Written evidence submitted by Mortimer Society (EPW0012)

1. PLANNING FOR THE WORKFORCE

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

Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) **Is the commitment on track to be met?**

1. Does the commitment have a deadline for implementation?

There has been no clear commitment for Social Care

2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

Social Care was minimally mentioned in the Manifesto and all the commitments were for the NHS

3. To what extent has the Covid-19 response affected progress on targets?

Extra funding was provided to Social Care to cope during the pandemic, and this allowed providers to provide the extra care needed and to remain viable

4. How has this commitment been interpreted in practice at local authority/care provider/trust level?

Local authorities provided extra COVID monies, as directed by central government. Fees for residents have remained static or increased at very low levels – below the cost of providing Living Wage for staff

5. Does data show achievement against the target (if applicable)?

As there have been no commitments there have been no targets

Was the commitment effectively funded (or resourced)?

1. Were specific funding arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?

The only extra funding has been for COVID. Fee increases have been very low – in 2020-21 our main funder (Kent County Council) gave no increase at all

2. What factors were considered when funding arrangements were being determined?

There appears to be no consideration of extra costs – in particular staff pay to meet the Living Wage (over 5%), but also food and utilities - in funding provided by local authorities / CCGs

3. Do healthcare and social care stakeholders view the funding as sufficient?

Social Care funding is insufficient – over the past 5 years fees have increased by an average of only 1.98% and 1.6% for the two main authorities, but every year Living Wage has increased by 5%.

Funding has not increased generally and reassessment of funding, so that it reflects the care needs of residents who are often deteriorating in their condition and abilities, has been difficult to negotiate.

4. Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences/ undesirable 'work arounds' at local level?

No new monies have been seen as yet – except for COVID support and the possibility of monies for training, of which we have no news

Did the commitment achieve a positive impact for patients and service users? *(Indirectly through impacting workforce)*

1. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

Any improvement has been despite any government action

2. Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?

No commitments and therefore no benefits

3. What category of staff, patients and service users have benefitted? And why?

Not applicable

4. Have some staff, patients and service users been adversely impacted by the commitment and its implementation?

Residents have received the care they need, despite funding as the Society has subsidised the care from charitable monies.

Was it an appropriate commitment?

1. Was (or is) the commitment likely to achieve meaningful improvement for health and social care staff and/or the health and care system as a whole?

There has been no clear commitment – the only message recently has been that there will be changes in the future – 2024/25

2. Is the commitment specific enough?

Specific commitments are needed for Social Care

3. Has the commitment had unintended consequences?

Not applicable

4. Was the level of ambition as expressed by the commitment reasonable?

There seems to have been no ambition / commitment for Social Care

5. Is the target contained in the commitment an effective measure of policy success (if applicable)?

No commitment / targets for Social Care

6. How has working to those commitments affected other aspects of care?
No commitment / targets and no effects

2. BUILDING A SKILLED WORKFORCE

Commitments:
- Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.

- £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities.

- Supporting moves towards prevention and support, we will go faster for community- based staff. 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, that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the
number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.

Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) **Is the commitment on track to be met**

1. Does the commitment have a deadline for implementation?

Social care has had little support. There is a need for an improved career structure, with adequate remuneration to encourage people to join the workforce

2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

There has been no clear policy for Social Care

3. To what extent has the Covid-19 response affected progress on targets?

COVID affected many Social Care providers, including leading to their closure. The lack of consideration discharges from hospital – now shown to have been unlawful – shows how the role of Social Care has been minimised and under-appreciated.

The extra funding, to cope with the extra expenses of coping with COVID, was appreciated but was limited.

4. How has this commitment been interpreted in practice at local authority/care provider/trust level?

There has been little commitment from Local Authorities / CCGs to improving funding, which

would allow an improvement in the workforce and there have been major issues with recruitment and retention of staff, with increased costs, which have not been covered by a fee increases.

5. Does data show achievement against the target (if applicable)?
No targets and no data

Was the commitment effectively funded (or resourced)?

