Written evidence submitted by Group 4 (Event 2) (EPW0084)

Transcript of roundtable event with members of the social care workforce held on Wednesday 11th May for the Health and Social Care Committee Workforce Expert Panel.

Group 4

Carol Atkinson: Lovely. Now I noticed your comment, Participant A. So perhaps we could just have a discussion about what terminology we would like to use and it sometimes it's service users, but I know sometimes it's also some preference not to use that. So, is there a particular reference that you would like us to use?

Participant A: There is a mouthful term that it seems people prefer, which is 'people who draw on social care services'. The reason why people seem to prefer it is because it doesn't show them as just a passive receiver of care, but their very active role and as far as I know I think service users is a not very liked term at all.

Carol Atkinson: Yes, I am aware of that, which is why I was trying to get a shared... so is everyone comfortable with 'people who draw on social care services'?

Participant B: Yeah, that's fine. I'll be honest, I'll probably slip in a few clients because that's the terminology I use day-to-day I'm afraid.

Carol Atkinson: OK. Yeah, that's great. So thank you for drawing that to our attention enabling us to get that kind of shared understanding as we start. So, you'll have identified already that we are a social care group, there's healthcare groups, there's social care groups. So, it's great that we're all able to come together in a social care group. I believe you have had a briefing pack, but just to run very briefly through what we're going to cover: we've got three commitment areas that we're thinking about. The first one that we'll think about is planning for the workforce, which is around ensuring that NHS and social care have the nurses, midwives, doctors, carers and other health professionals that they need. So that's our first one. We've got building the workforce, which is around, again, numbers of social care staff, infrastructure technologies and facilities. And our last one is around wellbeing of the workforce, which is around views of social care staff, how we support individually and collectively. Our starting point has been to identify, from information provided to us by the government, a series of commitments that they have made and we're seeking to evaluate those. However, one of the things that we identified a fairly early stage is that some of the commitments around social care are not particular well specified, particularly in relation to healthcare. So, we may have to go a little broader than that to have our discussions. So, the starting point, for example, is looking at government commitments to ensure staffing levels to meet the needs of the service are available, and their particular commitment here is around the advertising campaign to draw people into care which pledged to get an extra 20,000 people into care by the end of March. So, I would like to discuss that. But given that is the only real commitment, I think we'll have to discuss them more widely, staffing levels, skill mixes, etcetera in social care. But if I could start, we're a very small group, so I would encourage you just to chip in, but if you don't feel you're getting the airtime then just do, by all means put your hand up and I'll invite you to speak. But don't feel you necessarily have to do that. So, let's start with the one firm commitment that we have that 20,000 people in social care as a result of that recruitment campaign. Can I ask you your views on the extent to which that commitment has been met? And if you don't know, that's fine.

Participant C: Can I jump in? So, this is actually something we liaise with the department on quite a lot in that they would send us a lot of the campaigns and, we would disseminate it to our members.

And the only thing I would say is that it generally didn't get a lot of engagement from our members because an advertisement campaign isn't going to draw people in. It doesn't really feel like a proper commitment from the government to get individuals into social care and we've also asked the team to provide us with numbers as to how many people that have actually been recruited by these campaigns and they haven't actually been able to provide us with those numbers. We can't actually see whether this commitment has been successful because no one's told us whether there's X amount of people that have been employed via this route. So, it's really hard to understand whether this commitment has been met.

Carol Atkinson: So that data is not available. Is that what we're saying?

Participant C: I don't know whether it's available or they've actually looked into it. From what I understand when we asked is that it was quite hard to find out from employers whether individuals were directly employed via this route or that they were attracted via this advertisement campaign. So whether these numbers are available or aren't, they haven't been provided to us. So we can't actually see whether or not this commitment has been met.

Carol Atkinson: OK. Thank you. I'm just going to go around the room, and then there's a couple of points I'd like to come back to. Participant B?

Participant B: I think Participant A had her hand up before me, so.

Carol Atkinson: Sorry, apologies Participant A

Participant A: Thank you Participant B, that's very kind. Yes, I completely agree with Participant C. I think we've been fobbed off many times, saying we can't really see the numbers, which is very disappointing. That was the last recruitment campaign, as far as my memory serves, we've had three rounds of those in the last two or three years, all of which seemed very expensive campaigns that haven't really come to much in terms of return. So, our view at the charity has been that money would be better spent in bonuses for care workers, whatever else, than actually very expensive, very flashy campaigns. So, I don't think that commitment was met mainly because we can't access data, but also feedback that I've heard from care providers is that they've not seen much coming through that route. And feedback from care workers always around the HSC campaigns is that's not really the route they go through, it's employee referrals and that kind of thing where people come in it. It won't be a big campaign like this because we are not in at this stage I don't think with the sector where we have an attractive enough offer compared to other sectors for people to see a poster like this on the tube and say “ooh yeah, I must go in and apply to social care” so there are many reasons behind it. But coming down to the particular commitment not having the figures, seeing anecdotal evidence, I do not believe that that commitment was made.

Carol Atkinson: OK. Thank you and Participant B?

