



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health & Social Care**

# The adult social care workforce in England

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Department of Health & Social Care

# The adult social care workforce in England

Report by the Comptroller and Auditor General

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National Audit Act 1983 for presentation to the House of  
Commons in accordance with Section 9 of the Act

Sir Amyas Morse KCB  
Comptroller and Auditor General  
National Audit Office

5 February 2018

This report considers the Department of Health & Social Care's role in overseeing the adult social care workforce and assesses whether the size and structure of the care workforce are adequate to meet users' needs for care now, and in the future, in the face of financial challenges and a competitive labour market.

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## Key facts

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**1.34m**

was the estimated number of jobs (excluding personal assistants and NHS jobs) in the adult social care sector in England in 2016-17

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**2009**

was the last time a national workforce strategy was published by the Department of Health & Social Care

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**6.6%**

was the vacancy rate for jobs across the care sector in 2016-17

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**£16.8 billion** is the sum of £14.8 billion of net current expenditure on care by local authorities and £2.0 billion allocated from the NHS through the Better Care Fund in 2016-17

**27.8%** was the turnover rate across all care jobs in 2016-17

**£7.50** was the median pay per hour for a care worker in the independent care sector in 2016-17

**11.3%** was the vacancy rate for registered managers in 2016-17, the highest vacancy rate in care

**16%** of registered nurses in 2016-17 who were non-British European Economic Area nationals, the highest percentage for any care job

**2 million** was the Centre for Workforce Intelligence's 2014 principal projection of the demand for full-time equivalent jobs in adult social care by 2035

# Summary

**1** Adult social care comprises personal care and practical support for older adults who cannot manage the tasks of everyday life and for working-age adults with physical disabilities, learning disabilities, or physical or mental illnesses. It also includes support for their carers. Most care is provided unpaid by family or friends (known as ‘informal care’). The amount of informal care provided affects the amount of formal care that is needed, provided and publicly funded through local authorities or through people funding their own care privately. Policy choices on eligibility for publicly funded care changes the number of people who qualify, and therefore the number who might need to buy their own care, rely on informal care, or have their care needs unmet.

**2** In 2016-17, net current expenditure by local authorities on care was £14.8 billion. Additionally, around £2.0 billion of funding allocated to the NHS was transferred to pooled budgets with local authorities, through the Better Care Fund, to support care. Local authorities commission most care from the independent (private and voluntary) sector. Around 65% of providers’ income comes from care arranged by local authorities, so public funding is essential to the sustainability of the sector. Care arranged by local authorities includes some contributions from users. Estimates by the Office for National Statistics and Carers UK, respectively, of the value of informal care range from £57 billion to over £100 billion per year. Demographic trends suggest that demand for care will continue to increase and people’s care needs will continue to become more complex. To meet these challenges, the care workforce needs to grow and the nature of care and support needs to transform.

**3** In 2016-17, the care workforce in England consisted of around 1.34 million jobs in the local authority and independent sectors. The full-time equivalent number of jobs was around 1.0 million. This excludes an estimated 145,000 job for personal assistants, employed by recipients of personal budgets and self-funders, and 91,000 people who have care jobs but are employed within the NHS. In our report, unless otherwise stated personal assistants and NHS staff are excluded from our analysis.

**4** The Department of Health & Social Care (the Department), formerly the Department of Health, is responsible for adult social care policy, as it was before its name-change in January 2018. One of the nine priorities in its *Shared Delivery Plan: 2015 to 2020*, published in February 2016, was to “make sure the health and care system workforce has the right skills and the right number of staff in the most appropriate settings to provide consistently safe and high quality care”. The Department has an objective to integrate health and social care more closely by 2020.

**5** Local authorities commission care. The Care Act 2014 sets out minimum standards of care that local authorities must offer. It places a duty on local authorities to ensure that there is diversity and quality in the market of care providers so that there are enough high-quality services for people to choose from. Local authorities must also step in to ensure that no vulnerable person is left without the care they need if their service closes due to business failure. Most care is provided by independent providers, which are autonomous businesses responsible for employing, training and setting pay, terms and conditions for their own workforces. There are around 20,300 organisations providing care, resulting in a care market that is fragmented with complex chains of commissioning, provision and accountability.

**6** Skills for Care (an independent charity and company limited by guarantee) is the Department's delivery partner for leadership and workforce development in care. Skills for Care provides practical resources and support to help care providers recruit, retain, develop and lead their workforces. In both 2016-17 and 2017-18, the Department provided £23.5 million in funding for Skills for Care, including around £2 million for maintaining the National Minimum Data Set for Social Care (NMDS-SC). This data set is the leading source of workforce information for the whole care sector, collected from local authorities and, on a voluntary basis, from care providers. We have drawn extensively on these data in our report. We follow Skills for Care's terminology throughout the report, unless where stated otherwise.

## **Our report**

**7** This report considers the Department's role in overseeing the adult social care workforce and assesses whether the size and structure of the care workforce are adequate to meet users' needs for care now, and in the future, in the face of financial challenges and a competitive labour market.

**8** In Part One, we profile the range of care jobs and the workforce, and examine workforce trends and cost pressures within the care sector. In Part Two, we examine the challenges that providers face in recruiting and retaining workers in three job roles facing pressures: care workers, registered managers and registered nurses. We also examine the number of non-British European Economic Area (EEA) workers in the care workforce. In Part Three, we examine the adequacy of strategic workforce planning at national, regional and local levels.

**9** Our main methods were analysis of available workforce data; visits to local areas to meet with representatives of local authorities and independent providers; interviews with representatives of other organisations operating within adult social care; a review of published research on the care workforce; and a review of relevant departmental documents. Our audit approach and methods are covered in Appendices One and Two.



## Key findings

### Signs of problems within the workforce and wider impact

#### **10 Turnover and vacancy rates across the social care workforce are high.**

In 2016-17, the annual turnover of all care staff was 27.8%. The proportion of vacancies in care rose from 5.5% in 2012-13 to a peak of 7.0% in 2015-16, falling slightly to 6.6% in 2016-17. Two roles in particular – care workers and registered nurses – have high vacancy and turnover rates compared with other roles within social care. High vacancy rates and turnover can disrupt the continuity and quality of care for service users and also mean providers incur regular recruitment and induction costs (paragraphs 1.7 to 1.9).

#### **11 Growth in the number of jobs has fallen behind growth in demand for care.**

The Department commissioned modelling based on 2014 data that suggested the number of full-time equivalent jobs in care would need to increase by around 2.6% per year until 2035 to meet increased demand. However, the annual growth in the number of jobs since 2013 has been 2% or lower. The failure of formal care to meet this increased demand may have contributed to the growth in individuals' care needs not being met. Age UK estimated that 1.2 million people over the age of 65 had some level of unmet care needs in 2016-17, up from 1 million in 2015-16 (paragraphs 1.6, 1.17 to 1.18 and 3.2 to 3.5).

**12 In October 2017, the Care Quality Commission (CQC) stated that the sustainability of the care market remained precarious.** In its annual report on the state of health care and social care, the CQC said that demand for care is increasing but capacity is reducing. It was concerned about a reduction in the number of nursing home beds, the high level of vacancies across the care sector and the severe pressures acute hospitals are facing. As at 31 July 2017, 19% of adult social care providers required improvement and 1% were rated as inadequate. Of the five areas in which the CQC judges providers, 'safety' is the main one in which providers need to improve. The CQC says 'safety' is linked to the number and quality of staff (paragraphs 1.15 to 1.16).

### Recruitment and retention challenges

#### **13 Care work is viewed by the public as low skilled and offering limited opportunities for career progression.**

Research by the UK Commission for Employment and Skills found that employers reported recruitment challenges due to a negative perception of the care workforce and lower-level caring roles in particular. Roles in the care sector suffer from low prestige and perceived poorer options for career progression when compared with similar roles in the NHS (paragraphs 2.2 to 2.4).

**14 Providers and commissioners of care have raised concerns that low pay for care workers is contributing to high vacancy and turnover rates.** In 2016-17, the care worker vacancy rate was 7.7% and turnover was 33.8%. Around half of care workers were paid £7.50 per hour or below (the National Living Wage was £7.20 in 2016-17). There was lower turnover among higher-paid care workers. Research by Skills for Care found that care providers with the lowest turnover rates ensured people knew that they paid at least the National Living Wage, and made care work more attractive by, for example, investing in staff development and offering flexible working (paragraphs 1.7 to 1.9, 2.6 to 2.10, and 2.15 to 2.16).

**15 The vacancy rate for nurses more than doubled between 2012-13 and 2016-17.** The vacancy rate for registered nursing jobs in care was 9.0% in 2016-17. This increased from 4.1% in 2012-13, despite the overall number of jobs falling from 51,000 to 43,000. In February 2015, the Department hosted a symposium to look at the issues around recruitment and retention of nurses in care. Attendees noted the lack of prestige of working in care compared with working for the NHS and the poorer options for career and pay progression (paragraphs 2.19 to 2.22).

**16 In 2016-17, 7% of the care workforce were non-British EEA nationals, with nursing the job role in care that had the highest proportion of non-British EEA workers.** There was wide regional variation in the proportion of non-British EEA nationals working in care, from 2% in the North East to 13% in London. Non-British EEA nationals made up 16% of registered nurses working within care. Across health and social care, the number of nurses joining the Nursing and Midwifery Council register from the EU (excluding from the UK) increased from around 16,800 in March 2013 to around 38,000 in March 2017. However, since July 2016 the number of nurses joining the UK register for the first time from the EU has dropped (paragraphs 2.23 to 2.26).

**17 Providers have particular difficulty recruiting to the role of registered manager.** Since 2010, CQC has required all regulated adult social care establishments to have a registered manager. This regulation is regarded as essential to providing a safe service. The registered manager, along with the registered provider, is legally accountable for compliance with laws and regulations. In 2016-17, the vacancy rate for registered managers was 11.3%, the highest rate across all care roles. There is concern in the sector about the low number of care workers willing to seek promotion into this role because of the high level of responsibility compared with the level of pay (paragraphs 2.17 to 2.18).

## Strategic oversight and support for workforce planning

### **18 The Department does not have an up-to-date care workforce strategy and roles and responsibilities of the bodies involved in delivering care are not clear.**

The Department's last workforce strategy, *Working to put people first: the strategy for the adult social care workforce in England*, was published in 2009. It is available on the National Archive website only, and gives responsibility to some organisations that no longer exist. Health Education England published a draft workforce strategy, *Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027*, for consultation in December 2017. The draft strategy is mainly concerned with the health sector, and coverage of the care sector is short and lacking detail. Despite publishing the strategy, Health Education England has no formal responsibility for the adult social care workforce; responsibility lies with the Department. The Department is currently working with Skills for Care on a consultation exercise to inform future strategies. The Department acknowledges that a strategy for care will need to take into account proposals in the green paper on care for older people, which is due to be published in summer 2018. A comprehensive strategy will require the roles of the various bodies involved in delivering care to be more clearly defined and agreed across the sector (paragraphs 1.2 and 3.7 to 3.11).

**19 Local and regional bodies and partnerships are not taking the lead on workforce planning in the absence of a national strategy.** Our review of local authorities' market position statements and of sustainability and transformation partnerships' plans found that few local areas have detailed plans for the care workforce. The Department does not oversee the workforce planning of local authorities or partnerships (paragraphs 3.12 to 3.15).

**20 The Department cannot demonstrate that the sector is sustainably funded, which makes workforce planning difficult.** Between 2010-11 and 2016-17, spending on care by local authorities (including funding transferred from the NHS through the Better Care Fund), reduced by 5.3% in real terms. Spending power for local authorities, in total, is forecast to reduce a further 0.2% in real terms between 2017-18 and 2019-20, despite rising demand, increased complexity of care, and financial pressure such as the National Living Wage. The sector remains concerned that there is no certainty about whether the extra £2 billion in government funding for social care between 2017-18 and 2019-20 is a permanent increase. In the Association of Directors of Adult Social Services' 2017 annual survey, completed by 95% of directors, only 3% stated that they were fully confident that they will be able to meet their statutory duties relating to care in 2019-20. Uncertainty over the sustainability of funding makes it difficult for local authorities to plan how much care, and at what price, they will be able to purchase. This affects providers' ability to undertake workforce planning (paragraphs 1.10 to 1.11).

**21 Four-fifths of local authorities are paying fees to providers that are below the benchmark costs of care.** Our analysis shows that only 18% of local authorities were paying an average fee for homecare that was at or above the United Kingdom Homecare Association's recommended minimum sustainable price for homecare of £16.70 per hour in 2016-17, a rate that the Department, in the guidance to the Care Act 2014, suggests local authorities should have regard to. In 2016-17, local authorities paid an average cost of £15.52 per hour for homecare. In November 2017, the Competition and Markets Authority estimated that if local authorities were to pay the full cost of care home placements for all residents they fund, the additional cost to them of these higher fees would be around £1 billion per year. Self-funders paid on average 41% more for a care home placement. Fees in future years will need to take account of the requirement for providers to pay increases in the rate of the National Living Wage. There is a risk that continued low fees will deter future investment by providers in areas with high proportions of people receiving care funded by the local authority (paragraphs 1.12 to 1.14).

**22 The Department is not doing enough to support the development of a sustainable care workforce.** Both providers and commissioners from local authorities told us that current funding constraints mean they must prioritise the provision of care in the short-term over offering extensive long-term support for learning and career development to their staff. Nationally, Skills for Care is the Department's delivery body for leadership and workforce development. In 2016-17, the Department provided £21.5 million in funding for Skills for Care (excluding the money to maintain the National Minimum Data Set for Social Care) to oversee and administer workforce initiatives. This equated to just £14 per worker. As a result, initiatives to support the sector are generally small-scale, which reduces their coverage and potential impact (paragraphs 2.4 to 2.5).

**23 Integration of health and social care is not expected to significantly reduce the number of care jobs required.** While integration may meet the needs of service users more effectively, workforce modelling commissioned by the Department in 2014 suggested that increased levels of health and care integration will not significantly reduce the forecast increase in the number of jobs required. In February 2017, we reported on the slow pace of integration. Barriers to integrating the health and social care workforces include differences in working culture, professional boundaries and different terms and conditions across the health and local government sectors (paragraphs 1.3 and 3.6).<sup>1</sup>

<sup>1</sup> Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017.

