

Workforce to Care Force: Who Cares?

**IPC Discussion paper
John Bryant**

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1 Introduction and context

This discussion paper has been prepared by John Bryant, Head of Integration and development at Torbay Council and chair of the Workforce Group for Association of Adult Social Services (ADASS) South West branch. The paper explores some questions about the future of the health and social care workforce, and discusses some of the changes in assumptions and practices which may be needed across the UK in the next few years. The paper has been produced as one of an occasional series of discussion papers by the Institute of Public Care at Oxford Brookes University, intended to stimulate discussion and debate in the health and care sectors. The views are the author's own.

It is an obvious statement that the effectiveness of health and social care is based fundamentally on the quality, reliability and availability of the right staff. It is also obvious to everyone who works in the sector that we are facing unprecedented challenges in ensuring this. For example:

'The future of England's health and social care system relies on its staff, those providing face to face care all day, every day and those working behind the scenes to keep our NHS and care services functioning. Good health and social care relies upon easy, dependable access to staff who know what they are doing have the time to do it and treat us with respect and compassion.....the current total NHS vacancies for nurses, midwives and allied health professionals (AHPs) are almost 42,000. (NHS, 2018)

"Social care cannot continue as a Cinderella service – without a valued and rewarded workforce, adult social care cannot fulfil its crucial role of supporting elderly and vulnerable people in society. Pressures and demands on the health and social care systems are increasing, so the Department needs to respond quickly to this challenge by giving the sector the attention it deserves and needs, instead of falling short and not delivering value for money." Amyas Morse, head of the National Audit Office, 8 February 2018 (NAO, 2018)

The following figures provide a little more detail on the impact of these challenges on care:

| Number | Issue |
|--------|--|
| 48% | Of hip fracture patients missed a day of rehabilitation in hospital because a physiotherapist was not available (Chartered Society of Physiotherapy, 2018) |
| 15.2 | Average number of days patients waited for a physiotherapist to begin their rehabilitation (Chartered Society of Physiotherapy, 2018) |
| 33,000 | Number of nurses leaving the NHS in 2016-17 – up 20% since 2013-14 (NHS Digital, 2018) |

| Number | Issue |
|---------|--|
| 3,000 | More nurses left the NHS in 2016-17 than joined (NHS Digital, 2018) |
| 62,000 | 5.6% of all NHS Staff are from other EU countries and subject to the impact of Brexit (Commons, House of, 2018) |
| 26.1% | (1,674) fewer district nurses since 2012 (NHS, 2018) |
| 36.5% | (842) fewer Learning Disability Nurses since 2012 (NHS, 2018) |
| 700,000 | Projected number of adult social care jobs required to meet the proportionate rise in the 75+ population by 2030 (Skills for Care, 2017) |
| 6.6% | Vacancy rate in adult social care which has risen year on year between 2012-13 to 2015-16 (Skills for Care, 2018) |

The impact of these figures is wide ranging in terms of present and future strategy. The delivery of national agendas including lengths of stay, re-ablement, care closer to the community and Transforming Care Partnerships, along with further developing the integration between health and care are all affected by this situation.

It would be easy to wring one's hands, put these issues into the 'too complicated, long term' box, and hope somehow that macro-economic circumstances will address them while focussing on the necessary immediate operational pressures. However, those daily pressures on staff and organisations are already telling and evidenced by unacceptable retention rates and business closures. I think that there are things that we can do as a combined health and social care system, to help address the capacity and financial challenges that future population demands pose. This paper offers a discussion as to:

- A combined approach to the health and social care workforce challenge.
- How, in part, it can be funded.

2 The care force

My starting assumption - I hope fairly uncontroversial – is that people in receipt of care and support want, amongst other things, to have a seamless service delivering the right care at the right time. The Nuffield Trust in its report – 'Reshaping the workforce to deliver the care patients need' (Imison C, 2016) suggested that there are three options available to meet the demand challenge:

1. Produce larger numbers of the same types of staff.
2. Develop the skills of the existing workforce.
3. Produce new types of worker.

I want to go further than just concentrating on the paid workforce and explore the potential of promoting and developing the capacity of the wider care-force through our communities. Developing the value of care and enhancing people's understanding of what it offers and what they have to offer will be crucial. In the 'Proud to Care South West' campaign for example three domains were created:

- Paid Care.
- Unpaid Care.
- Community Awareness (Citizen Appreciation).

Focusing on all three domains is helping us to develop a strategy to begin to build a wider cultural awareness and interaction with our care services, and break down unnecessary barriers between informal and formal care roles.

Having worked for an integrated health and social care organisation in Torbay for the last few years, I have seen that the greatest impact on preventative care and support has laid with Local Authorities and their partners in the community, where in addition to the social care workforce, there is access to housing, environment and culture to create a better environment for people and support their wellbeing. A statement from Joseph Addison in 1712 is one that continues to be useful to me in thinking of a beneficial community approach: *'Health and cheerfulness mutually beget one another'* (Addison, 2018)- a motto which, incidentally, is inscribed upon the Torbay Town Hall.