Participant B: Yeah. I guess in terms of say as a commitment, you know, like the government can probably evidence that, yes, we spent the money, we did the adverts, we met the commitment. But the fact that you can't actually pull through the data to see whether it was effective… and my perspective on the advertising campaign is either seeing it as getting stuff sent through it as a potential recruiter stuff to tag into and use; or just physically seeing the adverts on the TV; or hearing on the radio; or seeing there’s actually a poster around the corner from my office which I walked past every time I go back to my car to update my parking ticket. The advertising campaigns, they don't really seem to encapsulate what working in social care is about and what it's like, and I don't think it particularly increases its profile in terms of raising the esteem of working in social care.

So yes, technically the box can be ticked that the work was done, you know, they ran the advertising campaign, but I don't think it was particularly effective. Also, again the flipside of those advertising campaigns that there has been a lot of negative stuff about social care workers coming from political sources over the last couple of years in terms of things like the vaccinations as a condition of deployment and some of the comments around “well, if staff don't get a vaccine they don't deserve to work in care”, so with comments like that undoes however many thousands of pounds you want to spend on posters and adverts. You look at the example of like Angela Rayner recently with her negative publicity: in one of the things, she was negatively compared to Boris Johnson because she used to be a care worker and compared to him going to Oxford and going in in the debating society. All that negative stuff in terms of impact far outweighs the posters and TV adverts. They would be better off spending most resources on positive communication around what social care is rather than trying to do it as “we've done three months’ worth of campaign adverts”; if people don't see social care jobs as being, esteemed, skilled, valued, then you can advertise as much as you like, but if people think they are basically unskilled minimum wage jobs, that you're disposable, that anybody can do it, that's what stops people wanting to get a job, not the lack of the availability. You go on any job site, and they'll be hundreds of care jobs advertised. So, people who want to work in care, it's not finding the vacancies that is the issue because any means of job search, you'll find hundreds of care jobs, it’s just the fact that people aren't wanting to make that leap.

Carol Atkinson: OK, I'll come to you in a moment, Participant A. That’s really interesting, thank you. I think it was Participant C who said it won't draw people in and I think you talked about referrals Participant A there. So, I'm kind of quite interested in if the adverts do not work, why not, well I think we’ve covered why not, but how do we draw people in? Do you have anything to say on that Participant A? If not, just make the point you wanted to make and then we'll move into that.

Participant A: Yes I think what works, and there has been studies about it, you know, care friends have recently received a lot of funding from local authorities, etcetera, they've worked with skills for care where there is an employee referral when they just talk to their friends or other people who may be looking for job, people who already work in social care they get to financial reward for that, and they can encourage the people to work because they can share the experience. And Participant B said exactly the point why the campaign didn't work the first round, it just made care workers look like they're dancing sets, they hang bird feeders and doing shopping. They never show the right level of the skill that you have to have, so I generally perceive them as rather disrespectful. They've improved from the first to the last one, but they are still not in the right place saying that social care is quite difficult, I think to present to the public for people to really understand. The referral thing is one thing but for me in many ways, there's absolutely no point doing in a recruitment campaign where the sector doesn't have funding that it needs to pay people the wages it needs and offer them terms and conditions where we can compete with other sectors like a hospitality or retail, where the responsibility doesn't exist for another human beings life (what we have in social care) and benefits are much better. So, I think it's definitely a sticking plaster, throwing money at the problem that's not going to help it, when what you need to be doing is reforming the whole sector, rather trying to recruit to the sector that that needs a general reform, not just a few extra people in it.

Carol Atkinson: OK, that's helpful, thank you. If I could just extend it a little, then. So we've talked about the recruitment campaign not being successful. We've touched a little bit on shortages, I know we all recognize it there, but to explore that a little more: is there an appropriate levels of skills, levels, roles to ensure high quality care? Do you have a view on that and numbers within that? Yeah Participant B.

Participant B: Yeah, I just think it's that perception that anybody can be a carer and just because you can enter it without any previous experience, qualifications or training doesn't mean it's unskilled. I mean the skills you need to be a good career are quite complex and the best carers have got amazing skill sets, and over time they can maybe gain the qualifications to reflect that. But I think because the entry level is on, or close to, minimum wage and the perception is basically anyone can join, and that's kind of almost where the problem comes in. There's no equivalent of a register registration for care workers - I mean, there is obviously the general Social Care Council and the Code of Conduct - but there's nothing to sign up to say I'm a registered care worker. I'm now a registered manager with CQC, but I got to that stage 17 years into my career. If within six months having…. because when I started there wasn't really the Care Certificate, there was barely NVQs, but if a process was that you do your care certificate within 12 weeks and then you become a registered care worker (because we care is a recognised qualification itself), but then that almost starts to build up that sense of a professional body. Again, you look at the vaccination situation, obviously it was imposed on care homes, but the minute they tried to impose it on nurses and doctors, what happened? The ICN kicked off, BMI kicked off, and they backed off. There's no equivalent for social care workers to give them that status, that recognition, and that would be a potential starting point that may…. you know, because Participant A is right, there is fundamental structural problems that need billions of pounds worth of investment, but there are also other things that may be could be done that would maybe cost with equivalent of that marketing campaign. I was actually looking at the Care Workers Charity website in preparation for this, and obviously the 17th of March was the reflection or Remembrance Day, but that was also Saint Patrick's Day which is also Guinness Marketing Day. So how much publicity and reflection did that get? You know, you think between March 2020 to May 2021, 922 care workers died, you know, in 20 years of conflict in Afghanistan UK forces lost 457 personnel […]

Carol Atkinson: […] stark systems. Yeah, I will come back to career training and investment in our second lot of commitments, I am really interested in that, but we'll come back to that shortly. Participant A.

