**Royal College of Nursing response to Public Accounts Committee inquiry into Adult Social Care Markets**

With a membership of around 450,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

## 1. Overview

1.1. The adult social care market in England is in a period of instability. A key indicator of market-stress is high staff vacancies and turnover amongst registered nurses. There is also a lack of comprehensive data which prevents robust scrutiny and transparency. Ultimately, this instability compromises the delivery of safe and effective nursing care in social care settings, and also impacts on the health system.

1.2. It is important to recognise the current context within adult social care. Effective integration is reliant upon sufficient funding for all parts of the health and care system, including that required to enable staffing for safe and effective care. The National Audit Office identified that "Many authorities are setting budgets for 2021-22 in which they have limited confidence, and which are balanced through cuts to service budgets and the use of reserves"[1]. The NHS Long Term Plan was based on a commitment that social care funding would not impose additional pressures on the NHS[2].

1.3. The RCN has long been concerned that increasingly stretched local authority budgets, in the context of rising care needs of the population, have led to a rise in the threshold for accessing care and increase in unmet needs. This trend, if sustained, will put additional pressure on other frontline services; in particular general practice and community nursing.

[1] National Audit Office (March 2021) Local Government finance in the pandemic. Available at: https://www.nao.org.uk/report/local-government-finance-in-the-pandemic/

[2] NHS Long Term Plan (2019) "*When agreeing the NHS' funding settlement the government therefore committed to ensure that adult social care funding is such that it does not impose any additional pressure on the NHS over the coming five years. That is basis on which the demand, activity and funding in this Long Term Plan have been assessed."* Available at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

## 2. Recommendations

2.1. There are a number of areas which must be addressed within adult social care reforms for true integrated service planning and delivery:

2.1.1. **Pay, terms and conditions**: Nursing staff[1] working within social care settings should have pay, terms and conditions that are comparable to those received by their colleagues with the same level of knowledge, skills and responsibility within the Agenda for Change structure.

2.1.2. **Investment:** Funding for social care should be sufficient to ensure staffing for safe and effective care in all settings (based on the projected needs of the population), and to ensure all staff have access to fair pay, terms and conditions.

2.1.3. **Workforce demand assessment duty:** The Government should take the opportunity in upcoming health and care legislation to assign an additional duty to the Secretary of State. This duty should require them to undertake a regular assessment of workforce demands based on population needs. This will inform decisions about workforce strategy, including supply and funding.

2.1.4. **Workforce strategy**: There should be a fully costed and fully funded workforce strategy covering all parts of the health and care workforce. The workforce strategy must be based on a transparent assessment of the workforce demands of the health and care system, to meet projected needs of the population, and include projections and costed policy recommendations for overall nursing supply, staffing levels, skill mix and professional education.

2.1.5. **Immigration**: We are calling on the Government to ensure appropriate routes are available for social care workers from overseas to be able to join the UK workforce. This could be undertaken through the development of an additional immigration route or adapting the existing Health and Care Worker visa route.

2.1.6. **Career progression**: National bodies should investigate ways to introduce clearer career pathways to promote all nursing roles in the sector, make nursing roles in the sector more attractive and/or promote movement between social care and the NHS (on a secondment / training arrangement).

2.1.7. **Government accountability:** The Government should hold the ultimate accountability for ensuring that there is a safe, effective and stable social care market which meets the increasing needs of the population. There should be transparent data collection and publication to aid scrutiny and give assurance that funding and provision is sufficient to meet growing needs.

2.1.8. **Collaborative problem-solving:** During the pandemic, Government has been working closely with social care providers and trade unions. This type of three-way identification of problems and design of solutions should continue to tackle wider, longer-term issues.

2.1.9. **Nursing leadership**: New integrated care systems should be mandated to include nursing leadership roles at board-level and throughout the decision-making structures. Nursing leadership is key to facilitating joined-up care, refocussing on prevention and designing patient pathways.