Within this paper I will offer some questions and suggestions which explore both the need and a mechanism. This is an opportunity, to shift the workload and the activity in the system, and develop a 'care-force' which goes well beyond traditional workforce agendas and helps to build community support and resilience. I hope also to convince you that this is affordable and cost effective.

3 The future care force?

If we are going to produce a new model of care and if we are going to have engagement of stakeholders to optimise the opportunity and get delivery then we need to be clear about the workforce we are speaking about. My starting point is we need to be thinking about the care system as a whole, comprising both employed people in the NHS, local authorities, the private and voluntary sectors, AND the huge number of people playing an informal or family care role. We cannot start by dividing these sectors up and competing for people within them:

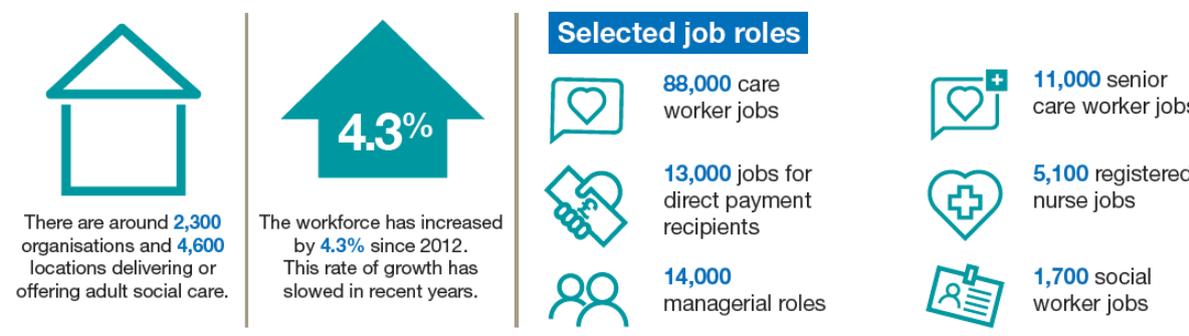
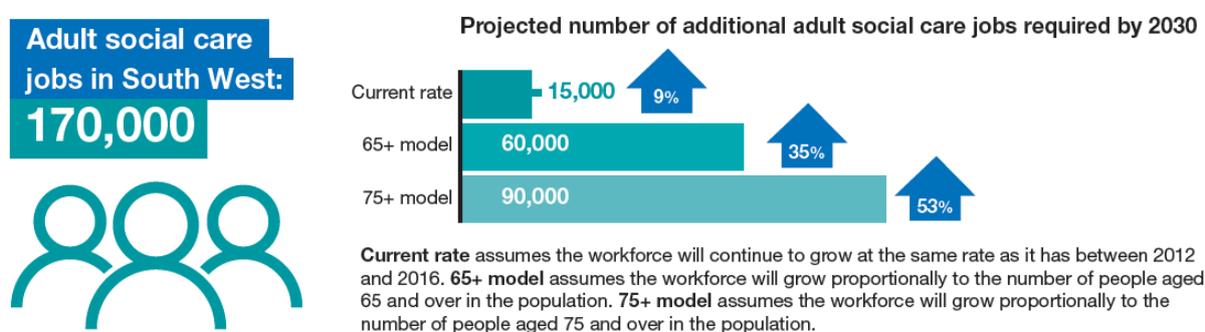
"This isn't about competing between social care organisations or between health organisations. It's not even about competing between health and care. It's about competing for talent and in our case, talent and compassion. There are many industries and sectors, and many employers within those industries that are seeking the same people. We need to 'compete' for who we want, we absolutely need to 'compete' for who we need." Proud to Care SW – Campaign Report

The care system is actually in competition with other industries and services. It is in marketing territory. This is not something that is often spoken about in health and care but in terms of people, we are in competition with other sectors. We have lots of advantages – for example the size of the workforce. While the NHS is not quite the largest employer in the world (that's Walmart with 2.3 million employees worldwide) the UK's NHS workforce is huge - around 1.3m people, similar in size to Indian Armed Forces or Chinese National Petroleum. Even larger is the paid social care workforce which in England alone is around 1.45 million, including those in the independent, charitable and public sectors. In total, the paid care and health workforce accounts for 13% of all jobs in the England. (NHS, 2018). That is quite a system in which to ensure

capacity and competence, and, with the well-known demographic changes facing the UK over the next few decades I do not see the need for this proportion reducing - I am certainly not convinced that whilst they may be part of the solution, that we can pass over the care skills needed to support individuals effectively to robots or other forms of assistive technology. Care is fundamentally a human interaction in which personal care and compassion is inherent.

Health Education England’s (HEE) workforce strategy document Facing the Facts, Shaping the Future (NHS, 2018), projects that 190,000 new clinical staff will be required by 2027. When combined with the Skills for Care predictions that the adult social care workforce will need to grow by an additional 700,000 staff by 2030 (Skills for Care, 2017), we can see the extent to which we will need to compete for people. In the area in which I work, the South West alone, 90,000 extra social care staff will be required, as can be seen in the infographic below:

The information for this infographic is taken from Skills for Care’s ‘State of the adult social care sector and workforce in South West 2017’ report and uses workforce estimates based on data from the National Minimum Data Set for Social Care (NMDS-SC).



