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Interviewer: I’m from Manchester MET, Manchester Metropolitan University. We’re doing a project that is funded by the National Institute of Health and Social Care research, but sponsored by the Department of Health and Social Care. They have commissioned us essentially to look at pay and reward in adult social care. We’re doing a number of pieces of work, a big analysis of the adult social care workforce data set, which looks at pay levels, pay modelling, pay strategies and outcomes for things like recruitment retention and skills, skills development. We’re also feeding into that local conditions and local authority fee data, so try and have a real look at how all those things fit together.

We’ve done our own survey, which hopefully you’ll have seen, of providers, and this part of the project we’re talking to providers and care workers about their views on pay and reward, and again, all those issues around does it attract, does it retain, what are the challenges in the labour market, what are the implications of local authority commissioning practices etc. So I’ve got a series of questions to work through, but I’m also interested in your views about anything that I don’t cover and I know you’ve very helpfully sent back some detailed information. Just before I start, I sent out some information and a consent form to take part. Can I just confirm you’re happy to take part and happy for me to record this?

Respondent: Absolutely.

Interviewer: It’s all confidential and anonymous, but it just means I don’t have to spend my time scribbling things down. Before…

Respondent: If it helps not to make it confidential or anonymous, then plough ahead, because what we say, we don’t mind being quoted on.

Interviewer: Okay, that’s helpful, that’s good to know. Do you want to just give me a little bit of background on the business before we get into the more detailed questions?

Respondent: Yeah, okay, so family firm, we’ve been in care since [year], so we wake up in the morning thinking we’ve seen everything and we obviously haven’t yet. But we’ve seen an awful lot of change. Today we have six homes, 210 beds. There are three nursing homes and three residential homes and we employ circa 300 people.

Interviewer: You sent me your breakdown of pay rates and they obviously change across your homes.

Respondent: Yeah.

Interviewer: Can you tell me a little bit about you arrive at those rates and the reason for the variation in those rates?

Respondent: The reason for variation is probably easiest, that we don’t run as a group. We say to the managers, it’s your business, you define its positioning in the market, its how your team, how you hire and fire and all the rest of it. And also the services are somewhat different. So I wouldn’t expect necessarily to see the same skill mix within each service, yeah, as another. So we discourage any comparison between the services in terms of, even staffing numbers, staffing ratios or whatever. It is done on a very unique basis.

Interviewer: Okay.

Respondent: So how do we get to the rates? Well, they’re driven by the market. Can we recruit the number and quality of people that we want? And fundamentally that’s what drives it. And I guess a cross-check is do we actually have the revenues to support the pay rates that we need to offer, as distinct from what we want to offer or feel we should offer. They’re two very different things.

Interviewer: Hypothetically then, what would you want to offer?

Respondent: Okay, we need to probably break that down by job role. I think this is one of my big issues with a lot of work that’s done by people like Skills for Care, that they cannot seem to approach it from a blanket point of view and focus on care assistants at the bottom of the stack. And I don’t think that’s right. So I’m not sure we’d want to change what we offer the managers any. I think that most of our managers are pretty fully remunerated, they have bonus schemes on top blah blah blah. So yeah, I’m okay with that. I think most of our deputies fall into the same category. And with the exception of our clinical leads, in the nursing homes, I think our nurses are between fully and over-compensated.

Interviewer: And that is about attraction?

Respondent: It’s about attraction, yeah, all right? I think we’re probably averaging 22 something an hour for our nurses, yeah, 21/22, yeah. So they do a few extra hours. They’re typically earning circa 45 a year. And they come in and they do a nursing job, but they’re not showing the extra commitment or whatever, all right, yeah, that you might expect, or I might expect for that kind of salary. And that’s pushing them quite close, well in most cases over what we pay a deputy, which kind of is that right? No it isn’t. And they’re getting quite close to a manager’s salary, but just for doing a very… a three day a week, 36-hour job. So that’s a problem.

Beneath there we’ve then got team leaders and seniors, beneath them, care assistants. And here’s where we’ve got a real issue. The seniors and team leaders are typically paid an increment above what the care assistants are, and let’s say that increment is £1.25 an hour, something like that. As I say, that’s over and above the care assistants. I would like to see care assistants on £13.50/£14 an hour, something like that, certainly for our most demanding services, which then mean that the seniors and team leaders need to be £1/£1.50 an hour above that.

Interviewer: And the constraints on that then, I’m presuming are the way you’re commissioned?

Respondent: Yeah, it’s local authority funding, yeah.

Interviewer: Do you want to say a bit more about that, how that works, your relationship with the local authority? You’ll have a number, I’m thinking, of different local authorities?

Respondent: Yeah. Badly, differently… each local authority seems to feel that it is unique. That the labour force issues and the costs associated with it are completely unique to their county and therefore that it’s very smart for them to decide their commissioning fees in complete isolation. And my view is with the exception of inside the M25 and perhaps one or two urban areas, but it’s a perhaps, there is no fundamental difference in the market issues, certainly in terms of the labour market. And as labour costs are 80% of our overall costs, that’s the same for every care home, irrespective of the location, why should fees differ across the country?

Interviewer: And how much do they vary across the local authorities that you work with?

Respondent: Well, there’s two answers to that question and [colleague name] help me out here. So answer one relates to what their base fees are. And answer two, depends on what they actually pay us.

Interviewer: Can you help me understand the difference between those two?

Respondent: Yeah, so the base fee varies, goes from £625 to eight something for residential.

Respondent 2: Yeah, it’s not entirely apples with apples, but yeah, the lowest rate that we get is probably from [LA] at the moment, which is £620 odd. That is for a basic entry level residential placement, no dementia, just… when I say ‘no dementia,’ that’s not true. There is some level of dementia, it’s just not complex dementia. Highest fee rate is probably, for residential, is probably out of [LA], which is just… I think it’s now just over 800, 815, off the top of my head. But that’s a short-term placement with top-ups and what have you there.

Respondent: And then nursing goes from £707.50 to 900.

Respondent 2: Yeah, bizarrely, take that previous number, add £150 on because every local authority discounts because you get the FNC, which is £219 on top. So they always take £50 back for some reason.

Respondent: Those are the base rates. Depending on our home and location, we would get substantially different to that. So take the most extreme example of that. One of our nursing homes specialises in mid to high end dementia nursing. We do about 10% of the nursing for [LA] anyway. And our average weekly fee there is touching £1,900 a week for nursing. So it’s over a thousand more than [LA]’s base rate. That relates to the type of resident we have in there. And just to extend that, we currently have seven/eight residents in on one-to-one and that one-to-one is typically 24 hours a day, seven days a week and roughly charged at £25 an hour, because we have to use agency nursing for that, because… or agency staff, because the commissioners will not guarantee us a certain level of one-to-one.

So it can vary wildly from month-to-month, so we can’t staff it with our own people because we can hire to do that and then we end up with no one-to-one, so we’re over-staffed and having to carry the cost. So the consequence of that for them is we charge them far more because we’re using agency, but we can switch that on and off.

Interviewer: Is all your care spot commissioned or do you have a proportion that is block?

Respondent: Increasingly it’s all spot commissioned. Because we can’t run our businesses on what they will give us for block.

Interviewer: So that’s your choice to have more spot than block, but because the block fees are too low?

Respondent: Yeah. Yeah.

Respondent 2: And also there are not enough block bed contracts available in the marketplace in order for us to sustainably run our business on that basis.