1. Were specific funding arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?

Specific funding was received due to COVID but this was to maintain services and safety. Specific funding is helpful but does not address the overall issue of under-funding which would allow recruitment of staff, training and support in a career in Social Care

2. What factors were considered when funding arrangements were being determined?

Funding has been minimally increased – at less than 4% - even though staff costs, which comprise the largest cost for the Society, have increased by at least 5%, to meet the government's laudable target of proving the Living Wage.

The increase in fees to meet the increased care needs for residents has been very difficult to achieve and there is no regular (annual) reassessment of care needs, and the necessary fee increase, for the majority of residents.

Only by an increase in fees can staff be paid appropriately, retained within the service and trained and have the ability to progress within a clear Social Care career structure, which is not present at the moment

3. Do healthcare and social care stakeholders view the funding as sufficient?

As explained above funding is far from sufficient and has reduced in real terms over the past 5 years – only 1.98% and 1.6% increase in average fees from 2018-2022 from our main authorities.

This does restrict the workforce – deterring staff as the wage levels are low, for the responsibility and roles they undertake – an error could cost the life of a resident whereas in a shop the risks are merely financial and rarely life threatening, although the remuneration may be similar or even better in the shop.

Social Care remuneration and career structure is haphazard and variable, with little structure and fewer opportunities to progress, with increased remuneration. This is in stark contrast to the clear pay scales and levels within the NHS. A clear national pay scale and career structure would help to develop Social Care as a career and a profession, encouraging recruitment and retention at all levels – as carers and as managers.

4. Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences/ undesirable 'work arounds' at local level?

COVID monies were limited and specific. No further resource streams have been available – with only a promise of changes in the future – changes which may not benefit the care of people with physical disability/ progressive disease / under 65 years of age.

Did the commitment achieve a positive impact for patients and service users? *(Indirectly through impacting workforce)*

1. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

The commitment to Social Care funding needs to be immediate and not in the future. There should be a commitment to increasing all funding – and not merely the funding to allow people to rely less on selling their home for ongoing care provision.

The Mortimer Society does not have self-funding residents and relies on Local Authority / CCG funding. The support from these sources needs to be adequately funded so that they can pass on realistic fees to provide the care needed for residents, who have complex and specialised needs.

2. Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?

Neither residents or staff benefit from reduced funding in real terms – resident care is threatened and maintaining quality is impaired and recruitment / retention of staff is compromised

3. What category of staff, patients and service users have benefitted? And why?

None have benefitted

4. Have some staff, patients and service users been adversely impacted by the commitment and its implementation?
There has been no commitment as yet

Was it an appropriate commitment?

1. Was (or is) the commitment likely to achieve meaningful improvement for health and social care staff and/or the health and care system as a whole?

A commitment is needed to adequately and appropriately fund Social Care – according to people's specific needs. If this is provided care can improve and staffing levels will be improved, allowing training and progression within a clear structure, that needs to be developed for Social Care.

2. Is the commitment specific enough?

Commitment needs to be specific and implemented now for Social Care – not in the future.

3. Has the commitment had any unintended consequences?

No commitment has led to reduced care / availability of places/ closure of providers / delayed transfer from hospital

4. Was the level of ambition as expressed by the commitment reasonable?

The commitment needs to be now, not in the future

5. Is the target contained in the commitment an effective measure of policy success (if

applicable)?

No commitment / target for Social Care

6. How has working to those commitments affected other aspects of care?

Not applicable
The Society has implemented a digital system for the administration of medication and the recording of
all activities. This has not been funded separately – but from the reserves of the Society.

3.WELLBEING AT WORK

Commitments:
- Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.

- Reduce bullying rates in the NHS which are far too high.

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

Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) **Is the commitment on track to be met?**

1. Does the commitment have a deadline for implementation?

This seems to apply to the NHS. Social Care should have the same access and services available

2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

There has been little listening to Social Care providers as yet

3. To what extent has the Covid-19 response affected progress on targets?

The consultation with Social Care may have been delayed

4. How has this commitment been interpreted in practice at local authority/care provider/trust level?

As a provider the Society has not been consulted

5. Does data show achievement against the target (if applicable)?
Not applicable

Was the commitment effectively funded (or resourced)?