Furthermore, these numbers do not allow for the compound effect of turnover within these periods. This suggests to me that simply continuing with the same approach to workforce as we have always done going to be neither feasible nor affordable. We need to accept that we need to do something different.

4 Is there capacity in the system?

In ‘Facing the Facts Shaping the Future Strategy’ (NHS, 2018). Professor Ian Cumming emphasises:

Both parts of the health and care system will need to work together to ensure that success in recruiting and retaining key staff in one sector does not drain much needed staff in another.

I would wish to reinforce and develop this by suggesting that there are not just two 'parts of the system' – we have to look at the multiple parts including voluntary, private and informal sectors as well as the NHS and local authorities, and we need to recognise that so-called 'health' or 'care' roles are actually intertwined with each other. For example, there are presently 5,100 registered nurse jobs in social care settings in the south west (Figure 1), without whom there would be much less capacity to support people in the community and avoid referral to acute settings and a reduced ability to discharge from hospitals into the community.

Similarly, domiciliary care continues to be a recruitment and retention challenge and an area of the system often cited in respect of delayed transfers of care. The 'value' of this service is worthy of particular note – pay levels (see below) have remained very low over the last five years, despite an increasing recognition of the vital role this part of the sector plays in reducing demand for more complex care packages. Delayed transfers of care (DToc) have been headline issues in the national media in the winter of 2017/18 and a focus for many managers and staff within the NHS and Local Authority systems. The importance of domiciliary carers, people that are getting paid the national living wage or just above, is often not recognised, but in terms of supporting people including those with high levels of need in the community, they are arguably some of the most important people in the system.

Since the introduction of the mandatory National Living Wage on April 1 2016, care workers' pay in the independent sector has increased at a higher rate than previous years – but it remains a debatable point as to whether this represents the true value that they provide to the system and a 'hygiene' factor that until addressed will constrain other 'motivators' and care and capacity development. (Figure 2)

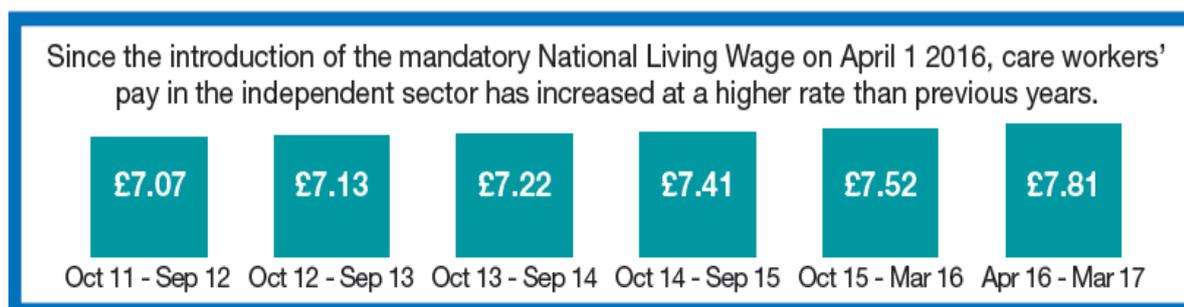


Figure 1 - Source: www.skillsforcare.org.uk/regionalreports

Skills for Care also note that 17% of the workforce is still on zero hour contracts. Perhaps we are not training or employing them in the best way, or in fact deploying them as well as we might. Could we offer them a set of activities that they could do that would use their time to best effect for client/patients and the 'system'? Similarly The Royal College of Nursing (Ball, et al., 2014) reported that of those community nurses surveyed 75% said *they left a home visit with tasks they considered clinically necessary undone*. This means that their daily functional work is not wholly aligned to their deep held personal or professional values. (NHS England, 2016) - It should therefore be of little surprise to learn that there has been a reduction in community nurses of:

- 47% in the 10 years to 2014 (Ball, et al., 2014).
- 26.1% between 2012 and 2017 (NHS, 2018).

If we continue with the current arrangements then it is doubtful that we will ever be able to secure greater capacity in the system. In terms of producing a balanced system, demand and capacity both need to be managed. Reducing demand and increasing capacity in an affordable way are key components of delivering the aims of, for example, 'The Five Year Forward View - health and wellbeing, care and quality, funding and efficiency'. (NHS, 2014)

Prevention and self-care lie at the heart of such an aspiration. As we seek to identify where we can find people to communicate and engage in positive and enabling ways with our population, it is worth reflecting that domiciliary care staff in England deliver over 239 million hours of face-to-face contact time per annum to over 873,500 people (UKHCA, 2016). This represents a huge opportunity to connect with those in receipt of services and their families, the communities around them and to disseminate key messages and enabling approaches. For those delivering care, how much additional reward and satisfaction might that personally offer them? I would suggest that we need to build on the asset that is our frontline care-force but to do that we need to make sure it is itself 'cared for', making the role 'person-centred' as well as the care and support delivered. Let's look at some more statistics:

| | |
|---------|--|
| 27.8% | Estimated staff turnover rate of directly employed staff working in the adult social care sector – England 2016/17 |
| 350,000 | Number of leavers from Adult Social Care positions/roles per annum |
| 33% | New entrants (workers) to the market per year |

Figure 2 (Skills for Care, 2018)

The good news is that:

- There is a core of workers that have 8 or more years' experience.
- 70% of workers stay for at least 3 years.

