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SUMMARY

60-SECOND SUMMARY

Although some carers and care providers manage to provide outstanding, compassionate care in difficult circumstances, there are growing concerns about the standard of social care services relied upon by some of the most vulnerable people in our society.

There are three primary concerns: high levels of user dissatisfaction, rising numbers of abuse alerts and the large number of providers requiring an action plan for improvement.

Poor outcomes are associated with chronic underinvestment, weak regulation and oversight, and a lack of effective workforce planning and management skills. NHS statistics such as delayed transfers of care are increasingly demonstrating that higher demand for adult social care and pressure on local authority social care budgets is seriously affecting NHS performance, and threatening the financial stability and sustainability of the health and social care systems.

A reliance on migrant labour in the care sector has masked the absence of effective workforce planning strategies, with employers turning to migrant labour to fill posts that may otherwise be difficult to recruit for.

Around 6 per cent of people employed in social care – approximately 60,000 workers – are European Economic Area migrants. Around 20,000 of these workers have arrived since 2012. With uncertainty around the future of freedom of movement the flow of EU migrant workers could provide a less reliable source of labour for British employers in future. Even if freedom of movement were to be preserved as part of a future Brexit deal, it is unlikely that labour shortages can be avoided in the short to medium term. However, the majority of immigrants working in social care (191,000 people) come from non-EU countries. As the government has pledged to review non-EU migration, the future flow of workers from non-EU countries is also less secure. We project that the UK will need to have recruited and trained 1.6 million low-skill health and social care workers up to 2022 in order to replace those leaving the profession as well as to meet increased demand. This is the equivalent of two-thirds of the current low-skill health and social care workforce, and is larger than for any other occupation in the UK.

Social care competes with other low-wage sectors for its workers. If it is to attract more UK workers, the care sector will have to consider how to improve working conditions and strengthen opportunities for development and progression. There is, therefore, an urgent need for an ambitious workforce strategy that tackles longstanding weaknesses in the workforce structure and working conditions.

There are growing calls for a cross-party consensus on funding before the end of this parliament to prevent the complete collapse of the social care system. Successive governments have commissioned reviews into social care funding – most recently the Dilnot commission in the last parliament. While the recommendations we outline below will help tackle the problems identified in this report, these cannot fully be addressed without a sustainable funding solution for social care.

RECOMMENDATIONS FOR RAISING STANDARDS IN SOCIAL CARE

Our vision to improve standards in the care sector has three elements.

1. Effective minimum standards to push up quality, developed by Skills for Care in conjunction with a representative board, and enforced through a stronger Care Quality Commission (CQC).
2. Better conditions for workers, enforced through a stronger CQC in partnership with HMRC.
3. An industrial strategy for care with a new focus on innovation, including stimulating the potential of new technology to drive productivity improvements.

1. Effective minimum standards for training

Minimum qualifications and appropriate training to attain them are essential to ensure services are of a consistently good quality, yet the UK has neither. In not setting minimum standards for training in social care, the UK is an outlier compared to other advanced economies.

The care certificate has had some success in formalising a minimum skills floor, but it remains unenforced while many carers are not even given the opportunity to have this training. **We recommend building on the certificate as a route to improving standards in care.**

To improve care outcomes, the care certificate must be:

- a robust indicator of high-quality skills and knowledge
- mandatory for workers and enforced by a regulator
- delivered to a high standard by training providers or employers.

Recommendation 1

The care certificate should be a legal requirement – and it should be fully enforced – in order to create an effective minimum qualification floor for the care sector.

2. Oversight and monitoring of quality standards

In addition to strengthening the role of CQC to enforce minimum standards of training, **we recommend that the role of CQC is broadened to tackle the exploitation of low paid workers in the sector**. CQC should have a duty to refer cases of underpayment of the national minimum wage to HMRC, as recommended in the Kingsmill review. Giving CQC the remit and resources to support HMRC in enforcing the higher minimum wage (or national living wage) is likely to shed more light on these illegal practices and to reduce their prevalence in the long term.

Recommendation 2

The CQC should be given two new duties:

- to enforce minimum standards, by requiring that employers proactively demonstrate that they have trained their employees under the care certificate curriculum, though high-quality training.
- to tackle the exploitation of low paid workers, by broadening its inspection regime to include employment outcomes, with a duty to refer non-payment to HMRC.

The cost of resourcing these new duties for the CQC should come from employer fees, set at a level that is acceptable to employers and enables reform to the commission.

3. A new industrial strategy for the care sector

These recommendations need to be combined with a wider vision for the sector: supporting the integration of training between NHS and non-NHS carers; supporting technological innovation in care; and moving towards responsible procurement in all local authorities.

There are numerous successful tech innovations happening at the frontline of social care, but the current underutilisation of both medicinal and digital technology means that there is real opportunity to unleash a new wave of innovation that could have a revolutionary impact on how care is delivered, and how patients interact with professionals to manage their own health and care.

Recommendation 3

We recommend pump priming of technological innovation through match funding for new applications that will improve the delivery of social care:

- match funding for new technological applications that will improve the delivery of social care
- fund could be small, up to £5 million, delivering seed funding of £20–50,000 for individual projects
- require open standards so that new tech systems are compatible with each other, rather than recreating the NHS IT barriers.

