Homecare Association

Workforce: recruitment, training and retention in health and social care

Submission to the Health and Social Care Committee Inquiry

About us

The Homecare Association is a member-led professional association, with over 2,300 homecare provider members across the UK. Our members encompass the diversity of providers in the market: from small to large; predominantly state-funded to predominantly private-pay funded; generalist to specialist; and from start-ups to mature businesses. Our purpose is to enable a strong, sustainable, innovative and person-led homecare sector to flourish, representing and supporting members so that people can live well and independently at home. As such, our response to this consultation will focus on the social care sector, with a specific interest in care delivered in people's own homes.

Executive Summary

Unmet need for homecare is high and rising, with potentially dire consequences for older and disabled people and their families, wider communities and the NHS. This is driven in large part by inadequate workforce capacity. In turn, this is a result of years of under-investment by central government, which has led to poor practices in commissioning and purchasing of homecare by councils and poor pay, terms and conditions for careworkers.

Our members report that recruitment and retention of careworkers is exceptionally challenging. In November 2021, 85% of respondents in a survey of homecare providers (n=339) said that recruitment is the hardest it has ever been. Regulations enforcing vaccination as a condition of deployment will make this situation even harder. Current data on vaccine uptake suggest we are set to lose up to 20% of the

homecare workforce after 1 April 2022. At the same time, careworkers are leaving in droves for better paid jobs in retail and hospitality where vaccination is not required. Neither central nor local government appear to have a contingency plan for how to provide care for those who lose access to it.

We call on the government to:

- Fund social care adequately so that homecare workers are paid fairly for the skilled roles they perform, and at least on a par with equivalent public sector roles. We recommend NHS Band 3 Health Care Assistant pay of £11.14 per hour.
- End the practice of councils and the NHS of purchasing homecare "by-the-minute", move to payment in advance on planned care and focus on achieving the outcomes people want.
- Support development of an expert-led workforce strategy for social care and a 10-year workforce plan, aligned with the NHS People Plan.
- Create a professional register for careworkers in England, covering all paid social care workers in both regulated and unregulated care services. Registration of careworkers needs to be adequately funded and carefully implemented.

While there are elements of the Government's announced reforms (including those in the *People at the Heart of Care White* Paper) that are to be welcomed, we are concerned that proposals are not backed by the level of funding that would be required to substantially improve pay or terms and conditions in the sector. Whilst pay and terms and conditions are not the sole factor affecting recruitment and retention in social care they remain fundamental and must be addressed to relieve current pressures and ensure the Government's vision for future social care can be delivered.

70% of homecare is commissioned by the public sector (LaingBuisson 2020). Our 2021 Freedom of Information research, outlined in our Homecare Deficit Report suggests that the average Councils and CCGs in England were paying per hour of homecare in April 2021 was £18.66. We believe that to cover direct careworker costs at the national legal minimum wage of £8.91 per hour plus on-costs (NI, pension, sick pay, holiday pay, travel time and mileage) and other operating costs (e.g., management, supervision, training, recruitment, Insurance, regulatory fees, governance, rent, rates, utilities etc) requires a minimum of £21.43 per hour. Care is not a minimum wage job and competition in the labour market means that many employers are having to offer higher wages to attract any applicants at all.

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To offer a fair and competitive wage and one that is equivalent to a similar skill level job in the public sector, we suggest that care workers should be paid the equivalent of a Health Care Assistant Band 3 in the NHS at £11.14 per hour – which would mean the provider would need £26.31 per hour to cover all costs (in the 2021/22 financial year). £3.6 billion (over three years – so £1.2 billion a year) has been set aside to meet the care cost cap changes and fair cost of care reforms. To cover the gap in what local authorities are paying and our **minimum** price for care would cost £471.5 million alone – almost half of the total and that is not accounting for the costs of residential care, or other parts of the sector or the costs associated with the care cost cap. This is clearly not enough funding. To increase careworker wages to the equivalent of an NHS Band 3 Health Care Assistant, we believe £1.3 billion a year would be required for the homecare sector alone – i.e. £3.9 billion over three years.

The government has provided emergency funding in three tranches of the Workforce Retention and Recruitment Fund. Whilst all funding is gratefully received, short-term grants are complex and time-consuming to administer and do not allow long term planning in a sustainable manner. Dissemination of the monies by local authorities is highly variable, with some choosing to exclude providers that do not contract with them, typically providers serving the private pay market.

Additionally, the Government's approach to workforce planning (indicated in *People at the Heart of Care*) appears to rely on local authority and NHS commissioners working together in local areas to develop a vision for the shape of the local market based on residents needs and preferences and then to develop a local workforce plan based upon this. This gives rise to two concerns – firstly, that commissioners are a step removed from frontline delivery and the recruitment, retention and other workforce issues that the sector is facing. How will providers be adequately included in these discussions? Secondly, some of the relevant policy interventions to address identified issues (notably funding but also training, immigration policy and other factors) will be national. How will information on local markets and workforce be collected in a way that is consistent enough that a meaningful national picture can be put together for national policymakers to act? We believe that there should be an expert-led national workforce strategy for social care, that sits alongside the NHS People Plan (if this is informed by local data, then that data must be consistently collected).