These people are providing us with the opportunity to engage with them and develop them. These are not people that are turning over in 4 or 5 months. But somewhere along the line we lose them. I would suggest that between 2-8 years we have the responsibility to support and develop these people offering them progression to move as far and as quickly as they can. Similarly, we are all aware of how many nurses we need to meet the required capacity in the system. If we develop our ways of working together and look at the whole care-force at the same time, I think we can find ways to redesign roles and tasks to ensure that there is enough care capacity for the future to carry out those tasks. But we have to invest in, and support people, particularly people with direct care roles so that they are all involved in care are able to support one another.

Dan's Story – Values verses Value

I was leaving work late one evening and I happened upon Dan mopping the floors in the office toilets. I made some quip about dancing on ice, as the tiled floors were wet, and from that we got talking. Dan told me that he used to be in a direct care role. Dan was in his role for six years. He enjoyed it enormously and continued to work in it though paid just over the national living wage. He worked with many different clients. On one

occasion, Dan was asked to get some biscuits by a gentleman he was looking after. On his return, it was determined by the client that Dan had taken too long. As Dan reached forward to give him the biscuits – the client head-butted him.

Dan reeled back. The client, having thrown himself off balance fell to the floor. Dan despite his own hurt instantly reached down to help the client and as he did so, he was head-butted again. At that point with his nose smeared, he said “that’s enough, I’m not willing to do this anymore.”

Dan took up two part-time, non-contracted shifts cleaning floors and earned more than he was earning in care. He was epilepsy trained, dementia trained, all his mandatory training was up to date on top of the six years’ experience. Six months into his new jobs, his work and commitment were recognised and he got a permanent contract for cleaning services. Dan is now earning £4,000 more than he was after six years in care, working in a single location, in a dry environment, with no travel and set hours.

Dan said to me “John, it’s not that I don’t want to go back into care. I’d love to. I just can’t afford to.” I would suggest that this is an example of profound waste within our system, and an indication that to some extent the health and care system is being subsidised by compassionate colleagues - raising a moral and ethical as well as a sustainability question. We should make sure that we build on the compassion rather than expect people to do it because they are compassionate. There is a case for checking that care staff are not being asked to deliver high quality care despite the system rather than being supported by it. The alignment of these things will enable a resonance with values-based recruitment and care.

5 What are the barriers and attractors to work in health and care?

There is a great deal of research on why people come into, stay and then leave their jobs. A neat summary from the 1950’s which still seems to me to hold is the Hygiene and Motivational factors identified by Frederick Herzberg (Herzberg Frederick: Mauser Bernard: Petersen & Capewell, 1959)