Interviewer: And you couldn’t do a mix of spot and block, it’s one or the other?

Respondent: We could do, but to a small level. We’re looking at it in one of our homes, but that’s… what’s it, five block isn’t it [colleague], in a 47 bedder.

Respondent 2: Yes, [LA] was out for tender, yeah, five block of beds across the whole of the county.

Interviewer: Okay. Just thinking a bit more about your workforce, what is your balance in terms of gender, age, ethnicity? I’m interested around then also about international recruitment, your experiences of that?

Respondent 2: So, we’re about 75/25 female to male. I haven’t done an age split for quite a while actually, probably should do. But we’re probably 50/50 in terms of age. But I think the traditional perception of social care is its women of a certain age and younger people. We certainly don’t have many men in caring roles, but we do in the domiciliary maintenance check role, and I think it kind of balances itself out a little bit. In terms of…

Respondent: We have very few non-ethnic men in care roles, very few. So where we have men in care roles, most of them are from overseas or second-generation ethnicity.

Respondent 2: Yeah, and then in terms of overseas recruitment, we got our Tier 2 visa license in the summer of 2021 and since then we’ve recruited 50 overseas employees.

Interviewer: So it’s fair to say that’s a big source of labour for you then?

Respondent 2: Well yeah, we have roughly 300 staff, fulltime equivalency of about 260 odd. So to say that, yeah, we recruited 50 from overseas in the last two years is a very big number for us.

Interviewer: How has that worked for you? What are your experiences of that?

Respondent 2: In terms of the staff that we’ve been able to recruit, they’ve been largely good. One or two issues, but actually on a percentage basis, that’s a really good outcome. Because of the definition of a ‘senior carer,’ when we first brought them over, and then the care assistant role entered, as shortage definitions, that created a small pay issue that we had to just navigate from an HR perspective.

But that was fine. In terms of the actual process, getting enough certificates of sponsorship licenses is a bit of an issue. Just on a time basis, it can take a couple of months sometimes to get them through, that’s a Home Office issue. And in terms of cost, with spending now £3,250 for a three-year license, plus whatever the visa costs are, plus whatever the cost of getting them over is. So it ain’t cheap. But…

Respondent: It’s cheaper for us than for the employees, because what we found is a significant proportion of them have been treated awfully by the agency in their home country.

Interviewer: Can you say a bit more about that?

Respondent: I think a significant number of them have had to pay in the thousands, an agent in India or wherever, to put them into this process and find a job. And that’s a very significant sum of money. It’s generally, I understand, on a pretty high interest rate as well, because they’re paying it off over time. I know a couple, three of them have struggled or are struggling significantly.

Interviewer: To repay those… sorry, go on?

Respondent 2: And that is us using the NHS ethical recruiters list, for all direct applicants. So we are desperately trying to avoid the situation that… a large number of our recruits come from India, particularly actually from [town], bizarrely. And they tend to be friends of friends at the moment. So we can sort of circumnavigate it, but even then, the cost of saying, okay, I’m going to go from India to the UK, there’s a good £2,000-3,000-4,000 worth of cost there. And they take out family loans to cover it.

Respondent: I think there’s another element we should comment on. I think the attitude of many of these people is phenomenal. We’ve had people coming out of [town in India], arriving with us in January to a care home in the middle of the [area], it’s just unbelievable, it’s the first time they’ve been out of [town in India] and they really set to and it is amazing. But, and here’s the but, generally… well obviously English is their second language. And culturally they’re very different and quite distant from an 85-year-old gentleman who may have dementia and has got, at best, suppressed racist tendencies. But even something we laugh about it, but it’s actually not funny. We found in one care home that a couple of our Indian staff were putting custard on lasagne.

Interviewer: So it’s just like cultural awareness.

Respondent: Yeah, yeah. We kind of got to a point where in some of our homes, we think we’ve got the maximum ratio that will work. And I had a real run-in with someone from Skills for Care a couple of weeks ago because they were going on and on about overseas recruitment as if it’s going to be the panacea. And I said, “No, you can’t fill these vacancies with overseas people because you’re going to get this cultural imbalance.” And it’s not fair on these staff to beat them up and say, well, you need to be English. We wouldn’t do that; you know what I mean?

Interviewer: Yeah, it’s a big transition for them. And as you say also, for residents, it’s a very different approach. If you are perhaps at the maximum of what you think your balance of international recruitment is, what does that mean in terms of your home recruitment, how are you finding that?

Respondent: It’s better than at its nadir. I mean each week we probably need 30 staff, but they’re not all in care roles, but I guess 60% of those are care roles.

Interviewer: When you say you ‘need them,’ you’re trying to recruit that each week?

Respondent: Yeah, that’s probably our need, yeah. It’s declining a little bit. How we’re finding it, the answer to that depends on which home we’re talking about. We’ve got a couple that are fully recruited and have been for a little while. Those aren’t fully recruited; it tends to be… I think it’s related to geography. So a little bit out in the sticks is an issue or it’s in an area where it’s just difficult to find people. So a site, funnily enough, midway between [town] and [town], which you think should be relatively easy, but it isn’t, and when you look into the demographics, you kind of see why.

We’re doing it… I think we probably put more focus and effort on it than the larger groups. So we’ll run targeted Facebook campaigns and they are very targeted. Again, it’s this home-by-home basis, rather than saying, we’re [large national provider], come and join us because we’re a big group. It’s come and join [name of care home] because it’s us and here’s the difference. We use Indeed, none of the other jobs boards seem to have any real effect.

Interviewer: So it’s mainly Facebook.

Respondent: There’s a massive problem with Indeed… Facebook is much better than Indeed, but the problem with Indeed, and it also relates to Facebook, is the bloody benefit system. Where to get on benefits, to be on benefits, you have to evidence you’re looking for a job. Well all you have to do is send in copies of Indeed applications. You don’t have to evidence that you’ve been for an interview and been rejected. So I would guess… well, I’m not guessing, less than one in 10 of the people who respond to us on Indeed for a care assistant role, who agree to come for an interview show up.

Interviewer: So that’s just fulfilling their benefit requirements?

Respondent: Yeah. That’s a massive issue for us.

Interviewer: And that’s less so on Facebook then I’m thinking?

Respondent: Yeah, yeah. And as you go up the hierarchy of roles, that decreases. It doesn’t go away totally. We’ve had RGNs who have said they’re coming for interviews and haven’t shown up and disappeared.

Interviewer: To what extent, what is the competition like in the labour market for your homes? I know they’re geographically different, so there may be different answers, but in terms of the NHS, hospitality, retail, are you significantly in competition with those sectors or is it mainly with other care providers?

Respondent: So NHS, what we tend to do is lose motivated seniors and team leaders who want to have a career in the NHS. They start with us and they transfer… it’s only a few, probably only a few. [Colleague], correct me if I’m going wrong here. I don’t think we lose many, if any nurses, back to the NHS. Obviously when we’re hiring, we are, I guess, competing with the NHS, but it’s not the worlds biggest issue at all, I think. For care assistants and seniors, well for seniors… no for both of them, I think our competition is mainly other care operators. I can’t remember, [colleague] is closer to this than me, but I can’t remember hearing many care assistants going off to hospitality or Aldi or Lidl anymore.