## Conclusion on value for money

**24** The one and a half million people working in adult social care in England provide essential support to adults with care needs, yet the care sector is undervalued and its workers poorly rewarded. Providers are having increasing difficulty recruiting and retaining workers, and the number of individuals with some level of unmet care needs is increasing.

**25** Despite these highly visible challenges, the Department does not have a current workforce strategy and key commitments it has made to both enhance training and career development and tackle recruitment and retention challenges have not been followed through. There is no evidence that the Department is exercising oversight over local authorities and local health and care partnerships for their responsibilities relating to the adult social care workforce. As a result, the actions taken by the Department in its oversight role have not demonstrably improved the sustainability of the workforce and so have not achieved value for money. The Department needs to address this challenge urgently and give the care workforce the attention it requires, so that the sector has the right people to provide consistently safe and high-quality care.

## Recommendations

**26** A care workforce that is suitably planned, supported and resourced would improve the quality of care, thereby improving the experience and safety of users, and in addition alleviate pressures on the health service.

**a** **The Department should produce a robust national workforce strategy to address the major challenges currently facing the care workforce.**

The Department has policy responsibility for the care workforce, and should involve other key stakeholders, principally the Ministry of Housing, Communities & Local Government. The strategy should be consistent with reforms stemming from the planned green paper. If a strategy is combined with health, care must receive equivalent prominence.

**b** **The Department needs to understand and plan long-term for the effect on the workforce that integration of health and care, and other potential changes to how care is delivered, will bring.**

The Department should set out clearer career pathways for workers in care that link with roles in health. The Department should consider how best to address differences in pay and conditions across the health and care sectors, in relation to supporting recruitment and retention in care.

- c The Department should encourage local and regional bodies to produce workforce strategies that complement the national strategy.** The Department should gain assurance that every area has a clear plan, aligned with the national strategy and local NHS plans. Local areas should plan how to work effectively with other statutory bodies, such as local Jobcentre Plus offices. The Department should gain assurance that local or regional bodies are holding providers to account for delivery.
- d The Department should assess whether current initiatives, both national and local, to support recruitment, retention and development are sufficient.** The Department should identify ways to boost the impact of these initiatives and consider increasing the scale of those shown to be successful.
- e The Department should establish how much funding the sector will need over the long term and make the consequences of any funding gap clear.** The Department should consider sharing its modelling of cost and demand pressures on the care sector to help commissioners set appropriate fees for providers; this includes the costs arising from future changes to the National Living Wage.

# Part One

## The care landscape

**1.1** This part of the report profiles the care workforce and the organisations involved in delivering and overseeing care. It examines trends in care jobs, and assesses the financial environment.

### Responsibilities for the adult social care workforce

**1.2** Arrangements for managing and supporting the care workforce are complex, with many bodies involved (**Figure 1** overleaf). The Department of Health & Social Care ('the Department') has overall policy responsibility for the adult social care ('care') system. The Department has formal responsibility for the adult social care workforce. The Department funds its delivery partner, Skills for Care to support care organisations in recruiting, developing and leading their workforces. Local authorities commission most care from independent providers. Providers are autonomous businesses responsible for employing, training and setting pay, terms and conditions for their own workforces. Providers may make decisions for commercial reasons that are inconsistent with the Department's or local authorities' objectives. For example, local authorities told us of nursing homes re-registering as care homes because they could not recruit nurses. This may exacerbate local shortages of nursing home beds and cause disruption for people with nursing needs. Providers must follow statutory regulations monitored by the Care Quality Commission (CQC). The number of bodies involved, the long delivery chain and overlapping responsibilities can make accountability for addressing workforce issues difficult to delineate.

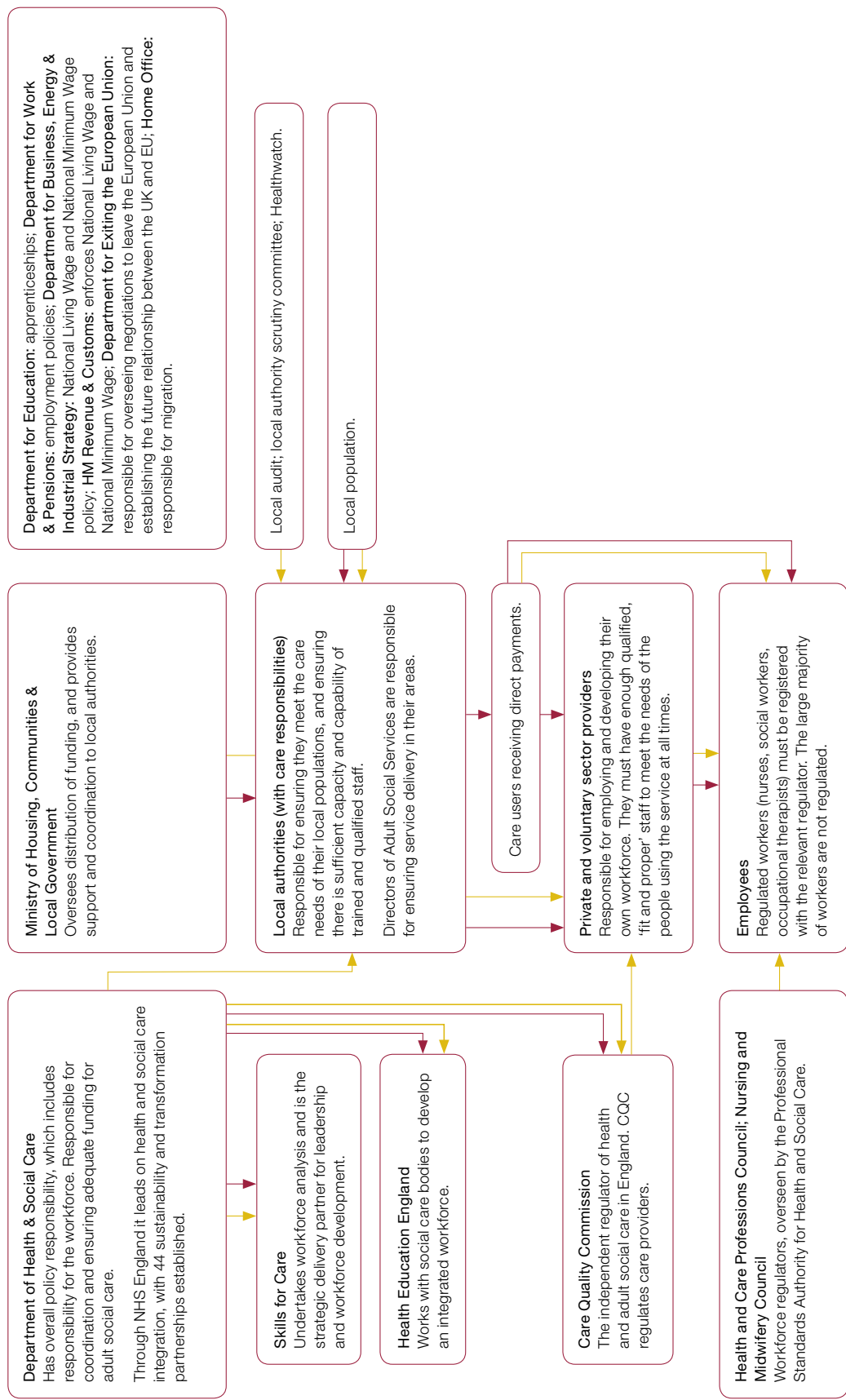
**1.3** The Department has an objective to integrate health and care services by 2020. In our February 2017 report *Health and social care integration* we concluded that the Department did not yet have the evidence to show that this can be delivered at the same time as meeting the existing pressures on the health and care systems.<sup>2</sup> In our May 2016 report *Discharging older patients from hospital*, we concluded that social care providers' difficulties recruiting and retaining staff had contributed to an increase in the time it takes to arrange care packages for people leaving hospital. This in turn has contributed to the significant increase in delays in discharging people from hospital.<sup>3</sup>

<sup>2</sup> Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017.

<sup>3</sup> Comptroller and Auditor General, *Discharging older patients from hospital*, Session 2016-17, HC 18, National Audit Office, May 2016.

**Figure 1** Organisations with responsibilities relating to the adult social care workforce

Roles and responsibilities for the care workforce are complex



➔ Financial flow ➔ Oversight

Source: National Audit Office



## Profile of adult social care workers

**1.4** In 2016-17, the care workforce in England consisted of around 1,340,000 jobs in the local authority and independent sectors, across more than 20,300 organisations. This excludes an estimated 145,000 jobs for personal assistants, employed by recipients of personal budgets and self-funders, and 91,000 care jobs within the NHS. Most jobs in care – around 1,230,000 – are with independent organisations; around 113,000 jobs are with local authorities. The role with the largest number of jobs is that of care worker (**Figure 2** overleaf). In our report, we exclude personal assistants and staff working in the NHS from our analyses, unless otherwise stated.

**1.5** In 2016-17, features of the workforce included:

- 82% of care jobs were undertaken by women, compared with 47% in the economically active population.
- 6% more workers in the care sector were aged 45 and over compared with the economically active population.
- The care workforce was more diverse than the population as a whole: 20% of the workforce were from black, Asian or minority ethnic backgrounds, compared with 14% of the population.
- British nationals made up 83% of the workforce, with 7% from other European Economic Area (EEA) countries and 9% from non-EEA countries. There was wide regional variation: 96% of the workforce in the North East were British, compared with 61% in London.
- Most jobs were in residential care homes (665,000), followed by homecare (525,000), community care (115,000) and daycare (36,000).<sup>4</sup>

## Growth in number of jobs

**1.6** The rate of increase for all care jobs, including personal assistants and care jobs in the NHS, has slowed. Between 2014-15 and 2015-16, there was an increase of 30,000 jobs compared to increases of 70,000 between 2012-13 and 2013-14 and 90,000 between 2010-11 and 2011-12 (**Figure 3** on page 17). The annual growth rate in jobs has been below 2% since 2012-13.

<sup>4</sup> Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates*.

**Figure 2**

## Numbers of jobs in the care workforce in England, 2016-17

Most roles are jobs that involve providing direct care to users

<b>Managerial</b>	<b>Number of jobs</b>
Senior management	16,000
Registered manager	22,500
Other managerial	78,000
<b>Total managerial</b>	<b>115,000</b>
<b>Regulated profession</b>	
Social worker	17,000
Occupational therapist	3,000
Registered nurse	43,000
Other regulated profession	2,000
<b>Total regulated profession</b>	<b>64,500</b>
<b>Direct care</b>	
Senior care worker	85,000
Care worker	815,000
Support and outreach	60,000
Other direct care	23,000
<b>Total direct care</b>	<b>985,000</b>
<b>Other jobs</b>	<b>175,000</b>
<b>Total jobs</b>	<b>1,340,000</b>

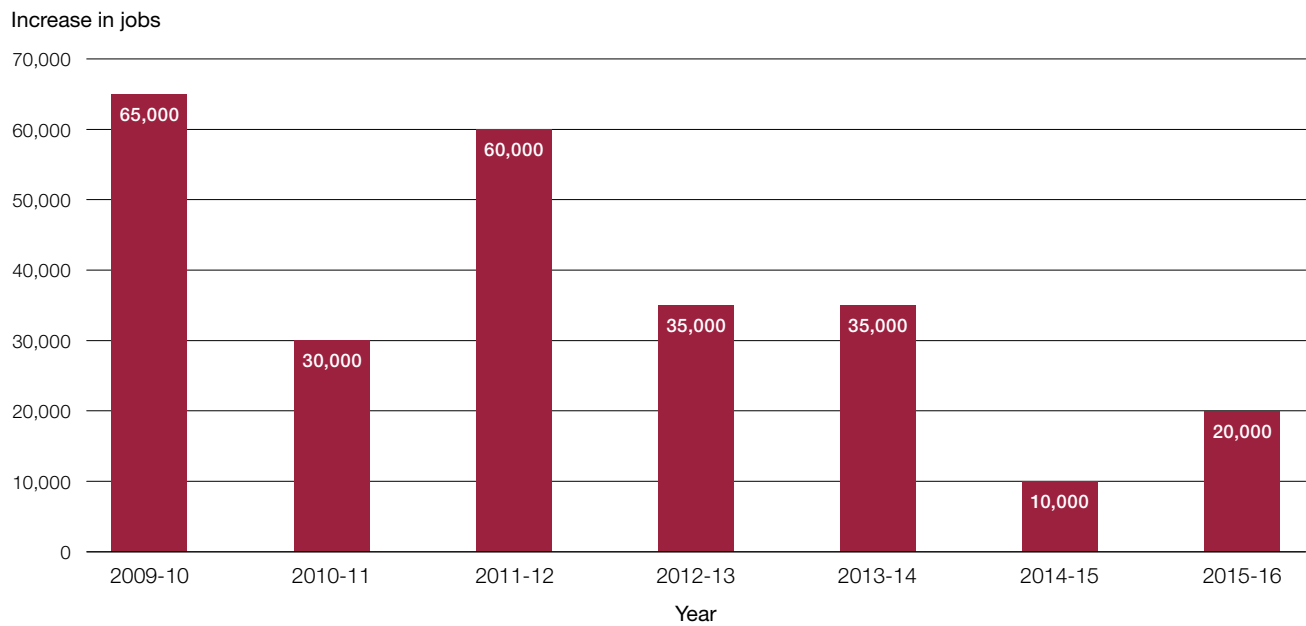
**Notes**

- 1 Number of jobs, including totals, rounded by Skills for Care to nearest 500, 1,000 or 5,000 depending on the number of jobs.
- 2 'Other' roles include chefs, cooks, cleaners and maintenance staff.

Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC)*, 2016-17 workforce estimates

**Figure 3**

Estimated annual increases in care jobs, 2009-10 to 2015-16

**Growth in the number of jobs has slowed****Notes**

- 1 Figures rounded to nearest 5,000.
- 2 Includes employees of local authorities and independent providers, personal assistants and NHS staff working in care.

Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC)*, 2016-17 workforce estimates

## Vacancy and turnover rates

**1.7** The vacancy rate across all roles increased from 5.5% in 2012-13 to a peak of 7.0% in 2015-16, before falling to 6.6% in 2016-17. In 2016-17, for roles with more than 20,000 employees, the highest vacancy rates were for registered managers (11.3%), registered nurses (9.0%) and care workers (7.7%) (**Figure 4**). In 2016-17, the average vacancy rate in homecare was 9.1%. This was significantly higher than the average vacancy rate in residential care homes of 4.4%. London, the South East, the South West and the East of England had high vacancy rates in both homecare and residential care homes (**Figure 5** on page 20). Vacancy rates have remained high despite the rate of increase in jobs slowing.

**1.8** The turnover rate of all care staff has been increasing since 2012-13 (**Figure 6** on page 21). In 2016-17, the turnover rate of all care staff was 27.8% and was particularly high for care workers (33.8%) and registered nurses (32.1%). In 2016-17, turnover rates were higher in homecare than residential care homes. The average turnover in homecare was 32.2% while the average turnover in residential care homes was 26.3%. The South West had the highest turnover rate in both homecare and residential care homes (**Figure 7** on page 22). In 2016-17, data from Skills for Care indicated that 67% of workers were recruited from within the care sector, so the skills and experience built up by a worker leaving a care job are not necessarily lost to the sector as a whole.<sup>5</sup> However staff turnover is costly to the sector as providers incur costs in recruitment, replacement and induction of staff.

**1.9** By way of context, in 2016-17, the Office for National Statistics reported that during the period, the vacancy rate across all sectors in the UK averaged between 2.5% and 2.7%.<sup>6</sup> There is no precise recognised turnover rate, but average turnover is estimated to be around 15%. A high vacancy and turnover rate can affect the quality of care that service users receive. People receiving homecare may experience shorter visits than necessary if care workers have higher workloads and service users may lose continuity of care. The CQC found a link between high vacancy and turnover rates, and poorer levels of care being provided.<sup>7</sup> For providers, high vacancy rates mean there is a shortage of suitably qualified staff, and providers may have to use non-permanent staff to cover shortfalls. In 2016-17, 10% of care jobs were filled by temporary staff.<sup>8</sup>

<sup>5</sup> See footnote 4.

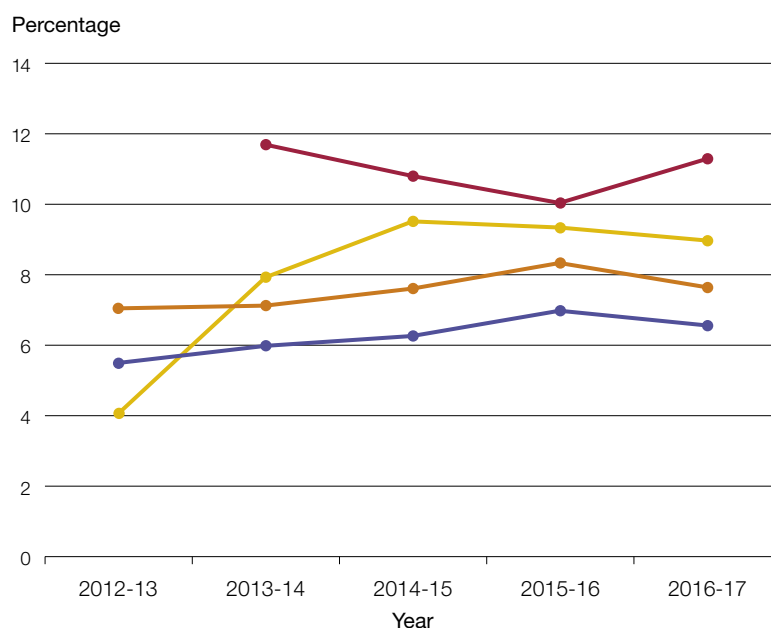
<sup>6</sup> Office for National Statistics, *Vacancies by industry*, December 2017, available at: [www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/datasets/vacanciesbyindustryvacs02](http://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/datasets/vacanciesbyindustryvacs02).

<sup>7</sup> Care Quality Commission, *The state of adult social care services 2014 to 2017: findings from CQC's initial programme of comprehensive inspections in adult social care*, August 2017, available at: [www.cqc.org.uk/sites/default/files/20170703\\_ASC\\_end\\_of\\_programme\\_FINAL2.pdf](http://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf).

<sup>8</sup> See footnote 4.

**Figure 4**  
Vacancy rates by role, 2012-13 to 2016-17

The vacancy rate for all care jobs was 6.6% in 2016-17



	2012-13	2013-14	2014-15	2015-16	2016-17
Registered manager	–	11.7	10.8	10.1	11.3
Registered nurse	4.1	7.9	9.5	9.4	9.0
Care worker	7.1	7.1	7.6	8.4	7.7
All job roles	5.5	6.0	6.3	7.0	6.6

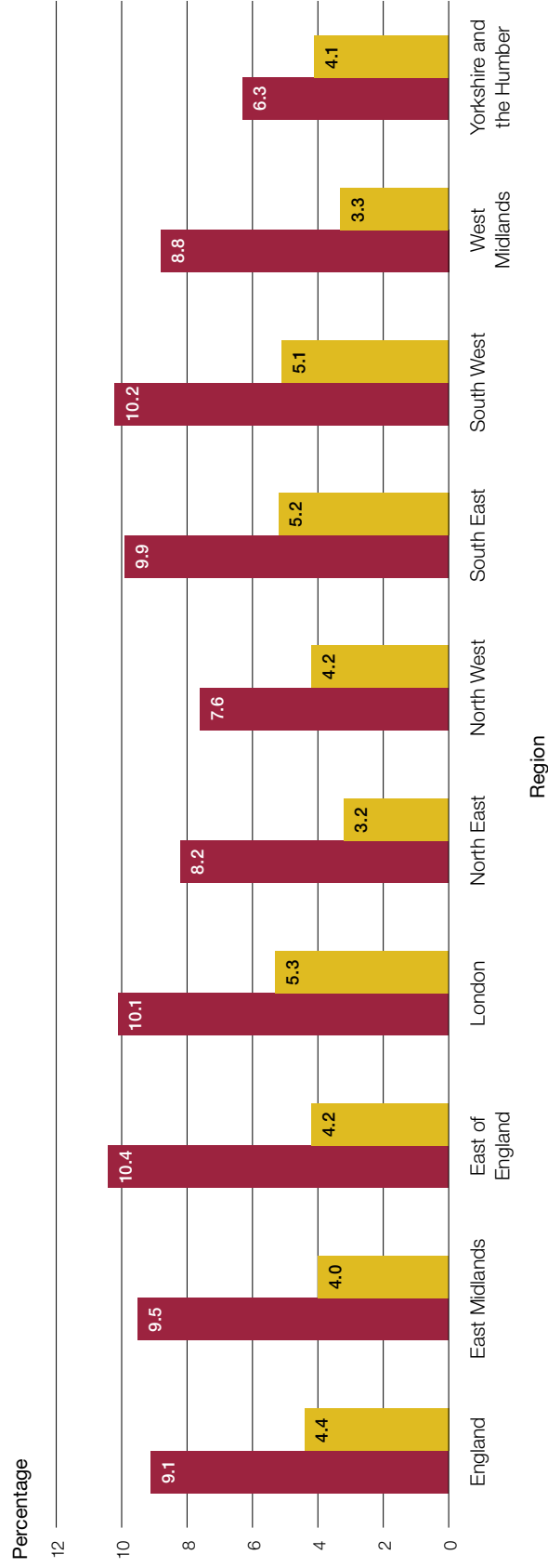
**Notes**

- 1 Vacancy rates are calculated by dividing the number of vacancies by the sum of employed staff and vacancies.
- 2 Data are not available for the vacancy rate for the role of registered manager for 2012-13.
- 3 'All job roles' includes all the job roles listed in Figure 2.
- 4 We have only compared all job roles with care workers, registered managers and registered nurses, as these are the three job roles with the highest turnover and vacancy rates where there are over 20,000 jobs.

Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC)*, 2016-17 workforce estimates

**Figure 5**  
Vacancy rates by region for homecare and residential care homes, 2016-17

Vacancy rates are higher in homecare, and in southern regions



■ Homecare

■ Residential care homes

**Note**

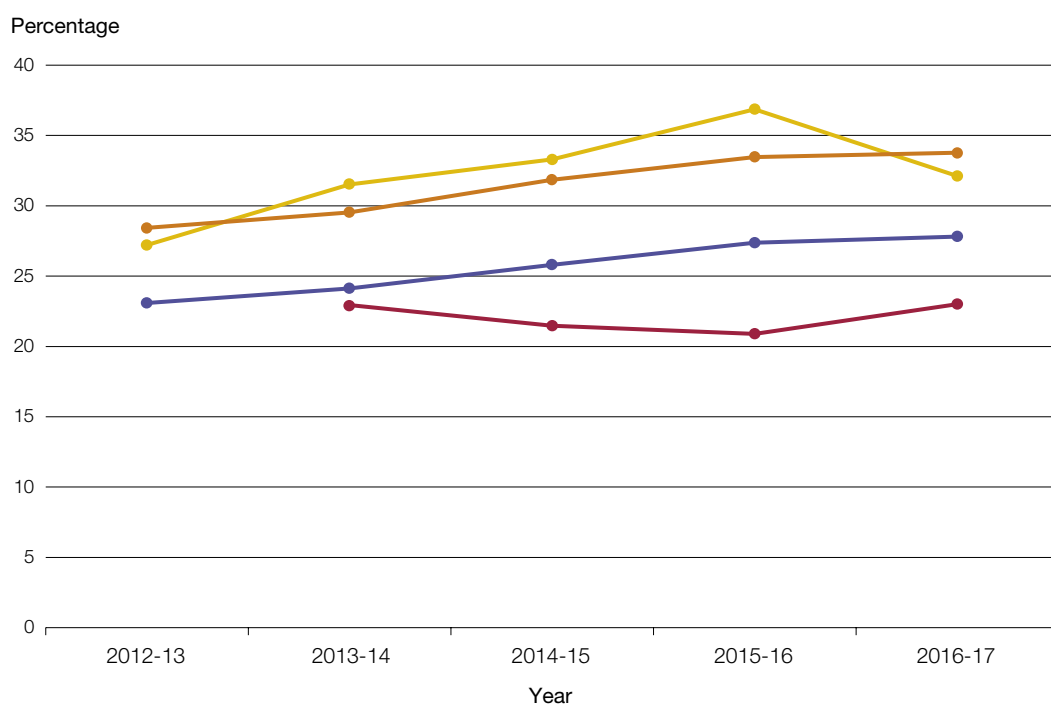
1 Includes all job roles within homecare and residential care homes.

Source: Skills for Care, National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates

**Figure 6**

Turnover by role, 2012-13 to 2016-17

Overall, turnover has been increasing since 2012-13



	2012-13	2013-14	2014-15	2015-16	2016-17
Registered manager	-	22.9	21.5	20.9	23.0
Registered nurse	27.2	31.5	33.3	36.8	32.1
Care worker	28.4	29.5	31.8	33.5	33.8
All job roles	23.1	24.1	25.8	27.4	27.8

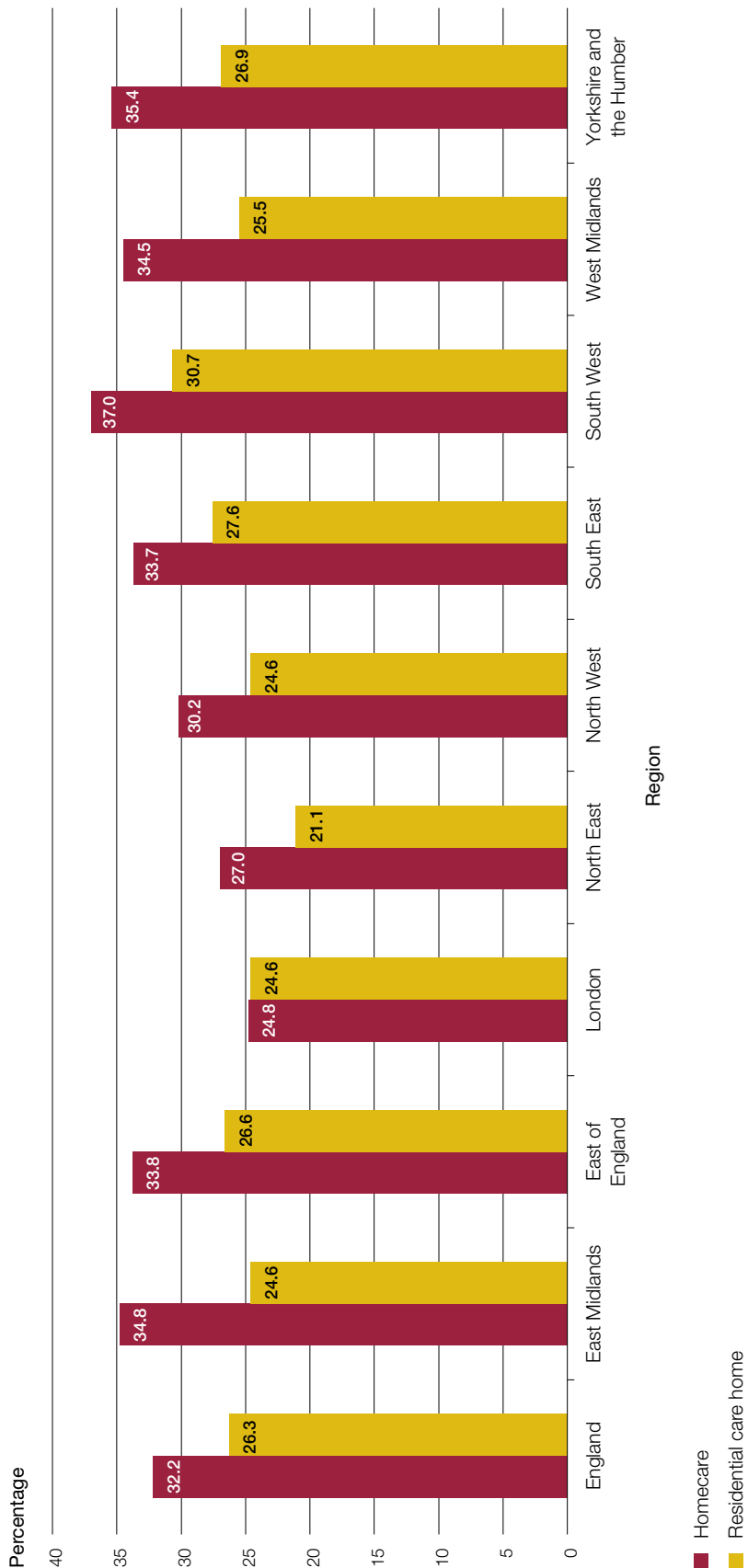
**Notes**

- 1 Establishments record the numbers of permanent staff, temporary staff and leavers. Turnover rates are calculated by dividing leavers by employed staff.
- 2 Data are not available for the turnover rate for the role of registered manager for 2012-13.
- 3 'All job roles' includes all the job roles listed in Figure 2.
- 4 We have only compared all job roles with care workers, registered managers and registered nurses, as these are the three job roles with the highest turnover and vacancy rates where there are over 20,000 jobs

Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates*

**Figure 7**  
Turnover by region for homecare and residential care homes, 2016-17

Turnover rates were higher in homecare than residential care



**Notes**

- 1 Establishments record the numbers of permanent staff, temporary staff and leavers. Turnover rates are calculated by dividing leavers by employed staff.
- 2 Includes all job roles within homecare and residential care homes.

