



Social Care

Elevation, Registration & Standardisation:

The Professionalisation of Social Care Workers

An Inquiry Report by the All-Party Parliamentary Group on Social Care

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Introduction and Outline - Louise Haigh MP and Gillian Keegan MP

It is widely acknowledged that Britain has a social care crisis. In recent months, this too often hidden issue has burst into the mainstream media and justifiably so. Few would argue that a major upheaval of the sector is required, as is a serious injection of funding.

But there is another, far less discussed crisis within this sector; the workforce crisis, and comprehensive evidence presented to this All-Party Inquiry suggests that it is widespread, acute and urgent.

High quality, sustainable social care is fundamental to a healthy and dignified society, yet care workers - the vital frontline foundation of the social care system - are too often overlooked in terms of investment, training, remuneration and value. This oversight is clearly impacting workers themselves and the vulnerable people who rely on their work.

This inquiry set out to examine in detail the status quo for staff working within the care sector, including the frameworks that exist for professional development, the service levels required and provided in the care sector, and opportunities and systems for training, development and remuneration of social care workers. To this end, we issued an open call for evidence from four key fields of expertise and experience: employers and providers, care workers, specialist academics and relevant institutions and charities.

We sought to establish a forum for evidence and discussion (confidentially if required) as a beltway to assemble cogent, innovative and concrete proposals for workforce reform and the professionalisation of social care workers. We allowed the agenda to be evidence led and entirely formed by those who gave evidence. By extension, the central findings of this inquiry are substantively empirical.

Given the wider political context of an overdue, impending Green Paper on Social Care reform, we set a very tight timetable for the inquiry process. The material evidence could then form a dynamic contribution to the wider consultation process that will naturally accompany the publication of the Green Paper, when that political moment arrives.

In this regard, and to achieve adherence to this significant time sensitivity, some limitations have been placed on how far we have been able to explore this complex, multi-faceted issue. However, we hope that this report encourages debate around social care reform, to always include the professionalisation of social care workers as a prerequisite.

To this end we will ensure the work of this All-Party Group continues to offer an open forum for and political impetus to the issue of professionalisation and reform.

Structurally this report is divided into two sections: the first, a selected digest of evidence presented to us, ordered into five key areas of focus prioritised by evidence providers themselves. This bank of evidence has not been published in its entirety; each individual submission, be it written, oral or both was solicited and received without condition of publication and always under the option of confidentiality. Therefore, digest extracts with citation have been selected on the basis of salience.

The second section presents concrete recommendations and options for reforms that may advance the professionalisation agenda, prioritise and incentivise upskilling, and greatly improve social care provision and sustainability immediately and in the future. This section highlights the most consistently reoccurring propositions provided to us during evidence sessions, often under the relative autonomy of closed or informal sessions.

This inquiry report is presented and published simultaneously alongside the accompanying paper *“Professionalisation At Work in Adult Social Care”* prepared by Dr Lydia Hayes ([School of Law and Politics at Cardiff University](#)), Dr Eleanor Johnson ([The Centre for Research in Health in Social Care at Bristol University](#)) and Alison Tarrant (Independent living and Disability Rights Researcher at Cardiff University) for the All Party Parliamentary Group - under commission from our secretariat, and it should be noted that our inquiry report cites this document quite frequently, as it is intended as a comprehensive supplement to it.

We owe a great debt of gratitude to Dr Hayes, Dr Johnson and Alison Tarrant for their expansive, thorough and vigorous report to us, which has proved to be a great help in increasing our understanding of how this sector presently functions, and the challenges that it faces. We also owe considerable thanks to the dozens of individuals, bodies and institutions that provided evidence, every contribution provided invaluable insight, reflection and crucially, suggestions for change.

It should be noted that evidence cited in this report has been provided by both domiciliary and residential providers and workers, and thus this inquiry overall reports as a holistic picture of the sector, but demarks and recommends specialised approaches be taken subject to the environments, tasks, and disciplines associated with different forms of social care provision.

There were several related and highly relevant concerns identified throughout this inquiry, such as the current commissioning structures. These frameworks only pay for contact time and overall, make very little consideration for the fair cost of care. We also heard descriptions of a fractured commissioning market fixated with time and task, as opposed to outcomes.

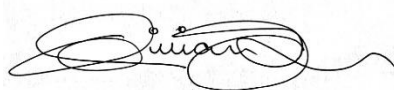
Owing to time limitations these issues were not fully investigated, however, we would welcome further investigation on the impact of commissioning on the care sector.

We wish to conclude this introduction with the following remarks. Nurses and healthcare assistants presently working in our NHS are rightly cherished by the public and courted by political actors, but the same cannot be said for their colleagues providing all levels of vital care, that is increasingly medicalised, complex healthcare. The fact that values led, dedicated carers are so undervalued and undermined must be systemically corrected.

It would seem self-evident that the higher the quality of the training that care workers receive, the more care work will be given the status and respect it deserves. In turn, more people will be attracted to it, and vitally, if there is real scope for career development & learning new skills – people will *remain* in the care sector.

There is a need for a substantial funding settlement in social care as a matter of national priority. This inquiry has concluded that workforce reform must be carried out simultaneously if we are to avoid financial wastage on a broken and incoherent system.

We fervently believe that by putting party political differences to one side, we can help to deliver a system that both care workers and the cared for deserve. It is time to value, respect and elevate those who work so hard to provide care, and transform this world of work and healthcare for the better. We as joint Chairs of this All-Party Parliamentary Group commit to working together collectively and constructively with all colleagues to ensure that it is.



Gillian Keegan MP



Louise Haigh MP

Foreword - Professor Jill Manthorpe

Everyday hundreds of thousands of people get up and go to work in social care, some have been working throughout the night, others live in the places they work. They are often invisible in public. Little suggests their vital role in keeping people alive or supporting them with the basics of a good life as far as possible and in being there, often, at life's end. This report places them centre-stage. It is a rare opportunity to hear what care workers want to tell Parliamentarians and their voices shine through this report. We hear also from people supported by care workers and their families, as well as employers and managers. What a rich tapestry of experience and insight.

This report is unique in moving from lamentation – how bad and sad many things are - to practicable policy recommendations. It has chartered a course to the professionalisation of the social care workforce, having identified that this is the optimal development. It presents the 'working out' of its recommendations, how it got to its conclusions, and steps to bringing the recommendations to legitimacy. It has gathered evidence to decide what is feasible, where accountability should lie and some of the questions about cost-effectiveness – noting where money is probably wasted, not spent to good effect and how overall savings in the public purse might follow. It is clear that the authors of the report and many of those supplying evidence see responsibility as lying with central government – even though the sector will need to support the development and sustainability of the proposed solutions.

Four key steps are in this report, a close examination of the current state of the social care workforce; one that is not drowning in figures but presents its human face. There is much evidence of a common starting point. The next step lies in its investigations of complications and tensions, such as increasing and changing demand for social care but also debates over funding and funding sources. The questions that arise are pretty clear; what are our options? And the substance of this thinking and deliberation about the options lie here in the title and sub-title of the report, 'Elevation, Registration & Standardisation: Professionalisation of Social Care Workers'. The three pillars of elevation, registration and standardisation are the underpinning of a process of professionalisation that has already happened with good effect in social work and indeed in healthcare.

There are three further points to make – first that the term 'professionalisation' is not a 'dirty word' meaning distance and superiority, but here means skilled both in terms of expertise and in relationship building.

The second is an acknowledgement that many people working in social care have been failed by our education system – we owe many of them opportunities to make the most of their skills and to improve those that they would value further. It is not only education and training opportunities that are different according to whether you work in the NHS or in social care – these often reflect a lifetime of educational disadvantage.

And finally, while some of the report mentions that improved social care workforce support may help the NHS this is not the only argument for so doing. Social care can help the NHS in other ways, such as supporting people to live with risk and by adding quality not just years to life. The next steps for this report will be in digesting feedback and making changes where needed; but also, to start the journey of working out what a legislative framework would look like. As a first start to any drafting, the principles in this report should assist with this task.

I know that the Parliamentarians responsible for this ground-breaking report look forward to comments and suggestions.

Special Thanks

The All-Party Parliamentary Group on Social Care would like to thank the following organisations and individuals for their contributions to and collaboration with this inquiry:

Terry Donohoe ([UK Homecare Association](#))

Professor Martin Green OBE ([Care England](#))

Dr Chair Patel ([HC One](#))

Dr Karla Zimpel-Leal ([Centre for International Research on Care, Labour & Equalities – University of Sheffield](#))

Professor Sue Yeandle ([Centre for International Research on Care, Labour & Equalities – University of Sheffield](#))

Professor Jill Manthorpe (Director of the [NIHR Policy Research Unit on Health & Social Care Workforce & Associate Director NIHR School for Social Care Research, King's College London](#))

Dean Hochlaf ([Institute for Public Policy Research](#))

Sally Burlington ([Local Government Association](#))

Georgina Turner ([Skills for Care](#))

Karolina Gerlich ([National Association of Care and Support Workers](#))

Simon Bottery ([King's Fund](#))

Geraldine Donworth ([City and Guilds](#))

Jane Ashcroft CBE ([Anchor Hanover](#))

Sharon Lowrie ([Be Caring](#))

Billy Davis ([HFT](#))

Sophie Chester-Glyn ([Manor Community](#))

Pavan Dhaliwal ([MHA](#))

Madeleine Jennings ([British Association of Social Workers](#))

Anna Davies ([Independent Age](#))

Kelly Andrews ([GMB](#))

Emma Hanwell ([Folkestone Homecare](#))

Alan Miller-Young ([HC One](#))

Simon Baker (Head of Commissioning Partnerships& Market Development [Kirklees Council](#))

Mark Coup ([Welcome Independent Living Ltd](#))

Barbara Stoddart (Well Being Co-ordinator [Beechcroft Care Home, Runcorn](#))

Ann Stoddart ([Beechcroft Care Home , Runcorn](#))

And especially to all care workers who provided evidence (in confidence, under closed session or under option of pseudonym).

We also wish to thank the [GMB trade union](#) for the secretariat support of the APPG on Social Care.

A Summary of Recommended Options for Reform

1. The immediate formation of a **national programme** of work – concurrent with prerequisite governmental sponsorship – to plan and develop a workforce strategy for England - up to the establishment of a new identifiable national care body, with bespoke identity and livery; implying equal status with NHS staff, and establishing a new framework of governance, accreditation and leadership.
2. As part of that immediate national programme, a collaborative exploration be undertaken between existing sectoral stakeholders in England, and [Social Care Wales](#), the [Scottish Social Services Council](#) and the [Northern Ireland Social Care Council](#), to examine the desirability and feasibility of new, equivalent NHS signified sectoral bodies operating within the four nations to offer corresponding regulation, standards and fluid, equative qualifications and skills structures.
3. The creation of a new national care body for England with NHS affiliation - as a sectoral institution - working towards the following objectives:
 - I. To provide national identity for social care
 - II. To offer formal recognition of existing skill levels and diversity of extremely medicalised tasks routinely undertaken by the current workforce.
 - III. To further professionalise the workforce
 - IV. To design a new standardised training and career development framework and scaffolding that prioritises upskilling.
 - V. To consolidate into one single body the funding allocation for workforce training in England.
 - VI. To promote and oversee far greater integration with NHS services, including a greater linking of information flow between social care and the NHS. Including better use of technology in care homes and care at home, to assess and monitor the needs of service recipients, offering significant savings to NHS budgets.
4. The formation of a governing *Council for England* for that national care body, comprised of service providers, commissioners, trade unions and service user groups.

A national Council of this type should seek to establish and implement:

- An effective model of registration for England (in line with Wales, Scotland and Northern Ireland) – with 24-36 months as a reasonable and practical timetable for mandatory registration to be completed, and for the drafting and consideration of the legislation.
- A defined qualification package, starting from a reformed, compulsory and accredited Care Certificate with specific balancing to residential and domiciliary tasking - as an engaging framework of multi-faceted training leading to a matrix of career development pathway (CDP) badging/digital credentials for the employee, and transferable point of recruitment confidence/integrity for the provider – reducing the chronic waste of resources in training repetition and excessive emphasis on expensive, continuously duplicated induction programmes.
- This qualification package would formally recognise pre-existing, medicalised, complex care skills that too often sit unacknowledged, unvalued and unrewarded.
- The framework and apparatus for CDP badging of digital credentials; traffic light coded to indicate progression of attainment.
- Clearly defined job titles consolidated by CDP badging attainment with a corresponding pay banding stratum similar to those used in NHS services.
- In advance of the establishment of a new training and qualifications framework with a digital badging element, a national care body Council should work in collaboration with the [Care Quality Commission](#) (CQC) to define:
 - The terms of and timetables for the necessary passages of equation, equalisation and/or equivalence for existing qualification holders – be those qualifications vocational or academic.
 - The precise form of refresher certificates required for existing, longer term social care sector workers.
 - A fully agreed matrix of recognised compatibility standards between England, Wales, Scotland and Northern Ireland.

