Written evidence submitted by Dr Carolyn Downs (EPW0001)

Introduction

Dr Carolyn Downs is a senior lecturer based at Lancaster University Management School. She is PI on the LAPIS project (Learning for Adult Social Care Practice Innovations and Skills). This EU-funded project ends in 2023 and is collecting data from five EU countries (UK, Poland, Italy, Greece, and Bulgaria). LAPIS follows on from the HELPCARE project (Recruitment and Retention in Adult Social Care), (2015-2018) which covered the same five EU countries. Dr Downs is also course consultant for social-care degree programmes at Blackburn and Blackpool Colleges and has significant expertise in curriculum development in social care.

Our response to the UK parliament request for evidence is based entirely on data collected in England from both projects.[1] Our data includes training needs analysis with 100 UK care workers (500 across the project), interview data from 25 UK care workers, 25 UK managers, 10 UK users and 10 UK commissioners of care, and detailed case studies covering innovation in care, training for care, work-based learning barriers and opportunities, staff and patient well-being, recruitment, retention and commissioning and work on digital exclusion in the care sector.

Planning for the workforce:

Government Commitment - Ensure that the NHS and social care system have the nurses, midwives, doctors, carers, and other health professionals that it needs

Overview of Evidence from the Helpcare and Lapis projects

We are working with experts from the NHS, care organisations and care umbrella organisations (some of whom are listed in the footnote[2]) on workforce planning, training, innovation, and development. Our findings are that Central Government have not put in place the systems needed to address the recruitment and retention problems within social care.

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[1] The UK social care system is devolved. Northern Ireland, Scotland and Wales is devolved. This means funding, registration and organisation differ from the system in England. This document comments on the situation in England but addresses our evidence to the UK Parliament.

[2] Sue Capstick – Programme Lead - Digital Adoption and Transformation in Regulated Care, Lancashire and South Cumbria Health and Care Partnership Digital Team. Maggie Asquith – Integrated Voluntary Services Project Lead – Lancashire and South Cumbria Integrated Care System, Lesley Stewart – Head of Care Services, Delight Supported Living Ltd , Sally-Ann Turner - HR Strategy Manager - Workforce Development Commissioning (Care and Health) - Devon County Council, Louise Coulson - Quality and Governance Officer - Quality and Safeguarding Team - Morecambe Bay Clinical Commissioning Group, Nicky Ryder - Occupational Therapist and Mental Capacity Assessor , Tabitha R Sims – Operations Manager - Digital Adoption and Transformation in Regulated Care, Lancashire and South Cumbria Health and Care Partnership Digital Team, **Adam Parnell and the** Institute of Health and Social Care Management, Northern Ireland Social Care Council, Digital Social Care , The Work Foundation , 360 degree Healthcare and Rehabilitation Services Ltd , n-compass and many other individuals and organisations within the sector.

Our key finding is that significant structural and socio-cultural barriers exist which will prevent the care sector recruiting and retaining the carers and other health professionals needed.

Background

The UK care sector is highly fragmented. There are around 17,700 care providing organisations and over 39,000 care establishments .most of which are for-profit SMEs. The large number of providers and relatively small size of the organisations makes central planning or integration of care with the NHS extremely challenging for all involved. Reducing fragmentation in the sector is not government policy, although greater integration of health and social care is a government priority.

The social care sector has grown since 2019, but the need for more staff remains critical. Care homes are closing to new patients due to staff shortages, and domiciliary providers are unable to take on new cases or provide the full range of services required by service users (cutting back on time per visit, or services provided). Skills for Care report that the staff vacancy rate is now above pre-pandemic levels and note that recruitment and retention issues continue to bedevil the sector. Staff turnover in the UK care sector is around 35-38% and as of April 2022 the care sector vacancy rate was 10%. The withdrawal of government funding to support recruitment and retention at the end of February 2022, coupled with the ending government support for sick pay and the minimum wage requirement of £10.40 per hour to get a visa for overseas care workers also act to depress recruitment and retention in the sector, where profit margins are small and wages low, placing additional burdens on this fragmented industry.

Our Findings

Care workers experience low status, poor pay, lack of training, low morale and high levels of stress in the workplace. We find that social perceptions of care work, coupled with low pay (72% of care workers are paid below the Real Living Wage, and 38% are paid less than the National Living Wage) act as invisible but tenacious constraints upon recruitment and retention.

Some examples from our interviews highlight the lived experience of care worker and illustrate our finding that care work is perceived as a low-status and unappealing career option, a *"last resort"*, *"my duty"* or *"all that is available at the current time"*. A UK carer said, she rarely told people about her job because of the stigma associated with the role, *"Only really close friends know I do care work. I'm too embarrassed to tell people, even though I've been working in care 10 years now. It's viewed very negatively by people."* Others working in care reported: *"I am struggling to get out of the care sector, I am underutilising my skills"*. Care workers felt they were second-class workers, with some reporting being abused and unhappy at work and often feeling poorly supported by management, care commissioners and relatives of people receiving care.