Taken together these measures will bring about a more coordinated and strategic approach to social care that focuses on the workforce and puts personal, relational care with high-quality interactions at its core.

INTRODUCTION

In recent years there has been increasing concern about both the availability and quality of adult social care services. One-third of social care users are not satisfied with the care provided (Quality Watch 2016a), and there has been a growing number of abuse alerts (HSCIC 2014). These problems go back many years, but the pressure on the sector has intensified due to recent public spending cuts. Falling public investment has come at a time when the complexity and demand for adult care services is increasing due to an ageing population (Kings Fund 2013, Age UK 2014).

This situation has created a crisis in the availability and quality of adult care services, as well as putting increasing pressure both on NHS resources and informal carers forced to compensate for failures in formal adult care services.

This situation is only likely to deteriorate in the coming years. IPPR projections suggest that the UK will need to have recruited and trained 1.6 million low-skill health and social care workers between 2012 and 2022 to replace those leaving the profession as well as meet increased demand – the equivalent of two-thirds of the current low-skill health and social care workforce (Clifton et al 2014). The required increase in the size of the care workforce is significantly larger than for any other occupation in the UK.[1] Yet poor workforce conditions mean that the sector already struggles to recruit, train and retain workers with the skills to deliver high standards of care, and problems attracting younger workers. In London in particular, migrant workers have helped to fill the gap – but the government's commitment to end freedom of movement with the EU, and to reduce net migration to below 100,000, raises questions about the sustainability of this strategy.'

This report explores the drivers of inadequate standards of care in the UK, including chronic underinvestment, the reliance on a low paid, poorly trained workforce and high levels of staff turnover. We set out a vision for the sector that seeks to support people with care needs to live life according to their own priorities. This more relational, personalised vision for care depends on a workforce with the skills, expertise and resources to understand how people want to live (and die) and how to build a care package that enables them to do so. The final section of the report looks at how progress might be made against these aims. We focus on England, though our conclusions can be broadly applied to all the devolved nations.

1 72.7 per cent of the low-skill care workforce as it stood in 2012 (see Clifton et al 2014).

1.
A PERFECT STORM?

The circumstances in which care is delivered are often highly challenging. The UK's ageing population has led to sustained increases in demand and more complex medical needs. In recent years the combination of long-term demographic pressures with fiscal austerity has created a perfect storm. Funding cuts have led to a fall in investment in the sector and the workforce at a time when the skills, expertise and resources required have increased. This situation has led to a sharp fall in the availability of care services and rising concerns about poor standards.

1.1 RISING DEMAND – CHANGING ADULT NEEDS

Demand for care will increase as the over-65 population grows by 33 per cent between 2016 and 2030 – from 11.6 million to 15.4 million. By contrast, the working age population (16–64) will increase by only 2 per cent, reducing the availability of informal care. The number of over-85s in need of care is also expected to increase significantly, as this population nearly doubles by 2030 (ONS 2015). The health and care system was designed in order to meet the needs of people who would most often experience acute conditions, such as broken limbs or infectious disease. Today the most common health conditions are chronic, long-term and often involve multiple physical, social and mental health problems. Health and care needs have become increasingly complex as a result. Shifting the locus of care in to people's homes and neighbourhoods will be a vital means of reacting to changing demand. This will have a significant effect on how we conceive of the health and care workforce. However, funding for this sort of care has been subject to severe funding cuts in recent years, leading to increasing pressures on the social care system.

1.2 FALLING INVESTMENT – FUNDING ADULT CARE

At the heart of poor performance in the care sector is inadequate public investment to meet rising demand. Expenditure on formal services totals almost £30 billion each year in England alone – this is predominantly public spending in the form of local authority-commissioned care packages, although approximately one-third is private spending by self-funders (Skills for Care 2013a). Some 1.55 million people are estimated to work in social care (Skills for Care 2015a). This is larger than the NHS workforce, at just over 1.2 million[2] (HSCIC 2016). There has also been a much larger growth in the number of people needing social care compared to health care (King's Fund 2014a).

2 There is some crossover between the two: about 6 per cent of adult social care jobs are in the NHS (Skills for Care 2015b).

Despite the size of the sector, the magnitude of its workforce and the large and growing need for care services, the social care sector is underfunded and undervalued. The sector receives far lower levels of funding than the NHS (£17 billion a year compared to £100 billion a year on health), and local authority adult social care budgets fell by 7 per cent between 2009/10 and 2014/15 in real terms (NAO 2016). There is some new money coming into the system. The change to enable local authorities (LAs) to raise local rates to generate social care revenue could open up the potential of up to £2 billion in additional funds by 2019/20 if all LAs make full use of the power (DCLG 2015). The government have also announced an extra £1.5 billion a year by 2020 for the Better Care Fund, a financial transfer from the NHS to councils. However, this additional funding does not make up for the large cut to LA-led public services and, even if fully utilised within social care, would still show an overall fall in funding. The potential £3.3 billion in cash terms by 2020/21 is not enough to cover the £8.4 billion required to maintain the current level of provision, given both cuts in funding from central government and the rising demand for social care (Thompson 2016).