5. Such is the extent of sectorial complexity, diversity and fragmentation evident in the current regional picture, the formation of a national care body Council would consolidate regional workforces, allow for devolved and regionalised reflections of demographic need and operate regional skills shortage registers, up to and including innovative, digitised models of local monitoring and provision.

6. That all sectoral stake holders and indeed policy makers and politicians now commit to the elevation of the multi-faceted, complex, increasingly highly skilled/medicalised social care workforce up to NHS parity.

1: The Evidence Recruitment and Retention

“People look at care and think it’s an easy job. You can have 15 people start one week, and one left the next. They don’t explain to people what the job actually is¹.”

1. As is widely reported and documented, the social care sector has a significant problem with recruiting and retaining staff at all levels. Indeed, it has been reported that the sector has the highest turnover of any sector in the UK², with one in three workers leaving the sector every year. The national turnover rate is estimated to be around 31%, compared to the average across all employment sectors of 15%³.

2. Other estimations, including from our colleagues in the [Communities and Local Government Committee](#) estimate that almost half of care workers leave the job within the first twelve months of employment⁴.

3. Future projections and the overall prognosis for retention are also highly disconcerting. A 2019 report commissioned by the [Care Association Alliance](#) (conducted by legal specialists [Royds Withy King](#)) found a demoralised, low paid workforce with high reliance on female employees and EU nationals. Speaking on report publication, CAA Steering Group member Charles Taylor summarised:

“The sector needs to recruit 128,000 new members of staff every year to replace those that retire or leave, and to meet increasing demand. Increased demand alone means that in 10 years’ time the sector needs 500,000 new members of staff. In 2016, the latest data we have, the sector managed to recruit just 20,000⁵.”

4. Further specific focus was provided to our inquiry by the Local Government Association:

“Two roles in particular – care workers and registered nurses – have high vacancy and turnover rates compared with other roles within social care. High vacancy rates and turnover can disrupt the [...]

¹ Oral evidence to APPG Inquiry – Provided by a careworker from Wakefield – June 2019.

² <https://www.homecare.co.uk/news/article.cfm/id/1607171/staff-turnover-in-social-care-cited-as-the-highest-of-any-sector-in-the-uk>

³ <https://www.health.org.uk/news-and-comment/newsletter-features/stemming-the-tide-retaining-the-social-care-workforce>

⁴ <https://www.independent.co.uk/news/uk/home-news/care-home-workers-half-leave-jobs-within-year-staffing-levels-problem-report-communities-and-local-a7658281.html>

⁵ <https://www.roydswithyking.com/128000-new-care-workers-needed/>

continuity and quality of care for service users, and also mean providers incur regular recruitment and induction costs....

The vacancy rate for nurses in care more than doubled between 2012-13 and 2016-17. The vacancy rate for registered nursing jobs in care was 9.0 per cent in 2016-17. This increased from 4.1 per cent in 2012-13, despite the overall number of jobs falling from 51,000 to 43,000⁶.”

5. Skills for Care also highlighted salient facts⁷:

“A large proportion of staff turnover is a result of people leaving jobs soon after joining. A longitudinal analysis of turnover showed that care workers under 30 years old were more likely to leave their jobs, as were those with relatively lower rates of pay. Workers holding a relevant social care qualification had lower turnover than those without a relevant qualification...”

“... Skills for Care estimates that 8.0% of roles in adult social care are vacant, this gives an average of approximately 110,000 vacancies at any one time. The vacancy rate has risen by 2.5 percentage points between 2012/13 and 2017/18. This rise in vacancies, in the context of a workforce that has grown at a slower rate in recent years, suggests that the sector is struggling to keep up with demand as the population ages.”

And offered their own sobering projection:

“Skills for Care forecasts show that if the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population between 2016 and 2030, an increase of 31% (500,000 jobs) would be required by 2030. The 75 and over population is forecasted to grow at a faster rate than those aged 65-74, and if the workforce increases proportionally to this demographic then a 44% (700,000 jobs) increase would be required.”

6. Evidence provided to this enquiry inquiry identified four live factors driving retention rates high and deterring potential workers from joining the sector in the first place. These findings have been supported by several research studies. It is worth itemising and substantiating each factor with this primary evidence to comprehend fully the extent of the problems faced.

⁶ APPG Inquiry evidence provided by LGA – April 2019.

⁷ APPG Inquiry evidence provided by Skills for Care, Spring 2019.

Pay and Employment Conditions

“Because the pay is so low, the employers probably know the candidate isn’t the ideal person for the job, but they have to take them anyway⁸. “

7. It has been made overwhelming clear to this inquiry – both in written and oral evidence – that endemic low pay and sometimes unfairly calculated pay are key factors in deterring people from joining the sector, or retaining those that do, especially within the first 12 months of employment.

8. This force of this evidence has been repeatedly verified by research and polling conducted by various organisations and institutions, notably a survey of 56 employer organisations conducted by the [Centre for Economic and Business Research](#) (under commission from the care charity HFT⁹) that demonstrated emphatically that low pay is perceived as by far the biggest problem when it comes to attracting new employees and retaining serving staff members - 76% of responding employers identified “better-paid careers” in other sectors elsewhere as core reason for high turnover.

9. Medium and large-scale employers provided inquiry evidence as to the extent of low pay as a negative sectorial factor. HC One, a leading provider of adult social care in residential and nursing home settings that operates 330 homes in England, Scotland and Wales and by that is the largest corporate provider in the sector stated:

“Pay levels are comparatively low. The majority of care staff are paid close to the national living wage. Nurses are paid in accordance with national scales, but career opportunities cannot match those in the NHS. Employers would like to pay more, both as a reward and an incentive, but resources are constrained by the fee levels paid, particularly by public sector commissioners.

Responsible national providers understand the financial pressures on local councils in particular, but care sector inflation substantially outstrips general inflation, driven by reasonable demands for improved quality and facilities. Employment costs make up around 60% of the cost base for a residential care provider, meaning important and welcome policies such as the increase in the National Living Wage have a significant impact on provider finances and the fee uplift needed from commissioners.

⁸ Oral to APPG Inquiry - evidence from a care worker / Yorkshire region – June 2019.

⁹ <https://www.hft.org.uk/wp-content/uploads/2019/.../Hft-Sector-Pulse-Check-2018.pdf>

Very few commissioners will accept a fair cost of care analysis as a basis for the level of fees paid. All of this creates a perfect storm for the care sector, contributing to an increase in instability and uncertainty.

There are simply too few people wanting to join and stay in adult social care roles. Despite regular efforts by government, Skills for Care, and employers, including a recent national recruitment campaign in England, the tide has not been turned whilst the demand for care continues to grow [...] The inability to access enough qualified, motivated and values-based carers and nurses is the biggest single threat facing the sector¹⁰.”

10. These issues were echoed by Be Caring, an employee owned social enterprise delivering care in people’s homes across the North of England:

“We recruit a significant number of new colleagues every month, but we also lose a significant number of employees every month so like any other care providers, often we are recruiting to stand still. The main reason for this is as follows: Care is commissioned by the hour so as soon as a client passes away or goes into hospital the money stops hence it is impossible to continue to pay the employees.

This makes guaranteeing a weekly wage very difficult for employers and hence the uncertainty of income drives our colleagues to look for alternative employment. It is extremely difficult to pay the right amount of travel time between calls. As an example, the UK Homecare Association (UKHCA) state that the fair price for care is £18.93 per hour to pay the national living wage plus travel time and a contribution towards overheads to drive the quality of the service.

Across our services we have a range of hourly rates from £14.50 to £16.78. As you can see this is some way from the £18.93 quoted by the UKHCA. This can mean sometimes carers can only be paid for 70% of the time they are out of the house¹¹.”

11. This was further amplified by Manor Community, an organisation that supports people with mental and learning disabilities based in the south west in Bristol and rated outstanding by CQC:

“The most immediate and common issue is pay. This is the key factor in improving the recruitment and retention of care staff. Economic pressure has led to a wide variety of the types and quality of providers. This lack of legitimacy, size and continuity in providers worsens the image outside the [...]

¹⁰ APPG inquiry evidence provided by HC One – March 2019.

¹¹ APPG inquiry evidence provided by Be Caring – May 2019.

industry of care being low-status and short-term which worsens the issue of what people are expecting when they apply and so the workforce issues worsen as well¹².”

12. Independent Age, the national elderly advice charity provided startling evidence around low pay in the sector:

“... low pay remains to be a major problem to staff retention and recruitment. Research supported by Independent Age in 2018, found that over 500,000 jobs in social care were paid below the real Living Wage. One side effect of the introduction of the National Living Wage has been to flatten the pay differentials between lesser and more experienced care workers. As Skills for Care have noted, as of September 2015, a care worker with over 20 years of experience in the adult social care sector could expect an hourly rate which was, on average, 26p higher than a care worker with less than a year of experience (equivalent to 5% higher). However, the experience pay gap has reduced each year to only 15p (2%) in March 2018....

All of these factors demonstrate the low value currently attached to social care roles compared to other industries, and even similar roles within healthcare. Research by Independent Age has found that you can earn similar wages in retail and hospitality sectors with less responsibility and with more potential to progress than working in social care¹³.”

13. In oral session to the inquiry, Dean Hochlaf a lead researcher from the [Institute for Public Policy Research](#) identified:

“... a strong correlation between retaining workers and pay, and pay and the quality of care. 500,000 carers are working for a wage below real living wage rate. There is a massive compression of wages between top and bottom of care workers. This is work we need professionals to be doing. Over 75s have more complex care needs and there has been greater medicalisation of the work we are expecting care workers to do which we can't continue to expect to pay the minimum for¹⁴.”

14. HFT, a national charity that provides specialist care and support to over 2,900 adults with learning disabilities offered further, specialised insight:

“Low pay is by far seen as the main barrier to recruitment, with 80% of providers citing it as their biggest challenge. Social care is currently commissioned by local authorities on the assumption of National Minimum Wage/National Living Wage pay rates. This is despite the fact that staff are [...]

¹² APPG inquiry evidence provided by Manor Community – April 2019.

¹³ APPG inquiry evidence provided by Independent Age – March 2019.

¹⁴ Oral evidence to the APPG inquiry provided by IPPR – May 2019.

becoming increasingly specialist and as demand for supporting adults with complex needs or ... behaviours that challenge continues to grow. For as long as social care remains under an enforced low wage model, recruitment will continue to be challenging for many providers.... “

“At the heart of the social care workforce challenge is the systemic low pay that carers receive for what is increasingly becoming physically and emotionally hard, skilled work... “

[...] Feeding a vulnerable Resident with dementia through a PEG tube is a highly skilled and complex task – it should not be a low-skilled, low salaried responsibility. In any other sector, individuals with equivalent skills and responsibility would be remunerated at a level that recognises these – this is almost impossible when providers are already spending 80% of fee income on staffing costs, with carer salaries at or around the National Living Wage¹⁵.”

15. Information provided by the National Association of Care & Support Workers concurred further and expanded on some of the recurrent issues with conditions and work systems including:

“... Low pay and issues with the NMW not being upheld by some providers, this includes travel time not being paid, very low rates for sleep-in shifts and low rates of pay for 24-hour periods for live-in carers (we have had reports of those rates being as low as £50/24-hours)

Lack of job security because of zero hour contracts, which in practice often mean that rotas may be directed by favoritism of the office staff; care workers are being forced to come in on their days off and receive their rotas last minute (some as late as the Saturday of the week before) which means it is challenging to have any work-life balance and plan life further ahead than a couple of days¹⁶”

16. On the issue of pay and associated terms and conditions of work, it has often been oral evidence presented to the Inquiry in confidence by care workers themselves that has proved to be the most sobering. In one such closed session held in Leeds city centre¹⁷, a female care-worker offered the following overview:

“I worked out over one month, I did nearly 210 hours work and was actually paid for 105. Over a working week I don’t get to see my kids for 3 or 4 days, and I’d be paid for 7 and a half hours work, when with travel, I’d actually done 15 hours.”