Respondent 2: If we ignore pre-Covid, because I can’t remember beyond that, past, well, from 2020. So during Covid you obviously had people leaving social care because fear and had enough and burn-out and what have you. That has largely stopped. I think we still get a few people going, “I can’t cope with this.” Where individuals join us for six months, you have some people saying, either the complexity of the residents that we have at particular homes is too great or they’re not suited to care, and they’re trying it for the first time. So there’s a bit of a shake-out there. But once you’ve got past the first six-month period, yeah, the majority of leavers are either pretty serious disciplinary issues or they’ve gone to another provider.

Interviewer: And why would that be? What is it that creates that churn?

Respondent: Money.

Respondent 2: Yeah, money and sometimes just a change in scenery. If you think about it, every four years, in theory, our resident group would have churned at least twice. So you come in day one, here’s your 40 residents, two/three/four years later you’re going to be thinking, I don’t know anyone here, they’ve all gone. And it’s often the death of one particular resident who that particular person may have latched onto, will actually start this process of, oh actually, I don’t know anyone and I want to move on. So there’s some emotion to it.

Interviewer: Yeah.

Respondent 2: And we’ve had a senior at one of our care homes, there was a new build down the road, they’re offering a bit more per hour, it was a new build care home and she went along and she came back. She said, “I can’t do anything there. I went for benefits, but actually I’ve come back because this role is better for me.”

Interviewer: And that was about the content of the role, she had more autonomy perhaps?

Respondent 2: I think because of the nature of the residents that she was dealing with, she felt that she was very much sort of… the phrase she used was, ‘it was upstairs/downstairs, except in residential care.’ The care home itself was specialising in low level dementia, elder person care and she said, “I’m just standing around with my hands behind my back in a living room, not doing anything, except for when someone summons me to get them something.”

Respondent: I think, that to me epitomises quite a split in the issues in the market. This particular lady is married, she’s in her early to mid-30s and she’s been in care quite a while. Does she want to progress career-wise? Maybe not too much, perhaps because of childcare issues or whatever. But the job she does is really important to her, and the environment in which she does it. You can contrast that with a young care assistant who kind of most of them have got very low self-confidence and self-esteem. They come into care because they think that’s all they can do.

They perhaps marginally prefer to do it than shelf filling, even though that could be a little bit more money. And oft times they will change jobs because bluntly, they’re changing partner, or their living circumstances, it’s a different world out there than certainly I encountered at that age. So I think they’re far less likely to sort of say, I’m going to stay in this job and bed down. For them changing jobs pretty regularly doesn’t matter. Now there’s another aspect to this, which I think is worth commenting on, and that is that as with any industry you have a proportion of people who, in my opinion, shouldn’t be working in it.

They’re not suited for it, personality, motivation, they just don’t do a great job. Unlike nurses where there is a threat of an NMC referral, poor performers in care industry recirculate. And that’s because many employers won’t give references these days. Employment law allows you to get away with name, rank and serial number. And so there is an underlying swirl of people who just move from job-to-job and get performance managed out.

Interviewer: What about something like mandatory registration? That’s something that comes up from time-to-time, also in terms of perhaps improving the esteem, you talked about coming into care because that’s all they think they can do. What about mandatory registration, what would your views on that be?

Respondent: I would be supportive of it, if employment law was changed to enforce proper referencing. It won’t work otherwise because… I suppose if you had a body where you could refer someone to for poor performance, then maybe…

Interviewer: It’s a bit like the NMC, you’d be deregistered if you didn’t perform adequately or did something, safeguarding-wise, and be taken off the register.

Respondent: Yeah.

Interviewer: Conversely, some people think it would put people off coming into care, it might deter people, I don’t know. Particularly for the attached qualifications, which we haven’t really talked about yet, so perhaps we could link it to that. In terms of training and qualifications, what is your staff uptake of that? Do you link that to pay?

Respondent: We do give a little increment for NVQ twos and threes, yeah. I don’t know how many of our staff have twos and threes. It’s a reasonable proportion. However, we focus on our own internal training, we have a really, very comprehensive set of training courses. If someone really wants to knuckle down, there’s probably 25 or 30 courses that they could do.

Interviewer: Do they get paid time for doing those?

Respondent: Most of them, they will find a way of doing it within their working time. Not always. If someone comes on board and joins us, we expect them to have done a minimum number of the mandatory training before they walk in through the door. So things like remote learning on moving and handling, some basic fire stuff and what have you. And we target the homes on achieving at least 90% compliance on all our mandatory courses for all staff.

Interviewer And they are popular or not? Is that something staff like to engage with?

Respondent: It depends on the level of staff. As you go up the hierarchy, the popularity, well actually no sorry, I was going to say it increases, it doesn’t always because we sometimes struggle to get nurses, for example, to do training. And I don’t think it’s just… we’ve already done it or we know it all, it’s just they’re reluctant. So it depends. It depends. I think the majority of staff like the idea that at the end of a period they could be told, yeah, you’ve got a care certificate or whatever. But the majority of them aren’t career minded. It’s not like they’re saying, I want to go to university and get a degree, or I want to do a vocational degree level qualification.

Interviewer: We hear a lot about the need for career paths, but when I speak to providers, often I hear that comment that a lot of them are not career minded. To what extent is a career pathway and career progression part of the solution to retention or are we looking at the wrong things in thinking about that?

Respondent: I think we have to fix pay first and that will then encourage… I’ll just be politically incorrect and say ‘the right kind of people,’ to want to look to come into care. And then you can start building on it from a career point of view. The big fix tool of this is our education system. But in a current ‘woke’ environment, you ain’t going to fix that. But that’s where this lack of self-confidence and low self-esteem comes form.

Interviewer: Can you say a bit more about that, in terms of its relationship to care?

Respondent 2: Well I’m just going to dive and just go full on, go from the top level…

Respondent: Save me!

Respondent 2: Yeah, pretty much. We use a recruitment tool called [psychometric tool]. It’s a values-based recruitment tool. And we’ve run this for a number of years, starting pre-Covid. Consistently what has come out of it is that our team are low in confidence and that’s self-confidence. And therefore that feeds through to self-motivation. I think there are two ways of looking at this. One is the educational system. For me it’s actually almost a societal problem, that I think, and we can discuss this, but I think we’ve written up quite comfortable saying this is where I’m from, this is where I’m going and that’s okay.

My wife used to work at a school where the kids, in primary school, the kids were saying, “My mum and dad are on the dole, I’m going to be on the dole.” And it’s endemic at that level. I live down in [town], it’s endemic in quite an affluent area. So if you have this acceptance of, this is my social status in life and I’m never going to progress, and that is endemic within our society, culture, educational system, whatever, actually you’re never going to get people going away from, I am just a carer.

And we need to remove this stigma of ‘just’ from that phrase. We need to say well actually, you go and be a carer and it’s a really worthwhile and valuable career and you do amazing things. The pay is good enough, that you can get a pay. There’s some equality bit that needs to happen between us and the NHS around pension. That’s a personal bugbear of mine. But then you go through and say, okay, look, what does a manager earn? A manager is on £50/60 grand a year in a basic care home, plus bonuses. You go to a larger group, a large care home, they can be on £100,000 year.

So it’s not a poorly remunerated profession at the top end. A lot of work to get there, NVQ 5, 7s and what have you. But then you’ve got quality roles, you’ve got training roles and £40-50 grand a year is not unattainable. And actually I’ve just heard via [LA] that there are now nursing associate qualifications, come in as a carer, nursing associate, get on a training course, go to the NHS and become a nurse, but you do all your training in care.