The significant and sustained fiscal constraint has serious implications for the ability of the social care system and the NHS to deliver high-quality care to all those who need it. Recent national policy decisions – including the introduction of a higher national minimum wage for over-25-year-olds and the introduction of an apprenticeship levy on all large firms – will pose further challenges to the sector. The increase in pay for the lowest-paid is welcome, but given the high proportion of social care workers who are on or near the minimum wage, the cost is likely to be high for public and private providers alike.[3]

1.3 THE IMPACT ON THE AVAILABILITY OF CARE

Funding cuts have had a serious impact on the availability and quality of care services. Around three-quarters of the fall in spending has been achieved by reducing the amount of care provided – for example by raising eligibility thresholds and shortening the time allocated for visits – and the remaining quarter by reducing the price local authorities pay to providers (NAO 2014). As a result those who are in need but not in a critical or high-risk situation are becoming ineligible to receive care. The number of publicly funded carers has gone down (Quality Watch 2016c) – and those who remain eligible are likely to receive a lower quality of service in many places (LGA 2014). Most adults (87 per cent) now live in LAs that set the eligibility threshold for substantial or critical needs only (NAO 2014).

It is not only the social care system that suffers from funding cuts to care. Funding cuts also shift demand from social care to the NHS, with people who would previously have been looked after in the community now increasingly being admitted for reasons associated with a lack of available care, or being unable to be discharged due to a lack of social care. A third of inpatient discharge delays from hospital in August 2015 were found to be the result of problems in accessing social care – representing an increase of 21 per cent on the previous year (King's Fund 2015). This comes with a

3 Gardiner and Hussein (2015) estimated that moving frontline care workers to the new national living wage would have cost £1.4 billion in 2013/14 for publicly funded services alone, with private services incurring additional wage bills of just under £1 billion.

significant cost impact. Monitor and the Trust Development Authority (TDA) estimated that delayed transfers of care cost hospital trusts £270 million over a six-month period (Monitor and NHS TDA 2015).

As well as supporting patients when they leave hospital, good-quality social care can ensure they do not need to go back in. Emergency admissions, particularly those for older people with preventable issues, have also increased considerably over the past five years (Blunt 2013). In 2012/13 the Care Quality Commission found that 1 in 10 over-75s and 1 in 5 over-90s experienced an avoidable admission over the last year – which could have been prevented if they had received better support outside hospital. It expressed concern over 'a general acceleration in the rates and numbers of these avoidable admissions from 2010/11 onwards' (CQC 2013).

1.4 CONCLUSION

These are longstanding challenges, but the situation has deteriorated in recent years and has now reached crisis point, due to the combination of deep budget cuts over the past six years and demographic pressures caused by an ageing society. Further planned cuts to local authority budgets over the course of this parliament will only exacerbate the pressure on adult social care services (ADASS 2016). The immediate crisis also makes it difficult for the sector to adopt more innovative models of care or prepare for the challenges facing the workforce over the next 5 to 15 years.

2.
QUALITY OF CARE

As well as limiting service availability, chronic underinvestment is affecting the quality of care. The highest profile and most worrying manifestation of this is the rise of very short visits that leave little time to care. However, the quality and continuity of care is also being undermined by the reliance on a low-paid, poorly trained workforce and high levels of staff turnover. While many carers and care organisations continue to provide outstanding care in challenging circumstances, this situation can lead to high risks of error and, in the worst cases, abuse. This is exacerbated by a weak regulatory system that does little to drive up or enforce high standards of care. In this chapter we examine the main drivers of variable quality of care.

2.1 THE CONSEQUENCES OF UNDERINVESTMENT IN THE CARE WORKFORCE

Persistent underfunding in the adult social care sector has led to a reliance on a relatively low-paid, often poorly trained workforce. Care workers are some of the lowest paid workers in the country, and will usually earn less than their equivalents by skill level and task in the NHS. The median hourly wage in domiciliary care is just 15 per cent higher than the minimum wage, and around 160,000 care workers are effectively paid less than the minimum wage because travel time and wait time between clients is not taken into account (Gardiner 2015).

This problem is likely to be exacerbated by the increase in the national minimum wage for those aged 25 and above. The increase in pay for the lowest-paid is welcome, even if it does fall short of a genuine living wage. However, this increase will have a considerable impact on the sector. The cost of moving frontline care workers to the new national living wage (NLW) has been estimated at £1.4 billion for publicly funded services alone, with private services incurring additional wage bills of just under £1 billion (Gardiner and Hussein 2015).