Participant A: I was actually going to follow up on the career investments. But going back to your original question, so they're definitely skills and experience that aren't properly recognized; they're not recognized in pay, they're not recognized in title, and I strongly believe that social care is the only industry or somebody can work for 20 years and still be paid around the minimum that the sector pays and not have had four or five promotions if they work hard and be looked down upon for having been a frontline care worker for 20 years rather than being applauded for it as we do for healthcare. That is a huge issue. There are some people that lack skills and experience and the right values because the sector is so incredibly desperate due to staff shortages that unfortunately I know some providers have to make compromises and take people that maybe, if we weren't so desperate, they wouldn't be taking on because they are a step away from the right values, but the staffing levels are becoming unsafe. That's a very big concern. I think a big concern is that the Care Certificate that has never been accredited and was written by God knows who mainly with health input, most of it in its plain form doesn't make sense. It's not very helpful and providers have to spend a lot of money for bulking it out and making it usable, but it's not standardized across the sector. So, we have a qualification that was supposed to be helping everybody and bringing everybody up to a standard, but it's not standardized and the money that's been spent on the recruitment campaign would have been much better spent on redoing the Care Certificate. For some reason that I completely cannot understand, DHSC is completely refusing to redo the care certificate having been told for years now that it is absolutely useless, and it needs starting from scratch. Not trying to improve it, it just needs completely redoing. And then we have qualifications like NVQs,

apprenticeship, there is a wide variety. But again, there is a lack of consistency across the country on who does what. There's no consistency if you reach a certain level of qualification - this is your title, now this is your pay now - so you have no pay scales, so somebody could move across the country on a completely different pay or title, and we don't acknowledge additional training. And what we also don't do is give care workers enough opportunities to upskill where the care workers themselves they feel they need upskilling. The biggest issue being around de-escalation training that I've heard from many, many care workers over the years, who have been physically hurt because they haven't been given proper access to the de-escalation training that they needed, and they want to do their job and they want to do their job well, but they are not necessarily being given the tools. There are skills in the sector; I've been campaigning for years for a professional register for care workers, that really needs to happen which is compulsory, which includes PA's -because if you do a route out, everybody's going to go that route and suddenly we're going to have everybody with PA's everywhere – and that's where it needs to be. It needs to be recorded and people need to have a sense of belonging. Care workers need a professional body so they can feel they belong to a profession so there is somebody to stand up for them, so there is somebody to support them, and there is somebody to hold them accountable. And that doesn't exist. And for a profession - because care working is a profession - to have no sense of belonging, mental health damage coming from that, that's what we're seeing.

Carol Atkinson: OK. Thank you. OK, we'll come back to health and wellbeing in a little while. I just like to go back to something you said because it's one of the questions I have around staffing levels and the impact on care quality. You touched on staffing levels being unsafe. So, I'd like to invite you all to express your views on staffing levels and then their implications for care quality.

Participant B: OK, I'm happy to go first if you like cause unless I because as I say currently I'm working the home care sector that in Norfolk, and with home care when you have low staffing the impact tends to be in your capacity to take on care rather than in a residential home where if you don't have enough stuff you end up using agency or if you don't not have enough on the floor managers have to put the gloves on and do the work instead of being manager, but in home care it's around the capacity: I've got the amount staffing hours I've got available and that's how much work I can take on. In Norfolk, I mean again I checked with figures today, there's 688 people with unmet needs totalling just over 8281 and a half hours of assessed care not being delivered because there isn't enough workforce among all the providers of home care in Norfolk to meet that need. That's not even people who have a care package that may be the provider isn't able to meet all the hours, or is in contingency planning, or is not providing the quality of care that they'd like because they're stretched with staffing - that's people who have their either in hospital or they're at home without any support or family or having to provide support that they're not actually really capable of maintaining. So that fundamentally is the impact of not having enough people [working in home care].

Carol Atkinson: And it's that has to do with your ability or lack of ability to get enough staff?

Participant B: Basically, yeah. If I could recruit 10 new people tomorrow to start on Monday, within two weeks, our capacity would triple, and I'd then be able to go from supporting 15 people to 30 people. If every provider did the same, that 688 goes down to probably about… because I mean pre-COVID those figures were never that that high. If every provider could recruit all this staff, all those people care needs could be met. Like I said, that shows you just in Norfolk and that is today's figure. I've seen as high as about 750-800 at the peak of COVID.

Carol Atkinson: Thank you. Participant C, would you like to come in on that?

Participant C: Yeah, I echo a lot of what Participant B said. From our members across the country, we've heard a lot of them saying they're having to hand back contracts because they simply don't have the staffing levels to offer the quality of care that they would like to because they don't want to take on a contract and then offer poor quality care because then that reflects badly in CQC inspections. And then also we've heard from members about them having to restructure their staffing ratios so that they can fit that within their care homes to fit around their workforce shortages. We've ran a survey of our members, and some providers are facing up to 20% vacancy rates, which is massively impacting their ability to provide the quality care, and to take in new individuals into their care homes, which continues to have a massive knock-on effect and is a massive vicious cycle. I think they're my two main points.