Source: Skills for Care, National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates



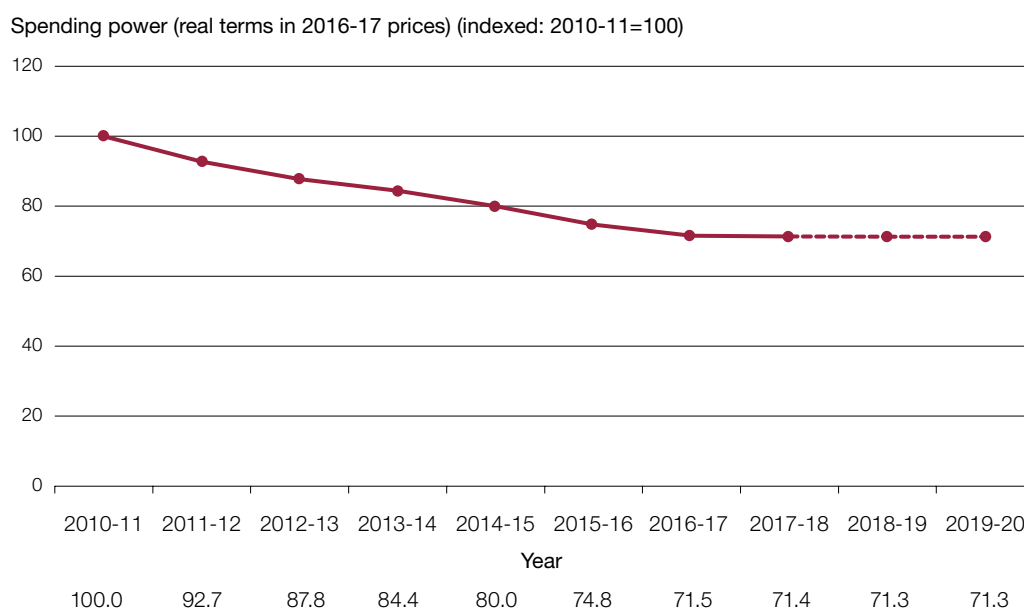
## Funding of local authority arranged care

**1.10** Around 65% of providers' income comes from care arranged by the local authority, so public funding is important to the sustainability of the sector. Local authorities' spending power (made up of government grants, locally retained business rates and council tax) fell in real terms by 28.6% between 2010-11 and 2017-18 (**Figure 8**). Estimated net expenditure on care by local authorities, including transfers from the NHS through the Better Care Fund, reduced by 5.3% in real terms between 2010-11 and 2016-17.<sup>9</sup> Since 2015, the government has made changes to the way that local authorities raise funds for care (**Figure 9** overleaf). After accounting for these changes, we estimate that, between 2017-18 and 2019-20, the total spending power for local authorities will fall by a further 0.2% in real terms.

### Figure 8

Estimated change in local authority spending power, 2010-11 to 2019-20

Spending power has been falling since 2010-11



#### Notes

- Our measure of spending power uses data published annually by the Ministry of Housing, Communities and Local Government. However we exclude public health grant, the Better Care Fund and NHS transfers for social care where they are included in the years 2011-12 to 2015-16. We use a chain-linking approach in order to address discontinuities in the definition of spending power from 2010-11 to 2015-16. We use the method set out by Robjohns, J, 'Methodology Notes: Annual Chain Linking', Economic Trends, Number 630, Office for National Statistics, May 2006.
- The dotted sections of the chart show forecast change in spending power.

Source: National Audit Office analysis

<sup>9</sup> NHS Digital, *Adult social care activity and finance: England 2016-17*, October 2017, available at: <http://digital.nhs.uk/catalogue/PUB30121>. Based on Table C1: Net current expenditure on adult social care services in cash terms: by source of funding. (Includes net current expenditure by local authorities and certain funding streams from the NHS, including Valuing People Now, NHS transfers to local authorities, Better Care Fund expenditure on social care and winter pressures' transfers).

**Figure 9**

## Changes to funding of local authority care, 2015 to present

**There have been regular changes in the way care is funded**

Spending Review and Autumn Statement, November 2015	Extra funding to be allocated through the improved Better Care Fund, worth £1.5 billion by 2019-20.
Local Government Finance Settlement for 2016-17, February 2016	Introduced the adult social care precept – the option for local authorities with care responsibilities to add up to 2% to council tax (on top of the standard 2% referendum limit that applied at the time) to fund care, for up to four years from 2016-17 to 2019-20.
Local Government Finance Settlement for 2017-18, February 2017	Amended the rules around the adult social care precept to allow local authorities to increase the precept to 3% in 2017-18 and 2018-19, provided increases do not exceed 6% in total over the three-year period to 2019-20.  Introduced the adult social care support grant, worth £240 million in 2017-18.
Budget, March 2017	An extra £2 billion (in totality) for social care between 2017-18 and 2019-20 through the improved Better Care Fund. There is no certainty over the future continuation of this grant.

Source: National Audit Office analysis of government spending reviews, budgets and local government finance settlements

**1.11** Local authorities have welcomed the extra central funding intended for care and the opportunity to raise additional funds through council tax. However, in July 2017, the Local Government Association withdrew support for the Department's guidance on how to spend the extra £2 billion announced in the March 2017 Budget.<sup>10</sup> This was because local authorities were not told of targets and potential penalties if they failed to reduce delayed discharges. Senior representatives of local authorities we visited told us that they were reticent about using this funding to increase fee rates to providers because they assumed that the funding is one-off. In the Association of Directors of Adult Social Services' 2017 annual survey, completed by 95% of directors, only 3% stated that they were fully confident that they will be able to meet their statutory duties relating to care in 2019-20.<sup>11</sup> Long-term workforce planning is very difficult if funding is short-term.

10 Local Government Association, *Councils respond to government rules around spending on social care money*, July 2017.

11 Association of Directors of Adult Social Services in England, *ADASS budget survey 2017*, June 2017, available at: [www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf](http://www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf).

## Cost pressures for providers

**1.12** The most significant long-term cost pressures facing local authorities are rising demand for care and cost pressures from pay and overheads. In the medium term, the National Living Wage, the minimum pay for over-25s introduced in April 2016, is a considerable cost pressure. The Department for Business, Energy & Industrial Strategy is responsible for National Living Wage policy. The National Living Wage was set initially at £7.20 per hour, with a plan for it to rise to 60% of median earnings by 2020. In July 2015, the Office for Budget Responsibility estimated that the National Living Wage would be £9.35 per hour by 2020.<sup>12</sup> In November 2017, it reduced its estimate to £8.56 per hour, to reflect lower than expected wages growth.<sup>13</sup> The expected costs to the care sector were modelled by the then Department of Health before the 2015 Spending Review. The model was agreed with HM Treasury. Our assessment is that the Department's ongoing modelling of the additional costs associated with the National Living Wage is robust. In 2015, forecasts by the Department suggested that the cost pressure arising from the National Living Wage would, by 2019-20, consume nearly all the monies forecast to be raised by local authorities from the adult social care precept. The reduction in the expected National Living Wage rate has reduced this proportion, although the cost pressure remains significant. The Department does not share its modelling with local authorities. The Local Government Association and the Association of Directors of Adult Social Services told us that understanding how the Department has modelled the impact of the National Living Wage would help local authorities set fee rates and budget sustainably.

**1.13** In November 2017, the Competition and Markets Authority (CMA) reported that the current system for providing care across care homes is not sustainable without additional funding.<sup>14</sup> It estimated that if local authorities were to pay the full cost of care for all care home residents they fund, the additional cost to them of these higher fees would be around £1 billion per year (assuming this money is directed specifically to those homes where local authorities pay fee rates below total costs). The CMA estimated that self-funders pay a 41% premium for a care home placement. It also found that care homes with higher proportions of self-funded residents have had higher operating profit margins than those that mainly have residents funded by the local authority. It cautioned that providers that focus on residents funded by the local authority are likely to be affected the most by future challenges, and that they may exit the market. Recent investment in care homes has mainly been aimed at self-funders. There has been limited investment for those homes most exposed to local authority funded residents.

12 Office for Budget Responsibility, *July 2015: Fiscal and financial outlook*, July 2015, available at: [http://budgetresponsibility.org.uk/docs/dlm\\_uploads/July-2015-EFO-234224.pdf](http://budgetresponsibility.org.uk/docs/dlm_uploads/July-2015-EFO-234224.pdf).

13 Office for Budget Responsibility, *November 2017: Economic and fiscal outlook*, November 2017, available at: <http://obr.uk/efo/economic-fiscal-outlook-november-2017/>.

14 Competition and Markets Authority, *Care homes market study final report*, November 2017, available at: <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>.

**1.14** The Care Act 2014 guidance sets out that local authorities should have regard to guidance on minimum fee levels, taking account of the local economic environment. The guidance signposts to possible approaches for local authorities, for example the United Kingdom Homecare Association (UKHCA) Minimum Price for Homecare tool, which indicated that a minimum sustainable price for homecare was £16.70 per hour in 2016-17.<sup>15</sup> In 2016-17, local authorities paid an average of £15.52 per hour to external providers. Our analysis shows that only 18% of local authorities were paying an average fee rate that was at or above the UKHCA minimum fee rate.<sup>16</sup> Some major providers have withdrawn from the local authority homecare market or from major local authority contracts. They cited under-funding and workforce affordability among their reasons

### **Service sustainability**

**1.15** In its October 2017 report *State of health care and adult social care in England 2016-17*, the CQC stated that the sustainability of the adult social care market remained precarious.<sup>17</sup> It noted that demand for care is increasing because of an ageing population with increasingly complex health conditions but that the capacity of the care sector was shrinking, with fewer nursing home beds in particular. The CQC noted that reductions in the availability of social care services increases pressure on hospitals.

**1.16** At the end of July 2017, the CQC rated 80% of care providers as good or outstanding, 19% as requiring improvement and 1% as inadequate. Of the five areas in which the CQC judges providers, 'safety', which the CQC links to the level and quality of staff, and 'well-led', were the main areas in which providers needed to improve.<sup>18</sup>

**1.17** The Department accepts that there is some unmet need for social care and that the workforce is not large enough to fully meet all users' needs. Only 27% of councils have arrangements in place to monitor unmet need.<sup>19</sup> Age UK estimated that in 2016-17, 1.2 million adults over 65 had unmet care needs, up from 1 million in 2015-16. Of these, 291,400 people in 2016-17 had needs that would have met Care Act eligibility for support.<sup>20</sup> In 2016, the Health Survey for England estimated that 24% of adults over 65 had some unmet need.<sup>21</sup>

15 £16.70 was the rate in 2016-17. United Kingdom Homecare Association, *The homecare deficit 2016*, October 2016, available at: [www.ukhca.co.uk/pdfs/ukhca\\_homecare\\_deficit\\_2016\\_final.pdf](http://www.ukhca.co.uk/pdfs/ukhca_homecare_deficit_2016_final.pdf). The 2018-19 rate will be £18.01.

16 National Audit Office analysis of NHS Digital, *Adult social care activity and finance: England 2016-17*, October 2017, available at: <http://digital.nhs.uk/catalogue/PUB30121>.

17 Care Quality Commission, *The state of health care and adult social care in England 2016/17*, October 2017, available at: [www.cqc.org.uk/sites/default/files/20171123\\_stateofcare1617\\_report.pdf](http://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf)

18 Care Quality Commission, *The state of adult social care services 2014-2017*, July 2017, available at: [www.cqc.org.uk/sites/default/files/20170703\\_ASC\\_end\\_of\\_programme\\_FINAL2.pdf](http://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf).

19 See footnote 11.

20 Age UK, *Health and care of older people in England 2017*, February 2017, available at: [www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The\\_Health\\_and\\_Care\\_of\\_Older\\_People\\_in\\_England\\_2016.pdf](http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf).

21 NHS Digital, *Health Survey for England 2016*, December 2017, available at: <https://digital.nhs.uk/catalogue/PUB30169>.

**1.18** There are not enough precise data to quantify how much informal care occurs, but indicators suggest it is rising. The estimated number of informal carers in England increased by 11% between 2001 and 2011, from 4.9 million to 5.4 million.<sup>22</sup> The Office for National Statistics estimated that across the UK between 2009 and 2014 there was a 9.5% increase in hours of unpaid care (from 7.4 billion to 8.1 billion) and a 14.3% growth in people receiving unpaid continuous (168 hours per week) care.<sup>23</sup> This may be due to the fact that between 2008-09 and 2012-13, over 400,000 people stopped receiving care funded by the local authority, and some local authorities have worked proactively to identify more carers.<sup>24</sup> The number of carers being paid Carer's Allowance increased from 481,000 in May 2008 to 815,000 in May 2017.<sup>25</sup>

22 Office for National Statistics, *2011 census analysis: unpaid care in England and Wales 2011 and comparison with 2001*, February 2013, available at: [www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/2011censusanalysisunpaidcareinenglandandwales2011andcomparisonwith2001/2013-02-15](http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/2011censusanalysisunpaidcareinenglandandwales2011andcomparisonwith2001/2013-02-15).