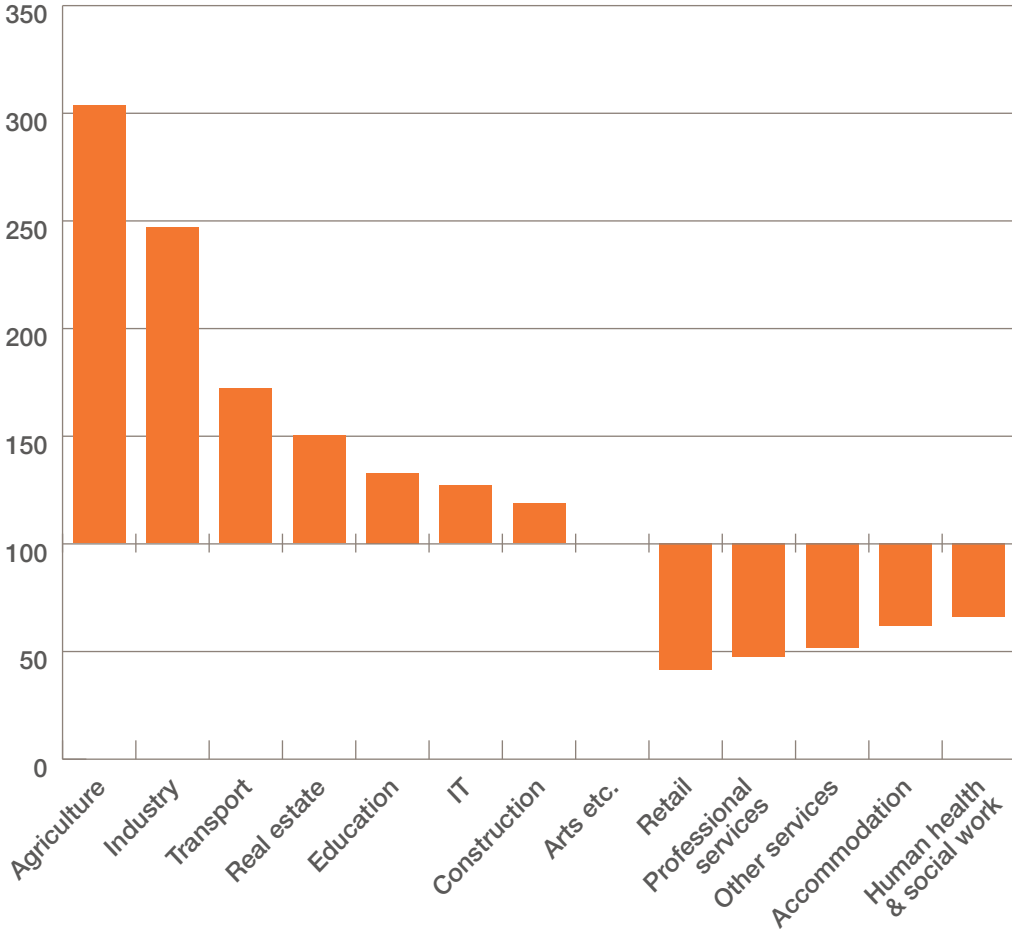
Low pay is coupled with high incidence of zero-hours contracts – it is estimated that almost one-quarter of jobs in the adult social care sector (23 per cent or 300,000 workers) are operating on a zero-hour contract (Skills for Care 2015c) – and a trend of deteriorating employment conditions (Unison 2013a).

This situation has been exacerbated by the recent reductions in funding to the sector, leading to a fall in investment in workforce training. Net capital expenditure per worker in human health and social work activities (including social care) has fallen considerably below the average level across all business sectors (see figure 2.1) – to the detriment of both servicer users and carers themselves.

FIGURE 2.1

Net capital expenditure per worker in human health and social work activities has fallen well below the average level across all business sectors

Net capital expenditure per worker by sector, relative to all business sectors (excluding financial services) (average = 100), 2014



Source: IPPR analysis using ONS, 'UK non-financial business economy: 2014 revised results (Annual Business Survey)' (ONS 2014)
Note: 'administrative services' is not included above as the most recent available data was for 2013 only; as an indication, when indexed as above its value is 66.1.

2.2 LACK OF EFFECTIVE MINIMUM STANDARDS

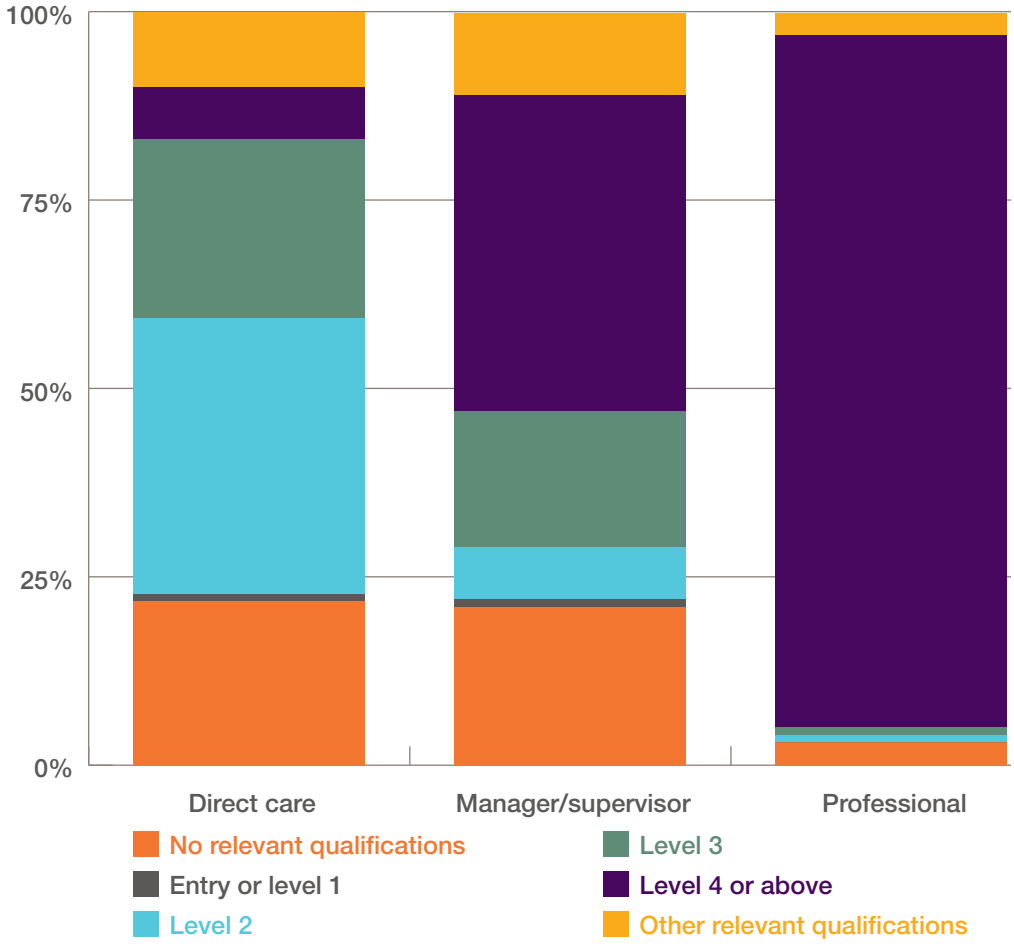
Carers effectively have no compulsory or consistent training.

