



A PEOPLE PLAN

FOR SOCIAL CARE

WHITE PAPER March 2023

A CALL TO ACTION

Prepared by the Institute of Health and Social Care Management's Social Care Innovators People Plan Subcommittee





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Foreword

Three Prime Ministers. In the 15 months since we published the first People Plan Report, we have had three different people take the lead of our government. We have seen promised social care reforms take the back seat, pushed back years down the line, and we once again seem to be doing nothing more than talk about how to fix social care with the occasional chunk of money being thrown in (without plan) for good measure. This revolving door of leadership is not the change we had envisioned or hoped for.

During this same period, the Institute of Health and Social Care Management and the amazing individuals who make up its People Plan subcommittee, were working hard on creating the latest People Plan white paper. It was whilst writing the paper following feedback from the consultation that it was decided that this had to be more than just another, “this is what’s wrong with social care” exercise, and instead had to really emphasise the need for immediate action to improve our understanding, but also to help us inform real change and reform.

This People Plan white paper is a call to action. A call to everyone living and working in social care to work together to help achieve a healthier and safer future for social care. It examines in depth what might not be working well and where there are barriers and obstacles when it comes to Access of Care; Equality Diversity and Inclusion; Mental Health and Wellbeing of People Using Care; Policies, Guidance, and Regulation; and Greener Care, but it also looks at real and practical solutions that currently exist or could be implemented to improve the situation.

Most of what is in the report may not be breaking news to some of you reading this, but it comes from the people who matter and who are most impacted. It comes from those working in care, those living in and with care, those who commission and regulate it. It’s a paper which manages to unite what is usually a fragmented voice into one document. Now we must work to do the same when it comes to taking action. We need to be able to work together, with everybody, to advance the improvements that we need.

Building on last years report, when read in conjunction, both People Plans provide a holistic overview of the ten most critical issues affecting social care. This paper is an incredible achievement from a group of people truly passionate about improving the state of Social Care. Now is the time to take action, to pledge to make social care a better place for all.

Adam Purnell

Director of Social Care

Institute of Health and Social Care Management



Introduction

When we published last year's white paper '[A People Plan for Social Care: A Special Insight](#)', the first People Plan created *by* social care instead of just *for* social care, we hoped that it would be received well and help a variety of people, whether they work in care, draw on care support themselves, advocate for others who receive support, or are just really passionate about the social care sector.

We're firm believers that help can come in many different forms and social care is deserving of so much more recognition and help than it normally receives: it's a sector which boasts a wealth of talent who, each day, provide person-led, compassionate, and safe care to our most vulnerable people in society. Without the incredible work from those in our sector, care quality will decline, needs will go unmet, and pressures experienced by multiple areas of society, not just the NHS, will only increase exponentially.

We hoped last year's report would help kickstart long overdue conversations by providing a unifying voice in a fragmented sector, that it would show how collaboration can help achieve both short-term successes while building towards long-term sustainable change and, most importantly, we wanted to empower people in the sector to directly create positive change themselves – not all innovation or reform needs us to wait for it to happen, instead people can be the change they want to see in the world.

Well, safe to say, we were blown away with how well it was received by so many different areas of the sector! It's easy to forget that, although as a sector social care employs more people than the NHS and supports more individuals than the NHS, it's actually a very fragmented sector with 80% of the sector made up of SMEs, of which 80% of care providers only own one care home or 70% operate a home care service out of only one office. The big names may get all the headlines,

but they're only representative of 20% of the sector.

With fragmentation comes isolation and loneliness. Who do you reach out to for support when you need it? Who do you ask questions to when you don't know the answers? How do you implement good practices if you don't know where to find accessible templates of those good practices? Last year, we included a 'Good and Outstanding Practice' section for each of the five topics covered (Public Image, Recruitment, Training, Retention and Wellbeing, and Pay and Conditions) in order to provide exactly that support: one central location to showcase the existing wonderful work our remarkable sector has achieved, ideas and solutions that individuals or providers could implement directly based on the recommendation of the people who know the sector best – their peers. Innovative, cost-effective where possible, and supportive, they were included because the respondents to last year's consultation told us they'd found them to be impactful.

So we were incredibly pleased to have countless individuals, providers and organisations reach out to us afterwards to say that the examples included had made them feel less isolated, more hopeful and that the ones they tried out for themselves were already proving to be impactful. The recommendations for change had been split into those which could be actioned by providers themselves as well as ones which would need to be actioned by local and/or central government, and so we were delighted when some Local Authorities and Care Associations also agreed to start the process of piloting some of those recommendations. We look forward to receiving their progress updates next year.



"I didn't know there were so many resources out there"

"I thought I was alone in facing these issues, but everyone is facing the same problems which makes me feel so much less alone"

"I've implemented some of the recommendations already and they've had such a huge impact, I'm so grateful!"

We are very conscious that social care never stops; it's always innovating and, unfortunately, there's still always new problems emerging so we never intended for the 2021 People Plan to be a report which was just read and ignored once published. Instead, we were keen to keep it as a 'doing report' which regularly reviews the largest issues facing the sector, the possible solutions, and builds a collaborative movement to turn those ideas into actions.

During the 2022/23 consultation with the sector, it quickly emerged that the five topics from the prior year were largely unchanged (both the issues and the recommendations for change), so this white paper instead provides a comprehensive review of five other major issues facing social care as well as recommendations of how and where we can move forward in a positive and collaborative manner. We recommend reading the [2021 report](#) in conjunction with this report in order to get the most complete and inclusive overview of the challenges and solutions for the sector as a whole.

The 5 Topics of this People Plan

This People Plan examines the following five topics:

1. Access to Care
2. Mental Health and Wellbeing of People Using Care
3. Policies, Guidance and Regulations
4. Equality, Diversity and Inclusion
5. Greener Care

Through feedback from the consultation, there were common themes which became clearly identifiable and will be discussed in greater detail in their respective sections.

Common Themes

Access To Care

- Reducing Capacity but Rising Demands
- Rising Costs of Care – Private Care too expensive
- Extensive Waits
- Pathways to Arrange Care are Difficult and Confused
- Delays Due to Lack of Equipment

Mental Health and Wellbeing of People Using Care

- COVID created a mental health and loneliness crisis
- Wait times too long to access support
- More support needed from Commissioners and Regulators
- There needs to be more focus on the Care Act and Training
- There are signs of improvement.

Policies, Guidance and Regulations

- Incoherent guidance with little to no consistency
- Confusing and too frequent changes with little time to implement
- Internal policies exist to tick boxes
- Wavering Trust in the regulators

Equality, Diversity and Inclusion

- Lack of diversity/ discrimination against minority groups
- Not meeting the needs of those using care
- Government can do more
- Employers can do more
- Lack of training

Greener Care

- Not enough is being done right now
- Lack of support, awareness and understanding
- Potential Solutions



This year's People Plan is a sincere and carefully considered compilation of ideas, opinions and views received through a consultation of people within the sector who wanted to have their say. Two things really struck us during this year's consultation.

One was the transformation from budding hope to frustration and disillusionment that has occurred within the last 15 months, so we hope that by the time you finish reading this report, you not only feel inspired to help make change happen, but that you also have a concrete foundation for where to start and who to engage with in order to implement those changes.

The other was just how much love and passion people have for social care, even when they feel like they are getting ever-closer to their breaking points. Part of the frustration so many who work in, use, advocate or support social care feel is **because** they care: they can see its value and its

potential, and they want to make it better. They just need help to do so. The People Plan does not claim to be perfect, but it is bold, it amplifies and unifies the voices of so many that wouldn't normally be heard, and it is a hopeful reminder of just how much people in the sector care.

The People Plan will continue to be regularly updated and improved as the sector evolves. Thank you for reading it and we would be delighted to receive any and all feedback so that we can refine and develop the People Plan further to ensure we fully reflect the views and opinions of all who interact with this vital and brilliant sector. Please provide any feedback that you would like via this survey monkey link

<https://www.surveymonkey.co.uk/r/XYZP8JP>

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Background

Social care is developmentally and structurally years behind the NHS and other public services despite it being the UK's largest employed sector.

Social care reform is becoming a hollow phrase. The lack of commitment and frankly, interest, in social care is something that this, the second People Plan white paper, aims to address whilst recommending change for the future and empowering and encouraging people to get involved. To understand why this new report exists and why it is more relevant than ever, we need to look at the journey social care has been on over the last 15 months.

In December 2021, through the incredible work of our People Plan subcommittee, we (the Institute of Health and Social Care Management - IHSCM¹) published our People Plan for Social Care². A few days prior to that, the government had finally published their own long-awaited social care white paper 'People at the heart of care'³, within which promised a raft of changes all designed to impact and benefit the people who draw on social care and the workforce. Upon reading the government's white paper, a sense of mild reassurance and dare we call it hope began to grow because many of the points included in our report following our consultation with the sector had also been included in the government's report. The people in social care, whether they work in it or draw on care themselves, were finally being listened to. Social care was finally receiving (some) of the credit it deserved after almost two years of a pandemic which had brought the importance of the support it provides more firmly into the public eye.

The Health and Social Care Levy

However, 15 months later, that hope has once again returned back to disillusionment. Promises of reform and action have been broken or postponed (again), and the sector is once again

being treated as the NHS' poor cousin rather than the equal pillar of society that it actually is.

The public had been told in 2021 that their National Insurance contributions **had** to increase as of April 2022 in order to fund the social care levy that would "fix" social care. Despite its considerable flaws (including the regressive nature of the tax which would adversely impact those that were already the most disadvantaged), it seemed that social care was going to finally benefit from some love, care and attention: the wider public generally swallowed any dislike of increased taxation because they agreed that, at some point or another in their life, nearly everyone will interact with social care in some form so it was important to invest in it.

Unfortunately, of the nearly £36bn it was predicted to generate over three years, only £5bn was actually earmarked for social care with the remaining 85% going to the NHS. This wasn't a social care levy; this was an NHS levy. The public were promised that their care costs would be capped at £86,000 after October 2023⁴. What the headlines didn't say was that only the **care** costs for their **assessed needs** were going to be capped, i.e., the costs associated with the actual hours worked by staff, and that "accommodation" costs which cover everything else such as food, their room if they live in a care setting, daily equipment, prevention or reablement costs weren't going to be capped⁵.

Over that same 15-month period, we've since had two new Prime Ministers, two new Secretaries of State for Health and Social Care (Steve Barclay and Therese Coffey, the former of which was in position, removed and then reappointed under two months later), the departure and then reappointment of MP Helen Whately as Minister for Care, an economic crisis brought on by former Prime Minister Liz Truss, an ongoing economic crisis from the fallout of Brexit, the ongoing aftermath of the height of the pandemic, a Cost of



Living Crisis, and a care sector facing its biggest ever pressures. Care settings are derided for their lack of continuity of care if they have high staff turnover, and it definitely feels like the care sector has had a lack of continuity of care from leadership at the top.

Amidst all of the political and economic turmoil, and a care sector that is already on its knees, there were increasing concerns about the feasibility of the proposed reforms. Some of those concerns included the complexity of the task, local authorities not having enough funding or resources to administer it, people who need domiciliary care (homecare) for a long time before moving into a care home may end up paying significantly more in the long-term, and regional disparities such as people on lower incomes and/or from poorer regions like the North East, Yorkshire, the Humber and Midlands facing a significant erosion of their protection against catastrophic care costs⁶. Eventually, it was announced on November 22nd 2022 that the planned reform for social care was being postponed a full two years until October 2025⁷. The country was, once again, left in limbo without any clear guidance on when anyone would actually do anything to help social care.

Fair Cost of Care Consultation

Another action which has been delayed is the Fair Cost of Care (FCC) Consultation. Started in March 2022 and delayed in the Autumn 2022 statement until at least October 2025⁸, it was meant to be a once in a generation attempt to transform and ensure social care is funded appropriately by understanding what the actual true and fair costs of care are, especially in light of the National Audit Office's report on a Department of Health and Social Care assessment that most local authorities pay below the sustainable rate for care home placements for adults aged 65 and over, and below the sustainable rate for home care⁹.

Laing Buisson's Care Cost Benchmarks 2020 report, which doesn't even account for the surging costs and inflation since the pandemic began, stated that residential care homes in 2019/20 needed to charge between £696-£849 per week (and nursing homes between £969-£1075 per week in order to be sustainable¹⁰.

Three years, a pandemic and cost of living crisis later which have all significantly increased those costs, providers openly exclaim how they're still often receiving fees as low as in the £400s or £500s, i.e., only 50% of what it costs them to provide the support individuals need.

Unfortunately, decades of broken promises by successive governments have left many providers very disillusioned: one of the most striking (and regular) comments we received about the FCC from providers during the People Plan consultation was *"What's the point of wasting time and energy I/we don't have completing it when we know that they're just going to ignore everything we say"*. Before any new FCC's begin, it's recommended that an all-party approach put in meaningful work into rebuilding the trust of the sector. The issues with the FCC are well known and have been widely reported within the sector:

- Too cumbersome to complete
- Not enough time, information or resources given to support the completion
- Too much focus on historic costs rather than forward-planning for what future costs would be, i.e., increasing complexity of care needs
- Doesn't factor in sunk costs all providers have to account for, e.g., interest costs, taxes etc
- Doesn't factor in the costs of commissioning new care settings which are already significant and ever-increasing
- Doesn't factor in future costs, e.g., investing in improving ventilation to better support against future pandemics, making their care setting more environmentally sustainable etc

Care in crisis

The adult social care committee report 'A Gloriously Ordinary Life': Spotlight on Adult Social Care¹¹ asks "If not now, when?" and further claims, "Adult social care, with the exception of recent proposals for funding reforms, has been historically relatively invisible in terms of national policy and politics. This is now increasingly damaging to both those who draw on and who provide unpaid care at a time of growing need, rising costs and a shrinking workforce". From the



state of the constant headlines over the last few months, it would appear that the biggest issue facing the sector and a “deadly crisis”¹² to the NHS is the inability to discharge people from hospital who are ready and safe to do so because of a lack of social care support (also known as the more demeaning term ‘bed-blocking’).