1. Were specific funding arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?

There has been no funding available. Better overall funding would help in the support of staff – allowing better working conditions / staffing levels, improved opportunities for training and

career progression, improved working conditions

Services for staff should be available for Social Care staff as for NHS staff

2. What factors were considered when funding arrangements were being determined?

Unknown

3. Do healthcare and social care stakeholders view the funding as sufficient?

There have been no changes for Social Care. If these are introduced there should be adequate and appropriate funding

4. Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences/ undesirable 'work arounds' at local level?

Not applicable

Did the commitment achieve a positive impact for patients and service users? *(Indirectly through impacting workforce)*

1. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

Not applicable as no actions have been undertaken

2. Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?

Staff support and easy and speedy availability of musculoskeletal and mental health services, would benefit Social Care staff and facilitate their return to the workplace, and therefore help in the ongoing care of residents.

3. What category of staff, patients and service users have benefitted? And why?

All staff should be able to benefit, allowing all residents to benefit

4. Have some staff, patients and service users been adversely impacted by the commitment and its implementation?
Not applicable

Was it an appropriate commitment?

1. Was (or is) the commitment likely to achieve meaningful improvement for health and social care staff and/or the health and care system as a whole?

A commitment to improving services for staff would improve staff morale, retention and allow their earlier return to work, or allow them to remain in work.

2. Is the commitment specific enough?

Social Care needs to be included immediately and not in the future

3. Has the commitment had any unintended consequences?

Not applicable

4. Was the level of ambition as expressed by the commitment reasonable?

Not applicable as no commitment to Social Care

5. Is the target contained in the commitment an effective measure of policy success (if applicable)?

Not applicable as no commitment to Social Care

6. How has working to those commitments affected other aspects of care?
Not applicable

RESPONSE FROM THE MORTIMER SOCIETY

The Mortimer Society is a charity (Number 287579) which aims to provide quality and safe care for those with a physical and/or a learning disability and in particular those people living with Huntington's disease and other neurological conditions. The service aims to provide holistic, high quality and appropriate care that meets individual needs in a homely environment by highly trained staff. Our residents will be empowered as far as possible and also be supported, shown dignity and respect at all times. We aim to provide a specialist and inclusive service that meets the needs of the individuals in our care. We will enable and encourage each individual in our care to live a rewarding and meaningful life that is unique to them. We will encourage residents to reach their potential and achieve exceptional outcomes.

The Society operates two care homes, with a maximum occupancy of 52- Frindsbury House with 23 residents in Strood, Rochester, Kent and Birling House with 29 residents in Snodland, Kent.

Funding of residents is predominantly by Social Services, from several authorities across southern England, and occasionally Continuing Health Care funding.

The majority of residents have Huntington's Disease – a hereditary progressive neurological disease which progresses over years after diagnosis usually in the 30s or 40s and leads to severe physical disability and dependency and cognitive change. 85% are under 65 years of age. Many residents have been in the homes for long periods of time: 8% over 20 years, 28% over 10 years, 57% over 5 years, 83% over 1 year.

The residents the Society cares for are mainly with physical disability and are younger than 65 years old. This area of Social Care has not been represented in the debates about funding and the Society is not able to set fees for people who are self-funding to compensate for the lower fees from authorities. Moreover, the residents have specialised and complex needs and require individualised assessment and fees to meet these needs.

There are serious issues which are interconnected with the issues of funding, discussed below but in particular the issues are:

(a) Status of care workers
Care workers appear to have a low status and often are seen as "just care workers" – with a lack of understanding of the skills they do need to deliver the care, including personal care, of people with severe disabilities. This was highlighted in the documentary on BBC2 by Ed Balls - Inside the Care Crisis with Ed Balls.