¹⁵ APPG inquiry evidence provided by HFT – April 2019.

¹⁶ APPG inquiry evidence provided by NACAS – March 2019.

¹⁷ APPG inquiry evidence session 08/07/19 – Leeds.

17. With extreme candour, an employer speaking in confidence in a later session in Leeds stated:
“It’s close to below minimum wage. I’m forced to rip off my carers every week by not paying them petrol money.”

18. In closed, oral session, another care worker provided a harrowing account of her first role in the care sector:

“I spent £53 one weekend in taxis doing visits. I did two half days of training. On my first day I was shadowing. On my second day I got called to do proper work. Then I had 127 hours of end of life care. They took £100 off you for your DBS (Disclosure and Barring Service check) and your uniform. I ended up in a right state from my first job- I ended up poorly. Stayed there 2 months, and ended up off with stress. Signed off by the doctor¹⁸. “

19. This inquiry also heard oral evidence of extremely small pay differentials between entry level workers and those who have progressed to further training, new skills and qualifications. One estimate provided to us was of a 17p per hour differential between an entry level employee and an experienced employee who had completed the Care Certificate and considerable in situ training and experience.

Full Employment / Entry-level Competition

“We are the employers of last resort. All of our staff in Warrington left because Amazon opened up a distribution centre, and they paid £9.50 an hour¹⁹. “

20. All four fields of evidence provision to the inquiry reported that high levels of employment and competition from other historically low paying sectors such as hospitality or retail, when combined with the real challenges of social care work, have driven high staff turnover, again, particularly with the first 12-18 months of employment.

21. The physical and emotional realities of social care work and the demands it makes on employees; the cycle of bereavement, misunderstanding of what the role will involve, the common inflexibility of working hours, the under-staffing of care homes and the overall esteem in which the sector is held all contribute to the endemic negative staff churn.

¹⁸ Oral evidence to APPG Inquiry – provided by a careworker, Wakefield region, June 2019.

¹⁹ Oral evidence to APPG Inquiry – provided by a care-home manager, Leeds, June 2019.

22. In oral evidence to the inquiry, HC One founder Dr Chai Patel summarised:

“In recent years, there has been a high level of employment generally in the British economy, and currently the number of people employed is at the highest level since records were first kept in the early 1970s. As social care in residential and nursing home settings is a continuous service, its staff face unsocial hours, difficult intimate tasks, and unpredictable work demands. DBS clearance is required for all posts. Alternative employment is often less demanding, more predictable and better paid, particularly in retail settings.”

23. These reflections were consolidated by the Local Government Association:

“Salary levels in social care are significantly below comparable roles elsewhere in the public sector and in many competing areas of the labour market, such as retail and hospitality. In February 2018, the median hourly rate for a care worker in the independent sector was £7.82²⁰; for comparison, in April 2018 the National Living Wage (NLW) reached £7.83. This also illustrates the significant impact changes to the NLW have on the sector²⁰.”

24. The Institute for Public Policy Research added²¹:

“Providers have competed by driving down pay and conditions, and they have faced little resistance given the limited bargaining power of the workforce and the limited enforcement of employment rights. These factors are combining to create a social care workforce crisis.”

25. And startling comparative research presented by Independent Age²² demonstrated that *“you can earn similar wages in retail and hospitality sectors with less responsibility and with more potential to progress than working in social care”* – an observation rendered graphic by tables presented by the charity which contrasted the starting pay and training package of a typical social care worker²³ with “start day” roles such as an NHS Healthcare Assistant, a Customer Services Assistant (supermarket) and a McDonalds Crew Member.

26. It should also be noted that providers also noted increased competition for recruitment with the NHS, with major employers like HC One stating *“the most direct competitor for staff, the NHS, provides a national career structure, generally enhanced pay levels, and better service conditions, like*

²⁰ APPG Inquiry evidence provided by LGA – April 2019.

²¹ APPG Inquiry evidence provided by IPPR – May 2019.

²² APPG inquiry evidence provided by Independent Age – March 2019.

²³ The main duties and responsibilities for Care Workers and the NHS Healthcare Assistant are an amalgamation of different job descriptions found on agency sites and the NHS recruitment website. The Customer Assistant role for a supermarket represents the duties as outlined by Waitrose and Tesco.

[...] pension contributions. The government has announced a major additional funding package for the NHS over the next decade, which will lead inevitably to more opportunities and increased pay.”

Lack of Training and Career Development Pathways

“You’ve got to fight to go on the courses ... You’re limited in how long you can wait to go on it. I am still waiting for funding for my Level 2 Health and Social²⁴.”

27. In oral sessions with care workers in London and in Yorkshire, combined with evidence submitted to the inquiry privately very clearly demonstrate that a majority of social care workers appear to lament and complain of a lack of career development opportunities, and inadequate training for the work they are asked to do.

28. These submissions were echoed by Independent Age stating: *“Numerous pieces of research have been conducted to understand why so few people are joining the sector, when so many are leaving. A commonly identified theme is the lack of career progression within social care. Research has shown that only a third of those working in social care were happy with their career prospects. The absence of career progression, similar to the NHS can act as a huge deterrent to retention...”*

The lack of training has been highlighted as a factor contributing to the poor perception of working in social care. This can leave workers feeling fundamentally underprepared for the role they take on.”

(This issue is dealt with more substantively in Chapter 2/Page 25.)

Brexit Uncertainty

29. The fourth most commonly raised element in understanding the present retention and recruitment crisis was the uncertainty and flux regarding the process via which the UK will leave the European Union, and the ramifications for free movement within the EU.

30. The Social Care Workforce Study²⁵ commissioned by the CAA reported: ‘33% of all nurses and 16% of care assistants are foreign nationals. In London, this rose to 65% of care assistants and 84% of nurses.’

²⁴ Oral evidence to APPG Inquiry – evidence from a care worker in Yorkshire and the Humber region – June 2019.

²⁵ <https://www.homecare.co.uk/news/article.cfm/id/1607171/staff-turnover-in-social-care-cited-as-the-highest-of-any-sector-in-the-uk>

31. In this context, employment lawyers and employer groups²⁶ (and indeed the Care Association Alliance) have called on the Government to rethink post-Brexit immigration proposals in light of significant staff shortages in the social care sector. A spokesperson for the CCA stated:

"The proposed visa that would allow low-skilled people into the UK for a 12-month period is simply not good enough. It would be costly for care employers to manage whilst further exacerbate staff turnover [...] We would urge the government to introduce a social care visa which would only be available to people working in that sector. Such a model already exists for those working in the agricultural sector. If the Government cannot support the sector, care providers will be forced to close, leaving the vulnerable and elderly without sufficient care and support."

32. In evidence to this inquiry, Care England also registered similar concerns and echoed warnings:

"It would be irresponsible for the Government to accept the Migration Advisory Committee's recommendation that no special arrangement should be made for social care workers without accepting the further recommendation namely the way to attract more British workers is through better funding and enhanced employment terms. Furthermore, 'low skilled' is an inappropriate term to apply to social care workers²⁷

33. As did IPPR in stating: *"Constraints on EU migration post-Brexit threaten to exacerbate the growing workforce crisis. Our modelling shows that – on current trends, and assuming the ending of freedom of movement – there will be a shortage of nearly 400,000 workers in social care by 2028."*

34. Echoed by Independent Age, who noted²⁸:

"Despite the overall reliance of the sector on migration for staffing, care workers do not currently appear on the Tier 2 shortage occupation list. Furthermore, the proposal in the government's Immigration White Paper for a £30,000 minimum salary threshold will also risk perpetuating the growing staff shortages in the social care sector [...] Research for Independent Age following the 2016 referendum found that in a low-migration scenario, there will be a social care workforce gap of more than 750,000 people by 2037²⁹."

²⁶ <https://www.roydswithyking.com/128000-new-care-workers-needed/>

²⁷ APPG inquiry evidence provided by Care England – March 2019.

²⁸ APPG inquiry evidence provided by Independent Age – March 2019.

²⁹ low migration scenario is one where the sector remains no more attractive than it is today and the government delivers on its commitment to reduce levels of net migration. Full details of the methodology can be found in the report: Independent Age and ILC, Brexit and the future of migrants in the social care workforce.

35. The importance of social care workers from the EU to current service provision was highlighted by [Dr Heather Rolfe](#), who also warned of the dangers of a £30,000 minimum salary threshold as mooted by the UK Government. *“The last thing the system needs is a migration policy that will make its problems worse by not allowing it to recruit the skills and labour it so badly needs³⁰.”*

36. The post-Brexit £36,700 [minimum salary threshold proposal](#) from Home Secretary The Rt Hon Priti Patel MP would have an incredibly negative impact on social care service provision in the UK, and this All Party Group would support the [social care sector exemption](#) for this policy, or a new sectoral visa or equivalent impact.

³⁰ <https://blogs.lse.ac.uk/brexit/2018/11/13/how-eu-migrants-have-propped-up-britains-social-care/>

2: The Evidence Training & Development

1. Throughout evidence sessions for this inquiry, the issues of training, development and career pathways were consistently raised by all field providers in a tone of frustration, and often exasperation. Many reported a willingness and keenness on the part of workers to take on new training opportunities but that hard-economic realities, time constraints and inconsistent work patterns were thwarting this aspiration.

2. Almost all fields reported a training landscape dominated by induction, and that these often time consuming and expensive inductions are endlessly repeated, due to a lack of standardised, portable and immediately transferrable qualifications. All care workers who provided oral evidence in closed session reported experience of an inadequacy of training for the tasks they have been expected to carry out, and many called into question the value of that inception point – the Care Certificate. This critique was also shared by many providers and sector experts.

3. In Section Two of this report, we will highlight some of the innovative good practice training and development models being developed and implemented across the sector, in the fields of domiciliary, residential, and specialist care provision. But it in this section we will explore the issues raised by multi-field providers. As a preface to that exploration, it is valuable to consider an overview of the present training and development picture.

4. The Hayes/Johnson/Tarrant report to the All-Party Parliamentary Group offers the following overview and itemised summary of the present training/professionalisation picture in the UK:

“... the type and degree of training undertaken by care workers varies by employer and by care setting. All training in England, including induction training, is employer-led. Across the UK, training is characterised by localised, as opposed to centralised, delivery. This leads to much variation in who provides training to care workers, when and where such training takes place, how it is delivered (online, using DVDs, face-to-face), the quality of learning experiences, how learning is assessed, and whether training achievements are certified.”

➤ In England, there is a reliance on induction rather than occupational registration. However, there is no legal requirement on employers to ensure engagement with the Care Certificate. The Care Certificate is not a qualification.

➤ Only 1/3 of care workers in England have completed the Care Certificate, a further 1/3 have begun it but not completed it and the remaining 1/3 have not started.

- There is a large discrepancy in the number of care workers in different type of services who have completed induction training.
- In Wales, the emphasis is on training as a mechanism through which care workers can learn that they are valued by employers. The purpose of sector-wide training is to provide good care and it is mandatory for workers who must register.
- In Scotland there is no national induction programme as yet, but it is forthcoming.
- In Northern Ireland common induction standards and a training programme must be completed by all workers within 6 months of starting a new role. Applying for registration is part of the induction and completed training and learning is recorded through registration.
- Many workers in Wales, Scotland and Northern Ireland are already registered or in the process of registering as social care workers. Registration is linked to training in all these nations.
- ‘On-the-job’ shadow-shift training is a very important practice within the sector, but it is underrecognized and under-researched. Workers’ abilities to train up their peers and new starters are not formally acknowledged or valued.
- ‘Off-the-job’ formal training is predominantly concerned with health & safety and safeguarding issues, suggesting employers are motivated by reducing potential liabilities in the event of errors or accidents.
- The type and extent of training varies by employer and by care-setting. All training in England is employer-led, including inductions.
- “➤ Across the UK, training is characteristically localised, there is much variation in who provides it, where it happens, how it is delivered and assessed, and the quality of learning, including certification.
- Levels of relevant qualifications across the care workforce are unclear. Between 50%-70% of care workers in England do not have an occupationally relevant qualification. Levels of qualification are much higher in Wales, particularly in the Welsh public sector where 68% have a relevant qualification. In England, 39% of PAs have at least an NVQ level 2 qualification compared with only 15% in Wales.
- Care workers have expressed concern about gaining formal qualifications and anxieties about the range of competencies required. Fears about literacy and numeracy abilities may be an important

[...] factor. There is a view that qualification may accredit existing practices but does not improve skill levels. If training is not certified it may be regarded as worthless.

