

Dartington review on the
future of adult social care:
*The future adult social
care workforce*

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Summary

Expectations of the adult social care workforce in England will change significantly by 2020. This review examines what these changes are likely to be and the steps required to respond to demographic and social challenges. Robust data to underpin workforce planning is not available in 2009. This is essential to plan effectively for 2020 and data collection systems will also have to be sophisticated enough to recognise that a substantial minority of workers will be employed directly by people using services rather than by small, medium or large organisations in the private or voluntary sector. There are an estimated 1.5 million social care workers (CSCI, 2008) and this number will need to increase by 2020. Campaigns to recruit more people, including young people and men, began in 2008 and will continue, but more information is needed about what attracts people into social care work, and what makes them stay or move into other fields.

Traditional explanations that movement out of social care is primarily prompted by pay have not been substantiated and little is known about the impact of economic recession in diverting workers into social care. One of the methods to attract more people into social care is to raise its status in the minds of the public. Between 2010 and 2020 this is unlikely to be through increased pay or conditions of work - unless these improve because there is a severe scarcity of workers and restrictions on migrant workers remain in place. Before decisions about qualifications and registration for social care workers are consolidated, there should be a fuller debate than has taken place in 2009 about their influence in attracting workers into social care or raising professional standards.

This discussion excludes the 90,000 social workers in England. They have been the subject of a major government sponsored enquiry by the Social Work Task force (The Social Work Task Force, 2009).

The workforce strategy for adult social care in England is located within the broad framework of the debate stimulated by the politics of the user movement. Analysis is made urgent by the imperative to reform a social care system deemed unsustainable because of a perceived mismatch between demand and resources, even before the current economic recession.

The initial desire by disability pioneers to reduce the involvement of public services in their personal lives has led to determined questioning of all the components of the current system which could be seen to deny or restrict choice. This includes the construction of services, roles taken by staff in the care system, and the training or regulation of the social care workforce. Although the views are not universally held, there is a vocal, well-connected and significant lobby for minimal intervention and maximum freedom of choice, including the right to take risks in relation to one's own care. The right to user choice and control, stimulated particularly by people with a physical disability, has been translated by central government in England into the personalisation agenda for all user groups. The elements of personalisation are well described by the Social Care Institute for Excellence (SCIE, 2008). They include how users exercise choice, perhaps managing an individual budget provided after assessment by a local authority, but also how services are tailored for individuals and how universal services are accessible by all. This complex agenda is being implemented as best they can by local government and providers of social care through the staff they employ.

Alongside these care specific developments, the wider population has expanded its aspirations within a consumer framework. This paradigm holds that standards can rise while costs fall, driven in part by competition, in part by efficiencies and in part by eliminating elements of personal service deemed replaceable without too much effort by individuals (and supported by information and communication technology). This has further driven up expectations of adult social care.

BOX 1

The social care workforce

Expectations from social care will also rise

- That services will be more personalised
- That there will be enough for everyone
- That their quality will be good
- That they will meet modern ideas of privacy
- That they will offer more than care, that they will be life-enhancing and aspirational

Data taken from DH, 2009a

A summary of public opinion by the Department of Health in 2009 suggests that 86% of people fear getting older and living alone or being in poor health, with 38% worrying particularly about living in poverty (Municipal Journal, 2009). There is increasing awareness of the potential impact of a growing number of older people, who are the majority users of adult social care services, on the care system. They also represent an increasing proportion of the adult population and are living longer, with consequential increases in their requirements for health services and social care support.

Resource use

This has triggered a public debate about the provision of care and how to fund it. The models set out in the government's Green Paper for England (HM Government, 2009) outline potential funding models ranging from those fully or partially met through taxation to those relying on voluntary or compulsory insurance in various forms. An estimated 50% of people fund their own care either completely or partially, rising in some areas to 90%. The number of people who have paid for their own services until their resources have been reduced to £23,000, the level at which contributions are made from the public purse, will be much larger than this. In addition, the Office of Fair Trading found that a third of families contribute 'top ups' when their relative's care is funded from the private purse (HM Government, 2009).

The resource framework for social care is shifting in advance of the outcome from the Green Paper debate. A policy announcement in England promises free care at home for 280,000 people of any age most severely in need, from 2010 (Hansard, 2009). This is already creating stresses in the calculations of local authorities about eligibility criteria, market distortions and affordability. The current assessment process for eligibility for a personal budget is based on need and income, but decisions on spend are entirely a matter for the individual in receipt of the payment. This is a completely logical extension of the existing social security system, where similar freedom applies for those in receipt of benefits.

