Written evidence submitted by Group 5 (Event 1) (EPW0080)

Transcript of roundtable event with members of the social care workforce held on Thursday 5th May for the Health and Social Care Committee Workforce Expert Panel.

Group 5

Due to technical issues, the beginning of the recording was missed.

Participant A: We haven't got enough staff. The big drive to get everybody into dom care is fine, but unless we make it seen to be a more professional service, with a career route, then we're not going to get staff in. So on the pledge on having the right amount of people, the answer is that every single domiciliary care company and social care company in the country is struggling with recruitment. They're struggling with getting the right people through the door, and once they're there, they've struggled to retain them- that's my personal view. We haven't got enough people, and 27% of workforce are aged 55 and over so we're facing a massive crisis. The King's Fund does say that there has been a rise of 13% of people under 25 going into the care sector, but we unless we do something quickly, they're not going to stay for long. There is very little pledged around social care for us to even be following, we just need to make sure that we've got the right amount of staff to deliver the services whether it be domiciliary care, supported living or care homes, and everything I know of is being run on a shoestring. And I don't mean a shoestring in terms of money, I mean a shoestring int terms of the actual physical resources that they've got. And the staff we have are burnt out too.

Carol Atkinson: OK, so we'll come back to burnout and wellbeing, but that was really helpful. It's probably fairly uncontentious- unless someone wants to challenge me- that there is not enough staff. So perhaps if we go into this idea of skills, and skill mix, what is your view around whether we've got an appropriate mix of skills and roles and roles to deliver the care that we need to deliver.

Participant A: I was going to say that I think we need to start having staff recognised as professionals. We need more training. There are apprenticeships now for nursing associates and nurses, but there are care managers and coordinators and there is no real structure and training for these people, and they deliver an immensely important part of the job. Registered Managers qualifications are fine but they're not practical, and even the NVQs or CQCs (whatever we call them) don't really teach the experience that they need. Years ago there was something called the NHS skills escalator, and we need a system or a model like that where people can see that care is an ongoing long-term career where you can progress, and these are the routes that you need to get there. We need an appropriate set of qualifications that fit the very different services that we all offer.

Carol Atkinson: Thank you. Let's go to Participant B.

Participant B: So we do not employ workforce, but we support workforce, that's our job, and we've got a decent perspective of health and social care. Sticking with social care for a minute, the workforce shortages are clear to everyone, and in terms of being able to attract people there's two things that might be worth mentioning. The first one is that there is still competition between health and social care, and that is quite significant and something that we hear a lot. I will also comment yesterday on the report from the Migration Advisory Committee, on this point that the NHS sometimes (and with the best intentions), try to attract staff that would otherwise have been available to social care, and they perhaps have more recruiting power at the moment. So there is this internal competition between health and social care, which goes back to the opportunity to join

up careers, and truly join up careers between health and social care. That's the first thing. The second thing, goes back to what Participant A said which I completely echo, is the ability to attract people because you offer career development opportunities, and once they're in to engage them and support them in that direction. That doesn't mean that everyone wants to become a manager or a director, but it means that everyone should be offered opportunities for development within social care. So the first two things that come to mind: career development opportunities and the need to think about joining up health and social care at the base of- I don't want to say bottom- of the workforce.

Carol Atkinson: That's really helpful, thank you. Participant C, do you want to come in?

Participant C: Just regarding the skills element as someone who has to source a lot of the training and development, I actually find that there is quite a lot out there, especially with the Workforce Development Fund and the ability to access that for our staff. We're also accessing the leadership programmes through the NHS as well, and we can access that for free. So there is lots of funding out there. But because of the staff shortages that we have, we don't always have the ability to put our staff on these courses or access the skills. We want to be able to support them, mentor them and develop them but we don't have the space to be able to do that because we need them on the ground at all times. So there are things that we can quite easily access as a company, but it's the actual practicalities of us being able to give that to our staff.

Carol Atkinson: So there are problems with releasing people. Did you want to come in on that point Participant D?

Participant D: Yes, I'm listening quite intensely because there was a lot of agreement, but I'm thinking about the dynamics of the market that we're actually in. We've got this dreadful thing of zero-hour contracts, and we're attracting people on zero-hour contracts for the flexibility of the work practices, and they can decide on their hours and decide when they're going to work. The dynamics of the marketplace in home care is very much driven by social services and their purchasing practices, and that is a self-fulfilling prophecy unfortunately. It was interesting what I think Participant A was saying about the NHS, because I think if you have a social care equivalent of the NHS, a brand or organisation that can be recognised, then you will have people who join that brand, and work their way through- either with their zero hours, 20 hours a week or as a permanent employee, which is where I'd like to be- and it would encourage people to have a career path.