➤ Care workers can find it hard to access training outside of working hours and they often have no time for 'homework'. There is little financial reward for becoming better trained and little opportunity for career progression. Homecare workers, in particular, can find training difficult because they have no fixed place of work and insecure and zero-hour contracts are especially common in homecare jobs.

➤ Managers have expressed concerns about whether they have the knowledge to support staff and assess their learning. They can have difficulty in finding cover for staff in training and risk wasting resources on training staff who often leave their jobs within the first few weeks.

➤ Employers have expressed concerns about a lack of funding for training and about the low rates of local authority funding for social care services, which does not include the costs of training.³¹ “

5. All facets of the Hayes/Johnson/Tarrant report are reinforced by multi-field evidence presented to us. The systemic disincentivising of training highlighted here in that paper:

“...there is demand amongst care workers to attend additional training courses and update their skills. But significant barriers to this include long working hours, insecure employment contracts, and workers not being paid or allowed time off to complete or attend training. In addition, few chances of career progression and a minimal wage difference between care worker and senior care worker roles means that there are few career-oriented or financial incentives for workers prioritising training.”

6. This is enhanced – especially in the context of resource restrictions - by the views of employer Be Caring – a provider widely acknowledged to be at the highest quality end of provision:

“There are insufficient resources to guarantee to pay people for their basic training to ensure they are fully equipped to undertake the role. Be Caring pay for the week-long induction but only if they then go on to deliver care. No one wants to put new workers through unpaid training which in any other sector would be classed as basic induction but because of the way care is commissioned we simply do not have the resources to avoid this³².”

³¹ Hayes/Johnson/Tarrant 2019

³² APPG inquiry evidence provided by Be Caring – May 2019.

7. One domiciliary care worker in evidence to an open session in London explained succinctly:

“The two days induction didn’t really teach me anything, there was very little training, and then only 2 hours of shadowing. I can remember getting out there and thinking I don’t know how to use this machine, what do I do? I’d been involved in PEG-feeds despite having no training³³”

8. Reflections such as this have proved to be commonplace, and often point to service providers either unwilling or simply unable to train social care workers to the standard that they need. Time and time again, sector employers, organisations, NGO’s and charities and specialist academics pointed to a lack of resources for adequate training programmes.

9. Care England, the representative body for independent care services in England expressed deep concerns and indeed warnings about:

“... the lack of parity in typical training for the social care workforce (£16.00 per head per year) compared with that offered to the NHS Workforce at (£3,615 per head per year). For example, the proposals in the Mental Capacity (Amendment) Bill Impact Assessment suggest that half a day’s ‘familiarisation’ should be sufficient for care home managers to be up to speed in LPS (Liberty Protection Safeguards); we strongly disagree and maintain that these extra burdens run the risk of driving social care staff out of the sector. Shifting the costs and burdens onto providers will not be successful.”

10. These observations were reinforced by providers from the specialist field, in this case a national charity providing services for people with learning disabilities:

“Currently within social care there is a wealth of what are considered ‘mandatory’ training requirements with ‘refresher’ periods ranging from 6 months to 3 years. Given the current funding crisis coupled with the recruitment crisis many providers can just about manage to meet the mandatory requirements within available (people and money) resource.

Where providers only offer the mandatory training to staff, we witness a workforce whose continued professional development is stifled and ambitions are squashed. This would mean HFT’s claim that social care should be viewed as a profession is left in doubt³⁴.”

11. And a more structural, practice-based reflection from a charity providing care, accommodation and support services for older people throughout England, Scotland and Wales with 7,000 staff and around 5,000 volunteers:

³³ APPG oral evidence session – July 2019.

³⁴ APPG inquiry evidence provided by HFT – March 2019.

[...] “We find that, while new recruits are experienced in the care work and come with various certificates and training, we often need to revalidate qualifications and provide further training to ensure staff are trained to the standards we set. For example, if a care worker presents with a moving and handling people certificate from their previous employer, we don’t have any way of knowing the quality of the training they have received and therefore to ensure... .. the safety of our service users and themselves we shall require them to complete our training. This is the same across all mandatory training topics.

As a consequence of the requirement to complete the mandatory training, staff development and non-mandatory training become less of a priority. This occurs where, as a consequence of recruitment challenges, we deliver care with the minimum staff to resident ratio. Where there is no capacity to cover shifts in order to facilitate non-mandatory training, that training doesn’t occur³⁵. “

12. The inquiry also received insight into the domiciliary provider experience from UKHCA, the professional association of home care providers:

“(UKHCA) offer training workshops for supervisors and managers, which are popular and well-attended, however, a national association cannot operate localised training for the front-line workforce. UKHCA administers the Workforce Development Fund (WDF), funded by the Department of Health and Social Care which allows employers to seek retrospective reimbursement of costs for the qualifications or learning programmes undertaken by their staff. Similar schemes operate in Wales and Scotland.

However, training and recruitment costs providers and these costs must be weighed against the impact of the consistently low fees paid by council-funded work and other factors such as the annual increase in the registration fees levied by the Care Quality Commission, the sector’s regulator in England. Providers have expressed concern that although reimbursement schemes exist, they are inflexible, restricted to whole courses and do not cover induction training – an important issue in a sector which sees high turnover [...] Employers also struggle to identify which training providers offer best value and reliable services³⁶.”

³⁵ APPG inquiry evidence provided by MHA – April 2019.

³⁶ APPG inquiry evidence provided by UKHCA – March 2019.

13. It should be noted that, overall, evidence providers from all fields concurred with the Hayes/Johnson/Tarrant description on the Care Certificate. Whilst many did welcome it as a potential step in the right direction and a limited number of care workers recorded finding the Care Certificate useful, there has been clear unanimity on its shortcomings.

14. Evidence provided by Dr Karla Zimpel-Leal, an Innovation Fellow within the Sustainable Care Programme at the Centre for International Research on Care, Labour and Equalities (University of Sheffield) stated:

“There is a lot of criticism from both workers and providers that this (Care Certificate) qualification offers very little value and applicability for their work. Most care providers will offer inductions that might include some formal training. This varies considerably in terms of quality, duration and applicability.

Having a high-quality standard training that provides care workers with the skills, knowledge and confidence before they join any provider would be beneficial to all involved. Each provider could then frame their inductions according to their organisation’s values and structure, without needing to retrain staff every time they join in from another organisation. A framework will also provide a structure for various career paths that a care worker can pursue, from specialisms, advanced employment, to leadership roles. This will offer assurance to both care workers and care providers, ultimately improving the lives and quality of care provided to care recipients³⁷.”

15. The National Association of Care & Support Workers offered the following blunt assessment:

“In terms of the current state of training standards and professional development in the industry at the moment, they are not consistent or available to everybody equally. The Care Certificate was a hugely missed opportunity in terms of introducing a transferable qualification for the industry. The certificate not being accredited and handed to the providers to deliver means that there is no quality assurance....”

“... We have had many reports of care workers having to do the Care Certificate two or three times as well as different reports in terms of the lengths of delivery. Some providers seem to deliver it in two or three days whereas others take weeks or months. This means that there is no consistency in what can be expected from a care worker that has completed the certificate³⁸.”

³⁷ APPG inquiry evidence provided by Dr Karla Zimpel-Leal – March 2019.

³⁸ APPG inquiry evidence provided by NACAS – March 2019.

16. Skills for Care provided additional valuable observational understanding:

“The variation in how the Care Certificate training is delivered has led to uncertainty over the quality of training received by care workers in other organisations, and in turn devalued the Care Certificate. Portability between care organisations was not evident. National accreditation of the Care Certificate and professional registration of its holders could strengthen its perceived value. Furthermore, integration with National Vocational Qualifications and other relevant learning is needed to acknowledge prior learning when embarking on the Care Certificate. More formal recognition of the attainment of the Care Certificate through the formal presentation of certificates could benefit the motivation of care workers and the support from organisations to complete the training.

Foremost among barriers to implementation is the time commitment imposed by the Care Certificate which disproportionately affects smaller organisations, and acts as a disincentive to both prospective trainees and care managers. Successful implementation could be achieved through planned and comprehensive integration of the Care Certificate across the organisation, which was supported by existing organisational infra-structure and organisational leaders. Mentoring, buddy systems and group teaching were identified as mechanisms that facilitated learning and development on the Care Certificate.”

17. Finally, it is worth reflecting on the outcomes and impact of a training and development framework that is manifestly incoherent, under-resourced and fragmented, and the enormous value of investment in training for social care workers and recipients. Both aspects are driven home by observations from Hayes/Johnson/Tarrant:

“We were told of instances where care workers have been disciplined for unnecessarily restraining or shouting at a service-user in circumstances where they have not received adequate training in how to deal with escalating behaviour. Many care workers who work with people who have dementia or people with learning disabilities do not receive specialist training for their roles. They need to be trained in order to feel confident in how to identify and prevent behaviour escalation. This is an important part of ensuring service-users and staff feel safe.”

“High quality learning experiences have the potential to transform caring relationships. Jenny used to be a hands-on care worker. She told us about training that she received that she felt had transformed the quality of care which she was able to provide to service-users. When she started in her role, a more experienced care worker led a training session on the importance of body language. This training was hands-on and involved new recruits sitting in a wheelchair whilst another member

[...] of staff simultaneously fed them a yoghurt and spoke to another care worker. Jenny told us about the insight she gained from this training. It had helped her see how service-users' felt when care workers did not focus on them or talk to them whilst undertaking care tasks and it resulted in her providing more dignified care to service-users throughout her career³⁹."

³⁹ Hayes/Johnson/Tarrant 2019

3: The Evidence **Service User Impact**

“This is personal care now. Having to give someone a wash or a shower. Changing stomas or catheter bags. PEG feeds, controlled drugs, nebulisers⁴⁰.”

1. In the last year, and in particular the last six months, stories of poor or inadequate provision of social care— particularly to the elderly and most vulnerable – and indeed repeated accounts of no availability or provision of care *at all* have permeated broadcast, print and digital news media coverage, perhaps second now only to the Brexit issue as a domestic “news story” in terms of sheer volume.
2. Whilst it would serve little purpose to repeat or rehash terrible, distressing stories⁴¹ here, it would perhaps be reasonable to point to the impact of the BBC Panorama series produced by the BBC producer Alison Holt⁴² as indicative of the type of important coverage of the plight of older people and vulnerable people with recourse to domiciliary or residential care that has become relatively commonplace.
3. The lack of funding, training and professionalisation evident across much of the social care workforce is clearly a major factor in negative service user experiences, and during the course of this inquiry, we have heard accounts of the use of multiple care workers to support someone, and the associated unfamiliarity with people, insufficient time allocated for care duties, a lack of continuity of care, and indeed a lack of any kind of care worker at all.
4. Perhaps the most arresting evidence provided to the inquiry in this regard came from Independent Age, unsurprising given the estimate⁴³ that over 1 million people annually access the information and advice that the charity offers to older people and their relatives:

“We know that the state of the care workforce is a real concern for older people and their families. The basic structures of shift work and multiple carers make it very difficult to make a reality the understanding of ‘wellbeing’ outlined to in the Care Act 2014 - which includes emotional wellbeing, personal dignity and individuals having a control over everyday life... “

⁴⁰ Oral evidence to the APPG Inquiry – provided by a careworker in the Yorkshire region – June 2019.

⁴¹ <https://www.express.co.uk/news/uk/1144706/social-care-delay-elderly-people-die-waiting-help>

⁴² https://www.bbc.co.uk/news/extra/MYx8zCtDRI/the_crisis_in_care

⁴³ <https://www.independentage.org/about-us/annual-reports-accounts-and-reviews>

“ [...] In a set of focus groups conducted last year (2018), we heard individuals express a number of concerns about the ability of the current workforce to deliver good care. We heard concerns about the length of time care workers could spend on visits:

“14 minutes in and out...that’s not caring for someone.” Female, Manchester

And about the way that pay and conditions impact on recruitment:

“They can’t get the carers they need because the wages are so low... The time that they have to spend going from one house to another, they do in their own time. It’s bad.” Female, Newcastle.