There are consequences for choices made by the individual which leave assessed needs unmet, but these have yet to be worked through by those responsible for public funds. At present, there is little seeming public interest in how personal budgets are being used, although there is spasmodic trade press publicity on the freedom of people to buy football season tickets or pay someone to accompany them to the pub. There could be a public backlash against what might be seen by some as luxury expenditure rather than meeting the costs of care, funded by the taxpayer, when those on low incomes or who are unemployed could never afford these choices. Personal choice of expenditure should not be considered to pose greater inherent risks than other forms of support, but the level of public concern may change when personal budgets become the main method of meeting people's assessed needs. Individuals or social care workers and managers may be blamed for 'allowing' harmful or dangerous situations to occur when the choices result in health and safety risks that require additional public expenditure.

As personal budgets become more widespread and more widely known about, these questions may be asked. Box 2 sets out the key considerations of different models of funding and quality assuring social care which will underpin the public debate.

BOX 2

The social care workforce

REACH	QUALITY	COST
Volume of services available	Standards of services and degree of regulation and inspection	Public willingness to pay for welfare
Eligibility for services if public funding required	Availability locally and in form preferred	Private or family resources
Range of options available to choose from	Personalised, matching resources with availability	Perception of value

Data taken from DH, 2009a

How those who substantially self-fund make their choices is not well understood. They are entitled to an assessment and advice from their local authority, but this may not be realised by potential recipients of this service, or may not be valued. From April 2011 local authorities have to ensure that assessment and advice are available locally. Currently around half do so (ADASS/LGA, 2009). Self-funders with high levels of personal resource are likely, as now, to find the future more comfortable and their choices wider as long as they can continue to fund their own care needs.

The outcome for the social care workforce will depend on the balance struck for society and individuals illustrated in Box 2 above. The perception of value, in particular, will pose some interesting social challenges if, as seems to be the case, unregulated services involving the personal employment of assistants, are, in isolation from other factors, less expensive in relation to volume and are more responsive than regulated services provided by the independent sector or a local authority. The local authority direct employment option is already most likely to be the more expensive option, largely because of better workforce conditions (including pension arrangements) and higher levels of supervision and management within their structures. They are also more likely to bear a higher share of corporate costs than an independent sector provider. For many assessors, a more efficient personal service may translate into a shorter or more concentrated one. This may not be what a user of service wants, given the value placed on personal contact, continuity and relationships.

The effect of ending age discrimination in health and social care by 2011 is as yet unquantified. Apart from the ability of older people to continue working, there are major implications for the distribution of resources. In setting personal budgets, for example, it is understood that the level of allocation for a younger person with a disability or mental health need currently is likely to be higher than that which would be available for an older person in the same circumstances. The modification of this imbalance would mean either a general rise in the resource dedicated to older people, already the major part of local authority social care spend, which may not be deemed affordable; or a levelling down of the personal budgets available to younger people, which would be contentious. The result is likely to be an even firmer drive towards the use of personal budgets in response to assessed need. This would both answer questions of perceived value and, perhaps, ensure that the most difficult choices are made by the individual themselves rather than the local authority on their behalf.

Delivering within this evolving policy and practice patchwork is dependent in the main on social care workers, their supervisors and managers. To assess their readiness for the challenges and their future implications, it is necessary to know who is in the current workforce, how this may change and what needs to be different.

Existing social care workforce data

Social care workforce planning is heavily dependent on the comprehensiveness and reliability of information collected from individual employers. This approach is in stark contrast with health and education where workforce planning systems external to the employer exist. Three significant factors underpin these other systems:

- the workforce is regulated and independent information is available at a national level about the numbers of staff and their qualifications
- there is a view about the level of complexity of the work that can be undertaken by staff with different qualifications and
- the vast majority of providers and their staff are in the public sector.

Social care workforce planning is difficult because:

Data is incomplete

Skills for Care (the Sector Skills Council for Adult Social Care in England) is responsible for collecting and analysing social care workforce information. Their analysis is generally derived from the National Minimum Data Set (NMDS) (www.nmds-sc-online.org.uk), which they designed and commissioned. Its accuracy depends on returns from registered providers of social care in the private and voluntary sector. An estimated one-third of providers are not inputting into the system or providing paper returns as at November 2009. Local authority statistics are collected through the Department of Health returns.