Carol Atkinson: Can I just ask- it might be obvious but for the transcripts it would be helpful to have it explained- why, if you would like to offer full time permanent employment, are you not doing it?

Participant D: I am, well I'm doing both. I've taken over a business that had all zero contracts and I'm trying to convert it into full time employment, but it doesn't meet the needs of all the people that I took over. I'm getting more applicants, including applicants from Indeed, but the problem is that they've got really strange work patterns. I had one care worker today who wants to work Mondays, Wednesdays and every other Saturday, but they want to do 16 hours a day. That's what they want to do, so I can give them a full-time contract but it's a peculiar one. It's not in the same tradition as an NHS contract, if you take my meaning.

Carol Atkinson: Thank you. That's helpful. We're going to move onto the next topic shortly, so Participant A do you want to come back in quickly on that.

Participant A: I was just going to say that we offered permanent contracts to all the staff in my previous employer, and 4% took up the offer of permanent equivalent paid roles. The others turned

it down. The other thing that we need to think about is all social care providers could absolutely put the right training in and all of that, but there isn't enough margin to allow us to do that. And lots of us could join together, and do it really well, but there isn't the money for it at the moment.

Carol Atkinson: So there is a massive funding issue. Can I just come back to you on the low take up of guaranteed hours? Some of the work that we've done suggests that that can relate to the fact that the zero-hour contracts give the workers flexibility, as well as the employer, and there is too little flexibility if you go into a guaranteed hours contract. So that is in part what deters people from those contracts. What is your view on that?

Participant A: So we offered them 40 hours on a wage of £35,000, so a good wage, but then we offered them 20 hours with a variance contract so that they could do overtime at a slightly enhanced rate, and we still got a 4% take up.

Carol Atkinson: Sorry this is my hobby horse, so I'll move on quickly, but is that to do with the fact that they can't determine their hours, in the 20 hours option?

Participant A: No, we were happy to work on their patterns with them, as long as we set them at the beginning, and we had 28 days' notice when they want to change their patterns. We were happy to go with them. We offered everything.

Carol Atkinson: That's interesting. Time is ticking away so let's move to the next question, which is around workforce planning, which might be more appropriate to healthcare, but we're still interested in whether it exists in social care, and if it doesn't exist then raising that as an issue within social care. So I'm interested in any on national, regional or even local systems of workforce planning that you may be aware of, or involved in, and whether this is effective or not effective.

Participant D: I've run the biggest organisation in the country, as well as now running a much smaller one, and I've never been involved in workforce planning. And that includes NHS as well as social services. One of the problems is that the marketplace itself is an open market, that the more resources you put in, the more it will be taken up. There's never ending demand for social care.

Carol Atkinson: But if we think about the NHS, I'm not suggesting that they're necessarily effective systems, but there are systems of trying to work out how many doctors to train, and how many places to commission for that training. Do we see any of that in terms of the social care workforce?

Participant A: Skills for Care have got the workforce data set where you can upload all your training, but that is a voluntary thing and it's not mandatory. It's a huge set of work, and I can see Participant C nodding here head. It's not friendly

Participant C: I had to do it to access the Workforce Development Fund, and it is a massive job.

Participant A: We don't use that funding, and I'm not currently running any services, but genuinely it's a huge piece of work. That data is so essential, but it doesn't take into account supported living services, unregistered services, and all the other services that are now supplied through PHB trough private staff. In fact the PHBs are out biggest worry because somebody can employ somebody without a police check, without any training.

Carol Atkinson: That's like a personal assistant, isn't it?

Participant A: Yes. So they get paid an amount of money for their care and they can run it as they see fit, as long as they meet their outcomes. And that for me is a huge risk for individuals and workers. How can you plan a workforce in health and social care when you don't even know what

your workforce is? The Department of Health and Social Care don't even understand what our workforce is, they haven't even got the numbers.

Carol Atkinson: And you don't work with local authorities or commissioners to do any kind of modelling around workforce planning?

Participant A: I have done some stuff with Hertfordshire County Council and Hertfordshire CCG, who are amazing. What they did is pick a couple of providers to come in to what they could offer. They've got the fantastic Hertfordshire Care Association set up over there, the lady won an OBE, and they are really good there, and people can go and access all sorts of training and pay a minimal amount of money. But that is a rare occurrence. I believe there's one in Surrey, and there's a couple in Walsall that are ok- these are the ones I know of, but there are probably more around the country. But that's kind of a survey once a year, and I don't think that's not very meaningful.

Carol Atkinson: Thank you. Participant C, I think you said you worked in HR so have you got a view on this?

Participant C: Yes. So, when you say workforce planning, obviously we do ours at an organisation level, because we have set beds, we can do that, and we estimate for our turnover percentage etc. So we do that at an organisation level.

Carol Atkinson: But is there any interaction with the local authority, who might be thinking that over the next five years this is the likely growth in care needed, so how are we going to commission and work with providers to plan that capacity.

