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The Social Care Workforce in England

THE CURRENT POSITION AND THE CHALLENGES
OF SUPPLY



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THE SOCIAL CARE WORKFORCE IN ENGLAND

The current position and the challenges of supply

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King's **Fund**

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Summary

Social care services are very labour intensive so the availability and quality of staff is critical in achieving the desired outcomes. This section considers the current position with the workforce, whether labour force meets demand, and what constraints will affect future supply.

- In 2003/4, an estimated 559,000 people were formally employed in England providing 'core' social care for older people, not including around 120,000 further NHS staff also doing some care work for older people.
- Staff costs represent a significant proportion of care costs. For instance, wages for care assistants average just over half the unit costs of local authority commissioned home care services. In care homes, staff costs are estimated to account for just over half the weekly 'fair price' for care homes providing personal care, and nearer two thirds of the 'fair price' for homes providing nursing care.
- Pay rates for social care jobs have for some time risen in line with or at a faster rate than the average earnings index. Prior to 2002, rises in pay rates for this group were lower than inflation, but since then, they have been in line with or higher than inflation. The relationship with the national minimum wage has been variable.
- The limited information available shows that vacancy rates are high, both absolutely and relatively. In 2004, for example, there were 53,000 vacancies for social workers, occupational therapists and other care-related occupations notified to Jobcentres in England. This potentially imposes a significant constraint on service expansion.
- Wider use of technologies, such as telecare, could influence the quantity, skills and price of care staff in the future, and other influences also exist.
- The social care workforce is increasingly monitored and regulated. This improves quality but can also push up costs.
- Perceptions of care work are generally not positive, among either the public or the staff themselves. Pay levels, conditions and career prospects are all factors in this. Perceptions of the care staff themselves, however, can be positive.
- Quality of care provided is variable. There is insufficient evidence to recommend action to remedy this or to estimate the cost. This needs to be addressed and appropriate action taken.

The key question about whether the social care workforce could expand to meet higher demand for higher-quality care is difficult to answer. There is a range of circumstantial and anecdotal evidence that is, on balance, positive. But there are no definitive studies to answer this question. The difficulty of interpretation is compounded by the complexity of the issue. Supply of labour to the social care market depends on wages and conditions, people's willingness to work in social care, barriers to market entry, the capacity in the wider economy for people to work in the low-pay sector, the action of competitor industries such as health care and so on. Also, the United Kingdom is operating within an international labour market in a way not seen previously. It is clear that the sector will need

to act in a more competitive manner to attract staff in the future. This then needs to be combined with appropriate and cost-effective training to ensure the outcomes received are of a high quality.

Introduction

The workforce is a particularly important element in social care because services in this sector are extremely labour intensive. The human capital available thus has a significant impact on the services provided to clients. The number of staff needed for the operation of an effective social care service in 2026 will depend on the outcomes the service expects to achieve, the services offered, their location and the way in which they are structured.

This appendix expands on chapter 7 in the main report for the Wanless Review (Wanless 2006). As such it will follow the same structure, that is, a brief assessment of the current position and the challenges of supply in three main parts:

- the current position (numbers, pay, vacancies, training provision and cost)
- the nature of the social care labour market (including the responsiveness of the workforce)
- factors affecting supply (any constraints impacting on the available supply and cost of training).

In addition, there will be an assessment of what the possible future position might be.

Where possible, the discussion focuses on the workforce for the client group under consideration for the Review, namely, those over the age of 65 in England. On occasions, however, the data available is not specific enough to limit the discussion to this staff group, so the workforce as a whole has been discussed.

Current position

It would be fair to say that the collection of reliable data on the workforce has not been characteristic of social care. Issues with the collection of the data itself have been compounded by the complicated nature of service provision fragmented across statutory and independent sectors, resulting in information that is generally incomplete and inadequate (as detailed in chapter 7 (Wanless 2006)). Benchmarking, succession planning, and staff development and training have been severely hampered by this poor baseline information, as has identification of recruitment and retention problems and skills shortages on both a local and national level. Potentially this situation will be improved by the introduction of the National Minimum Data Set for Social Care (NMDS-SC) (Skills for Care 2005a), which will collect standardised data across social care services. This tool is certainly a significant step in the right direction, and will add to the work of such individuals as Christine Eborall in her *State of the Workforce* reports for Skills for Care, which currently form the basis of the data available for the social care sector (Eborall 2005). However, significant deficiencies remain.

The problems with amassing necessary data on the size and structure of the workforce include:

- limited information on many areas, including the independent sector workforce; employees of partnership bodies; social care staff in the NHS; agency staff
- possible double counting of individuals who are employed in different organisations or sectors
- variation in use of headcount or whole-time equivalent (WTE) numbers
- discrepancy in use of definitions
- issues in separation of adults' services from the children's services workforce figures.

Staff numbers

Public and independent sector

In 2003/4, an estimated 922,000 people were employed in England in 'core' social care as traditionally defined, that is, including local authority social services staff, residential, day and domiciliary care staff, some agency staff and a limited number of NHS staff (Eborall 2005). (This figure should be considered with the caveat regarding sources and resulting differences in numbers discussed below.)

In addition, some 198,000 people are employed by the NHS but undertake some social care work, and are considered outside this 'core' staff. This increases the total size of the social care workforce to 1,120,000. This figure still excludes the estimated 477,000 people employed in children's services (school assistants, early years staff, and so on). (See table 1 for more details.)

TABLE 1: ESTIMATED SIZE OF SOCIAL CARE WORKFORCE IN ENGLAND (HEADCOUNT), 2003/4

Service type	Size of workforce			Total	% of core total	% of wider total
	Local authority	Independent sector*	NHS			
Social services departments (central, area, field, other)	112,000	–	–	112,000	12	7
Domiciliary care services	56,000	107,000	–	162,000	18	10
Day care services	38,000	57,000	–	95,000	10	6
Care homes (including nursing staff)	72,000	390,000	–	462,000	50	29
Agency staff	11,000	19,000	Not known	30,000	3	2
NHS (narrow definition)	–	–	62,000	62,000	7	4
Core workforce total	288,000	572,000	62,000	922,000	100	58
<i>% of core total</i>	<i>31</i>	<i>62</i>	<i>7</i>	<i>100</i>		
NHS (including other unqualified staff who may do some care work)	–	–	198,000	198,000		12
Total for child-specific services	145,000	332,000	–	477,000		30
Wider workforce total	433,000	904,000	261,000	1,598,000		100
<i>% of wider workforce</i>	<i>27</i>	<i>57</i>	<i>16</i>	<i>100</i>		

Source: Adapted from Eborall 2005

Note: All figures are rounded.

* Includes both private and voluntary sectors.

An estimated 61 per cent of the ‘core’ workforce’ (approximately 559,000 people) were working in services for older people (Eborall 2005). If the same proportion of staff outside the ‘core’ workforce also worked in services for older people (121,000), this would increase the total numbers of people working in social care relating to older people to 680,000 people.

There is disagreement over this number, however. Estimates vary according to the source of the data and how it is identified and collected.

- **Source.** The main sources of data for workforce numbers in all sectors are the Labour Force Survey (LFS) and local authority data, neither of which is definitive (see Annex 1, pp 41–3).
- **Definition.** As highlighted throughout the report, the definition of social care varies. This translates across to staffing creating issues in comparability of data collection and reporting.

- **Inclusions.** In addition to the distinction between the ‘core’ social care workforce and other occupations that provide social care services (mentioned above), many sources tend to exclude key staff groups such as managers, nurses or support services, or staff employed by other sectors, such as the NHS, all of whom are a vital part of the services provided.
- **Data collection.** The detail of the data obviously varies according to the factors that are addressed when it is collected. SIC92 (Standard Industrial Classification) in the LFS, for example, does not differentiate between age groups of clients, so it is not surprising that it is difficult to extract this information. Variations also occur with regard to whether data collected refers to headcounts or whole-time equivalent (WTE) staff. This makes comparison of data problematic.

The staff numbers in table 1 are arguably the most reliable available. It should be noted, however, that they necessarily use a number of different sources that have various shortcomings with the data collected. These are discussed further in Annex .

‘FLEXIBLE’ OR AGENCY STAFF

The term ‘flexible’ staff refers to ‘any sort of staffing which falls outside the norm of employment for an unspecified term on fixed basic full-time or part-time hours’ (Laing & Buisson 2004). In addition to the short-term absences with which temporary cover is normally associated such as sickness or pregnancy, use of agency staff frequently extends to more regular arrangements, with these staff often becoming semi-permanent.

Use of agency staff has various advantages for the employer, including most notably the nature of the employment arrangement. Staff are, as the name suggests, flexible, in other words, instantly available and dismissible and thus easier to manage from some perspectives, such as reduced administration and lack of on-costs. Some people choose temporary work either to ‘tide them over’ until something more permanent comes along, or because they are unable to find permanent work, but there are also substantial numbers of people who prefer to work on a temporary basis. Temporary work can offer greater choice and flexibility (regarding hours, shift patterns, location, workloads and client group), and better pay(not taking other financial benefits into account). Employment of flexible staff is also used to overcome recruitment freezes on appointment of staff on a more permanent basis in times of financial pressure, a practice that is anecdotally widespread.

Agency staff are rarely included in workforce figures for social care (and this is also true of other sectors), and where they are, data is poor. Table 2 gives details of the estimated numbers of staff in some social care related occupational groups for the United Kingdom, together with an indication of their position in the wider workforce. It is difficult to discern any trends over time from this data.

The numbers of people employed as temporary workers appears to be relatively small. However, the expenditure on such employees (across health and social care) is considerable. Laing & Buisson estimate that in 2003 expenditure on flexible staffing in the United Kingdom for health and social care (for all ages of client) was £4.47 billion (Laing & Buisson 2004). It is not possible to determine how much of this is expenditure is spent on flexible staffing for social care specifically.

TABLE 2: TEMPORARY EMPLOYEES IN HEALTH AND SOCIAL CARE OCCUPATIONS IN THE UNITED KINGDOM, 1994 TO 2003

Temporary employees	1994	1997	2000	2003
Care assistants <i>% all care assistants</i>	18,350 5.0	30,450 6.4	36,731 6.7	35,784 6.3
Nursing assistants and assistant nurses <i>% all nursing assistants and assistant nurses</i>	14,650 7.7	14,150 8.5	8,908 7.1	13,531 6.3
Social workers <i>% all social workers</i>	6,582 5.0	9,276 7.9	9,293 8.2	7,117 8.9
Occupational therapists <i>% all occupational therapists</i>	1,986 7.1	835 2.6	1,523 3.6	1,678 5.8

Source: Adapted from Laing and Buisson 2004

PUBLIC SECTOR

The data available for the public sector specifically is more extensive than that for the private sector or for all employees, but still less than an ideal level. According to figures drawn from the local authorities' estimates (discussed further in Annex 1, pp 41–3), in 2003 there were an estimated 269,200 people working in social care in the statutory (or public) sector. Of these, approximately 130,300 staff were working in older people's services, a figure that represents 21 per cent of the provision for the older age group and 48 per cent of statutory sector provision in social care as a whole (Eborall 2005).

As discussed above, there are some concerns over the reliability of local authority data, so information has been sought from other data sources. According to the 2004 SSDS001 return (Department of Health 2005), in September 2004, there were 213,300 WTE members of staff employed in England by Councils with Social Services Responsibilities (CSSRs). This excludes agency staff (considered below). This figure comprises:

- 113,500 area office / field work staff (53 per cent)
- 48,900 residential care staff (23 per cent)
- 28,600 day care staff (13 per cent)
- 20,400 central / strategic staff (10 per cent)
- 1,900 other (1 per cent).

A recurrent problem with this data is that many staff are recorded as working in generic services and cannot be attributed to a particular client group, with figures recording instead the condition of the client. As a result, it is difficult to identify a figure for staff working with clients that are over 65 specifically. One way to estimate figures specific to the over-65s is by identifying staff that definitely do not work for over 65s (for example, those who work with children), and subtracting this from the total figure. However, this method will arguably produce an overestimate of the total numbers supporting older people specifically (though as older people use the majority of the services provided it could be argued that they also use the majority of staff resources). Some services are

TABLE 3: CSSR-EMPLOYED STAFF INVOLVED IN CARE OF OLDER PEOPLE, BY CLIENT GROUP/SPECIALTY, NUMBER (WTE) AND GENDER

Staff group	Client group/specialty	Number (WTE)	Female (%)	Male (%)
Area office/field work staff	Domiciliary care	34,400	95.0	5.0
	Adult services	15,100	80.2	19.8
	Generic provision	3,700	72.3	27.7
	Hospitals/other health settings	3,300	80.9	19.1
	Assistant directors/area managers	2,600	58.1	41.9
	Physical disabilities/mental health	10,500	69.7	30.3
	HIV/AIDS/drug and alcohol abuse	600	67.6	32.4
	Clerical support	14,400	89.5	10.5
	Drivers/attendants/escorts	1,600	36.6	63.4
Residential care staff	Elderly/elderly mental health	21,600	91.7	8.3
	Specialist needs establishments/resource centres	4,200	82.5	17.5
Day centre staff	Elderly/elderly mental health	3,500	85.6	14.4
	Mixed client groups	2,600	54.1	45.9
Central and strategic staff	Relating to all client groups	20,400	80.5	19.5
Total		138,500		

Source: Based on 2004 SSDS001 data from the Department of Health (2005)

detailed as specifically for older people, and where this is the case, this figure has been used.

Through use of this very simplistic subtraction method, Table 3 details the estimated number of staff who work in care for older people in public sector – a total of 138,500 WTE (September 2004). This figure is not far removed from the figure of 130,300 generated by the local authority data (representing the number of staff working with older people in the statutory sector in 2003).