The revolving door of care workers means older people and their relatives are having to retell their story numerous times. Calls to the Independent Age Helpline confirm that poor retention can have an impact on older people who rely on social care workers. Older people and their families tell us about their experience of having to adjust time and time again to a new person helping them in their home because individuals rarely stay in post for very long. The case studies below illustrate the impact a lack of continuity of care on older people and their families.

“Linda”, whose mother is living in a care home:

When staff did not know Mum they were not able to use background knowledge to give her care experience centred on who she was as a person. I felt sorry for the staff trying to get to know someone in a short period of time. Personal care was done well but there was no relationship there. There was a carer who worked nights who would have long chats with mum about her past and she had been at the care home for 9 years. Mum enjoyed these times and when I saw the carer after mum died, she said the same.

The care home had cut Mum’s hair so short. She was hardly eating so she had lost her curves. Then, when I was visiting Mum, a temporary member of staff said to me, ‘Is this a man or a woman?’ I thought, ‘Do you know my mother at all?’

“Alice” 82, describing care for her husband Jack:

“Before Jack went into residential care, we had carers in for a week coming to settle him at home for the night. They would arrive any time between 3 and 9pm – who wants to get ready for bed at 3pm?

We live in a village without street numbers or names so I spent every night waiting for a different person to come to care for Jack. It was a hopeless situation. Most evenings I was standing on the street with a torch seeing if anyone was cruising up and down looking for our house. If Jack had had regular carers, he might have been able to stay at home for longer. They might have become a kind of extension of our family. Instead they were totally anonymous and they stay for such a short time.

[...] *Now he's in the nursing home he knows everyone there by name. That makes things so different: the regular care, people who know him he can have a laugh with."*

"Andrea", whose mother has dementia and is cared for at home:

"My Mother's care is much better now as we've been with the same agency for some time and she has the same carers, who know her and her various quirks. I would say more agencies need to recognise the importance of providing the same carers when looking after dementia patients - as they need that continuity of care and routine in order to trust their carers and feel safe.

Carers have to know how to work around someone who has dementia, if they're going into someone's home. They'd say to me, 'Your mother's behaving strangely today,' but it's her illness and she can't control her behaviour. Carers aren't given the training they need to look after the elderly with the different complex health conditions they have. They don't know how to adapt to individual needs. It's a battle and many of them are learning on the job.

In the past we've had carers who would come at lunchtime. They'd arrive at noon, quickly give Mum lunch and then leave. They'd write in the logbook they will write down they've been there for half an hour. I caught them out and refused to pay. Carers are not paid well and as a consequence they often don't see any value in the work they do. This means many do as little as possible in order to achieve the right results. This system can never work⁴⁴."

- (Independent Age confirmed case study names have been changed)

5. We would also highlight the important assessment offered from the domiciliary care field (and regional distinctions) by UKHCA:

"Increasingly, homecare workers have found their roles expanding into areas previously undertaken by district nurses, for example in providing assistance with enteral feeding and wound dressings. This is analogous to the increased use of care assistants in NHS settings. However, where the latter are seen to be in support of healthcare professionals homecare workers carrying out similar roles in the community are not. This is then reflected in perceptions of relative status and professional skills.

Scotland and Northern Ireland have introduced schemes for the compulsory registration of care workers with the aims of giving recognition to care workers and giving those receiving care and their families the confidence in the quality and safety of the care they receive. Wales will introduce a similar scheme in 2020.

⁴⁴ APPG inquiry evidence provided by Independent Age – March 2019

[...] Government has chosen not to introduce this model in England, not least because additional funding would be required to make registration an attractive prospect. Similarly, although Health Education England (HEE) offers healthcare assistants, employed within the NHS, access to support, professional ... development and progression opportunities there is no equivalent scheme for homecare workers. Proposals for a voluntary register have also been raised but, without the benefit of compulsion, are not in our view a practical incentive to improve professionalisation of the workforce.

A registration scheme that improved the status of homecare workers and offered a route to enhanced training and development opportunities would assist in the recruitment and retention of staff as well as improving their status. However, such a scheme would require investment and greater integration of health and social care funding streams and resources.

Efforts at integration between health and social care have been disappointingly unproductive to date, a major factor being the differences in funding mechanisms between health and social care and in employment conditions between the two sectors.”

“... Scotland is seeking to integrate health and social care provision better through the introduction of Integrated Joint Boards 4. However, progress has been hampered by funding issues and lack of effective management as highlighted in Audit Scotland’s report, published in November 2018⁴⁵.”

6. And an important observation from HFT highlighted:

“.... funding cuts have meant that growing numbers of providers have had to make internal efficiency savings, which will invariably mean that providers’ training offerings will differ depending on the provider. This will, in turn, affect the quality of care people supported by the sector will receive, as providers’ offerings will vary from the legal minimum to those with exhaustive training suites.

Indeed, one of the more alarming statistics from our Sector Pulse Check was that 11% of providers warned that any further funding cuts were likely to result in a deterioration in the quality of care that they were able to provide to their service users¹¹. This is the first-time providers have expressed such sentiments.”

⁴⁵ APPG inquiry evidence provided by UKHCA – March 2019.

7. Startlingly, oral evidence presented by care workers face to face in closed Inquiry sessions drew a bleak picture:

“You’re lucky to have 3 carers looking after 40 people for the day shift. Shouldn’t we be able to give them dignity of care? We can’t even do that. We’ve been banging on about this for five years, but the CQC do nothing. The beds empty a bit, they paint the rooms a bit, but they don’t change anything. Everyone has got to be held responsible for how we’re failing in social care. We have a different agency nurse every day, they see something they don’t like, they don’t come back again⁴⁶.”

“In nursing homes, it’s a vicious circle- the local authorities come in and say “this isn’t how it should be; this isn’t being done right, this isn’t being done right” and then they will put an embargo on. Then they’ll come back in and lift the embargo, and they don’t address the root causes. But then when they let people back in, they keep the same staffing levels and fill it back up, so then you’re back there again within 12 months. And the people who suffer are the residents and the staff. What really changed, other than that you got to a safe staffing level while the embargo was on? It’s the funding! Nothing changes⁴⁷. “

8. And most concerningly, evidence supplied by NACAS relating to the “grey area” of informal service provision:

“There are many people in the community that provide care on a cash-in-hand basis, often without any training or accountability. We see care jobs advertised on Craigslist, Gumtree, or Facebook. We have seen people with live-in housekeepers who double up as carers; who, never trained in care, do ... not know that we cannot force medication, food, or move people without proper equipment. Care work is a responsibility for another person’s life, and such a significant responsibility must be ... adequately regulated [...] The decrease in the care quality has been shown to come from understaffing and the workforce being overworked and undertrained⁴⁸.”

9. In relation to this evidence, it is important to note that little academic evidence or indeed significant media reporting exists to verify the scale of “informal provision”. However, a good number of care workers who engaged with this inquiry confirmed the area as evident and growing.

⁴⁶ Oral evidence to the APPG Inquiry – evidence provided by a careworker from Merseyside, June 2019.

⁴⁷ Oral evidence to the APPG Inquiry – evidence provided by a careworker from Leeds, June 2019.

⁴⁸ APPG inquiry evidence provided by NACAS – April 2019

10. This inquiry would note the real, increasing health risks to service users and indeed the safety of social care workers when carrying out increasingly clinical or healthcare tasks with insufficient training. This concern is of particular relevance to the growing “informal sector” of provision which is, by definition, without regulation or accountability.

11. Lastly, as a caveat perhaps to the prevalence of some of the negative stories surrounding poor care provision and the tone of overall media coverage, it is worth holding the following assessment and assertion presented to us by HC One – as something of a consideration, or even a counterweight:

“The general public is entitled to expect that publicly funded and regulated services will be provided to a high professional standard. Although this is achieved in the vast majority of cases, there is insufficient evidence of quality assurance throughout the system. The external regulator, CQC in England, publishes reports on each service centre and makes announced and unannounced visits to establishments. However, it is largely left to individual employers to maintain and improve standards, provide sufficient resources and deal with queries and complaints.

Unfortunately, public perceptions are conditioned too often by a series of media exposures of poor practice, and occasional physical and mental cruelty. Whilst this is only a tiny minority of cases, it has a substantial reputational impact. Unlike the NHS, with its overwhelmingly positive image, social care suffers from a poor public perception and misunderstanding about both the quality of care provided and the calibre of delivering that care⁴⁹.”

⁴⁹ APPG inquiry evidence provided by HC One – March 2019

4: The Evidence Perception and Esteem

“It is perhaps not surprising that the public are dissatisfied with a public service that is unfair, unclear and unfit to meet the rising needs across the population. That dissatisfaction remains high suggests there is much to be gained from moving forward with the long-promised reform of social care services – the over-reliance on informal carers and self-funders to prop up the system is not sustainable⁵⁰.”

1. It is undeniable that a combination of negative media coverage, disjointed personal experience, distanced indifference and systemic under-funding and under-valuing have combined to create a low perception of social care work and the sector’s workers. Of all of the elements of evidence this inquiry received and explored with the people that make up the sector, this was perhaps the most lamentable and disheartening.

2. The chasm between the levels of commitment, compassion, professionalism, dedication and resilience displayed during this process by so many care workers, providers and commissioners, and the low esteem in which they appear to be held “externally” is probably at its widest point. This distinction has its most likely starting point in the sheer public confusion around how the sector works, who works in it, and who they work for, as demonstrated by Ipsos Mori polling in 2017:

“People do not generally have faith in the social care system – only a fifth (20%) think government has the right social care policies and two thirds (65%) lack confidence social care services will be available when they need them. There is also widespread lack of awareness about how and who provides social care services – the majority think the NHS provides social care services and just under half (47%) wrongly think social care is free at the point of need⁵¹.”

3. This nebulous identification appears to be exacerbated by the low funding levels allocated to the sector, and a widespread ignorance of the skilled, medicalised tasks that both domiciliary and residential care workers are expected to undertake, often routinely.

⁵⁰ Hemmings N (2019) “What does the British public think about social care?”, Nuffield Trust comment. <https://www.nuffieldtrust.org.uk/news-item/what-does-the-british-public-think-about-social-care>

⁵¹ IPSOS MORI <https://www.ipsos.com/ipsos-mori/en-uk/public-perceptions-austerity-social-care-and-personal-data>

4. The management team at Be Caring shared interesting reflections with us on this subject:

“The public are aware that there is a crisis in Social Care and they know through experience that the system is broken. Everyone knows someone who is involved in one way or another in the care system. What role that perception plays is difficult to comment on other than to say that if the public became aware that no matter what the need out there is, the resources are driven to fit with an average hourly rate of less than £16.50 an hour to cover the entire cost of the care they would, quite rightly, be appalled.

No other public service is measured and commissioned by the hour and no other public service is deliberately priced to undercut what almost every expert and independent authority researching this issue come up with. Care Work is undervalued by our councils and government so it’s hardly surprising that it is undervalued by some of the public too. Our leaders, both locally and nationally need to champion the value of care work and those that are employed within the sector, they don’t, because they fear they would have to match their words with resources⁵².”

5. And as this section of evidence from HC One demonstrates, from a medium-sized, employee owned service to the nation’s largest residential care provider, these sentiments are gathering weight:

“There is no doubt that social care has an insignificant or negative public image. It is highly valued by most service users and their families, but largely ignored by everyone else. That is why the profile must be lifted and its workers understood and celebrated [...] Social care is too often treated as an addendum to health, not least in the name of the responsible government department. Yet it makes a major contribution to wellbeing, prevention, community support and the social fabric of society

The vast majority of people who require professional support are in the social care system, which can relieve the pressure on more intensive and expensive services. If the sector can attract, retain and improve the skills and job satisfaction of dedicated staff, public perception should improve and confidence in services will grow. Professionalisation of the care workforce is therefore crucial to this wider ambition.

The people that work in care homes should not consider themselves simply ‘just a carer’ – as I often hear many of my colleagues referring to themselves. Rather they should see themselves as delivering a professional care service with the benefits – both financial and in terms of how society perceives the role – that comes with a professional career. Until we reach such a point, the care [...]

⁵² APPG inquiry evidence provided by Be Caring – May 2019.

sector will continue to be plagued with high turnover and low retention, which ultimately will impact on the ability of providers to maintain the continuity and quality of care that residents deserve⁵³.”