## 3. Evidence

### 3.1. How adult social care is currently provided and structured

3.2. There are several indicators which demonstrate there are issues within the delivery and structures of adult social care that impact the delivery of safe and effective nursing care. It is well established that there is a fragmented provider market, and many instances when providers fail and services change hands. This is distressing for both staff, residents and clients, and is an indication of an unsustainable system.

*3.3. Workforce shortages*

3.4. RCN members have been reporting for many years that there are too few nursing staff to provide safe and effective care. In social care, trends indicate that the numbers of registered nurses are declining, despite needs amongst the population increasing. Nursing staff working in social care often have high caseloads, unsustainable ratios with clients/residents and work long hours.

3.5. Challenges surrounding recruitment and retention of staff in care homes includes a history of underinvestment in the sector, a national shortage of nurses, low public and professional perceptions of working in social care, long and unsociable hours, low pay, little career progression, zero-hour contracts and the demanding nature of care work[3].

3.6. Rhetoric about nursing shortages often focuses on the acute sector, but the reality is these nursing shortages have been negatively impacting social care for several years and are as a result of failure by government to consider the needs of nursing in social care in workforce planning and to invest in the supply of a registered

[3] Devi et al (2020) Attracting, recruiting and retaining nurses and care workers working in care homes: the need for a nuanced understanding informed by evidence and theory. Age and Ageing 50(1): 65-67.

nursing workforce in social care. In addition, recent changes in UK immigration policies will make it difficult to recruit staff from overseas. Currently international staff make up around 26% of the workforce in nursing homes, and 5% in residential homes[4].

3.7. Skills for Care (2020) report that employers who use values-based recruitment and retention approaches attract staff who perform better, with lower sickness rates, and achieve greater levels of success in developing the skills needed in their roles. This approach may also result in reducing the cost of recruitment and training, as well as reducing turnover. Research shows how retention is influenced by the level of learning and development, the values of the organisation, and the involvement of colleagues in decision-making[5] [6].

3.8. The latest data from Skills for Care [6](collected prior to the height of the pandemic), shows that there are currently an estimated 36,000 registered nurse jobs in adult social care. Most of these in care homes with nursing, in the independent sector (33,000).

3.9. The overall number of adult social care jobs increased by around 9% since 2012/13, and by around 1% between 2018/19 and 2019/20. However, registered nurses were one of the only jobs in adult social care to see a significant decrease; down 2,800 jobs (7%) between 2018/19 and 2019/20 and down 15,000 jobs (30%) since 2012/13. In addition, the highest vacancy rate was for registered nurses at 12.3% (around 4,200 vacancies), up by 7.3 percentage points since 2021/13.

3.10. This data shows a concerning trend, but due to a lack of comprehensive data about service models it is challenging to draw a narrative about the range of factors which has contributed to this situation. We are concerned that some nursing homes may have been replaced with care homes, which would reduce the requirement for registered nurses.

3.11. The concern for the RCN is that this reduction in the registered nurse workforce in social care is happening at a time when it is widely documented and understood that the dependency and complexity of care needs within social care is increasing. This is a pattern that is due to continue in the aftermath of COVID-19 that will see an increase in people experiencing chronic ill health conditions.

3.12. The proportion of workers employed on a permanent contract are 84% of registered nurses. Most are employed on a full-time basis: 68% of registered

[4] ibid
[5] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-are-sector-and-workforce-in-England.aspx
[6] Devi et al (2020) Attracting, recruiting and retaining nurses and care workers working in care homes: the need for a nuanced understanding informed by evidence and theory. Age and Ageing 50(1): 65-67.

nurses. The numbers employed on zero hours contracts are: 16% of registered nurses[7].

3.13. When there are too few nursing staff, care is compromised. In social care, staffing shortages can lead to services closing or reducing their provision for people with higher needs.

3.14. In England, there is no workforce strategy covering the social care sector. This can mean that insufficient funding and resources are being deployed to grow and develop the social care workforce.

3.15. One additional issue is that data for the nursing workforce in social care is not regularly collected or published. This means the information we can access about the workforce is patchy. Usually data covers only part of the sector and is not updated regularly. This prevents robust scrutiny into workforce trends.