Carol Atkinson: Thank you. Participant A

Participant A: We monitor a lot of online forums with hundreds of thousands of care workers and care managers on them. So, in terms of capacity, first of all you have people who are leaving who are burnt out and you can retain them, but then you have staff that have stayed that are having to take on additional work. So, even if there are the numbers, they can't deliver the quality because they're just so overworked and they're doing extended hours. From our charity's point of view, we're saying it's an unfair expectation on care workers to expect them to deliver outstanding quality of care when they struggle with the finance, hours, burnout, etcetera. That's one problem. The other problem is when care workers fall ill - well, COVID's been a very unfortunate example of that - they don't receive full sick pay, it's either SSP or nothing really, and they're having to make a very difficult choice of going to work, potentially putting people at risk, especially with COVID (but, you know, even flu, cold, these are things that you can give to other people), or staying at home and losing income. With the withdrawal of the Infection Control Fund as of recently that that's become even worse. I think you know staffing levels are unsafe around that either because don't enough people because they're sick, or because they're going in potentially spreading the virus because they can't afford not to go to work. And that is an impossible and unfair choice to be put in care workers in as well because they are having to consider their finance and the quality of life of other people's lives and potentially infecting them.

Carol Atkinson: Thank you. Yeah, it's a very powerful point. So, starting point was about 20,000 people coming in through the advertising campaign. In health, the government regularly set numerical targets for certain staff groups. So, I'm just wondering if you have any views on how useful those targets are, so if we had them into social care, for example, would they be helpful? Sorry, you did put your hand up Participant B, so please do also say what you wanted to say.

Participant B: Yeah, just to touch upon the point Participant A made around the impact of COVID and the situation we're in now where we're one of the few sectors that is still testing people regularly, so we're still losing staff, asymptomatic staff to COVID tests. People are mixing in society, you never see any masks anymore, the hand gel stations in the shops are standing empty, and if I was just running, I don't know, an office and plumbers, I wouldn't be being affected anymore by COVID unless somebody happened to develop symptoms and then tested and then they disappear for a fortnight, I could have half my team with COVID asymptomatic and not know but as a care agency all those staff would be out and we'd know about it because they're still testing regularly. I mean, I've been able to maintain daily testing because I stocked up before they changed the limits, but even if you're just doing the twice a week testing the recommended amount. It's almost like with those Japanese soldiers they kept on finding them in Pacific islands in the 1960s, still fighting World War Two. That's where we still are, but whereas before when everyone was testing it was helping protect us, whereas now staff are more at risk of picking up COVID and then realizing it because

they've done a test and it's popped up as positive and then they're out for a week-10 days depending, and we're suffering that impact. And I say the workers are suffering because they're either not getting paid anything; or it's SSP; or the organizations are trying to support them paying sick pay that they're not receiving funding for, which when you look at their business models and the margins that that impacts further down the line. But yeah, I just wanted to add that.

Carol Atkinson: Yeah, that's really helpful. Thank you. And the point about whether targets would be helpful? In Government committed to target, pledges, what is your view on how helpful that would be? Go on Participant B, and then I'll come to Participant C.

Participant B: I mean the thing about targets is it depends on what the consequences for not meeting with target is. It's a bit like, again, all through COVID there was a lot of talk about we've got to make sure the NHS keeps working, doesn't collapse. What was the measurement for the NHS collapsing? How many critical incidences were declared? How long did waiting lists go? You could say we need to be recruiting net 20,000 care workers each year. But if then each year once report is done, if we've only had a net increase of 5000, what happens? Who's accountable? Who's responsible? What does it mean? What is it showing? What are we learning? Because a target, if it's actually going to trigger something in terms of either accountability or additional funding…yeah.

Carol Atkinson: OK, thank you. Participant C, did you want to come in?

Participant C: Yeah, I was just going to echo that a little bit and I was just going to say that it's all well and good having these target numbers, but they need to come up with pragmatic solutions. If you're not saying that this is how we will get the numbers, then there's no point saying we want these numbers because if you're not, as Participant B said with the funding and things like that, going to provide care providers with this funding or the ability to actually meet these numbers and improving things like the pay, terms and conditions, and the recognition of care workers, there is literally no point in having these numbers to commit to if there is nothing to support that commitment. Putting a number out there into the sector and saying we want you to hire this many people by this year, if there's no means to support that commitment, is virtually pointless.

Carol Atkinson: OK, that's an interesting point. So, to extend on that, workforce planning: to what extent do you get involved in workforce planning with CCGs, your local authorities? Is there a process that you're aware of that helps you plan what workforce you need and what workforce your local authority might need to deliver those kind of care packages? You've talked about its Participant B, and if so, what is that? Participant A?