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Changes are urgently required to meet people's needs for care and support and turn around the staffing shortages the sector face. However, the changes introduced must grapple with the long-standing, systemic issues to have a real impact.

Current situation

There are currently exceptional pressures facing the homecare workforce, and these have been increasing over the previous six months. These are having a significant impact on the availability of care for those who need support, with many people not receiving the support that they need.

In November 2021 a survey of our members indicated that 85% of homecare providers were saying that recruitment is the hardest it has ever been. 75% of homecare providers said more careworkers were leaving their jobs than before the pandemic.

93% of providers stated that demand for their services had increased or significantly increased over the previous two months. Against a picture of increased demand, this has significant implications for the ability of the sector to meet that demand.

The consequence of these pressures can be seen in the fact that almost half of providers said they were unable to take on new work; 38% were handing back some contracts to the NHS or local authorities and 74% were concerned or very concerned about the financial viability of their organisation in the long-term.

As the ADASS Snap survey shows, 1.5 million hours of commissioned homecare could not be provided between August and October due to lack of staff and the NHS Confederation has raised concerns about the need to resource social care services to reduce pressure on hospitals and other parts of the NHS (with delays in hospital discharges a significant concern). Over New Year 2021/22, half of Directors of Adult Social Services responding to an ADASS survey said that they were prioritising (i.e. rationing) social care services due to exceptional pressures and staff shortages – this could include prioritising life sustaining care, such as helping someone to eat, over supporting someone to get out of bed.

The Nuffield Trust estimated that the homecare sector could have already lost almost 30,000 staff between April and October 2021. In the immediate future, the sector faces worsening staffing pressures as some loss of (often experienced) staff is an inevitable consequence of the Government's Vaccination as a Condition of

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Deployment policy, which will come into force in April 2022. At the time of writing (COVID-19 weekly announced vaccinations at 6 January 2022) 80.2% of homecare staff have received two doses of the vaccination but in some regions little more than half the homecare workforce meet the vaccination requirement to date. We have seen no evidence of a credible contingency plan for how care will be provided to those who need support if the workforce is further reduced.

While the Government have announced temporary access to the Health and Social Care Visa it is unclear how successful this will be, or whether the costs associated with it are likely to be financially viable in the medium term.

Against this backdrop there is an urgent need for policy interventions to recruit and retain the social care workforce that the country needs.

In order to provide focused answers, the rest of this submission is organised by the questions specified in the Committee's Call for Evidence.

What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?

Short term steps

This year, the following policy interventions are needed to support the social care workforce:

- **Competitive pay -** social care must be funded adequately so that homecare providers can afford to pay careworkers fairly for the skilled roles they perform, and at least on a par with equivalent public sector roles. Care work is not minimum wage work, and in the current labour market, providers in many parts of the country will find it hard to recruit if they offer the minimum wage.

  In our November survey 55% of providers said that pay and terms and conditions was the most significant issue affecting recruitment and retention. The temporary one-off funding supplied by the Government in the Workforce Recruitment and Retention Fund does not allow providers to sustainably increase wages – this requires a long-term financial commitment. There is no

certainty over what rates local authorities will pay in the new financial year and if these would sustain a wage increase.

70% of homecare services are commissioned by the public sector. Commissioning fees are extremely low in many parts of the country. This means that providers do not have the profit margins available to sustainably increase careworkers pay without securing more income – which means additional funding is needed from the Government.

Our 2021 Freedom of Information research, outlined in our Homecare Deficit Report suggests that the average Councils and CCGs in England were paying per hour of homecare in April 2021 was £18.66. We believe that to cover direct careworker costs at the national legal minimum wage of £8.91 per hour plus on-costs (NI, pension, sick pay, holiday pay, travel time and mileage) and other operating costs (e.g., management, supervision, training, recruitment, Insurance, regulatory fees, governance, rent, rates, utilities etc) requires a minimum of £21.43 per hour

To offer a competitive wage and one that is equivalent to a similar skill level job in the public sector, we would suggest that careworkers should be paid the equivalent of a Health Care Assistant Band 3 in the NHS at £11.14 per hour – which would mean the provider would need £26.31 per hour (in the 2021/22 financial year). This would improve the chances of homecare providers being able to recruit when competing with other service sectors, such as retail, hospitality and so on.

£3.6 billion (over three years – so £1.2 billion a year) has been set aside to meet the care cost cap changes and fair cost of care reforms. To cover the gap in what local authorities are paying and our **minimum** price for care would cost £471.5 million alone – almost half of the total and that is not accounting for the costs of residential care (noting that the Competition and Markets Authority estimated in 2017 that £1 billion extra was required for local authorities to pay the full cost of care in the care home market), or other parts of the sector or the costs associated with the care cost cap. This is clearly not enough funding.