Many of our participants find care work fulfilling but low pay and low status act to push staff to leave the care sector, *"I want a better job, better pay"*. Around 26% of our care worker participants saw care work as a route to other, more professional care-related roles,

aiming to progress to nursing, social work, physiotherapy, speech therapy, or occupational therapist training within three to five years. Care workers in our sample often moved onto better paid and higher status roles as Health Care Assistants in the NHS, or to train for health-related roles. For example, a UK care worker in Greater Manchester, qualified to PhD level, had to hide her qualifications to get a job within the care sector and experienced significant distress at being unable to access training, equipment or to be respected as a skilled carer after four years in the role – she moved on to general nurse training and on qualifying has rapidly been promoted within the NHS.

Failure to retain staff impacts on senior management too, the director of an organisation employing 800+ care workers told us, "*I dread Aldi or Lidl opening a new store near any [of our] homes because every time four to five staff leave*".

Building a skilled workforce

Government Commitment – points relevant to Helpcare and Lapis findings extracted from table provided in request for evidence.

1. Help support staff develop the skills they need
2. £1 billion extra of funding every year for more social care staff and better infrastructure, technology, and facilities.
3. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan.

Overview of Evidence from the Helpcare and Lapis Projects

LAPIS and Helpcare find increased pay could improve recruitment and retention. The promised £1bn of extra funding each year will largely go towards covering the costs of care, which may (or may not) allow for salaries of care workers to increase. However, there appears to be no conditionality within the **Market Sustainability and Fair Cost Fund** to ensure providers should use this money to increase rates of pay.

The care sector does not have the capacity to roll-out universal mobile digital systems by 2025 as proposed by the Government. To put this in place would require significant additional funding and development of a system of central coordination for training, infrastructure and support systems. How the maximum 25% of the extra funding from the **Market Sustainability and Fair Cost Fund** which can be spent on infrastructure will be allocated is unclear.

Our key finding is that the care sector urgently needs access to a mandated, validated, and comprehensive programme of staff training and development covering practice, administration, and soft skills. Such a programme does not currently exist. Training is an essential underpinning element of enabling universal uptake of digital systems in the care sector.

Background

Within the UK it is required that all Care Workers undertake the Care Certificate. The Care Certificate is an agreed set of 15 standards defining the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. When developed and rolled out it was envisaged these standards would form part of a robust induction programme. The Care Certificate does not include digital training.

The NHS is working on implementing the roll-out of digital care planning in 80% of care homes by 2024 but no comprehensive evaluation of the capacity of the 17,600 UK care homes to implement this change has been conducted. There are 8,800 domiciliary care providers registered with the Care Quality Commission, who are not currently included in the aim to roll out digital care plans. The Digital Skills for Care Rapid Review of Evidence paints a worrying picture of a sector with widely differing digital infrastructure and capabilities.

The 2021 'Digital Skills for Care Rapid Evidence Review' concluded there was

- Limited quantitative evidence on current digital skills in the care sector
- Limited evidence on the current and future demand for digital skills in the care sector
- Limited research on the extent or reasons for not engaging with digital technology (digital exclusion) within the care sector
- Barriers to learning and development of digital skills in the care sector are poorly researched

Our Findings

The Helpcare and LAPIS project focussed on our respondent's experience of learning within the care sector. We found care workers could readily identify training needs, and more than 400 individual training needs were proposed by our sample. However, the universal experience was that training to meet their needs was not available in most organisations, although many respondents had taken the UK Care Certificate multiple times, as they changed employer, usually in their own time (unpaid), often via online learning and in many instances, accessed via mobile phones as the care staff participating in our study did not have a laptop or desktop PC to use for this purpose. We found that the care certificate was not delivered in a uniform way across organisations. Some organisations (Mencap for example), had in-house, well-developed training programmes, but organisations offering care for older people tended to have very limited training programmes outside the care certificate or in some organisations facilitating staff to study BTEC Level 2/3 in Health and Social Care in their own time.

Some respondents had studied for Level 2 and 3 qualifications in Health and Social Care. The general view was that these qualifications were interesting, but largely theoretical. There were no level 2 or 3 qualifications available in any of the many areas highlighted by our participants as training needs (for example, stoma care, stroke, nutrition, frailty, dementia, end of life care, cancer, wound care)

> *"The carers don't see any way for professional development. Sometimes I meet carers for 15 years who have good skills and knowledge who were never pushed up. Do you understand? Still a simple care assistant." (UK care worker)*

Care workers with longer experience in the sector said that informal learning from district nurses or other healthcare professionals had helped fill the training gap in the past, but this no longer took place as there were widespread staff shortages. Lack of training was a common theme across UK care workers.