So there are routes towards it, but I think there is a natural reluctance to look beyond the concept of, I am just a carer, I am just a cleaner, I am just a kitchen assistant.

Interviewer: But how do we get to that? You’ve talked about pay, which I agree is really important. But I don’t think that is the be-all and end-all, is it? It is largely female dominated, there is that sense of lack of esteem. How do we address those issues? Pay will help but I don’t think it will solve all of that?

Respondent: Okay, well, I think it’s perhaps a bigger driver than any of us think. I can think of numerous examples of our staff who said, “It’s not worth taking on the additional responsibility of a role.” And they mean that in a financial sense. The basic pay, the increment that they would get to move up to more responsibility doesn’t justify what they see is a really big ask and that’s, again, relates to their level of self-confidence and what have you. We’ve got staff who have stepped back. There’s a lady at the home outside [town] actually, who used to be a senior and she was one of our best seniors. And she has progressively stepped back to being a kitchen assistant.

Interviewer: And that is because?

Respondent: She doesn’t want the stress and the hassle; she sees it as a senior job. And she actually is surprisingly well qualified. It’s [name], [colleague], I’m talking about, you’ll realise.

Respondent 2: Yeah, yeah.

Respondent: But I mean she could easily blow a degree qualification out of the water. And it’s not uncommon this. We’ve got a kitchen assistant at a home in [town] who speaks multiple languages, who is really, really sharp and I keep saying to him, “Come on, let’s develop…” “No, I don’t want to, I’m okay.” It’s what [name] is saying, it’s societal, their aspirations have been kicked out of them through our education system and I honestly can’t see a way of us fixing that by repositioning… only by repositioning care and saying, ‘this is an exciting career.’

And I think the other part on it, is having been in many other industries, the care home industry has got a very narrow pyramid. So you look at staffing in a typical 40 bed care home. Yeah, you’ve probably got, let’s say 60 staff on the payroll, of whom, I don’t know, I’m guessing, 35, so more than half are care assistants. You might have 10 seniors; you’ve then got one deputy and one manager.

Interviewer: Quite a flat system.

Respondent: Yeah, so you look at it as a motivated care assistant and say, how in this home am I going to get up there? And you’re not, especially in a good home where the manager you hope to retain for a long while. So we’ve got an industry structure that actually forces people to have to job hop to get on. Which ain’t great.

Interviewer: No, no, and I guess it comes back to the funding support, paying more for qualifications, so that is at least a competency-based structure if you like, but that does become really expensive. Can I take you back to your comment about the nursing associate, where you were saying they’d come and do placements and then move on? How do you feel about that? I hear concern sometimes about social care being a training ground for the NHS. Do you think that’s a positive thing? Is that a concern for you?

Respondent 2: Okay, I’m going to start by saying that we can’t retain… so we can’t retain everyone. Is it a good thing for us to go and say to people, look, come to us, be a care assistant, we’ve got you for three years and then you’re going off into the NHS as a… or you’ve got this additional qualification of nursing associate, which actually operationally to us has benefit. Is that a good thing? Yeah. Career path and what have you. Going to your point about the NHS and whether we’re a training ground for the NHS, I actually don’t think we are.

Interviewer: Okay?

Respondent: No.

Respondent 2: We had one person email me that I know of, who said, “I want to be a doctor, I’m 18, can I come and do some shifts with you?” So we have one every so often. We have a couple of nurses who are… who are moving between us and the NHS and we occasionally have care assistants who go through a pathway. We don’t train from the NHS. I think what we do is we actually take nurses from the NHS more and more.

Respondent: Yeah.

Respondent 2: Because I think we are a better employer than the NHS, for a definition of an employer. I think what we do need though, and I’ve said this before, is a quality in staffing and the remuneration of our staff, between us and the NHS. And if there’s one thing I would be changing, it would be the pension.

Interviewer: So we haven’t talked a lot about your actual benefits package at the moment. Can we perhaps come onto that? We talked about your pay rates, sickness and pension, SSP and your 3% contribution, is that what you’re doing?

Respondent 2: Yes, that’s it, yes.

Interviewer: And so for you, that is a big issue, the disparity between the NHS pension and your provider pension… your employer pension?

Respondent 2: It’s not a big issue for us, I don’t think any of our employees actually realise how big of an issue it actually is. And I’m certainly aware that some of our nurses continue to do bank shifts with the NHS because it means they top up their pension and what have you. But our care assistants don’t understand it and I’m quite grateful for that because we would lose care assistants very quickly if we did. It’s a point of principle. We are a fundamental underpinning point of the NHS, we saw that during the pandemic and you’ve seen it in the last couple of years, that if social care isn’t functioning, the NHS cannot work.

So why the heck don’t we have access to some form of defined benefit pension scheme? I’ll go you one further. Everyone that we deal with, NHS, CQC, local authority, they all have defined benefit pension schemes. Why don’t we? The answer is, that we’re privately funded and we’re private providers. But it just sticks with me.

Interviewer: Yeah, I understand absolutely the point of principle. I’m just wondering as an attraction retention tool though, how valuable that would be if, as you say, it’s not well understood, or do you think if you made it better understood that would be a powerful tool for you?

Respondent: I think if we could offer something that was better, we’d make it better understood. But if we publicise the difference now, we’re shooting ourselves in the feet.

Interviewer: Absolutely, yeah, if it was better understood, that would be important for you?

Respondent: I think turning it… well, not turning it around, but just picking up. If we were able to recruit people who were more career orientated, a higher proportion of them would be more motivated by pension, yeah?

Interviewer: Yeah, absolutely.

Respondent: Someone who is job hopping between us and hospitality or supermarkets, by definition generally is only worried about their next pay packet, or how to get through to the end of the four-week period rather than pension.

Interviewer: Absolutely.

Respondent 2: I suspect the answer would be, we’d end up with more people probably aged 30-40-50 saying, I tell you what, I’m come and do the minimum period, 10-15 years, whatever that is, in social care, to get my contribution up, so that actually I do earn that extra 12 grand on my pension.

Respondent: Just a couple of points with the NHS. I don’t care, really, I think it’s positive if people move from us towards the NHS. What gets me is if we just spent a lot of money on training them and then they go, within say a six-month period. So that’s the only thing that does niggle and we try and have some kind of claw back clauses on that. So someone who is doing an NVQ 5 or 7, that costs quite a lot of time and money and if they then hopped off immediately, that would be an annoyance.

There’s one other thing different with the NHS that really does get to me. I think the last Skills for Care report indicated about 25% of the staffing in adult social care is agency. And we are competing with the NHS for those agency staff. But there’s a difference. The NHS, their HR and staffing teams use the excuse that from a regulatory point of view, they have to have a certain minimum level of staffing and that overrides any economics.

So I can quote you examples, best out of [LA], where our last January… yeah, New Years Eve, they were paying £110 an hour to our GM, to work in the NHS. And if we needed GMs for that shift, we would have had to pay the same, because the NHS just crank it up. It’s crazy. And if I was prime minister, I’d just say, end to agency, stop. Because those people are only in agency because they can earn more money going through an agency rather than being permanently employed. And then the agencies are putting huge premiums on top of it.

So that whole thing is sucking… it must be billions out of the health and social care sector. And it’s a major issue. If it was stopped, those people would come back to being parttime or fulltime employees at well less than half the cost.

Interviewer: But that is nurses, you’re not in competition for carers…

Respondent: Yes, we are.