The weakness of the qualification requirements relative to the professional competence that would be expected in other countries is reflected in the low levels of relevant qualifications among care workers. Figure 2.2 shows that 22 per cent of direct care workers possess no relevant qualifications at all, while 37 per cent possess level 2 qualifications (GCSE A*–C equivalent) and 24 per cent possess level 3 (A level A*–C equivalent).

FIGURE 2.2

Almost one-quarter of direct care workers possess no relevant qualifications

Highest qualifications held by workers in adult social services jobs by job role group



Source: HSCIC, Personal Social Services Adult Social Care Survey, England - 2014-15 (HSCIC (2015)

The level and quality of training of care workers in the UK – and particularly in England – is significantly lower when compared to other similar economies. A 2011 study by Gospel et al compared England – where the minimum requirements for an elderly care assistant at the time were 24 hours of induction training and three days paid training a year – with extensive initial and continuing vocational training for care workers in Japan and Germany. For example, at the top occupational level in Germany, elderly care workers train for three years, with 4,600 hours of theoretical education, off-the-job and practical training at work under the supervision of a qualified mentor. At the lower end, elderly care assistants in Germany receive less training, but still substantially more than in England. England is the only country where care workers are not required to have any underpinning knowledge.

This situation has deteriorated since the Gospel research was published. National minimum training standards for care staff to have an NVQ level 2 have been removed in favour of a weaker requirement that staff should be 'appropriately trained'.

Care work is not low skilled. Care workers deal with people with complex physical and mental health needs and are sometimes (and increasingly) expected to administer medicine and even perform invasive procedures (Cavendish 2013). Yet specialist training is poor. More than 4 in 10 care workers do not receive specialised training to help deal with their clients' specific medical needs, such as dementia and stroke-related conditions (Unison 2013b). Our research with care workers provided further evidence of these problems, with some voicing concerns that the quality of training provided left them feeling unprepared for the work required of them:

> *'There's no check that you've understood, and [the trainer's] not even qualified to do what she's teaching. She just reads a book out.'*
> Social care worker

> *'We did get induction training but it was very superficial … It doesn't prepare you for the work. You don't practise with real patients.'*
> Social care worker

Some progress has been made since the 2013 Cavendish review, which recommended establishing common training standards across health and social care through a 'Certificate of Fundamental Care'. A new care certificate, intended to provide a portable minimum standard of care, was subsequently introduced in 2015. Developed by Skills for Care, Skills for Health and Health Education England, the certificate is supposed to be completed within 12 weeks of starting work and to include a personal development plan. However, while the standards provide guidance, crucially they are not mandatory or enforced by a regulator, and concerns have been raised about quality assurance, portability and suitability (Skills for Care 2014b). The limited training requirements for care workers stand in direct contrast to nurses, who must renew their registration every three years by confirming that they have met established continuing professional development (CPD) standards.

2.3 LACK OF OPPORTUNITIES FOR PROGRESSION

Care workers also report a lack of progression opportunities (UKCES 2015). Vertical progression is inhibited by bottlenecks in to more senior roles of the same type (such as senior care worker) or management/supervisory roles. This is due particularly to the structure of the workforce: while 76 per cent of jobs are direct care roles, only 7 per cent are managerial roles (Skills for Care 2014b). A further inhibitor is the sometimes sharp increase in qualification level between roles of increasing seniority within 'direct care', from direct care to management, and from direct care to professional roles, unlike in the health sector which offers more intermediate opportunities.

The lack of training, low pay and weak progression opportunities contribute to high turnover rates and low job satisfaction. Skills for Care found that there can be huge variability in turnover and retention rates among social care employers, with average turnover at 24 per cent. The most common reasons for social care staff leaving between 2010 and 2012 were personal reasons, leaving to join another employer and issues linked to career development. Pay and conditions were reported to account for decisions to leave the sector in one out of five leavers (Skills for Care 2013b).