23 Office for National Statistics, *Home produced adult care services*, April 2016, available at: [www.ons.gov.uk/economy/nationalaccounts/satelliteaccounts/compendium/householdsatelliteaccounts/2005to2014/chapter3homeproducedadultcareservices](http://www.ons.gov.uk/economy/nationalaccounts/satelliteaccounts/compendium/householdsatelliteaccounts/2005to2014/chapter3homeproducedadultcareservices).

24 Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017.

25 The figures for Carer's Allowance include all of Great Britain, excluding Northern Ireland. Department for Work & Pensions, *DWP benefits statistical summaries*, December 2017, available at: [www.gov.uk/government/statistics/dwp-statistical-summaries-2017](http://www.gov.uk/government/statistics/dwp-statistical-summaries-2017).

## Part Two

### Recruitment and retention challenges

**2.1** This part of the report looks at the challenges faced by providers in recruiting and retaining care staff. We examine recruiting and retaining care workers, registered managers and registered nurses. The Department of Health & Social Care (the Department) has identified these three roles as facing the greatest challenges – they have the highest turnover and vacancy rates for roles where there are more than 20,000 staff.

#### **Prestige of care as a career**

**2.2** Almost all representatives of local authorities, providers and bodies that represent and support the care sector that we interviewed told us that lack of prestige is a major impediment to recruitment. Skills for Care also regards lack of prestige as a significant impediment. Some potential recruits view providing personal care to people as an unpleasant and demanding occupation compared with jobs that offer equivalent pay, such as retail. Nearly all representatives felt that occupations in the health service are held in higher regard than those in care.

**2.3** In May 2015, the UK Commission for Employment and Skills reported the results of its survey of employers and sector representatives which said that the public image of social care jobs was a challenge to recruitment.<sup>26</sup> Employers reported competing against negative perceptions of the care workforce and lower-level caring roles in particular, partly due to recent scandals. However, many people working in care find it a rewarding career. Skills for Care is carrying out work with providers to promote care as a career through 'I-Care Ambassadors'. Ambassadors are mainly staff from providers who promote care through career fairs, and through giving presentations or informal talks. Skills for Care recognises that activities to promote care as a career need to be scaled up, and it is preparing a proposal for a national recruitment campaign.

<sup>26</sup> UK Commission for Employment and Skills, *Sector insights: skills and performance challenges in the health and social care sector*, May 2015, available at: [www.gov.uk/government/publications/sector-insights-skills-and-performance-challenges-in-the-health-and-social-care-sector](http://www.gov.uk/government/publications/sector-insights-skills-and-performance-challenges-in-the-health-and-social-care-sector).

## Career development and training

**2.4** We heard from sector representatives that the widespread public perception that care work offers limited opportunities for career progression, particularly compared with health, is a barrier to recruitment. Care Act guidance states that local authorities should encourage training and development of care staff, but providers are not formally required to offer development opportunities to staff. Local authorities lack the strategic ability to require providers to support training programmes, so development opportunities for staff vary depending on the provider. Both providers and commissioners from local authorities told us that current funding constraints necessitate them prioritising the provision of care in the short-term, over offering extensive long-term support for learning and career development to their staff. They told us that providing better training would be a priority if extra funding was available. The Department has not followed through on commitments to training made in the 2012 white paper *Caring for our future: reforming care and support* (Figure 10).<sup>27</sup>

### Figure 10

White paper commitments and National Audit Office assessment of progress

#### Commitments made by the Department have not been followed through

Publish clear and accessible information on staff training so people can understand the skill mix of staff at different care providers.	<ul style="list-style-type: none"> <li>● The Department has not ensured publication of information on staff training.</li> <li>● Skills for Care only hold records of training that is supported by the Workforce Development Fund.</li> </ul>
Work with care providers, service users and carers to develop a sector-specific compact including a skills pledge, to promote culture change and skills development.	<ul style="list-style-type: none"> <li>● The Department launched the Social Care Commitment in 2013 and described it as a key part in improving workforce quality, but due to low take up the Commitment is now closed to new employers wishing to sign up.</li> </ul>
Expectation that local authorities and care providers will identify appropriate resources to support training and development as part of the commissioning process.	<ul style="list-style-type: none"> <li>● The Department is unaware whether local authorities and care providers have identified resources to support training.</li> <li>● During case studies we saw limited evidence of joint planning of training by local authorities and providers.</li> </ul>

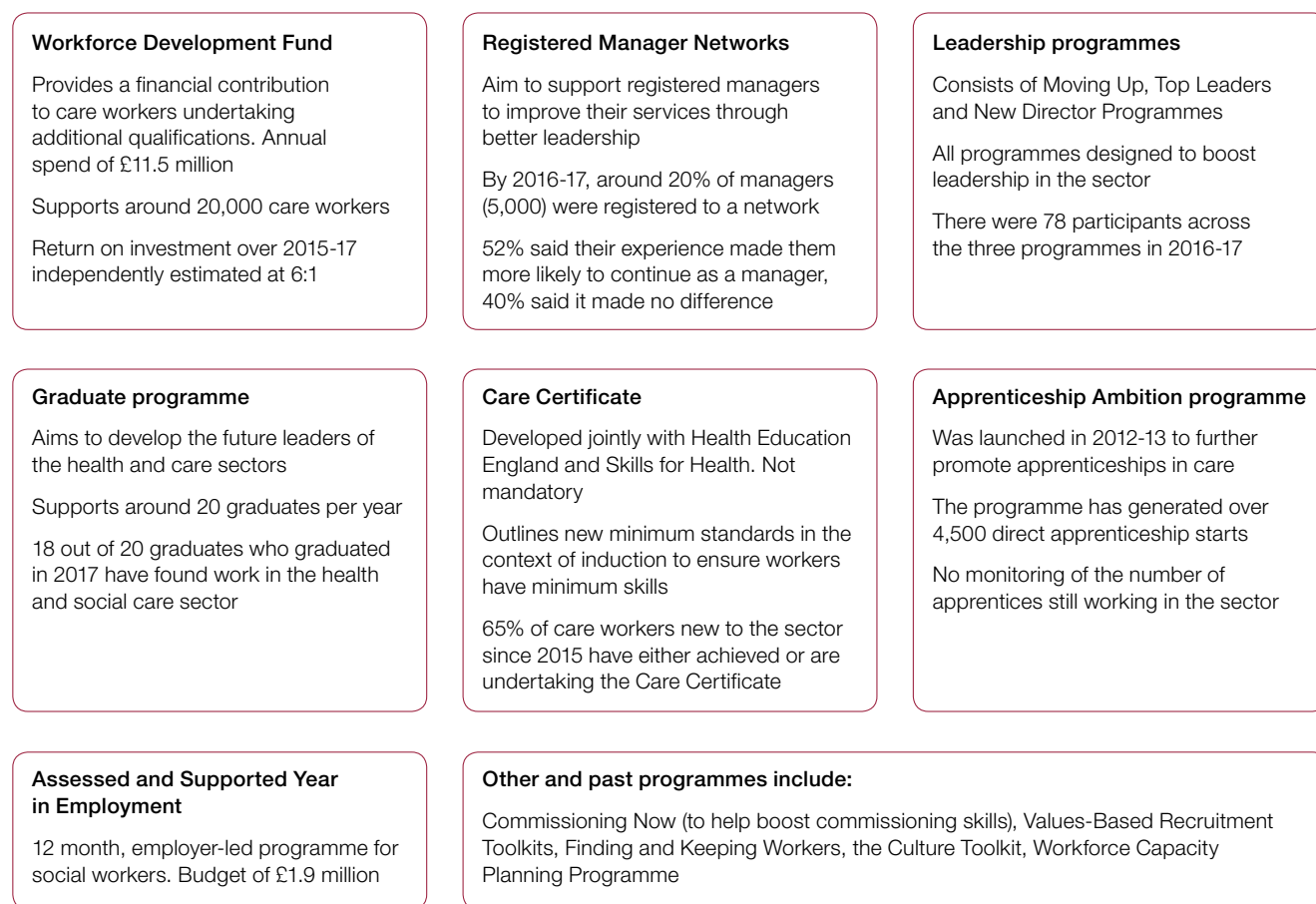
Source: National Audit Office analysis of Department of Health, *Caring for our future: reforming care and support*, July 2012

<sup>27</sup> Department of Health, *Caring for our future: reforming care and support*, July 2012, available at: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf)

**2.5** Skills for Care delivers most of the national initiatives to develop staff working in care (the National Apprenticeship Service oversees apprenticeships). The Department gave Skills for Care funding of around £21.5 million in 2016-17 to support learning and career development in the sector. This equates to around £14 per worker.<sup>28</sup> Skills for Care runs several initiatives, most of which are small-scale and constrained by the amount of funding, which it acknowledges limits the impact the initiatives can have (**Figure 11**).

**Figure 11**  
Examples of Skills for Care initiatives to develop staff

Most of the schemes are small in scale



**Note**

1 National Audit Office analysis of Skills for Care work programmes.

Source: Skills for Care



## Pay and working conditions for care workers

**2.6** Participants in our case studies said that low pay for care workers, who make up the largest component of the care workforce, was the main barrier to recruitment. Working conditions can be tough, involving significant travel time, unsocial hours and physical challenges. The UK Commission for Employment and Skills reported that pay and working conditions, as well as status, inhibit employers' ability to recruit staff.<sup>29</sup>

**2.7** We compared the earnings of care workers in 2016-17 with workers in the wider economy (**Figure 12** overleaf). Around half of care workers were paid £7.50 per hour or below (the National Living Wage was £7.20 in 2016-17). An hourly rate of £7.50 per hour equates to an annual salary of around £14,625, before tax is deducted.<sup>30</sup> At least 30% of care workers were paid at, or below, the National Living Wage.<sup>31</sup> Just under 90% of care workers were among the lowest 25% of earners in the wider economy. Furthermore, the pay levels for care workers could be overestimated. In our May 2016 report *Ensuring employers comply with the national minimum wage regulations 2016*, we found that around 11% of care workers may not have received the National Minimum Wage, due to unpaid training time, unpaid travel time and pay deductions for items such as clothing.<sup>32</sup>

**2.8** Care workers in the independent sector received, on average, a 4% real-terms pay increase between 2011-12 and 2016-17.<sup>33</sup> However, the differential between the average pay of a care worker in the independent sector and the National Minimum/National Living Wage has reduced over time. In 2011-12, the average pay of a care worker in the independent sector was 15% higher than the National Minimum Wage. By 2016-17, this differential (with the National Living Wage) had dropped to 8%.<sup>34</sup>

**2.9** Higher-paid care workers are less likely to leave their role. In 2016-17, turnover in the independent sector for care workers that were paid between £7.20 and £7.59 per hour was 29.8%. Staff turnover within the independent sector reduced at a steady rate for workers that were paid more, up to around £8.70 per hour, at which level the turnover rate began to plateau (**Figure 13** on page 33). Providers who pay lower rates are likely to incur higher recruitment and induction costs.

29 See footnote 26.

30 Based on a 37.5 hour week, for 52 weeks.

31 In 2016-17, the average hourly rate for a care worker at the 30th percentile was £7.20. For under 25s, the legal minimum pay is the National Minimum Wage, which is lower than the National Living Wage.

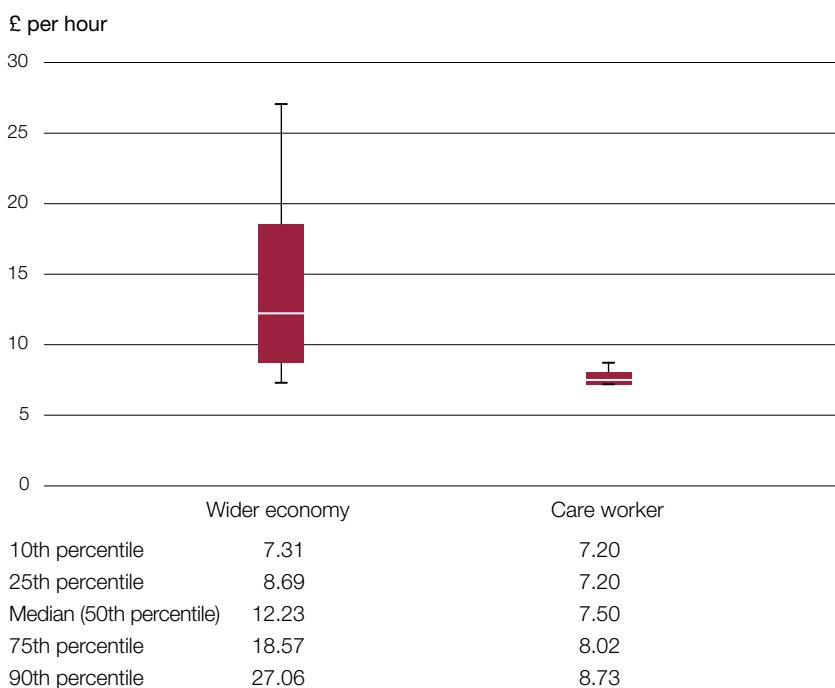
32 Comptroller and Auditor General, *Ensuring employers comply with the national minimum wage regulations*, Session 2015-16, HC 889, National Audit Office, May 2016.

33 In 2011-12, the average (mean) pay of a care worker was £7.44 per hour (real terms in 2016-17 prices). In 2016-17, the average (mean) pay of a care worker was £7.76 per hour.

34 National Audit Office analysis of Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates*, compared with National Minimum Wage or National Living Wage data.

**Figure 12**

Pay for care workers, compared with pay for workers in the wider economy

**Pay for care workers is low compared with pay in the wider economy****Notes**

- 1 Care worker pay is pay for a care worker in the independent sector. Providers submitted data between 1st April 2016 and 31st March 2017.
- 2 The wider economy statistics are taken from the *Annual Survey of Hours and Earnings* data for April 2016.
- 3 The lower and upper bars show the 10th percentile and the 90th percentile respectively.
- 4 Unweighted data between March 2016 and March 2017 (see Appendix Two, paragraph 2).

Source: National Audit Office analysis of Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates* and *Annual Survey of Hours and Earnings 2016* data

**2.10** Most care workers are likely to receive small real-terms pay increases until 2020 due to the introduction of the National Living Wage.<sup>35</sup> In April 2017, the Low Pay Commission estimated that, in the wider economy, 3.3 million workers (12% of all workers) will be paid the National Living Wage by 2020.<sup>36</sup> The National Living Wage will likely standardise pay rates at the lower end across low-paying occupations, such as retail and hospitality. We heard concerns from providers that the small pay advantage that care sometimes enjoys over other low-paying occupations may disappear, exacerbating retention and recruitment difficulties within the sector.