Participant C: That wouldn't be within my role, so I wouldn't be able to comment on that.

Carol Atkinson: OK.

Participant D: Caroline in both systems, both NHS and social care, they fail to take into account private healthcare. So the NHS planning, which we know is 100,000 nurses short and that there is a doctor shortage, misses out on ever talking to the private sector to consider their needs at private hospitals, so they're always going to have a problem on the NHS front. On the social services front, private payers (they're who keep my company alive) have a much greater demand and a much greater flexibility, and we'd much rather work with them, and they're never measured or known about by social services.

Carol Atkinson: So they're a massive gap, you're right. Participant B, this might not be one of your areas of expertise, but do you want to come in at all on that?

Participant B: We do not have visibility, with anyone that we work with, of any structural workforce planning that is done at organisational level. As Participant C said, it is done by individual providers, but we do not have any visibility of system level planning.

Carol Atkinson: Welcome Participant E. Would you like to introduce yourself?

Participant E: Apologies everyone, I was stuck behind a car accident. I'm a director of marketing, communications and customer engagement. I'm currently overseeing social care reform and the transition that we might have to make to get ready for that.

Carol Atkinson: Excellent, thank you. We won't all do introductions again because of time, but I'm on the special advisors to the panel. Stephen is a panel member, and the other four people in the room, in addition to yourself, have expertise in working in the social care workforce. We've talked about our first commitment, which was planning the workforce, and we're going to move onto

building the workforce. The first question around building the workforce is the funding for more social care staff that was pledged, so that goes back to October 2021 and the levy that was started in April 2022. So I'm interested in your views about the availability of funding. Has that commitment made a difference?

Stephen Peckham: Can I just come in? I was interested in the comment about the hassle of loading data, because accessing the money to support staff development from Skills for Care is depending on going that way.

Participant A: So if I give you an idea. You upload the standard data, so all our data and information about who works for us, the nationality, their age groups and all of those things- as well as the large training matrix that goes alongside it- and if you're not accessing the funding it takes 25 minutes to upload this data for each person. At the time that we were doing that we had about 350 members of staff. And once you've got it on that's fine, but you have to update it every months about who is actually working. But the first upload took something like 10 staff days. And we're a fairly big provider, but a small provider just hasn't got the time to be doing that. They don't access a huge amount of workforce funding, because the funding that's now available is quite specific to specific areas. It also hasn't got a huge amount for domiciliary care staff in there because it's mainly focussed on care homes, because you have the data on care homes. And it goes back to the point; how can they possibly plan, work out if they've got enough, until they get some accurate data on the level of domiciliary care, supported care, PAs and private care that goes on in the UK? It's chicken and egg; until you get the right data, you can't work out what you can do. And interestingly, as you said they've pledged that money, which is great, but most local authorities have given out rises of 2% on social care, or below. There are some higher ones, but most of the providers I speak to aren't feeling any real benefit from it.

Carol Atkinson: So that 2% is not necessarily about training, is it? It's about staffing levels and the funding of care commissioned.

Participant A: But when they pay us, or they pay people, within your costing is a training element and that's what were meant to train people on.

Carol Atkinson: Yes. So most people have been given 2% and you're not feeling the benefit. So does anyone else want to come in on that? Have you seen any benefit from increasing funding flowing though, and not just for training, but for staffing levels more widely?

Participant E: During COVID, yes, we did see an increase with funding from local authorities, that did close the gap between the actual cost of it and what the cost of providing it is. It definitely closed the gap a bit. We didn't see it everywhere, but there were definitely some local authorities where you felt it had gone up. But it's gone now, and it's just back to normal and it's probably the same for everyone. People are staying home longer, and the Government's message is clearly 'home first', and this worries us because we are increasingly seeing a much higher care need. And actually some people shouldn't stay at home for as long as they do and it's not good for them, and it's not good for the provider. So what you think is residential is actually not, its borderline nursing which progresses very quickly to nursing. It's at crisis point; people need it right now and are really distressed. But the funding doesn't seem to have matched that and our staffing levels have challenged on it. The training point is less relevant for my organisation as we offer a lot of training, and we have a big L&D department, because we're a large organisation. But from a funding point of view the gaps fill bigger than they've ever been, especially because we've just been hit by an energy bill for this year and it's

going to go up £950,000 a year, which is an increase of 125%. How much of that can you pass that onto the family, who is likely having the same problem? And the price of food as well.

Carol Atkinson: The funding still feels squeezed, doesn't it? Does anyone else want to come in on that?

Participant C: I would agree, and we've also got increased energy bills. To remain competitive to retain staff, we've had to put our salaries quite substantially above the amount of funding that we will be getting. For some people, we've put them up by 10% because we know that we've got so much competition against other care homes, and retailers, for those staff. So the funding doesn't match what we've had to put our salaries up to.