Some additional information is known about some occupational groups working in statutory settings, such as social work staff and occupational therapists. Within the overall figures however, staff for both these occupations are recorded within the area office / field work staff (and in the case of social workers, also in day care staff numbers), alongside generic and cross-client services. Thus, even with more detailed information, it is not possible to further refine the total figures to give a more accurate estimation of staff providing services to older people specifically.

ADDITIONAL SOCIAL CARE WORKFORCE IN THE PUBLIC SECTOR

Social care staff in the NHS

It is relevant when estimating the social care workforce to consider the staff that are employed by the NHS, and in care trusts, who have a role that can be identified partly, or wholly, as social care, (such as occupational therapists, and health care assistants). An array of local structures and circumstances makes it difficult to identify the budget stream covering these employees. However, a general trend appears to be that the NHS employs

TABLE 4: ESTIMATE OF STAFF PERFORMING SOCIAL CARE FUNCTIONS EMPLOYED IN THE NHS IN ENGLAND AT 30 SEPTEMBER 2003 (HEADCOUNT), EXCLUDING THOSE SPECIFICALLY WORKING WITH YOUNGER PEOPLE

Occupation	Total number of staff	Staff working generically, across ages or cannot be classified	Total number of staff potentially working with older people
Qualified occupational therapy staff	15,391	15,391	15,391
Occupational therapy students/trainees	14	14	14
Occupational therapy helpers/assistants	2,427	2,427	2,427
Qualified social services staff	241	241	241
Social services helpers/assistants	464	464	464
Health care assistants in all areas except hotels, property and estates	39,444	36,530	36,530
Total	57,981	55,067	55,067

Source: Based on data from the NHS Hospital and Community Health Services Non-medical Workforce Census 2003, cited in Eborall 2005

these staff, while they are frequently considered to remain ‘social services’ staff’. This dual role leads to many staff having two sets of line managers and being required to know and abide by two or more sets of policies and procedures, leading to scope for confusion on both a theoretical and practical level. This is compounded by the fact that NHS employment of social services staff does not appear to be happening in a consistent pattern across the country (Eborall 2005).

This confusion in the positioning of occupations that transcend the boundaries of traditional organisational and care provider distinctions, (and frequently involve elements of both health *and* social care), is also evident in the recording of these staff. At September 2003, the number of social services staff (in a narrow sense, recorded as being employed in the NHS was 705 (241 qualified social services staff and 464 assistants / helpers to social services staff) (Eborall 2005). However, it is estimated that the number of people employed in the NHS performing tasks that would involve personal care was closer to 62,000 (in 2003, Eborall 2005). Under the broader definition of social care, these staff would be considered as working in a partially social care role.

Table 4 gives details of the estimated number of staff employed in the NHS that were potentially performing social care functions in 2003, excluding those specifically working with younger people. The total figure is an estimated 55,067 staff. This figure excludes support workers, nurses, or nurse learners employed by the NHS (estimated to total 198,000) some of whom arguably also undertake personal care functions (Eborall 2005). The figure for staff that can be identified as not working with children is only 2,914 smaller than the total number of staff for the occupations listed. As with the CSSR-employed staff above, the numbers of staff cover generic and cross-client services, and it is not possible to refine this number further for the staff working specifically for older people. It is for this reason that numbers are the same in table 4 for both the column regarding staff ‘working generically, across ages or cannot be classified’ and that showing the ‘number of staff potentially working with older people’.

Despite the considerable uncertainty over these figures (both in terms of the extent to which they relate to older people, and the amount of time that can be attributed to ‘social

care' roles), it is evident that social care functions are undertaken by professionals employed by the NHS to a significant degree. This arguably adds to the public confusion over the distinction between health and social care services, and the massive financial implications this can have for individuals and their families depending on their eligibility for one or other service. This is discussed further in Background Paper 2 ('NHS Continuing Care in England') in the Appendix.

Agency staff in the public sector

Research indicates that in 2003 there may have been the equivalent of 8,400 WTE long-term agency staff (approximately 11,000 headcount, nearly 4 per cent of total staff) working in local authority social services departments in England (Eborall 2005). This figure includes all occupations working in services for all client age groups. Predictably, the information available on these staff is less than ideal. From the data available however, we can estimate that there are approximately 2,083 WTE working in services either specifically concerned with older people, or in generic or non age-specific services (once again this uses the methodology of subtracting from the total those numbers of staff that are evidently *not* working with older people).

PRIVATE SECTOR

It has been observed that 'apart from the local authority estimates... whose reliability is not easily verifiable – there is still a paucity of reliable information about the size and structure of the independent sector social care workforce', which is rightly identified as 'a cause for concern given the importance of this sector in providing social care services for the nation' (Eborall 2005). Initiatives such as the NMDS (SC) illustrate an awareness of this lack of information and the beginnings of attempts to remedy the situation, but the fruits of this will not be reaped for some time. For the purposes of this Review therefore, we have limited data on the private sector staffing situation.

The private sector is the largest employer of paid workers in social care, ahead of both the public and voluntary sectors. Local authority estimates indicate that the private sector workforce is a substantial part of the labour force, accounting for approximately 411,100 people working in older people's services. This figure represents 68 per cent of the provision for the older age group and 73 per cent of private sector provision in social care as a whole (figures subject to caveats on data collection and its reliability outlined above).

The most significant aspects of private sector provision are the employment of care assistants and home care workers, which account for 31 per cent of the total staffing compliment. The private sector supplies 67 per cent of these staff, a total of 307,530 people, 224,500 of whom work in services for older people.¹

VOLUNTARY SECTOR

The voluntary sector accounts for a significant minority of the social care workforce, and yet is frequently under-rated or overlooked completely. Local authority estimates give a figure of a voluntary sector social care workforce of 171,600, with an estimated 67,500 of these staff providing social care services for older people. This represents 11 per cent of total provision for the older age group, and 39 per cent of voluntary sector provision in social care as a whole (Eborall, 2005 – once again, figures subject to the caveats on data collection and reliability outlined above).

There has been increasing recognition of the voluntary sector in recent policy and initiatives (Department of Health 2006, for example) although perhaps less than the size and prominent role of the sector demands. This recognition has generally been specific to certain client groups, probably most notably for the older client group (see SCIE 2005). It is therefore particularly significant that very little information is available on workforce in this sector. This needs to be addressed.

Excluded figures

Despite the relative detail with which the social care workforce has been considered, there remain several groups of people that provide care services to older people that are not included in these figures. Excluded groups include (list not exhaustive):

- care staff employed in sheltered housing or assisted living establishments;
- unpaid volunteers and informal carers (discussed in chapter 8);
- people paid cash for care services – sometimes called the ‘grey’ workforce (also occasionally called ‘informal’ care, but that is NOT what is meant when the term is used in chapter 8);
- the overtime worked by staff in the public or independent sector.

The last of these is of particular significance. Anecdotally the amount of overtime worked by social care staff is high, both paid and otherwise. If this is the case, it would mean that the hours actually being worked to deliver social care are significantly under-estimated. The consequence of this would be that the *de facto* WTE numbers would be higher than stated, and thus the numbers of staff required both to provide the existing services and to increase provision would be higher than anticipated. More comprehensive information is needed on this to enable effective workforce planning both for the immediate and longer-term future.

Training

Given the labour-intensive nature of social care provision, the training of staff is a significant factor in the provision of a high-quality service. At present much of the social care workforce is minimally qualified and often poorly trained. While initiatives to improve training and increase the proportions holding appropriate qualifications do exist, the extent to which these are directed by evidence varies considerably, as does their success in producing better outcomes for service users. The delivery of training is not something that it has been possible or appropriate to cover in depth during this Review. There are, however, certain questions that need to be addressed, albeit briefly, in assessing the current state of training in social care. These include:

- what is the range of training offered?
- what numbers and proportions of staff are currently undergoing training?
- what is the cost of training and who funds it?
- what are the incentives to/ benefits of promoting and undertaking training and qualifications (both for the employer and the employee)?
- how do improvements in training make a difference to outcomes?

These will be addressed briefly in turn.

Range of training

The training available to the various occupational groups involved in social care provision is broad, in both level and type. The *levels* of training range from basic induction and statutory training (Common Induction Standards (CIS): fire awareness, and so on) through the vocational training and qualifications (NVQs, post-registration training) to the more intensely

TABLE 5: ESTIMATED NUMBERS OF PEOPLE EMPLOYED, SELF-EMPLOYED OR IN GOVERNMENT TRAINING SCHEMES IN SELECTED SOCIAL CARE-RELATED OCCUPATIONS AS MAIN JOB WHO ARE CLAIMING TO HOLD QUALIFICATIONS LISTED, ENGLAND, 2003

Qualification	Number of people with qualification by SOC2000 code and occupation						
	2442 Social workers	3222 Occupational therapists	3231 Youth and community workers	3232 Housing and welfare officers	6111 Nursing auxiliaries and assistants	6114 House parents and residential wardens	6115 Care assistants and home carers
Degree-level including PGCE or professional membership	29,000	14,000	24,000	32,000	9,000	2,000	18,000
Diploma in higher education	11,000	4,000	5,000	8,000	4,000	0	7,000
HNC, HND	3,000	0	4,000	6,000	2,000	1,000	5,000
ONC, OND	1,000	0	1,000	1,000	1,000	0	2,000
BTEC, BEC, TEC	2,000	2,000	4,000	5,000	7,000	1,000	11,000
SCOTVEC, SCOTEC, SCOTBEC	0	0	0	0	0	0	0
Teaching qualification (excluding PGCE)	2,000	1,000	4,000	5,000	1,000	1,000	2,000
Nursing or other medical qualification	5,000	3,000	2,000	6,000	20,000	4,000	10,000
Other higher education qualification	5,000	0	3,000	3,000	1,000	0	3,000
A level or equivalent	31,000	15,000	24,000	41,000	20,000	5,000	34,000
SCE Highers	0	0	0	1,000	1,000	0	0
NVQ, SVQ	8,000	1,000	13,000	17,000	57,000	7,000	135,000
GNVQ, GSVQ	0	0	2,000	2,000	6,000	1,000	14,000
AS level	0	0	2,000	1,000	2,000	0	1,000
CSYS or equivalent	0	0	0	0	0	0	0
O level or equivalent	34,000	11,000	30,000	56,000	37,000	9,000	79,000
SCE Standard/O Grade	0	0	1,000	1,000	1,000	0	1,000
GCSE	13,000	7,000	20,000	29,000	45,000	4,000	102,000
CSE	10,000	3,000	12,000	22,000	31,000	5,000	74,000
RSA	2,000	1,000	8,000	9,000	13,000	2,000	30,000
City and Guilds	5,000	0	9,000	11,000	14,000	4,000	41,000
YT certificate	1,000	0	0	1,000	1,000	0	6,000
Other professional, vocational or foreign qualification(s)	43,000	8,000	37,000	62,000	75,000	15,000	200,000
Total workers	67,000	19,000	66,000	111,000	181,000	27,000	459,000

Source: ONS Labour Force Survey 2003 Annual Dataset, cited in Eborall 2005

academic (Diploma in Social Work (DipSW), the new degree in social work, and post-qualifying and advanced awards). The *types* of training also vary considerably depending on the purpose of the training, the environment within which the person works, and the client group with which the staff member is working. In addition, the range of occupations involved in social care span not only the care assistants, social workers and managers, but also include some health professionals, administrators, clerical staff and support staff. Each occupational grouping will have training specific to their line of work, also at various levels.

TABLE 6: PERCENTAGE OF PEOPLE EMPLOYED, SELF-EMPLOYED OR IN GOVERNMENT TRAINING SCHEMES IN SELECTED SOCIAL CARE-RELATED OCCUPATIONS AS MAIN JOB WHO ARE CLAIMING TO HOLD QUALIFICATIONS LISTED, ENGLAND, 2003

Qualification	Percentage of people with qualification by SOC2000 code and occupation						
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Degree-level including PGCE or professional membership	43	74	36	29	5	7	4
Diploma in higher education	16	21	8	7	2	0	2
HNC, HND	4	0	6	5	1	4	1
ONC, OND	1	0	2	1	1	0	0
BTEC, BEC, TEC	3	11	6	5	4	4	2
SCOTVEC, SCOTEC, SCOTBEC	0	0	0	0	0	0	0
Teaching qualification (excluding PGCE)	3	5	6	5	1	4	0
Nursing or other medical qualification	7	16	3	5	11	15	2
Other higher education qualification	7	0	5	3	1	0	1
A level or equivalent	46	79	36	37	11	19	7
SCE Highers	0	0	0	1	1	0	0
NVQ, SVQ	12	5	20	15	31	26	29
GNVQ, GSVQ	0	0	3	2	3	4	3
AS level	0	0	3	1	1	0	0
CSYS or equivalent	0	0	0	0	0	0	0
O level or equivalent	51	58	45	50	20	33	17
SCE Standard/O Grade	0	0	2	1	1	0	0
GCSE	19	37	30	26	25	15	22
CSE	15	16	18	20	17	19	16
RSA	3	5	12	8	7	7	7
City and Guilds	7	0	14	10	8	15	9
YT certificate	1	0	0	1	1	0	1
Other professional, vocational or, foreign qualification(s)	64	42	56	56	41	56	44

Source: ONS Labour Force Survey 2003 Annual Dataset, cited in Eborall 2005

This huge variety has the benefit of offering the potential to accommodate each staff member at their own level of ability and development in their particular career direction of their choice. However, it also offers scope for confusion within the service, for both staff and employers, and among the public in terms of their understanding of the competence level of staff caring for them. It also means that questions about training and qualifications are complicated to address. The key types of training for care staff and social workers are outlined in Annex 2, pp 44–5, while the quality measures regarding the training undertaken and the quality of care more generally are addressed in Annex 3, pp 46–7.