As always, there is greater nuance involved. The wait times for discharge from hospital back into the community with appropriate care packages are awful, but only 20% of care requests come from hospital discharges and the remaining 80% of requests for care support originate from the community¹³. Emergency discharge funds in the millions aren’t going to fix a sector which needs billions of additional funding and a well-thought-out plan, and it’s disingenuous to claim otherwise.

Headlines about how the NHS and social care have received more funding than ever in recent year don’t fully explain the intricacies that lie within. Yes, in the last three years, both sectors have received larger lump sum amounts, but within those numbers is also the £37bn spent on the inefficient Test and Trace, funding for Covid-specific needs (e.g., PPE, testing etc), as well as the billions wasted on corrupt deals made using the VIP lane which was declared unlawful by the High Court¹⁴.

We only need to look to the historic split approach to the NHS and social care to see the impact of not having collaborative joined up planning in place: despite the NHS budget being ringfenced during the austerity cuts of 2010-20, merely maintaining health spending for an ageing and ailing population has proven to be insufficient; social care has felt the brunt of local authorities’ reduced funding capacities; sharp cuts in the 2010s on healthcare capital expenditure means that even if you increase the number of doctors/nurses/care professionals, the UK doesn’t currently have enough resources such as beds and equipment to help people faster; and cuts to other areas result in inequalities which can often develop into further health (physical and mental health) conditions, placing a greater long-term strain on both the NHS and social care¹⁵.

The situation facing social care becomes all the more sobering when we realise that:

- **Over 1.6 million people** need care and support and are unable to access this care due to inadequate funding and workforce capacity¹⁶;
- In the six years between 2015 and 2020, 1,578 care homes closed, forcing the relocation of around 48,600 vulnerable people to places that were not necessarily their or their families’ choice¹⁷;
- In 2017, a record number of care homes were declared insolvent due to cuts in contributions from local authorities and rising staff costs¹⁸;
- After the first wave of the pandemic in 2020, as many as 6,500 small care homes were at risk of closure due to financial pressures¹⁹;
- The number of economically inactive people in the workforce because of long-term sickness has increased to 2.5 million in the last few years²⁰ (due to what appears to be a combination of Long Covid, increasing numbers of people reporting mental health and nervous disorders, an ageing population and longer NHS waiting time). People in this group who aren’t already receiving support from social care are likely to in some capacity in the coming years;
- 52% of the UK public – 34.5 million people – know someone who has been diagnosed with a form of dementia²¹
- The number of people living with dementia in the UK is expected to increase beyond one million by 2025²²
- Social care doesn’t have an equal seat at the table in Integrated Care Boards (ICBs) – it’s mostly represented by Local Authorities instead of independent care providers representing a variety of types of care



Funding

More funding needed seems to be the common theme whenever you talk to someone in social care, whether they are a part of the workforce, receiving care themselves, an advocate, or a third-party supplier. While it's great that everyone is in agreement with this, they're also in agreement that the answer isn't just increasing fee rates. That's the basic requirement. For social care to really maximise its potential to provide the best care and support possible in the short, medium and long-term, targeted funding initiatives (beyond fee rates) should look at more nuanced and holistic innovation. Joined up thinking and working in collaboration across multiple stakeholders can help achieve a variety of goals. For example:

- Funding the creation of a care register to professionalise the sector would improve retention, training, quality of care provided, the public image of the sector (which then links in with future recruitment) etc;
- Funding for incubators to support Registered Managers to make the transition from management to ownership would support retention at a time when managers are leaving the sector at a faster rate than ever and prevent the loss of cumulative decades of experience;
- Funding initiatives in collaboration with architectural and construction firms to incorporate biomimicry into the design of new care settings would support the sector's journey to net zero²³;
- More funding into research on issues which affects certain demographics more than others so that a greater understanding can improve the quality of care provided to individuals as well as support in retaining the workforce, e.g.,
 - 65% of people living with dementia are women²⁴
 - Black and Chinese children are 26% and 38% respectively more

likely to be autistic than other ethnicities²⁵

- Members of the LGBTQIA+ community are more likely to have developed mental health conditions
- Investigate other metrics and models such as Doughnut Economics²⁶ when assessing funding reform and initiatives to ensure there is a balanced and nuanced approach to social issues, sustainability, and feasibility²⁷

Innovation and collaboration

Social care knows it can't afford to wait for reform. On a short-term basis, a significant number of providers are terrified the extended impact of the Cost of Living crisis has hobbled their financial viability and they risk closure within the coming months. On a medium and long-term basis, the demand for care is far outstripping supply, a trend which will continue to increase in the coming years, and so, as so often is the case, the sector has looked towards itself to, at least, get the ball moving and start building a movement towards collaborative innovation.

Sometimes, a sector can benefit from being disrupted from the outside, but sometimes the people who know the sector inside out just need to be listened to. One of the aims of this white paper and last year's paper was to provide a unifying voice for everyone in social care: where the first People Plan paper focused mainly on the workforce (Public Image of Social Care, Recruitment, Retention and Wellbeing, Training, Pay and Conditions), this white paper sets out to primarily address the issues that are affecting all people in social care. We recommend reading the [first paper](#) in conjunction with this one.

Whether it's working on building its own care register, or looking to learn from innovative ideas being trialled internationally (e.g., timebanks in Switzerland and Beijing²⁸, or Dutch universities offering free rent to students in exchange for volunteering in local care homes²⁹), it already has an abundance of innovation, imagination and creativity. The sector knows that time is of the



essence, that the time has come for us all to stop talking so much about 'fixing social care' and, by working together and uniting voices, to actually start doing it.



Methodology

This People Plan White Paper is the result of a ten-month consultation with people who draw on care services, their relatives/friends/advocates, care managers, providers and leaders, frontline staff, suppliers, commissioners, and other social care stakeholders by the Institute of Health and Social Care Management (IHSCM) and the IHSCM Social Care Innovators People Plan Sub-Committee. The consultation ran from May 2022 to the end of February 2023.

As the aim was to produce a People Plan by the sector, throughout the process, having as wide and diverse a range of contributors to the consultation was of huge importance and so the consultation consisted of:

- An online survey using Survey Monkey
- An easy read version of the survey
- Virtual Round Table discussions (Appendix 1)
- Voices of Care Forums (September 2022 and February 2023)
- Panels during care conferences such as the Healthcare Plus Show and UK Care Week
- Podcasts
- One-to-one consultations with
 - People working in care
 - Drawing on care themselves
 - Loved ones of people using care
 - Advocates
- Email submissions
- Telephone consultations
- Video consultations
- Direct talks with our own networks and peer support groups
- Social media outreach
- Clubhouse – The Health and Social Care Club – Topical discussion
- The Caring View – The Social Care Chat Show
- Relatives Groups
- Managers’ online networks
- Webinars and meetings with sub-sections of the sector
- Lived examples and experiences of members of the IHSCM

We learnt lessons from the first People Plan, mostly around improving the accessibility of the consultation period to all people, e.g., creating an Easy Read version of the online survey, reaching out to various advocate support groups to ask them to share the consultation with their networks of people receiving care, and offering additional resources to support individuals’ accessibility to the consultation.

We are firm proponents on improving Equality, Diversity and Inclusion and strongly believe that different perspectives will bring about more equitable change. Therefore, we consciously included a variety of personal and professional demographics when inviting individuals to be panellists on our virtual Round Tables. For each Round Table, our invites included diverse guests to provide expert opinions. We ensured we had people who were related to or drew on care themselves, diverse ethnicities and genders, people working in a variety of position within care, and important stakeholders.

The consultation used to inform this People Plan was shared with managers and leaders from all areas of the social care sector (care home, home care, learning disability care, sheltered accommodation etc) and did not to focus solely on elderly care. Each contributor was asked to share further with their own networks in order to build up as wide ranging a group as possible. Running in parallel to the consultation, a desktop review occurred where a number of existing research reports, recommendations, surveys, evaluations, and thought pieces were reviewed.



Furthermore, in addition to the Consultation Survey, the IHSCM conducted several other surveys during 2022 (e.g., the Leadership and Development Report, a snapshot Cost of Living survey and the annual Public Image of Social Care survey) which have also been used to inform this People Plan. Finally, feedback was also provided by respondents via other communications throughout the consultation period, including email and consultation sessions.

The consultation undertaken focused on 5 main areas of social care:

1. Access to Care
2. Mental Health and Wellbeing of People Using Care
3. Policies, Guidance and Regulations
4. Equality, Diversity and Inclusion
5. Greener Care

Definition of terms

- **IHSCM:** Abbreviation of Institute of Health and Social Care Management
- **EDI:** Abbreviation of Equality, Diversity and Inclusion
- **Care Professional:** Refers to care assistants / paid care workers/ carers, a person in a paid caring role.



ACCESS TO CARE

Reducing Capacity but Rising Demands “Due to staff shortages, care is being rationed”

Access to care is the ability to access good quality and timely care services to meet an individual’s holistic needs which can include personal care, emotional care, spiritual, and pastoral amongst others .

There are challenges to accessing care at every step of a person’s care journey, from understanding what care is, what services are available, initial assessment, sourcing care, funding care, hospital discharge to name just part of the process etc. In this section, we summarise the key factors choking access, including:

- The focus on fixing the NHS with social care merely as an afterthought;
- Deficiencies in implementing or utilising existing infrastructure, e.g., the Capacity Tracker which people do not use at the same consistent standard
- Financial pressures affecting social care providers
- Growing wait times within various stages of the process and their causes then having a ripple affect to the entire process
- The difficulty of navigating care pathways and understanding the process
- Delays due to lack of other resources and equipment such as hospital profile beds amongst others.

Access to care is a crisis that is affecting both social care and the NHS. It’s often reported that the NHS is near collapse due to the inability to

discharge people back to their own homes or into residential/nursing care settings due to social care shortages. It’s estimated that the number of older people living with unmet care needs in the UK is around 1.5m⁴². This excludes working age adults who make up approximately 35% of the sector.

In 2019, Age UK reported that a lack of social care had resulted in £587m costs to the NHS in a two-year period with around 2,750 people being kept in hospital during that period who were otherwise well enough to go home with care and support had it been available to them.⁴³

In 2022, it was estimated that one-seventh of the NHS’ capacity (c.13,000) was taken up by people fit to be discharged, but unable to do so due to a lack of social care resources⁴⁴. Successive Health and Social Care Secretaries in autumn and winter 2022 announced emergency discharge funds for social care to help speed up the discharge of those who are fit for discharge: £500m in November 2022 was to be split between improving bed capacity (£300m) and reducing the c.165,500 workforce vacancies in the sector (£200m)⁴⁵; and an additional £250m⁴⁶ in January 2023 to further increase bed capacity by allowing Local Authorities/Trusts to block purchase beds in care homes and other community care settings.

However, some providers have reservations about this with one respondent saying “*The hospitals are under pressure, but we have empty beds which we have never had before. This does not make sense.*”



and another saying, *“It’s all well and good the public hearing the headlines about additional funding, but considering that ICBs (Integrated Care Boards) have barely interacted with the social care providers in their region since they came into operation in July 2022, few providers have actually been given the information on how to access that funding and who exactly it is allocated for”*.

“The hospitals are under pressure, but we have empty beds and no matter how many social care and health care professionals we inform we are not getting enquiries which we have never had before. This does not make sense.”

Even with systems such as the Capacity Tracker in operation whose sole purpose is to assess the availability of services, communication seems to be failing. We had one care home provider advise that:

“We have tried everything to tell everyone in NHS and Social Care about the empty beds and capacity that we have but it appears that no one is willing to make the time to discuss this with us despite all the news headlines advising that there is no capacity within social care”

Whilst the promised increases in funding from government all sound very promising, it’s important to note that the total amounts of £750m promised are a drop in the ocean for a sector currently facing a funding gap of billions and that promises don’t match reality with many providers commenting that, even as late as February 2023, they still had not receiving any of this ‘winter funding’.

Furthermore, the government and public focus is still very much on the NHS as the sole problem that needs fixing, whereas many in social care feel like they are expected to fend for themselves without any well thought out sector-wide plan to reduce vacancies or increase care capacity. No plan has currently been devised or disseminated to local areas or care services (or, if it has, it has

not been communicated to providers well enough) as to how the discharge fund may improve capacity, but the emergency funds appear very much to be a temporary fix without addressing the root causes of the problem.

In the six years between 2015 and 2020, 1,578 care homes closed, forcing the relocation of around 48,600 vulnerable people.⁴⁷ Of these closures, almost half were rated ‘Good’ by the Care Quality Commission (CQC) which suggests that they did not close due to the quality of care they provided, but that their closures were likely to be due to external factors and pressures, most likely financial: extortionate rising costs including those of wages, inflation, food, utility bills, staffing vacancies and difficulty engaging with commissioning teams and discharge co-ordinators despite the introduction of Integrated Care Boards which should be streamlining these processes. It should also be noted that in the years between 2010 and 2020, overall available hospital beds reduced by 8.3%⁴⁸ (circa 13,000), resulting in the UK having the second-lowest number of available beds proportionate to its population when compared to comparable OECD and European countries.

Money seems to be the biggest factor that has driven both closures of care settings up to this point and the opening/building of new care settings (commissioning costs for providers who commissioned a new care home after 2010 were 16% higher than for those who commissioned prior to 2010⁴⁹). After a lengthy, onerous and somewhat poorly structured consultation into the Fair Cost of Care (which has been swiftly renamed as the Cost of Care) targeted at providers around England, and following on from the constant upheaval and uncertainty of government, any changes to the cost of care and process of commissioning have been pushed back to at least 2025⁵⁰.