6. Furthermore, observations on wider public perception from the specialised standpoint of HFT deserve interpretation, and thus we present a sizeable section here:

“Social Care has often been described as a Cinderella service to the NHS. On the whole, the NHS is widely revered as a “national treasure” and, in recent years, has enjoyed largely positive media coverage – whether that be the plethora of celebrative events to mark the 70th Anniversary of the NHS19, or the institution’s prominent role in the London 2012 Olympic Games’ opening ceremony20. By contrast, social care is usually portrayed as being a safety valve, or supplementary service, to the NHS. This is particularly noticeable in the winter months, when a “winter crisis” highlights how gaps in adequate social care provision results in bed-blocking in overcrowded NHS hospitals.

Studies in the USA show that media portrayal of nursing home care is generally negative in tone, and that this has had a detrimental effect on the way such care services are perceived by the American public. While similar longitudinal research does not yet appear to have been conducted for the English social care system, it can be reasonably assumed that the negative portrayal of social care in British media will have similar effects on the public’s attitudes towards social care to that of their American counterparts...

“With “The Ageing Society” being identified as one of the government’s Grand Challenges, it is unsurprising that much of the media and policy attention tends to gravitate towards care for the elderly. This inevitably means a focus on support during later life, with an emphasis on frailty, mental and physical decay [..]

However, support for working-age adults with learning disabilities is one of the fastest growing areas of adult social care in terms of demand. It accounts for 35% of the total adult social care spend in England and a growing number of local authorities are now spending more on working age adults ... than they are older people. For providers such as HFT, our focus is on ensuring these adults live the best lives possible and to see them thriving rather than merely surviving. HFT would welcome a more nuanced portrayal of social care in the media, showing the positive benefits that good support ... staff can make to an individual’s life, and reflecting the varied activities and that providing such support can bring.

⁵³ APPG inquiry evidence provided by HC One – March 2019

The government's national recruitment campaign will go some way to addressing this imbalance. The #EveryDaysDifferent campaign will be effective at highlighting the various activities that high-quality, person-centred support includes and should complement the activities providers are already engaging in to recruit new staff. However, while this is a welcome move, it is little more than window dressing if it is not matched with clear policy initiatives to help address the root causes of the recruitment crisis⁵⁴."

7. UKHCA were emphatic in where they feel the important transformation of external perception of the sector to a higher status must start from:

"We believe that workforce registration, if properly implemented and funded, would demonstrate a level of status, in both the organisation and the individual, celebrates the attainment of relevant qualifications and can be used to encourage ongoing professional development of registered workers. Continuous personal development improves the skills-base and a registration system provides transparent evidence of expertise and the investment in individual workers⁵⁵."

8. And NACAS gave advanced disclosure of some of their own concepts and ideas to challenge negative or low perception:

"Low perception of the job, with judgments, often being that care work is 'unskilled', 'women's work', 'easy', 'anybody can do it' and not challenging, mean that not many people want to enter the sector as they do not perceive it as a sector with many opportunities."

The societal view also has a negative impact on the current workforce. We have heard many times that people leave the sector because they have had enough of being looked down on, disrespected and treated like servants. We know public perception plays a vital role in sector development and that is why last year we started an annual Professional Care Workers' Day on the 4th of September. ... We want to use that day to appreciate and reward the workforce within the sector itself but most of all to educate the public about the highly skilled and amazing work that care workers do every day [...] We have recently been awarded a grant and a place on a programme run by Nesta and the Dunhill Medical Trust on the basis of professionalisation of care work as a social movement. They have recognised and agree that change has to include the sector and the wider society and that perception has a powerful impact on the care that people receive⁵⁶."

⁵⁴ APPG inquiry evidence provided by HFT – March 2019.

⁵⁵ APPG inquiry evidence provided by UKHCA – March 2019.

⁵⁶ APPG inquiry evidence provided by NACAS – March 2019

9. This section of evidence is vitally important to understand if the sector is to be meaningfully transformed for the better. In this context, we shall conclude it with a profound section of written evidence presented by Skills for Care, focusing on societal value:

“(Skills for Care) believes that the most important mechanism to achieving a national consensus is to change the narrative around social care and the key role it plays in our communities. The true value of social care needs to be recognised, valued and made central to any discussion about its future...

There is currently a lack of awareness and understanding of the contribution the social care sector makes in both the public and political conversation. Too often social care is referred to in relation to how it helps or hinders the health service achieve targets, the reality is that when it is at its best, social care transforms lives. Added to this is the lack of attention given to those working in social care services. This perception means that the general public know very little about social care and do not know who to turn to for information should they need it, which is often a point of crisis and distress. This also accentuates the mistaken belief that social care is a low pay, low skill sector. Sadly, it is the former, it is most definitely not the latter.

There is a widespread lack of understanding of the value of social care and a perception, perpetuated by the media, that it is both less important than other sectors and that standards are poor. This has a significant impact on the status and profile of the sector and careers in it, hampering employer’s efforts to recruit and retain a values-based workforce. Tackling this lack of parity of esteem must be a priority in order to secure the future of the workforce and improve quality of life for social care professionals. Social care is the bedrock of local communities, ensuring the wellbeing of millions of people and providing high quality services for our fellow citizens. Social care provision and those working to provide it means people who need to access services can live their lives to the fullest with genuine choice and control⁵⁷.”

⁵⁷ APPG Inquiry evidence provided by Skills for Care, Spring 2019.

5: The Evidence the Funding Question

1. Recent months have seen extensive news coverage and many dozens of political interventions on the subject of the adult social care funding crisis. There is copious evidence available of serious underfunding in the care sector, and some important reports informing the policy debate include the King's Fund/Nuffield Trust "*Home Truths*" report⁵⁸, the Institute for Fiscal Studies "*Adult social care funding: a local or national responsibility?*"⁵⁹ paper, and the House of Lords Select Committee on the Long-term Sustainability of the NHS report "*The Long-term Sustainability of the NHS and Adult Social Care*"⁶⁰.

2. Most recently, our parliamentary colleagues on the House of Lords Economic Affairs Committee produced "*Social Care Funding: Time to End a National Scandal*"⁶¹ which quite rightly generated vast coverage and debate. The report states:

3. "It (the government) should immediately invest £8 billion in adult social care, which is the amount the Health Foundation and the King's Fund estimate will be required to restore quality and access to 2009/10 levels, funded nationally and distributed according to a fair funding formula. It should then introduce free personal care over the next five years. Free personal care should be available universally by 2025/26.

4. And on the workforce specifically, the Committee notably stated:

"Increased funding for adult social care will allow for investment in the care workforce. Higher pay is required for care workers in publicly-funded care providers to allow those providers to compete with other local employers.

The care workforce needs a career structure which better reflects the skills required to be a good care worker and the social importance of the sector."

5. Four core observations from the Hayes/Johnson/Tarrant report to this inquiry around the centrality of the funding gap expand upon that vital interconnectivity between immediate funding and a new professional structure:

⁵⁸ https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf

⁵⁹ <https://www.ifs.org.uk/uploads/BN227.pdf>

⁶⁰ <https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf>

⁶¹ <https://www.parliament.uk/business/committees/committees-a-z/lords-select/economic-affairs-committee/inquiries/parliament-2017/social-care-funding-in-england/>

“> Training, occupational registration, concern for safeguarding, terms and conditions of work and funding are intricately connected and improvements must be made on all fronts to recognise and reward the skills and professionalism of care workers.

> Adequate funding for adult social care must be restored as a first step in recognising care work as a profession.

> Better learning outcomes for care workers and professionalisation of the sector cannot materialise in the absence of security of income, security of hours of work and protection of workers’ wellbeing and health.

> The extensive skills involved in care work and support make it wholly inappropriate for care workers’ wages to be pegged at or around the applicable statutory minimum wage rates. Recognition of the professionalism of care workers means wages must be put on a professional footing⁶².”

6. In the overall context of increased public funding for adult social care, it is worth looking at evidence of public attitudes towards greater investment.

7. The Health Foundation hosted in-depth research workshops in London, King’s Lynn and Leeds to examine the funding options most popular with the public:

“People weren’t expecting a gold-plated service but would like to see a basic level of care provided for everyone by the government, even though they realise that would be expensive. Most people supported a social care tax, and tended to favour a high level of government responsibility for paying for care costs ...⁶³.”

8. And the Nuffield Trust/King’s Fund analysis of the British Social Attitudes Survey⁶⁴ drew similar conclusions:

“... there is now growing evidence of public consensus to pay more for a system that works better, with one recent survey finding that **82% of the British public** support a 3.9% increase in social care spending, and another paper finding a high degree of consensus across the UK that everyone should pay in to a **collective, public fund** for social care [..]

⁶² Hayes/Johnson/Tarrant 2019

⁶³ <https://www.health.org.uk/newsletter-feature/understanding-public-perceptions-around-social-care-funding>

⁶⁴ https://www.nuffieldtrust.org.uk/research/public-satisfaction-with-the-nhs-and-social-care-in-2018?gclid=EAlaIqobChMI44yLobfm4wIVDbTtCh2nlg_XEAYASAAEgIip_D_BwE

After nine years of austerity, there is therefore a clear opportunity in the 2019 Spending Review and green paper for the government to take steps to secure a sustainable future for social care⁶⁵.”

9. Outside of the universally acknowledged need for urgent funding of adult social care, this Inquiry report does not seek to take a position on any particular funding formula or framework. However, we represent below evidence provided to the inquiry by various sectorial contributors:

10. [Dr Zimpel Leal](#) identified the impact of the funding void and the lack of organisation within the workforce itself to challenge endemic low pay:

“The present impact of chronic under-funding in social care and the professionalization of care services has contributed to the workforce crisis and made this job market unattractive and without a viable career path. Government funding for local authorities has been cut by half since 2010, leading to cuts to care budgets just as demand is rising. Compared to healthcare, social care has a profoundly poor funding system.

For example, NHS training spends 233 times more than social care. Skills for Care training budget is £21million whilst the Health Education England training budget is £4.7 billion. NHS workforce is 1.2 million (hospitals and community) and Social Care is just under 1.5 million. Securing an adequate workforce is one of the greatest challenges facing care, which relates to difficulties in recruiting and retaining an adequate workforce, fuelled by a perceived unattractiveness and low status of care work, alongside low pay levels and poor job security [...] The social care workforce currently has limited bargaining power to improve pay and conditions, consisting of no accredited professional recognition, low levels of union membership, widespread use of zero-hours contracts and a lack of enforcement of basic employment rights⁶⁶.”

11. Anchor Hanover, a provider with the highest proportion of good or outstanding care homes among all large providers, illustrated the coalface impact and care provision and highlighted possible savings for the NHS from better funding of adult social care:

“With an ageing society, more people face multiple health conditions and complex care needs. Social care, including specialist housing and care, provides a valuable preventative service, significantly reducing pressure on the NHS. However, lack of access to social care is causing many older people to

⁶⁵ <https://www.nuffieldtrust.org.uk/news-item/what-does-the-british-public-think-about-social-care>

⁶⁶ APPG inquiry evidence provided by Dr Zimpel Leal – March 2019.

[...] remain unnecessarily in hospital. This means investment in social care could generate significant savings, as numerous reports – most recently from Policy Exchange – have suggested.

[...] The funding situation is impacting on Anchor Hanover as we are experiencing customers delaying their decision to enter into care, resulting in customers joining us with more varied and complex needs. We are continually reviewing our learning offer to ensure that we develop our care colleagues to deal with increasingly frail customers and a broader range of health requirements.

As the funding landscape is becoming increasingly complicated, the role of the manager is changing with an increasing need to handle debt and have debt conversations with local authorities and families. At Anchor Hanover we have had to develop extra training to support managers with this changing financial landscape⁶⁷.”

12. Be Caring noted that they are presently testing greater NHS integration models to improve service:

“Given it is virtually impossible to treat carers right in terms of fair pay for a fair day’s work, it is also virtually impossible for us to invest in the career pathway which we’ve designed. We are committed to testing this on a small scale in Leeds and Newcastle in partnership with our NHS colleagues, but it isn’t something we can roll out on a national scale purely because of the lack of resources due to poor commissioning.”