Participant A: On workforce planning, not as a provider but from what we're seeing I think first main concern coming up is… what are they called Integrated Care Boards? I'm always forgetting terms. This new thing that's now you know being created that CQC is going to oversee and be involved in, what is going to be the involvement of social care in that? Because they still look incredibly health heavy with a very little impact. So, I think that's the main concern that's coming up. And in terms of other planning, I think from what I'm seeing from managers, especially those who are leaving the sector, is that they speak to their local authorities, they tell them how much money they need, they tell them to add five, six, seven pounds onto what they're receiving an hour, and they're getting no response. Everything has gotten more expensive in terms of costs for the provider right now but that's not being reflected in the uplifts from the local authority, and that includes workforce planning, being able to pay people more so they can meet rising cost of living etcetera. So that's just my bit you know from what I've been seeing. But I think that Integrated Care Boards are of a huge concern of what's going to be happening there.

Carol Atkinson: Thank you. I want to come back to funding in a moment, but just if anybody else wants to come in on that point? Participant B, did you want to talk about workforce planning?

Participant B: Yeah, in terms of my experience in Norfolk, I mean, I'm quite actively involved in a couple of agencies within Norfolk called Norfolk Care Association, Suffolk Care Support and they do engage with Norfolk County Council around stuff like workforce development. So, there is a route to have that communication. But I say Participant A made a fundamental point. When you go back to… and local authorities are effectively the biggest funder for the majority of providers, so the rates are set where you have to then benchmark and pick where you can put your salary rates and training investment and all the rest of it. Norfolk it was a six percent uplift which was already below inflation at the time it was announced (and obviously inflation's going up and up and up) and their explanation is there's no more money. They'll explain in quite a lot of detail how they have no more money in terms of how overspent social care is. I believe they're telling me the truth, I'm sure it's absolutely true, but that doesn't really help when you're explaining the rates of funding, we're receiving doesn't make it viable for us around recruiting good quality staff, paying kind of competitive rates of pay and all the rest of it. So yes, it can be that engagement and conversation, but it's a very one-sided outcome. We can feed in as much information as we like to a local authorities or health funding as well, as they do fund quite a few people here who receive social care, but they'll just come back and say, "we don't have the funding to fund you". And that's where the snake eats its tail, basically.

Carol Atkinson: OK, thanks. Funding is a question, you're leading me into it nicely, but just Participant C if you want to talk about anything or workforce planning first?

Participant C: No, I think my point would be about funding and things such as workforce recruitment and retention fund: how there's actually been specific funds to help support workforce and increase the recruitment and retention and yet most of our providers didn't actually see that money […]

Carol Atkinson: So that was going be my question, there was this billion-pound worth wasn't it of extra funding, which was for staff, infrastructure, technology and facility. So, let's start with staff: in terms of your view on the adequacy of funding, I'm getting a sense that it's not adequate, but I don't know if anybody wants to add to that?

Participant B: OK, so my experience of that funding is that we did receive it, we did spend it, and it helped towards… because our annual pay review happens generally around April and it meant that we were able to do a second review in October and respond and increase our salaries, which didn't really help recruitment, but it did help retention. But actually, it probably only funded about 60% of cost of that uplift. And also, the trouble of funding like that, as a one-off hit, lovely, but in terms of long term planning and development we can't kind of rely on finding pots of gold at the end of a rainbow every once in a while. Other organisations probably did use it on additional training or running recruitment campaigns, etc, which might have brought a few more people in, but fundamentally the funding needs to be much more sustainable and long term reliable, not just scraping from one pot of money to another. There has been lots of different pots of funding over the last couple of years, but none of it has come with a long-term guarantee, which means that you can't do long-term planning. All you can do is use it in the here and now and then hope that something else comes along later to maybe sustain it or, like I said, find a different way of funding a pay rise or say alright, pay rises won't be as high because let's say that funding ran out, so we're now having to revert back to what we were receiving as our baseline.

Carol Atkinson: OK, thank you. Participant A, I think did you want to come in on that?

Participant A: Yes. So first of all, baseline funding is insufficient to pay what providers need to run as proper businesses, and not worry day-to-day; and for local authorities, I think to really give social care a chance and for care workers to receive what they deserve. There were big issues around infection control recruitment and retention funds. The first issue was how quickly they had to be delivered. Those three-month periods where you had to get the money out from LA to the provider and provider had to spend and then you had to report on it, and some people have told me it was more stressful than it was worth. So, I think looking into the future if any funding like this is to be delivered it needs to be for at least a period of 12 months, if not longer, for people to be able to spend it the best way possible rather than scramble around. The other issue with the funding in the last couple of years was that all of that was delivered through local authorities in England, and care workers in England never received retention bonuses or COVID bonuses as they did in Wales, Scotland, and Northern Ireland. So, then some local authorities try through the retention recruitment fund, and would say to providers "oh yes, you can use it for your attention bonuses". That's all great, but the problem was you have providers spread across different local authorities, if not all of them are offering that money for retention bonus, then a provider can't give retention bonus to just some of their staff in one local authority and not give it to the rest in the other local authority. So, I've heard from providers who are saying well actually we had to say no to that money that was being given to us for bonuses because there wasn't a nationally agreed approach on that because each local authority was doing their own thing, and there was disparity between money being given to care homes and then home care. PAs were completely lost in all of that funding, testing, PPE and everything else, that's been awful. But yes, I think there is a big issue when trying to create a coherent system of social care when your funding comes through local authorities, - they set the different rates to the providers, they set the different rules around certain bits of funding - on top of not having a standardized rate of qualifications, on top of not having registration, just making everything so broken into tiny pieces that is very hard to make it all work together.