*3.16. Disparity in pay, terms, and conditions*

3.17. Social care comprises many different types of providers and employers and does not have a national pay framework to underpin staff pay scales. This means that there is wide variation in salary levels throughout the sector, with many nursing staff being paid at levels that do not equate to Agenda for Change pay scales. Box 1 identifies the annual rates of pay across local authorities and private providers across England.

| Job Role | Local Authority | Independent Sector |
|---|---|---|
| Registered Manager | £40,400 | £30,800 |
| Registered Nurse | £31,800 | £24,500 |
| Senior Care Worker | £24,500 | £18,400 |
| Care Worker | £20,500 | £16,900 |

*Box 1: Annual rates of pay across local authority providers and independent providers in England[8].*

3.18. There is a link here between pay and turnover. Staff turnover rates are higher in the independent social care sector (31%) than in local authority areas (13%), and turnover for RNs was 41.3%, with most of these being employed in independent social care provider organisations (turnover of RNs in the NHS was around 9.4% in March 2020).

[7] ibid
[8] ibid

3.19. Nursing staff in social care also experience disparity in their terms and conditions. They are less likely to benefit from sickness pay or overtime pay, have fewer holidays or less control over their shift patterns. Staff members have poorer access to support or mentorship, and reduced opportunities for career progression and continuing professional development compared to their NHS counterparts.

3.20. Alongside these formal disparities, there are also perceptions amongst nursing staff in social care of reduced public value compared to colleagues in other settings. Nursing staff in the NHS often benefit from discounts or exclusive access to deals; this was particularly true in the early stages of the COVID-19 response.

*3.21. Concerns about the impact of the UK's departure from the EU and changes to the immigration system*

3.22. The social care workforce is heavily reliant upon international workers. In England for example, 35% of registered nurses working in social care are internationally recruited staff[9].

3.23. The social care workforce is straining under the pressure to provide services for a growing ageing population who have increasingly complex needs. The UK's departure from the EU has exacerbated this pressure[10]. In the two years following the EU referendum, over 7,000 established EU nurses left the register, compared to just over 4,000 who left in the three years preceding the referendum[11]. Research from the National Institute for Social and Economic Research (NISER) cautions that care is needed to ensure the UK's exit from the EU does not weaken the social care sector's ability to recruit workers with the necessary skills it needs in order to provide good care to vulnerable groups in the future[12].

3.24. The UK's departure from the EU has led to changes in the immigration system, including qualification and salary requirements for people seeking work in the UK. The potential impact of these changes is concerning for the future of the social care workforce. Many roles within the social care sector do not meet the minimum qualification or salary requirements within the new immigration system.

[9] ibid

[10] Dolton et al (2018) Brexit and the Health and Social Care Workforce in the UK. National Institute for Social and Economic Research.

[11] RCN briefing, available at https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/may/pdf-006982.pdf

[12] ibid

This is likely to reduce the supply of international workers, putting services at risk of unsustainable, unsafe staffing levels.

3.25. We note that while some changes have been made in the Shortage Occupations List with the recent addition of senior care worker roles, most of these roles fall well beneath the salary threshold required for a visa, and as such are unworkable.

3.26. The Government should also remove financial barriers to international recruitment throughout the UK by ensuring that health and care employers are exempt from the International Skills Charge and by ensuring automatic exemption, and reimbursement where appropriate, of the Immigration Health Surcharge for all health and care staff.

## 4. Impact of COVID-19

*4.1. Opportunity to learn from COVID-19 ways of working*

4.2. While it is important to reflect on the decisions relating to social care which did not work well during the pandemic, the nursing workforce reports many positive new ways of working which should be maintained going forwards. Local authorities and social care providers were able to rapidly build more collaborative relationships with community and NHS partners. This has helped accelerate the journey towards integration.