To increase careworker wages to the equivalent of an NHS Band 3 Health Care Assistant (£11.14 per hour, a more competitive and fair offering given the skills required), we believe £1.3 billion a year more than is currently paid would be required for the homecare sector alone – i.e. £3.9 billion over three years.

- **Targeted support with vaccine hesitancy –** the Government should provide proactive and targeted funding and support for the providers and regions most affected by vaccine hesitancy in the workforce, as well as resources to support the whole sector, to encourage vaccine uptake.

  One-to-one discussions about vaccinations for hesitant staff with people with the relevant clinical skills would be particularly valuable, and has been found to be effective within the NHS. It should also be accessible to care staff. This is urgent. The current deadline for an unvaccinated careworker to have the first dose of the vaccine if they are to be fully vaccinated by 1 April is 3 February 2022.

  Providers who stand to lose a significant proportion of their workforce could also face significant recruitment and training costs, as well as needing to invest time and seek additional legal or HR advice to appropriately manage the dismissal of staff who do not meet the vaccination requirement. Grant funding should be available to support providers who lose a significant proportion of their workforce in order to reduce the likelihood that staff loss will cause financial issues so substantial that providers will cease operating. (During the consultation period for Vaccination as a Condition of Deployment we surveyed 150 providers across England and 24% thought that it was certain or likely that they would have to close the business if the policy was introduced. The severity of the impact of this policy for some providers should not be underestimated).

- **Offset overseas recruitment costs –** the costs of sponsoring an overseas worker can run up to £7,000 plus a significant amount of administration (potentially thousands more in staff time). While the Health and Social Care Visa has reduced costs in relation to some factors (such as the Immigration Health Surcharge); there remain additional costs that will present a barrier to many providers.

  Additionally, the salary requirements for careworkers visas (with the shortage occupation list status, salary must currently be a minimum of £20,480) are often higher than the going rate (Skills for Care estimate that the mean FTE annual pay for 2020/21 for independent sector careworkers was £17,900).

  This means that if providers cannot recruit within the UK and need to recruit overseas, costs may increase (both due to sponsorship fees and admin costs

and also due to salary costs). As outlined above, the majority of care is commissioned by the public sector and margins are very tight – so if costs increase due to needing to recruit internationally, funding will also need to increase to cover these costs. If the only way to recruit enough staff is to look internationally and the costs are not met then this will increase the risk that providers will face issues with the financial viability of their businesses.

The Government should consider increased fee rates for providers or grant funding to support the recruitment of careworkers that the country desperately needs.

- **Emergency funding needs to reach front-line care providers –** funding such as the Workforce Recruitment and Retention Fund is welcome, but it remains at the discretion of local authorities how to use this funding and we believe that in some parts of the country it is not reaching front-line care providers in the independent sector (or their staff) quickly, or (in some cases) at all. Dissemination of the monies by local authorities is highly variable, with some choosing to exclude providers that do not contract with them, typically providers serving the private pay market. The guidance in relation to the Fund was published on 3 November. We asked our members in a webinar on 8 December 2021 how the fund was being used in their area – the majority of members said that they were unaware of there having been an announcement from their local authority on how it would be used. Some providers still have not heard in mid-January.
- **Job adverts –** advertising jobs can be costly, if it is possible to include social care in regional NHS recruitment events and also consider a specific social care recruitment website (along the lines of WeCare Wales) we believe that this could assist recruitment at a national level.

Medium term steps

- **End the practice of councils and the NHS of purchasing homecare "by-the-minute",** alternatively focusing on achieving the outcomes people want. While on the surface, this may not seem to be workforce related; the way that care is commissioned has a direct relationship with the terms and conditions that providers can offer and with job satisfaction.

If providers are only paid for the minutes of direct care delivered, (often using electronic call monitoring) then this makes it difficult to run a financially viable business without the use of zero hours contract employment. Competition has driven down the rates paid so that, as outlined above, we believe that the hourly rates received no longer adequately cover the full operational costs (for 2021/22 we calculate the minimum required to operate sustainably is £21.43 and the amount offered by councils and CCGs in England averages at £18.66).

Local authorities' use of by-the-minute commissioning is driven by financial pressures that result from the real terms cuts in their spending power over the last ten years. It should be recognised that to create change in commissioning practices requires funding.

Substantial investment would be needed if care staff were to be moved to shift patterns. This would mean that purchase rates would need to be high enough to cover more gaps in rotas where it is not possible to fill these. Alternatively, consideration should be given as to how preventative services (such as additional respite provision or other kinds of service) could be commissioned to fill gaps in rotas so that commissioners also consider how to make the best use of staff time and enable regular shift patterns thorough their commissioning practices.

If this were possible, regular shift patterns may attract different people to the sector, who might be less interested, able or willing to undertake zero-hours based work.

Time and task commissioning can also be de-motivating for careworkers whose priority is supporting the service user, if they feel like they have to work through an inflexible checklist of tasks, clock in, clock out and move on as quickly as possible to fulfil their contract.