Existing data is not coherent

The policy objective is to provide integrated support across organisational and professional boundaries, but neither the Skills for Care statistics nor those collected by the Department of Health cover the workforce in non-registered services such as community projects, training and education or housing support. More significantly there is no requirement for providing data on the growing number of people working in the capacity of personal assistants for individuals or families and who are employed directly by them. A further gap is information on the number and types of new worker emerging through funding from personal budgets, although the evidence is that in the main they are undertaking similar tasks to workers within the established categories. It is too early to identify whether there are any trends in the specific patterning of tasks to meet the requirements of specific individuals or groups of individuals (Skills for Care, 2008b).

There is likely to be double counting

About a third of the workforce is employed part time (TOPPS, 2000) and some of these may be working for more than one employer. As the NMDS system counts people employed by each provider rather than full time equivalents, there will be an over-representation in the statistics where people are registered with more than one employer and a lack of clarity on workers who work only a few hours each week.

Within the limitations of the data, a summary of the workforce is included in Tables 1 and 2. Table 1 sets out the composition of the workforce using traditional categories.

TABLE 1

The social care workforce

Social Care core data from 2007-8:

- 1.75 million people used care services
- Local authorities spent £16.5 billion
- About 1.5 million people work in social care
 - _ 42% in residential services
 - _ 33% in domiciliary care
 - _ 15% in community services
 - _ 4% in day services
 - _ 6% work for agencies or are self-employed

Data taken from DH, 2009a

Who the workforce is employed by has changed over the last twenty years from a majority in local authority services to a majority being in the private and voluntary sectors. The largest proportion work for employers of between one and ten people.

TABLE 2

The social care workforce

Social Care core data:

- Numbers employed increased by 8%
- Numbers in local government went down from 228,000 to 221,000
- Numbers in the independent sector went up from 988,000 to 1,070,000
- Numbers of personal assistants went up from 113,000 to 152,000
- 58% of staff work for employers of 1-10 people
- Turnover rates vary between 3% and 22% - huge variations between sectors and roles

Data taken from DH, 2009a

Future demand for adult social care and the associated workforce

Longevity and population growth are predicted to increase the demand for social care. By 2026 there are expected to be double the number of people aged over 85 and four times the number aged over 100 (HM Government, 2009 p37). Leaving aside advances that may extend the period of older people remaining healthy, these developments will require a similar increase in the social care workforce from its current estimate of 1.5 million people. The majority of the workforce engages directly with people using services, but the proportions differ between sectors: 74% in the private sector, 71% in the voluntary sector and 50% in local authorities (Hussein, 2009). This proportion is unlikely to change significantly. Technological advances will have a marginal impact because people with complex needs will still require support with their personal care and help to use the technology. Working to Put People First (Department of Health, 2009a) estimates that the increase in the number of people with a social care need will rise from 6 million in 2007 to 7 million in 2025 and 8 million in 2040.

Increased user expectations about standards of care and personalised services, derived from social care policy and from consumer expectations more widely, will also impact on workforce demands. Government expects that 30% of people using services will have personal budgets by 2011. The Carers Strategy (Department of Health, 2008) offers carers a life of their own as well as carrying out their caring role. Carers UK estimates there are six million family carers, some 1:8 of the population; 3 million (1:7 workers) are part of the UK workforce (Carers UK, 2009). The 2001 Census figure provided a lower estimate of 5.2 million carers or 1:10 of the population in England. 175,000 carers are under 18 years old and the policy objective is that they should not be relied on to provide an inappropriate level of care. Given that service users wish to remain at home for as long as possible and that this also coincides with national policy objectives, the pressure for family members to provide substantial amounts of care will continue.

The increased demand is not expected to be met in full by family members however or the efforts of volunteers and community initiatives, significant though these are. All this is in the context of increasing evidence of a gulf in public understanding and perhaps willingness to grasp the funding consequences of the demographic changes; the differences in charging systems for health and social care; and the unresolved debate on the balance of how care should be paid for between the state and the individual.

Those who wish to become providers or workers must demonstrate considerable commitment to adult social care, but the framework is not at present entirely consistent. Services provided for people within settings or from agencies providing services for people at home are still to be regulated (even if specific workforce standards disappear). Services purchased by individuals for themselves and delivered to them in their own home are free from workforce regulation.