13. Care England implied the benefits of health parity and integration:

“A new health and social care workforce must be considered as equals. It makes little sense to treat each part differently, particularly in terms of pay and conditions. Care England would welcome a more even-handed approach and the NHS Pay Award should be extended to the social care workforce. Bringing pay levels up to the minimum guarantee for NHS auxiliary staff and cleaners (set at £18,000 pa) is crucial to address the poor standing care workers currently experience. Pay awards should be channelled through commissioners. Such a move would cost approximately £1bn over the 3-year NHS Pay Award period to increase the pay of the 400,000-care staff assumed to working at the National Minimum Wage rate⁶⁸.”

⁶⁷ APPG inquiry evidence provided by Anchor Hanover – May 2019.

⁶⁸ APPG inquiry evidence provided by Care England – March 2019.

14. HC One offered a structural assessment of the present crisis⁶⁹:

“There are two fundamental problems with the current system: a) State financial support for individuals in need is restricted to those holding personal assets of less than £23,500. The increase in property equity in recent decades alone means that most service users are supported from their own means. Various attempts to increase this threshold, most recently through the Dilnot Commission and the Conservative General Election manifesto in 2017, have not been proceeded with, due to perceived resistance by taxpayers and those individuals standing to inherit assets. b)

Whilst NHS funding has been ‘protected’ through the period of financial austerity over the last decade, local authority funding has been amongst the most restricted. Despite short term fixes, like specific grants and a Council Tax supplement, all time limited, the quantum of resources available to commissioners has decreased substantially relative to the ever-rising level of demand.

Commissioners in the NHS have also been restricted, claiming that resources are insufficient to meet demand in social care and elsewhere in the NHS.

In the residential and nursing home sector, all this has led to a two-tier fee structure, with private payers paying the realistic cost of care and public sector commissioners only being able to support far lower rates. For a company like HC-One, where up to four in every five residents are supported at public expense, this is unsustainable financially, and perceived as unfair by private payers.”

15. Furthermore, HC One founder Dr Chair Patel submitted a graphic comparison to illustrate funding constraints:

“The average fees we are paid to deliver services to a very vulnerable and largely state-funded Resident group break down as follows:

- **Residential Dementia** – £80.14 per Resident per night
- **Nursing** – £102.14 per Resident per night (including the Funded Nursing Care contribution)
- **Nursing Dementia** – £106.42 per Resident per night (including the Funded Nursing Care contribution)

For £80 to £100 per night (or around £4 per hour) we are expected to provide high-quality 24-hour care, accommodation, all meals, and social activities to some of society’s most vulnerable older ... people. In the area with the lowest local authority fee rate, we are expected to deliver this service for just £60 per Resident per night. More than 30 local authorities that we work with across the [...]

⁶⁹ APPG inquiry evidence provided by HC One – March 2019.

north east and north west pay less than £70 per Resident per night. This is the stark reality of the economics of delivering complex personal care to Residents who meet the high and critical needs assessments of local authorities.

If we consider this point further, and compare the fees we receive to that of a budget hotel – where no meals, care or activities are provided – we find the following breakdown in some of the major cities and towns that we operate in.

| City | Local Authority Fee/week | Budget Hotel/week* |
|---------------|---------------------------------|---------------------------|
| Liverpool | £426.01 | £550 |
| Milton Keynes | £447.10 | £456 |
| Manchester | £451.28 | £481 |
| Coventry | £460.38 | £496 |

*data accurate as of 16th May 2019. Pricing taken from Travelodge.co.uk and based on a seven-night city centre stay 16th June to 23rd June 2019.

There is clearly a question for policy makers, government and society about whether we are comfortable with the idea that it is more expensive to stay in a budget hotel than it is to receive 24-hour care. The level of Local Authority and Central Government funding for social care is insufficient to meet current need, let alone an aging population that enters care services in a frailer condition, and who live for longer with a higher level of acuity. Even more concerning is the current funding landscape leaves no room for providers to invest in developing new services for state funded Residents, or to replace the aging care housing stock – some 85% of care homes are more than 40 years old, according to Knight Frank research⁷⁰.”

16. HFT offered concerns for the immediate future of the sector and in particular, investment in career development:

“... underfunding has meant that providers have had to do more with less, and they have taken various measures to alleviate funding pressures that result from decreasing funding pots. Our Sector Pulse Check found that 92% of providers have taken measures internally to alleviate financial pressures, up from 75% in our 2017/18 survey [...]

⁷⁰ APPG inquiry evidence provided by Dr Chai Patel – June 2019.

Looking ahead, 62% list further efficiency savings as their first priority, should further cost-cutting measures be needed to remain financially viable. The result of this is that many providers will be reducing the amount they are willing or able to spend on learning and development. With providers only meeting their minimum mandatory obligations on staff training, this will cause moves to professionalise the social care workforce to stagnate⁷¹.”

17. These reservations were echoed by MHA:

“... care providers are receiving totally inadequate levels of funding from local authorities. In many of the 128 areas where our care homes operate, local authority fees are lower than true cost of care – this is a sector-wide issue. This adds a burden on care home budgets and hinders the ability to invest in staff and their development⁷².”

18. Manor Community presented a sobering statement:

“Unfortunately, there is a tipping point and we are pretty much there now where the level of funding needs to dramatically increase and the government must recognise the increase on pressures in social care and that social care providers are now providing services that were previously funded (at a much higher cost) by the NHS⁷³.”

19. And finally, the LGA noted the urgency of the funding issue:

“Adult social care faces a funding gap of £3.56 billion by 2024/25ⁱⁱ. This includes an immediate and annually recurring market provider gap of £1.44 billion – the difference between the estimated costs of delivering social care and what councils pay.

The 2018 Budget announced additional funding for social care: £240 million in 2018/19, £240 million in 2019/20 and a further £420 million in 2019/20 for adult and children’s social care combinedⁱⁱⁱ. This was welcome but it is another case of incremental, piecemeal measures. The money does not support long-term planning, and significant pressures remain, for example, increases to the National Living Wage [...] The Government must inject urgent additional funding to secure the sustainability of our social care system. Without such funding, we risk implementing funding reforms onto a system that is further destabilised by financial pressures. Short-term pressures cannot be managed through the social care precept⁷⁴.”

⁷¹ APPG inquiry evidence provided by HFT – March 2019.

⁷² APPG inquiry evidence provided by MHA – April 2019.

⁷³ APPG inquiry evidence provided by Manor Community – March 2019.

⁷⁴ APPG inquiry evidence provided by LGA – April 2019.

SECTION 2 - Options for Solution and Remedy

The Professionalisation Agenda: **Elevation**

1. As set out and established in Section One (Item 4/Page 39) the issue of poor perception and the low esteem of the social care sector is of fundamental importance to all sectorial stake holders. Source after source impressed upon this inquiry the impact and consequences of a demoralised workforce, and a structural atmosphere that allows low pay to become endemic, bad working conditions to become commonplace, and continuing under-investment to become the *status quo*.
2. In light of all evidence presented to us in this context, it is clear that the identity and status of the social care workforce must be transformed as a matter of some urgency, as a first stage of professionalisation.
3. Repeated evidence has presented a coherent and compelling argument for the existence of a negative policy correlation between a degraded perception of the sector in the public psyche, and a lack of sufficient or adequate funding for the vital work that service users must access. Poor perception of the sector in the public domain has been identified as a factor in depleted political traction.
4. A multitude of evidence sources identified the pressing need for parity of esteem between the social care case workforce and equivalent colleagues employed within the NHS.
5. Notwithstanding the current, universal political acceptance and acknowledgement of a social care funding crisis, when viewed via the prism of potential economic turbulence (as a consequence of the UK withdrawal from the European Union) and general, pressurised governmental spending considerations, the serious funding settlement required by this sector will need to do battle with a wide range of public service funding demands, in order to reach the levels of sustainability and workforce professionalisation that all stake holders now identify as socially and economically imperative.
6. The immediate challenge is for all sectorial stake holders, and indeed policy makers and politicians: the multi-faceted, complex, outstanding, increasingly highly skilled/medicalised work carried out by the social care workforce must be elevated to NHS parity.
7. To re-emphasis, the elevation of sector and workforce status will require an immediate injection of funding. The Hayes/Johnson/Tarrant report is crystal clear on this point:

“The objective of professionalisation is not a panacea for concerns about poor-quality jobs and service-user safety. Greater emphasis on training and skill cannot reverse the damage done to care quality by inadequate funding and low wages. A policy-shift to professionalise the care workforce cannot be successful while care workers’ hours of work remain chronically insecure and care homes are understaffed. Without dedicated attention to improving terms and conditions of work, appeals for professional conduct will fail to achieve optimal improvements in service-user safety.

Care workers and their employers face daily challenges associated with underfunding, high labour turnover, low wages, insecurity of working hours, labour shortages, complex care packages and intense cost competition. This reality has deep implications for the possibilities and practicalities of professionalisation⁷⁵.”

8. As illustrated by the Hayes/Johnson/Tarrant report, the four nations presently take distinctive approaches to the organisation and regulation of social care provision. This inquiry recognises those different approaches and the varied stages of professionalisation that currently exist between the four nations, and we seek to offer country specific recommendations thus. But this inquiry also notes that all four nations face very similar challenges, and therefore promotes, wherever possible, shared or corresponding initiatives of reform.

9. This inquiry recommends an urgent national programme – concurrent with prerequisite government sponsorship – to plan and establish a workforce strategy for England - up to the establishment of a new, identifiable national care service body, with a bespoke system of portable identity and livery; implying equal status with NHS staff. This would be a new institution offering governance, accreditation and leadership across the sector.

10. During the course of this inquiry, various suggestions have been submitted as to what form such a national care service body should take. By way of illustration, HC One floated the notion of the formation of a new Royal College to encompass the discipline(s) and sectoral enormity of social care. Others, such as Professor Jill Manthorpe recommended that body should be part of a new national integrated (with NHS) institution or college, to act as a body of professional accreditation for the social care workforce.

⁷⁵ Hayes / Johnson / Tarrant (2019)

11. Given well-founded expectations and projections that serious investment in and workforce professionalisation of the social care sector (especially in the area of upskilling) – when combined with deeper integration with NHS services - will actively and significantly reduce costs to the NHS and in-hospital care provision, this inquiry believes that the establishment of some form of new sectoral body to professionalise and greater integrate the sectors would be the strongest option.

12. This inquiry has heard that no other new or amalgamated identity would be as effective, dynamic and potent in transforming the poor perception of the social care sector and its workforce than identification with/equivalence to the NHS.

13. We recommend the ultimate creation of a new national care body for England - as sectoral institution - working towards the following objectives:

- I. To provide national identity for social care
- II. To offer formal recognition of existing skill levels and diversity of extremely medicalised tasks routinely undertaken by the current workforce.
- III. To further professionalise the workforce
- IV. To design a new standardised training and career development framework and scaffolding prioritising upskilling.
- V. To consolidate into one single body the funding allocation for workforce training in England.
- VI. To promote/oversee far greater integration with NHS services, including a greater linking of information flow between social care and the NHS, and better use of technology in home care and care homes to assess and monitor the needs of service users, potentially offering significant savings to NHS clinical budgets.

14. The formation of a governing national care body *Council for England*, comprised of service providers, commissioners, trade unions and service user and carer groups.

A national network body of this type should seek to establish and implement:

- An effective model of registration for England (in line with Wales, Scotland and Northern Ireland) – with 24-36 months as a reasonable and practical timetable for mandatory registration to be completed.
- A defined qualification package and scaffolding, starting from a reformed, compulsory and accredited Care Certificate with specific balancing of residential and domiciliary tasking - as an engaging framework of multi-faceted training leading to a matrix of CDP badging/digital

[...] credentials for the employee, and transferable point of recruitment confidence/integrity for the provider – reducing the chronic waste of resources in training repetition and excessive emphasis on expensive, continuously duplicated induction programmes.

- This qualification package would formally recognise pre-existing, medicalised, complex care skills that too often sit unacknowledged, unvalued and unrewarded.
- The framework and apparatus for CDP badging of digital credentials; traffic light coded to indicate progression of attainment.
- Clearly defined job titles consolidated by CDP badging attainment with a corresponding pay banding stratum similar to those used in NHS services.
- In advance of the establishment of a new training and qualifications framework with a digital badging element, a national care body Council should work in collaboration with the Care Quality Commission to define:
 - The terms of/realistic timetables for the necessary passages of equation, equalisation and/or equivalence for existing qualification holders – be those qualifications vocational or academic.
 - The precise form of refresher certificates required for existing, longer term social care sector workers.
 - A fully agreed matrix of recognised compatibility standards between England, Wales, Scotland and Northern Ireland.