- Support development of **an expert-led workforce strategy for social care and a 10-year workforce plan**, aligned with the NHS People Plan. The Government's approach to workforce planning (indicated in *People at the*

Heart of Care) appears to rely on local authority and NHS commissioners working together in local areas to develop a vision for the shape of the local market based on residents needs and preferences and then to develop an understanding of the workforce required based upon this. This gives rise to two concerns – firstly, that commissioners are a step removed from frontline delivery and the recruitment, retention and other workforce issues that the sector is facing. How will providers be adequately included in these discussions? Secondly, some of the relevant policy interventions to address identified issues will be national. How will information on local markets and workforce be collected in a way that is consistent enough that a meaningful national picture can be put together for national policymakers to act? We believe that there should be an expert-led national workforce strategy for social care, that sits alongside the NHS People Plan.

- Create a **professional register for careworkers in England**, covering all paid social careworkers in both regulated and unregulated care services.

  Scotland, Wales and Northern Ireland already have professional registers for careworkers. Registration of workers needs to be carefully planned and implemented and there are some risks associated – for example, it wouldn't be desirable to make the cost or requirements for registration disproportionately onerous so as to disincentivise people working in the sector.

  There are significant potential benefits in bringing together and registering the care workforce, however. This could provide a basis for improved recognition of care work. It would provide additional support and communication routes for care staff, that could encourage them to stay in the sector. It may also provide reassurance to people using services to know that their staff are registered.

  During the pandemic we have repeatedly seen situations where the Government have tried to roll out measures to all careworkers only to have difficulties communicating with parts of the sector that are not CQC regulated – such as Personal Assistants, micro-providers and self-employed carers. Registration would provide a mechanism to communicate with careworkers in

the more informal parts of the sector about PPE, vaccines, testing and wider policy issues.

There are also currently significant, and increasing, disparities between the CQC regulated care sector and other parts of the sector – for example, the use of Personal Assistants. PAs may not always have access to the same training as that which would be required from a CQC registered provider, which could put them or the people that they support at risk. Similarly, now the regulated sector are (from 1 April 2022) required to employ staff who are vaccinated, this requirement is not the case in the unregulated sector. Skills for Care estimate that 130,000 personal assistants are employed directly – this forms only part of the unregulated care sector.

If standards such as vaccination and certain standards of training are thought necessary for safe care delivery, then it is inconsistent for the Government to require this from some careworkers and not others. In effect this means that unregulated parts of the market could undercut regulated care by offering either higher wages or lower cost because they are not required to meet the same safety standards as other parts of the sector. Registration of all careworkers would help to address some of these disparities.

- **Extend access to the Shortage Occupation List.** The Government have indicated that careworkers access to the Shortage Occupation List will be extended for 'at least 12 months'. In fact there have been long standing shortages of careworkers (see Chart 29 in Skills for Care's *The state of the adult social care sector and workforce in England*, 2020), the vaccination requirements will reduce the number of available candidates when there is increased competition in the market and the situation is unlikely to be resolved by this time next year. We believe it will be necessary to extend access to the Shortage Occupation List in the medium term.

Long term steps

Skills for Care estimate that we'll need 29% more social care jobs by 2035. This will keep rising - the population of people aged 85 or more in the UK is expected to almost double by 2045 (ONS data).

While technology and new models of delivery might be able to assist with the delivery of care, this is unlikely to substantially remove the need for the human contact that is central to the provision of care and support. As such, the workforce plan for social care needs to be an ambitious plan that plans for expansion of provision over the next 25 years. The plan will need to be regularly reviewed and updated.

To maintain workforce expansion with an ageing population in the UK, it is likely that international recruitment may continue to be required by the sector.

What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?

It is true that the Government's reforms announced to date have included some elements in relation to the workforce, including developing a knowledge and skills framework and a portable Care Certificate. It is also the case that there is substantial data being collected on the care workforce, for example, by Skills for Care and Capacity Tracker. Skills for Care undertakes notable work, for example, on supporting Registered Managers. All of this is to be welcomed.

However, it leaves the most substantive part of workforce planning (i.e. to "understand what skills and knowledge the social care workforce will need to provide paid local care and support services that reflect what people want") to commissioners at a local level. How will the national Government ensure any such analysis is undertaken consistently? Will it be possible to collate this information in order to understand any systemic gaps in the workforce?

We would suggest that the Government needs to be able to understand the national picture in order to plan national policy approaches to support the delivery of the vision for social care.

A couple of areas that are of particular interest in delivering the Government's vision for the future of social care are as follows:

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More care at home

The Government's White Paper People at the Heart of Care renews emphasis on the delivery of care to people in their own homes. It should be noted that homecare workers have a distinct set of skills. For example, a careworker in a domiciliary setting may be more likely to need to undertake lone working, administer medication, undertake first aid, interact with NHS community teams or prepare food than a careworker in a care home. These are only a few of the differences. Both workforce policy and training can sometimes start from an assumption that careworkers are working in a care home setting. This must change.