Adding to financial pressures, the Nation Living Wage (NLW) in April 2023 is rising to £10.42, a 92p (9.6%) increase from 2022. Staffing costs can make up to 60-80% of provider costs yet, even as



late as February 2023, local authorities around England have yet to communicate to care providers the fee rates (funding) they will receive from local authorities from April 2023, making it impossible for providers to make financial forecasts for the immediate or even medium-term future, especially as care fee rates are increasing disproportionately to the National Living and National Minimum Wages increases.

In home care, the Home Care Association (HCA) found that “Workforce shortages were impacting on the amount of care being delivered, with nearly half of providers (47%) reporting that they were providing less care than this time last year.”⁵¹

With less places for 24-hour care and few people in post to provide care at home, the social care system is already beyond capacity. There are any number of potential targets to blame – decades of underfunding, Brexit, the COVID pandemic etc – yet the fact remains that capacity in care is not increasing and no one with the power to make a change appears to have a plan to tackle it.

As usual, we begin to look within the sector itself for a solution to this growing crisis.

The National Care Group, for example have said they have “*made significant investment in benefits to support the attraction of candidates. These include paying for HRT for menopausal colleagues, wellbeing initiatives, private healthcare, and death in service benefits. Amongst many others.*” It is initiatives like this which look at a broader picture of how to improve and innovate in the supporting of our workforce. Our consultation also found that some social care providers have a step down / moving on bed scheme where people come to stay for 2-6 weeks while their care packages back into the community are sorted out, and they return home.

Rising Costs of Care – Private Care too expensive

Those lucky enough to source social care, however, are facing rapidly rising costs for services. Many told us about the costs their or their loved ones with one person telling us that they have both “parents living with dementia, costing over £5K a month”.

The cost of care is being driven by a number of variables:

- Wage Costs - The national living wage has risen £2 (over 20%) since 2018⁵² and 2022⁵³
- The Energy Crisis
- The Cost-of-Living Crisis
- Fee rates for local authority funded placements which are significantly below the average cost of care
- Lack of funding/grants being provided to social care providers despite the vulnerability of the sector.

Although it is understood why the cost of care is rising, it is of no comfort to the millions of people currently paying for or sourcing their own care packages to meet their needs with one respondent saying:

“Unfortunately, care is a business, some care providers only take private clients because it is a business. The privatization of health and social care is disproportionate”.

For providers, there is a necessity to increase their care fees. However, there is a fear that doing so will deter people from using their services. They are in a catch-22: without increasing fees, their businesses will no longer be viable, yet without attracting people to use their services, their businesses will also no longer be viable. A provider responding to our consultation said:



“Heating costs have risen, food cost has risen, insurance costs are astronomical as are interest rates. None of this has been reviewed or reflected in the rates we get paid.”

This is further supported by The National Audit Office who reported on a Department of Health and Social Care assessment that most local authorities paid below the sustainable rate for care home placements for adults aged 65 and over, and below the sustainable rate for home care⁵⁴. £5k a month out of context sounds high, but for two people living with dementia, this averages out to approximately £625 per week which is actually well below the average cost of care for someone in either a residential dementia or nursing dementia care setting.

From our consultation, we found that there is a belief that a lot of the funding problems facing health and social care are being fuelled by wider mismanagement of resources, or from existing services, including the recently formed ICBs, failing to communicate and work together effectively. Many believe the use of qualified social workers (also in short supply) to conduct needs assessments is slowing down the commissioning of care, adding to NHS bed occupancy pressures, and wasting time and money.

Money is also a factor to the viability of services providing state or health funded care packages. There appears to be delays or poor management of finances when it comes to paying for these contracted services. Some providers told us that:

“It can take local authorities months to pay us our invoices”

“Continuing Health Care and Local Authorities keep passing the book to each other whilst we continue to provide care unpaid for....FREE...How can we sustain this?”

There’s also a concern that people will begin to limit their interaction with health and social care for fear of burdening or wasting resources, or that a two-tier system will become more prevalent with only those with greater financial resources able to access good quality care.

“My Mum has a lot of mobility issues and over the years they first send her to physio which always ask her questions give her the same exercises she was given 10 years ago then say there is nothing else they can do. What a waste of resources and time someone else should have had that appointment we do not want to be wasting time and money.”

“My father was provided access to an NHS physio who told him that he will never walk again, and he was wasting his time. This resulted in me hiring a private physio and my father was walking with the use of mobility aids within 4 months.”

In truth, the cost of care was something the government had planned on addressing. However, like most things related to social care reform, both the ‘Fair Cost of Care’ consultation and creating a cap on care costs has been postponed from 2023 to at least 2025⁵⁵.

One cost that isn’t currently factored in for most CQC registered providers is the cost of PPE as, until March 2024 or until the Department of Health and Social Care’s stocks are depleted (whichever is sooner⁵⁶), all PPE is provided to organisations free through the PPE portal. Once this service is inevitably closed down, providers will face yet another mounting cost which will in turn see people finding their care bills increasing even further.

Extensive Waits

As the capacity to provide social care services decreases, waiting times for receiving services (be that commissioned care packages, direct payments, assessments, or even just care needs



reviews) is increasing. In August 2022, Association of Directors for Adult Social Services (ADASS), reported that waiting lists for social care services had increased by 37%⁵⁷.

Some families have reported that it has taken approx. 6-9 months from asking for support and the assessment just to access day care services. Day care services are currently unregulated by the Care Quality Commission so tend to have less restrictions or requirements in order to provide services, yet they too are seeing delays and backlogs in requests for support.

Waits also come in the form of the inability to move from one care setting to another. Whilst most care providers endeavour to provide a continuous service for individuals, people's needs change and the care they require changes along with them. Through this consultation we were told

“When we can't meet someone's needs, we try to work with everyone else to help move them to a care setting more suited to them, but this can take months, if at all. This puts our service in danger as well as the person”

This is one of the main concerns about rapid and forced discharges from hospital to places of care: just because someone is now receiving care doesn't mean it is appropriate or able to be tailored to their needs.

It's important to remember that, despite what the news may portray, the majority of care requests actually originate from local communities rather than hospitals as evidenced by the King's Fund 360 Report from March 2022 which stated “The source of requests for support has not changed significantly since 2015/16: around 4 in 5 requests originate from the community and 1 in 5 from hospital discharge⁵⁸.”

Unnecessary wait times are further created by regional disparities in state funded home care packages having their payment arrangements and/or packages terminated should the person they're supporting end up in hospital for any

period of time. One person consulted for this paper said:

“when people go into hospital local authorities usually stop payment for the care. In other local authorities' retainers are given so staff can be retained and the space for the person should they return back home...there is inconsistencies in the way local authorities support their provider market.”

The unwillingness or financial inability to provide home care organisations with retainers is an important point as it impacts both business viability and workforce retention. People working in home care are generally only paid for the time they work or, sometimes, even just for the time spent at visits with travel time between clients excluded. In most cases, empty 'gaps' in people's working days result in lost income, inability to predict future income, reduced job satisfaction and, ultimately, them finding employment somewhere else which provides more stability. In contrast, those who work in care homes or other 24-hour care settings are paid for their full shift even if the individual goes to hospital because the care provider is paid to keep their accommodation arrangements in place, which means 24-hour care settings are able to provide, at the very least, more predictable income patterns for their teams.

With staff vacancies of 165,000⁵⁹ across all care settings, staff leaving one type of service such as domiciliary care for another such as a care home isn't going to solve the underlying issue of total sector workforce vacancies and, instead, creates additional pressure on business viability, especially for smaller providers, because unfilled vacancies need to be filled with agency workers who are much more expensive and don't provide continuity of care to the individuals they are supporting.



Pathways to Arrange Care are Difficult and Confused

The current approach to commissioning care and sourcing care is causing difficulties for all involved.

Care Pathways are multidisciplinary approaches with interventions from health and social care designed to support individuals in sourcing the correct care for their needs, but poor communication and understanding persist. Despite the existence of charities and organisations designed to support people to choose the right care, many are still having to contact their local authorities directly with little to no information about what services are available. For those who are aware of what their care needs are still face obstacles in sourcing the correct care and support.

“My disabled 83-year-old mother was unable to see a Doctor face to face for 14 days with a compression of the spinal cord and only then because I was constantly insisting could send her to A&E but was 12 hour wait on a trolley before seeing someone. Given she has Parkinson’s medication to take at 4 hour intervals and not been allowed to attend with her this was not an option also social worker did not visit Mum once but accessed without seeing her after 17 days agreed a temporary care home could be looked at terrible when she needed 24 hour care and gave me an hour and half to get her there and I would have to organise disability transport to do this she couldn’t walk stand unaided and was totally incontinent how can this occur in 2022 the system is broken.”

Some claim that there is “Limited face to face contact to explain the care system to somebody with a disability or needing extra support.” Other responses we had about the difficulty of sourcing and arranging social care include:

- *Very disjointed, care homes not working with acute services, GPS being fully unaware of their patients’ needs due to*

the pandemic. Telephone consultations poor.

- *Families find it difficult to navigate.*
- *Lack of support with direct payments and personal budgets.*
- *Integrated care systems are not working.*
- *Sign posting and support from Social Care is limited.*
- *Postcode lottery, different boroughs, different information*

Delays Due to Lack of Equipment

It must also be understood that the capacity in social care is not just down to the availability of beds in care homes or time slots in home care services, it’s also about the availability of services and equipment required to allow social care services to provide safe and effective care. People who responded to the consultation expressed frustration that:

“Admissions to residential homes are delayed due to waiting for the correct equipment to be supplied, also waiting for social workers to arrange contracts.”

It tends to be transfer equipment that is unavailable on discharge, especially discharges to community settings. It is either not ordered and delivered in time prior to discharge (particularly on weekends), or the equipment is incorrect and unsuitable for the individual who requires it.

If social care is being called upon to be able to increase its capacity to deliver services, there should also be a robust infrastructure of equipment delivery and supportive health services available to support and enable this. Discharging someone to their preferred place of care will not be as effective if they arrive there without the means to be able to transfer safely, or without access to the relevant supportive services, e.g., community mental health or occupational therapy services. The ineffective care then runs the risk of



readmission to hospital or unnecessary decline in their health and wellbeing.

From a provider perspective, this also puts the care setting at risk of safeguarding for accepting a resident whose needs they cannot meet with the incorrect equipment. One provider told us:

"No matter what we do, it is not good enough and there is always someone wanting to make us out to be the scapegoat when other people fail to fulfil their obligations"

All areas of health and social care appear to be underfunded and under supported, but clear care

pathways are required to ensure smooth transition and support of care. It seems that communication is continuously breaking down and the main publicly announced priority being that of freeing up bed stock availability in hospitals without proper planning for continuous care and support. Moving forward, any reform or action implemented to improve the access of social care services and increasing the availability in health settings must have a primary focus on multidisciplinary working and clear communication structures.



Recommendations

It is evident that based on our consultation and subsequent report, there are many issues currently affecting access to care. This plan is, and remains to be, a People Plan, so the recommendations we make are to improve the impact and outcomes for individuals working in care and receiving care. Below we list our recommendations of how we can begin to address the current crisis and implement solutions to address:

- Commissioning at crisis point;
- Delayed discharges;
- Social care capacity;

Prevent commissioning at crisis point

1. **Develop clear and concise pathways of care that are available to everyone**

- a. There should be a self-assessment tool to give an idea of what services might be beneficial to those that are unfamiliar with how social care works with an emphasis on choice, direct payments etc;
- b. Create a potential care funding calculator
 - i. This must include guidance on available funding options with the results transparent
- c. Integrate 'MECC' (Make Every Contact Count) into social care which is an approach to behaviour change that uses the day-to-day interactions that health and social care staff have with people to support them in making positive changes to their physical and mental health and wellbeing;
- d. Explore self-referral options to empower people to seek their own support rather than being stuck in a queue awaiting assessment and guidance;
- e. Location based signposting tool to provide a parity of awareness for all social care services available – not just focussing on homecare or care homes;
- f. Mandatory training for NHS on social care and social care function so they understand the relevance more;
- g. Warning signs around mental health, signs to look out for (individual and for others) so that people can pick up early warning signs before it is too late;

2. **Develop a Care journey planner** – Utilising the experts in social care, people who use care, and other stakeholders, we recommend that a care planner be developed and free for use to enable people to plan for future care needs. This should build upon work already done regarding advanced care planning, advanced decisions, and preferred paces of care/death.

3. **Improve transfer of individuals from inappropriate care settings:** There needs to be a finite deadline for commissioners and social workers to support in the transfer of people from inappropriate care settings (i.e. if they are unable to meet their care needs) to appropriate care settings. Care needs should be funded at their correct rate, i.e., increasing in line with the complexity of their needs, during that finite period to ensure adequate care prior to transfer so that care providers are not left out of pocket;

4. **Improve support post dementia diagnosis** – More support, information and signposting is required for people post diagnosis of dementia. This information should be provided in accessible formats beyond just digitally;

5. **Make adult social care as visible as your health care service.** People know their local hospital and GP surgery; but they don't know where to go when they have a care crisis. We know that most people will end up seeking advice from their Local Authority and / or primary health. Councils are responsible for a large range of services. We recommend working with Local Authorities on visible physical and/or digital hubs to make care visible and accessible. This could be utilising existing digital resources e.g. Care Choices, or Care Umbrella, and learning from the effectiveness of information booklets used locally.



- 6. Introduce a 24-hour social care triage to the 111 service.** We recommend that 111 is expanded to have access to signposting social care resources in their local area (after they have received training on the different areas of social care).