Managers of high-retaining employers identify clear benefits of staff retention for service users including, most importantly, continuity of care. Linked to this are the relationships that staff can build with service users which are consistently proven to put service users more at ease. This also allows carers to become familiar with service users' preferences (as well as what they do not like), which helps to embed personalised care. Managers also identified a range of organisational benefits as a result of greater staff retention, including better team-working, more skilled and experienced staff and being better able to match care workers' strengths and interests to clients' needs and requirements. Cost savings can also be achieved and reputations enhanced through having low levels of attrition. There are numerous factors that play a part in employers achieving and then sustaining high levels of staff retention. Among the most important were training, and providing employees with autonomy and flexibility (ibid).

2.4 A RELIANCE ON MIGRANT LABOUR

A reliance on migrant labour in caring occupations has helped to mask the absence of effective workforce planning strategies. Employers may turn to migrant labour to fill posts where they have difficulty attracting workers to replace those leaving the workforce, or more skilled workers where there are skills shortages. This is particularly the case in London, where nearly half (46 per cent) of carers are non-UK nationals. Just under one-quarter (23 per cent) of carers are non-UK nationals in the south-east, compared to 7 per cent in the north-east (Skills for Care 2015a).

The removal of senior care workers from the Tier 2 visa occupations shortage list in 2008, coupled with the entrance of eastern European countries into the EU a few years earlier, has led to a shift from skilled migrants from the Commonwealth countries with a required level of English, to EU migrants with no training or language requirements. This has led to some concerns about the skills and English proficiency in a role that involves intimate work and involves high levels of human interaction and communication. Today more than 1 in 20 carers in England have emigrated from other EU countries, while 1 in 7 are of non-European Economic Area origin (ibid).

Depending on the outcome of the negotiations over Britain's exit from the European Union and the implications for freedom of movement, there is also a question about the sustainability of a workforce strategy reliant on migrant labour from the EU (see, for example, Independent Age 2015). High churn in the sector means that the fall in future EU migrants will have a considerable effect on the size of the workforce. Demographic pressures are likely to exacerbate this situation, as increasing demand

for social care drives up the already high levels of 'replacement demand' in care over the coming years. Yet under current conditions, providers are likely to struggle to improve their offer to British-based workers and potential new UK workers may be attracted to sectors with more favourable employment conditions.

2.5 A WEAK REGULATORY STRUCTURE

The protection of adults using social care services in the UK is largely dependent on standard-setting and inspection. In this context, the problems faced by the regulator, the Care Quality Commission (CQC), are cause for concern. The CQC is responsible for the regulation and inspection of care providers against minimum standards of quality and safety, and was declared ineffective by the House of Commons' public accounts committee in December 2015 (PAC 2015). Headline cases of abuse and neglect, such as Winterbourne View care home, Orchid View care home (Southern Cross), and more recently St Anne's Community Services which was taken to court and fined for the avoidable death of a resident (Silman 2016), have indicated the extreme results of poor regulation.

Social care regulation, through the CQC, is more 'light touch' than in other sectors in which the workforce cares directly for vulnerable individuals. Children's social care, for example, uses a more rigorous approach, with inspections carried out by Ofsted.[4]

More broadly, there has been an attempt to raise standards by giving council-funded service users more control over the shape of services through the use of personal budgets. In use in social care for up to 20 years (Muir and Quilter-Pinner 2015), personal budgets are perhaps the most radical of recent innovations to empower citizens in relation to public services, and are likely to soon shake up how health services as well as care are delivered (NHS 2014). At their most powerful in the form of direct payments, they hand public money to the citizen to directly purchase the care and support they want, representing a radical break in the orthodox model of state provision of services.

There are mixed views on the impact of personal budgets in social care. Offered to all those in receipt of social care since 2008, they have been shown to have improved outcomes and wellbeing for those who use them compared to those who do not (Hatton et al 2013). Yet within the social care market, take-up varies between groups – 83 per cent of those with learning difficulties have taken them up, compared to 29 per cent of eligible people with mental health problems (Fox 2014). Key weaknesses mean that even with personal budgets many citizens are far from empowered (McNeil and Hunter 2014), and some have argued that they are contributing to a race to the bottom.

4 Source: IPPR interviews with stakeholders.

The weak institutional framework in England has limited the effectiveness of previous attempts to raise skill levels in the sector. Regulation alone has had a limited impact on employers' competitive and human resource strategies. Many employers reliant on a low-cost workforce failed to utilise, build on or reward the skills gained by staff undertaking (admittedly relatively limited) care qualifications (Gospel and Lewis 2010). There is some evidence that recent attempts to drive up the quantity and quality of apprenticeships are meeting a similar fate. Health and social care has seen a big increase in apprenticeships in recent years, but serious concerns have been raised about the standards of training being offered by employers (Ofsted 2015), and one recent study found that Level 2 and 3 apprenticeships in health and social care provide no wage returns at all (Broughton 2015).

The UK's market-led voluntarist system contrasts with the approach in other northern European countries, where strong legal training requirements are designed to encourage a self-regulatory ethos across a wide range of occupations – particularly in sectors where consumers have an interest in being protected from irresponsible or poorly trained practitioners. Countries such as Australia and the US also make greater use of occupational licensing to set standards (Humphris et al 2009), and England is unusual in the fact that care workers are not required to have any underpinning knowledge in order to practise (Gospel et al 2011).