Participant D: On my side as well, we've taken a unilateral decision to increase pay rates, because we don't rely on social services. So we've increased our pay rates by approximately 33% in the last year, we're at £13 an hour, whereas we were at £10 an hour. I'm kind of giving the social services notice about not wanting any of their business, because they gave me a 6% rise in the last two years, let alone one year. 6% in two years. That doesn't cover the increase in minimum wage. It's perverse.

Carol Atkinson: Just to clarify, you're doing that because you're taking mainly private funders.

Participant D: That's right. So I'm actually applying the price rises to the clients and using all of the money to go into my workforce.

Carol Atkinson: I know that this is very much perceptual, but would you perceive then that you are struggling to recruit less than other people?

Participant D: No. But I've still got the challenge because it's a very tight marketplace. I have the proud boast of paying the highest salaries, or pounds per hour, but it's still a challenge to actually recruit enough. I could double my business, if I could double the number of care workers.

Carol Atkinson: Thank you. Participant A did you want to come back on that?

Participant A: I'm just going to stick up for care homes now. They've got low residency, and my figures are out of date, but two years ago it was £440 for a bog-standard hospital bed per day, which compared against the between £650 and £800 care homes get for a bed week from the Government, how on earth with low residency…we're in a real crisis and we're going to lose care homes. And then those beds will be gone. And that's without any of the domiciliary care or anything else. I just think the money isn't enough, it's never been enough. The Home Care Association has said that for anybody working inside London the hourly rate should be £29.50, and outside it should be slightly lower. You can't provide a decent care home bed without supplementing it with your private clients, and even at the top of that range at £800, that's less than £100 a day, which works out at £4 an hour for everything- heating, lighting, insurance, food. And it's just impossible for them to do.

Participant E: I just wanted to add something to that, which is that we have colleagues in the NHS in hospital discharge teams, that say tell us that they wished that we would get more money because they can't discharge people from their beds. So it blocks the whole system downwards. So I think the NHS are supportive of it.

Carol Atkinson: One of the senior members of the nursing bodies actually came out and said that last week.

Participant E: Yes, because we have to push it down and say no to hospital discharge, and it's with a heavy heart but we just can't do it.

Carol Atkinson: So I'm going to widen the funding question from staff specifically, out to better facilities and more technology. So perhaps if we think about facilities first. Have you seen funding for facilities increase, or how adequate is funding for facilities? Participant C, that is an unusual expression.

Participant C: I would say no, I haven't. But it's not something that I would necessarily keep track of, as it's not my area.

Participant A: Carol I think it's really hard for us to see what is going to happen, because you've got to remember that we're kind of in limbo with the ICSs. So we might not see what's going to happen. There might be loads of plans in the pipeline that we haven't seen yet, and 1st July we might see those, but we won't see them until then.

Carol Atkinson: Yes, it's a fair point. But the piece of work on evaluating pledges is happening now and I suppose that's a fair reflection that, ahead of what we see with the ICSs, is that we're not seeing that. Let's move to technology. What are your senses on this? Because again there was this view that there was a big uptake of technology during COVID and that that had been funded and was beneficial.

Participant D: I'm a real believer in technology. We should maximise whatever a human being can do in their ability to get hands on, and supplement it as much as possible with remote healthcare monitors, any form or robotics, smarter software systems, communications between care workers and clients, and doing all sorts of added value for monitoring healthcare at home with individuals. The problem is that social services don't pay for it, therefore I'm going to create my own marketplace for it. But social services haven't recognised it, and I don't think the NHS have either.

Carol Atkinson: So you aren't getting local authority funding for your technology? You're funding it from your private payers?

Participant D: Yes, none at all.

Carol Atkinson: Ok thank you. Participant E you're nodding, would you agree with that?

Participant E: We've done a bit of focus on technology. Everyone is now on digital care plans in our homes, and we've made tablets accessible throughout the pandemic to connect people, but that was from our own fundraising and not of that came from anywhere else. We had to kind of go off of our own backs or draw into our income, because we saw that that was a big part of preserving somebody's wellbeing at a very difficult time.

Carol Atkinson: What about staff use of technology? Is there a greater uptake of the kind of things that Participant D was talking about?

Participant E: The revolutionary thing for us was moving onto Nourish Care, so getting off of paper records. There has always been a perception that frontline staff can't use technology, that they won't be able to do it, and we've seen that that was a load of rubbish. They have massively embraced it, and we do feel that it's enhanced the care in our homes in being able to track things. It's not such a positive spin on things, but obviously we get complaints, and we have investigations, and we finally have that robust data that we can draw on when we do our investigations which we didn't have before. So I think it makes the staff feel quite supported. In my organisation they embrace it, and it enhances what they do.