Improve discharges

- 7. Creating a consistent standard for Multi-Disciplinary Teams across all regions ensuring:**
 - Communication required to ensure continuity of care
 - Clear structure of which team is responsible for what without relentless redirecting.
 - Measurable Impact and Outcomes
 - Ensure they have the resources be it financial or people.
- 8. Review how data from Capacity Tracker is used to conclude whether to maximise its potential or stop its use.** The tracker is a time consuming, legally enforced requirement exercise for providers. Multiple NHS Trusts have reported that the data is not useful to help with discharge. Feedback has included that room availability alone is not enough information for discharge teams but should also include
 - Type of care available
 - Level of care achievable
 - Type of funding accepted for submitted availability.
 - (For example, Autumn's Dashboard for Accelerated Discharge which claims it reduces delays by up to 3 days).*
- 9. Investment into services to reduce pressure on unpaid carers.** This could be:
 - More day care and respite options
 - Funding for community projects that provide meaningful experiences – e.g., community clubs instead of day care
 - Funding for support groups to provide peer-to-peer support to unpaid carers
 - Funding into mental health support for unpaid carers to support them navigate emotional and complex journeys
- 10. Provide crisis support services 7 days a week seeing as social care is not only Monday to Friday:**
 - Mental Health Support
 - Dieticians
 - Social Workers/ Social Services
- 11. Fund and create media campaigns that raise awareness of how to access and plan for social care needs (All ages).** Similar to NHS campaigns which educate on the correct health care paths to take, social care could break own stigmas and make care more accessible.
- 12. More recruitment of Social Workers** - or a different role specifically for those working with people with care needs and/or their families to help plan their care journey.

Increase long-term social care capacity

- 13. Adult social care to have parity with NHS regarding peoples pay and terms and conditions** based on positions of responsibility. The vital work of adult social care needs to have parity with the NHS.
- 14. Investigate and explore innovative and creative solutions to provide additional and alternative routes to provide funding for adult social care.**
- 15. Mandate a care register (England Only)** – The idea behind the care register would be to professionalise social care to elevate its public image and boost recruitment and retention. It is something that is employed in Wales and Scotland and should now also be explored for England. The register should not exclude so there should be no minimum qualification requirement but it should:
 - Support transferable qualifications



- b. Be for all care professionals, including micro-enterprises
- c. Utilise a standard reference of employment that would be recognised by the regulator
- d. Signpost and support registered care professionals

16. Conduct transparent review of how and when payments are made to providers who currently provide local authority commissioned care – The feedback to this report suggests that many care providers are providing local authority commissioned care but waiting many months to receive payment for the services delivered resulting in a lack of cashflow and affecting business stability.



MENTAL HEALTH & WELLBEING OF PEOPLE USING CARE

COVID created a mental health and loneliness crisis

“Our residents have been isolated and mistreated by the governments who still keep rules that do not make sense.”

When consulting on the mental health and wellbeing of those living in or accessing care, we found that:

- The COVID pandemic created and/or contributed to a loneliness crisis;
- Wait times to access support were too long;
- Both providers and people accessing care said they needed more support from commissioners;
- People felt like the Care Act was being ignored;

- BUT there is hope with some saying they have seen signs of improvement in the last year.

The COVID pandemic tested the UK. Where people once lived with the freedom to engage in their daily lives, meet with the people they love, eat at the places they liked to eat, find safe places to be away from abuse, they now faced an uncertain future locked behind doors as society closed down.

For those living in or with care, their freedom of choice and independence appeared disproportionately affected. Care home operators



describe rigid and impractical guidance from government, fears about invalidating insurance cover and concerns of regulatory action. People drawing on care and their families describe unfair restrictions to access of family, lack of communication, and an unwillingness to be seen as ‘partners in care’ as severely affecting their wellbeing.

Care homes were instructed to reduce all incoming traffic to an essential minimum (relatives didn’t meet the essential criteria until months into the pandemic), people living at home with care were restricted from seeing their relatives, and those who relied on unregulated services such as day care were suddenly without their usual networks as they ceased operating. Yes, when the pandemic hit, the mental health and wellbeing of most people using care was affected. A one year on review by Age UK⁶⁰ found that conditions such as anxiety, depression, low mood and resilience were all negatively impacted and that those with pre-existing mental health conditions experienced them getting worse throughout the pandemic and in the following years. This is a sentiment echoed throughout responses to our consultation such as this one:

“Everyone’s mental health is poor at the moment due to lock down. Some people with mental health who struggled with social situations before now really struggle because they haven’t had to be involved for so long.”

Whilst some put the blame of increased isolation and the impact of mental health and wellbeing on the care services, the providers are quick to point out that they had only been acting on the instruction of the government and regulators and join in the concerns and dismay of the effects such restriction have and still are having on those they support:

“Terrible. Our residents have been isolated and mistreated by the governments who still keep rules that do not make sense. Why do we still have masks here when no one else does? It’s ridiculous when residents are hearing impaired, rely on lip reading or it impacts their dementia”

“Our staff are trying so hard for our residents but all these changing guidance is not good for anyone let alone a vulnerable resident with so many mental health needs.”

It was also evident through this consultation that some believe the effect to mental health of those receiving care is mirrored and partially linked to those delivering the care. With resiliency hubs that provide mental health support to staff undergoing threats of closure⁶¹, the worsening cost of living crisis many workers are struggling, and the experiences people had working during the pandemic in homes that suffered outbreaks has resulted in many feeling overwhelmed and burnt out. If the mental health of the social care workforce is poor, then the sector will inevitably struggle to maintain and support the mental health of those relying on care services.

“Not good. Carers and the cared for are exhausted and depressed.”

“COVID raised awareness. The level of moral injury, burn out and PTSD is dreadful”

It’s not just the paid workforce being impacted. Data has shown that in 2021 there was circa 5 million residents aged 5 or over in Wales and England providing some sort of unpaid care⁶². Unpaid carers are relied upon to meet the shortcomings of social care provision due to lack of available services. During the pandemic and beyond, they have continued to provide care, but only 12% saying they get enough support⁶³. Lack of support for unpaid carers also exacerbates existing inequalities: women provide a larger



proportion of unpaid care⁶⁴ and there is a substantial body of evidence that unpaid care has negative impacts on carers' paid employment, mental health and wellbeing⁶⁵.

"Our cared for has experienced multiple and extended traumas as a result of failures of care and as unpaid carers, we are doing the counselling. Stop hurting us."

The wellbeing of unpaid carers requires a renewed focus. As the access to care crisis keeps getting worse, the reliance of unpaid carers means that if they were not there, then there would be millions more people at crisis point throughout the UK. Ensuring unpaid carers are able to access respite is essential, as reported in MENCAP's Breaking Point report⁶⁶.

MENCAP also reported in their Loneliness Engagement Report⁶⁷ that people living with learning disabilities felt that the discrimination they face increased during the pandemic, and many said their mental health was negatively impacted by both the various lockdowns and their aftermaths: they found it harder to access support because their disabilities are considered hidden ones, a lot of their support services including social activities closed during the pandemic, and many felt that the easing of lockdown did not mean a return to their life before the pandemic because concerns remained about their increased vulnerability and so they are still reluctant to leave their house.

In addition, the dismantling of Human Rights in the government's proposed Bill of Rights has increased concerns that people living with learning disabilities will have some of their legal protections removed⁶⁸, especially ones they rely on to live the lives they want⁶⁹.

Wait times too long to access support

In October 2020, it was reported that two fifths of people were resorting to A&E services⁷⁰ to seek support for their mental health as waiting times through the correct routes were taking too long. In the years since this finding, there has been little evidence to suggest that the situation has changed. In fact, people responding to this consultation expressed concerns that they are still struggling to access the right services. One person said:

"People with mental health need to be assessed correctly to find right help. My mother-in-law has mental conditions and has had for the last 50 years. She isn't sectioned but resides in a normal care home and we now in her fourth care home since my father-in-law died that have refused to have her there longer due to her violence and threats. This is due to the NHS won't section her because then she would not pay for care and now she does. This is dangerous to others and should not be about money so totally overall needed"

There are now concerns that mental health services may struggle to remain viable in part due to the rising cost of living crisis⁷¹. If this is the case, then responses such as the following are only going to become more common:

"Waiting times are ever increasing to access outside mental health support for residents, including securing a bed for those assessed to require a mental health hospital bed."

Whilst claims of financial motivation to not support or treat mental health conditions in people living in care are hard to quantify, it is concerning that people feel that their needs are not being met and they believe this is now posing



a risk to the physical and mental health of other people residing in the same care settings. What is more upsetting is that people’s lives are becoming traumatic for them and their loved ones/carers, sometimes for years, and any efforts to support are hindered by the lack of available services and resources. This is even more prevalent for those who attempt to have control over their care needs through the use of personal budgets/direct payments.

“Control by individuals about their care needs is limited to certain areas. The long wait times leads to neglect.”

More support needed from Commissioners and Regulators

The lack of support for the mental health of those drawing on care appears to also be as a result to current commissioning and regulation practices. One response to the consultation said:

“The sad truth is that when a LA / CCG commission care, they have no regard for the support network of the person drawing on care and this is negatively impacting on the individual and their support network. We have to create a culture that is inclusive and whole heartedly focus on the wellbeing of the individual drawing on care and this can only be done if there is holistic care in place that gives the individual control over their care with joint up working between the funder, provider and their support network”.

Whilst the concerns raised in this comment are linked to the other common themes collated from this consultation, it is worth noting that people believe that commissioning at present is just

about focusing on freeing bed capacity in hospitals rather than locating the most ideal care environments for individuals.

The consultation also found that, although there is a focus on monitoring the work care providers are undertaking to ensure the mental health and wellbeing of the people they support are focused on, there is currently little support, resources or funding around providing practical examples or templates that services can draw upon or adapt.

“Commissioners and regulators use KLOE’s to ascertain performance in this area but do not offer support or good practice examples”

Although this is a belief shared by many, there seems to be a lack of awareness around the available guidance from NICE (National Institute for Health and Care Excellence). Some of the most relevant guidance includes:

- Mental Health and Wellbeing of older people in care services⁷²
- Care and support of people growing older with learning disabilities⁷³
- Learning disabilities and behaviour that challenges: service design and delivery⁷⁴
- Transition between inpatient mental health settings and community or care home settings⁷⁵

The NICE guidance presented are not enforceable but are great starting points for services to ensure they are doing all they can to support those in their care,

There needs to be more focus on the Care Act and Training

Promoting the wellbeing of people is the first section of part 1 of the Care Act 2014⁷⁶. This section details the responsibilities of local



authorities. The responsibilities as laid out in the care act state:

“Promoting individual well-being

1. The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual’s well-being.
2. “Well-being”, in relation to an individual, means that individual’s well-being so far as relating to any of the following—
 - a. personal dignity (including treatment of the individual with respect);
 - b. physical and mental health and emotional well-being;
 - c. protection from abuse and neglect;
 - d. control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
 - e. participation in work, education, training or recreation;
 - f. social and economic well-being;
 - g. domestic, family and personal relationships;
 - h. suitability of living accommodation;
 - i. the individual’s contribution to society.”

Many who responded to the consultation for this paper expressed concerns that the Care Act 2014 exists purely in a tokenistic existence and isn’t really adhered to. It is important to note that the Care Act is a legal requirement, so it is a legal requirement for local authorities to ensure that they are promoting the wellbeing of people who require care services.

“This is not in the care act section 1 : duty of wellbeing. Wellbeing is thrown around as a general word these are attached to needs to show that needs are being met. It's fundamental part of the care act yet ignored, and It also includes socio economic wellbeing i.e., having enough money. People think wellbeing is a service as do staff and senior officers. Very few realise its part 1 of the care act and everything else is based around it.”

“No one pays any attention or realises its even part of the care act.”

This may be a symptom of struggling to locate available carer services for people and commissioning occurring on a “whatever is available” basis, but it may also be an awareness issue. Either way, if local authorities aren’t doing all they can to promote the wellbeing of those using care, it is a breach of the care act 2014.

The legal requirements of the Care Act also extend to all care providers. Organisations should be doing more to anchor the work they do in the Care Act.

There also seems to be a perception that there is a lack of training around mental health within care settings, for both the workforce and those using care.

“I’ve not seen mental health training in this sector for staff or managers- this is becoming the Norm in corporates.”

“At the moment I fear very basic needs are not being met so concerning all well-being needs increases”

“Mental health awareness, training, and support is getting better but could use more work”



There are signs of improvement

Things aren't all bad however, what follows are some reassuring comments from people who responded to this consultation who believe that there are signs of improvement, albeit with some caveats.

"Improving, but lots more can be done to educate our teams, particularly with dementia patients"

"I think there has been big improvements in the importance of mental health and wellbeing, within social care. with the advent of new services such as social prescribers, we as society are starting to take these issues a lot more seriously and this is impacting on the social care sector"

"Mental health is just as important as physical wellbeing. Companies are seeing this and investing more in lifestyle and activities"

"I think there are some really good support networks and providers out there being overshadowed by the ones that make the media for abuse and the wrong reasons."

"Mental health first aiders in the work place - has been beneficial to my place of work."

"Mental health support had improved. However, since the pandemic, this has become increasingly difficult to access, more so in a face-to-face environment for assessments to be undertaken effectively etc."

"Care Organisations should now be able to register for 'Join Dementia Research' along with individuals and health services. This makes it easier for people to sign up and to raise awareness"



Recommendations

Invest in Understanding and Learning

1. **Review the use of direct payments as a holistic commissioning model** – This review should include the knowledge of commissioners, social workers or those in similar fields, as well as identifying the percentage uptake of the direct payments model based on how often it is offered as a viable funding option to people using care
2. **Conduct a review on the duration between referral to receiving of mental health support for people using social care services;**
3. **Commission research into trauma informed care to develop standardised training for social care providers;**
4. **Commission research into sexuality in social care** – this research should look at people’s ability to explore and meet their sexual needs when drawing on social care.
5. **Undertake an urgent review of advocacy services** to ensure fitness for purpose and fair consistent and accountable advocacy for all.