Interviewer: You are, so carers as well?

Respondent: Yeah, it’s right the way through the hierarchy, yeah. Anyway, end rant.

Interviewer: That’s okay. I’m interested in agency… we talked about agency previously, didn’t we? I’ll need to come back to benefits, I’m jumping around. We talked about agency previously in terms of the one-to-ones that are spot funded. Do you have much use of agency beyond that?

Respondent: We desperately try not to. Coming out of the pandemic we used an awful lot because it was that bad. We’re now down to a very few percent and it’s generally to cover exceptional situations. So yeah, we pushed it right out by working very, very hard on it.

Interviewer: Okay, going back to benefits then. Are the benefits financial or non-financial that you offer and again, how important you think they are?

Respondent: Well working with me and [colleague] is a huge benefit!

Interviewer: Of course, of course. (Laughs)

Respondent: I don’t know what else we do. I think honestly being a small family group is a benefit. Obviously, it’s not financial, but I think people recognise that compared to working in a corporate. We do a bit on free staff entertainment, I guess that’s unusual, that helps. We try and push things like the Blue Light card and what have you. We have free wellbeing services, upper management have access to a fully insured Bupa healthcare scheme, which actually if there was interest from other staff we might well look to extend, because we can do it on a salary sacrifice basis, but I don’t think the interest is there. What else do we do [colleague], have I missed anything? Not a lot.

Respondent 2: We are, I think, a bit more flexible than most employers are around advances and just general… in loans. I think there’s one incidence in the last three years where we’ve turned around to someone and said, “No, we’re not going to advance you the money,” and that was because someone said, “I need £3,000,” and she was a care assistant and not earning… it would take her two years to pay it back, we just said, “This isn’t going to work.” But yeah, fundamentally we’re pretty flexible on that.

Interviewer: And have you seen a big need for that, with the cost-of-living crisis, for example?

Respondent 2: We did at the beginning of the year. I think it’s tailed off now. There was one request for a couple of hundred quid, but other than that, not really.

Interviewer: So you’re not seeing a lot of need… people asking for advances on a particular regular basis?

Respondent: No, not really. And I think… we did some survey earlier in the year and I keep asking the question of, what could we do? And I think the answer comes back, we’re trying to get inside, what are the priorities for our care team? And therefore what could we do to respond. And when you ask, what the priorities are, it tends to come back as smartphone, believe it or not. Enough money to go out once a week. An overseas holiday, surprisingly… once a year is surprisingly high up there. Food and drink. A roof over your head and then generally heat and light and power.

And I think most care assistants, unless they’re in a relationship with a partner and they’re perhaps in their mid-30s and what have you, their whole focus is on how do they maximise their net take home? They’re really not interested in things like pensions or anything like that. I’ve been surprised at the low level of take-up of the Blue Light card.

Interviewer: Really?

Respondent: Yeah. And that kind of doesn’t figure with what I’ve said about the maximisation of the net take home. Some staff down in [town] the other day, oh, it’s a lot of work to get one. But it is so simple.

Interviewer: Yeah.

Respondent: But the cards which require you to put money upfront, they don’t want, because they see that as taking… well, they often just don’t have the money to put upfront, because they’re living so much hand to mouth and in hock the whole time.

Interviewer: Right, okay. Another thing I’m interested in is working patterns. Because obviously there’ll be lots of unsocial hours, weekends etc. I see that most of your staff are on guaranteed hours. How much flexibility is there in their working patterns, how much they need, how much they get, how do they feel about that? How much of an issue is that for you?

Respondent: It’s relatively significant for the managers. It’s quite difficult in staffing a care home to have flexibility, it takes an immense amount of time to rejig rotas. And that’s probably the big issue. And also those that require flexibility are generally seen by the rest of the team to be letting them down more frequently. So we do have a few staff who we have recruited, knowing that they can only work x and y. But it is relatively few. I think that’s what I can say. I think it is very difficult to do flexible working unless you completely rejig your workforce.

Interviewer: All right, but that doesn’t tend to… although it’s a headache for the manager to deal with, it doesn’t tend to cause you a lot of turnover. For example, people don’t say, “I’m not working weekends anymore,” and leave?

Respondent: We get some people whose personal circumstances change and they come to us and say that, generally driven by childcare issues. And to extent you have to take that on the nose. There’s not a lot you can do about it. But if you’re going to go for real flexible working, then you need a high proportion of your team who are prepared to work for six or eight hour shifts, and multiple of those during a week. That’s difficult to do. But also it’s quite difficult to fit in to provide high quality care. So if you’ve got a shift that is constantly changing its members, during a working day, that can be quite a challenge in terms of quality-of-care continuity.

Interviewer: Do you tend to do 12-hour shifts?

Respondent: Yeah.

Interviewer: I heard your point about not comparing homes on pay rates, but I was interested in the different turnover levels across your homes? I wonder if I could ask you to reflect on that?

Respondent 2: Can you give me 30 seconds?

Respondent: I’ll start off by saying it is related to managers and I think we underestimate the impact a good versus a weak manager has on staff retention. When we change managers, then often that precipitates a churn in the staff team. The historic relationships are there no more, or the incoming manager has a different view on what ‘good ‘looks like. So there’s those kinds of things. But there are some other factors which [colleague] is going to annunciate in a nanosecond.

Respondent 2: If you look across our entire group, the staff turnover the last 12 months is 55%.

Respondent: Horrendous.

Respondent 2: However, if you look at those who were within… if you exclude those with 0-3 months service, then it’s 42%. So we have a large number of people who come in and they don’t last the first three months and we part ways with them. So yeah.

Interviewer: The table you supplied to me, I don’t know what the acronyms are, but FH, for example, was 70%, whereas NL was only 30%. I was just interested in the difference in those patterns? I know [name] has said it might come down to manager.

Respondent: Okay, FH is outside of [town], why has that been high? We had a management, well, a double management change, both manager and deputy within that time period and I knew… I know that’s shaken some things up. But also as I alluded to, we have found it difficult to recruit in that area and that’s driven by the demographics. And the proximity to the western side of the [city] conurbation.

Interviewer: So they go and work over that side, you’re in great competition.

Respondent: Yeah, and NL is in [town], which doesn’t have an awful lot, apart from a few sheep within 10 miles radius of it.

Interviewer: So there’s not a lot of options.

Respondent 2: Yeah, so [care home], this is slightly updated data, last 12 months, 72% churn. If you exclude those… and that’s… in terms of that, that’s 46 people. However, if you look at the numbers, 19 of those had 0-3 months service and 24 had 0-6 months service. So actually you’ve only got half the people… half of the… sorry, you have 50% churn if you exclude those with 0–3-month service.

Interviewer: A familiar…

Respondent: Being blunt, this is the sequester of paying people very little money.

Interviewer: Yeah, so they come in and decide it’s not worth it for the money, it’s not for them, given what they’re being paid.

Respondent: Yeah, or it’s just people are coming in because they’re looking for something to tide them over for three or six months. I’m not being critical of them, it’s a societal systematic failing, but that’s where we’re at.

Interviewer: And once you get them past the six months, do you have much longer periods of service then?

Respondent: Yeah, yeah.

Interviewer: And you described it as ‘horrendous’, I’m sure you’ve reflected on this yourself many times. But interested in how you might influence that to reduce that?