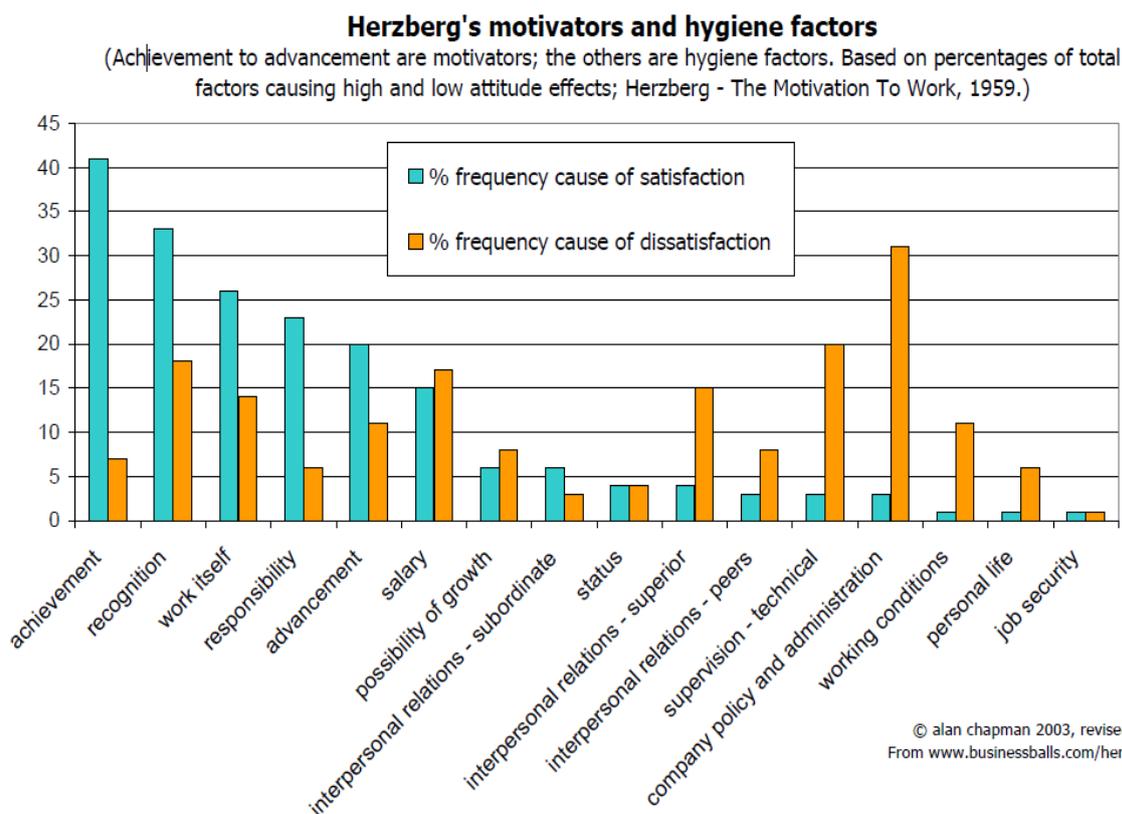


Figure 3

Addressing these causes of satisfaction and dissatisfaction are crucial if we are to be able to build a high quality care-force across the system. At an analytical level international studies have shown that health workers associate with such motivators and hygiene factors. ‘Meeting the needs and achieving the goals of both the employee and the organisation is the cornerstone of job satisfaction and this is of crucial importance for management’ (Lambrou P, 2010). If we are to be successful with engaging people across the three domains described earlier, then attention needs to be given to such drivers, increasing those that are incentivising, removing or mitigating those that are de-motivating.

6 Rethinking the care-force?

Figure 5 illustrates a population growth prediction for the south-west of England – the trends of which will be familiar to planners and commissioners across the UK.

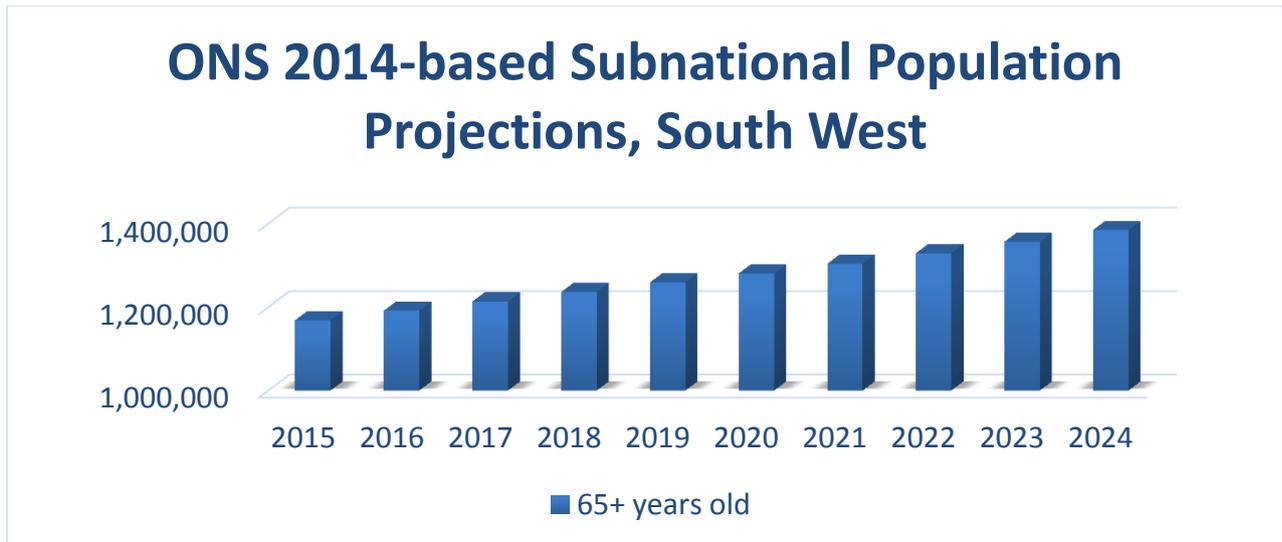
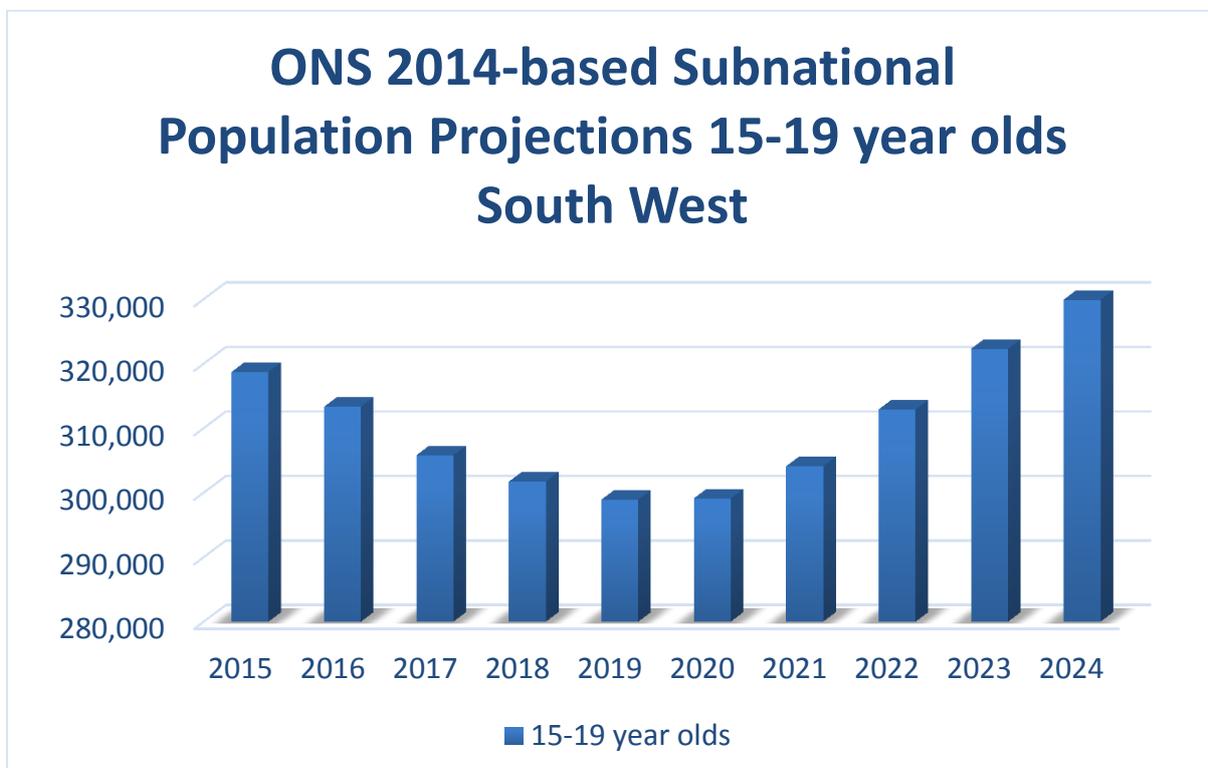