4.3. Nursing staff working in social care settings were given access to online training and development. This will have helped remove previous barriers which prevented staff from accessing CPD, particularly in situations where they may have been the only member of nursing staff on shift, making it hard to attend offsite training courses. Staff members have also now received access to a much higher provision of personal protective equipment (PPE). Given the vulnerabilities of social care clients to other infectious diseases, it is important that access to PPE is maintained even when the risk of COVID-19 is reduced.

*4.4. The absence of data on care homes*

*4.5.* Early in the pandemic there was no reliable mechanism for collating data on infection rates in care homes. It wasn't until 28th April, that the government developed a mechanism for collating death certification data and presenting these alongside statistics for hospital deaths through the Office of National Statistics. Coupled to the lack of data from swab tests, this hindered efforts to provide

comprehensive public health provision and support to prevent the spread of COVID-19 in care homes[13] .

*4.6. The failure to value and support care home staff*

4.7. While there was a national initiative, "clap for carers" early in the pandemic this was initially referred to as; "clap for the NHS", where the social care workforce was only seen as an afterthought. Social care staff form lasting bonds and close personal relationships with their residents and the pandemic has been emotionally gruelling for care home staff.

4.8. During the pandemic the UK media has been filled with stories of care home staff going "the extra mile" for their residents including numerous examples of staff moving away from their families and into care homes to cover staffing shortages or to maximise infection control. There is no doubt that the public estimation of care home staff has shifted during the pandemic. Yet social care staff remain underpaid and under-supported in comparison with their equivalently skilled NHS counterparts[14].

**5. Department of Health and Social Care (DHSC) effectiveness in overseeing the market and holding providers to account; and its understanding of future demand, costs and alternative delivery models**

5.1. The evidence we have provided shows that there is failure within the adult social care market. This indicates that Government is not being effective in overseeing the market and holding providers to account for quality, outcomes or financial sustainability. At this point in time it is unclear what the responsibilities of the DHSC are in regard to market oversight and provider accountability. There are clear lines of oversight between social care providers and their regulator, the CQC, but this does not exist for the DHSC. Without transparency about their responsibilities, it is not possible to make assessments of their effectiveness.

5.2. During the pandemic, the DHSC established a working group with employers and unions. This was successful at identifying and resolving issues specific to social care and should be maintained following the pandemic. This working group was particularly successful in achieving full pay for staff during any COVID-19 related absence and avoided the risk of staff members working whilst unwell or infectious because they could not afford to live on SSP alone. This type of collaborative working should be maintained after the initial pandemic response is over. This will

[13] Devi et al (2020) The Covid-19 pandemic in UK care homes – revealing the cracks in the system. Journal Nursing Home Research Sciences. Vol 6: 58-60

[14] ibid

allow for a more robust and considered approach to be taken to overcoming wider, longer term issues in the sector, particularly financial sustainability.

5.3. It is important to note that many of the challenges facing adult social care are rooted in insufficient investment and funding, rather than a lack of regulation. While we would support the DHSC having a larger role in providing support and facilitating consistency amongst social care providers, it is essential that appropriate investment and funding is made available.

*5.4. Lack of population-based workforce demand assessment*

5.5. The DHSC (along with other national bodies such as NHSE/I and HEE) is not taking a population-based approach to identifying future workforce needs. In most situations decisions about staffing are made based on affordability at service level. We are also concerned that national initiatives to improve supply, recruitment or retention are typically NHS-focussed, despite the supply routes for registered nurses entering the profession span the full range of public and private health and care sectors.

5.6. The Government should include in the upcoming health and care bill an additional duty to the Secretary of State for Health and Social Care to undertake an assessment of current and short term, and long term, future workforce demand, at regular intervals.

5.7. There is a clear rationale for this additional duty – to resolve what current legislation does not currently provide for. It will allow assumptions about future workforce trends to be tested. This will give assurances about staffing levels, skill mix, capacity and workload (including non-patient facing time). In future situations, such as a pandemic, the impact of factors affecting productivity can be modelled; for example, if staff need additional time to comply with infection prevention controls. It will also allow for reassurance that targets are achievable and will help identify where efficiencies can be made. Services and systems will then be better placed to make informed decisions about workforce needs, and therefore overall service and staff development funding levels.