Raising the status of social care workers

A further strand of government policy which will need to continue as an aid to recruitment is raising the status of social care, and of those who work in it. The most significant barrier to improved status may be the absence of any distinctive regulatory or qualification requirements, other than those which apply to any employer. Current legislation, enforced in England by the Care Quality Commission (CQC) requires providers of social care services, that is residential care, some day services, and domiciliary care, to register in order to run a business. Staff employed directly by someone, however funded, are exempt from registration. For registered services, there are currently specific workforce standards, for example, the number of staff, some of them must have particular qualifications (the manager), some must have particular professional qualifications (as a registered nurse for nursing homes), and a proportion of operational staff must have vocational qualifications. All must have received induction, and the training necessary for particular tasks (such as health and safety and food safety).

The growing trend towards direct employment by people using services will reduce the number of workers subject to regulation as individuals or through their employer. Some local authorities may limit the selection of personal assistants as part of their agreement to provide personal budgets, but this is not universal.

The Care Quality Commission (CQC) is intending within its regulatory regime to change from measuring what are described as 'inputs' towards measuring outcomes for those who use services. As the CQC has not yet announced how it will operate its new outcomes based system, it is not possible to assess its impact. At first analysis this laudable aim may result in defined workforce standards being removed as incompatible with an outcomes focus. Standards, in future will have been met if the service provided meets its defined objectives from the user perspective. Less positive are the implications for the status and standing of the social care workforce. National standards for the adult social care workforce would disappear, as would the drive towards improved professionalism through requirements for the achievement of key qualifications and learning.

By 2007 there had been significant improvements in the proportion of registered providers meeting the qualification targets, and an increase from 60% in 2006 to 66% in 2007 of social care workers holding at least a level 2 National Vocational Qualification (NVQ) in health and social care - the current requirement for service providers (CSCI, 2008). Taking account of the characteristics of the social care workforce (Skills for Care, 2008a) it is likely that this will represent for many their first adult qualification, or only qualification, as they may well have left school with few, if any.

Interestingly, the children's services workforce, supported in England by the Children's Workforce Development Council (CWDC, 2009) and regulated by Ofsted, is moving in

what could be seen as the opposite direction. Their combined expectation is a continuing use of qualifications as a proxy measure for workforce quality, and a raising of the foundation level requirement for staff from level 2 at NVQ to level 3 within a career framework carefully extended to level 7.

This move has been made when very little is known about the links between qualifications and quality in social care. An overview study of the evidence, commissioned by the National Skills Academy for Social Care from **research in practice for adults** reports in early 2010. There is an acceptance that qualifications and training have to be deployed effectively for good care practice to follow. This depends on the attitude of individual workers, on employers providing supervision and support in putting workers' skills into practice, and on the overall culture and values of the employing organisation in promoting and supporting good practice. Workers can become frustrated when they are unable to use the knowledge and skills they have acquired because the context in which they are working undermines good practice.

In other sectors, qualifications are still widely expected and supported by employers. In hairdressing, for example, qualifications are an industry wide expectation, reinforced by insurers. There is an acceptance that the consequences of poor staff skills is unhappy customers and could result in physical injury from the tools and products in use. In other sectors, qualifications are combined with regulation of the workforce to improve public confidence and public safety. Two widely different examples are train drivers and door supervisors. Railway train drivers are trained and assessed for every route that they take a train on, and are required to update this training regularly. They are then licensed to take trains only on these routes. Clearly the consequences of poor train driving could be fatal. Door supervisors are required to undertake an online qualification, which is independently run and assessed under the supervision of the Security Industry Authority. They then undergo a criminal records check before being licensed, if all is well, to perform their duties. They may not be employed without their licence. Two strands underpin these requirements: the consequences of poorly managed door security could result in public disorder, and the desire to ensure, as far as possible, that some trades are free from criminal associations.

The potential for injury from poor skills in social care may be different, but harm can be caused both physically and emotionally and affect public confidence no less than in other sectors. Indeed, people have died in social care from scalding baths and radiators, choking whilst eating or dying from falls. The characteristics of the workforce may be very similar between childcare, hairdressing or door security in relation to education or class. It is interesting to speculate why qualifications and regulation are questioned in social care in England for both services and individual workers, whereas in Scotland and Northern Ireland neither is under question and the regulation of the workforce is being extended. In contrast in England, the extension of regulation from social workers to domiciliary care workers has been postponed indefinitely.