> *"Sometimes the management forget about additional training, they don't speak with the staff. They are only interested in making sure the rota is OK. Also, they want to maximise work from the staff doing the shifts, because sometimes there are 32 patients on the floor, 3 care assistants and 1 nurse but we have no right to speak up and get changes to improve safety."*

In larger organisations with a training programme staff reported a lack of flexibility, and no option for personalisation and training that did not meet their day-to-day needs. The training was often bought in from external providers at the direction of the manager, without consulting staff about what might be useful, with staff seeing this as a 'tick-box' exercise to show inspectors, patients, and families that training had taken place. One member of staff at a UK care home reported taking part in the same or very similar training session each of the five years she was with one employer. A significant proportion of the care workers participating in the studies undoubtedly feel that lack of training limits their skill level, and this may be a strong motivation for seeking a move into nursing, social work, or other related careers.

Lack of training and lack of infrastructure mean the care sector in general is not equipped to roll-out mobile digital services or digital care plans and domiciliary care (the largest part of the sector) is the least prepared.

The LAPIS and Helpcare projects found there is poor digital infrastructure and patchy digital literacy (effectively, digital exclusion within the adult social care sector). However, we could not identify any policy directed to improving digital infrastructure and literacy and found little commissioner knowledge on these issues. For example, our review of 200 NW England care sector organisation websites conducted in Nov. 2021 found many were single page sites while almost 15% of organisations reviewed had no web presence other than basic phone number / address listing. Research shows web presence acts as an effective proxy for organisation digital capability, and so our finding flags up an important issue of digital exclusion within the sector. While the NHS is working with care homes to improve take up of digital care plans the target of 80% of care homes using these by 2024 is extraordinarily ambitious given problems identified by LAPIS, including; non-compatible software systems across the NHS and different care settings, limited access to IT within some care settings, no detailed picture of care setting readiness for move to digital care plans, cost of staff training and barriers to digital skills acquisition among care sector staff.

Wellbeing at Work

Government Commitment: Listen to the views of social care staff to learn how we can better support them – individually and collectively.

Overview of evidence from the Helpcare and Lapis projects

We have worked with more than 200 UK care workers and managers; we find that care workers wellbeing at work is poor. Care workers experience high levels of stress, physical injury, low self-esteem, feel undervalued, overworked, and powerless.

Our key finding is that the wellbeing of care workers is neglected, and this directly affects recruitment and retention.

Background

The UK has a highly fragmented model of care delivery, with many thousands of independent, profit-making companies involved in the commissioning and delivery of care. This makes the burden of care almost invisible to those not engaged directly in provision of services and contrasts with the prominent position of health care and higher status of health workers within communities. The care sector comprises a largely female and older workforce paying a care premium (through low wages, low status and compromised mental and physical health) which arguably should be borne more widely. Academic literature suggests societal expectations constrain care workers role, deeply embedding low status, low wages and providing few opportunities for progression within the sector (Grey, 2009; Palmer and Eveline, 2012; Folbre, 1994, 2006, 2008; Cuban, 2013). Folbre (1994) describes this situation as structures of constraints, which are deeply embedded. Overcoming these constraints is a necessary element of improving care worker wellbeing.

Our findings

Our respondents reported poor physical (work-related) and mental health, stress in the workplace and low self-esteem. These indicators provide significant evidence of a wellbeing shortfall among care workers. For example, carers mentioned unsafe working practices leading to injury (usually muscular-skeletal),

> '*Sometimes the work of the carer is also very unsafe especially when they are using the hoist, sometimes no proper hoist, no proper sling you know…unsafe work is normal, you cannot complain'.*

Carers routinely felt they were not listened to,

> *"The organisation sometimes doesn't want to show that the opinion you've put across is important, they'll play it down'.*

All project interview data contained indicators of poor wellbeing among care workers. The data collected for Helpcare and Lapis projects indicates a combination of socially constructed beliefs about care, underfunding of the care sector, staff shortages, lack of training, and few opportunities for progression all act together to reduce staff wellbeing and significantly contribute to the severe problems experienced across the sector with recruitment and retention of staff. The care premium (poor pay, low status, stress, physical injury etc) is paid by a largely female workforce, while the externalities related to care work (including root causes of poor staff wellbeing) remain largely unaddressed.