5.8. The workforce assessment should be independently verifiable. This will allow for assurances to be made about the credibility of the assumptions and findings. This will include ensuring that the assessment reflects the drivers of recruitment and retention of different age groups within the workforce. It should also take into account turnover and attrition rates of supply routes in order to get an accurate assessment of future education route output joining the workforce. Assumptions relating to the reliance on international supply routes can also be tested to ensure that they comply with UK Government obligations to ethical international recruitment, and for sustainable domestic workforce planning.

5.9. Plans and models for future workforce supply should be tested to ensure that all options have been considered. For example, if it is identified that domestic workforce supply is insufficient, has there been a reciprocal increase in domestic training places, rather than immediately moving to increasing international recruitment Another example is ensuring that all methods for increasing retention have been utilised, including those related to pay, terms and conditions.

5.10. This duty should cover the workforce in all types of publicly funded health and care settings. Our view is that this duty should cover a period of at least five, and up to twenty years into the future, in order to give sufficient data upon which strategic decisions can be made. The workforce assessment should not be undertaken in isolation, but integrated into wider decision making on service, finance and resource planning. To be effective, this will involve also integrating and sharing information with planning being undertaken at regional, ICS and provider levels.

5.11. *Nursing leadership*

5.12. Nursing leadership is vital to delivering the ambitions of integrated care. Nurse leaders are well placed to understand both the health and care needs of their populations and identify opportunities for joining up relevant parts of the patient pathway. We also know that nurse leaders can transform systems away from a focus on acute services and treatment to one which prioritises prevention, health promotion and public health. This has great benefit to local health economies, in terms of preventing avoidable ill-health and reducing the burden on expensive secondary services.

5.13. Nursing is the largest professional group within social care, and we welcome the introduction of the Chief Nurse for social care. We are confident this role will provide excellent clinical leadership for the workforce. In addition to this senior leadership role, it is also imperative that nursing leadership is present at the decision-making tables at all stages of commissioning.

5.14. We know that there is variation in how nursing leadership is embedded within the existing ICSs, and this will lead to variation in quality and safety of care and in health outcomes, potentially exacerbating health inequalities. Although we recognise the need to allow flexibility at local level to determine approach, it is critical to have a consistent approach and role for nursing leaders across all ICSs. Current CCG structures have a statutory requirement for registered nurse representation on the board; a similar approach should be in place at ICS level.

5.15. Nursing leadership should be embedded throughout ICS structures, as well as within executive or decision-making functions. There is a particularly important opportunity for including nursing leadership from social care. Nursing expertise is critical to ensuring decisions are made in the best interests of patients. This is a valuable component which needs to be protected at all levels, and in all types of settings. Nursing staff describe their experiences within current structures in which

the nursing voice in community settings and primary care is often lost to medical perspectives. It is important that both are represented, along with other health professions.

5.16. *Poor data coverage and transparency*

5.17. Currently there is disparity between the national reporting of workforce data between independent (or local authority) and NHS providers, and also between the data collected at local level and that which is published nationally. This means that service and workforce planning cannot be credibly undertaken for the NHS or for the wider health and care system as a whole.

5.18. It is critical that all providers are required to allow their workforce data to be reported on publicly, not only NHS trusts. This needs to include primary care and services which are commissioned by local authorities, including public health and social care providers. Reporting must include FTE numbers of staff by role and care setting, along with vacancy data. All providers should be required to collect and report on vacant posts, including a breakdown of how many posts are being filled by bank or agency staff. All workforce and vacancy data, for all providers should be made publicly available.

**5.19.** Providers should also be required to produce and publish timely sickness data; currently available data is 4 months delayed for the NHS and lacking in many parts of social care. In a pandemic situation this does not allow for robust scrutiny into the impact of the pandemic upon staff members. The DHSC should also consider the need for clinical outcomes measures in social care settings along with acuity tools. This will help progress towards staffing for safe and effective care.

**About the Royal College of Nursing**

The RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

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