Carol Atkinson: Thank you. Participant B do you want to come in on that?

Participant B: I just wanted to echo what Participant E was saying in terms of staff embracing technology. Most of our programmes, all the way through the pandemic and most of them now, are delivered remotely through Teams and Zoom and it works beautifully. We work with domiciliary care workers, residential care workers and healthcare support workers in the NHS, and sometimes these colleagues join out programmes from their car in between visits on their mobile phones. And they do it so naturally, and it works beautifully. So that's a very superficial use of technology, but just to echo what everyone is saying I think the desire to adopt technology is undoubtedly there form the workforce. I cannot comment as much on funding, but the desire and the ability is undoubtedly there.

Carol Atkinson: Thank you. Participant A did you want to come back in on that?

Participant A: Yeah, I was just going to say that tech is great, but lots of small care providers don't have the money and therefore can't do it and will stay paper based. But I think if we really want to join up health and social care, and get a real picture, then health should be able to look at our records (obviously you give permission and allow people to opt out) and so should the CQC. If we want to be transparent, everyone should be able to look at those records if they are providing care as part of an MDT, and originally there was talk about a system like that. The other great thing about tech is that it can be really helpful for staff wellbeing, for checking in on people. Interestingly enough, they gave an iPad to every care home in the UK during the pandemic, but they didn't do the same for domiciliary care. We issued them so that people could talk to their families at certain times, and we would facilitate those calls. I just think it's so underused, but it's underused because there are lots of small providers that don't have the knowhow, or the money, or the staff resource, to get it up and running. Also because it's just kept there, we're missing a huge trick because there's so much data there that we could share, to really give the Government the picture on early intervention for care, the different ZAP makes. We know that people are getting social services later i.e. accessing social services support later, but in terms of continuing healthcare they're accessing it much earlier and it would be interesting to know why that's happening. There isn't enough money in it and there should be more investment, because we're missing huge tricks in trends of what is going on in our older generation and our vulnerable clients.

Carol Atkinson: Thank you. Participant D.

Participant D: I'd like to pose the position that social care is far better at using records than the NHS. We've got a real time medication compliance because of using a software system, that is a revolutionary effect and it's kind of standard in social care. So we know when our care workers have administered, or been involved in the administration of, medication the minute that it takes place. They don't have that in the NHS, they can hardly deliver patient records in the NHS, and yet we're putting in what happens in every single care call and making it available to family or professionals. So I think that there is a lot that can be learnt from the dynamics, even if from a small provider Participant A - a lot of small providers are really dynamic for it.

Participant A: I'm not saying that there aren't good small providers, but a lot of providers aren't doing it because they're worried about the cost.

Carol Atkinson: So the ones that are doing it, who's funding that?

Participant A: They are.

Carol Atkinson: So they're self-funded. I'm going to move on now to wellbeing, and issues that we've not picked up already in building and planning the workforce may well come up in wellbeing. It goes back to a very early point that Participant D made about 'well what are those commitments', so the commitments are quite generic, and we'll talk about what they are, but your wider views would also be very much appreciated. So there was a commitment on listening to the views of social care staff to learn how they could be better supported. So I'd be interested in the extent to which you feel that has happened, how that has happened, and action taken as a result of that.

Participant D: I have personally never been approached for views, and I've pursued social service to try and give views in a constructive manner. So there isn't a mechanism, that I can see, in the UK, or in England, or at the local council level that enables a genuine meeting of views. Maybe this is something that CQC could actually play a role in, or maybe UK Homecare.

Carol Atkinson: There have been a couple of surveys, haven't there? I don't know if you've been aware of those.

Participant D: Surveys in what sense? Because I've taken part in a lot of surveys.

Carol Atkinson: I'd have to take a look at my notes, I can't remember the exact reference, but there have been surveys done quite recently.

Participant A: The Homecare Association do regular surveys for feedback. They're often very last minute, because we're helping the DHSE or the Government with some feedback about a specific area. But not everybody is a member of the UK Homecare Association and Care England so you're only getting feedback from some. I was a secondee with David Pierson and I can tell you that we got lots of feedback, as requested by him, and it was completely ignored. Nobody did anything with it.

Carol Atkinson: What kind of feedback was asked for?

Participant A: One of the things that we wanted feedback on was complex care around the AGP, and the level of AGP having to be worn with young people, and the guidance around that. We fed back that it was a real problem, and it never got addressed. We fed back about the lack of PPE, about the zoning i.e. if you've got a care home and you don't want people to move between care homes, that is nearly impossible in some places. There was a lot of stuff that we fed back on, and so many concerns were raised, and because it doesn't fit with what they know in terms of the demographic data that they've got on social care, they couldn't relate to it, and that was the problem. It's not that it didn't want to help, they just couldn't relate to the services that were happening.