Conclusions

In summary, the findings from the Lapis and Helpcare projects indicate the government are not intervening to develop solutions for the crisis in social care recruitment and retention – there is no overarching workforce planning. The highly fragmented social care sector is not able to develop comprehensive solutions – largely because co-operative working across the sector is discouraged by the market in care, meaning providers are naturally in competition with each other.

The government aim to build a skilled workforce in social care supports the aims of care workers, who readily identify their training needs but are unable to access suitable training. However, the findings of the Lapis and Helpcare projects suggest the government commitment for a skilled care workforce is unlikely to be met because high-quality, validated training programmes for the specialist skills needed do not exist and there are no plans to develop curricula beyond the current Care Certificate or Health and Social Care BTECs currently on offer.

A commitment to listen to social care workers and support wellbeing at work can only be met if there is a robust mechanism for both listening and taking action. Currently there is nothing in place. Care workers would welcome initiatives to support wellbeing, many care workers, especially those working full time, suffer high levels of stress, physical injury, and low self-esteem, these all indicate staff wellbeing is a low priority within the sector.

Overall, the evidence from the Lapis and Helpcare projects indicates that the government have a failed to meet the commitments set out on page 1 of this report and have a very long way to go to improve social care in workforce planning, building a skilled workforce and improving workforce wellbeing. The current vacancy and staff turnover rates in social care are unsustainable, and already leading businesses to close down, the fragmented model of social care is unsustainable and prevents achievement of the wider aim, of integrating health and social care. To ensure vulnerable people receive the social care they need from a professional workforce there is a need for a radical vision for the future.

General Recommendations

Organisation of Social Care

1) Integration of health and care services is essential and could assist in raising the status of care workers as well as ultimately ensuring a more cost-effective service.
2) Urgent efforts should be made to defragment social care. This could be through incorporation into the NHS (effectively, nationalisation) or via putting in place funding mechanisms and commissioning structures that encourage co-operative working (as exemplified in Glasgow)
3) Models of good practice such as Northern Ireland, Hertfordshire, Devon County Councils, Buurtzorg Model (Netherlands), should be explored and learning shared to support in building a care sector which offers excellent, cost-effective services

Training and Development

4) A national registration scheme for care workers should be developed (as in Northern Ireland). This could be implemented over 5 years. It should require working in care

as the initial pre-requisite for registration but should aim to move to a requirement for specific, validated training at least at level 1 as a requirement of registration by the fifth year of implementation of a registration scheme. Registered care workers would need to demonstrate participation in validated CPD as a requirement of continued registration. There should a route for unregistered care workers to commence work and move onto the registration scheme within 1 year of entry into the sector.

5) A wider curriculum for care workers needs to be developed and formalised, with national qualifications, validation of qualifications (the UK Care Certificate is not validated externally) and a suite of qualifications from level 1 (entry level) to level 7 (master's degree level) covering specialist knowledge.
    a) As an example, level 1 could cover key skills (literacy, numeracy, digital, communication and administration) alongside the 15 core competencies of the current Care Certificate, moving onto Level 2 (programmes covering more specialised knowledge such as dementia, stroke, end of life care, diet etc) with a wider curriculum developed at Levels 3-7 ensuring existing Health and Social Care programmes incorporate a range of practical skills and experience alongside theoretical knowledge.
    b) The development of specialist training for care workers should be accompanied by a new job role, specialist care practitioner [stroke, dementia, diet, end of life, frailty etc] which attracts a pay premium. Care providers should be encouraged to employ specialist care practitioners and commissioners should recognise the availability of specialist staff in setting contract rates. Smaller organisations could be encouraged to co-operate to share specialists so that expertise is available widely across the sector.
6) All care providers should have a specified person responsible for training and development of staff and a programme of CPD that staff undertake in working time
7) Training and development should include a focus on soft skills, compassion, dignity and ethical practice alongside important technical skills such as stoma care, stroke, dementia, diabetes etc.
8) All care organisations should employ at least one member of staff educated to degree level in an appropriate subject and with the ability to plan and deliver staff training and development.
9) Staff should be paid for time spent training and this should be recognised in the commissioning process.

Wellbeing at Work

10) The pay scales, pensions, and routes for progression of care workers should be directly comparable to those of Health Care Assistants in the NHS
11) There should be clear routes for progression within the care sector, with additional qualifications leading to additional responsibility and pay. This could be best managed in smaller organisations cooperation across organisations (see points 2 and 5b above). Progression routes and opportunities within the sector could significantly improve retention

12) Inspection needs to be more effective especially for domiciliary care and should increase its focus on training and development, staff retention and management of care alongside care standards
13) There should be a formalised procedure for whistle blowing, carers are frightened to report abuse and fear for their job if they make a complaint.
14) The role of emotional stress in retention of care workers should be recognized by employers, with the provision of support services for staff wellbeing

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