Numbers

Given the range of occupations, and levels and types of training available, putting numbers on the staff undertaking some form of training is a complex task. Tables 5 and 6 (see pp 12–13) give details of the numbers and percentages of people who held various types of qualification in 2003 for selected occupations. Figures are estimates, but this nevertheless provides some idea of the scale and extent of training within the social care sector (more detail available in Eborall 2005). The data available is consistent with findings on other aspects of the workforce. There is reasonable information regarding the local authority workforce, but information for the independent sector providers is poor.

Costs

Expenditure committed to staff training differs hugely between organisations. Information obtained from industry sources for the Review suggests that the amount spent on training can range from the equivalent of £100 to £350 per head, per annum. Where training teams are employed specifically, this can represent a significant cost for the organisation. One industry source estimated that the costs of the training and development team alone in their organisation was more than £240, 000 per annum, a significant proportion of the organisational budget. There are beacons of excellence, such as St Anne's Community Services in Leeds, that generate funding through offering training services outside their own organisation, but this is an entrepreneurial approach with a finite market, and does not detract from what is still a considerable expense to the organisation.

Information about the specific costs of training activity is tentative at best. Estimating and calculating costs is problematic, complicated by the range of training available, various occupations involved in social care and varied levels of input required for each individual (dependent on the levels of competence and qualification of staff in the workforce). It is not possible to comprehensively examine the costs of all types of training for all the occupational groups here. This Review has concentrated instead on the cost of training care workers to the three NVQ levels (from various stages of development). While this addresses only one aspect of training for one occupational group within the social care sector, care workers represent a large proportion of the workforce; it therefore makes sense to focus on this group.

Work completed for the Review by Skills for Care indicates that the costs of achieving NVQ levels 2–4 include not only the training and assessment for the NVQ itself, but frequently also the additional costs of getting an employee to a basic level of competence prior to their being able to work effectively in the workplace and start more formal training. It is suggested that approximately 50 per cent of staff recruited for levels 2 and 3 need assistance with 'essential skills' (work-related ability to write records and numerical work

TABLE 7: ESTIMATED COST OF TRAINING CARE WORKERS TO NVQ LEVELS 2–4, PER INDIVIDUAL BY LEVEL OF COMPETENCE

Training unit	Cost of achieving level of competence (£)			
	NVQ2	NVQ3	NVQ4	Total to NVQ 4
English as an additional language	2,000	2,500	3,000	3,000
Essential skills	1,000	2,000	3,000	3,000
NVQ learning	600	800	800	2,200
NVQ assessment/registration	600	770	770	2,140
NVQ only total	1,200	1,570	1,570	4,340

Source: Prepared for the Review by Skills for Care

on dosage and time sheets, for example), and up to 40 per cent of recruits need assistance with English language training, both initially and incrementally as they progress with training. This can add between an estimated £1,000 and £4,500 per person to the cost of training, depending on the educational and skill level of the individual. The core estimated costs for the training and the additional ‘skills’ training are shown in Table 7 below. These figures are an estimate of the total *de facto* training costs and do not amount to an indicative suggested price that should be charged for training.

In addition to these, there are other costs that need to be considered when estimating the unit costs of training. These include:

- supervision and appraisal of staff and human resources costs (estimated at 10 per cent of workforce costs and 5 per cent of workforce costs respectively)
- accessing supplementary funding to support staff training. The sources of supplementary funding are many but rarely generous and require a level of technical knowledge and brokerage to access. It is estimated that the cost of organising this can add an additional 20 per cent on the training costs
- replacement costs to provide cover for staff released for training
- other mandatory and statutory training required to support NVQs learning.

Skills for Care have estimated that training an employee up to NVQ level 2 can cost between £2,400 and £6,400. This can have significant implications for social care organisations (especially for smaller providers) with consequences for the amount of training that employers are both willing and able to offer staff.

Further information on the estimated costs of NVQ training are included in the separate appendix (‘Costs of establishing a competent workforce’) produced by the Review by Skills for Care.

Funding methods and sources

The current situation regarding availability of funding for training is complicated. Funding can be acquired from a number of sources, all of which have different criteria for approval and separate application processes. At best this is a time-consuming process, and at worst it acts as a barrier to employers and individuals accessing funding for development and acquisition of appropriate skills for the work undertaken.

The sources from which funding can come include:

- **external agencies** such as the General Social Care Council (bursaries), Skills for Care or HEFCE
- **government programmes** for entry to work / back to work
- **local authorities**, through sponsorships (especially for social work training)
- **further education colleges** that receive government funding for essential skills training (it is reported that employers have little or no access to this resource other than by negotiation with colleges)
- **the employing organisation** can provide support both financially, and indirectly through the replacement cost of releasing staff for training;
- **the individual** can experience considerable personal cost. This includes not only the opportunity cost for the individual of spending time completing training (frequently expected to be in the employee's own time), but can also involve direct financial costs. These can include costs of child care, travel, materials and all or some of the fees.

Access to funding to support staff training is complicated, and requires some knowledge of the system to accomplish. As a result, some 20 per cent can be added to the cost of the training reflecting the costs of what is effectively, brokerage. This is clearly an ineffective use of resources, making the process far more complicated than desirable.

There is some work currently under way through Skills for Care exploring the possible savings (financial and otherwise) of streamlining the process for accessing funding. At the time of writing no actual work on simplifying the process had begun.

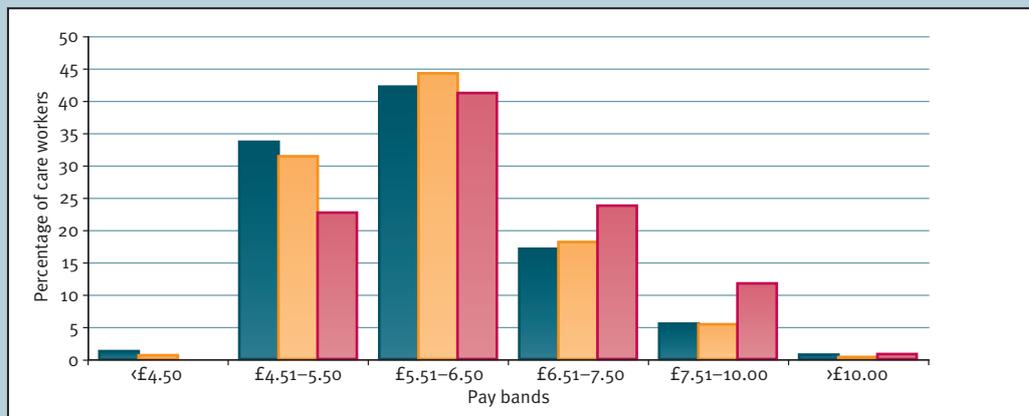
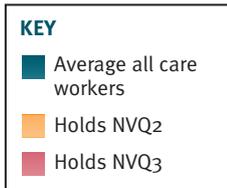
Incentives

The costs of training (direct and indirect) can be considerable both for individuals and their employing organisations. It is important therefore that both the individuals and the organisations see some purpose in investing time, effort and resources to facilitate or obtain training and qualifications. This needs either to be in the form of benefits or incentives (in the widest sense) or through some coercion or sanctions (and probably a combination of these measures).

Employers are required to meet some standards of training, (such as those required by NMS or legislation), but as discussed above, these frequently form a minimum requirement. There needs to be an incentive for them to invest resources in exceeding this baseline. Initiatives such as Investors in People provide recognition, but this may offer only an indirect return on investment and has apparently little measurable impact on service outcomes (see next section).

For the individual employee, the main incentive to undertake training appears to be a personal sense of achievement. Some organisations explicitly recognise qualifications in pay increments, this is by no means universal. The Review has found (through industry sources) that some organisations that previously graduated pay according to qualifications no longer do so, or that differentials were now very small. Figure 1 shows that while the acquisition of NVQ3 may have some impact on wages (raising some people over the £5.50 hourly rate), many people who have achieved NVQ 3 continue to earn less than the average hourly rate. The attainment of NVQ 2 appears to have little impact on pay.

1 PAY BANDS FOR CARE WORKERS BY QUALIFICATION, ENGLAND



Source: McClimont and Grove 2004

The pay differential between qualified and non-qualified staff appears to be slight. Where it does exist, it would arguably not give sufficient incentive *in itself* to incur the cost and inconvenience of training out of choice, unless this was combined with other benefits or the intrinsic satisfaction derived by the individual. In addition, there is currently no enforced link between the attainment of appropriate qualifications and enhanced levels of pay. If it is decided that achieving qualifications is an effective and cost-effective way of improving service outcomes, some incentive will need to be introduced.

The impact of training

In the current system, a great deal of emphasis is placed on the acquisition of NVQs as a *de facto* guarantee of quality. At best, however, qualifications are merely a proxy for improved service quality and it is somewhat surprising that so little work has been undertaken on the impact training and qualifications, NVQs in particular, have on service outcomes, or on the relationship between the qualifications of carer staff and the quality of care provided. Given the costs associated with training (on national, local, organisational and personal levels), it is important that the considerable investment is maximised in the most effective way possible.

Some argue that the current method of expenditure is not a cost-effective way of improving outcomes. Significant funding has been invested in training and qualifications recently, with subsequent increases in the training received by the staff. For example, over the last three years councils expect to have directed training grants worth £48 million to improve the qualifications of care workers in the private and voluntary sectors. Despite this, however, it is apparent that there remain problems with the quality of care delivered. This is illustrated, for example, in the recent report by the Commission for Social Care Inspection (CSCI), which identified ongoing issues around medication administration and management in homes for older people (Commission for Social Care Inspection 2006). One can argue that it cannot be assumed investment in training will immediately result in raising the quality of care services across the board; it will take time for the full effects of training to become apparent in improved services and fewer matters of concern.

Meanwhile, others also question the assumption that qualifications actually demonstrate competence and quality of care. There is an argument that important elements of quality are associated with variables that cannot be easily measured, such as approach and attitude. It is important that training addresses these interpersonal dimensions (which are also central to the underpinning values of the Codes of Practice for social care workers and their employers). It might be argued that whatever the shortcomings of present training, there is a lack of a viable alternative, and working to improve the current system is preferable to introducing a wholesale replacement. It is also argued that investment in training and development shows a level of commitment to employees, and the social care sector itself, which should have a positive impact on the motivation, recruitment and retention of staff.

There is some evidence of a positive correlation between the training record of organisations and the quality of care provided. The CSCI report on managing medications in care homes found that performance against the medication standard was strongly related to all other standards and led to ‘the unsurprising conclusion that good homes tend to do well on managing medication and vice versa.’ In particular, standards on staff training were strongly associated with the medication standard (65 per cent of homes meeting the training standards also met the medication standard, while for homes not meeting the training standards, only about 40 per cent met the medication standard). It is noteworthy, however, that other factors were also prominent in the reasons given for good practice, such as policies, procedures, storage and record keeping (CSCI 2006). It is also asserted that good management has a significant impact on staff retention, and thus improves continuity of care for recipients (Robinson and Banks 2005). Research currently being undertaken by PSSRU (Ann Netten, Karen Jones and Sima Sandhu) promises to offer some quantitative results on the relationship between qualifications obtained and outcomes for the clients. These results should fill an important gap in the knowledge and evidence base.

Research demonstrates that there are substantiated links between other training-related factors and the service outcomes, which are of potential significance.

- Some types of training are associated with improved job satisfaction and reduced staff turnover and vacancy rates within an organisation. Examples include the methods used in ‘magnet’ hospitals (Kramer and Schmalenber 1991) and practice learning activities (Parker and Whitfield 2006).
- Various management theories suggest that staff motivation impacts on performance, and thus on the quality of care provided to patients and recipients of care. Research on magnet hospitals, for example, shows a relationship between better staffing indicators and improved quality of care (Aiken *et al* 1994 cited in Milton Keynes and South Midlands Health and Social Care Sub-Group 2005).
- Skills for Care state that ‘where employers demonstrate commitment to the ongoing learning of their workforce through continuing professional development, there is generally an improvement in recruitment and retention and the quality of practice, as well as faster progress to meeting qualification targets because there is a working environment where people want to stay’ (Skills for Care 2006b).
- In addition, some work has been done on ‘practice learning experiences’ in social work and the impact of these on the quality of learning (Practice Learning Taskforce 2005). Although this does look at process and quality issues, it appears to mainly examine the learning itself, rather than the impact changes in training have on the quality of outcomes achieved as a result.

Training is only one of a number of factors in the delivery of high-quality care. To attribute high quality of service to one factor alone would be to massively oversimplify the inter-relationship of different variables. Although there is some evidence that training can improve outcomes and raise service quality, there is also some indication that it is most effective in conjunction with other factors. Decisions on the future direction and sources of expenditure require careful analysis to ensure money is being spent in the most effective way and for the maximum benefit of the older people using social care services.

Staff costs

Public and independent sector

Consistent with the picture that has been outlined previously, the data available on staff remuneration in the social care sector is better for the statutory than for the independent sector. Table 8 gives an indication of the wage levels for a selection of social care occupations as at 2004. The factors that are striking here (although perhaps not surprising) are the differences:

TABLE 8: AVERAGE AND MEDIAN GROSS WEEKLY PAY FOR PROFESSIONAL AND SELECTED ASSOCIATE PROFESSIONAL/TECHNICAL OCCUPATIONS,¹ APRIL 2004

Occupation	SOC2000 code	Male employees: median (£)	Male employees: mean (£)	Female employees: median (£)	Female employees: mean (£)	Female full-time employees: median (£)	Female full-time employees: mean (£)	Female part-time employees: median (£)	Female part-time employees: mean (£)
All professional occupations	2	620.30	687.40	520.60	527.10	571.40	603.10	263.40	284.90
Health professionals	221	1,048.90	1,089.40	681.40	758.30	798.80	884.20	401.70	453.00
Social workers	2442	475.30	456.80	448.30	437.90	492.80	497.70	249.90	270.40
Health and social welfare associate professionals	32	439.10	435.00	376.60	376.20	456.10	463.60	247.90	251.30
Health associate professionals	321	475.30	475.60	393.70	390.30	470.30	476.60	265.80	265.70
Nurses	3211	484.10	480.20	395.90	391.00	467.70	477.70	266.00	264.40
Occupational therapists ²	3222	–	–	–	–	467.90	465.70	–	–
Social welfare associate professionals	323	380.50	372.50	317.60	312.80	392.90	406.50	179.40	184.40

Source: ONS Annual Survey of Hours and Earnings (ASHE) 2004, cited in Eborall 2005

¹ Excluding those whose pay was affected by absence.