Respondent: By focusing… having good quality managers. By focusing them on retention and doing things to build team morale. To really try and… there’s a lot you can do by just talking to people and managing them, sensitively to retain them. But also to sharpen up on recruitment as well. So they move quickly with candidates, new candidates, but they don’t jump on the first bus that comes along because often that is going off to an unknown destination in the short term. So there’s a whole number of different things, but it is challenging, it is very, very challenging.

Interviewer: Okay, that’s really helpful. I’ve asked the questions I wanted to ask, I wonder if there are things that I’ve not touched on that you want to raise, that you think is important?

Respondent: I think there’s a big thing… you’d be surprised, I think, at how aware, and pardon the phrase, pissed off the staff are with the view of care from central government and local authorities, and the ambulance service.

Interviewer: Can you just say what that view is, just so that I’m in no doubt what that view is?

Respondent: Okay, that they are treated… they’re not valued and by their supposed colleagues in the health service, generally, they are treated as untrained, unmotivated, not even second class/third class citizens.

Interviewer: And so with the ambulance services, that’s when residents are admitted to hospital, those interactions?

Respondent: It’s typically when paramedics come out on an emergency call-out, the way that they interact with our staff is… sometimes it’s appallingly demeaning. This is quite specific. They are very aware of how the DHSC and central government portray the care. When Hancock tried to brand care, and give out these bloody badges, the reaction to that was… it wasn’t surprising, but it was shocking.

Interviewer: Can you just tell me why? It was seen to be demeaning or?

Respondent: Yeah, they just didn’t see it… it was not meaningful, it was just trying to put… Hancock trying to put a sticking plaster on things. I think it goes back to… a lot what [name] was saying about parity with the NHS. It’s parity in terms of… was social care applauded during the pandemic? We were all outside banging pots for the NHS, well, we had residents dying around our ears, literally. And that really has stuck with people.

Respondent 2: Put it another way, a couple of months ago there was a big conflab at Downing Street, where if you read the press, NHS leaders get together to discuss the future of how the NHS is going to get through the winter. The people who attended that were primarily social care. There were some NHS England people there, but actually if you look at the social media, that was 75% social care organisations attending that. [Organisation names], the big guys, and some of the better networks for operators.

So we were lumped in with the NHS, but we are not the NHS and I think we’re proud that we’re not. So there is a complete lack of recognition of what social care is, at a very fundamental level in central government. I don’t think that’s deliberate. I think if you actually got, for example, Jeremy Hunt, who I think myself and [name] have a little bit of respect for…

Respondent: I’ve got lots…

Respondent 2: Yeah, and some of the MPs I’ve dealt with, very much understand that social care is different to the NHS and they’re supporting. But I think at a systemic level, it’s too each so to go, oh, social care is in with the NHS. We’re not.

Respondent: Let me be more blunt than. During the pandemic especially, but subsequently, I’ve been involved in quite a lot of forums where I’ve had contact with people in the DHSC, and I have been appalled at the quality of them, at the attitude and the fundamental lack of understanding or even attempt to understand social care. And I’m being kind and subtle with the words I use. You just… you wouldn’t believe it.

Interviewer: I think there has been a change in name and practice is very slow to follow, it’s still very much a health rather than a social care focus.

Respondent: I don’t even think it’s health. The head of Care England, used a really nice term. He said, “The NHS is a sick service,” It doesn’t mean it’s sick, it’s not about health. And I think adult social care is about holistic wellbeing. So we’ve got an outfit that only worries about sick people, not about health and it’s got no perception about how you provide fantastic wellbeing for someone whose probably in their last two to five years of life.

Interviewer: Yeah.

Respondent: And take that back to our staff, when they see that, all right, and they get constant fundamental abuse through safeguarding some hospitals or just being put down or whatever, it really is very demotivating. So when you go back to a group of staff who are short on self-confidence and self-esteem and they get this, it’s uphill work. And why would you go do it? And that’s people in the care home where they’ve got day-to-day management, who can prop them up and say, “No, forget it, you’re doing a great job, they’re wrong.” We’ve got to look at the other side of this, which is domiciliary care. Those people are out on their own and they must be getting beaten up in exactly the same way.

Interviewer: Yeah, without that support, yeah.

Respondent: Without the support, yeah.

Interviewer: No easy answers and obviously some very deep-seated problems.

Respondent: One easy answer is to get Skills for Care out of this, by the way, because…

Interviewer: (Laughs) I’m not going to recommend that, but go on, why?

Respondent 2: No, you must do.

Interviewer: Okay, so why?

Respondent: You’ve got, what’s supposed to be a charity, all right, that is totally motivated for doing things to increase its revenue and its staffing. And fundamentally staffed by people who are so far distant from the front line and they never ask proper questions. It’s unbelievable. It really is a major negative in this piece of work.

Interviewer: So if it was an effective organisation, how would that differ? What would you want them to deliver? Or you just do away with it altogether?

Respondent: If it was an effective training organisation, that’s one thing. But coming out and being treated as an industry consultancy body, no. You were going to say something [name]?

Respondent 2: Yes, the WDS is one, not fit for purpose. There are huge data errors in it, which you will identify. And secondly, it’s a closed loop system. I cannot automatically import data from my system to that. So there is a huge inefficiency that we all have to sit there on, Skills for Care, physically type, yes, okay, you can do uploads, bollocks to that, it doesn’t work and it’s too complicated. And if you run six care homes, me updating the WDS, and it’s only a couple of people every year, takes me a whole day in terms of data scrape, get the information and then upload it. For what, 50-60 quid per time? It’s an irrelevancy. So I almost may as well not bother.

Interviewer: You fed that back I presume?

Respondent 2: No, because people don’t like it when I swear at them.

Interviewer: (Laughs) Okay, I might put it a bit more politely then. But we are using it and you’re right. There’s better and worse data systems, no such thing as a perfect data system, but I am aware that there are significant gaps in it.

Respondent: I think the other thing I would feed into you, being blunt, is the industry feedback is very skewed by the top six big groups. They only represent a small proportion of the care homes, but they operate in a very different way to the majority of other providers. And what they have to do in their metrics are very different as well. So we’re members of Care England, but I have a massive issue with Care England that their thought process and what they say are dominated by the big groups.

Interviewer: And how would that differ to what you would want to be represented?

Respondent: I think, on a broader basis, there are too many representative groups, representing social care. And having a care providers alliance is just a load of rubbish, because actually whoever chairs it, is trying to sit on a whole set of supposedly repeating interest. We should have one representative body going forward. And that should have a balance of representatives looking at all the different sectors. Domiciliary care didn’t get a shout in most of these things. It’s the agency ones, the [large one]’s who have a couple of hundred residential homes, who are trying to placate their investors with a new build strategy.

The majority of the sector doesn’t do new build. The [large firm] and agency ones have to, but they’re focusing on the top end of the self-funder market, so everything is very different there. So yeah, I think the whole representative piece is problematical, and that extends down to the area in regional Care Associations. So for example, we’ve got one in [county] that effectively decides where placements go, believe it or not. Represent the Care Association, works with [LA] on where placements are made.

Interviewer: Right.

Respondent: As part of their contract. They’re not representative. We’ve got [area] Care Association, which is frankly… I would have a chocolate teapot compared to them. And there’s no way they don’t have elected boards, they decide who sits on their boards, you can’t get rid of their chief executives. So they can talk absolute nonsense to local authorities or whoever, or the ICBs and the care providers have got no control. I mean this is another problem, that Skills for Care tend to go to these local care associations for input and it’s not valid input.