Digital skills

NHSx has been undertaking substantial work into the digitisation of care records and use of technology in the care sector. The digital and data handling skills of the workforce need to keep pace with training. This is, arguably, an area of focus at the moment already. That focus needs to be maintained.

Training across health and care systems

Integrated Care Systems should look at ensuring that some training can be provided to both health and care staff in their area. Places on NHS training could be made accessible to care staff. Pilots that have looked at combined training have reported positive outcomes. As well as the immediate learning from the course, helping health and social care professionals to network and better understand each other's roles can have a positive impact.

It may also be possible to improve the care and support provided to individuals by providing enhanced health training to homecare workers so that they better understand the health conditions of the people they are supporting, the likely progression of that person's needs and how best to support them. Consultants, doctors or nurse specialists may be able to provide neutral professional support to care staff across an ICS area who are actively involved in caring for people with the condition that they specialise in. There could be significant benefits to more joined up working in terms of prevention and improved outcomes. Ideally, ICSs should also consider funding for this kind of opportunity.

Delegated healthcare tasks

We have seen an increase in demand for care staff to deliver delegated healthcare tasks during the pandemic. There might be some clear advantages to care staff being able to undertake some of these tasks – for example, it might prevent the need for another professional to visit that person as frequently if the careworker can undertake some of the more complex tasks when they are visiting anyway. It might also make the care feel more 'joined up' to the person being supported. However, the delivery of delegated healthcare tasks requires not only training but also for staff to have their competency to deliver the tasks signed off by someone clinically qualified (often a nurse).

Often nurses and healthcare professionals do not wish to take the personal risk to their professional registration of signing off the competency of careworkers to do delegated healthcare tasks is something goes wrong. Some complex care providers might be able to manage this if they have an in-house qualified nurse. However, many homecare providers do not employ healthcare professionals.

If the future model of care involves care staff undertaking more delegated healthcare tasks, then a mechanism needs to be found to not only train staff, but also to arrange the sign-off of their competency to undertake such tasks.

Increased skill levels also need to be reflected in the pay and terms and conditions for staff who are undertaking these more skilled roles (and, therefore, this needs to be considered in commissioning practices and fee rates).

What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term? What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?

During 2021 careworkers were not eligible for sponsored skilled worker visas at all; and only senior careworkers or managers could be recruited internationally.

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Even if pay and working conditions are significantly improved in the care sector, the fact that:

a) there have been long-standing staff shortages (see Chart 29 in Skills for Care's 2020 Report) in the care sector;
b) care work is skilled work that requires certain values and motivations, and not everyone is suited to it;
c) the vaccination requirements reduce the pool of people eligible to work in the sector;
d) the number of over 85s is expected to double by 2045; people are also living longer with multiple and complex health conditions – this is likely to correspond with an increase in demand for care and support services; and
e) the care sector currently has 100,000 vacancies, and a turnover rate of 28.5%.

This suggests that the country will continue to struggle to fill vacancies in the care sector. For this reason, we would suggest that international recruitment should remain an option in the short, medium and long term and careworkers should continue to be eligible for the Health and Care Visa (as the current agreement is only short-term).

There are significant costs associated with international recruitment and for the large part (except perhaps in live-in care which, as previously explained, recruitment approaches are slightly different); providers tend to prefer to recruit locally if they are able to. Given the severity of current workforce shortages, we suggest that the Government consider off-setting international recruitment costs.

If more competitive pay and terms and conditions can be offered this may reduce the need for international recruitment. While some Government officials have previously suggested that attracting local job seekers to the care sector depends on providers offering staff better pay and terms and conditions, this fails to recognise that most of the sectors' income comes from the Government, and to increase pay and improve terms and conditions requires Government investment.

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What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors?

Initial training

The Government's proposals around increased portability of initial training within the care sector are to be welcomed. However, it will remain individual providers responsibility to ensure that their staff are competent. It is vital that any standard, portable certificate recognises the diversity of the care sector in terms of how, where and who care is delivered to.

There have been historic concerns that generic initial training for the whole of the care sector fails to recognise diversity in how, where and to who care is delivered. There can be a tendency for training to focus on residential care settings and this may make it insufficiently tailored, or even hard to complete, for staff who work with people living in their own homes. While some moves have been made to recognise the needs of domiciliary care recently, the diversity of the care sector needs to be constantly borne in mind. It is more likely that staff will lose confidence and leave the sector if they are undertaking a role that their training does not prepare them for because it is too generic or focus on one setting only.

Any training requirements also need to be proportionate to the role and achievable for staff with a range of learning styles. They also need to be affordable for care providers (or if significant additional training is required, the consequence in terms of the increased cost of care delivery must be recognised).

Ongoing training

The Government have stated an intention to develop "a knowledge and skills framework, careers pathways and linked investment in learning and development to support progression for care workers and registered managers". While this is needed it should be linked to the skills needs that flow out of a wider vision for the sector and

a workforce strategy, as well as taking into account the interconnections between health and social care roles.