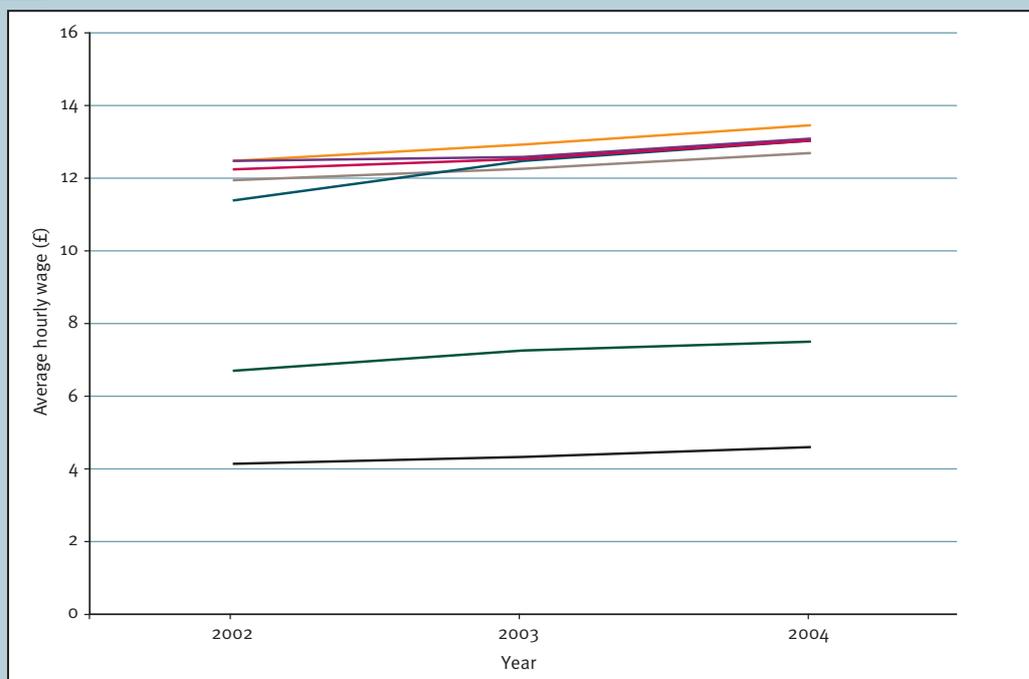
² Where data is missing, the sample was too small to be reliable.

- **between male and female employees:** this does become much less stark, however, (or is even reversed) when full-time female employees are compared with males
- **between full-time and part-time employees:** although the data available here relates only to females, this is sufficient to highlight the variation
- **between occupations:** although this is not noteworthy in itself, the pay for all the social care related occupations listed, for both sexes, is below the average for all professional occupations, sometimes considerably so. This is made all the more stark by the fact that 'health professionals' as a generic group, earn considerably more than the average.

The differences in pay according to the working hours and gender of staff are added to other factors that impact on the pay received by social care staff. As data is not available at this level of detail for the workforce as a whole, this is discussed in more depth in respect of the public sector (below).

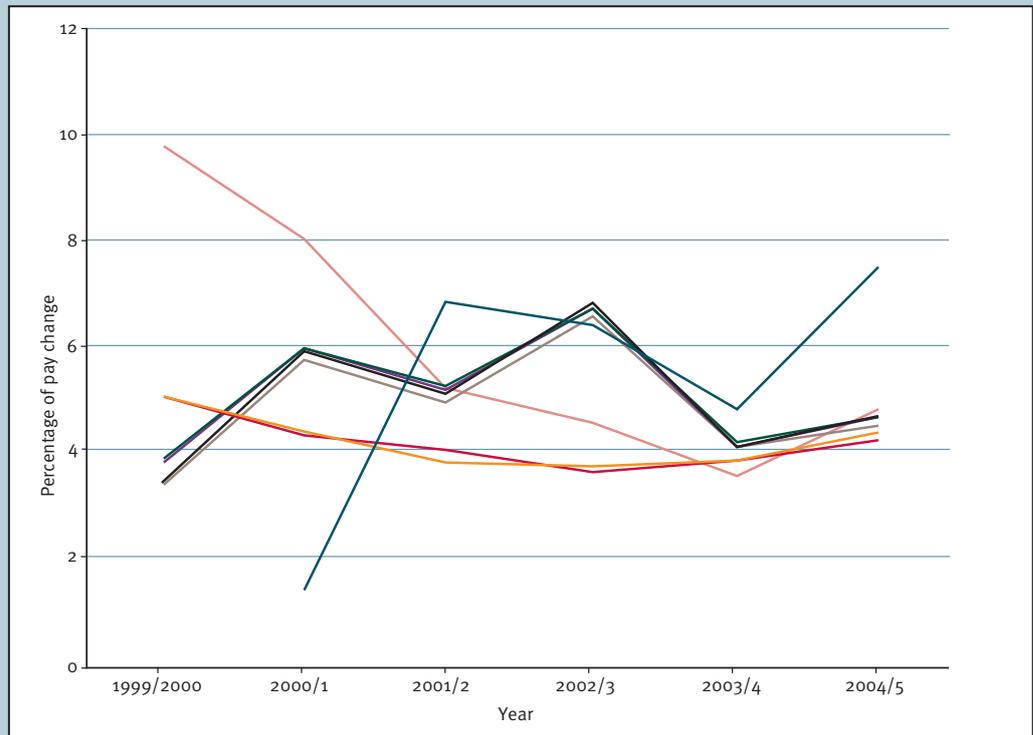
The difference in pay between occupations is frequently cited as a reason for the high vacancy and turnover rates in the social care sector (see below). The Low Pay Commission Report includes social care (in residential care specifically) as one of the 'low paying sectors' where the impact of the minimum wage has a significant impact, albeit to a smaller extent than previously (Secretary of State for Trade and Industry 2005). This has been accentuated by developments and initiatives in other public services, notably Agenda for Change in the NHS, which have not been replicated in social care, although the roles performed are frequently comparable.

2 HOURLY WAGE RATES FOR SELECTED STAFF TYPES, 2002 TO 2004



Source: Prepared for the Review by the Department of Health

3 COMPARISON OF WAGE RATE GROWTH IN THE SOCIAL CARE SECTOR WITH CHANGES IN NATIONAL MINIMUM WAGE, INFLATION AND AVERAGE EARNINGS INDEX, 1999/2000 TO 2004/5



- KEY**
- National minimum wage¹
 - Average earnings index² (LNMM)³
 - Average earnings index² (LNMQ)⁴
 - Personal social services⁵ (all)
 - Personal social services⁵ (all adults)
 - Personal social services⁵ (local authorities, all)
 - Personal social services⁵ (local authorities, adults)
 - Inflation + 2%

Source: Prepared for the Review by the Department of Health. Based on data from the Office for National Statistics and the Personal Social Services Research Unit

¹ National minimum rate changes are based on the Adult Rate national minimum wage, which is calculated in terms of hourly pay. The national minimum wage changes in October each year, so the national minimum wage rate used to calculate the change is six months of one year and six months of the next. The national minimum wage rates for 2006/7 have not been confirmed.

² Average earnings changes are calculated using quarterly average earnings index data from the Office for National Statistics, averaged over Q2-4 in year 1 and Q1 in year 2.

³ Average earnings index for the whole economy including bonus (series 2,000 = 100 – not seasonally adjusted).

⁴ Average earnings index for the whole economy including bonus (series 2,000 = 100 – seasonally adjusted).

⁵ Weighted average personal social services salary changes are calculated using changes in gross weekly pay for relevant occupations weighted by share of the pay bill. Each occupation's share of the pay bill is calculated using Department of Health estimates of workforce numbers and ASHE (Annual Survey of Hours and Earnings) data on mean pay. The estimated personal social services pay change for 2004/05 is calculated as the average real pay change in the previous three years combined with projected inflation (HMT GDP deflator).

Although obviously significant, it is not only wage rates *per se* that are of significance in social care, but also the direction and rate of change. Figure 2 gives some indication of the comparative wages in selected occupations (through a comparison of hourly wages and the monetary difference and per cent change from 2002–2004, between the different work areas, national average and National Minimum Wage(NMW)). While the data available is inadequate to allow definitive conclusions to be drawn, there appears to be some superficial correlation between wage rates, with the per cent change over the two years in question being similar for the national average, the NMW and the occupations listed.

The situation is different when the comparison is made with growth rates. Figure 3 (above) compares pay estimates for staff working in Personal Social Services (PSS) with the Average Earnings Index (AEI) for the whole economy and a GDP + 2 per cent estimate of pay. PSS figures include pay estimates for staff in the sector as a whole and for staff

working with adults specifically, and for both these spheres in the local authority. PSS pay is calculated through use of ONS survey data on average pay by occupation group which is weighted by each occupation group's share of the pay bill (proportion of staff and average salary) to produce a weighted average pay trend for the full sector. The pay trends by occupation groups cannot be broken down further. However, the proportions of staff in each occupation group, and hence the weights applied, vary by sector (local authority or independent) and client group, so four separate series have been calculated. Pay changes for 2004/5 were projected using an average of the deflated pay changes in past years. This assumes that pay increases each year will be in line with the previous trend. The method used was to calculate the pay changes in each year adjusted by the respective GDP deflator, calculate a three-year average of these real pay changes, and then inflate the result by the 2004/5 GDP deflator to generate the projected nominal pay change.

The key points illustrated by this comparison are:

- PSS pay appears to change at very similar rates across sectors and client groups
- PSS pay rates have been rising at a higher rate than the AEI for some time
- prior to 2002, PSS pay rate rises were lower than inflation, but since then, they have been in line with or higher than inflation, although the relationship with the NMW has been variable.

Rather than failing to keep up with the economy, the comparative changes in pay suggest that since 2002, PSS pay has in fact risen in line with or at a faster rate than inflation and the AEI.

PUBLIC SECTOR

As mentioned above, the data available for public sector pay levels is of a higher quality and reliability than that for the independent sector and provides us with some indication of other trends within social care pay. In addition to the factors highlighted above (gender, type of contract and occupation), there are other influences on wage rates.

- **Geographical location.** Some parts of the country appear to pay consistently lower wages to social care staff than others. In December 2005, for example, pay rates for care assistants ranged from £8.11 and £8.24 (median max and median min) in London to £5.87 in the East Midlands. For care managers, however, the differential was less stark. Salaries for care managers in the South East (frequently the region with the highest pay rates, after London) ranged from £21,000 to £29,400, which were only slightly different from rates in the East Midlands, which ranged from £20,400 to £29,000 (data from Employers' Organisation 2005b).
- **Client group.** It appears that staff working in children's services frequently receive higher pay than their colleagues in adult services. In 2003, the average minimum and average maximum pay for care workers in England (total) was £6.16 to £6.57 for employees in care homes for older people, against £7.80 to £9.77 for employees in children's homes (SCHWG Social Services Workforce Survey 2003, cited in Eborall 2005). While the difference is much less marked in additional benefits, there is a trend of more favourable benefits for children's home employees (see Eborall 2005).
- **Nationality.** Data on this variable is sparse, but information that exists suggests that foreign-born staff earn less than their UK-born colleagues (Redfoot and Houser 2005). There is not sufficient data available to assess whether there is also a distinction between black and minority ethnic groups born in the United Kingdom.
- **Size of employing organisation.** It appears that managers employed in care homes with

larger numbers of residents are, on average, likely to earn more than their colleagues in smaller establishments. The magnitude of this difference is mediated by regional factors, and can vary from less than one hundred to several thousand pounds. There is some indication, however, that other benefits do not necessarily follow the same trend (see Eborall 2005).

Influencing factors are frequently inter-related, and can combine to either accentuate the differences or cancel each other out.

INDEPENDENT SECTOR

Evidence about pay rates in the independent sector is sparse but suggests that employees in the private sector in particular earn less than their public sector counterparts (see Ungerson 2000). Sources from within the sector suggest that some organisations pay up to half their carers at the minimum wage. One explanation for this may be that the inadequate budgets for home care commissioned by local authorities restricts providers' capacity to pay realistic wage rates, or it may be that there are excess profits in care homes (although in practice such margins are thought to be low) (Knapp *et al* 2001). There is not enough evidence to confirm or refute these explanations.

Vacancies and turnover

Public and independent sector

The limited information available suggests that vacancy rates within the social care sector are high, and anecdotal evidence supports such an impression. In 2004, there were 53,000 vacancies for social workers, occupational therapists and other care-related occupations notified to Jobcentres in England, with vacancies running at over 50,000 per quarter since the last quarter of 2003. Vacancy rates for 'care assistants and home carers' between April 2003 and January 2005 varied a great deal and ranged between 4,200 and 13,500, with no particular increasing or decreasing trend being evident (based on data from Eborall 2005).

It is not only the absolute vacancy rates that are high, but also the relative rates. The National Employers Skills Survey showed in 2003 that vacancy rates in social care were about twice as high as those for all private and public sector business activity in England (Eborall 2005). Even with the significant geographical variations reported across the country, this still represents an issue for social care. Turnover rates reflect a similar pattern. National rates are high (Revans 2005 cited in Parker and Whitfield 2006), although there is little information to substantiate this across the sectors.