Figure 4

Clearly, assuming that there is some degree of correlation between age and care needs, the simple increase in numbers of older people will lead to additional demands for care and support. One approach often proposed is to apply our efforts and resources to obtaining more school and college leavers. The sense is that we need to get more young people into care. However, the problem is that we are not only in a very competitive environment for young people there may actually be fewer of them to access. For example, in the South-West we have a dearth of people coming through our college system in the next 10 years.



At the same time, more young people are securing training and qualifications which are not necessarily suited to direct care roles and therefore not making it a first choice. This shrinking cohort is illustrated by the following:

'The proportion of UK 18-year-olds applying to university has climbed to a record high, with 37.1 per cent of school-leavers hoping to enter higher education, compared with 36.8 per cent last year, but demographics meant that the total number of applications from this cohort fell by 4,260 (1.6 per cent). (The Times Higher Education , 2018). The present approaches by health and care are predominantly directed at trying to succeed in a competitive market where there are fewer people to access. Are we expending our efforts in the right areas, in the right ways? Where best could we put our resources?

One solution is to encourage more of the older population to be part of a new model of care; to create a community capacity for caring that offers new roles, flexible working and shorter blocks of time. However, this comes with a cautionary note. These will be people with lived experience. They will be really clear as to their views on split shifts, poor parking options, and frequently changed rotas to be carried out in all weathers for low pay – an often-experienced domiciliary care offer. We could perhaps save ourselves the cost of the advert!

Here it is important to go back to the motivators and determine what is rewarding whilst taking responsibility to deal with the hygiene factors which affect job satisfaction. These people, this significant section of our population, have so much to offer but they will be really clear as to what they do and do not wish to become engaged with.

What could we do to create an offer to older people in particular that could make care-force roles meaningful and rewarding? The good news is that there are already a range of activities which could be accelerated, expanded and optimised at a regional level by local authorities, NHS organisations and the private and voluntary sectors working in partnership. A few examples are:

| Reference | Outline/Description | Collaborative Suggestion |
|---|---|--|
| Talent for Care www.hee.nhs.uk | An initiative to improve opportunities for those working in support roles Get in – starting a career Get on – being the best you can be Go Further – career progression including registration | Expand the offer – extend to a wider age range – target the largest growth area of the population – the over 50's and ensure learning is flexible Deliver a consistent message of the opportunities across health and social care |
| Widening participation www.hee.nhs.uk | Improving the quality of and capacity of care by widening participation in the development of the current and future healthcare workforce | Deliver common competencies for skills passports across the system |
| Return to Practice www.hee.nhs.uk | Updating skills and knowledge | |
| Apprenticeships | To earn and learn to degree standard A clinical and qualified social worker and care-force | Produce rotational positions for people to find out which area of care most speaks to them supporting longevity and |