Carol Atkinson: Thank you. So, we talked about funding for staff. What about career and professional development? What is your view on the availability of funding to support career and professional development? You're shaking your head, Participant A.

Participant A: I was shaking my head because it boggles my mind how bad it is sometimes. Commitments from the White Paper last year were set out, when for health you have a very decent amount of money to support continuing professional development. Whereas for care workers, "we'll look at the Care Certificate". That is the commitment that we're getting. We are not going to look at the register currently, maybe at a voluntary one. The whole issue around 500 plus million that has now been announced by my count at least four times in four different press releases, it is always the same money for different things that is just not going to stretch that far for a workforce of one and a half million, not just for training, let alone for all the other initiatives that are supposed to be included at that money. In the past, in terms of Health Education England that was given responsibility of funding some of social care training. We are talking about thousands of pounds for health workers and £200 for social care workers. So, it has never been sufficient, the way it's being looked at in terms of reform or commitments still doesn't show any improvement really. So that is a very big issue. And dishing out free NVQs level 2 is not the level of training commitment that the sector needs because the responsibility that care workers have been well beyond NVQ 2 on daily basis from day one, from when you start the job, and it needs to be a lot more support and funding around practical training as well, because the job is practical and that's what people need to learn.

Carol Atkinson: Thank you. Participant C, would like to come in on that?

Participant C: Yeah, I mean, I would echo a lot of what Participant A said. In a survey that we closed this week we noted about that 500 million that's there to develop the adult social care workforce, and we asked members what they thought would be the most useful outcome from that, and they all just said it wouldn't, we need the pay to increase. So, it's all well and good having this funding, but they're missing the mark. It's not enough. It's really not enough and that comes in the health and social care levy which is £39 billion of which only £5.4 billion is going to social care and the rest to the NHS. It just doesn't make sense. If you're wanting to actually make improvements in the social care sector you need to put it on parity with the NHS and give it a lot more money from this health and social care levy, rather than 1/6th of the fund that's going to be adult social care sector, which I think is a massive problem in itself. I think providers as well, they've also raised the issue that again with this funding to increase training, it's only going to be useful if providers have the capacity to produce that training. if they don't have the capacity to do that training, then no one is going to be able to run it, no one's going to be able to facilitate it, and it's just not going to work.

Carol Atkinson: OK. Thank you. Just a bit conscious time. So rather than asking you the same question, Participant B, I'm going to ask about technology. So, part of that billion was also for technology and the idea that better technology would underpin better social care, whether that's making it more cost efficient or offering new services. Have you seen that funding come through to support increased technology? And if so what kinds of technologies?

Participant B: I've not directly seen funding for technology. My current service and the one before I transferred from paper files and paper care plans and paper day recordings to electronic systems and it does produce efficiencies, but it doesn't necessarily directly improve the quality of care or make it cheaper. We seem to be a long way off from being able to import those Japanese care robots you keep seeing, so until I have that workforce, I have still got to use people, and again you can't telecare supporting somebody to get to a toilet that needs to be a physical person with the right skills and abilities and values and all the rest of it. So in terms of technology it tends to be online training which can be helpful, but again the depth of the quality compared to when you sit in the training room with a qualified experienced trainer and 10 to 15 colleagues, it's not just the syllabus you learn, it's everyone's experiences you learn whereas one of the areas where money is saved is by doing lots of online training which for basic information is fine but not for depth. I mean you compare doing an online first aid course to the sitting in a state course run by an experienced first aid trainer. There's no comparison.

Carol Atkinson: What about things like iPads in care homes for domiciliary care, those kinds of things? Have you seen funding for those come through?

Participant B: Yeah, and I've introduced them to services. The improvement that delivers is potentially the quality of information you're documenting (the fact that you haven't got hundreds of different people's handwriting), and it's and in terms of if you want to analyse it as a manager the data of the care being delivered, if it's an electronic system it's so much easier; because rather than having to go into 20 different people's rooms or to 10 people's different houses across the county, you can get on your laptop and you can start accessing all the records that have been recorded by all the staff. Now, as with any data, it's only as good as what's inputted; if you're staff, do not know how to document accurate information, or they're not doing it in a timely manner, or they're not doing it to a professional standard, bad data still leads to bad outcomes. So, in terms of technology, it doesn't replace people, and the benefits it brings isn't necessarily in terms of the quality of care, it's in terms of the quality of the data about the care.

Carol Atkinson: There are some experiments about things like wearable technologies that can predict things like falls, that kind of stuff. You're not seeing those kinds of technologies coming through then?

Participant B: Not in a formalised way. You get the classic kind of care alarm button things that people press and those go for it that triggers an alarm if they fall. Norfolk County Council haven't gone out and bought 500 Fitbits to distribute. If you're talking 10 to 15 years ago the idea of kind of tracking devices would have been met with horror whereas I now… I think I probably got four technologies: I've got my Fitbit, I've got my work phone, my personal phone, and my tablet sat in front of me and my laptop, so if anyone wants to know where I am you can find out where I am and what I'm doing. Some organisations maybe investing in some of it on an individual basis, but it's not being led as[…]

Carol Atkinson: No. See, that's more strategic leadership. Participant A or Participant C, if you've got similar or different experiences?