PUBLIC SECTOR

The high vacancy and turnover rates are confirmed by figures in the public sector, for which there is, once again, more comprehensive information. Table 9 (overleaf) gives an overview of the local authority position in England as at September 2003. It is apparent that while both the vacancy and turnover rates vary according to the occupation and client-group, they are generally high.

The figures seen above are not unusual. As Figures 4 and 5 show (see pp 25–6), high vacancy and turnover rates have been variably, but consistently, high for some time.

TABLE 9: VACANCY AND TURNOVER RATES AND EXTENT OF RECRUITMENT AND RETENTION DIFFICULTIES FOR SELECTED SOCIAL SERVICES EMPLOYEES IN LOCAL AUTHORITIES IN ENGLAND AT 30 SEPTEMBER 2003

Staff groups covered by survey		Number of employees	Vacancy rate (%) ¹	Turnover rate (%) ² including retirement	Turnover rate (%) ² excluding retirement	% rating current recruitment difficult/very difficult	% rating current retention difficult/very difficult
Number of local authorities providing data			78	100	79	n/a	n/a
Field social workers	Children	22,830	11.8	12.0	11.1	75	54
	Other	22,330	10.2	9.4	8.1	44	24
Occupational therapists		2,035	18.7	17.1	16.3	70	37
Domiciliary care	Organisers	2,360	8.9	11.5	9.0	16	11
	Employees	47,620	11.2	15.0	11.5	47	43
Residential homes: managers and supervisors	Children	3,850	10.3	9.1	8.2	43	15
	Older people	6,790	8.1	9.9	6.9	25	11
	Other adults	4,990	8.8	8.7	7.8	17	9
Residential homes: care staff	Children	21,440	12.5	13.5	12.3	33	22
	Older people	4,150	9.2	15.5	13.5	40	26
	Other adults	11,800	10.0	14.7	13.1	27	26
Total		150,195	10.7	13.2	11.1		

Source: Eborall 2005

¹ Vacancy rate is calculated as the number of vacant positions at 30 September which authorities are seeking to or will seek to fill as a percentage of all posts of this type.

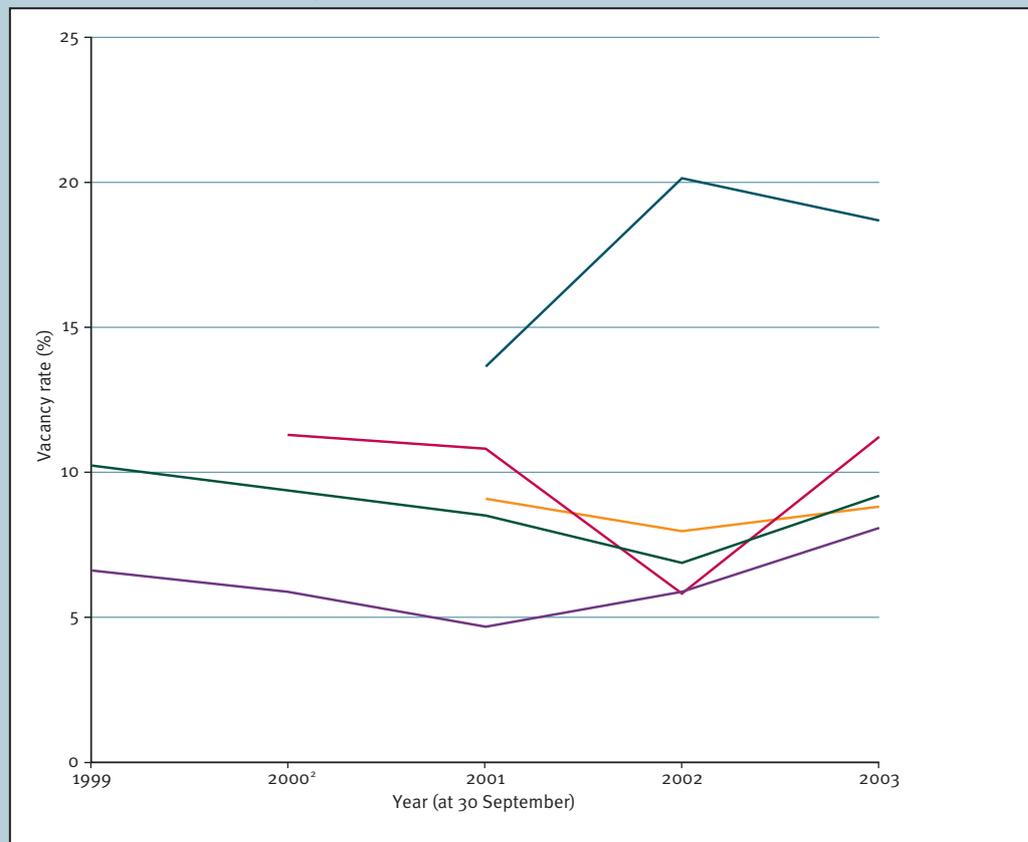
² Turnover rate is calculated as the number of leavers in the 12 months prior to 30 September as a percentage of the total of this type of staff employed.

As with pay rates, a range of factors influence the vacancy and turnover rates in the social care sector. In addition to the factors identified above and illustrated in Table 9 (occupation and client group), the other key main factor to note is that of location. In 2003 the range in vacancy rates was from 1.5 per cent (home care organisers in the Eastern Region) to 32.9 per cent (occupational therapists in London). Turnover rates meanwhile ranged from 5.7 per cent (home care organisers in the North East) to 32.3 per cent (occupational therapists in the West Midlands). Generally, in 2003, vacancy rates were markedly higher in London than elsewhere (17 per cent, one in six posts vacant), and also high in the rest of the South East and in the Eastern region, while lowest in the North East. Turnover rates varied less between regions, although they were particularly high in the South East (16.7 per cent). Moreover, in all regions there is wide variation between individual authorities (all Eborall, 2005).

INDEPENDENT SECTOR

Information on private sector turnover and vacancy rates is sparse, and does not exist on a national level. From the available information, vacancy rates seem to be at a similar level to that in the public sector (Eborall 2005). Many independent sector employers report difficulties regarding recruitment and retention.

4 VACANCY RATES (PERCENTAGE) FOR SELECTED STAFF IN LOCAL AUTHORITY SOCIAL SERVICES DEPARTMENTS IN ENGLAND, 1999 TO 2003



Source: Based on data from SCHWG Social Services Workforce Surveys 2001–03, cited in Eborall 2005

¹ Data only collected on years shown.

² The 2000 survey differed from others in that it was conducted in April 2000 and used a shorter questionnaire; 56 per cent of local authorities responded.

KEY	
—	Occupational therapists
—	Domiciliary care organisers ¹
—	Domiciliary care employees ¹
—	Managers and supervisors (residential homes for older people)
—	Care staff (residential homes for older people)

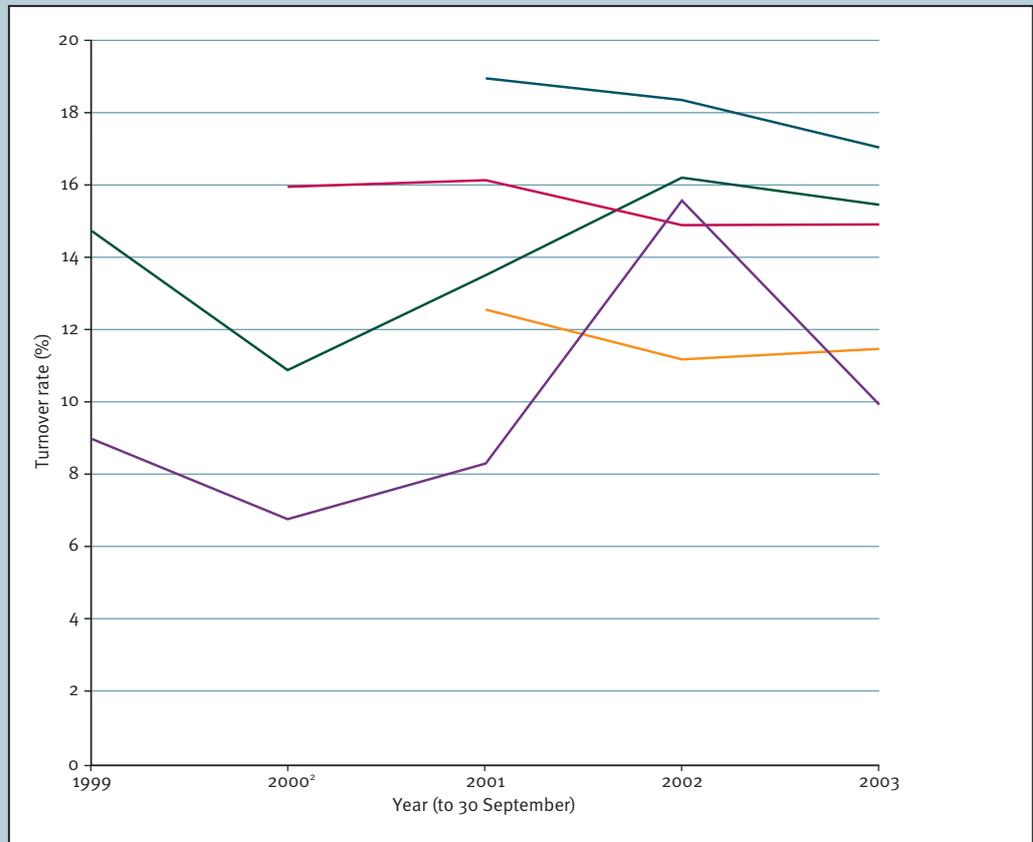
Supply and demand – mismatch?

The reasons for the ongoing problems with recruitment and retention in the social care market are complex and multi-factorial. Some of the reasons identified include:

- applications from unsuitable candidates – some providers suggest that individuals were applying simply to comply with employment benefit regulations, rather than because they possessed the skills and ‘caring nature’ required
- competition from other providers, and the trend for staff to be simultaneously on the books of several agencies
- insufficient applicants overall (Ware *et al* 2001).

There is insufficient evidence to identify one or more of these factors as being most significant, and it is unlikely that any single factor will be responsible for the situation identified. What is obvious, however, is there is a significant and enduring problem that presents significant challenges if it is to change. Put simply, there is no evidence of any slack in the system. In its current state, with the existing pay and benefit levels and other circumstances equal, it is hard to see how any significant increase in provision of social care could be effectively accommodated by the workforce. With the current difficulties in recruitment and retention, an increase in coverage could be achieved only through

5 **TURNOVER RATES (EXCLUDING RETIREMENT) FOR SELECTED SOCIAL SERVICES EMPLOYEES, LOCAL AUTHORITIES IN ENGLAND, 1999 TO 2003**



- KEY**
- Occupational therapists
 - Domiciliary care organisers¹
 - Domiciliary care employees¹
 - Managers and supervisors (residential homes for older people)
 - Care staff (residential homes for older people)

Source: Based on data from SCHWG Social Services Workforce Surveys 2001–03, cited in Eborall 2005

¹ Data only collected on years shown.

² The 2000 survey differed from others in that it was conducted in April 2000 and used a shorter questionnaire; 56 per cent of local authorities responded.

increasing caseloads, leading to less time being dedicated to each client, and reducing the role to the performance of specific tasks rather than allowing for dedicated client time and a flexible service response. This imposes significant constraints on service expansion.

Social care labour market

A crucial question when looking ahead is whether the supply of formal services can keep pace with the anticipated increase in demand for care. How quickly can workforce supply increase to meet growing demand? What quality of workforce will be forthcoming? What pay rates will be required to sustain a long-term increase in supply (quantity and quality)? What other factors influence and constrain workforce supply?

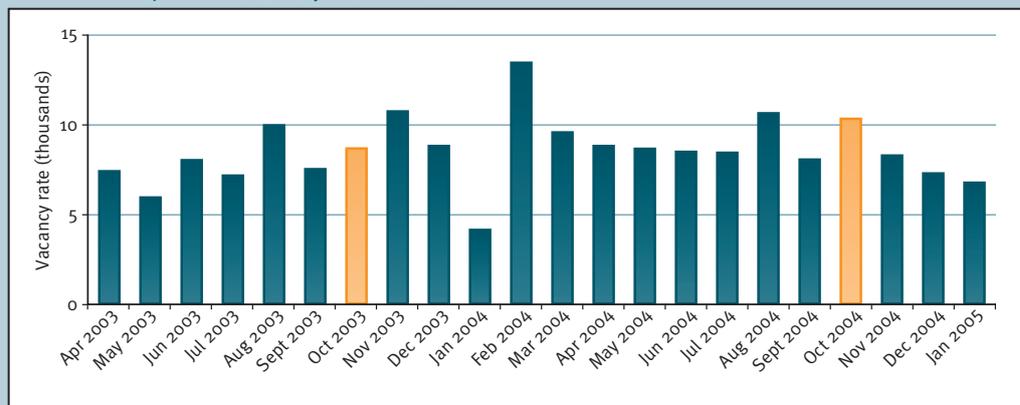
There is no direct research evidence on how quickly workforce supply could respond to demand. Nonetheless, there *are* indicators, some of which appear contradictory.

High vacancy levels suggest that either supply lags behind demand or it is unresponsive. In all industries, the workforce changes over time. However, as noted above, vacancy levels in social care appear to be high compared with the rest of the workforce. The introduction of the national minimum wage (NMW), which had some impact on the pay of the lowest paid in the sector (to varying degrees (Secretary of State for Trade and Industry 2005)), did not appear to have a significant impact on vacancy rates. The data available is not sufficient to offer an in-depth analysis, but only allow for a crude analysis (figure 6). This shows the vacancy rates in England for care assistants and home carers from April 2004 to January 2005, highlighting the months in the period in question in which the NMW changed (October 2004 and 2005, ONS National On-Line Manpower Information System (NOMIS) website cited in Eborall 2005). If the wages were directly and immediately affected by the rise in NMW, and if the workforce was very elastic, we would expect to see vacancy rates drop in October or soon after. This was not the case. A possible reason for this would be that increases in the minimum wage would have affected *all* low pay sectors in the same way, so it did not provide a significant comparative advantage of social care jobs relative to other low pay jobs. One could argue therefore, that the only way the introduction of the minimum wage could have raised labour supply in social care specifically would have been by bringing unemployed people into the workforce, rather than by attracting people from other sectors.