| Reference | Outline/Description | Collaborative Suggestion |
|---|--|--|
| | pipeline of the future | retention Standardising apprenticeship models via Skills for Health and Skills for Care |
| Fair Train www.fairtrain.org.uk | Work experience guidance, templates and accreditation to ensure an efficient and effective offer by the organisation and a good and informative experience for the participant | Ensure this ties in with apprenticeships, rotational experience and return to practice |
| Consistency in training and core/common competency development | Development of common competency frameworks through Sustainability & Transformation Partnerships (STPs) and Allied Health and Science Networks (AHSNs) | STP / Regional Skills Passport Training and skills recognised across sectors and employers – enabling development of staff versus re-training |
| Workforce mapping | Reviewing not only roles but the competencies that sit within them and spanning both health and care sectors | Develop a competency register producing a searchable database capable of quickly identifying individuals meeting or able to have marginal/minimum additional competency training to fulfil new roles in developing new models of care |
| Asset Based Working (Enablement Focus) | Examples such as Making Every Contact Count – referred to in Facing the Facts, Shaping the Future to achieve increased independence and self-reliance, minimising support interventions - <i>the best quality of life that can be achieved within the constraints of my condition</i> | A consistent set of principles whatever the approach where training and promotion are part of an on-going commitment to the new models of care not one-off tutorial rounds |
| Asset Based Working (Client resources) | Expert Patient Programmes and peer support groups which help system shapers and offer practical advice to condition sufferers | Expand the thinking to the assets that each client has to offer the community – beyond care as well as care. Engender contribution and remove the frame of passive recipient of care thereby supporting wellbeing with purpose and value |

7 Mapping activity- rethinking roles

To develop an offer that is both viable and attractive to potential staff, we need to rethink the ways in which jobs and roles and tasks are configured. Currently in the South West we are trying to identify what functions certain roles presently perform and the volume of the activity involved in these functions. We are trying to move away from traditional approaches of modelling workforce demand that tends to be predicated on seeking additional capacity in existing roles.

We want to know what is actually happening, what the hands-on business is at a really detailed level. We think this is the first step in taking a systematic approach to developing the skills of the existing (combined health and care) workforce and, in many places, developing a new offer in terms of skills, activities, terms and conditions for the care-force.

We hope the activity mapping will produce the data to enable frontline staff and service users to co-produce new ways of working with associated training, supervision and governance structures to produce care capacity that offers effective, safe and high quality *person-experienced* care. This may inevitably require a shift in balance of responsibilities between professions, and perhaps a care-force which is able to undertake a much wider range of activities supervised by highly qualified staff. This offers an individual a great deal more fulfilment and with it the likelihood of improved retention across each part of the system. It also begins to offer all staff the opportunity to focus their efforts and work 'to the top of their licence'.

8 Can we afford to rethink the care-force?

I think there are major areas in the current system where we spend money unnecessarily. For example, work done in the Torbay in 2010 looked at an acute and two community hospitals totalling 556 beds and tried to identify the number of patients in those hospitals who could have gone home – but did not - on one single day. A total of 82 people were identified who were medically stable and fit for discharge and could have gone home if the right care and support was in place.

Recognising this is a single example, if we extrapolate the cost of this situation, using £222 as an average cost of a bed day from national tariff 2015/16, enhanced tariff option (NICE, 2015)¹ this means that in these three hospitals £18,204 per day was being spent on supporting patients in an unnecessary hospital setting.

What this means is that at an average service rate of £18.01 (UK Home Care Association Rate for April 2018) that money could have bought about 1,010 hours per day of care at home – or some 12.3 hours of care for each of the 82 people who remained in hospital – far more than the normal level of support needed by someone medically fit and stable for discharge.

It is not just about skills, we also need services which are organised to provide rapid response to varying demand but ensuring that we have people with the right skills in the community to support timely discharge of people who often have complex support needs requires that we consider upskilling them and to pay appropriately, deriving value

¹ National Tariff for 2017/18 and 2018/19 continues to be in a range that supports this figure

for the system and responding to the client desire for continuity of care. This example suggests to me that it is worth exploring how, even with better pay and job conditions for those working in the community; we can make overall savings in the cost of care.