Carol Atkinson: That was really interesting. And what about the staff themselves, to what extent are individual staff member's views acted so? I understand that you're talking about service there, but if we think about job satisfaction, burnout, stress, those kind of things that we started to touch on earlier.

Participant A: We did wellbeing checks every week. We offered a counselling services, extra days off, study tie, family days. We offered all of that. And we do listen to staff feedback, I think you lose all your staff if you don't. But when you're really stretched, it's really hard to do that because you have to staff the floor.

Carol Atkinson: Absolutely, and I take the point that you're listening to your staff feedback, but is there any sense that, anywhere, policymakers or commissioners are listening to feedback, or vent seeking feedback? Lots of shaking of heads there.

Participant E: I've never felt like they've sought feedback on what our staff think, and what they're feeling. The thing that I've been asked to feedback on the most over the last two years is what we think of the Capacity Tracker- which isn't a lot- and whenever we feedback, the changes don't get made anyway. It felt like we were being asked about staff purely on a ratio level, it didn't feel like they were asking about wellbeing and burnout, and the thigs that you covered. It always felt like they were seeking feedback just because they wanted to know about our availability to take hospital discharges.

Carol Atkinson: So the NHS have their staff services, but I understand that it would be much more complex in social care.

Participant E: We do our own ones, but yes.

Carol Atkinson: But nobody has ever asked you for that data, the local authorities are not collecting that data?

Participant E: I don't remember.

Participant A: Adass have the PAM system, where you can upload how you think you're doing, and they will inspect you against it. But interestingly, there are no questions in there about staff feedback and wellbeing, because that's one of the things that I raised. So, the NHS have lots of support lines, and lots of things were set up whilst the pandemic was going on, but social care didn't, and questions weren't even being asked in their yearly monitoring. So I don't think that they do listen.

Participant E: I would agree with how you just summarised that, the distinction between the two.

Carol Atkinson: Participant B or C do you want to come in on that?

Participant B: Yes, we do our own staff surveys with the Homecare Association, with Care England and so on and so forth. But they're private initiatives, and we do them with our members to get a temperature check of what is going on. They're not fed into any other major database that are available to everyone who wants to see them. I don't want to sound provocative here, but it's pretty obvious how challenging the wellbeing situation is across health and social care. And maybe domiciliary care is affected even more, for fairly obvious reasons. I appreciate that we're comment on the specific pledge, but perhaps there should be a bit more on what we are going to do about it, because the last two years have significantly affected staff wellbeing. I suppose there is consensus around that.

Carol Atkinson: And so, do you want to say a bit more about that?

Participant B: Yes, absolutely. We have seen some evidence of funding coming into the NHS and social care, early on and throughout the pandemic, to support staff wellbeing in a reactive way. And we've learned a lot I think, all of us, over the last two years about what can work from a reactive perspective, but the interesting conversation now is what are we going to do moving forward in a much more proactive way. We've seen that in health and social care reactive measures work up to a point, but it's not about just catching someone when they're about to fall but preventing people from getting to that stage. And everything we're doing, with everyone that we're working with, is now focussed on that. We haven't completely abandoned that reactive element, and an element of that always needs to be available, but I think the real conversation, in terms of funding and support, has to be about taking what we've learnt over the last two years and turning that into proactive wellbeing support. What works from our experience, and there are surveys that confirm that, is

really engaging directly with frontline teams. This is a difficult thing to do because of time constraints, and resources constraints, but what we get is exceptional feedback on these wellbeing programs. Wellbeing hubs work to a certain extent, but they don't get used much. What seems to be particularly effective, and actually quite innovative, is the ability to say that we're going to put a cohort of 20 frontline domiciliary care workers, maybe from different organisations, on a 12-week supported wellbeing engagement program. These programmes not only give them access to support, but also access to learning more about how to look after yourself, and in turn how to look after everyone around you- whether that's your patients or your colleagues. And that active engagement in their wellbeing seems to be the thing that gets the most positive responses. It's not easy to do, but it's very doable.

Carol Atkinson: Was that happening before COVID, or is it as a response to COVID?

Participant B: We tried our very best to make it happen before COVID, because that's what we do, but in reality, there's been a major turning point during COVID. Staff wellbeing has changed and it's not going back, it's changed for good, and that's one of the positive legacies of the awful time that we all had over the last few years; we're going to look at staff wellbeing in a different way. And we are probably prepared to invest in staff wellbeing in a different way. So the answer is yes, it was happening on a much smaller scale before COVID, but now we're making it mainstream.

Carol Atkinson: And that investment that you refer to is that, again, privately funded as opposed to coming from any kind of local authority or NHS source?