Other evidence appears to show contradictory results. Analysis of the Labour Force Survey in Scotland (Bell and Bowes 2006) suggests that there was a significant increase in the numbers working in social care over a relatively short period. In the period that saw the introduction of free personal care, between 2001 and 2004, employment in the care sector increased in total by over 50 per cent and weekly hours by 11 per cent. Total hours supplied by care assistants increased by over 75 per cent in that period. At the same time, average hourly wages increased by only 5 per cent. The study was based on a small sample size, but does strongly imply a high responsiveness of workforce supply, at least among care assistants in Scotland at that time.

6

VACANCY RATES FOR CARE ASSISTANTS AND HOME CARERS AS NOTIFIED TO JOB CENTRES IN ENGLAND, APRIL 2003 TO JANUARY 2005



Source: Based on data from ONS National Online Manpower Information Systems (NOMIS) website, cited in Eborall 2005

In addition, in the past, the provision of services has appeared to react quickly to demand opportunities. For example, during the 1980s the numbers of care home places for older people increased by 90 per cent (1982 to 1992, Department of Health community care statistics). However, the reasons for this were complex, reflecting both a readily available source of public sector funding as well as major transitions in the economy which saw many small hotel businesses (particularly around the south coast) and large Victorian properties being developed by care providers for the first time. Analysis comparing local authorities in England estimated that significant increases in the supply of both care home places and home care hours would be forthcoming with only small increases in price, if demand increased (Fernandez and Forder 2002). This also suggests that the workforce *is* responsive.²

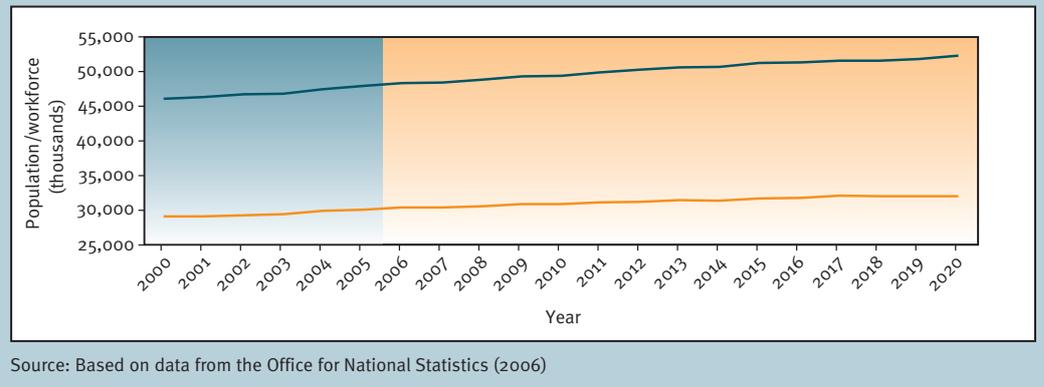
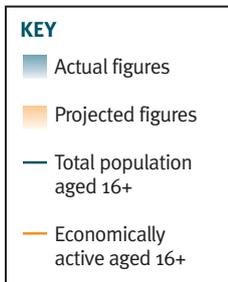
Factors affecting supply

The social care workforce is affected by trends in the workforce overall. There is a range of factors that could affect the future supply of labour to the social care workforce, especially in the case of any proposed expansion.

National labour force and population

The population of England is ageing; the number of older people in the population is expected to rise significantly over the next few years. It is generally assumed that the expansion and ageing of the population as a whole will be accompanied by the available labour force growing at a decelerated rate, or reducing in absolute terms. Analysis of available data shows that this is not the case. Estimates and predictions by ONS suggest that there will in fact be little change in the proportion of the adult population (over 16) that is economically active (see figure 6). This proportion changed from 63.1 per cent in 2000 to 63.0 per cent by 2006, and to a predicted value of 61.7 per cent by 2020. This would suggest the feared shortage of labour caused by increases in the proportion of people above the working age is not as significant as many assert. Numbers potentially available to form the social care workforce would therefore not appear to diminish substantially in the near future.

7 ESTIMATES AND PROJECTIONS OF THE SIZE OF THE LABOUR FORCE IN THE UNITED KINGDOM, 2000 TO 2020



Although relative numbers in the economically active population may not decline significantly, the average age of economically active people *will* increase. Over the next 30 years, the population aged over 50 will make up a higher share of the working-age population than ever before. The implications of this for social care are not fully clear, but possibly include (from Dixon 2003) the following.

- **Upward pressure on wage costs**, although there is the possibility that some labour cost savings may offset this for employers, such as lower turnover costs and lower absenteeism.
- **Downward pressure on levels of economic activity**, resulting from lower participation rates.
- **Reduced voluntary mobility between jobs**, with possible implications for movement into or out of the care sector.
- **Ageing of knowledge and skills of the labour force**. This increases experience, but also dates the knowledge and skills in the workforce. There are also implications for training: rates of participation in formal education and job-related training decline with age, and opportunity costs are greater while incentive to train further falls.
- **Increase in levels of ill-health and disability** in the workforce.

Such variables could have the potential to impose significant constraints on supply of labour in social care (as well as in the workforce more broadly). The ageing of the workforce will also create a change in circumstances that could act as a constraint or an opportunity, depending on how it is managed. There could be scope to tap into a previously under-appreciated and under-utilised pool of labour with a great deal to offer the social care workforce. There are suggestions, for example, that older care workers are well received by service users, while non-social care organisations that have actively sought to employ older people have found this to be beneficial for both the staff and the organisation (such as B&Q, see Audit Commission 2003).

Analysis by the ONS (Whiting 2005) indicates that the proportion of people in employment drops significantly after people reach their mid-50s, and people aged over 50 are currently under-represented in the labour market. It is estimated, however, that from 2004 to 2024 the proportion of older people in the population will rise from 34 per cent to 40 per cent of the total population, an increase of about 6 million. The 50–65 age group will therefore necessarily make up a larger proportion of the workforce, and will play an increasingly

important role. If substantial numbers of this group continue to leave the labour market, however, this will have a direct impact on the size of the working population.

It has been noted that the situation and characteristics of this group of potential employees (people aged over 50) differ both from those of people of other ages, and from this age group over time, and that factors which prompt them to participate in the labour market, or not, are also distinct from those affecting other groups (Whiting 2005). It is arguably possible to encourage a greater level of engagement in the workforce, but only through recognising and addressing the issues and the different needs of this older group of employees. Research has found that many older people are out of work (or have retired prematurely) when they still wish to be economically active and part of the labour market (Meadows 2002). There are many examples of approaches that will actively engage, recruit and retain older staff (Meadows 2002, Milton Keynes and South Midlands Health and Social Care Sub-Group 2005, and many others): the challenge is to put this into practice.

There have been attempts to raise the labour market participation of older workers, such as the New Deal 50 plus. In addition, by October 2006 the United Kingdom is required to introduce age discrimination legislation in order to comply with the European Employment Directive (2000/78/EC). As a result, regulations due to come into force on 1 October 2006 will protect people against being discriminated due to their age. It is expected that there will be a formalised responsibility of employers not to discriminate against those in the later stages of their career on the basis of age, and that employees will have the right to request to work beyond 65 (Employers' Organisation 2005a). In many ways, however, the onus remains on the organisation to surpass requirements and actively recruit and involve older people in the workforce. In an era where a constraint on supply may have implications for service delivery, it is important that this engagement of the older employee is encouraged.

Migration and immigrant workforce

The immigration of individuals from outside the United Kingdom, and internal migration within the United Kingdom, to work in the social care sphere is not a new phenomenon. In recent years, however, there has been anecdotal reports of the proportion of the workforce drawn from overseas increasing, and a change in the workforce structure as a result. The active recruitment of staff from other countries, particularly the developing world, together with the increased freedom of movement between EU states resulting from the 2003 Treaty of Accession (European Commission 2003), and the expansion of EU membership (Jandl and Hofmann 2004 cited in Redfoot and Houser 2005), would support this assertion.

The United Kingdom is now said to be one of the largest importers of professional health care workers in the world, with a large percentage of these staff working in the long-term care system (Redfoot and Houser 2005). In 2002, 14 per cent of foreign-trained nurses working in the United Kingdom were employed in private nursing homes, compared to 5 per cent of UK-trained white nurses. Nurses who first qualified overseas are twice as likely to work in 'older people's nursing' as those who first qualified in the United Kingdom (27 per cent compared to 13 per cent (Royal College of Nursing 2002)). It is argued that the relatively low prestige and poorer working conditions associated with long-term care have led to a disproportionate numbers of migrating health care workers finding work in long-term care settings where there is less competition for positions.

According to the 'neoclassic' economic model, the implications of increased immigration on the labour supply are positive, with the outcome being elimination of shortages in the labour market in a relationship that benefits all concerned (Howe and Jackson 2005, Rauhut 2004 cited in Redfoot and Houser 2005). There is controversy, however, over whether this is the case, and whether the 'importing' of staff, frequently from developing countries, is a positive force. Research in 2001 found that despite significant wage and unemployment differences (both key variables potentially determining workforce mobility between EU member states), labour migration had remained weak and no systematic convergence or divergence was evident (Raines 2000), suggesting that while some migration may occur, this may not necessarily be as substantial as others have predicted.

From both an ethical and economic perspective, there are concerns over the impact that sourcing staff from other countries (particularly those in the developing world), has on all parties.

- Acquisition of human resources from developing countries is considered by some to be a form of asset-stripping that can have a negative impact on the society and economy and leave a damaging care gap in the country in question (Redfoot and Houser 2005).
- Issues frequently exist regarding the prejudice and cultural preferences of both employee and care recipient, which can be obstacles to successful care-giving relations. There are also concerns about the skill levels and the quality of care provided by immigrant workers, although there is little evidence to substantiate or refute such claims.
- Possible issues are also identified around the impact of the migrant workforce on the conditions of indigenous counterparts. Some argue that employing workers from overseas can depress wages and undermine working conditions. Evidence for the actual impact, however, is mixed (see Redfoot and Houser 2005).

National guidelines on the immigration of health care professionals prohibit recruitment from certain less developed countries (Department of Health 2004a). However, this does not apply to social care staff, despite the high number of nursing staff that work in the social care industry. There are moves to address this situation, with consultation currently taking place on the development of a code of practice for international recruitment activities across social care in England.

An aspect often forgotten in discussing the migration of labour is that the movement of staff, is not only in one direction; staff from the United Kingdom frequently move elsewhere. In 2000, for example, 4 per cent of nurses in long-term care settings in the United States were from the United Kingdom, a total of 1,860 people (Redfoot and Houser 2005), while Canada and Australia are also becoming more active in recruiting in global markets (Milton Keynes and South Midlands Health and Social Care Sub-Group 2005). EU legislation will also make it easier for staff to migrate within Europe from the United Kingdom. It is important then, that England, and the United Kingdom more broadly, recognise they are competing in an active international market in a way that has not been seen previously, and respond accordingly.

If a significant part of the care workforce is sourced from the immigrant population then changes in national policy that could restrict immigration (particularly of people with low skills) could have a relatively large impact on social care. This will also impact on the trends in UK staff migrating abroad to work. It is essential that developed countries

benefiting from inward labour migration, England and the United Kingdom included, consider their moral responsibility to the source countries.

The trends in immigrant and migrant labour in social care could fundamentally change the labour supply and composition in England. It is unclear what the impact will be on the social care labour supply, and despite the potentially major implications for labour supply, little research has so far been conducted on the subject. This needs to be remedied.

Changes in service development and care technology

One of the most significant changes that could affect the types and numbers of staff required for the delivery of social care is the development of technology, either in parallel to existing care, or substituting for current models of service provision. Although technological developments have the potential to significantly impact on the need and demand for staff, little work has been done to assess this impact, the potential supply challenges, or the opportunities that might present themselves. There are several ways in which technology could influence staff supply.

- **Quantity.** Work done to date suggests that the introduction of technology leads initially to increases in staff requirements, before a subsequent fall. It is difficult to be clear about the size of any long-term substitution of technology for labour inputs, but a potential area is in supervision. While some work has been done to estimate possible savings associated with the introduction of technology (Audit Commission 2003), most attention has been on the positive impact on care-staff time, rather than on the issue of staff being required for monitoring and operating equipment; this has led to potentially misleading conclusions.
- **Skills.** More technological knowledge will be required of staff, both for monitoring and, to a lesser extent, for responding to alerts, which may include ‘front-line’ staff, particularly in home / domiciliary care.
- **Price.** It is likely that the specialisation of work and the introduction of a greater range of skills required will mean skilled staff both expect and attract higher salaries. Work done by the Audit Commission (2003) indicates that the overall costs of using technology would be considerably less than current labour-intensive models. However, research undertaken for this Review has found that rather than reduce costs overall, use of more technologically focussed methods may make better use of staff time, thus enabling them to care for more people, but that this would not necessarily generate cost savings overall, especially given the potentially higher costs of employing technically skilled staff.

In addition, potential issues have been identified with the impact any widespread introduction of technology may have on staff and services. The limited work that has taken place on this subject has mainly addressed the obstacles to progress (see Audit Commission 2003).

Chapter 9 and Background Paper 7 (‘Telecare and Older People’) discuss issues surrounding the use of technology in social care in greater depth.

