on the social care workforce: this research should consider the impact of new immigration rules on the ability of care providers to recruit to less senior roles.* (Paragraph 73)

Longer term reform of social care funding

16. The current system is unfair, confusing, demeaning, and frightening for the most vulnerable people in our society, and their families. It is therefore essential that the Government tackle the problems in the care sector as a priority. The success of the reforms in Japan has demonstrated that it is possible for a Government to grasp the nettle and take decisions on social care which, though they may be initially difficult, lead to positive and lasting change which is widely accepted by society. (Paragraph 89)

17. The Lords Economic Affairs Committee's report makes a persuasive case for the introduction of free personal care. This would cost around £5bn per year, which is only a small fraction of what is currently spent on NHS care. It would also simplify the current confusing arrangements for people who need care, and would put social care on a more equal footing with the NHS by ensuring that all basic care needs are met free at the point of need. Free personal care was also recommended by a joint report of the Health and Social Care Committee and Housing, Communities and Local Government Committee in 2018. (Paragraph 101)

18. We also strongly endorse a lifetime cap on care costs which could be implemented swiftly under the provisions of the Care Act 2014. Such a change would focuses resources on the most severely affected people, protecting those with very high care needs–and remove the injustice which sees the NHS cover certain types of extreme care costs but the social care system not cover others, including those with dementia, motor neurone disease or many other neurological conditions. Any reform package must therefore introduce a cap on care costs to protect people

against catastrophic costs. We believe this should be set at the level specified in Sir Andrew Dilnot's original report, namely £46,000 which will cost around £3.1bn by 2023–24. (Paragraph 102)

19. The COVID-19 pandemic has had devastating consequences both for vulnerable people using social care, and for the committed professional workforce that provide that care. These challenges have been exacerbated by long-standing funding and workforce issues which need to be recognised by the government in a social care reform package that must be brought forward before the end of this financial year. (Paragraph 103)

20. We believe that the starting point for the social care funding increase must be an additional £7bn per year by 2023–24 to cover demographic changes, uplift staff pay in line with the National Minimum Wage and to protect people who face catastrophic social care costs. This represents a 34% increase from the 2023–24 £20.4bn adult social care baseline projected budget at today's prices. In this report we have not examined how such an increase could be funded but we recognise the challenges involved and the need for innovative thinking to address them. (Paragraph 104)

21. But we are clear that this is only a starting point. It will not provide any improvement in access to care, which is urgently needed and would be improved through introducing free personal care as recommended by previous select committee reports from both the Lords and the Commons, which we continue to endorse as worthy of consideration. The full cost of adequately funding social care is therefore likely to be substantially higher than £7bn, potentially running to tens of billions of pounds. We recognise these are substantial increases at a time of severe financial pressure but the evidence we have heard both from those who use social care, and frontline social care workers suggests that the gravity of the crisis now facing the social care sector requires a bold response if we are to recognise the sacrifices made recently by the social care workforce and—most importantly—look after vulnerable people in our society with the dignity and respect they deserve. (Paragraph 105)

Formal minutes

Thursday 15 October 2020

Members present:

Jeremy Hunt, in the Chair

Paul Bristow	Neale Hanvey
Rosie Cooper	Barbara Keeley
Dr James Davies	Dean Russell
Dr Luke Evans	Laura Trott

Draft Report (*Social care: funding and workforce*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 105 read and agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 20 October at 9.00am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 9 June 2020

Professor Tine Rosgaard, Roskilde University, Denmark; **Paul Little**, Director for Integrated Health and Care, Suffolk County Council & East Suffolk and North Essex Foundation Trust; **Daphne Havercroft**, former carer and attorney for a social care user	Q1–25
Anita Charlesworth, Director of Research and Economics, Health Foundation; **Anna Severwright**, social care user and Co-Chair, Coalition for Collaborative Care; **George Stoye**, Associate Director, Institute for Fiscal Studies	Q26–48

Tuesday 23 June 2020

Sue Ann Balcombe, Registered Manager, Priscilla Wakefield House Nursing Home; **Mel Cairnduff**, Social Care Worker, Agincare; **Marlene Kelly**, Registered Manager, Auburn Mere Care Home; **Raina Summerson**, Chief Executive, Agincare	Q49–72
Professor Martin Green, Chief Executive, Care England; **Oonagh Smyth**, Chief Executive, Skills for Care; **Jane Townson**, Chief Executive, UK Homecare Association	Q73–101