15. Such is the extent of sectorial complexity, diversity and fragmentation evident in the current picture, the formation of a national care body *Council for England* would consolidate regional workforces, allow for devolved/regionalised reflections of demographic need and operate regional skills shortage registers, up to and including innovative, digitised models of local monitoring and provision.

16. In the immediate term, as part of the national programme, this inquiry recommends a collaborative exploration between existing sectoral stakeholders in England, and [Social Care Wales](#), the [Scottish Social Services Council](#), the [Northern Ireland Social Care Council](#) and the [Nursing and Midwifery Council](#), to examine the desirability and feasibility of new, equivalent NHS signified sectoral bodies operating within the four nations to offer corresponding regulation, standards and fluid, equative qualifications and skills structures.

17. Any road-map seeking to explore and establish a new national care identity comprised of those 3 devolved regulatory bodies and a newly formed national care body Council for England should include components relating to the automatic necessity to expand the role of the respective regulatory bodies (CQC, [Care and Social Services Inspectorate Wales](#), the [Care Inspectorate / Healthcare Improvement Scotland](#), and the [Regulation and Quality Improvement Authority](#) in Northern Ireland.)

18. This Inquiry recommends that all sectoral stake holders and indeed policy makers and politicians now commit to the elevation of the multi-faceted, complex, increasingly highly skilled/medicalised social care workforce up to NHS parity.

The Professionalisation Agenda: **Registration**

1. A high and increasing number of domiciliary and residential social care workers have registered or are in the process of registration in Scotland (Scottish Social Services Council), Wales (Social Care Wales) and Northern Ireland (Northern Ireland Social Care Council).

2. The current lack of an equivalent registration scheme in England was generally regarded as anomalous by evidence providers to this inquiry, and even by some as a deviation from what could now be regarded as standard accepted good practice.

3. In light of this observation, it should be noted that Hayes/Johnson/Tarrant offered a less emphatic, more caveated assessment:

“The viability and usefulness of care worker registration is contested. Some employers’ and union representatives are concerned that the need to register as a care worker may act as a disincentive for potential recruits to the care sector, making it harder to recruit care workers. In Wales, a related concern was that, put off by the need to register and meet new training and skills requirements, some existing care workers may leave their jobs, opting to join the unregistered PA workforce⁷⁶. “

4. On the empirical basis of this inquiry, we would recommend the immediate establishment of a register of social care workers – to include domiciliary care workers, residential care home workers, day care workers, and supported living workers – to cover England.

5. The unanimous view of evidence providers to this inquiry recorded broad confidence that the benefits of professional recognition and access to a unified, robust baseline framework of training – particularly under the auspices of an elevating national body with NHS identity – would far outweigh concerns and reservations centred around recruitment disincentivisation.

6. The argument that elevation itself (via a new, high-visibility/familiarity/esteemed sectorial body acting as a transmission belt to registration) and the presentation of a professional employment proposition and opportunity to potential workers, could prove highly potent and effective in recruiting new workers to the sector, had consistent resonance with providers and commissioners. The totality of reform (as opposed to registration in isolation) was perceived as key.

⁷⁶ Hayes / Johnson / Tarrant (2019)

7. The inquiry generally recorded 24-36 months as a reasonable and practical timetable for mandatory registration to be completed, and for the drafting and consideration of the legislation.

8. The inquiry would recommend that the precise terms of registration be determined by the national programme and ultimately by the national body that it might produce, but that a registration scheme open to employees either holding relevant qualifications or committing to work towards the completion of such qualifications should be looked upon favourably.

9. Registration should work hand in glove with participation in a reformed, compulsory and accredited Care Certificate, as an engaging framework of multi-faceted training leading to a matrix of CDP badging/digital credentials for the employee, and recruitment confidence/integrity for the provider – reducing the chronic waste of resources in training repetition and excessive emphasis on expensive, continuously duplicated induction programmes. This professional frustration has also been highlighted by care workers:

“there was no external validation of the [Care] Certificate. This meant that, while the participants’ care homes used the certificate to design its own induction programme, it could not be sure that care workers who had achieved the Certificate elsewhere had been adequately trained. They would therefore make them repeat the induction programme, and some employees would note differences between the difficulty of achieving the Certificate at their current care home compared to other homes outside of the organisation⁷⁷”

10. In relation to registration, the national programme scheme should discuss and establish:

- A strategy for registration to act as an incentive and importantly, a recruitment catalyst.
- The concept for registration to act as a foundation process for data collection, in order that specific skills availability or shortage be assessed, monitored and disseminated more efficiently.
- The practical imperatives and flexibilities of a reformed Care Certificate, taking into account both the universalities and distinctions between residential, domiciliary and specialist care, and the evolving skills matrix identified by Hayes / Johnson / Tarrant (Page 18).

⁷⁷ Evidence presented by care workers at a private meeting with members of the Economic Affairs Committee, House of Lords (fn3) Appendix 4.

The Professionalisation Agenda: **Standardisation**

1. Whilst there are a many examples of good practice and innovation in training across the social care sector, the spread of frustrations and shortcomings relating to the overall present, highly fragmented training system reported to this inquiry (and documented in Section One/Item 2/Page... of this report) too often highlight a system replete with incoherence, repetition, waste and needless expense.

2. It should be stated, acknowledged and indeed celebrated that across the spectrum of providers – from large scale multi-residential care home providers to small, localised domiciliary care providing social enterprises (and everything in between) – various examples of brilliant, pioneering good - practice training models exist and should be studied and shared.

3. However, in relation to publicly funded social care provision, the training issue is a systemic one. The problems are of funding, quality, accessibility, availability, flexibility, portability, accreditation and regulation.

4. Hayes/Johnson/Tarrant reported: *“a lack of regulatory clarity, lack of funding and a lack of enforcement in relation to training standards, especially in England where there continue to be few formal mechanisms in place to professionalise the workforce through upskilling or registration*

And further noted:

“The fragmentation of the care industry (with approximately 25,000 registered providers in over 50,000 locations) presents a difficulty for enforcing higher training and qualification standards within regulatory structures that enable considerable employer discretion⁷⁸.”

5. In relation to practicality and the context of sustainability within a low paying sector, academic study has noted: *“In England, for example, local authority funding for care does not incorporate a payment to care providers for time spent in training⁷⁹”*

6. This inquiry received compelling evidence of the need for well-funded, standardised training and accreditation from all five sectoral fields of evidence provision. We have listened carefully to ways in which the educational and development requirements of the social sector must evolve.

⁷⁸ Hayes / Johnson / Tarrant (2019)

⁷⁹ Atkinson, C, Crozier, S and Lucas, R (fn52).

7. Of paramount importance to the professionalisation agenda is the establishment and implementation of a clear, universal training framework that offers assurance and verified passportable qualifications to providers, and an incentivising, galvanising career pathway to employees.

8. On the runway from registration and the robust, baseline framework of a reformed, accredited and compulsory Care Certificate, this inquiry would advocate that a national programme is built upon research and presents an inter-connected, versatile framework of qualifications. This framework should include an innovative format of skills recognition such as digital credentialing.

9. City and Guilds has developed a universal digital skills recognition framework for a competing sector⁸⁰ (Hospitality) which could well offer good transferability to the social care sector; an open system of CDP badging in correlation to new skills that are acquired. Once achieved and accredited, digital skills “badges” can be physically worn by social care workers, and displayed on CV’s, recruitment profiles such as LinkedIn, and be made instantaneously available to employers (directly or via regional skills shortage registers) to ensure recruitment with day one recruitment integrity and confidence.

10. Outside of the general desire for the establishment of a new national sectoral body (as outlined earlier in this report), this inquiry has heard no views of what precise form a standardised training provider/regulator should take and the legal framework.

11. However – in addressing the aspiration for a new universal training identity and in specific relation to England, the employer’s body Care England outlined the possibility that:

“... the professional bodies of Health Education England, Skills for Health and Skills for Care should merge, pooling significant resources under the auspice of an integrated health and social care approach - whilst reducing significant transactional costs and artificial boundaries within a (new) joined up system. Potential savings could be achieved through headcount and more efficient ways of working⁸¹.”

⁸⁰ <https://www.cityandguilds.com/what-we-offer/global-certification>

⁸¹ APPG inquiry evidence provided by Care England – March 2019.

12. The inquiry notes that reform of this magnitude would have serious ramifications for the present system of the funding of training. In a merged scenario, the new care body *Council for England* may well wish to examine carefully the possibility/desirability of multiple training pots being pooled and allocated directly, as opposed to the present system of multiple bodies funding training modules.

13. We would note further that if a high level of standardisation is to be achieved, then a concentration of expertise along the lines alluded to by Care England - in the form of the merger of various training bodies into one complete body – should be looked upon favourably and explored energetically as a serious opportunity for the sector as a whole.

14. A consolidated body could offer the vital, universal scaffolding for training that residential and domiciliary care providers could then populate and embrace. An overarching training body and universal scaffolding could quickly establish national communities of best practice, new innovation funds prioritising the type of upskilling so desperately required in the sector and even develop “Catalyst Provider” funding for pioneering/best practice in-house interpretations of the universal scaffolding and traffic-lighted CDP badging system.

15. The inquiry would **restate** that this level of potential reform would be best explored, assessed and evaluated by a national programme scheme to develop and implement the composition of a new national care body and its possible extensions, to offer identity, status and accountability.

16. It should also be the responsibility of this national programme to collaboratively establish the precise extent of integration between a new NHS accreditation body and each of the devolved nations.

17. In advance of the establishment of a new training and qualifications framework with a digital badging element, the national programme should seek to define:

- The terms of/realistic timetables for the necessary passages of equation, equalisation and/or equivalence for existing qualification holders – be those qualifications vocational or academic.
- The form of refresher certificates required for longer term social care sector workers and returners to the sector.
- A full matrix of recognised compatibility standards between England, Wales, Scotland and Northern Ireland.

18. Acknowledging the serious levels of investment reform of this magnitude would require, the inquiry would recommend that the preparatory national programme scheme of work include direct collaboration with bodies such as the [Improvement Analytics Unit](#) (a partnership between the Health Foundation and NHS England) which has undertaken research into how the imperative of upskilling, and a professionalised and well-trained social care workforce may be able to make significant savings for the NHS and in particular hospital care.

19. This relatively new exploration has been highlighted by Dr Jennifer Dixon, Chief Executive of the Health Foundation:

“Recent analysis ... explored the types of clinical conditions older people are admitted for (such as urinary tract infections, respiratory infections, fractures and sprains), and found that about four in 10 admissions are potentially avoidable with more timely and effective care.

[...] The IAU analysed four such interventions where enhanced support initiatives associated with the NHS’ new care models programme had been implemented – in Rushcliffe, Sutton, Nottingham and Wakefield. Using innovative analytical methods, they found promising early results: decreases in emergency admissions of up to 23 per cent, in avoidable emergency admissions of up to 27 per cent, and in accident and emergency attendances of up to 29 per cent [...]

... the IAU’s analysis found that use of NHS emergency care is higher from people in residential care homes than from nursing homes. This is intriguing and deserves further investigation.

When reading a recent online piece on social care I was drawn to the observations of a reader who posted about the care of their father who lived his last few years in a care home:

“Neither the managers or the carers were medically trained so at the slightest sign of ill health an ambulance was called. We spent many an hour sitting in casualty because the care home staff were too frightened and reluctant to take on the responsibility of assessing his needs.”

.... “This fear by staff in residential care homes may be due to no experienced support due to staff shortages, a lack of skills in the face of complex needs, staff churn, poor staff development, all compounded by worries about regulation or potential litigation. This is a complex web of issues, which again needs a lot of attention: principally getting in the right numbers of staff, keeping them and skilling them up.⁸²”

⁸² <https://www.hsj.co.uk/emergency-care/reducing-emergency-admissions-from-care-homes-a-measure-of-success-for-the-nhs-long-term-plan/7025675.article>

Training and Development: **Good Practice Examples**

The Good Care Group

<https://www.thegoodcaregroup.com/news/training-good-care-group/>

Be Caring

<https://www.becaring.org.uk/our-core-values/>

Anchor Hanover

<https://www.anchor.org.uk/careers/why-join-us/our-training-and-development>

HC One

<https://recruitment.hc-one.co.uk/learning---development.html>