They face

- Physical issues – of moving and caring for people with, often, very limited movement of limbs and body, and with Huntington's Disease poor coordination and uncontrolled movement of limbs and body. Residents are at high risk of falls and injury to themselves and may need help in any movement, even when sitting in a chair or bed
- Nutritional issues – many residents have reduced swallowing ability and require very careful feeding of foods with the correct consistency – after assessment and advice of a Speech and Language Therapist- or feeding using a feeding tube (PEG)
- Psychological issues – residents may have cognitive change, becoming aggressive and verbally and physically abusive; they may become depressed and anxious
- Social aspects – as Huntington's Disease is hereditary (with a 50% risk of a child being affected) there may be issues of concern for the family. Often family may not continue to visit and keep contact with them, due to their own concerns and fears
- Spiritual and existential aspect – as they face a deteriorating condition, until death. The prognosis is very individualised but is often in terms of several years of severe disability

All of these issues can only be addressed by staff who have had training and understanding of the issues of care for the residents and are able to provide empathic, individualised care to the residents and families. Staff also provide social interaction, together with our activities staff, to allow maintenance of quality of life for residents

There is no national career structure or pay scale, which would provide a clear career for people – with opportunities for progression, education and the development of Social Care as a profession.

(b) Pay

The Society pays the Living Wage as the minimum for support staff, with increments for experience and responsibility for all staff, including carers. However, at the entry level for carers this is at a similar level to the retail industries locally, where there is also a less challenging role.

(c) Conditions

The working conditions for staff are often challenging, coping with people with complex needs. There are many opportunities for fulfilment as well, in providing good care for residents within a caring team. However, the area can be seen as less attractive than other employers, such as retail, particularly when the skills and challenges they face are not appreciated by society in general.

(d) Opportunities for advancement

Due to the restrictions on salaries throughout the sector there are limited ways for staff to advance in responsibility / remuneration. There is no clear pathway – unlike the NHS – and there is a need for social care to be developed and be seen as a career, with a clear structure through which staff may rise, if they wish and are able to do so.

(e) Opportunities for training

The opportunities for training are limited. All care staff undertake induction training, leading to the Care Certificate and we encourage staff to undertake further training. However, there is limited funding for this and without increased funding of residents' fees there cannot be adequate provision of training for staff at all levels. Such training – including restraint training and staff undertaking NVQ training and continuing education - would help in retaining staff, motivating them in the roles and improving care for the residents.

(f) Retention

> The retention of staff has become an increasing issue over the last year. The turnover has increased with some staff only staying for a matter of days or weeks before leaving – due to their concerns about pay and workload (which has increased as staffing levels may be reduced by shortages) as well as unrealistic impressions of the role. We have changed our recruitment procedures, whilst maintaining good and safe practice, but retention remains a problem.

There is a need for appropriate funding to be provided for residents in an individualised way, taking into account the specific, and often complex, needs of the residents. The funding needs to be increased immediately and as increased fees on a regular basis, rather than specific funds for specific issues, such as training. Fee increases would allow the Society to develop adequate staffing levels, adequate remuneration to attract and retain staff and to develop a clearer career progression.

Social care has not been able to develop a career structure and the remuneration has been low, with little encouragement for staff to remain within the sector and develop themselves, and thus their working environment. There is a need for greater recognition of the sector and of care staff – who are often seen, and see themselves as "just a carer", as demonstrated so clearly by Ed Balls in his BBC documentary. Consideration should be given to developing a national, clear structure within Social Care, similar to that in the NHS, with clear progression and remuneration of staff, so that they can see this is a profession with clear prospects and progress. This should be accompanied by clear education and training aims, set by a national body, to ensure uniformity across the country. Moreover, funding should be considered on a national level and funded according to the needs of residents, rather than competing within Local Authorities budgets. A National Care Service may be a way of providing this, eliminating the post code lottery that occurs at present. This funding should be reassessed for each resident on an annual basis, so that changes in care needs can be reflected in fees, so that the care provided can be optimal, and the quality of life of the resident maintained.

Social Care has an essential role within society and this must be recognised and funded appropriately and adequately if this important care to the most vulnerable people in society is to continue.

Dr David Oliver
Chair of Board of Trustees
Mortimer Society

May 2022