Types of staff/skill mix

It is not only the use of technology that has the potential to significantly impact on the skills and types of staff that are needed for provision of social care in the next 20 years. As

discussed in the main report for the Wanless Review (chapter 11), the services provided and the consequential input required may well change through time. The existing labour market is based on the skill mix required by the current service, however.

There have been many and varied suggestions on new types of role that may exist in future provision. For example, it is anticipated that more staff will be needed to act in support, advocacy and brokerage roles (including ‘care navigators’ and ‘care brokers’ associated with the expansion of Direct Payments and Individual Budgets). In addition, the consistently shifting boundaries between health and social care bring with them the possibility of new staff roles, including generic health and care workers. It is clear that the skills (and training) required would be different from those needed for existing roles and responsibilities.

The ‘Options for Excellence’ programme initiated by the DH and DfES in 2005 has recognised these challenges for workforce planning both in the short and medium term. There has been some analysis of extension and redesign of roles for the social care workforce (see Department of Health 2004b and General Social Care Council 2002) – although this is far less developed than in health care (see Jenkins-Clarke and Carr-Hill 1996, Richardson and Maynard 1995, Department of Health 2000, Department of Health 2002, Department of Health Modernisation Agency 2004a, Department of Health Modernisation Agency 2004b).

Many commentators argue that the work that has been undertaken in addressing the future social care workforce does not yet offer the coherent response to changes in demand that is really needed (for example, in Milton Keynes and South Midlands Health and Social Care (2005)). Considerable investment is still needed to develop and scope new roles so that they meet demands in the most appropriate and effective way. It is important that the likely consequences are considered ahead of changes being made, however, so the response can be adequate and timely, or even pre-emptive. To date, very little work has been done on the impact of changes on the market supply. This needs to be addressed.

Training capacity

A significant constraint on increasing labour supply is the availability of suitable training and development staff. A substantial expansion of workforce would, under current conditions, require a corresponding increase in staff able to facilitate the necessary training and assessment. Recent work by the Strategic Learning and Research group on supply side human resources identified a lack of capacity in the education supply side workforce to meet current training requirements. This is something that would need to be considered and addressed prior to any expansion of the workforce.

A lack of systematic data undermines attempts to quantify these requirements. For example, it is not clear what the existing maximum capacity is for training and development of staff in social care. This lack of information is especially surprising given the recent guarantees that training will be increased, apparently with no awareness of the capacity to do so.

This constraint could be overcome, but it would involve additional investment and a significant lead time to allow for training of the ‘trainers’ and subsequent training of new

staff groups. Any intended increases in staff would require forward planning. There would also need to be consideration of the appropriateness and feasibility of minimum training requirements during the period of expansion, with either additional time given for the training to take place, or changes in the standards themselves. Any change in the standards would require careful evaluation of the impact on service quality and potential risks to service users.

Regulation

The social care workforce is increasingly monitored and regulated. This has the potential to impact positively on the quality of services, but can also affect supply. Regulations inevitably bring with them administrative processes and associated costs, and can create barriers to the recruitment of staff. The Better Regulation Commission (formerly the Better Regulation Taskforce) advises the government on reducing unnecessary regulatory burdens and ensuring that regulation is: proportionate, accountable, consistent, transparent and targeted. Any further regulation in social care clearly needs to follow these principles.

Balancing protection against unnecessary regulatory burdens is clearly a difficult equation. Some areas of regulation in which there could be constraints (or potential constraints) on workforce development include the following.

- **Criminal Records Bureau (CRB) checks.** These are currently necessary for all people working with children or vulnerable people (including elderly people). The wait for CRB clearance was three months in 2005 (SCIE 2005), and the problems with the system are well known. There are ways in which this delay can be minimised (*see* CSCI 2005) but this still remains a potential constraint on staff employment, albeit only short term.
- **Qualification requirements.** The Department of Health previously set a target for 50 per cent of staff to reach NVQ level 2 in certain organisations. This has implications for recruitment of non-qualified staff (Department for Education and Skills 2003), while there are barriers to both the employers and the employees in acquisition of this level of training, with implications for the provision of services.
- **Qualifications from other countries.** The General Social Care Council (GSCC) has developed procedures to assess whether the qualifications, training and experience of social workers qualifying abroad are equivalent to the Diploma (and Degree) in Social Work. While this is arguably necessary to ensure public protection, such processes need to operate as efficiently as possible if they are not to exclude individuals with high levels of suitable expertise, and not act as a disincentive, or add to the length of time taken for staff to start working in England. The resource implications also need to be considered.
- **Care worker registration.** While this has many benefits in terms of public protection, there are possible consequences in terms of disincentives for staff coming into the labour market and administrative and resource implications for employers. This reservation has been voiced in the aftermath of the announcement by Liam Byrne on the registration of the next groups, most notably in the ECCA response (English Community Care Association 2006).

Motivation and perception

Perceptions of care work are frequently negative, both among the public and the staff themselves (Alcock 2003). Among the public, a poor attitude towards social workers and social care workers and the job that they do appears to be prevalent across age groups,

genders and socio-economic class (COI Communications 2001). This is largely reinforced by the media. Research shows that the majority of coverage is adverse, or frequently unrelentingly critical rather than supportive (Eborall and Garmeson 2001). Although some suggest that this poor perception is decreasing, anecdote and perception suggest that it still appears to be at the more negative end of the spectrum.

The negative perception does not necessarily extend to the staff themselves, however. Work commissioned from NOP by the GSCC in 2003 into views about the social care workforce found 82 per cent of people viewed social workers as making a 'very important' or 'fairly important' contribution to society (compared with just under 100 per cent for doctors and over 80 per cent for a range of other professionals). This proportion was higher (94 per cent) in relation to care assistants.

Within the social care sector, it appears the perceptions are also poor. Many still consider care work a vocation entered into despite pay and conditions (COI Communications 2001). This obviously has clear implications for recruitment. Research has highlighted several influential factors causing staff to reflect the negative emphasis seen externally (Eborall and Garmeson 2001). These include:

- staff feeling they are prevented from doing their work properly by problems such as overwork, bureaucracy and poor management, resulting in reduced job satisfaction
- fear of the present situation and the future, especially regarding violence, abuse and harassment
- perceived weakening of the moral and ethical position of social work
- lack of flexible working
- poor management
- inadequate resources and training
- barriers to returning to the service should they wish to.

In addition, those working in social care often believe that society undervalues them and their work. Social workers, in particular, feel their image is negative, largely as a result of media stereotyping (COI 2005). Qualitative research commissioned in 2005 by the Department of Health through the Central Office of Information explored motivations and attitudes to care work and found that while social care was often seen as a difficult job with long hours and little financial reward 'most care workers demonstrated great dedication to their work and their clients, and expressed a sense that this was their vocation.' Care workers value the time they spend with their clients and derive considerable satisfaction from this contact; relatively few of those working in social care regard the work as 'just a job' (COI 2005).

As discussed above, several theories exist that suggest the level of motivation of staff impacts on performance and thus on the level of care provided to patients and recipients of care. Thus this poor perception of social care within the service itself has implications not only for recruitment and retention, but also possibly for the quality of care itself. It is important for many reasons that the perception of social care from the user, staff and public perspective is improved.

In 2001 the Department of Health launched a sizeable campaign to promote understanding and a more positive image of social work careers. This stimulated considerable interest, but it is not clear whether the substantial number of inquiries

generated has translated into equally significant increases in recruitment (Parker and Whitfield 2006). A further campaign has been launched in 2006.

Conditions and career prospects

While pay levels are arguably a key factor in the recruitment and retention of staff, other benefits, both financial and non-financial, also have an impact on the appeal of the work and have a key role in motivating people to join the sector. Particular problems at present include:

- the lack of pension rights for some groups of workers (Ungerson 2000)
- the fact that pay is not graduated according to qualifications acts as a disincentive to those wishing to follow a career path
- care assistant jobs are traditionally non-unionised (particularly in the independent sector) and workers often do not have contracts (Andrews and Phillips 2000)
- where contracts do exist, these are frequently 'zero-hour' with no guaranteed hours for the working week
- there is frequently little, if any, recognition of travel time between clients (for staff working in the community) with time travelling and not spent directly on care frequently subtracted from paid-for hours.

Future position

This exploration of the future of staff in the social care workforce has concentrated on developments within the framework of the current model of service provision and funding. Knowledge of future social care workforce requirements and the impact on labour supply are fundamental to effective workforce planning, and to the creation and operation of an efficient market and high-quality service that meets demands. While there has been some increase in policy activity and awareness of the social care workforce and its future needs most recently through the 'Options for Excellence' work, this has arguably been less than would be expected, and is only a recent addition to the agenda. Given this, there is little evidence that can be cited regarding the future trends in the workforce. However, the following can be noted.

Unit costs

There has been some indication changes in unit cost over time, in both pay and training (although the actualisation of all indications is obviously subject to a range of political and economic factors).

Pay

There appears to be a general indication that there may be relative increases in unit costs. These particularly reflect the influences of the 2004 pay settlement and the National Minimum Wage.

- Under the 2004 pay settlement, local government made commitments to conduct job evaluation exercises and implement new single status pay and grading structures by 31 March 2007 (Incomes Data Services 2005). For an indication of the consequences of this, we can look at the equivalent initiative in the NHS Agenda for Change (A4C). As has been repeatedly reported in the media, this appears to be one of the factors that has contributed to the current funding problems in the NHS, due to the massive financial consequences of increases in pay for many occupational groups. It is certainly true that Agenda for Change led to increases in cost across the service that were significantly beyond those estimated in many quarters. Even if the results of the exercise in local government are not of the magnitude seen in the NHS, it is likely that there will be some increase in unit costs. However, the review is a positive and necessary move, given the widespread discontent caused by the perceived discrepancy in pay and reward between the NHS and social care occupations following from Agenda for Change, as highlighted in the *Report of the Local Government Pay Commission* (Local Government Pay Commission 2003).
- As noted above, the National Minimum Wage (NMW) appears to have had a continuing positive impact on the wage rates in social care, especially for the lower paid occupations, such as care assistants. This trend is likely to continue (unless there is a

significant shift in pay or change in circumstances that result in the sector responding to changes differently). The 2005 Low Pay Commission Report (Low Pay Commission 2005) stated that there was a 'strong case for continuing along the path of uprating the minimum wage outlined in the fourth report (2003), with a further increase relative to average earnings over the next two years', although given the need to 'proceed with caution' they recommended 'the increase over two years should be above predicted average earnings, but not substantially so' and should be 'phased'. The numbers recommended include an increase to £5.35 in October 2006, (subject to review). In addition, there will be a change in the upper limit for the youth Development Rate from the 22nd to the 21st birthday, and this age group will also see increases, to £4.25 and £4.45 in 2005 and 2006 respectively.

Training

Similar upward trends in training costs are evident. Recommendations on the development of training and skills (along with other areas) have been addressed in the *Report of the Local Government Pay Commission* (Local Government Pay Commission 2003). This included recommending greater investment in this area by both national and local government. The allocation of funding for training through grants, (which has included funding to support both local authority and the independent sector social care workforce) has had some impact and initiated what is believed to be increased funding in this area (or at least not a diminution of current levels).

Recent government statements (such as by Liam Byrne (Byrne 2006)) have noted the importance of training and the need for continuation and development (see below). The development of more training of any kind will require more financial input. The nature of this training and development and the environment within which it will be implemented will impact on who will bear the additional cost, but the unit cost will increase, with consequences somewhere in the system.

TRENDS AND IMPLICATIONS

There has been a series of political commitments with regard to training and development within the social care workforce.

- In February 2006, the Care Services Minister Liam Byrne stated that registration and training would be extended in social care. The extension of registration to the next groups of care workers will have implications for training and development requirements. It is unclear at the time of writing what the specific implications will be.
- The National Minimum Standards give specific targets for the attainment of qualifications in various settings. The significant requirements for our purposes are:
 - in care homes a minimum ratio of 50 per cent trained members of care staff (to NVQ level 2 or equivalent) needed to be achieved by 2005, excluding the registered manager and/or care manager, and, in care homes providing nursing, excluding those members of staff who are registered nurses (National Minimum Standard for Care Homes for Older People 28.1)
 - in domiciliary care, 50 per cent of care arranged by a domiciliary care provider is to be delivered by care workers qualified to at least NVQ level 2 or equivalent by April 2008.

Conclusions

The social care workforce is large and diverse and spread out across a wide range and number of employers. The data on the exact size and composition of the sector is varied in completeness and reliability, with the statutory sector holding the most comprehensive information. A number of promising initiatives are now in train to improve the quality of data across the board, but there is still a great deal that needs to be done.

There are two key issues pertinent to this Review. First, is the issue of whether there is currently sufficient capacity in the workforce. In the context of expected increases in demand for care in the future, there is a very real issue of whether it is realistic to expect supply to increase in response. Evidence about supply responsiveness, and about what factors might bring about increases in supply, is mixed. Trends in recruitment and retention suggest that current policies and pay are not closing the gap between demand and supply. However, a range of circumstantial and anecdotal evidence is, on balance, positive about future supply. Overall, the evidence base is limited by the absence of definitive studies that would allow confident conclusions and predictions. Interpretation of limited evidence is made difficult by the complexity of the issues. Supply of labour to the social care market depends on wages, people's motivation to work in social care, barriers to market entry, the capacity in the wider economy for people to work in the low-pay sector, and the action of competitor industries such as health care. In addition, the United Kingdom is operating within an international labour market in a way previously unseen. It is clear that the sector will need to act in an increasingly competitive market to attract staff in the future. Recruitment strategies need to be combined with appropriate and cost-effective training to ensure the outcomes of care services are high quality.