Participant A: I think in terms of wearable technologies that a lot of companies in the sector that have popped up in the last couple of years, wearable technologies, different things to track to help people by the end of the day, you still need somebody to turn it on, charge it, monitor IT support where there is a […]

Carol Atkinson: It was more about the funding. Whether you're seeing funding coming through for those kinds of initiatives?

Participant A: No. I've mostly seen them with self-funders, not funding coming through specifically for those things. I know that the Secretary of State made a demand for most care providers to have digital record-keeping by the end of 2024 I think and that definitely improved during COVID for infection control reasons and other reasons it was definitely there, but I've not really heard from either managers or care workers saying that you know there is funding available for them to implement those things, and they can be quite costly.

Carol Atkinson: OK. thank you. So, the last area, the third commitment, is around wellbeing of the workforce and we can talk about that generally in a moment, I'm sure you'll have lots to say, but the particular commitment was around listening to the views of social care staff to learn how we can better support them individually and collectively. So, I wonder about your views on the extent to which you think staff views and opinions have been listened to, have been collected? Participant A I think you just beat Participant B to it.

Participant A: I've been heavily involved with the Department around the whole wellbeing part from the White Paper. The Workforce Advisory Group is there, it has a forum to speak, whether it's listened to is a different question, a lot of the time not. I think there is an issue in terms of some approaches of lifting things straight from the health system and trying to drop it into social care. So there has been a suggestion of trying to implement freedom to speak up for guardians and social care that would be funded by providers, which I think is completely unworkable model in social care. In terms of what is needed I don't think what has been listened to is what effects wellbeing and also what capacity people have, because if you're overworked and burnt out the last thing, you're going to be able to do is attend group sessions around your wellbeing because you just don't have the mental capacity left in you to do that. And I think the idea of counselling, we do it at the charity and have supported over 140 people with that but again it's making sure that people have the time, giving people time to implement and reflect on what they've been taught or what they've discussed as well. I think some of what's been fed into the Department has been listened to, but a lot hasn't,

the main thing being you know around giving people a COVID bonus to show them that we appreciate the work they've done, but they did not do that even though everybody else is doing it, we're not doing it, so let's make care workers feel even worse. So that there are significant issues. But like I say, the whole idea of lifting something from health dropping in social care is quite worrying as well.

Carol Atkinson: OK. Thank you. Participant B, and then Participant C, you want to come in on that?

Participant B: Yeah, sure. So again, I'll reflect back to things I said very early on around, you know, you look at the impact of the fact about being a care worker is used to disparage Angela Rayner, whereas if she'd been a nurse that wouldn't be the same reaction. Certainly, should she have been a doctor, a lawyer, it certainly would be the same reaction. You look at the recent court case around the fact the Government broke the law in terms of discharging patients back into care homes; care workers knew that was wrong and unsafe and have been saying it from day one and when that decision finally came, and a lot of people were quite angry. Then you look at the response from the former minister and the Department of Health, it was all gaslighting around "if only somebody had told us", they had been told. I'm no scientist and no virologist but it was a fairly obvious risk. And, you know, we've had all that time of hearing soundbites about protective rings around care homes. When you know that people are saying that sort of rubbish and lying, that was impacting on care workers and wellbeing. Like I said, the fact that remembrance and reflection day was on Saint Patrick's Day, it had no publicity. I know there was some really valued and valuable events that went on that day but had no publicity, it wasn't in the news cycle, and the Guinness Marketing Board probably had more on the news agenda than that. So, if you want to know about how staff are listened to, and again like Participant A said, there's been no COVID bonus, and the other nations of the UK did it, no proper thank you. Even right back at the start of COVID when it started the kind of banging, the clapping and the pots and pans for a few weeks; again, that was all very much NHS and then care workers. The status of social care is nowhere near that of health, and that's across societally, politically. You look at how the social care minister compared social care workers as slaves compared to the NHS so that's even from inside the government. In terms of our social care staff listened to, is their wellbeing considered? No it isn't. Whatever commitments have been made haven't even been kept on paper. Going back, did the government run an advertising campaign and spend the money? Yes, they did. Did it work? You know, but whatever they've committed to in terms of the wellbeing of social care staff they haven't met any of it. They haven't done it, you know, and anything they have done, they've destroyed in, in other comments. Again, like I said, the vaccination stuff, basically saying, well, care workers are the only people who lost their jobs, were not having a vaccine. No other sectors, no other industries, just care workers in care homes. Everyone else had the right to make with personal choice around whether they took a vaccine or not, didn't matter where they worked, what they did, what other risks they presented to other people, only care workers and we lost what, five to 10 percent of our workforce. Even the people who didn't leave, even with people who took vaccines and were grateful for being offered a vaccine, still experienced that, this is how we're this is the level we're valued at in reality. So it doesn't matter how many speeches are made[…]

Carol Atkinson: That's the reality. And Participant C did you want to come on the that listening and feedback point?