Tuesday 14 July 2020

Kevin Caulfield, Disabled person and strategic lead for co-production, Hammersmith and Fulham Borough Council; **Pamela King**, former carer	Q102–115
Sir Andrew Dilnot, former Chair, Commission on Funding of Care and Support; **Yasuhisa Shiozaki**, former Minister for Health, Labour and Welfare of Japan; **Deborah Gray**, care user	Q116–125
Lord Forsyth of Drumlean, Chair, Economic Affairs Select Committee (HL)	Q126–149

Tuesday 8 September 2020

James Bullion, President, Association of Directors of Adult Social Services; **Sarah Pickup**, Deputy Chief Executive, Local Government Association	Q150–168
Rt Hon Matt Hancock MP, Secretary of State, Department of Health and Social Care	Q169–232

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

SCF numbers are generated by the evidence processing system and so may not be complete.

1 1st Enable (Jeff Dawson, Managing Director) (SCF0002)

2 Adam Smith Institute (Dr Eamonn Butler, Director) (SCF0004)

3 ADASS (SCF0099)

4 Affinity Trust (Leo Sowerby, Chief Executive) (SCF0054)

5 Age UK (Miss Daisy Cooney, Health and Care Policy Manager) (SCF0041)

6 Agincare Group (SCF0105)

7 The Aldingbourne Trust (Sue Livett, MD) (SCF0037)

8 Alzheimer's Society (Tom Redfearn, Public Affairs Manager) (SCF0034)

9 Ambler, Mr Tim (SCF0003)

10 Anchor Hanover (Mr James Floyd, Public Affairs Officer) (SCF0062)

11 Annabel Sykes (Annabel Sykes, Annabel Sykes) (SCF0110)

12 ARCO (Associated Retirement Community Operators) (Mr Sam Dalton, Policy & External Affairs Executive) (SCF0061)

13 Association of British Insurers (SCF0104)

14 Bell, Lesley (SCF0078)

15 British Association of Social Workers (SCF0088)

16 British Medical Association (SCF0039)

17 British Red Cross (Ms Ellen Tranter, Policy and Advocacy Officer) (SCF0045)

18 Bupa Care Services (Mr James Moseley, Head of Public Affairs) (SCF0035)

19 CAHSC (Cornwall Adult Health & Social Care Learning Partnership), Care & Support West, LinCA Workforce Development, Banes, Swindon & Wiltshire Care Skills Partnership, Aldingbourne Trust & Berkshire WFD, Leeds Care Association & South Yorkshire Care Network, Tyne & Wear Care Alliance & North East Centre for Social Care Excellence, West Midlands Care Association, Care Alliance for Workforce Development, and Thames Valley Workfor (Matthew Thomson) (SCF0053)

20 Care and Support Alliance (Mrs Anna Bailey-Bearfield, Policy and Public Affairs Manager) (SCF0032)

21 Care England (Mrs Louisa Collyer-Hamlin, External Affairs) (SCF0023)

22 Care Quality Commission (Miss Ayesha Carmouche, Senior Parliamentary and Stakeholder Engagement Adviser) (SCF0063)

23 Carers Trust (SCF0102)

24 Carers UK (SCF0106)

25 Centre for Health and the Public Interest (Mr David Rowland, Director) (SCF0055)

26 Centre for Welfare Reform (Dr Simon Duffy, Director) (SCF0007)

27 Chartered Society of Physiotherapy (Robin Hinks, Research and Policy Officer - England) (SCF0001)

28 Chester-Glyn at Coproduce Care CIC, Ms Sophie (SCF0050)

29 CHRISTIAN CARE HOMES REGISTERED CHARITY 299522 (SCF0077)

30 Co-Chair of Shaping Our Lives (Professor Peter Beresford, Professor of Citizen Participation, University of Essex) (SCF0071)