The second issue is the quality of care received by service users. Current systems of measurement concentrate largely on processes rather than on the outcomes achieved (although the development of an appropriate outcomes framework is currently being taken forward by CSCI). Minimum standards, such as bringing 50 per cent of social care staff up to a minimum NVQ level 2, concentrate on the levels of training as a proxy for outcomes achieved as a result. As set out above, the evidence on the relationship between achievement of qualifications and quality of service is not conclusive, and is dependent on other factors, including, most importantly, the existence of a working definition of what constitutes a high quality of service. Evidence suggests that training alone is not sufficient to ensure favourable outcomes in service provision, but must be combined with other factors. A great deal more work is required to substantiate possible correlations and produce viable methods of ensuring that positive outcomes are introduced in practice. Rigorous substantiation of a link between qualifications and quality would need to be followed with introduction of proven incentives for employees to undertake training and for employers to support and provide it.

In the models described in the main report, the central assumption is that unit costs need to grow consistently by at least 2 per cent in real terms over the 20-year period. The sensitivity of overall funding requirements is also tested. Work is urgently needed to objectively examine supply responsiveness of the workforce and the potential impact of pay on supply.

Annex 1

Source distinctions

The staff numbers in Table 1 (see p 4) are arguably the most reliable available. However, these numbers are necessarily taken from a number of sources, so issues with these sources need to be taken into consideration.

Labour Force Survey (LFS)

This source, while nationally representative, lacks specificity. It is difficult to use this data to estimate the size of the care workforce reliably as it uses a diversity of care occupations and employers and the classifications do not make it easy to separate the care workforce specifically from other types of work.

Two classification systems are available: SOC2000 (Standard Occupational Classification) or SIC92 (Standard Industrial Classification). Both have gaps in coverage and are based on self-assessment. However, both are thought to have positive aspects.

Using the Standard Occupational Classification (SOC2000), the care workforce is defined in terms of both social care workers and child care workers. This does not, however, include management roles, and shows only the main job, so does not account for the many care workers who have two or more jobs.

Under this definition, in 2003/4 there were an estimated 1.5 million people working in care-related occupations as their main job, in England (Eborall 2005). This figure falls to 930,000 after excluding the numbers of people working exclusively in the child care and early years sector. This figure then includes all adult care and some care for younger people and children (such as foster care and youth workers) as well as care for older people. It is not possible to separate out those working exclusively for older people from this information. The occupational groups included when estimating a figure of 930,000 are listed below in Table 10, along with details of the private and public / voluntary sector split for these roles.

Using the Standard Industrial Classification (SIC92), the care workforce is defined by the social work industry. This measure has the benefit that it includes managers, clerical workers, catering staff and cleaners (most of which are excluded when using the Occupational Classification SOC2000). According to SIC92 there are 1,235,000 workers in social work in Great Britain (Simon and Owen 2005). This figure includes those working with all age groups (children, adults and older people), and it is not possible to refine the data to a more specific client group.

TABLE 10: ESTIMATED NUMBERS AND SECTOR SHARE OF PEOPLE EMPLOYED, SELF-EMPLOYED OR IN GOVERNMENT EMPLOYMENT OR TRAINING SCHEMES IN CARE-RELATED OCCUPATIONS AS MAIN JOB, (EXCLUDING EDUCATIONAL ASSISTANTS), ENGLAND, 2003

SOC2000 code and occupation (self-declared)	People working in sector	% of total	Private sector % of total	Public and voluntary sector % of total
2442 Social workers	67,000	5	16	84
3222 Occupational therapists	19,000	2	11	95
3231 Youth and community workers (role includes some elements of social work)	66,000	5	35	64
3232 Housing and welfare officers (role includes some elements of social work and organisation of domiciliary care services)	111,000	9	44	56
6111 Nursing auxiliaries and assistants (occupation description includes personal care tasks)	181,000	15	15	85
6114 House-parents and residential wardens (including foster carers)	27,000	2	67	33
6115 Care assistants and home carers	459,000	38	67	33
Total (excluding child care and early years sector)	930,000			
6121 Nursery nurses	131,000	11	63	37
6122 Childminders and related occupations (including nannies)	107,000	9	91	9
6123 Playgroup leaders and assistants	49,000	4	67	33
Total child care and early years sector	287,000	24	74	26
Total (excluding educational assistants)	1,217,000	100	53	47

Source: Based on ONS Labour Force Survey 2003 Annual Dataset, cited in Eborall 2005

The information collected through the LFS is less reliable and exact than one would expect, and the figures that can be produced as a result are not sufficiently detailed or specific for information and planning purposes. The introduction of the NMDS (SC) is one way in which this situation will be improved, but this will still not capture information on some areas of workforce supply, and total figures will remain less than ideal.

Local authority data

An alternative way of producing workforce estimates is through use of local authority data on statutory and independent sector workforces. The introduction of this data set in 2003/4, was the first time local authorities in England with social services responsibilities were required to provide information on numbers of staff employed by the private and voluntary sector care providers in their area as well as on their own employees. The usefulness of this data is limited by its recent genesis and the fact that it is an estimate; there are additional concerns about:

- how local authorities collect the information
- the extent to which all providers are included
- how providers are categorised

TABLE 11: LOCAL AUTHORITIES' ESTIMATES OF THE SOCIAL CARE WORKFORCE CARING FOR OLDER PEOPLE BY SECTOR (ADJUSTED FOR INCOMPLETE- AND NON-RESPONSE), ENGLAND, 2003

Sector	Social care workforce	Workforce caring for older people	Older people workforce as % of sector total
Private sector	563,600	411,100	73
Voluntary sector	171,600	67,500	39
Independent sector	735,200	478,600	65
Statutory sector	269,200	130,300	48
Total	1,004,400	608,900	61

Source: Based on Social Services Inspectorate performance and assessment data and information, February 2004, cited in Eborall 2005

- whether non-contracted providers and contracted providers outside the local authority area are covered
- the extent to which the information from the various authorities is incomplete
- the accuracy and incomplete nature of data from some of the authorities.

The figures produced through use of the local authority data are lower than expected. After making adjustments for incompleteness, non-response and questionable numbers, the total figure for the social care workforce in England is 1,004,400. Of this number, an estimated 608,900 (61 per cent) work in older people's services. Details are illustrated in Table 11.

Annex 2

Main types of training for care and social workers

As stated above, there is a large variety of training available to staff working in the social care sector. The key types of training for care staff and social workers are briefly outlined below.

NVQ

NVQs are nationally recognised qualifications that are assessed against National Occupational Standards. NVQs are an assessment system rather than specific training courses that evaluate competence of employees to undertake their work. This competency is achieved through a combination of practical 'on the job' learning and theoretical preparation. NVQ awards are available at levels 2, 3 and 4 for health and social care. At levels 3 and 4 candidates can choose either an adult or children and young people pathway dependent on the work they are doing. Assessment takes place through assessors who in turn need to be trained to fulfil this role.

Diploma in Social Work (DipSW) and the new Degree in Social Work (information from General Social Care Council 1996 and General Social Care Council 2006b)

This has been the professional qualification for social workers and probation officers since 1989, replacing the two former awards, the Certificate of Qualification in Social Work (CQSW) and the Certificate in Social Service (CSS). Programme approvals, modifications and inspection decisions are all maintained through a central registry, under the GSCC, which is also responsible for student registration, recording awards of qualifications and maintaining lists of award-holders. From 2003 professional qualifying training for social workers in England changed to a degree in social work approved by the GSCC. The diploma in social work and all previous qualifications are still recognised as social work qualifications but new entrants to social work now apply to enrol on approved degree courses. Since April 2005 anyone employed as a social worker in England *must* be registered with the GSCC, and registration is contingent on holding an appropriate qualification.

Post-registration training and learning (PRTL) (General Social Care Council 2006c)

Registered social workers are required to keep their training and learning up to date. To do this they must undertake a minimum of either 90 hours or 15 days of training and learning (over a three-year period) in order to re-register with the GSCC at the end of the three-year

registration period, as is required. This can include studying for a certificated post-qualifying award, (although post-registration training and learning (PRTL) also embraces a wide range of activity including seminars, study days, directed reading and discussion etc). Registered social workers are responsible for maintaining records of this post-registration training and learning, and failure to meet the specified conditions may be considered misconduct. The GSCC Code of Practice for Employers of Social Care Workers states that employers are expected to support registered workers to meet the requirements for continuing professional development, and 'must provide training and development opportunities to enable social care workers to strengthen and develop their skills and knowledge'.

Post qualification (PQ)

The post-qualifying (PQ) framework enables qualified social workers to continue their professional education and training. A new three-level PQ framework (specialist, higher specialist, and advanced) will be operational from September 2007 and builds on the qualifying degree in social work. The post-qualification framework also enables social workers to fulfil their post-registration training and learning requirements. The revised PQ framework integrates academic and professional learning (that is, professional outcomes are integrated with university validated programmes and module learning outcomes (General Social Care Council 2005)). The new PQ framework also supports experienced social workers by accrediting prior learning and experience. All new PQ programmes must be linked to university awards (and the universities must apply to the GSCC for accreditation), but PQ programmes also incorporate workplace learning. To register for PQ training, individuals must hold a DipSW or equivalent. Awards are offered through 17 post-qualifying consortia in England, each composed of at least one employer and one educational institution.

There are currently two levels of PQ award:

1. The Post Qualifying Award in Social Work (PQSW) (of which there are 4 types):

- Mental Health Social Work Award
- Child Care Award
- Practice Teaching Award
- Regulation of Care Services Award

2. The Advanced Award in Social Work (AASW)

Additional qualifications are also available in specialist areas, enabling staff to take on roles as trainers, regulators, or in specialist areas such as Mental Health.

More comprehensive information is available at a range of sources. These include:

- GSCC (General Social Care Council 2006a)
- Skills for Care (2006a) (particularly the two Skills for Care reports published to date – 2004 and 2005)
- Selection of publications and data sources at the Employer's Organisation for Local Government (EO), e.g. Social Care and Workforce Group (2003).

Annex 3

Staff quality measures

In general, the entry criteria and standards for the various courses (social care specific) are set and specified by the GSCC with CSCI regulating the levels of training and qualification that need to be obtained within the organisation. Skills for Care meanwhile is responsible for the strategic development of the adult social care workforce, (and closely involved in the development of the National Occupational Standards, and common induction standards), but is not a regulatory body. With regard to quality measures however, the situation is less clear. In addition to the oversight of these bodies mentioned, there is also a range of other quality measures in place, ranging from those at the very local level, to those set and monitored on a national basis.

At a local level, the key quality measures revolve around the policies and procedures of individual organisations. Operational guidance and best practice is offered both through legislation and various organisations and sources. Certain standards are enforced indirectly through CSCI, with homes and agencies that fail to meet the criteria, processes being initiated that can eventually lead to the closure of the organisation, should this be necessary. Legislatively, the Disability Discrimination Act (1995), The Employment Equality (Religion or Belief) Regulations 2003 and the forthcoming Age Discrimination Act offer examples where employers are compelled to act in certain ways to ensure the legality of the operations. In practice however, these provide a minimum level of requirement for organisations, with the emphasis being on the organisation to exceed if possible and sought. In the case of the National Minimum Standards (NMS) for example, standards are specified for particular aspects of the service³ meaning that the standard achieved will not necessarily be indicative of the overall quality.

In addition, there are also other national measures and bodies that ensure certain standards and monitor quality. These include:

- **Various commissions** responsible for specific aspects such as racial equality and disability (Equal Opportunities Commission, Commission for Racial Equality and Disability Rights Commission -possibly soon to become Commission for Equality and Human Rights (CEHR)).
- **Codes of practice** (notably the GSCC Code of Practice for Social Care Workers and Code of Practice for Employers of Social Care Workers) introduced as a result of the Care Standards Act (2000) which 'provide a clear guide for all those who work in social care, setting out the standards of practice and conduct workers and their employers should meet' (General Social Care Council 2002). This is enforced by the GSCC, and by CSCI who 'take the codes into account when enforcing care standards' (General Social Care Council 2002).

- **Social Care Register** – a specific example of regulation through restriction of practice to staff recognised and assessed to be of a certain level, ‘trained and fit to be in the workforce’ (General Social Care Council 2006d), enforced through the protection of the title ‘social worker’ by law to those who are qualified and registered. The Social Care Register is to be extended over time to include other social care workers, and the next groups identified for registration are residential and domiciliary care workers (including staff working in adult social care and those in children’s services). The next groups were announced by the Minister, Liam Byrne, in July 2005, and in February 2006 it was confirmed that registration for social care staff was ‘going to happen’ (Byrne 2006) and the GSCC was asked to begin consultation on registration of the next groups.

The regulatory framework is complex. The GSCC is responsible for regulating the social care workforce, while the Commission for Social Care Inspection (CSCI) is the independent inspectorate for all social care services in England. There are possibilities of fragmentation of responsibilities but the key agencies have developed a partnership model of working to reduce these risks. The framework has undergone considerable turbulence (notably with the demise of the National Care Standards Commission), and with further change afoot in the merger of CSCI and the Health Care Commission by 2008 to create a single inspectorate across both health and social care. The regulatory framework is also of relatively recent origins (dating mainly from the Care Standards Act of 2000), and hence its development is in transition. At present the regulation both of the workforce and of services is incomplete, but this is work in progress and the significant challenges involved could only be approached on a phased basis given the scale of development that is required (such as in moving towards full registration of the work force which will inevitably take several years to achieve).

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Notes

¹ This calculation has been made using the assumption that the older age group represent 73 per cent of private sector provision for all occupations in social care equally

² This inference is not made on the basis of data collected regarding the elasticity of workforce per se, but indirectly from work on the supply of services, and as such, should be treated with caution.

³ The NMS for qualifications for example states that it is necessary for 'a minimum ratio of 50 per cent trained members of care staff (NVQ level 2 or equivalent) is achieved by 2005, excluding the registered manager and/or care manager, and in care homes providing nursing, excluding those members of the care staff who are registered nurses'.