In many of these countries, training requirements sit within a wider institutional framework that is designed to encourage professional competence and knowledge, overseen by strong industry-led sector bodies with the remit and powers to set high standards and ensure training keeps pace with workforce needs, and local bodies that carry out quality assurance procedures (see Lanning and Lawton 2012). Nobody has a comparable remit in England. Sector organisations such as Skills for Care and the Social Care Institute for Excellence provide information and promote best practice, but they lack the powers or resources to enforce higher standards or drive innovation in the sector, while local authority commissioning practices have, if anything, created a downward pressure on standards.

2.6 POOR COMMISSIONING PRACTICES

Carers are spending less time with those who are in receipt of care. The majority (74 per cent) of councils commission home care visits in 15-minute time slots, with 1 in 7 home care visits in these areas now being just 15 minutes long (Unison 2016). This is despite evidence suggesting longer time periods would improve quality of care in some instances (Lin 2011). These practices are unpopular among practitioners and the public (Leonard Cheshire Disability 2013), and can lead to rushed, poorer quality care (Unison 2013a). With practices such as these becoming more common (NAO 2014), it is not surprising that carers feel less involved than they used to in the care of their patients (Quality Watch 2016d).

'In home care you don't have a life. You're working for 70 hours and getting paid for 50. Even if you get paid for travel time, you're out for the whole day and not paid for gaps in between visits … If a client needs more than 15 minutes, that's on you.'
Social care worker

2.7 CONCLUSION

We have seen how the UK is an international outlier in requiring no minimum training standards for its care workers. A reliance on migrant labour in the care sector has helped to mask the absence of effective workforce planning strategies, and this in turn has perpetuated high levels of staff turnover and a lack of continuity of care. Social care needs a more coordinated and strategic approach that focuses on the workforce and puts personal, relational care with high-quality interactions at its core.

3. RECOMMENDATIONS FOR RAISING STANDARDS IN SOCIAL CARE

IPPR has previously argued for a more 'relational' role for the state in public services, where services are built around the quality of the relationship between an individual and a frontline worker (Muir and Parker 2014). This can only be achieved with a workforce that is properly supported and valued, with better working conditions and prospects for progression.

The sector is under great strain, suffering from decades of underinvestment and little long-term strategic vision. While the recommendations we outline below will help tackle the problems we identify, they can only be fully resolved with a sustainable funding solution for social care.

Our vision to improve standards in the care sector therefore has three elements.

1. Effective minimum standards to push up quality, developed by Skills for Care in conjunction with a representative board, and enforced through a stronger CQC.
2. Better conditions for workers, enforced through a stronger CQC in partnership with HMRC.
3. An industrial strategy for care with a new focus on innovation, including stimulating the potential of new technology to drive productivity improvements.

3.1 EFFECTIVE MINIMUM STANDARDS FOR TRAINING

Minimum qualifications and appropriate training to attain them are essential to ensure services are of a consistently good quality, yet the UK has neither. This situation contrasts with other areas of care provision for vulnerable individuals. For example, minimum qualifications are required for those working in health care, with vulnerable children and in other forms of social work. In not setting minimum standards for training in social care, the UK is an outlier compared to other advanced economies.

Any changes to the current provision, enforcement or regulation of training should take into account the current context of significant underfunding in the sector. Mandatory training that is costly for providers or workers would only exacerbate current pressures (in the short term at least). However, change is needed. The quality of care remains too low for too many. Mandatory, enforced minimum qualifications acquired through high-quality training would boost workers' skills and improve the quality of care they provide.

Moreover, there is a strong cost argument for improving the quality of care through better, enforced minimum standards. Regulations promote training (Gospel and Lewis 2010), and training in turn improves the quality of care. High-quality social care is both better for users and saves costs for local authorities and the NHS, who benefit from the reduction in avoidable critical cases and avoidable admissions respectively.

The care certificate has had some success in formalising a minimum skills floor, but it remains unenforced and therefore too many carers are not given the opportunity to have this training. The certificate was introduced with the aim of ensuring a minimum level of skill and knowledge among the workforce, and thereby improving outcomes for care users. Sadly it has not had the impact that was hoped for, being poorly delivered in some cases and ignored in others. **We recommend building on the certificate as a route to improving standards in care**.

In order to improve care outcomes, the care certificate needs to fulfil three criteria.

1. It must be a robust indicator of high-quality skills and knowledge
2. It must be mandatory for workers and enforced by a regulator
3. It must be delivered to a high standard by training providers or employers.

1. A robust indicator of high-quality skills, knowledge and behaviours

The content of the care certificate should ensure that those who earn this qualification have the skills and knowledge to provide high-quality care in a range of situations. Rather than relying on any single organisation to prescribe the content of this training, the certificate should be further developed by a consortium of organisations and individuals, including employers, carers and government.

Representative boards are effective leaders in other sectors, such as construction and the creative industries. The construction industry training board (CITB) has provided effective support and planning for the sector using employer representation, and Creative Skillset, the creative industries skills body, is effective in supporting a fragmented sector through an employer-led board. Skills for Care, the sector skills body, is in a good position to appoint a representative board and coordinate the ongoing process of ensuring the certificate is providing the right skills and knowledge sets to carers.