Participant B: It's mixed. In the NHS it is funded in so many different ways, from Health Education England to individual trusts and so on. In the care sector, in our experience, there are private care organisations that fund themselves. There are providers that work with local authorities that through different stages of the pandemic had access to additional funds, and the question is whether that funded will continue. There have also been things that we've learned don't necessarily work. All the funding that has gone into wellbeing hubs in health and social care, probably a bit more into the NHS, and we're learning what the return was on that. Not all the things that we did during the pandemic in a reactive way, will have the same benefit in a proactive way. So funding has been made available more than ever, for obvious reasons, and we've seen some of that coming into social care.

Carol Atkinson: Thank you, that's really helpful. Does anybody else want to come in on that, particularly in relation to any changes during COVID.

Participant A: I think there have been massive changes; I think carers realised their worth. We've got a real problem, because not so long-ago people were clapping them and now, they're not being treated as well. They're all burnt out and I think we're going to have a lot of PTSD. We've got a lot of carers that had really difficult times, within all services, and I think unless we invest now, we're going to have a much bigger problem very soon.

Carol Atkinson: Thank you for that. Anybody want to add to that, or on wellbeing more generally?

Participant D: Can I just had that wellbeing works very well when you have a sickness payment system that can support individuals. I know it's much more than just taking days off sick, I fundamentally understand that, but that's what's missing in the social care sector. We just don't have that mechanism in the same way that the NHS has. I think that's one of the reasons why many people are a bit worried about even tackling it on a broad basis.

Carol Atkinson: Can you expand on that as I'm not sure I quite follow.

Participant D: Because we don't pay for absence. And absence in domiciliary care means you've got a problem because you've got to cover the absence. You don't generate revenue unless you're actually delivering care, so absence of an individual means you've got a double problem. So the absence of sick pay being paid into social care works against any organisation being altruistic in developing good wellbeing programmes. So we need to tackle that absence of cost, in some form of support from the Government or from local social services.

Participant A: I would also say that we've got the added problem that the ICF fund paid full wages to people that had to go off with COVID, and that's now been withdrawn. So they're going to come to work irrespective. They set an unrealistic expectation that we could carry on with that.

Participant B: If we're talking about wellbeing, then the immediate correlation between sickness and absence is pretty obvious. But there's a medium term and long term correlation with engagement, retention and even recruitment that is going to be very significant for years to come because the expectation of staff, as a result of the pandemic has changed. Everyone expects to be more looked after in different ways. But having wellbeing structured within care organisations, or just the NHS investing a lot of money into wellbeing, will be essential to not only retain staff, but to also attract the talent of the future. Young people expect to be looked after, so we need to have wellbeing systems- that work- in place.

Carol Atkinson: OK, that's really helpful, and actually leads me nicely back into some of the questions that I was going to revisit around planning the workforce. So we recognised recruitment difficulties earlier, but we didn't talk a lot about recruitment practice. So your point about wanting to be looked after, and that expectation, is really helpful Participant B. I wonder if there were any other reflections that you on recruitment practices that might be helpful to share. How do you tackle these recruitment challenges that you face?

Participant C: Like I said earlier, I started this role in October and one of the first things that I looked at was recruitment as it was one of the big issues. There was a kind of thinking that recruitment is a constant challenge in the industry, and therefore just the way it is, so the methods that we were using weren't necessarily what would be seen as modern recruitment techniques- it would be popping an advert out and hoping for the best. So what we've done is a major focus on the different things that we could be doing on top of that: engaging with local partners, charities, the job centre and building those community links rather than just popping out those adverts. So recruitment is going to be something that costs us a lot of money, but it's something that we need. Rather than popping an advert in a newspaper we need a whole strategy.

Carol Atkinson: I realise that it's probably early days, but how is that working for you?

Participant C: The first thing we've done is hire a recruitment specialist to come in and build that strategy. So you can see an impact already. It's more to do with the impact on the home manager in that they're now taking recruitment more seriously, and they're getting a bit more a buy-in, rather than having that attitude of 'it's the industry, and it's hard to get people into care positions because the pay is low.' Our adverts are now going to be based more on what we can provide as an employer to those people that have the values and skills that we're looking for, rather than just one that focuses on low pay, that it doesn't require skills and that anyone can join. So impact wide, I suppose we haven't got the numbers to say that recruitments definitely gone up, but the actual culture around recruitment and getting buy-in has increased.