Commit to Support

1. **Retain centrally funded wellbeing hubs across health and social care** to provide free counselling and mental health signposting for the workforce and people drawing on care.
2. **Free mental health first aider training to be funded by the Department of Health and Social Care;**
3. **Pass legislation** that gives all those in health and care settings the legal right, to at least one Care Supporter (relative or friend) that can give in-person support to them in all circumstances including outbreaks and periods of national restrictions. This is an ask that has been championed by organisations such as Rights for residents with Gloria’s Law, John’s Campaign with Johns Campaign and the Relatives and Residents Associations.
4. **The Department of Health and Social Care should publish analysis and an impact assessment on the proposed Bill of Rights and how it will impact the mental health and wellbeing of people using care / living in care settings to aid the debate before voting on legislation**



POLICIES, GUIDANCE & REGULATION

Incoherent with little to no consistency “Providers and people that use services are unclear about the roles of the government, regulators and local authorities and why they are not always in line with each other.”

If we have learned anything from the COVID-19 pandemic when it comes to national and local policies, guidance and regulation, it's that nobody seems to be on the same page.

During the pandemic, and understandably so, there was a plethora of new policies and guidance being released on an almost daily basis. These policies addressed things like PPE, visiting in care settings, correct infection prevention procedures, available funds, admissions into care settings and much more. Needless to say, they were important. It was a time where providers and families were eager to find out more to understand how they were expected to provide care in the safest way, or for families, what their rights were when it came to accessing care and their loved ones. The problem was however, the policies and guidance being released by the Department of Health and Social Care and central government were vague at best.

Providers were left to interpret guidance themselves with very little support leaving an already stretched workforce stressed and burnt-out. Many new pieces of guidance called for things such as ‘providers should complete a

dynamic risk assessment’. However, no guidance or support was provided on what these risk assessments should actually be assessing or how they should be implemented to meet expectations. This led to significant resources being invested at local levels into a variety of different internal policies and approaches around the country. People who use care and their families would see the national guidance and, possibly rightly so, expect that guidance or policy to be implemented verbatim by their care providers. What some were unaware of though was providers would receive the new guidance, usually late evening on a Friday or Sunday, be expected to implement it the following Monday but would face conflicting guidance from their local authorities and local health teams. Confusion was further brought by the fact providers were first informed about the changes through the media, rather than through official and direct channels. As providers struggled and still do to keep up with the changes, unpaid carers and micro-enterprises feel lost, often missing out on any changes:



“Unpaid carers feel they don’t get informed of policy and guidance.”

“Some people feel left in the dark.”

In this ‘post-pandemic’ landscape, it very much feels to some providers that nothing much has changed. Rolling lockdowns in care homes are preventing providers from taking admissions even though they can evidence safe infection practices to minimise transmission. Even changes to guidance which allows care professionals to work without wearing masks pending robust risk assessments was met with immediate confusion as local governments proceeded to supersede the changes, continuing to enforce mask wearing for all providers.

This conflict of policy is added to when the care regulator in England, the Care Quality Commission, will also challenge the implementation of changes.

“Providers and people that use services are unclear about the roles of the government, CQC and local authorities. The LA advice is to do something a certain way and then CQC say that’s not correct or vice versa. An example is with Covid guidance the government removed restrictions, but a number of LA or NHS trust have said to continue with some Covid restrictions/testing”

“No joined up thinking or working in partnership.”

Some respondents said:

“CHC and LA are clear and specific about their requirements, but CQC guidance is more loosely worded and unclear.”

The incoherence of policies from the top down is leading to poor work satisfaction, animosity between care providers and people who use care and their families and what some perceive to be

unfair and ill-informed media stories which further damage the perception of social care.

All of the aforementioned are leaving those providing care feeling overwhelmed and short changed:

“Completely overwhelming over promised and underfunded”.

For social care to be able to improve its relationships with the people it supports, to empower those who use care, and to ensure greater communication between all parties involved, the release and implementation of policies need to be agreed at all levels with agreed pathways to implement them. Where policies are calling for risk assessments or changes to internal practices, templates or examples agreed in consultation with the care regulator should also be provided. Most care providers are so time and resource poor that they are having to rely on peer networks in order to meet the requirements asked of them and, although this shows the resiliency of the social care sector, there is little to no reassurance that the work they are implementing will be agreed or accepted by the various regulatory or commissioning bodies.

Confusing and too frequent changes

Another common theme we found throughout the consultation for this paper was that policy and guidance changes happen too often, and when they do the language used and the format of the documents are confusing to those they are geared towards.

Others hinted that the policies are just too convoluted with frequent changes and retractions making the situation hard to keep up with and resulting in people having different understandings of current requirements and leading to most providers following the ‘wrong’



guidance at any given time despite best efforts to keep up.

Some of the comments we received were:

"It changes all the time hard to keep up with"

"Absolute unfathomable confusing mess"

Confusing and Frequent changes."

"Lack of understanding of policies by social workers"

"Information is over complicated and too many words difficult to understand."

"How can we be expected to do our jobs and care for people when we're not sure what is expected of us day to day?"

Internal policies exist to tick boxes

Moving on from larger national policies to internal policies that organisations are required to have and the outlook changes very little. Providers can be expected to have anywhere from 20 to 50 policies and procedures within their organisations to ensure they are providing services to people who use care, and support to their workforce, in an effective and compliant way. Issues arise when there is no statutory expectation of what these policies should be, furthermore employers are asked to evidence that all of their employees have read and understood these policies and procedures. They're also required to evidence how changes to policies are communicated to their teams and how they are reassured any changes to policies and procedures have been read and understood.

All of this creates a mammoth task for employers and one that many admit they can't achieve.

"There are too many policies for my team to read, they will never have the time to go through them all and remember them"

"care staff work too many hours already, having them read all the policies would add to their working hours, we can't expect them to do it in their own time"

"Some policies are many pages long, they seem a bit pointless"

"Creates an administration burden."

It seems that to be deemed as being a good and compliant care provider, time, money, and resources need to be applied into communicating and embedding policies which, if we're honest, are seldom read or referenced in the day-to-day operations of running a care service.

With the social care sector being fragmented and around 80% of providers only owning one care home or 70% only operating a home care service out of one office, many organisations have to resort to writing their own policies to meet the requests of regulators and commissioners. Larger organisations will have head office policy writers who will create the necessary documents and disseminate them throughout their services, but even then, it comes as an additional cost and administrative burden to the company.

It's understood, and even agreed, that there is a place for certain policies in social care. They exist to protect the person receiving care and to ensure services meet regulations, but the current system of policy implementation is not fit for purpose. Some areas in the UK will have local safeguarding policies that organisations can adapt and use for their services, some even have other policies which focus on supporting people at the end of their lives, but there is currently no repository of free policy templates that providers can access. Although social care is a predominantly delivered by private organisations, it seems unfair that the NHS will have local and national policies created and disseminated which allow for health providers to focus on the delivery of care, whilst in social care the delivery of safe care is juggled with delivering policy documents.



Through this consultation we have also found that people believe that there are too many policies required of social care providers, with many appearing to exist to just “tick boxes”. One such tick boxing policy required of a provider mentioned to us in the consultation was “Visiting Celebrity and VIP policy”.

“I think there is a large amount of policies and procedures available however I feel many providers have these in place as a tick box exercise as opposed to actually utilising them for what they are there for”

Even if a provider manages to create and implement all policies asked of them, they still face the arduous task of ensuring all of their employees have read and understood them. Based on the current crisis of workforce and the turnover within an organisation there is not enough for management to focus on this. This leads to the perception that:

“Lack of knowledge of policies, regulation and guidance of people that work in the sector.”

How does one evidence competence in understanding a policy? If it is just the case of signing a disclaimer to say they have been read and understood without a competency assessment, how do we really quantify the efficacy? This isn't to suggest that all providers should start undertaking competency assessments for all of their policies, it's more to point out the irrationality of what is currently being asked whilst also painting a picture of how to do things properly would require impossible amounts of time and funding to achieve. It would probably also result in reduced work satisfaction and further deter people from working in social care.

Wavering Trust in the regulators

Regulation of social care can only be a good thing and is necessary. Regulation of healthcare can only be a good thing. People need to have trust in

the services they are receiving and that whatever rating/ranking/level that service is deemed to be rated is a genuine reflection on their service. They need to know that the people they are trusting with their or their loved ones' lives know how to do what they do and can evidence this. This isn't disagreed with by this report or by the sector, however, through this consultation we have found that the trust from providers and people who use services in England's regulators has waned in recent years.

Although there is a new framework for inspections that aims to be in use by 2024, some providers believe:

“General lack of support from CQC and a feeling that the inspectors are not consistent in their approach.”

Indeed, there have been many concerns raised that there is currently a lack of standardised approach to inspections and subsequent ratings of care homes depending on where you are in the country or who your allocated inspector is. CQC have a set framework, the Key Lines Of Enquiries (KLOEs), that they use to inspect all health and social care services, and whilst this is a good benchmark for inspectors to review services and for providers to prepare for inspection and indeed review their own practices, some feel that personal bias affects the regulators rating decision. We have no evidence to support whether they do or don't, and gathering such evidence would be incredibly difficult if not impossible. However, what we do have is evidence of a crumbling relationship of trust. This relationship breakdown seems to have only been exacerbated further since the beginning of the COVID pandemic:

“Definitely not. CQC make it impossible to do anything outstanding. All they do is abuse their power to bring down care services who have actually been working through the years whilst they all just sat at homes on their breaks.”



Concerns have also been raised through this consultation about the current lack of CQC inspectors within the CQC and also those that work in Environmental Health and Infection Control, that inspections are either rushed, are not happening often enough leaving homes with ratings that do not fit their service, or are being undertaken to a low standard with a perception that services are now being provided with more harsh ratings than before. We have also noted that Environmental Health have been struggling to meet their obligations and again there is a perception from respondents to this consultation that they too are now coming down harsher than ever before with their Food Hygiene ratings for care homes.

“We haven’t had a full site inspection for 5 years”

“A feeling that because there is a shortage of inspectors that CQC are keeping inspectors that are not good.”

Feedback from providers is that there should be more accessible opportunities to improve their services, what will support them in improving, and the ability to set realistic timeframes to showcase ongoing improvements. At present, providers can be waiting a year or more before inspections to ensure compliance, during which time business image and viability is negatively impacted. Those who participated in this report also mentioned that there was a fixation on issues that did not necessarily impact the outcome for the resident.

There is a consensus throughout this consultation that CQC’s current inspection model is not fit for purpose. The proposed single assessment framework aims to improve on the current model with providers finding it a refreshing change as they will have the opportunity to provide their own evidence of their service often and also have the opportunity to regularly get feedback from those using their services, visitors and professionals who are familiar with the service.

This is the power of digitisation and data which will ensure that providers are constantly focussing

on finding positive outcomes for the people using their services. Any move to a more ‘live’ and fluid representation of a services quality over a snapshot inspection that can have lasting effects over a number of years are welcomed by the sector. The ability to also get ratings changed quicker would be something that a lot of services would really appreciate to ensure that those who are improving are reward to do so, but those who are being complacent on their service are kept on their toes



Recommendations

Improve transparency and candour

1. **Conduct a transparent review of ICBs** to ascertain the level of involvement of independent social care providers within their structure as well as reviewing the experience and relevance of all ICB members.
2. **Improved transparency and impact reporting of social care funding** - Any future funding provided to social care to be done so with thorough action and spending plans. Transparency on division of funds and consultation groups with providers and people who use care as well as commissioners, regulators to devise best plan for spending to maximise impact. These should include:
 - a. Released statement to all to see and disseminated to all registered providers
 - b. Annual report with updates
3. **Reduce the number of central national data sets that social care providers input in to** – A centralised data set could be accessed by relevant stakeholders whilst reducing administrative time on providers.

Review and reform regulation

4. **Care Quality Commission to provide nationally consistent transparent Service Level Agreements to all providers** to define what services they receive for their fees and how often.
5. **Commissioners and regulators to provide consistent practical support** based on recommendations or to signpost to available free resources during regulatory exercises.

Improve access to policies and reduce requirements of providers

6. **Ensure local authorities cannot veto or confuse national guidance for care providers** - uniformity and parity of care delivery is required. Uniform systems to be in place for restricting guidance/policies and these restrictions should be made available alongside all policies etc.
7. **Reduce internal policies and procedures requirements for social care providers** – replace with practical and easy to follow plans. Flow charts or similar.
 - a. Required policies should be standardised and provided to social care providers instead of requiring them to create and maintain them themselves – national policy writing initiative.
 - b. Requirement of providers would then be to evidence internal processes that meet the set-out policies – rather than evidencing “all staff read and understood”
8. **Government Policies and guidance should be made accessible, including the use of accessible language.** Too many policies are written in a bureaucratic tone.
 - a. Ensure all come with easy read and text to speech versions.



EQUALITY DIVERSITY AND INCLUSION

Lack of Diversity/ Discrimination against Minority

Groups *“There is considerable disparity in the number of women in ownership and BAME people in senior management positions. This seems also to be true of people from the LGBT community and staff with disabilities.”*

The diversity of our society remains to this day one of the UK’s strongest attributes, yet representation from diverse and ethnic backgrounds is still disparate depending on the seniority of the position held. The State of Care report by Skills for Care⁷⁸ found that:

- While women constitute the majority of the social care workforce (82%) and of Registered Managers (85%), comparatively few women are owners, particularly of larger care home operators
- The Gender Pay Gap reports (where these exist) continue to evidence a persistent disparity between what women and men earn, primarily attributable to the over-representation of men at Board level
- “The adult social care workforce continued to be made up of around 82% female workers, the average age was 45 (with 28% aged 55 and over), 23% of the workforce had black, Asian and minority ethnicity and 16% had a non-British nationality.”⁷⁹
- Following the inclusion of social care on the shortage occupation list, SOL, (a past recommendation made in the People Plan), between February and August 2022, 11% of workers new to their role within the year had also arrived in the UK within the year. This was greater than the equivalent period in 2021 (4%) and 2020 (2%).”⁸⁰



This data supports previous surveys done on the adult social care workforce, but also shows the demand and reliance the sector has on international workers. Whilst the inclusion of adult social care professions on the SOL has been welcomed and will potentially stave off the collapse of the social care workforce, it isn't without its issues.