Interviewer: And so where do you make your voice heard? So Care England, or other mechanisms?

Respondent: Yeah, that’s about it. And trying to build influential relationships with commissioners. And I am pleasantly surprised that in general, if you get to talk to commissioners and say, look, not hostile, not attacking you, we understand that you have got your own issues, you don’t have enough money and what have you, let’s work together. You can have certainly off the record, some very, very sensible discussions. On the record, they have to tow the party line, which is what they’re told by their chief exec and finance officer. Budget constraints, budget constraints the whole time. And it’s empire protection as well, why does [LA] need a thousand people in its social services department? One thousand people!

Interviewer: Right, administering it. The admin…

Respondent: Yeah, yeah, will they have a discussion about how we could work with them to cut that down… but anyway, yeah, so you can have influence at a local level, but at a macro level, no you can’t. At the end of the day it’s not just about funding either. The system is fundamentally stupid where you’ve got 160 different people, plus the ICSs and the ICBs, trying to manage 17,000 care homes. It’s nonsense.

Respondent 2: You have to excuse me, I’ve got an 11:00, so I’m going to dive off if that’s okay?

Interviewer: Thanks, I appreciate your time.

Respondent 2: Thanks for your time, cheers, bye.

Interviewer: Bye.

Respondent: Yeah, and you know, we can go on and talk about workforce development, whatever, but while it’s managed like this, I’m not sure we’ll make headway. The government give grants, so the workforce development initiative, 200 million made available recently, yeah? Every local authority has got the right, and most of them are, to handle that differently. I think it was [LA], they’d given care workers £200, from their fund. In [LA], there’s not a penny of that that’s going to the frontline.

Interviewer: So what is happening to it?

Respondent: They’re saying they’re using it internally, and won’t tell us what for.

Interviewer: Right, okay.

Respondent: And this again goes back, I think, to the mismanagement by the Department of Health. They have lost control of both the NHS and the local authorities. I can give you a digitisation programme, each ICS is allowed to go off and do its own digitisation. They can all have different software systems, interface on adult social care. So that means providers will have to interface to multiple NHS systems. They can do pretty much what they want. Local authorities don’t listen to what the DHSC tell them to do.

Interviewer: Yeah, we were talking about that yesterday in a different arena about digitisation of care and it seemed strange to me that there was a whole raft of different approved providers. And the idea is that they will all interface with GP systems, with the GP system, but I wonder how effective ultimately that will be.

Respondent: With GP systems, yes, but the NHS are doing an awful lot else, in different areas with other systems. We’re talking here about really, really big things, but actually I think when you get things that… I mean everyone, politicians as well will say, it ain’t working. You’ve actually got to go back and look at things at 30,000-foot level and say, “Come on.”

Interviewer: How would you bring all those providers together? One solution obviously could be renationalisation, but that isn’t going to be a popular solution or even a feasible solution. So how would you bring them all together?

Respondent: If it was me, I’m going to be very contentious here. I would say you take the health element of social care away from local authorities. There’s a sub-step on that, which you just say to local authorities, you all have to do things in the same way and you have to pay at the same level, so you take discretion. But I don’t think that works, given the varying needs of potential residents.

So I would go back to the way it was originally envisaged and say local authorities, you’re responsible for care in the community. And everything else is responsibility of the NHS. So it’s commissioned from there. That way we can then get a close-up on… they can use the NHS budget to commission, which they can’t at the moment. You can then start building a common culture, you can get common pay rates and all the rest of it. And you can get consistency over the country, which is desperately needed.

Interviewer: So you’re saying you can do that even when you continue to commission in the private sector, you could still have that kind of top-down consistent approach?

Respondent: Yeah, I don’t think commissioning in the private sector is a problem. And if we were going back 30 years, would we have the kind of structure where you’ve got 17,000 homes that are effectively all privately owned, some who are not for profit or charity, but it kind of doesn’t matter, not for profit makes virtually no difference. You probably wouldn’t do that. But to nationalise that, the cost of doing that is just… it’s not possible, economically. So we’ve got to find a model where we say, it’s okay to commission into the private sector, but it needs to be done in a consistent centralised way. I think, and I think if we can do that… I heard Wes Streeting say something as well, I got a lot of time for him actually, I think he’s saying some really sensible things.

There is no point putting more money in to the NHS. I’m not sure there is any point putting more money into adult social care, because I don’t think it will get through to the wages, which is the critical issue. So I think we’ve got to sit down and say, okay, we’ve got an investment of x billion a year, into adult social care and health, how do we pull that in a way, within a restructured commissioning process, that allows… not actually allows, forces employers to pay the staff more. Now some local authorities are trying to do it at the moment by commissioning and saying, ‘you’ve got to meet the national living wage,’ rather than national minimum wage. But they’re not increasing their fees enough to do that.

Interviewer: Yeah, I’ve heard that quite a bit, so the real living wage, is that what you’re talking about?

Respondent: Yeah, real, sorry real living wage.

Interviewer: But they’re not getting enough fees to do that.

Respondent: No, they’re not. So they’re trying to do the right thing, but in the wrong way. And in doing that, what they’re doing actually is probably impacting the volume and quality of care.

Interviewer: Say a bit more about that?

Respondent: Well, if you’re going to a provider and saying, “I will commission this bed, but only if you meet these wage criteria,” whatever they are, then the employer is going to have to spend more, which means probably they can employ fewer people…

Interviewer: Because they’re not getting the fee uplift to support that pay increase.

Respondent: Yeah, because they’re not getting an increase. So by definition the quality of care will decline. And going back to the head of the conversation, why are we saying that we won’t take base rates from local authorities, it’s because we don’t believe that we can provide quality care on those fee rates. Other operators do. I’ve been in their homes; I applaud them for trying. But when I look at the result, I’m horrified.

Interviewer: Do you find between your private payers and your local authority funded, yeah, so you do.

Respondent: Yeah. So just what happened this year when we did the… we looked at our fees on April the first. We looked at what we were getting in fee uplifts from our local authorities, which in the case of [LA] was zero. Zero, yeah, given the rate of inflation. And we then said, okay, given our banking covenants, what EBITDA do we need to make, which was the same as the previous year. And we then said, okay, where is that gap on revenue and then we had to apply that to our self-funders. So self-funders got hit with a 17% fee increase. And I felt so, literally awful in doing that. Yeah?

Interviewer: Yeah, absolutely, I can see that, but equally there’s quite a big gap then isn’t there, between your local authority and your self-funders.

Respondent: Massive, absolutely massive. And it’s getting bigger and absolute… at proportional terms. That’s not right.

Interviewer: No.

Respondent: Absolutely not right. And this is impacting on so many things. And I get really wound up about this. When I go and talk to someone in the NHS and they say, yeah, it’s costing x hundred a night to keep someone in bed, and we can’t find a care home for them. The money is there, they can’t use it, they can’t even unblock that bed, for someone to go in for an operation. And if they unblocked it, they’d save money and give that potential resident a better quality of care.

Interviewer: It is that separation of budget, you need much better integration of budgets to make that work.

Respondent: Yeah, but it’ll never work, never work if you’ve got a local authority budget and an NHS budget. I mean today, all the local authorities I know are pushing back on the NHS on nursing. The last thing they want to do is accept a nursing placement from the NHS because the local authority money and all the NHS have to do is top up on the FNC. It’s ludicrous.