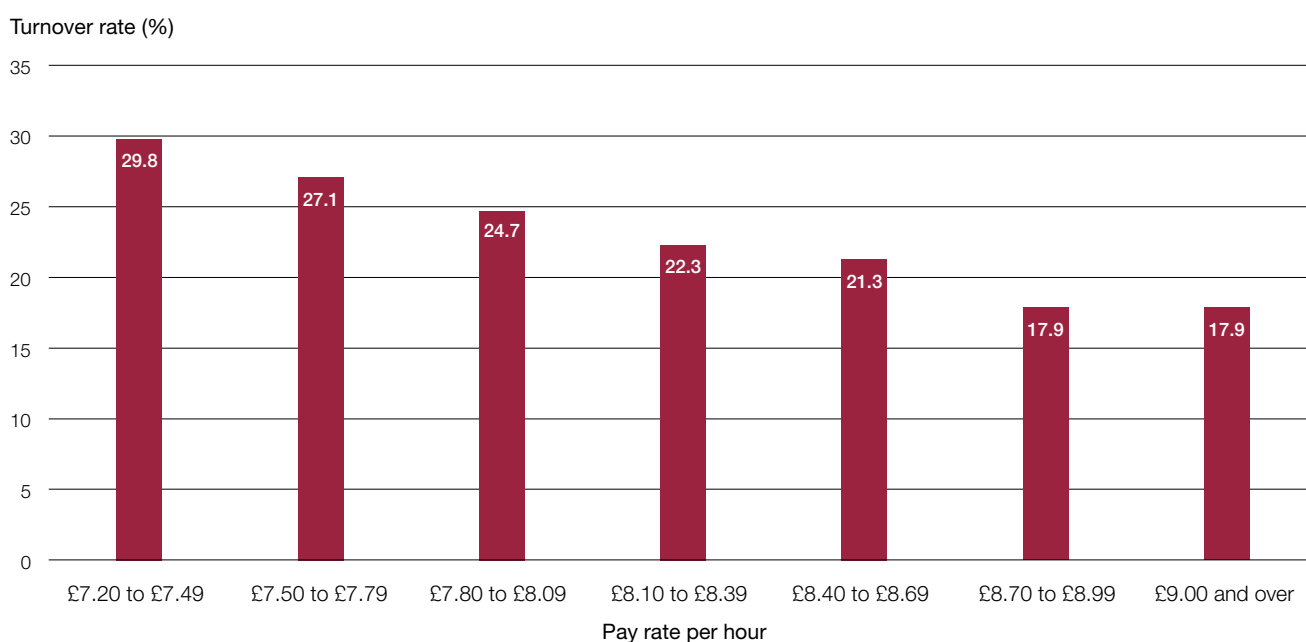
<sup>35</sup> National Audit Office analysis, incorporating Office for Budget Responsibility forecasts of National Living Wage rates.

<sup>36</sup> Low Pay Commission, *A rising floor: the latest evidence on the national living wage and youth rates of minimum wage*, April 2017, available at: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/604442/A\\_rising\\_floor\\_-\\_the\\_latest\\_evidence\\_on\\_the\\_National\\_Living\\_Wage\\_and\\_youth\\_rates\\_of\\_the\\_minimum\\_wage.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/604442/A_rising_floor_-_the_latest_evidence_on_the_National_Living_Wage_and_youth_rates_of_the_minimum_wage.pdf).

**Figure 13**

Care worker turnover rate by average hourly pay bands, 2016-17

Turnover of care workers reduced as pay increased

**Notes**

- 1 All other roles other than care worker excluded.
- 2 Data for the independent sector only.
- 3 Unweighted data between March 2016 and March 2017 (see Appendix Two, paragraph 2).

Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates*

**Zero-hours contracts**

**2.11** Zero-hours contracts are employee contracts that do not guarantee a minimum number of hours. In 2016-17, the care worker role had the highest prevalence of zero-hours contracts across care roles (**Figure 14** overleaf). Some 56% of care workers working in homecare are on zero-hours contracts, compared with 11% in the care home sector. Turnover for workers on zero-hours contracts is 28%, compared with 23% for care workers on fixed-hours contracts (**Figure 15** overleaf).

**Figure 14**

Proportion of staff on zero-hours contracts for selected job roles, 2016-17

Role	Total number of jobs	Proportion on a zero-hours contract
Senior management	16,000	4%
Registered manager	22,500	1%
Social worker	17,000	3%
Occupational therapist	3,000	2%
Registered nurse	43,000	19%
Senior care worker	85,000	10%
Care worker	815,000	34%
Support and outreach	60,000	15%
All job roles	1,340,000	24%

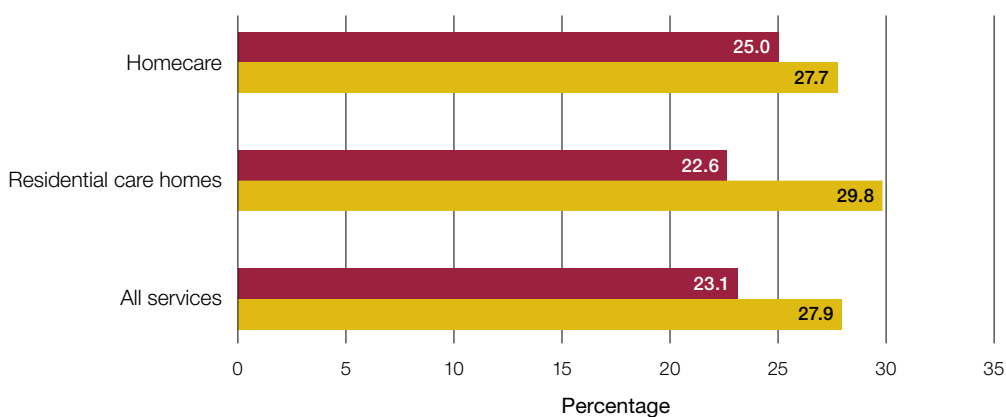
Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC)*, 2016-17 workforce estimates

**Figure 15**

Care worker turnover rate by contract type

**Workers on zero-hours contracts have higher turnover than those not on zero-hours contracts**

Care setting



■ Non zero-hours  
■ Zero-hours

**Note**

1 Unweighted data between March 2016 and March 2017 (see Appendix 2, paragraph 2).

Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC)*, 2016-17 workforce estimates

**2.12** Zero-hours contracts are a contentious issue. Representatives of providers told us that zero-hours contracts are essential to care work. They enable providers to cover sickness absence and manage periods of peak demand, which lessens the need to use agency staff. Many care workers appreciate the flexibility a zero-hours contract offers, as it allows them to work around other commitments. However, workers who need a regular income may not find care work attractive if regular hours are not guaranteed.

### **Recruiting Jobcentre Plus clients**

**2.13** In November 2015, Skills for Care entered into a partnership agreement with the Department for Work & Pensions. This aimed to support providers in recruiting care workers, including direct payment recipients who employ personal assistants, and give people a recognised route into working in the care sector. The partnership agreement, a generic agreement that other organisations also entered into, did not contain any targets specific to the care sector against which to evaluate progress.

**2.14** During our case study visits, we found that relationships between care providers and local job centres were mixed. Some providers and local authorities have partnerships with their local Jobcentre Plus that aim to ensure that only candidates with the right values apply for care jobs. However, we heard from some providers and local authorities of considerable numbers of candidates referred by Jobcentre Plus who did not turn up for interviews, attended only to avoid sanctions or were lacking the necessary values to carry out a care role.

### **Role of providers in developing care workers**

**2.15** In May 2017, Skills for Care published *Recruitment and retention in adult social care: secrets of success*, a summary of its research into why some providers had much lower turnover (less than 10%).<sup>37</sup> It found that successful employers invested in staff development, offered flexible or set working patterns, ensured that people were aware that they paid at least the National Living Wage and worked to develop and promote their organisation's culture. The research did not seek to establish whether the ability of providers to invest in their staff was related to factors such as local authority fee rates or the proportions of local authority clients versus self-funders. Providers have discretion over whether they adopt this best practice.

<sup>37</sup> Skills for Care, *Recruitment and retention in adult social care: secrets of success*, May 2017, available at: [www.skillsforcare.org.uk/Documents/Recruitment-and-retention/Secrets-of-success/Recruitment-and-retention-secrets-of-success-report.pdf](http://www.skillsforcare.org.uk/Documents/Recruitment-and-retention/Secrets-of-success/Recruitment-and-retention-secrets-of-success-report.pdf).

**2.16** To further professionalise care work, in April 2015 the Department and its delivery partners introduced the Care Certificate. The Care Certificate sets out the knowledge, skills and behaviours expected of care workers, and also applies to roles in health such as healthcare assistants. It is not mandatory for care workers to undertake the Care Certificate, but the Care Quality Commission (CQC) expects providers to demonstrate that relevant staff have, or are working towards, the skills set out in the Care Certificate.

## Registered managers

**2.17** CQC-regulated adult social care establishments should have a registered manager in post who, together with the registered provider, is legally accountable for compliance with the requirements of the Health and Social Care Act 2008.<sup>38</sup> The CQC stresses the benefits that a high-quality manager can bring to the quality of care provided. In 2016-17, the registered manager role had the highest vacancy rate in care, at 11.3%. During our case studies, respondents noted the legal responsibilities placed on registered managers and questioned whether the salaries offered matched the responsibility of the role. Some 96% of registered managers work in the independent sector, where average pay in 2016-17 was £29,600 per year.<sup>39</sup> Local authorities, providers and senior sector leaders told us of their concerns that not enough people working in care want to become registered managers.

**2.18** The Department does not have a strategy to promote the recruitment of registered managers. Skills for Care offers guidance and toolkits to new managers, and managers can join a support network. Around 20% of registered managers have joined a network. Just over half (52%) of respondents to an evaluative survey said being in a network made them more likely to continue as a registered manager, 40% believed it had made no difference and 8% were unsure.<sup>40</sup>

## Registered nurses

**2.19** The number of registered nursing jobs in care fell from a peak of 51,000 in 2012-13 to 43,000 in 2016-17. In 2016-17, the vacancy rate was 9.0%, up from 4.1% in 2012-13.<sup>41</sup> To help address this, the Department, working with Health Education England, is creating a new nursing associate role, which they envisage will bridge the gap between nurses and care workers, with 2,000 currently in training.<sup>42</sup> Health Education England plan to expand the programme with 5,000 nursing associate trainees starting in 2018.<sup>43</sup>

38 Regulation 6 of The Health and Social Care Act 2008.

39 Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates*.

40 Skills for Care, *Evaluation of the registered managers' networks 2015-16*, July 2016, unpublished.

41 See footnote 39.

42 Health Education England, *Health Education England announces training places for over 2000 nursing associates*, October 2016, available at: <https://hee.nhs.uk/news-events/news/%E2%80%8Bhealth-education-england-announces-training-places-over-2000-nursing-associates>.

43 NHS England, *Nursing associate*, October 2017, available at: [www.england.nhs.uk/leadingchange/staff-leadership/nursing-associate](http://www.england.nhs.uk/leadingchange/staff-leadership/nursing-associate).

**2.20** The total number of nurses and midwives registered with the Nursing and Midwifery Council fell from 692,556 in March 2016 to 690,773 in March 2017. In 2016-17, 33% of nurses working in care were aged over 55.<sup>44</sup> There are concerns within the sector that the rate of recruitment of nurses will not keep up with the rate of nurses retiring and the increase needed to meet rising demand for care. Health Education England is responsible for nursing supply across health, primary care and social care. In 2017, the Department announced funding to support an increase in nursing training places, from 20,680 in 2016-17 to 25,580 in 2018-19.

**2.21** In February 2015, the Department hosted a symposium to look at the issues around recruitment and retention of nurses in care. Attendees noted the lack of prestige that working in care has compared with working for the NHS and the poorer options for pay and career progression.<sup>45</sup>

**2.22** Between 2011-12 and 2016-17, average pay for registered nurses working in care rose by 12% in real terms, from £24,900 to £27,900 per year.<sup>46</sup> In 2016-17, the average pay for a registered nurse working in the NHS was around £31,000.<sup>47</sup> Despite real-terms increases, opportunities for pay progression is lower for nurses in care than in the NHS. There is no formal mechanism for linking changes in nurses' pay across the health and care sectors.

### **Non-British European Economic Area workers**

**2.23** In 2016-17, there were 95,000 non-British European Economic Area (EEA) nationals working in care, 7% of the total care workforce, an increase from 5% in 2012-13. There was wide regional variation: 2% of workers in the North East were non-British EEA nationals compared with 13% in London (**Figure 16** overleaf).

**2.24** The variation in the proportion of non-British EEA workers is greater at the local authority level. In 2016-17, the proportion of non-British EEA workers ranged from under 0.1% in Hartlepool to 21.5% in Richmond upon Thames. Some 18 of the 20 local authorities with the highest proportions of non-British EEA nationals were in London and the South East (**Figure 17** on page 39).

44 See footnote 39.

45 Department of Health, *Symposium report: The recruitment and retention of nurses in adult social care*, February 2015, unpublished.

46 See footnote 39.

47 NHS Digital, *NHS staff earnings estimates to September 2017* – provisional statistics, December 2017, available at: <https://digital.nhs.uk/catalogue/PUB30174>.