2. Mandatory for workers and enforced by a regulator

If enforced, the care certificate would in effect be a licence to practise for carers as recommended in the Kingsmill review (Kingsmill 2014). In order to achieve this, legislation should be introduced to create a legal requirement on care providers to deliver this training and to ensure that all their staff have this qualification. This change would mimic recent reforms in social work, and move closer to the qualification requirements in the health sector.

The Care Quality Commission (CQC) is best placed to enforce the provision of the certificate. Though the CQC currently includes workforce training as an element of its inspections, requirements are low and given too little weight in the overall inspection framework. Without reforms to the CQC,

requirements for minimum qualifications and investment in training are likely to go unenforced. **We recommend that provision of training and enforcement of the minimum standards are strengthened within the inspection framework**. In addition, **we recommend that the responsibility of proving whether training has been provided moves from CQC to employers**. As in other sectors (see below) employers in care should have a duty to proactively demonstrate that they have trained their employees under the care certificate curriculum.

3. Delivered to a high standard by training providers and/or employers

The persistent lack – and poor quality – of training in the sector has demonstrated that the social care market is not incentivised to provide high-quality training to its staff. The introduction of the apprenticeship levy presents an opportunity to improve the quality and degree of training in social care. The levy is a 0.5 per cent payroll tax on any company that has a payroll bill of £3 million or more. The tax is applicable to only the payroll amount over £3 million and comes into force in 2017/18. The levy will affect around 2 per cent of companies, and will not affect the majority of social care providers.

However, for those providers that are affected, the levy is both a challenge and an opportunity to bring about positive change. To bring about the best outcomes for service users, the levy should be flexible to needs of employers and employees, acknowledging that apprenticeships, though a common and effective course to higher qualifications for some, are not the best route for all. This can be achieved by collective pooling of funds to be used in line with employer/employee need and requirements. This would include the care certificate and CPD requirements, as well as apprenticeships. This will ensure that employers who pay the levy are incentivised to provide the minimum standard of training, in addition to apprenticeships and other longer-term qualifications.

Recommendation 1

The care certificate should be a legal requirement – and it should be fully enforced – in order to create an effective minimum qualification floor for the care sector.

3.2 OVERSIGHT AND MONITORING OF QUALITY STANDARDS

The care sector suffers from poor and/or illegal employment practices, such as underpayment of the national minimum wage, the widespread use of zero-hours contracts and the common practice of 15-minute care slots. Better conditions lead to better outcomes and benefit employees. More successful recruitment, higher levels of retention, improved job satisfaction and the higher levels of effort that go with it, benefit care users and employers.

Therefore, in addition to strengthening the role of CQC to enforce minimum standards of training, **we recommend that the role of CQC is broadened to tackle the exploitation of low paid workers in the sector**. In addition to including employment outcomes in its inspection regime, CQC should have a duty to refer cases of underpayment of the national minimum wage

to HMRC, as recommended in the Kingsmill review. National regulatory bodies like HMRC are overstretched and not currently effective enough in tackling exploitative working practices. Giving CQC the remit and resources to support HMRC in enforcing the higher minimum wage (or national living wage) is likely to shed more light on these illegal practices and to reduce their prevalence in the long term. This is particularly urgent now, when evidence suggests social care employers are both likely to struggle to cover the cost of the national living wage, and are more likely than employers in other sectors to use loopholes to avoid complying with minimum wage legislation (LPC 2016).Reforms to the CQC can draw on best practice examples from better-regulated sectors. For example, the Gangmasters licensing authority (GLA) requires that employers proactively demonstrate that they have met GLA requirements, rather than rely on an inspection regime. Employers are required to be a member of the authority and their fees cover the costs of regulation.

The CQC itself is moving to a fee-paying model in a response to funding cuts (from £249 million to £217 million over the current parliament). This transition could incorporate the requirement of membership for social care employers with fees set at a level that is acceptable to employers while also enabling the commission to strengthen its regime and broaden its remit.

Recommendation 2

The CQC should be given two new duties:

- a duty to enforce minimum standards, by requiring that employers proactively demonstrate that they have trained their employees under the care certificate curriculum, though high-quality training
- a duty to tackle the exploitation of low-paid workers, by broadening its inspection regime to include employment outcomes, with a duty to refer non-payment to HMRC.

The cost of resourcing these new duties for the CQC should come from employer fees, set at a level that is acceptable to employers and enables reform to the commission.

3.3 A NEW INDUSTRIAL STRATEGY FOR THE CARE SECTOR

These recommendations need to be combined with a wider vision for the sector: supporting the integration of training between NHS and non-NHS carers; supporting technological innovation in care; and moving towards responsible procurement in all local authorities.

There are numerous successful tech innovations happening at the frontline of social care, but the current underutilisation of both medicinal and digital technology means that there is real opportunity to unleash a new wave of innovation that could have a revolutionary impact on how care is delivered, and how patients interact with professionals to manage their own health and care.

Recommendation 3

We recommend pump priming of technological innovation through match funding for new applications that will improve the delivery of social care:

- match funding for new technological applications that will improve the delivery of social care
- the fund could be small, up to £5 million, delivering seed funding of £20–£50,000 for individual projects
- require open standards so that new tech systems are compatible with each other, rather than recreating the NHS IT barriers.

Taken together these measures will bring about a more coordinated and strategic approach to social care that focuses on the workforce and puts personal, relational care with high-quality interactions at its core.

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