Sponsorship licences can be hard to navigate and obtain; costs of using agencies are increasing due to demand; added logistics of housing, providing additional wellbeing support, funding the costs of international recruits and the wariness of legislation changing (again) all add to the reluctance of investment from organisations. Individual organisations also struggle to keep up to date with new or changing international agreements and policies, and run the risk of contributing towards exploitative practices⁸¹.

Announced in February 2023 was the £15m International Recruitment Fund⁸² to help tackle the barriers of international recruitment, while upholding ethical recruitment and employment practices which should reassure some of the concerns of the sector, should the fund translate into practical and realistic support.

Then there is the question, "Is our workforce ethnically diverse enough?" On one hand we have people saying,

"Although our workforce is diverse it does not reflect our population"

and on the other we have viewpoints such as

"Lack of English care workers"

, with the latter being sadly all too common.

We could, in fact, infer that both these viewpoints are incorrect. The UK population data of the 2018 census which reported 86% of the UK Population as white⁸³ with the remaining demographic (14%)

made up of other ethnicities. This means our current workforce is 9% more diverse than the last population data set, but still predominantly white British. So neither is our workforce not diverse or too diverse.

If the diversity of our workforce is actually more diverse than our overall population, why does it still feel so white? The answer to this question can be found in the leadership of social care. When we look at managerial and senior leadership roles within social care, the diversity of ethnicities other than white British drops 7% from 23% to 16%⁸⁴. It tends to be the people in these senior roles that are sought for comment in the media, represent at tradeshow, or are cited as the influential leaders of the sector. If the diversity in these roles is lower, then it will appear that the sector is led and managed without diversity.

It would be patronising to say more needs to be done to encourage people of non-white British backgrounds into these roles, instead, more needs to be done to change the mindset of organisations, to ensure that they are paid equal to their white counterparts⁸⁵ and to change how we market and visualise the people in these roles. More also needs to be done to replace obsolete leadership with fresh and proportional representation.

Whilst we work to improve our inclusion of other ethnicities, we must not lose sight on ensuring that equality and inclusion include other areas such as gender, age, living with a learning or physical disability, living with mental health conditions etc and that continued work is required to ensure all are included in both the workforce and the people they support.

The number of people living and working with disabilities continues to rise, including those with "invisible disabilities", which is incredibly positive, however we must ensure we are doing all we can to ensure that social care is an accessible career choice for people living with and working disabilities. Again, the Skills for Care State of care report found that 24%⁸⁶ of the workforce identified as having a disability and 15% of people who responded to the consultation for this people plan identified as having a disability. Organisations like Purple Tuesday are doing tremendous work to



engage with organisations from all industries to ensure they are disability inclusive.

Whilst the State of Social Care report from Skills for Care reports well on the gender and ethnicities of our workforce, based solely on their own ASC WDS (adult social care workforce dataset), it completely omits any mention in all its 153 pages of our LGBTQIA+ workforce. In fact, after some extensive searching, it has been difficult to pinpoint any accurate or reliable data from a large enough data set to take an estimate of what percentage of the social care workforce identify as LGBTQIA+.

This lack of focus on the LGBTQIA+ workforce is concerning as in the period 2020/21 there were 17,135⁸⁷ recorded hate crimes against people based on their sexual orientation within society, specifically the workplace, and 2630⁸⁸ against transgender people, an increase of 7% and 3% respectively from the previous reporting period. This isn't a one-off increase, hate crimes against the LGBTQIA+ community have been increasing steadily year on year since at least 2016. Whilst many job adverts now encourage diversity within their applicants, and it's reassuring to hear that employers are doing more *"As a social care provider, I believe we employ and also provide support to a really diverse range of people"*, it's uncertain how much work is being done to support the wider LGBTQIA+ workforce whilst protecting them from abuse from both other people in the workforce and those they support.

Working in social care is often a physically demanding role which can impact individuals' physical health, especially musculoskeletal, and sometimes on a long-term basis. It's unclear how many long-lasting physical health conditions are a result of working in social care, but this is something which needs to be addressed when considering improving the accessibility and inclusion of the workforce. Individual organisations need better training on Occupational Health including how, when and where to signpost team members who have either new or ongoing physical health conditions which require additional support such as Physiotherapists or Occupational Therapists. This

will help retain the workforce, whilst simultaneously working to mitigate some of their potential future care needs when they leave the workforce and help maintain their personal independence for longer.

Not Meeting the Needs of Those Using Care

This People Plan is just that, it's a plan for the people in social care so we must look at how we are currently supporting the equality, diversity and inclusion of the people being supported by the social care system.

When it comes to supporting diversity within care settings or care communities, our consultation shows there was a consensus that as a whole, we're not meeting the needs of those using care.

Not meeting service users' needs

- *The barriers can mean the real impact is felt by the people receiving the support.*
- *Very poor, not enough funding to look after the people who need it the most.*

There is a belief that *"if you can afford the care you get the best care, not enough government funding for the people that really need it"*. The idea that receiving good care is predicated on the ability to afford it is concerning on every level, especially as people from ethnically diverse backgrounds have higher levels of poverty than those who identify as white-British⁸⁹. Approximately 20% of the UK population are currently living in poverty across all demographics and ages⁹⁰. Without support or drastic changes, we will continue to see those from diverse backgrounds, especially when they have multiple factors which intersect with their income levels (e.g., age, gender, sexual orientation, living with a disability), struggle to access adequate quality care.

There is also the concern that there is *"resistance for people that are from ethnic*



backgrounds to take up social care as its usually a stigma in society.” Whilst it’s important to support the growth and continuity of our diverse communities, there is also a duty to ensure that our health and social care system is effective in its support of them. This may be through adapting in part the deliver or commissioning of care, but also potentially an educational aspect to highlight the importance of accessing care services and breaking down the stigmas⁹¹.

Some feel the easiest solution would be to have ethnic specific care homes, but currently it is *“Really difficult to find Indian/specific ethnic care homes”* and, furthermore, self-segregation may further the disparity in social care services.

People living with disabilities are slowly gaining more control over their care needs, how it is commissioned, and planning their life outcomes. However, this progress isn’t happening fast enough. TLAP (Think Local Act Personal) are leading the way in ensuring people with disabilities are leading the conversation in what they need, influencing government policy and social care reform. In the ‘3 Rs’ for Social Care Reform’ report TLAP suggest that risk-taking, respectful relationships and a sense of reciprocity are key to responding to the aftermath of the pandemic and indeed social care reform.

Positive risk taking should not sound or be an innovative concept, but sadly that’s how it feels. Positive risk taking had been promoted and encouraged in the years leading up to the pandemic, with many providers making great progress in ensuring people lived their lives with an equal balance of risk and life satisfaction. Since the pandemic began, this work has been lost with many now focused on risk aversion and minimisation rather than the promotion of life quality. It should, however, be recognised that this reluctance to shake off the risk averse approach is heavily influenced by restrictive government policies. Even when less restrictive policies are introduced by national government, these tend to then be superseded or ignored by local governments.

Sadly, as with the social care workforce, there is little research into treatment and care of people who identify as part of the LGBTQIA+ community. A Stonewall study the formed the basis of their ‘Unhealthy Attitudes’ report⁹² found that only 10% of health and social care employees say they are not confident in their ability to understand and meet the specific needs of lesbian, gay or bisexual patients and service users, and 24% saying they are not confident in their ability to respond to the specific care needs of trans patients and service users.

There is clearly more to be done to support the LGBTQIA+ community, especially as they face additional health inequalities than their heterosexual counterparts: non-heterosexual men over the age of 50 have a lower life satisfaction, non-heterosexual people are more likely to have attempted to take their own life, be more likely to smoke and have adverse mental health conditions⁹³.

It’s because of these inequalities that more research is required into how social care settings can further support people from minority backgrounds.

Government can do More

Many of the people consulted for this people plan believe the government can and should do more to support the diversity of those using social care and those in its workforce. Existing inequalities and inequities in how people use or work in social care are further exacerbated by regional inequalities and disparate funding, infrastructure and support for different regions of the UK.

The Care Quality Commission (CQC) for example requires all social care providers to adhere to the Accessible Information Standard⁹⁴, which aims to ensure all people with disabilities, impairments or sensory loss are able to access and understand the information they require in a format that is most suited and accessible to them. This requirement is something providers must evidence within inspection frameworks. However,



when it comes to inspection reports by the CQC that are made available to the public, only those for learning disability services are immediately available in an easy read format. Most inspection reports for older people’s services and most health services such as dentists, GP surgeries and hospitals do not have readily available easy read versions of their inspection reports. This omission instantly isolates a portion of our society from being able to access information to make a fully informed decision without first having to navigate the process of requesting such information. This in turn means people who rely on easy read documents to make informed decisions then instead rely on loved ones which takes away their freedom of choice. This places a higher support requirement on the sector than the regulator itself.

While some believe that the CQC have an **“Inadequate awareness by the regulator which is unable to assess this adequately.”**, others say they have little faith in **“a regulator whose Board is made up of predominantly white people and an executive team that is all white with only one female”**. Indeed, as of the time of this report being written, the CQC board is comprised of 80% people who identify as male, 20% of people who identify as female and when it comes to ethnicity, only 20% are people of non-white backgrounds and this 20% is 100% male. CQC seem to be aware of this and have addressed this in their 3 year strategy⁹⁵, however there are concerns that **“it’s all talk, nothing will change”**.

There is work being done within government and within local authorities to improve the diversity and inclusivity of workforces, the LGA for instance has an Inclusivity Guide⁹⁶ for local authorities to adapt. However, the impact of this appears to be minimal in the awareness of those working and living in care. Members and respondents to the consultation said:

- *I think there is lots of awareness on social media, however it is not known if this is making its way into care services. I think the awareness is present but the action to resolve and stamp out inequalities is still very present and slow to action.*
- *Unrepresentative and disconnected.*
- *Improving but still needs a lot of work. More diverse recruitment is needed. more training opportunities and leadership needed for minority groups.*

Employers can do More

What was refreshing from the consultation for this report was the fact that responsibility was not solely placed on the government to improve EDI within social care, but instead a strong emphasis on the responsibility of organisations and employers was highlighted.

Observations were made that

“EDI is better in NHS than social care, perhaps to the variety of private providers who fail to follow policies around EDI” and **“More work needs to be done in this sector, especially in organisations which haven’t moved with the times”**.

True, the fragmented nature of the social care sector makes it difficult to ensure that all providers are adhering to suggested national policies regarding promoting equality, diversity and inclusion, but some argue that their

“demographic is predominantly white UK people, working on diversity can be time consuming for us when it doesn’t really apply”.

Diversity and inclusivity doesn’t stop at ethnicity or gender, but also includes improving inclusivity and accessibility for people living with learning or



physical disabilities, members of the LGBTQIA+ community, people of different ages and mental health conditions etc.

Perhaps work needs to be done to minimise the individual responsibility for creating EDI strategies within social care and, instead, a national approach should be standardised and provided to employers. These approaches should not be limited to the workforce. They should also be applied to those using care services, and possibly with more urgency.

- *Needs improvement. Archaic views still in workplace. Decisions based on costs*
- *More work needs to be done in this sector, especially in organisations which haven't moved with the times.*
- *I think EDI continues to be an 'after thought', it is something always placed at the bottom of a very long list for providers/RM's, minimal resource, investment is allocated and it is seen as an 'optional extra'*
- *There remains work to do. In particular, for the LGBTQ+ community using social care services. The generation using elderly services is set to shift in coming years, and this will provide more openly sexual and gender diverse residents in homes, something at present, they are not used to or equipped for in terms of knowledge and training. Further training, development etc. is required within social care around this.*

Lack of Training

As we learned from the first People Plan, there is a consensus within our membership and the wider public that training in social care is currently not fit for purpose. It, therefore, should come as no surprise that the majority of people who responded to the consultation for this white paper believe that equality, diversity, and inclusion training also needs to improve.

Equality and diversity make up Standard 4 of the Care Certificate. However, as the Care Certificate is not a mandated or enforced requirement within social care, or the fact that it is not an accredited or standardised qualification calls into question its current reliability or quality of application to better educate the social care workforce.

As the reliance on international workers grows, organisations must be prepared to increase their awareness of other cultures and beliefs, and this should be reflected within their training:

- *There are so many staff members that are coming into the sector without English as their first language, we need to ensure that all staff have relevant EDI training that can help them. We are also now needing to recruit from abroad due to lack of staff locally wanting to work in social care so again it is important that we can keep the sector appealing to them and we can retain these staff too*
- *We need to educate better in terms of different cultures, abilities, and promote an open culture*
- *People are leaving their homes, families and support structures to come work in the UK. We have a responsibility to ensure that they are welcomed and supported when they arrive which covers more than just practical support such as housing and transport, but also their emotional wellbeing, access to social activities and hobbies etc. Otherwise, asking international workers to move to the UK is little better than indentured servitude.*

Respondents to the consultation also said:

- *EDI should be an integral part of each process in any business and the same for social care. Social care falls behind, because we do not have clear consistent promotion or development pipeline in Social Care*



- *People have very little or no training on how to support with people with disabilities.*

Training to enhance the lives of people with disabilities is essential. There are many organisations now that aim to bring awareness and support such as Living 4 Moments Ltd⁹⁷ began by providing bespoke disability training, in this case around hearing loss, but have since branched out in to learnings about other disabilities. Living 4 Moments is a key example of how disability training should be developed and delivered as hearing loss has directly impacted its founder.