Participant A: Although I run a service, I'm a recruitment specialist. So running nursing surgeries, everyone gets paid the same on framework, it's about who gives you the best service. I don't think

it's always about pay for lots of people. During the pandemic, people were allowed to work in key service whilst being on furlough, so we got a false level of staffing that we've never had before. And what we didn't do is work hard enough on making them feel values when they were there, so that they wanted to stay in care which is a bit of a problem. I don't have a problem recruiting staff, the problem comes when they want development, and they want to go to other places. The other point to raise, is that when I start in October, I will be calling my staff healthcare professionals, not carers. I think it's about standing, and levels of standing. Skills for Care have done an amazing job on recruitment initiatives around the country, so it would be really worthwhile to go and speak to them and getting feedback on that. But at well as the recruitment issues that we've got, what's much worse is that we've got droves of registered managers, that are really key to services, leaving the profession and that skill will never be replaced. We've got a limited amount of people that can do register manager roles, as it's really hard to train people, and nobody wants to go into it. So we've got specific areas that need real focus.

Carol Atkinson: Could you say a little more about why so many registered managers are leaving?

Participant A: So registered care managers that run care homes, and run services, absolutely work their socks off. If you run a care home and you had 22 residents, to keep the capacity tracker up to date- and these are figures from the DHSC- is a weeks admin. One person working a week on admin. So larger organisations have to set up whole divisions to do the admin on the tracker. So there are so many problems and extra things that you have to take on, and you can only do what you can do. Plus they had to do all the testing. So registered managers have become administrators, and box fillers, and they get the blame for everything. The Government are trying to blame them now, saying that they shouldn't have let people out of hospital, and they've had a really hard time there. They had families having a go at them about people not being able to visit. Honestly, registered managers of this world are my heroes. I was one of them, I worked frontline during the pandemic, and we did everything we could possibly do, and yet everyday we're being criticised. I run four registered managers group, and before you might get one or two people leaving and going to a new provider, but if you look at those groups now, there are three or four people every day telling us they're burnout out, that they're leaving care and never coming back. That's the real problem.

Participant E: Just to say that really resonated, I mean Amen to everything that you just said. It's all true. We're having the same problem with registered managers too. I think one of the problems as well is that during the pandemic there was more gratitude for frontline staff, and registered managers, because people thought they took on the role of family. Families couldn't go into the homes, so actually they became their family. And there was a real appreciation and gratitude. Our compliments went through the roof, and our complaints went down, and it was amazing. But now we're going back to normal, and it's harder. A lot of the same stuff is still there such as testing, which is reduced, but still there. And relatives have come back, expectations are back, and I think managers are sitting there thinking 'what have I done this all for?' They've kept the roof up, they've kept people alive, they've risked their live and made the most incredible sacrifices, and that's difficult. Everyone just expects the service to go back to normal, but you've got this exhausted burnt-out staff, so it never can. And I think that's why we're seeing them leave at the moment, personally. And they're not feeling valued, and I think they're asking themselves why they did it. From our point of view, and you may have covered it before I joined, there is definitely far more of a challenge in recruiting- and I hate to say it- but what are called skilled carers, so the ones with qualifications. That in itself is going to make you feel a bit crap, if you're not in that camp, isn't it? We are finding it hard to get qualified team leaders and nurses, particularly nurses. It's just a massive struggle for us, and it's really hard because there's tension there, which is ironic, because we're getting more nursing

care than we've ever had, and more hospital discharges, so this is the big block that's been created. We became a London living wage employer last year, because it was the right thing to do. My colleagues thought it was going to make a big difference, I didn't, and it hasn't made a big difference. It's good that we're doing it, because it's the right thing to do, but is an extra £1 an hour going to bring them in droves? No, it's not. And there's still a stigma around how you can have a career in care. It's also that they're really hard jobs.

Carol Atkinson: Thank you. I've been warned that we've got two minutes left and Participant B wanted to come in.

Participant B: I wanted to give a short example of a relatively large care provider that we're working with- it has 13 care homes across the Midlands- and they decided to invest in a program for deputy home managers to provide them with support, but also development opportunities, called Leaders of the Future. It is a combination of wellbeing, development and making them feel valued and invested in. They've been through a lot in the pandemic, they're burnt out, but the feedback has shown that doing something like that helps them to feel valued by their organisation, and the chance to look after themselves better. So I'm saying that it's not inevitable, it's hard and it needs to be funded, but it's definitely not inevitable.

Participant A: We need it everywhere Participant B because otherwise we're going to have no registered managers left. Then you're really in trouble.

Carol Atkinson: Just before we all get whisked away, I want to say thank you for your time and input. It has been absolutely invaluable.

Participant D: It's been an invaluable opportunity to feedback and listen other people, so thank you.

Participant C: I was going to say the same. As someone who is newish to the sector is nice to be able to hear what other people are going through, and the challenges that people are facing.

Stephen Peckham: Can I say, listening to this, what was interesting is that whilst you're in what is called a social care system, you're not really part of a system. You know you're not only in a market, you know you're operating in a workforce market, you're operating in a social care market, you're operating in an organisational market and funding is also very much fragmented as well. And therefore, should we be really talking about a social care system? I think the DHSC might see it as system, but they don't really necessarily think about the way it operates in practice.

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