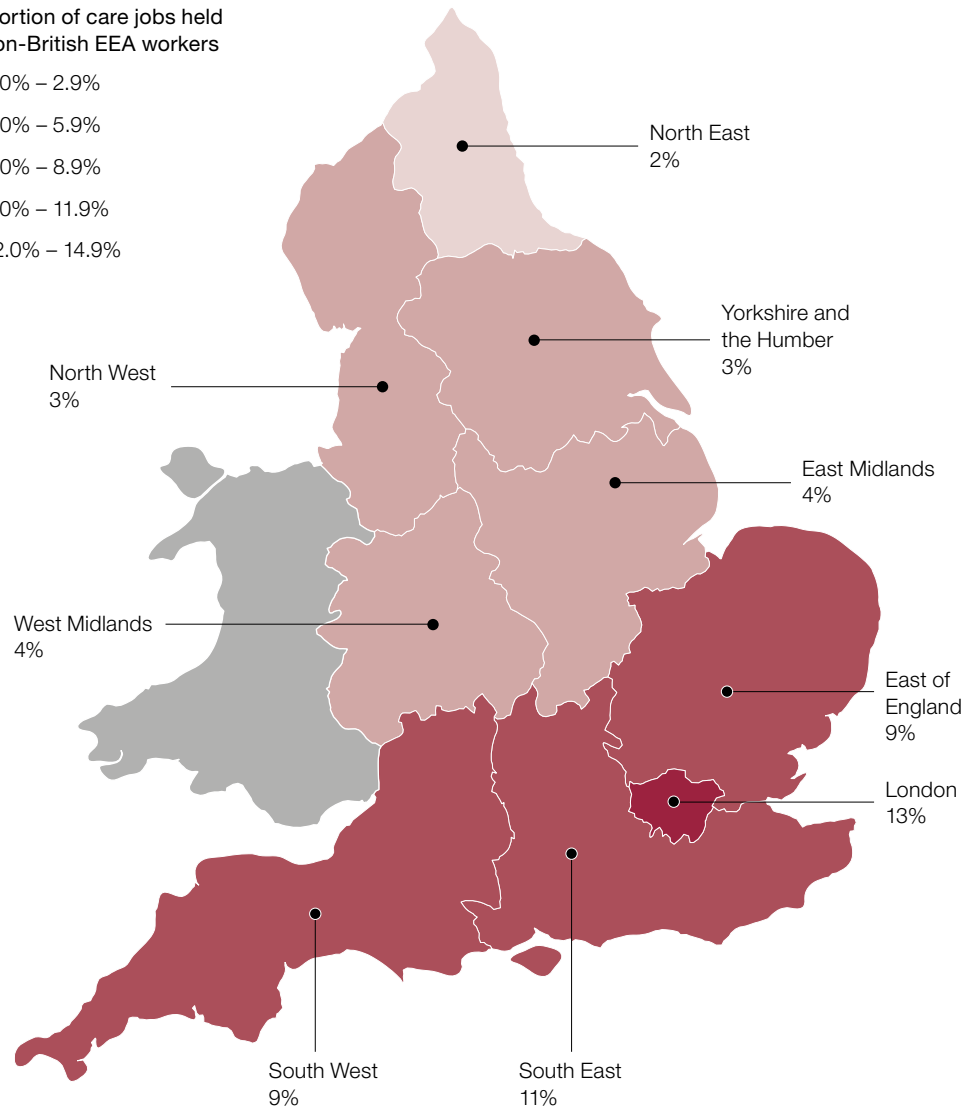
**Figure 16**

The proportion of care jobs held by non-British EEA workers in 2016-17

The highest proportions of non-British EEA workers were in London and the South East

Proportion of care jobs held by non-British EEA workers

- 0.0% – 2.9%
- 3.0% – 5.9%
- 6.0% – 8.9%
- 9.0% – 11.9%
- 12.0% – 14.9%



Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC)*, 2016-17 workforce estimates



**Figure 17**

The 20 local authorities with the highest proportion of care jobs held by non-British EEA nationals in 2016-17

**Local authorities with the highest proportion of non-British EEA workers were mainly in London and the South East**

Local authority	Region	Jobs	EEA (non-British)
Richmond upon Thames	London	3,000	21.5%
Lambeth	London	7,500	21.3%
Kingston upon Thames	London	3,500	20.8%
Barnet	London	9,500	20.8%
Harrow	London	5,000	20.1%
Camden	London	5,500	18.4%
Surrey	South East	31,500	18.0%
Hammersmith & Fulham	London	3,000	17.8%
Ealing	London	6,000	17.5%
Bournemouth	South West	6,500	17.2%
Bath and North East Somerset	South West	3,500	17.2%
Bracknell Forest	South East	2,000	15.6%
Buckinghamshire	South East	11,000	15.1%
Enfield	London	7,000	14.4%
Oxfordshire	South East	14,000	14.4%
Kensington & Chelsea	London	3,000	14.1%
Hillingdon	London	5,000	13.9%
Brighton & Hove	South East	7,500	13.7%
Sutton	London	4,500	13.6%
Slough	South East	2,500	13.4%

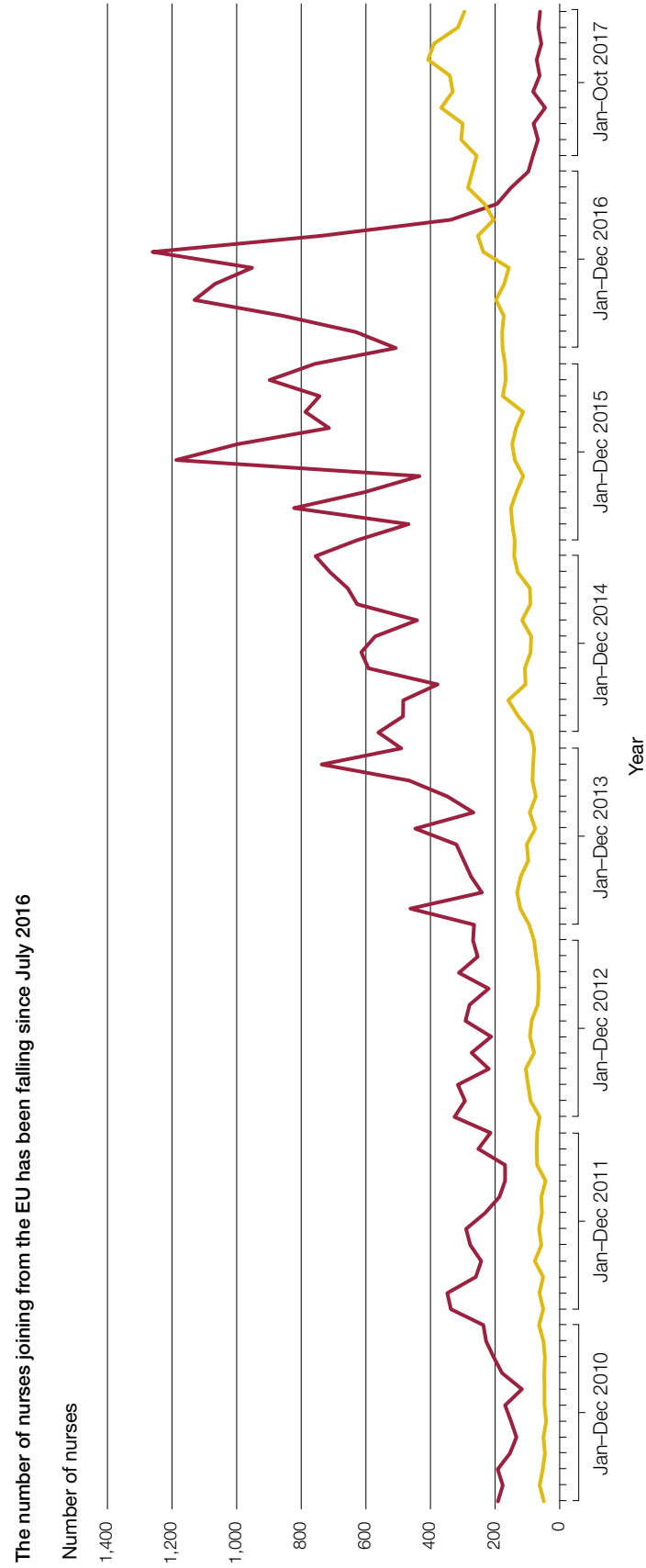
Source: Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC)*, 2016-17 workforce estimates

**2.25** Nursing is the job role that proportionately relies most on non-British EEA workers. In 2016-17, 16% of registered nurses working in care were non-British EEA nationals, ranging from 7% in the North East to 26% in the South East. The number of registered nurses available to work in care relates to the total number of nurses registered to work in the UK with the Nursing and Midwifery Council (NMC). The number of nurses and midwives from the EU, excluding the UK, registered to work in the UK increased from 16,798 in March 2013 to 38,024 in March 2017.<sup>48</sup>

**2.26** The number of nurses, excluding midwives or nurses with midwifery qualifications, joining the register for the first time from the EU, excluding the UK, has dropped steeply since July 2016 (**Figure 18**). The number of such nurses leaving the register has increased. Since October 2016, the number leaving the register has exceeded the number of new registrations. The Nursing and Midwifery Council believes there are several factors contributing to these trends, including: employers' recruitment choices; the UK's exit from the European Union; language testing for those joining the register; and, changes to the socio-economic conditions in EU countries.

48 An EU nurse or midwife is classified as such by the Nursing and Midwifery Council if they applied to its register to practise in the UK from an EU/EEA country (excluding the UK).

**Figure 18**  
The number of nurses from the EU (excluding the UK) joining and leaving the Nursing and Midwifery Council register since January 2010



— Joiners  
— Leavers

**Notes**

- 1 The data are only for nurses. They exclude any midwives or nurses with midwifery qualifications.
- 2 Country of initial registration might be different to country of current address.
- 3 The data for each month are as at the last day of the month.
- 4 Joiners includes only nurses registering for the first time.

Source: Nursing and Midwifery Council

# Part Three

## Oversight of workforce planning

**3.1** This part of the report looks at the systems and processes in place to support the oversight and strategic planning of the care workforce, including past and current modelling of job numbers.

### **Workforce forecasts and modelling**

**3.2** In July 2016, the Centre for Workforce Intelligence published *Forecasting the adult social care workforce to 2035*, commissioned by the Department of Health & Social Care (the Department).<sup>49</sup> This modelled a range of scenarios for how demand for care would increase and be delivered in the future. Its modelling used estimates of population growth and demographic change by the Office for National Statistics, in particular the forecast growth in the proportion of the population aged over 65. The modelling took into account other projected population-level changes, such as health, social vulnerability and the impact of known policy changes. The principal projection was that demand for care will increase by an average of 2.6% per year to 2035, and therefore that the overall number of full-time equivalent jobs in care would need to increase at this rate. This would mean that there would be 2 million jobs in care by 2035. Further modelling suggested that potential changes in service model delivery, such as integrating health and care services and greater use of technology, would reduce forecasts of annual growth in job numbers by only around 0.1% to 0.2%.

**3.3** The Centre for Workforce Intelligence was cautious about the projections in its report due partly to the coverage of the underlying data from Skills for Care.<sup>50</sup> The Centre concluded that it should not undertake more comparisons with future demand until the supply data became more robust. In 2017, Skills for Care assessed the National Minimum Data Set for Social Care and concluded that the weightings applied to the data, developed by their analysts in conjunction with academics and external partners, corrected for potential bias arising from a 55% collection rate, and therefore the data set produced reliable analysis of the workforce. The Department notes the importance of a robust evidence base to inform workforce analysis and the ongoing improvements to the data quality.

<sup>49</sup> Centre for Workforce Intelligence, *Forecasting the adult social care workforce to 2035*, July 2016.

<sup>50</sup> The report used Skills for Care data from 2014 that were 50% complete.

**3.4** The Centre for Workforce Intelligence was disbanded in 2016, with the Department bringing its expertise in-house. The Department's in-house team has not published any more forecasts. In September 2017, Skills for Care forecast that between 350,000 and 700,000 new jobs will be required by 2030.<sup>51</sup> That range is based on different scenarios as to the rate of growth of the over 65 and over 75 populations.

**3.5** Modelling by the Department on clinical staff in the NHS is used by Health Education England to inform long-term workforce strategies. There has been no similar process for the care workforce. The Department does not have assurance that future need will be met by an appropriately sized workforce. The Department acknowledges that addressing the current vacancy and retention rates will be challenging, and that more jobs will be required in the future to meet growing demand for care.

**3.6** The Department has an objective for greater integration between health and social care, but this is not clearly reflected in workforce modelling. *In our Health and social care integration 2017* report, we heard that differences in working culture, professional entrenchment and different terms and conditions across the health and local government sectors remain barriers to integrating and developing the workforce.<sup>52</sup> The Department has not carried out a major skills-mapping exercise across health and social care, or reviewed in detail how the health and care workforces can work better together. The Department is undertaking some pilots; for example, in partnership with Care England, it is piloting five nurse-led teaching care homes, which aim to develop and train an integrated workforce and to share subsequent good practice across the sector.<sup>53</sup> The pilot is being extended to a second wave of care homes across England.

### **National workforce strategies**

**3.7** The last national care workforce strategy written by the Department was *Working to Put People First*, published in 2009.<sup>54</sup> The main elements of the strategy were ensuring strong local leadership, creating good opportunities for career progression and remodelling the workforce in response to integration between health and social care. Despite changes within the sector since, for example the Care Act 2014, the Department has not refreshed the strategy. The strategy is only available on the National Archive website and gives responsibilities to some organisations that no longer exist.

<sup>51</sup> Skills for Care, *National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates*.

<sup>52</sup> Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017.

<sup>53</sup> Care England, *Teaching care home*, May 2016, available at: [www.careengland.org.uk/teaching-care-home](http://www.careengland.org.uk/teaching-care-home).

<sup>54</sup> Department of Health, *Working to Put People First*, April 2009.

**3.8** Instead of having a national strategy, the Department works principally with Skills for Care, the Local Government Association and the Association of Directors of Adult Social Services to identify and share good practice in recruitment and retention. Skills for Care developed a retention and recruitment strategy in 2011, and published a *Retention and Recruitment Strategy 2014–2017*.<sup>55</sup> The latter strategy was more akin to a business plan, detailing the activity that Skills for Care would undertake to boost retention and recruitment. The strategies were not an adequate substitute for a departmental workforce strategy. Skills for Care has limited influence over workforce challenges such as levels of government funding for care, and pay, which is set by providers.

**3.9** The Department recognises that an ageing society means that it needs to reach a longer-term sustainable settlement for social care. The government intends to publish a green paper by summer 2018, setting out proposals to reform care for older people. The reforms that will be proposed are currently being shaped by experts, stakeholders and users.