Another organisation aiming to break the stigma around disabilities and to get organisations more accessible and supportive is Happy Smiles Training CIC. Happy Smiles is a community interest company that aims to empower disabled people to create positive social change, create more inclusive, resilient communities and provide positive role models for young disabled people.

Whilst there are positive examples of training out there, very little training is actually a requirement in social care, or any other industry for that matter. Dementia training whilst prevalent in elderly settings is often overlooked in other settings as is disability training overlooked in elderly settings.

As the workforce becomes more diverse, and as the communities that access social care grow and diversify, the need for more inclusive training is become essential. Opening Doors⁹⁸ is delivering more training to organisations to help better support LGBTQIA+ people whilst LGBT Youth in Care⁹⁹ does similar but with a focus on the care experiences of younger people in care.

Again, whilst these training opportunities clearly exist, there is a financial restraint and time restraint experienced by care providers in order to access such training. This financial and time obstacle is in part, mainly due to the requirement to regularly undertake mandatory training and mandatory training refreshers. The lack of ability to transfer training qualification from one organisation to another adds to this burden not only for employers and their budgets, but for all care professionals and their job satisfaction. Less restrictive training requirements would free up organisations to explore and undertake a wider variety of training in order to enrich the lives of those they support and their teams.

Recommendations to overcome this have been made in the People Plan for Social Care and most recently, Florence have introduced a CPD Academy¹⁰⁰ which hopes to bring training passports from idea to reality.



Recommendations

Create Opportunities

1. **Provide funding support for paid internship placements for people from diverse backgrounds** into senior management or leadership positions. This could be funded through the workforce development fund or apprenticeship scheme.
2. **Develop and produce holistic support for international recruits and for organisations** using the international recruitment Fund. This should include recruits living in the UK awaiting or applying for citizenship.
3. **Develop culturally appropriate support networks** in partnership with the Department of Health and Social Care and other workforce groups such as Skills for Care, the LGA, CAA, Institute of Health and Social Care Management.

Develop robust strategies

1. **Support the development of Diversity and Inclusion strategies for Health and Social Care.** This could be through downloadable resources, interactive webinars, or digital training resources. This could be funded through the use of the workforce development fund provided by Skills for Care.
2. **Include data capture questions about the LGBTQIA+ workforce within the Adult Social Care Workforce Data Set (ASC WDS)**
3. **Conduct a review independent from Skills for Care of the engagement and awareness of the ASC WDS in the social care workforce.**

Increase knowledge and awareness

1. **Fund a national campaign about supporting people going through the menopause in the work place in health and social care.** This should include training and resources for all employers and people working in social care.
2. **Fund a national campaign about supporting people who develop physical health conditions, e.g., musculoskeletal ones, as a result of working in social care.** This should include training and resources on Occupational Health for all employers and people working in social care, and how/when to signpost teams to additional support such as Physiotherapists or Occupational Therapists.
3. **Department of Health and Social care to conduct or commission a report into the levels of discrimination against protected characteristics within the social care workforce.** This report should also investigate discrimination against people who draw on care services.
4. **Invest in Leadership and management training focusing on developing internal strategies and approaches to improving and supporting organisation diversity.** The Institute of Health and Social Care Management, or similar, could develop a structured leadership course to support the leaders within health and social care to promote and develop diversity of all types across all business areas.



Greener Care

Not enough is being done right now “Greener care isn’t on the agenda as much as in the corporate world - this sector is behind 10-15 years.

If we’re being honest, when we mention “greener care” more often than not we are met with vacant looks, a lack of understanding, but usually a desire to want to do more. Considering that approximately 5% of the UK’s carbon emissions come from health and social care alone and that the Lancet described the climate crisis as the greatest threat to global health of the 21st Century¹⁰¹, we cannot talk about a People Plan for the future of social care without including the impact of the climate crisis in it: it’s a crisis that is already and will continue to affect the health of our population and, therefore, the care and support they receive.

What has been evident through this consultation is many in health and social care feel that not enough is currently being done by the government, the social care sector, or even by society as a whole, but they want to do more. They understand the importance and necessity of moving to net zero, but are unclear of where to start, especially without wider support. Some of the responses we received were:

- *Almost no mention of working in a green way in the NHS.*
- *Greener care isn’t on the agenda - as much as in the corporate world - this sector is behind 10-15 years. Decisions are not made with this in mind - decisions made based on cost effectiveness.*
- *The amount of paper produced by the assessment system is horrendous, 10 years in why am I still receiving paper copies, when they could email.*
- *Things are thrown away too quickly - If we analysed the amount that care contributes to landfill, I can imagine it’s all too high.*

We need to become more sustainable as a sector.

- *Greener options is for the ‘rich’ and it’s too expensive to be ‘green’. In an underfunded system and world we are in social care, the last thing we can be paying for is all the costs that it takes to go green despite all of us knowing it is for the greater good.*

A survey by YouGov survey, conducted in August 2021, found that 87%¹⁰² of NHS staff supported the NHS Net Zero ambition. It may be reasonable to assume that care workers would give a similar response to questions asked about their own sector but have not yet been asked.

Care workers are a critical part of the complexity of local communities and are uniquely positioned to support individuals in the context of their own place and circumstances and connect to the environment. It is encouraging that those working in social care are environmentally aware but concerning that they feel their commitment and drive towards sustainability is not met elsewhere.

There are such huge similarities in the cradle-to-grave responsibilities of the care and health sector, that it is surprising that there has not been more progress in identifying and sharing opportunities for the care sector to decarbonise. Part of this may be due to the fragmentation of the care sector, with social work primarily the responsibility of Local Authorities, whilst much of the remaining critical care services are part of a mixed market economy including private, public sector, and third sector providers. However, part of the reason is also due to the regional disparities in place: [some councils, districts and boroughs](#)



[have declared climate emergencies](#) allowing them to higher prioritise supporting net zero initiatives, but others have not.

With the number of adults aged 85 years and older projected to increase by 77% from a base-line in 2019 to 2040, from 1.4 million to a staggering 2.4 million in England alone, there will need to be a radical rethinking of the way in which care is provided in order to reduce the pressures on clients, carers and their families and to ensure the responsiveness of the health and care system.

In addition, the life expectancy of infants and young people with complex medical conditions has extended significantly with the advances in medical care putting further pressure on already overstretched resources of Local Authorities, Schools, and Health Services.

It is of no surprise then that this sector has been distracted from the climate emergency whilst dealing with the combination of this, to be celebrated, population tsunami, a worldwide pandemic, the impact of constraints on employment of international workers, and now an escalating cost of living crisis, combining to make a perfect storm.

In fact, the financial implications of adopting greener approaches to care deliver were some of the most common responses to this consultation:

- *Who has time for greener care when we have no money ?*
- *Very little. Providers are asked about this by commissioners and there are expectations surrounding this in contracts but there has been no additional funding or grants to support providers.*
- *More costly for providers. No incentives or support to adopt greener practices*
- *Nothing. Most organisations are challenged just to maintain a financially sustainable service*

While some may consider it unlikely that climate issues may make their way to the top of the list of people who are struggling with day-to-day survival and support issues, there is clear evidence that the impact of climate change has a

significantly bigger impact on those that are disadvantaged. Vulnerable individuals and families are affected disproportionately by poor quality air and housing, and high costs and limited income restricts their choices.

In addition, researchers from McKinsey & Company found that companies which pursued sustainability with the genuine aim of creating additional value for society (not just attempts at greenwashing) generated higher profits for their organisation in both the medium term (3-5 years) and in the long term (5-10 years) than those which did not pursue sustainability¹⁰³.

From a legislative perspective, there is growing work within the bodies which create and update financial accounting standards that increased and more detailed sustainability related disclosures in statutory financial statements of organisations of all sizes are likely to come into effect, possibly sooner rather than later. Care providers and settings will need to start looking at sustainability practices soon if they haven't already done so in order to future-proof their organisations against future regulation. Therefore, both the increased long-term profitability and future-proofing against future regulation provide a business case for the necessity of pursuing sustainability, not just an emotional or ethical one.

Lack of support, awareness and Understanding

“There are far more pressing issues with a terribly broken system than being seen to be green”. This is the viewpoint of some of the respondents to our consultation. Indeed, we've addressed throughout this People Plan White Paper and, in the People Plan published in 2021, the myriad of issues currently plaguing the system, but does that mean there is currently no place for adapting our delivery methods to also care for the environment? This is probably more than a yes or no question and more of a “Who is primarily responsible for supporting the change?”

The People at the Heart of Care 2021 report on social care made no link or comment on the



consequences of climate change to the wider population, although extremes of temperature and the potential of flooding will have an inevitable impact on the people that the UK government has a responsibility to protect.

However, seven months later, the Health Care Act of 2022 embedded net zero by 2050 into legislation and required “all NHS trusts and ICBs to develop a ‘Green Plan’ with a responsible Board-level lead to detail how they will reduce emissions by the planned net zero date”¹⁰⁶. Yet, as most social care providers haven’t even received an introduction to their respective ICB in the eight months they’ve been operating, it’s unclear how making ICBs legally responsible for sustainability transformation will translate into direct action in the social care sector specifically rather than just the NHS alone. Once again, strategies are being announced without due consideration for joined up work between both sectors.

Connecting people, understanding their circumstances and connecting to the environment

The inter-relationship between health and care cannot be underestimated, with a direct and linear consequence to the access to timely emergency care now becoming increasingly apparent to politicians and the wider populations as ambulances continue to stack up at the doors of most A&E departments across the UK.

Two most distressing and illustrative examples may be those of Ella Kissy-Debrah¹⁰⁷, a 9-year-old whom the coroner described as a death directly related to an exacerbation of her asthma due to pollution in the roads around her house in London, and Awabb Ishak¹⁰⁸ who died at age 2 from chronic and prolonged exposure to the mould in his families flat in Rochdale. Both are tragic examples of the impact of the inability of the system to recognise the wider implications of the pollutants and consequences of poor-quality insulation in the increasingly unstable climate conditions across the UK.

Understanding the climate problem

As the temperature of the globe increases due to the human impact of industrialisation in parts of

the world, the climate becomes increasingly erratic, with extremes of heat and subsequent changes to historical weather patterns. This disruption happens as the ozone layer protecting us from the heat of the sun is depleted, and the amount of carbon dioxide in the atmosphere rises. The resultant increase in temperature has resulted in droughts, extensive floods, and devastating fires with inevitable impacts on both humans and wildlife. Biodiversity is under huge pressure with, on average, a large decline across tens of thousands of wildlife populations since 1970 due to changes to the fine balance of their natural environment compounded by the extension of human activity encroaching into their habitat.

At a local level, many people in urban settings have experienced increased heat, with the UK experiencing officially the hottest year on record in 2022. Whilst some rejoice in the additional sunshine, the consequence of this is more significant for others, with a measurable increase across Europe in respiratory and cardiac events and deaths due to heat stroke. Keeping older people cool in such extreme circumstances can be a major problem, with many trapped in their homes and suffering isolation whilst attempting to maintain a reasonable core temperature.

Hospitals and care homes struggle to provide environments that are stable and reasonable, during periods of extended high temperatures and have sought to be creative with iced beverages, shady spaces, and closed curtains along with fans to attempt to maintain a reasonable body temperature for patients and clients alike. Those major businesses that can afford to take action invest in additional air conditioning units for their outdated buildings, and in doing so compound the environmental issue. There is also the debate regarding air conditioners spreading viruses throughout a building that is not well ventilated.

On the other end of the spectrum, a significant number of people living with physical disabilities and complex health conditions who rely on electricity to run their support machines have had to choose between ‘eating and breathing’ due to extortionately high energy costs over the last



year, primarily led by high prices in fossil-fuelled energy and poorly insulated housing¹⁰⁹.

Moving to Net-Zero

Net-zero is the fine balance achieved when an individual, organisation or country has no impact on the natural resources that it necessarily consumes, as these resources are limited or replenished by means that are not damaging to the planet. An example of this would be the move to green energy, where natural wind resources are captured to turn turbines which create energy in the form of electricity. The balance is sensitive and will require a significant and mass change of habits and attitudes if we are not to outstrip the limited resources available in perpetuity.

The UK government has declared its commitment to delivering on climate change and in 2019 became the first major economy in the world to introduce legislation with a binding target to reach net zero emissions by 2050. To deliver on this ambitious but necessary aim will require all sectors to 'green' their activities including those within the health and care sector.

Greener NHS

The NHS in England has a net-zero plan and has publicly stated it wants to be the first healthcare system in the world to become net-zero. Healthcare, devolved in responsibility in other nations has had similar commitments to reduce carbon footprints from both the Scottish and Welsh governments, with the Northern Ireland draft plan awaiting ratification.

Whilst the aspirations and examples in the "Net Zero Strategy; Build back Greener" (UK Government, 2021) have needed to be translated into a more practical and granular service-specific level in the Greener NHS Plan (2022). This document describes the roles and responsibilities of service providers, purchasers, and partners in the necessary journey to Green the NHS, backed now by legislation mandating changes in practice. In addition, the clear lines of communication and control have resulted in a change of behaviours, with NHS organisations now required to collect and report specific details of their climate activities and detailed 'Green Plans' available for public scrutiny.

Greener Care

This direct comparison with the lack of clarity for the care sector is stark, and in part due to the fragmented and local responsibility for the delivery of the majority of these services. It has, for example, been impossible to date to attempt to make anything but the highest-level estimate of the carbon footprint of the care sector, made up as it is of multiple individual services. In direct contrast, the NHS has a confident baseline, built upon the aggregation of sources from all sectors of health, which gives a clear way to measure progress.