31 David Hinchcliffe (David Hinchcliffe, David Hinchcliffe) (SCF0111)

32 Department of Health and Social Care (SCF0069)

33 The Disabilities Trust (Mrs Jocelyn Gaynor, Head of Foundation) (SCF0026)

34 Ealing Reclaim Social Care Action Group (ERSCAG) (Ms Maggie Beirne, Secretary) (SCF0046)

35 Equal Lives (Mrs Hetal Murphy, Development Offiicer) (SCF0019)

36 Fine, Emeritus Professor Ben (SCF0009)

37 Free-Pearce, Mr David (SCF0018)

38 GMB (Miss Rachel Harrison, National Officer) (SCF0060)

39 The Guinness Partnership (SCF0093)

40 Hall, Mrs Maxine (SCF0081)

41 Hallam, Mrs. Maureen (SCF0010)

42 Hampshire Care Association (SCF0101)

43 Health for Care coalition (Mr Niall Dickson CBE, Chair) (SCF0031)

44 The Health Foundation (SCF0113)

45 The Health Foundation (SCF0070)

46 The Health Foundation (Ms Grace Everest, External Affairs Manager) (SCF0044)

47 HealthWatch England (MR Shueb Ansar, Public Affairs Officer) (SCF0047)

48 Honey, Mr Paul (SCF0018)

49 Inclusion London (SCF0089)

50 Independent Age (Ms Shelley Hopkinson, Public Affairs Manager) (SCF0043)

51 Kilgour, Mr Robert (SCF0014)

52 King at Coproduce Care CIC, Mr Arnie (SCF0050)

53 The King's Fund (Harry Dayantis, Press and Public Affairs Manager) (SCF0064)

54 The King's Fund (Harry Dayantis, Press and Public Affairs Manager) (SCF0038)

55 Leonard Cheshire (Ms Sharlene McGee, Policy Manager) (SCF0042)

56 Local Government Association (Miss Jade Hall, Public Affairs and Campaigns Adviser) (SCF0022)

57 London Councils (SCF0097)

58 Mencap (Mr Matthew Harrison, Public Affairs and Parliamentary Manager) (SCF0048)

59 MHA (Ms Pavan Dhaliwal, Head of Corporate Affairs) (SCF0057)

60 Mind (Rhea Newman, Senior Parliamentary Officer) (SCF0028)

61 Motor Neurone Disease (MND) Association (SCF0100)

62 National Care Forum (SCF0075)

63 NHS Confederation (Mr Niall Dickson CBE, Chief Executive) (SCF0065)

64 NHS Providers (NHS Providers Kerry Racher, External Affairs Adviser) (SCF0033)

65 NIHR Policy Research Unit in Health and Social Care Workforce (Professor Jill Manthorpe, Director) (SCF0051)

66 North East Lincolnshire Council (SCF0090)

67 Nuffield Trust (Mark Dayan, Head of Public Affairs) (SCF0056)

68 Nursing & Midwifery Council (NMC Gordon Cameron, Senior Policy Officer) (SCF0016)

69 Office for Statistics Regulation (Miss Romy Overton-Edwards, Parliamentary and Public Affairs Officer) (SCF0024)

70 Royal College of Nursing (Rachael Truswell, Public Affairs Adviser) (SCF0066)

71 Royal College of Physicians (Nikita Vaghjiani, Public affairs and campaigns adviser) (SCF0036)

72 Sanders, Mrs Anthea (SCF0074)

73 SeeAbility (SCF0098)

74 Sense (Dr Amy Kavanagh, Policy & Public Affairs Advisor) (SCF0020)

75 Shelford Group (Joanna Clason, Head of Communications) (SCF0059)

76 Skills for Care (Mr Paul clarke, Oonagh Smyth - CEO) (SCF0067)

77 Slasberg, Mr Colin (SCF0071)

78 Social Works Ltd (John Buttle, Managing Director) (SCF0025)

79 South East Strategic Leaders, and South East England Council (Head of Policy Neil Border) (SCF0015)

80 Sustainable Care programme, University of Sheffield (Professor Sue Yeandle, Principal Investigator) (SCF0049)

81 Trades Union Congress (SCF0072)

82 Transcripts of interviews with care home managers (SCF0112)

83 UK Women's Budget Group (SCF0092)

84 UNISON (Guy Collis, Policy Officer) (SCF0030)

85 United Kingdom Homecare Association (SCF0107)

86 University of Oxford (Dan Dennis, Philosophy Tutor) (SCF0103)

87 Wale, Mrs Marion (SCF0087)

88 WinVisible (women with visible & invisible disabilities) (SCF0094)

89 Women Against State Pension Inequality (WASPI) Campaign (SCF0080)

90 Woodward OBE, Mr John (SCF0027)

91 The Working Group of the APPG on Adult Social Care (Mr Peter Hand, The Secretariat of the APPG on Adult Social Care) (SCF0058)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2019–21

First Report	Appointment of the Chair of NICE	HC 175
Second Report	Delivering Core NHS and Care Services During the Pandemic and Beyond	HC 320
First Special Report	Process for independent evaluation of progress on Government commitments	HC 663