Taking this example a little further if we trained and paid community care and support workers (enhanced domiciliary care) to an NHS Agenda for Change Band 6 level, the pay would be (at the mid-point of the scale) £15.68 per hour (2017/18), a total cost figure of £24.39 to the employer. If as much as 5 hours a day was committed to the support, enablement and community connections for the 82 patients identified above there would still be significant savings to be secured for the system as a whole – and a very wide range of competencies and skills that could be purchased at these pay rates. In summary:

| | |
|---|----------------|
| Cost per day – 82 patients | £18,204 |
| Provider organisation hourly rate for Enhanced Care and Support worker through | £24.39 |
| Hours per day to client and family and neighbourhood | 5 |
| Total cost of Care and Support workers per day for 82 patients | £10,000 |
| Savings per day on present system with better outcomes for 82 patients | £8,204 |
| Recurrent savings per annum (BEFORE accounting for reductions in care package through enabling and community connections work above) for 82 patients. | £2,994,460 |

Recognising the multiple factors that in practice would be involved, I nevertheless consider that this example suggests it might be possible to transform care within the community to a service that is rewarded for the increased value it delivers. The value is derived through additional skills, enabling through front-loaded packages of care including building circles of support along with community connections for the client and signposting for family carers support to achieve increased independence, overall resilience and a reduction in on-going care package support. Such a service and capacity could help manage demand for services (see Philip Provenzano and Professor John Bolton's IPC discussion paper on 'Six steps to managing demand and producing better outcomes' (Bolton J, 2017) as well as recommendations by NICE (NICE, 2015).

A challenge to the above is that such savings are only possible if they are cashable. The good news is that this proposal is being made at a time when there are seismic shifts in the way facilities and services are being offered in our communities, with implementation of reductions in bed-capacity in different settings moving care closer to home. The funding for a new model of care can be made available.

9 A new model of direct care in the community

Many health and social care organisations are looking at the potential to release cashable savings through different care provision – but it is crucial to recognise that the demand for care is being shifted – it is not disappearing. To that end we need to meet the obligations to the community and offer a new model of care and care capacity.

A crucial part of this new model is to redesign domiciliary care. Put simply, I do not think enough people will want to do the job in the future as it is currently configured. We need to think more creatively about roles offering care & support that are rewarding, affordable and effective. And in so doing, support other frontline professionals such as nurses and physiotherapists to be able to manage the demand within the community by having access to new resources.

I think we should be looking for people in these care and support roles to have greater skills and better rewards. These will be people who can make a major contribution to supporting and enabling people in their own home, reduce demand on hospitals including the implementation of prevention initiatives. The opportunity is there to redesign the services offered presently as residential care and develop care-facilities. Increasing the breadth of those with skills to support and enable leads to the transference of skills to informal and unpaid carers. All of this ultimately ensuring that everyone who could achieve successful re-ablement is able to do so and leads of life of optimum wellbeing for them. At the same time investment can be made in the wider local authority responsibility for promoting community infrastructure and care-force capacity to minimise the proportion of people who need intensive care in the first place.

10 Caring for carers and promoting a career in care and support

In proportion to what could be seen as the largest combined workforce in the world, health and social care partners really seem to spend very little on organisational development, caring for the care-force or promoting care career paths for those that want them. I suggest that in an increasingly competitive employment environment more attention needs to be paid here. The argument that we cannot afford it does not stand up. For example, a 2% improvement in retention could release millions of pounds to fund a marketing campaign increasing capacity through retention, recruitment and the engagement of communities and volunteering as the profile of care is raised. This money is presently being spent but only on recruitment, and of course there are additional benefits through retained, experienced staff such as improved productivity versus new starters, mentoring opportunities, rotational working, and an organic workforce.

I hope the following figures will serve to illustrate the scale of the opportunity and the ability there is to fund a retention programme at no extra cost to the system. This is money that is already being spent by system partners on recruitment.

The Chartered Institute for Personnel and Development established the average cost of recruiting an employee as £2,000 (CIPD, 2017). I also asked an executive director of a national domiciliary care provider what he considered was the minimum the cost of recruiting an employee. The answer was £1,250.

27.8% is the turnover rate of staff in adult social care in England in 2016/17. This equates to 350,000 leavers (Skills for Care, 2017). This excludes the costs of turnover and recruitment in health and the other home nations. We are therefore collectively spending between £437,500,000 and £700,000,000 per annum to maintain the workforce as it stands.

Retaining the knowledge and skills within an organisation, network and team has huge value. A 2% improvement on the turnover rate would produce an immediate resource

of £8.75m - £14m per annum with no extra spend. A virtuous cycle is produced, one of increased skills and better outcomes with continuously improving retention rates and improved costs of delivery.

11 A New System for neighbourhoods and communities and their care.

As system organisers, facilitators, leaders and budget holders we need to offer the future care-force the chance to help patients and service users secure the support and care that they wish for and need; to develop ways in which people are able to lead the most fulfilling lives they can both those supporting and those receiving the support. We need to accept the challenge to develop a system that is supportive to all across the care system – paid and unpaid, and where we can offer people:

- A job that is rewarding financially & hugely satisfying with flexibility and loads of opportunity.
- Helps people make a difference – by making people’s lives better and enhancing their community.
- Work in a positive environment with career opportunities in many different organisations across the public, private and voluntary sectors.
- Work where your learning is recognised so that you build on it through your life-course.
- Where wellbeing is derived from what you do and what you give

The good news is that it is all possible and there are a range of tools and opportunities available to us to help achieve it.

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