It is also important that career progression, through the development of skills, is funded so that careworkers can receive remuneration that reflects their efforts. While the Government have stated an intention to develop a framework, as far as we can see there is no additional funding to fund pay differentials for staff who do undertake further qualifications.

Some careworkers work on a part-time or casual basis but are nevertheless valued parts of the team and excellent at their jobs. They may be combining carework with studying, caring for family members or pursuing another career, for example. For these staff, care isn't ever intended to be a career. While they do need training, they may not be able to undertake lengthy or intensive professional qualifications. This does not mean that they cannot have a valuable role to play within the sector. While on the whole, the professionalisation of the sector would be welcome, it would be undesirable for a professional skills framework to go so far that it excludes part-time or casual workers in the sector from any roles in care delivery.

Other points

There may be some points to consider around the regulation of training provision. At present there does not seem to be significant due diligence undertaken on training providers who are listed as preferred providers for apprenticeships, or by Skills for Care. Providers do not always have confidence in the quality of externally delivered training (in-person or online).

There also may be a concern around the fact that the changes that have been made to the CQC inspection process – both as a result of the pandemic and because of the new Strategy announced in 2021 – may mean that the CQC might be giving less attention to training standards and adequacy. Particularly, if it is the case that CQC inspections are data and intelligence driven – it is not clear what intelligence the CQC might be gathering on training.

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What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

Vaccination as a condition of deployment

The Government's own impact statement says that the Vaccination as a Condition of Deployment Regulations, due to come into force on 1 April 2022 will cause significant staff losses – 38,000 in the social care sector, or 7.6% of the workforce. The impact statement says "we cannot be confident that the system – even with additional funding – will be able to absorb the loss of capacity resulting from the implementation of this policy, without further intervention."

We fear this may be an under-estimate. At the time of writing – with two weeks left until the deadline for unvaccinated staff to get the first dose - just over 80% of the independent sector CQC regulated homecare workforce in England meet the double vaccination requirements. This leaves around 20% - double the 38,000 figure that the Government have estimated.

The impact of the policy will not be evenly distributed. During the consultation period, when we surveyed our members, 23% of providers expected to lose a quarter or more of their workforce as a result of the regulations, with some expecting more than 50% of their staff to leave. It remains to be seen if this will emerge, but it is clear that the financial and business impact on some providers could be severe and have significant implications for operational disruption.

Urgent support is required to engage with vaccine hesitant staff, as outlined in the first section of this consultation response. Of course, if the Government were prepared to consider this, a delay or a suspension of the introduction of the regulations would go some way in preventing a worsening of the staffing situation.

Other factors

We surveyed our members in November 2021 and received 339 responses. Providers reported that the key challenges to recruitment and retention were:

- Pay, terms and conditions of employment which do not fairly reward skill and experience (55% selected this as the factor that had the effect on their ability to recruit or retain careworkers)

- Competition with other business sectors (14% selected this as the most significant factor)
- Exhaustion and burn-out of careworkers (11% selected this as the most significant factor)
- Brexit or migration policy (8% selected this as the most significant factor)

The fact that careworkers' pay and terms and conditions of employment were the greatest challenge to recruiting and retaining homecare workers is, of course, closely linked to how the homecare sector is funded by the State, and what private individuals arranging their own care are willing and able to pay. We have outlined earlier in our submission what steps we believe are required in the short, medium and long term to address these factors including increasing the fee rates public sector commissioners pay for care services to enable competitive wage offerings; ending by-the-minute commissioning practices to tackle the terms and conditions for workers implicit in these; and creating a workforce plan that includes career progression options.

As mentioned above, pay terms and conditions and job satisfaction are also closely linked to commissioning practices. If care is being commissioned 'by-the-minute', this makes it virtually impossible for care providers to remain financially viable unless they use zero hour or variable hours contracts. Careworkers may also experience less job satisfaction if the contract that they are delivering places more emphasis on keeping precisely to a schedule of tasks rather than focusing on the person they are supporting.

Are there specific roles, and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?

There are certain roles within the care sector that are particularly hard to recruit to. These include finding good quality Registered Managers. The role is skilled, highly responsible, complex and carries a number of personal legal risks. A wide range of actions could help to address this issue, including greater professional recognition of the role; training and support for Registered Managers. Increased funding for the sector would reduce the pressures of the workforce issues that Registered Managers need to manage on a day-to-day basis.

During the pandemic Registered Managers have been trying to implement constantly changing Government guidance which is sometimes issued late at night or just before a weekend. This can be discouraging and heighten the pressures that Managers are experiencing. The Homecare Association has raised issues around the timing of guidance publication with the Department of Health and Social Care. Further work is needed to ensure that guidance is issued and communicated in such a way that supports a clear and organised implementation. The sector risks losing good Registered Managers if these pressures continue.