In contrast, whilst the same response has been required of Local Authorities, there appears not to be the granular detail within publicly available documents of the direct impact of the care sector hidden as it is within their wider responsibilities with almost no information available about services outsourced to private providers.

The ambition to reduce the carbon footprint of the care sector, although challenging to measure, remains an aspiration for all UK nations. Further encouraging work has been undertaken by Scottish Care, a membership organisation representing private providers across the country, which urges national attention to be given to achieve a "development strategy in social care that embeds sustainability environmental concerns and supports inclusive climate action".

As yet, only the Welsh government has published their "decarbonisation of the care system"¹¹⁰, which may prove to be a blueprint for other nations. However, it does give some clarity about the proposed approach which plans to appraise the assessment of the carbon emissions of the social care sector, improving the approach to data management before mandating the reduction of carbon emissions through new procurement contracts for social care providers and the social care related supply chain.

We would be wise to endorse the call to action of Scottish Care to "explicitly incorporate the Net Zero vision and other sustainable policy actions into social care to uphold an intersectional, equality and human rights-based approach to deliver social care in a changing climate".



A focus for action in the care sector

Although the care sector may be less environmentally damaging than the health care sector, there are some similarities to some of the service models where there could be some easy and immediate comparisons for action.

The term “Scope” in an environmental context first appeared in the Green House Gas Protocol of 2001 and forms the basis for mandatory greenhouse gas (GHG) reporting in the UK.

In the three categories of emissions, Scope 1 covers those emissions that an organisation makes directly, for example, the emissions from running the boiler in a care home. Scope two are the emissions made indirectly, like when the electricity it buys for running the lighting, or the ovens in a day centre is being produced on its behalf. Scope 3 emissions are those that the organisation is indirectly responsible for along its value chain. For example, if cleaning materials or PPE are purchased for care-at-home workers from a supplier, the impact on the environment comes from the products both during manufacturing and when they are used or disposed of.

In healthcare Scope 3 emissions account for 60%¹¹¹ of the impact of healthcare, and these are the most difficult emissions to impact. That explains why, in the first instance, the NHS Greener Care Plan is focussing on those issues where it can have the most control, heating, reducing waste, and the delivery of greener clinical services. New procurement procedures have also been proposed which will compel businesses supplying services to provide evidence of their green credential.

In the care sector, there will be an additional layer of complexity, with many of the providers potentially being impacted by new procurement rules of purchasing Local Authorities, and the financial consequences of delivering a greener pedigree to secure an ongoing contract having the potential to compromise the fragile market. Whilst this approach will be anticipated by mainstream businesses, it may prove more challenging for smaller private or third-sector providers.

Where to start

Local Authorities should attempt to disaggregate the carbon emissions from their total footprint to one that can be attributed to the care system under their direct control. This would then, at least give an indication of a baseline from which any changes to service or practice can be measured.

Given the fragmented model of services already discussed, it will be important that providers are supported to also develop a baseline of their carbon emissions, even if that begins simply with metered energy use.

Whilst there are many small and engaging projects that can be shared across the whole sector, the main areas of reducing the impact of buildings and heating, sustainable transport, and the use and disposal of PPE are obvious areas of global impact.

This should be supported in parallel with a carbon literacy programme to support leaders and front-line staff to ensure that they understand both the need for change and their personal contribution to reducing global warming.

It is our experience that staff across the health and care sector are keen to engage in this type of education which will help them to better understand the professional and personal contribution that they can make. Katharine Hayhoe’s [Ted Talk](#) provides a short and easy blueprint of how to discuss the climate crisis with people who don’t believe in it or know the importance of acting swiftly because talking about the climate crisis regularly is one of the easiest and most significant ways an individual can contribute to tackling it¹¹².

Centring the experience of people receiving care in the heart of sustainability policies is critical. For example, one respondent mentioned how they’d switched to LED motion-sensor lights to reduce their CO2 emissions, but found that it disorientated people living with dementia so they had to then add switches which would allow residents to manually turn the lights on and off.



In order to maintain motivation and maximise engagement, the professional bodies that represent workers in the care sector should be supported to take action, and share learning. There is good evidence to show that a contribution assists in removing a feeling of climate anxiety.

Local projects

Whilst the impact of local projects may be seen as minimal, each and every activity will make a positive contribution, and will have the added benefit of raising the profile of the importance of the climate emergency. This list is not meant to be complete, but more to ignite ideas and focus minds on the possibility of small changes which will amount to a big difference.

Reduce-Reuse-Recycle

When considering climate action, a jump to recycling often is suggested as a positive step. Whilst recycling is to be encouraged, there are two important and earlier steps. First to reduce the number of things that are required, as then there is less need to have them manufactured and no need to think about how they might then be disposed of.

Before considering the disposal of any materials we should consider their reuse as one of the respondents to the consultation pointed out *“Recycling of equipment needs to be considered. I've just put a toilet seat riser in my household waste. just wrong. My dad's catheter plastic waste was thrown in household waste too”*.

Creative uses of things that are necessary for use in the sector, for example, the reuse of linens or curtains, clothes or shoes which may be welcomed in other services or sectors.

Only after these two steps have been considered should we move to recycle. There are costs and consequences for recycling, and contamination can often result in the final landfill of those items being carefully separated. This is not to say that this is not a habit to be encouraged but to change the behaviour of manufacturers we will need to push as consumers and purchasers for them to provide more environmentally friendly packaging and materials for our use in care services.

What are the Solutions?

Cleaning and Laundry

There are many eco-friendly products that are now available for the care home market, which reduce the impact of the toxins in the water.

Reducing the temperature of the wash, maximising the load, and using eco-friendly washing products will also have a positive impact.

Micro-plastic catchers installed into the exit of washing machines prevents the discharge of these materials into the waste system.

Food and waste

Moving to more plant-based foods has a significant impact on global warming, as there is a larger carbon footprint from the farming of animals than from arable crops.

Having a 'meat-free Monday' or no meat before lunchtime are examples of changes that are impactful but not too compromising on carnivorous diets.

Smaller portions, from single containers, allow clients to make choices about the amounts of food served and reduce potential waste. Redirecting any waste to animal feed or composting projects further supports a cyclical economy.

The reduction of individually portioned foods and drinks, such as juices and separately packed cake prevents unnecessary packaging, and good processes for the delivery of fresh foods ideally locally sourced would support this effort.

Supporting local producers and providers to purchase seasonal foods is another way to reduce costs and food miles. Each and every mile of transport comes with a carbon contribution.

Heating lighting and cooling

It may seem obvious to mention improvement to insulation and moving to low-emitting bulbs, but it is surprising to see how many providers and homes have not already taken this action.



Staff providing care in the homes of clients may well see these opportunities to provide ideas or support to make changes which will also help to reduce costs.

Changing bedclothes to modern materials which are warmer without weight is an easy way to help to maintain heat in cold environments.

Closing curtains to maintain a cooler indoor temperature is a practical way to reduce the impact of hot days.

Procurement decisions

Many pieces of furniture that are designed for use in a care setting are made from materials that contain toxic plastics from their fire protection or softening agents. Suppliers should be asked to provide alternatives with non-PVC materials that will reduce the plastics in the environment without compromising safety.

Even vinyl floorings have a significant plastic content, with the chemical phthalates (PVC softeners) in common vinyl flooring taking up to 60% of which can leach into the local atmosphere and cause respiratory problems.

Refurbishment of buildings and rooms should take into account the materials used and include draft exclusion options to maintain building temperatures.

Travel and transport

Care services are often dependent upon transport, for both staff and clients whether being taken to a day centre or delivering care direct to someone in their own home so attention should be given to greener transport and active travel.

As well as investment in electric cars, there are some examples of subsidised bike and trike options for staff within close areas to prevent emissions and assist in active lifestyles.

Concerns raised through the consultation included:

- Some of my dad's carers walked or cycled between clients. Mainly due to low

wages. Goodness knows how that must be 18 months on in the current crisis.

- Travel to both acute care and social care tends to rely on transport by car. Work is needed to align public transport systems.
- Cars are overused by care assistants for starters.

Personal Protective Equipment (PPE)

The necessary explosion in plastic PPE has inevitably seen more of these items sent to landfills. Keeping staff safe is of paramount importance, but there are often examples of PPE being used when not necessary, and simple good hygiene would suffice. This is most evident when gloves are used for all care tasks resulting in complacency in both hand hygiene practices or changing and replacing gloves between each task.

Many of the items used regularly, such as aprons and face masks have been developed into reusable and washable items with the price per use now decreasing. This, of course, must be offset by the carbon cost of additional washing but the move to reusables is gaining momentum and will ultimately be a good solution to meet the needs of the care sector.

Plastic gloves are also not always necessary in the delivery of care, so careful reconsideration of the protection required and the impact of the plastics being used should form the basis of a local discussion.

Hope for the future

One of the key themes which arose in this section of the consultation was the importance of communication and collaboration: many of the examples cited were provided by respondents who have already started implementing individual changes that have proved to be beneficial to either themselves or the people they support, who want to do more, but require a lot more support from either their organisation, their local authority or their local community.

This section of the people plan was contributed to by Dr Elaine Mead, PhD student University College Dublin, Director Improvement, Care and Compassion¹¹³



Recommendations

Understand the current situation

1. **Conduct an environmental sustainability audit of social care providers and the sector as a whole to understand the current landscape of how and where social care is contributing to the climate crisis** (similar to how this was calculated for the NHS), whether it's calculating the sector's carbon emissions or impacts on local and national waterways etc.
 - a. As part of the ICB's legislative responsibilities to develop a 'Green Plan' with a responsible Board-level lead to detail how they will reduce emissions by the planned net zero date¹¹⁴, ICBs to coordinate and organise the sector-wide environmental sustainability audits
2. **Undertake and provide national training to those running care businesses on greener and more sustainable approaches, including templates on building the business case for becoming more sustainable.** This exercise should be conducted by the Department of Health and Social Care or commissioned to another official body, such as Skills for Care or the Institute of health and Social Care Management.
3. **Undertake a national consultation with social care providers to determine how environmental sustainability initiatives could be affordably adopted.**

Support to make change

1. **Department of Health and Social Care to Develop action plans/ contingency plan templates** for all types of care services to help with developing and adopting greener care strategies. This should be done with a working group of providers and other organisations such as, The Institute of Health and Social Care Management, Skills For Care, Care Association Alliance etc. other contingencies to consider are:
 - a. Include winter contingency plan for energy/heating/water
 - b. Contingencies and support around power outages – LA contingency to supplement and support SC Contingency
2. **Develop and deliver government funded/commissioned training and development to support organisation with their understanding of sustainable approaches.** This training should be available in multiple versions to support various positions within organisations – e.g., aimed at Directors, managers, housekeeping teams. This training should be commissioned and delivered with practical resources and support guides.
3. **Provide funding initiatives that work alongside other stakeholders in the solution** to help the sector achieve a more sustainable future.
 - a. Public transport discounts for workforce including against congestion charges, ULEZ charges and other
 - b. Discounts on hybrid/electric vehicles – business purchased or individuals.
 - c. Discounts/funding for greener energy models including reusables such as solar energy panels
 - d. Upgrades to laundry equipment to reduce microplastics.
 - e. Provide discounted or free parking/ social care parking permits, for care professionals who are out doing care work.



What Happens Next?

Some of the wider public will believe that social care has now been fixed because of the Social Care Levy. Others will believe that the biggest issue facing the NHS and social care is the inability to effectively discharge people from hospitals back to their homes or care settings with appropriate care packages in place. In reality, social care's issues are a long way from being resolved, and although pithy headlines or social media sound bites may give the illusion of change, they need to be backed up with nuanced and well-thought-out strategies which centre both the people receiving care and the wider workforce.

The next election in 2024 will likely see all of the political parties claiming **only they** have a valid plan to reform social care. What is actually needed is cross-party collaboration and work to create a joined-up strategy which will be effective regardless of which political party is in power or not. The 2021 and 2022 People Plans have provided not only the building blocks for a long-term sustainable strategy, but have also proved the value of how collaboration and engagement with multiple stakeholders across social care can help create innovative and impactful recommendations.

Now that this People Plan has been published, our Social Care Innovators People Plan sub-committee will continue to meet regularly to discuss future recommendations for revisions of this plan, as well as identifying other areas that require consideration and support. The coming year (2023) will be focused on working in collaboration with different stakeholders on action plans for implementing some of the recommendations from both reports so that the next report in 2024 will be able to include progress updates on the changes occurring within the sector.

An ongoing survey will be available to provide feedback about this report. Data from this survey will be used to inform future revisions of this plan. The link for the survey is:

<https://www.surveymonkey.co.uk/r/XYZP8JP> . The People Plan sub-committee will also host round tables and other virtual and potentially in-person forums to invite wider discussion and input on both the action plans and future versions of the People Plan. Over the next twelve months, we are going to have a stronger focus in encouraging engagement from social care providers, primarily around good and outstanding practices.

Ideally, we would welcome communication from local and central government, namely the Secretary of State for Health and Social care, and the Minister of State for Care and Mental Health to discuss coproduction options moving forwards to help further unite and represent the social care sector. Finally, we will be looking to work with other representatives of the social care sector, including providers and leaders, to begin actioning the recommendations within this People Plan.



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People Plan Introduction	Public Image	Recruitment	Training	Retention	Pay and Conditions
Professor Martin Green	Marlene Kelly	Michelle Reynolds	Mindy Sawhney	Jay Dodhia	Joan Bothma
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Joan Bothma	The mother of someone who draws on care		Paul Blane	Martyn Dawes	
			Rachel Barber		



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Finally, we would like to acknowledge the support and dedication of our sponsors **UK Care Week**¹²⁴.



- ¹ <https://ihm.org.uk/>
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