**3.10** In December 2017, Health Education England published a draft strategy for consultation entitled: *Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027*. The strategy aims to improve productivity, boost training and retention, open up new routes into nursing and prepare the future workforce for technological advances. Health Education England intends to produce a final strategy by July 2018.<sup>56</sup>

**3.11** Health Education England has no formal responsibility for the adult social care workforce; responsibility lies with the Department. The draft strategy focuses predominantly on the health sector, with a short chapter on care. The chapter summarises the challenges facing the care sector but lacks suggestions for improvement. The Department is currently working with Skills for Care on a consultation exercise to inform future strategies. The Department acknowledges that a strategy for care will need to take into account proposals in the green paper on care for older people, which is due to be published in summer 2018.

## **Regional and local workforce strategies**

**3.12** Under the Care Act 2014, local authorities must facilitate local care markets that offer a diverse range of high-quality and appropriate services. In doing so, they must ensure that these services continuously improve and encourage a workforce that supports the market effectively through standards, skills, qualifications and apprenticeships.<sup>57</sup>

<sup>55</sup> Skills for Care, *Adult social care workforce recruitment and retention strategy, 2011* and *Skills for Care, Adult social care workforce recruitment and retention strategy 2014–2017*, June 2014.

<sup>56</sup> Health Education England, *Facing the Facts, Shaping the Future – a health and care workforce strategy for England to 2027*, December 2017, available at: <https://hee.nhs.uk/our-work/planning-commissioning/workforce-strategy>.

<sup>57</sup> Paragraph 4.21 in Care Act 2014 statutory guidance.

**3.13** In our case studies, we found that local authorities fulfil this duty through their contract management arrangements with providers. Contract management best practice ensures that providers are subject to competitive tension and that strong oversight and incentives are used to ensure that providers meet their contractual obligations. In most contracts, local authorities include obligations to ensure that a provider has enough suitably qualified staff and that the provider will develop their workforce. Local authorities told us that, given the pressures facing providers and the negative consequences if a provider left the local authority funded market, they were cautious about challenging providers over their investment in workforce development.

**3.14** Local authorities are encouraged to describe their activities to support local care markets in published market position statements. The Department intended local authorities to co-produce market position statements with providers and to use them as the basis for strategic commissioning. From our review of a sample of 22 market position statements, we found that few included defined actions to address the issues that providers are experiencing with recruiting and retaining staff, or workforce development. Local authorities lack the legal and strategic ability to require providers to coordinate their work on recruitment, training and development, or that providers work with the local authority to ensure that there will be a sufficient supply of staff across the system in future. We did not see evidence that the Department is exercising oversight over local authorities over the quality of their market position statements. Instead, they rely on local processes, for example review by local authority scrutiny committees.

**3.15** In 2015, NHS England established 44 sustainability and transformation partnerships (STPs) across England. In autumn 2016, each partnership jointly produced a plan setting out how local services would meet rising demand over the next five years within the resources available.<sup>58</sup> Among the local authorities we spoke to, some regarded the STPs as NHS-led and NHS-focused, and felt the process had not adequately engaged with local authorities. There was a section on the workforce in every plan, but references to the care workforce were often brief and not a major consideration. The plans did not visualise how care roles would change in the future, or how the workforce would develop and integrate with health. Few plans mentioned how local bodies would attract greater numbers of people into care jobs. The 17 performance indicators that NHS England set out to evaluate STP plans against did not include an evaluation of progress towards workforce integration.<sup>59</sup>

58 NHS England, *View sustainability and transformation partnerships*, available at: [www.england.nhs.uk/systemchange/view-stps](http://www.england.nhs.uk/systemchange/view-stps).

59 NHS England, *Sustainability and transformation partnerships progress dashboard – baseline view*, July 2017, available at: [www.england.nhs.uk/publication/sustainability-and-transformation-partnerships-progress-dashboard-baseline-view](http://www.england.nhs.uk/publication/sustainability-and-transformation-partnerships-progress-dashboard-baseline-view).

# Appendix One

## Our audit approach

**1** This report considers the Department of Health & Social Care's role in overseeing the adult social care workforce and assesses whether the size and structure of the care workforce are adequate to meet users' needs for care now, and in the future, in the face of financial challenges and a competitive labour market. We reviewed:

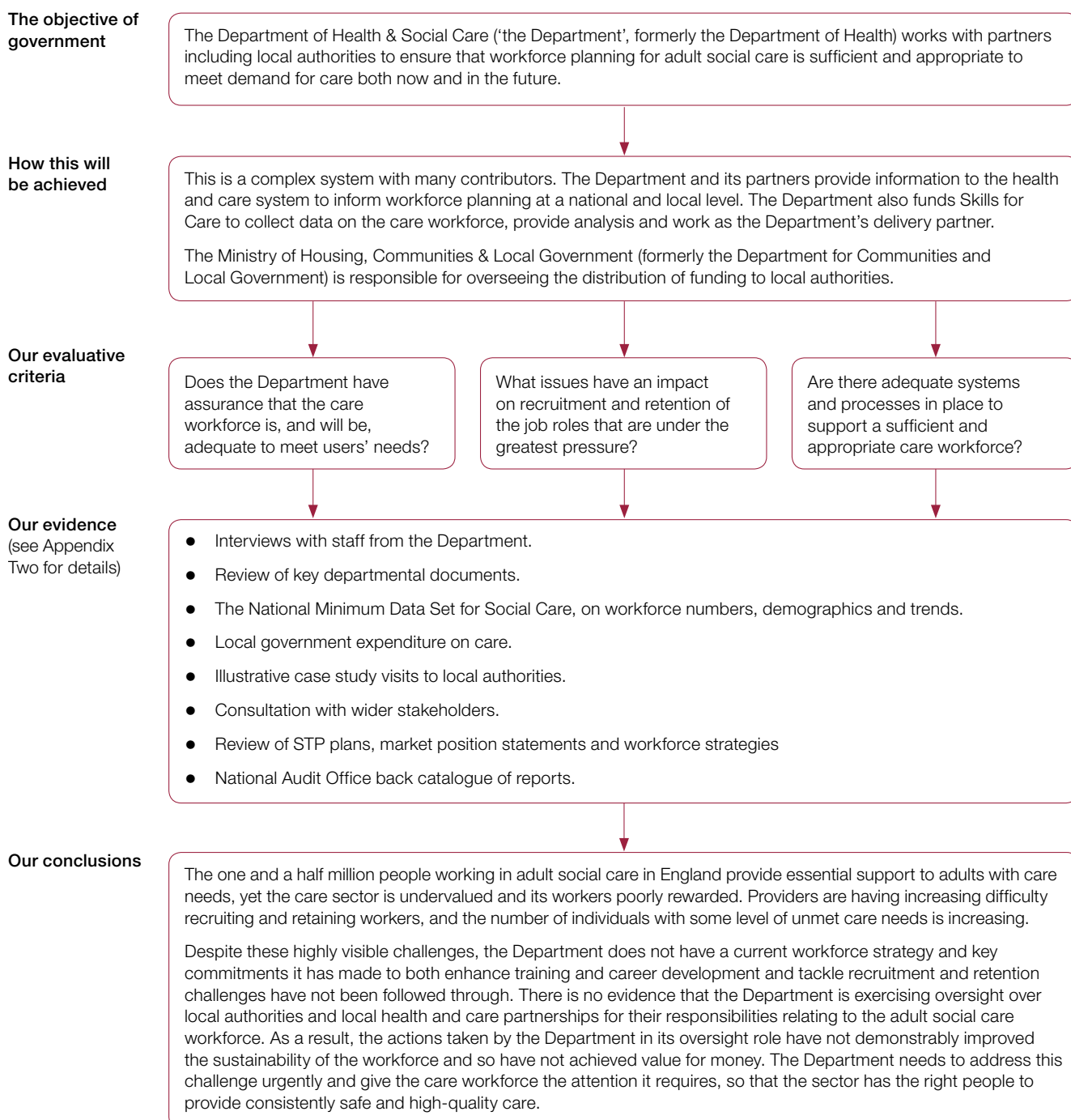
- the range of care jobs, workforce trends and cost pressures within the care sector;
- the challenges that providers face in recruiting and retaining workers in three job roles facing pressures: care workers, registered managers and registered nurses;
- the number of non-British European Economic Area (EEA) workers in the care workforce; and
- the adequacy of strategic workforce planning at national, regional and local levels.

**2** Our audit approach is summarised in **Figure 19**. Our evidence base is described in Appendix Two.



**Figure 19**

## Our audit approach



# Appendix Two

## Our evidence base

**1** We reached our independent conclusion on whether the Department of Health & Social Care (the Department) has overseen the care workforce effectively by analysing evidence collected between January 2017 and January 2018. Our audit approach is outlined in Appendix One.

**2 We analysed data on the care workforce, primarily data from Skills for Care.** Skills for Care collate the National Minimum Data Set for Social Care (NMDS-SC) which includes data on workforce demographics, pay, job numbers and trends. The data from Skills for Care are the most comprehensive available on the care workforce. The NMDS-SC currently has 55% coverage of all CQC-regulated social care establishments. In 2017, Skills for Care assessed the NMDS-SC and concluded that the weightings applied to the data, developed by their analysts in conjunction with academics and external partners, corrected for potential bias arising from a 55% collection rate, and therefore the data set produced reliable analysis of the workforce. Skills for Care aspire to achieve a 65% collection rate from CQC-regulated social care establishments. Where we have used data that have not been weighted in our analyses, this is indicated in the notes. The Department notes the ongoing improvements to the data quality. We also assessed forecasts from the Centre for Workforce Intelligence.

**3 We analysed other, non-workforce, data.** We evaluated: data published by NHS Digital, the Annual Survey of Hours and Earnings (ASHE) data, the United Kingdom Homecare Association report on fair fees for homecare, Care Quality Commission reports on standards in care, the Association of Directors of Adult Social Services 2017 annual survey and data from the Nursing and Midwifery Council.

**4 We analysed spending documents.** These included budgets, autumn statements and local government financial settlements between 2010 and 2017.

**5 We reviewed key documents.** The documents included:

- the Department's 2009 strategy, *Working to put people first: the strategy for the adult social care workforce in England*;
- 2012 white paper, *Caring for our future: reforming care and support*;
- Skills for Care, *Recruitment and retention strategy 2011*;
- Skills for Care, *Recruitment and retention strategy 2014-2017*;
- evaluations of Skills for Care strategies and initiatives;
- Centre for Workforce Intelligence, *Forecasting the adult social care workforce to 2035*, 2016;
- Care Quality Commission, *State of health care and adult social care in England 2016/17*, 2017; and
- Health Education England, *Facing the facts, shaping the future – a draft health and care workforce strategy for England to 2027*, 2017.

**6 We reviewed minutes of the Department's working groups.** We reviewed minutes from the Adult Social Care Recruitment and Retention Working Group and minutes from the Nursing Symposium held in February 2015.

**7 We visited six local authorities in England, where we conducted semi-structured interviews with local authority employees and local independent adult social care providers to understand local issues affecting planning of the workforce.**

We also reviewed several documents from each local authority area to supplement our understanding from the interviews. In each location, seven to eight interviews were conducted with staff covering the following topic areas: strategic overview; commissioning; workforce quality, training and development; medium and long-term workforce planning; integration of health and social care workforce; provider perspective; scrutiny and challenge. Our final list of local authorities visited and dates of visits is below:

<b>Local authority</b>	<b>Date of visit</b>
Southampton	13 March 2017
Derbyshire	16 March 2017
Halton	20 March 2017
Hammersmith and Fulham	23 March 2017
Sunderland	29 March 2017
West Berkshire	18 and 27 June 2017

**8 We reviewed market position statements.** We reviewed all the market position statements of the local areas visited and we analysed a further sample of market position statements to ascertain whether these provided strategic direction about the workforce.

**9 We reviewed sustainability and transformation partnership plans.** We reviewed all 44 draft local sustainability and transformation plans published in autumn 2016.

**10 We reviewed seven homecare and seven care home provider accounts and reviewed reports from the Competition and Markets Authority.** We looked at these to help us understand the financial pressures facing providers.

**11 We interviewed staff from the Department of Health & Social Care, the Ministry of Housing, Communities & Local Government, the Department for Business, Energy & Industrial Strategy, and the Department for Work & Pensions.** The people we interviewed included staff tasked with the strategic oversight and development of the care workforce.

**12 We interviewed a range of other organisations involved in, or with an interest in, the care workforce. The organisations included:** The Association of Directors of Adult Social Services, Care England, the Care Quality Commission, Care UK, the Competition and Markets Authority, the Health and Care Professions Council, Health Education England, the King's Fund, the Local Government Association, the Nursing and Midwifery Council, the Professional Standards Authority, Skills for Care, the Social Care Institute for Excellence, and the United Kingdom Homecare Association.

**13 We analysed the change in local authority spending power over time.**

- Our analysis shows real-terms change in revenue spending power to local authorities over the period 2010-11 to 2019-20.
- Our analysis of change in spending power draws directly on data published annually by the Ministry of Housing, Communities & Local Government (the Ministry) alongside the announcement of the local government finance settlement.
- The Ministry publishes data on the components of revenue spending power which includes council tax and government funding. We use these data but we exclude funding for Public Health grant, the original Better Care Fund and NHS funding for spend on social care that also benefits health. This funding was removed from the Ministry's definition of spending power from 2016-17 onwards. To improve consistency over time we remove this funding from the time series as a whole.
- Our figures do not include the possible impacts of business rates retention pilots.

- From 2015-16 to 2019-20, the Ministry has published data on a consistent basis and is therefore comparable over this time period. However, during the period 2010-11 to 2015-16 there were significant changes in the duties placed on local authorities and the way financial data was reported. This means that a like-for-like comparison over time is only possible if the data are adjusted to account for these changes.
- The Ministry addressed this by publishing annually an adjusted base year alongside the new data for that year. This means that data published by the Ministry in this period is comparable over any two consecutive years. However, it is not possible to join pairs of adjusted years into a time series.
- We address this by creating a chain-linked index in which pairs of adjusted years are linked by a weighting process. We use the method set out by the Office for National Statistics.<sup>60</sup> We use the chain-linking method to link the data for 2010-11 to 2015-16 to the later data for 2015-16 onwards.
- This means that the results from our time series analysis show percentage change in a weighted index. This provides a good estimate of change over the period that is not skewed by changes in duties and reporting approaches, but it cannot be used to estimate absolute change in funding.

60 Robjohns, J, 'Methodology Notes: Annual Chain Linking', *Economic Trends*, Number 630, Office for National Statistics, May 2006.

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