There are also a small number of homecare agencies that deliver complex care at home. Recruitment of in-house nurses, occupational therapists or other registered health or allied-health professionals can be difficult due to shortages within these professions nationally. As healthcare colleagues will highlight, this involves ensuring that sufficient nurses and allied health professionals are being trained to meet the country's needs.

The live-in care sector was particularly affected by Brexit as providing 24/7 care to a person in their own home, potentially for a few weeks at a time, requires a particular lifestyle choice and may not be attractive to UK based workers who want to go home to their family at the end of the day; but will be attractive to some overseas workers who want to spend some time in the UK. We hope that the extension of the Shortage Occupation List to careworkers will help to ease some of the pressures in the live-in care sector.

Vaccination as a Condition of Deployment will clearly affect some areas more than others, with notably high vaccine hesitancy rates in some areas. London may be particularly affected by staff losses in relation to this policy, but vaccination rates by local authority area are easily available for analysis via NHS England's weekly vaccination statistics. The five local authorities with the lowest reported vaccination rates for Independent CQC regulated homecare at 13 January were Barking and Dagenham (51% of staff had two doses); Lewisham (51%); Camden (56%); North Somerset (56%); and Merton (57%).

Offering competitive wages is harder in regions where local authorities pay lower fee rates to providers and can increase instability in the market and difficulties recruiting. We believe there is a correlation between local authority areas with higher levels of deprivation and a tendency towards lower fee rates for providers. Our Homecare Deficit report (based on Freedom of Information requests around fee rates paid in April 2021) suggests that in Northern Ireland, the North East, the West Midlands, the

North West and Greater London the average hourly rate paid to providers was under £18 per hour. We believe the minimum required to sustainably deliver homecare and pay workers the statutory minimum wage is £21.43 per hour.

As outlined above, to mitigate this issue we would suggest increasing careworker pay to the equivalent of a Health Care Assistant Band 3 in the NHS (£11.14 per hour). We believe that in 2021/22 this would mean commissioning care at £26.31 per hour and would require an extra £1.3 billion a year in funding for England as a whole. This needs to be consistently implemented across the country. Relying on local authorities to raise the social care precept to increase funding disadvantages regions that are less well-off and have higher levels of care needs, so we would suggest that this needs to be funded centrally.

However, it is worth noting that even where higher rates are offered local labour market conditions can be prohibitive and further investment may be required. We are aware even relatively high wage rates (over £12 per hour) may not always attract staff in some parts of the country (for example, Oxfordshire). In these localities, the result can be that there is insufficient homecare provision and more people (who would often prefer to be cared for in their own homes) end up being supported in a residential care setting, like a care home. This is obviously not a desirable result for anyone involved.

What should be in the next iteration of the NHS People Plan, and a people plan for the social care sector, to address the recruitment, training and retention of staff?

We are calling on the Government to develop an expert-led workforce strategy for social care and a 10-year workforce plan.

We would suggest that the development of the workforce strategy should include consideration of:

- An **analysis of population needs and preferences**. Careful consideration needs to be given to what care and support needs there are in the community (including an agreed method of determining unmet need levels) and also to how people would like these needs to be met. The analysis of needs should go beyond the present to consider what needs can be prevented, and how need levels are expected to change. Existing Joint Strategic Needs Assessments

often focus primarily on health and not necessarily on social care or support. It is also difficult to synthesise existing information at a national level.

- Informed by the needs assessment, a wider **strategic vision** of the volumes and approaches to care delivery or types of care that are likely to be required and what workforce size and skill-mix is required to deliver this. This needs to include consideration of strategic factors based on our understanding of what the future might look like. For example, how care technology will shape roles, and what employed roles are required to support unpaid carers. (Do we, for example, need roles in the care sector that specifically help unpaid carers with care technology? What would training for these roles look like? What roles could be changed as a result of technology? What other new roles might there be and what do these look like?). In *People at the Heart of Care* the Government appears to assign this to local commissioners of care. If this work is to be led at a local level, how will data consistency be ensured so that information can be meaningfully compared and collated to plan any national policy interventions required? While commissioning may be local, key decisions on funding, training and immigration might be made at the national level and these need to be strategic.
- Analysis of **desired vs actual levels of staffing/skills** comparing the current situation to the vision (again, if done regionally, how will this be collated consistently? How will those undertaking planning involve employers who are the ones who better understand the make-up of the workforce and what might be needed?).
- A credible **plan to recruit and train** the workforce to reach the desired workforce composition. This should include consideration of how to fund any expansion required.
- A plan for offering **structured career progression** in the sector (perhaps based on the already announced idea of a knowledge and skills framework and career structure), but this must be accompanied by funded renumeration that reflects skill levels.
- A plan to ensure that **funding** (i.e. fee rates paid by commissioners or grants) is sufficient to offer a fair wage, including at higher rates for staff who have undertaken further training.