Interviewer: Because of those different systems, they do definitely desperately need bringing back… not back, but bringing more closely together. And you haven’t seen the ICS made much difference to that, because that was obviously one of the…

Respondent: It made it worse.

Interviewer: Because?

Respondent: Because the ICSs are building new empires and they, to be honest, most NHS administration… I’m not guessing this, we’ve got a close friend who used to be HR director for an NHS trust, she’s now left. So I got a really good insight to it. And she said NHS administration have got a really negative view of local authorities. So they don’t see themselves on a peer level, they really don’t want to work together, unless they can find a way of offloading problems. So if I’m trying to offload a problem onto someone and I got a negative view on them, I’m probably not going to do that in the right way. Or in fact try and offload the problem.

I’ll give you an example that is perhaps less contentious. The NHS is having a real drive on reducing falls in care homes. Why? Because they say that it’s a major contributor to admissions of elderly people into hospitals. They’ve not looked at the data. And they’re involving local authorities in it, they’re spending tens and tens of millions on this, and introducing things that won’t work. If you look at the data, and I managed to get this on a regional basis, the proportion of people who go into… elderly people who go into hospital because of falls in care homes is very, very small. But you can’t reduce the number of falls dramatically.

So they’re working on something, I understand why they’re trying to do it, but it’s the wrong… they’re trying to pull the wrong lever to reduce hospital admissions. There’s a much bigger cohort of hospital admissions that are preventable, or reducible, sorry, with a lesser investment.

Interviewer: And what is that?

Respondent: It’s providing better support to care homes through the primary care function.

Interviewer: So they’re dealt with in the home rather than admitted to hospital?

Respondent: Yeah, and you prevent them getting conditions which would result in hospital admissions. A very simple thing, would be to say every GP is mandated to do a weekly ward round in a care home. Mandated, they have to do it and they can’t dictate that to an advanced nurse practitioner. That has a dramatic effect on overall wellbeing and prevention.

Interviewer: Yes, just that interaction with the GP, that early diagnosis etc.

Respondent: Yeah, and/or, actually saying, “Look, I’ve seen Elsie for the past six weeks, she is deteriorating, she is on end of life, so let’s agree to go and talk to the family, make sure their wishes are properly recorded and not if, but when this happens, let’s not phone the paramedics.” Yeah? And that’s huge… that’s in everyone’s interest, unless of course the resident is saying, no, I want every attempt… but most times they don’t. So it’s this kind of thing. But again, because of the fractured system, I mean GPs aren’t part of the NHS, right?

Interviewer: No. In one way they are, but they’re self-employed, private businesses, yeah.

Respondent: Yeah, they’re private businesses. So their motivation is different to that of the NHS and ourselves would really want. Another example, we cannot get a dentist in [county] for our residents, period. We’ve got residents who have been four years without any dentistry at all. Why is that? It’s because of the way… the dentists are saying, “We’re not taking anyone else on, on the NHS,” because they’re paid so poorly and to check oral healthcare for someone with dementia is challenging. It’ll take a lot longer than you or me willingly lying in a chair.

Interviewer: Yeah.

Respondent: But if we go to those dentists and say, “Okay, how much do we have to pay you to pop in and check 40 residents?” “Oh yeah, can we come in tomorrow?” I’m not criticising the dentists…

Interviewer: No, it’s the system isn’t it, it’s the way the system is established.

Respondent: Yeah, so that’s kind of where I’m at. I don’t think this comes down to saying like many people, you’ve got to put 10 billion more into this or that or whatever. It’s saying, let’s get this right so that we actually build a service where we’re doing the right things, everyone feels part of it and everyone is being remunerated fairly for doing a bloody difficult job. I think the money is there.

Interviewer: Yeah, just differently used, differently allocated. I think you might be right. It takes that leap of faith to move it from the NHS, if you’re not integrating the leap of faith to move from the NHS into social care, is a leap of faith that has not yet happened, we’ll see.

Respondent: You could look at it in another way. We could do this in baby steps. As an example, we’ve got… I think there’s 161 local authorities, all of whom have got their own quality monitoring teams. And they’re big teams, and they run around and they check the quality in care homes. We’ve got the Care Quality Commission doing exactly the same bloody thing and we have to pay them thousands a year for the privilege of being registered for them to do that. So they’re duplicating what the local authorities are doing and now the ICSs are setting up their own quality teams as well.

We’re inundated, now the NHS has found social care, we’ve very well meaning and very nice people, coming into care homes saying, you should do this and do that. Well hang on a minute, 25 years, I think we might know that and by the way, this isn’t a hospital, it’s someone’s home. But hey, let’s work together, let’s do it, yeah? But the duplication and triplication, you think of 161 local authorities and the cost of their quality teams, if we just said… someone said, “No, this is CQC,” and put that saving into the frontline…

Interviewer: It would be enormous.

Respondent: Yeah. Commissioning, the way it’s done is, as an ex-technology guy, it drives me absolutely loopy. It wouldn’t take… you wouldn’t have to PricewaterhouseCoopers to find a way of saving half the money that’s used in commissioning.

Interviewer: Because it’s not an efficient system.

Respondent: It’s built on conflict, conflict of fighting for lack of funds, a perceived lack of funds. Fighting with the NHS etc. And you’d need a lot of people, if you have a conflict system, we’re trying not to do things, you’d need a lot more people than if you got a positive system.

Interviewer: Yeah, absolutely. Yeah, there’s some big challenges to resolve. I appreciate your time, that’s been really, really helpful.

Respondent: Okay, sorry to rant.

Interviewer: No, it’s fascinating stuff, challenging to think how we’ll resolve some of it, but we’ll…

Respondent: I’ll look forward to hearing that you’ve resolved it and seeing the report, yeah?

Interviewer: (Laughs) Well, the report will be out… it will be with the Department of Health and Social Care for the Comprehensive Spending Review in the spring, but I don’t… the final report won’t be there until the summer, but I imagine the pace of publication might mean it’s out in the autumn. But it will be with them for the spring for that policy process.

Respondent: Okay.

Interviewer: Hopefully it will make some difference.

Respondent: Sorry, one final… I meant to do this an hour ago, when you touched on something. Take cost of care, all right, know why they did it, the fallacy is why would it be different across all the different local authorities? It shouldn’t be. The key thing that it negated is as local authorities are placing fewer people, especially in residential, but actually it’s going through the whole needs thing… what we’re finding coming into the care homes are increasing needs of the residents.

Interviewer: Yeah.

Respondent: And that means that the difference in needs, in a 40-bed care home is far more marked than it was four years ago, which makes it virtually… nothing is impossible, but it makes it very, very difficult for a provider to say, “I can accept a blanket cost for all my residents.” So as the needs go up, spot commissioning to me becomes far more important and relevant than if you’ve got everyone with a relatively low level of needs, that’s quite similar…

Interviewer: Yeah, because you can respond to that individuals need level.

Respondent: Yeah, and that’s where I think myself and a whole load of other providers, I’ve spoken to have felt was the major fallacy in the fair cost of care exercise. It might have worked better if there was more granularity in the definitions of types of care. But effectively having four definitions, two for residential, two for nursing, didn’t work.

Interviewer: Okay, all right, that’s really, really helpful, so thank you for that. And thank you again for your time, I really, really appreciate that.

Respondent: No, it’s a pleasure, thanks for listening.

Interviewer: Thanks.

Respondent: Cheers.

Interviewer: Bye.

END OF AUDIO