Participant C: Yeah. I would definitely agree with that. As a representative body, we send a lot of letters to ministers to explain the changes that need to be made. One of them the other day took seven months to respond, and I just think that echoes the lack of listening to social care. Each time they just regurgitate the same thing that we've allocated this funding, and this is our commitment,

but they have no actual evidence to prove that these commitments have been made, and I think that evidence is the fact that they don't listen to social care because they can't actually prove that funding is actually working or is doing what it needs to do. As Participant B said, the VCOD policy is the case in point: they introduced it in social care and never even really apologised to the social care staff that left their jobs to that policy they just said, “oh well after kind of reviewing with all the different variants we're not going to introduce it and we will revoke it”. They owed an apology to those staff that had to leave the sector and they didn't provide that apology to them, and I just think that speaks volumes again to the lack of listening to social care. I think we often describe it as thoughts fall on deaf ears and I think that that really is what it is. I think the thoughts of the NHS often subsume social care and it just puts it on the back foot of everything, and its social care that supports the NHS and I think people really forget that those social care staff are propping the NHS a lot of the time and they just forget that. So yeah, I don't think that the commitment's been followed through at all, I don’t think that social care staff have been listened to at all with wellbeing and support and anything really to be honest.

Carol Atkinson: OK, thank you very much for that. That's sad, but very interesting to hear and helpful to hear. My last question is around support services during COVID, the extent to which they were offered and whether they're continuing. But I'm also aware we've only got 5 minutes left. So you can address that question or if there is anything I've not asked that you'd like to tell me in the last five minutes, please do feel free. Participant A?

Participant A: What Participant C was saying about sending letters then getting responses - responses are a template and I think we've all got the same response to the last letters we've sent and that's very disrespectful. It shows what we're not being listened to. But the main point that I think we struggle with the HSC is being constantly told that social care’s pride of providers with their own private businesses so it's nothing to do with the central government. But what's been mentioned before, when you look at it actually in detail, the local authorities are the biggest funder of social care. So it should be the government's responsibility to look at it because it's the local authority funding that really determines the quality of care in many ways, because if you don't have enough money to pay people better and employ more people, etcetera, that affects the quality of care. I don’t think I’m just speaking for myself here; I’ve had a conversation about it with many leaders in the sector, the constant excuse of this isn't this is private businesses is just not good enough because majority of the funding comes through local authorities. And to me that means that needs to look be looked at again.

Carol Atkinson: Thank you. Participant B, did you want to come in on that or a different point?

Participant B: Yeah. It’s kind of following on from Participant A’s point in a sense of the government has set the marketplace and they're the ones we've promoted private providers and moving away from it being like a social care provided and funded by local authorities. They’re the ones who have set the mark, that's how they wanted it to be, so to then almost penalize the industry for being private providers and making profits is…. if they don't want providers to make profits then they need to renationalise it and make it a national service, but generally speaking, they want to go the other way and actually make nationalized services privatized. So, you'd almost think politically they would want to promote how social care works above the NHS, but because the NHS has that emotional resonance with people that social care doesn’t… very few people actually understand social care workers are generally speaking. When I'm speaking to clients’ families and they're desperate for finding the right care and support for their loved ones, that's their first interaction with social care, whereas we all we all understand the basic tenants of the NHS - it's free at the point of delivery, etcetera. Social care, it's you know, it's just a confusing mess. In the run up to the government

announcing its policy I had to stop watching with breakfast news because I would have lost a couple of TV's, because all I saw was conversations around people selling their houses, blurry images of people shuffling around care homes and that is part of social care, but what about all the working age adults with disabilities? What about what people with learning disabilities? What about, all these other parts of social care, which is actually bigger than the NHS? It's more people, it's more hours, it's more staff, but it's almost like the NHS is a big shining castle on the hill. And if the Minister herself described it as we're treated as slaves that says it all really.

Carol Atkinson: Thank you. Participant C? Just couldn't conscious that you may wish to come in case we got probably second left now.

Participant C: No, it's fine. I just thought was thinking more looking forward, I think there's a real danger as we move to integrated care systems that social care will continue to be ignored. At a meeting with one of the CEO designates for the ICS's, he basically said "oh well, there's 42 ICSs and 35 of them are NHS so there's probably not much point trying". So, I think there's a real danger even as they try to move to more integrated care, these are still NHS dominated and social care continues to not be involved in that decision making, which I think is hugely problematic.

Carol Atkinson: I'm not quite sure that we are going to have time to explore this, but I wasn't quite clear about the numbers in that with integrated care systems, that NHS versus non-NHS, surely, they both should be in.

Participant C: From what I understand with the Integrated Care Boards which are the ones that oversee the decisions, the majority of those sitting on those boards at the moment are NHS, and when we've asked adult social care providers to have a seat on those boards we've just been told that's not the place for adult social care, they should be there at place level, which is problematic because how do you get adult social care providers inputting in the decisions that affect them if they are dominated by NHS leaders?

Carol Atkinson: We're trying to integrate but the leaders of those are still very much healthcare based. OK. I'm just going to say in the case we get whisked away. Thank you so much for your time. Really appreciate it. And I know how busy you are, but it's really important that we get your views.