- A plan to ensure that **commissioning practices support good terms and conditions** of employment. For example, and as explained previously, 'by-the-minute' commissioning should be abolished – and as it is driven by budget constraints, this will require investment. While the Government have said that they will support local authorities with market-shaping, commissioning and contract management; we are concerned that this will still leave room for some poor practices which should simply not be used. The CQC, who will be inspecting care commissioners in future, is used to primarily considering outcomes for people using services. Will it be able to adequately consider commissioning practice from the perspective of staff terms and conditions?
- **Contingency arrangements** for periods when the workforce is under strain due to high vacancy rates or high levels of sickness absence, for example. We have repeatedly asked what the contingency arrangements will be if staff are lost due to Vaccination as a Condition of Deployment and have not yet seen a credible answer.
- Plans for **workforce registration**. The Government's proposal to create a digital social care workforce hub does not go far enough. Workforce registration is already used in Scotland, Wales and Northern Ireland and, if implemented carefully, could enable greater professional recognition of careworkers. This should include consideration of how to register and support the workforce of the unregulated care sector to ensure safety (offering an alternative complaints mechanism for service users) and quality standards (supported by training, distribution of information about key policy information, PPE, vaccinations and so on) without detracting from personalisation (e.g. for micro-providers, self-employed carers or PAs).

Elements of the work that the Government has already announced could also be developed and incorporated into the wider strategic picture for the workforce, for example:

- Wellbeing and occupational health support for the care workforce
- Expanding the roll-out of the social care workforce Race Equality Standard, and consideration of any other relevant diversity and inclusion issues.
- Support for social care leaders and Registered Managers.

To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills?

As we have already noted, the way that homecare providers are commissioned at the moment (e.g time and task or 'by-the-minute' commissioning) means that care providers are only paid for the time that the careworker is with the person being supported. This is a direct consequence of years of under-funding forcing local authority's commissioning approaches to focus on reducing costs. The National Audit Office have highlighted how local government spending power has reduced in real terms over the last ten years. With low rates paid to providers and narrow margins, it is difficult to work within this model and maintain financial viability through any route other than by using zero-hours or variable hour contracts.

Time and task approaches may also take an overly controlled approach that presents barriers to the careworker and person being supported making modifications to their care plan and can reduce job satisfaction.

The increasing budgetary pressures over the last 10 years have also meant that proportionately less work that can be done outside of peak hours may be being commissioned by the public sector (e.g. supporting people to go out in the afternoon; respite sitting services and so on). This can mean that care workers are more likely to end up with fragmented or split working patterns.

Changing the regularity and hours that careworkers work would require a rethink about how care is commissioned (e.g. not time-and-task) and what care is commissioned. It would also most likely need substantial investment – including being prepared to occasionally pay for careworkers to have some down time or additional training time where there are gaps in rotas.

What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

While different ICSs operate in different ways, ICSs often tend to operate with a primary focus on the NHS. Where there has been representation of social care this

has tended to be from local authorities. Local authority commissioners may not be fully aware of operational or workforce issues in the area and do not directly employ the majority of the care workforce. Without more ICSs speaking to local care sector employers, it is difficult to see how ICSs can successfully improve care sector recruitment and retention.

In discussion with providers, ICSs should develop a strategic view about local care needs and staffing levels required compared to actual staffing levels. They should be involved in tailoring and applying any national workforce plan to their areas and should support local recruitment efforts.

In terms of staff retention, ICSs should consider carefully how their commissioning approaches are shaping the employment experience, pay and terms and conditions of care staff. Practices like purchase of care 'by-the-minute' should end.

ICS's could support the integration of health and care training (where appropriate) by allowing care staff to join NHS training sessions on relevant topics.

ICS's could also further the use of multidisciplinary support by, for example, offering enhanced health training and professional support to carers in the local area who are providing support to people with particular needs. This could be, for example, enhanced training in supporting people with a particular condition, such as Parkinson's Disease. It could also cover what role carers can play in falls prevention or in managing frailty – linking this into the work of local health systems.

Better planning at ICS level around training and equipment provision might also be able to improve outcomes and prevent needs escalation. In some cases providing the right equipment can enable care to be safely carried out by a single carer that would otherwise require two carers, reducing ongoing costs.

Conclusion

Urgent action is required to ensure that people have the support that they need where and when they need it. The current staff shortages, when taken against a backdrop of commissioning by-the-minute and low pay are impacting the capacity of the sector to deliver the care required. This is adversely affecting people who need support in their day to day lives, placing increased pressures on their families and contributing to pressures on the NHS. Staff shortages are also placing increased pressures on the existing workforce.

We call on the government to:

- Fund social care adequately so that homecare workers are paid fairly for the skilled roles they perform, and at least on a par with equivalent public sector roles. We recommend NHS Band 3 HCA pay of £11.14 per hour.
- End the practice of councils and the NHS of purchasing homecare "by-the-minute", move to payment in advance on planned care and focus on achieving the outcomes people want.
- Support development of an expert-led workforce strategy for social care and a 10-year workforce plan, aligned with the NHS People Plan.
- Create a professional register for careworkers in England, covering all paid social care workers in both regulated and unregulated care services. Registration of careworkers needs to be adequately funded and carefully implemented.