Securing the future workforce

The future constellation of workers in adult social care is likely to be undertaking roles which are very similar to those already in existence:

- conducting assessments of circumstance and wishes, and matching them in some way with eligibility criteria for a resource
- supporting others in deciding on the allocation of their resource budget between organised services and those they may wish to provide for themselves
- managing and providing those services operationally either for organisations or for individuals
- regulators of those assessing and allocating resources and of those providing services where regulation is required.

Possible differences:

Options for undertaking assessments

The delivery of assessments and matching them with eligibility criteria are likely to remain in the control of the public sector whatever the political colour of the next national government. The announcement in November 2009 about the creation of a National Care Service, and of expectations of close cooperation with the NHS, suggests that joint processes will be expected to achieve this. Certainly the NHS will need support from social care in managing the introduction of the promised personal health budgets, given their absence of any experience in this area.

The exclusion of disability benefits from the funds available for personal budgets, and their retention within the social security framework, creates the possibility for the whole assessment process to be carried out by the Department for Work and Pensions (DWP) as part of their generic work. This would have the advantage of being a national service, available to all regardless of age, with national criteria for eligibility – and the opportunity to ensure that every individual was maximising their entitlement to the public funds available to them. The disadvantages are also evident, not least that the DWP does not have universal acceptance for the sensitivity of its assessments, basing them on inability rather than ability: the policy expectation in the social care sector. The DWP or its predecessor the Department for Health and Social Services (DHSS) did not do well either in managing a burgeoning spend on residential care during the 1980s, prior to the funding being transferred to local authorities to use across social care within a capped budget. DHSS did not at that point have a national assessment of eligibility in place and relied on local assessments. A national service through DWP is likely to be more cost effective than the current multiplicity of systems in operation across 150 local authorities.

The implications for the workforce are a potential loss of assessment roles within local authorities, and/or their transfer to DWP.

Brokerage and advice services may become chargeable

If assessments are disconnected from the local authority, there may be a further impact on the roles of advice and brokerage, discharged by the local authority or in some cases commissioned by them from the independent sector. A tighter public spending climate may mean that intermediate roles (those not providing direct care) are deemed to be less affordable, however desirable. Within a national assessment system, brokerage or other advisory services may become services that have to be paid for or are only available to a limited number of people who are assessed as needing support to reach decisions about their care. Some people already pay for this service within their personal budget allocation, and this could be generalised. The implication of this for the workforce is that such roles are further externalised from the local authority into organisations that develop a business model to sustain them. The risk is obvious: the choices available to personal budget holders are limited by their knowledge of what is available, which might be choosing either to manage their own staff or use regulated services. The use of intermediaries elsewhere in a consumer world, whether it is travel agents or even retail stores, is diminishing, and reliance on self-directed purchases using whatever information is available free is increasing. These could include comparison-based websites similar to those already available for purchases such as insurance. Slivers of Time is but one example, which provides information on the availability and skills of personal assistants and demonstrates an emerging trend toward providing for consumer use free on-line information and booking systems in social care.

A more limited role for regulated services

Regulated services are expected to survive. They will be used from choice by those who prefer their care provided by others rather than organised by themselves. They may be imposed:

- as a result of decisions that individuals or the public must be safeguarded
- to protect the public purse following persistent misuse of personal budgets
- if regulated services are used substantially for safeguarding individuals, the public and the public purse, social care workers will require higher level skills in working within a social control framework.

Pressure on NHS in-patient resources will continue to support the use of nursing homes for people with longer-term conditions and what are deemed to be high personal care needs. This combination will test both the assessment and resource determination parts of the care system, as such services are likely to be more

expensive than any package incorporating personal assistants who are self-employed funded from a personal budget. The pressure on price and therefore on costs will continue to make it difficult to improve the pay and conditions of staff in any adult social care service without an explicit broader social inclusion agenda. Those who remain in the regulated sector may well have more stable employment, better and more consistent support and professional development and some professional supervision, in contrast to what is available to personal assistants.

The future distribution of the social care workforce

BOX 3

The social care workforce

Skilled and professionally qualified	Experienced and vocationally qualified	Experienced with some on the job training	Casual and flexible	Family carers and volunteers
Assess risks and plan protection	Provide high need and regulated services	Provide front line services, mainly regulated	Take on PA and support roles – not regulated	Provide family and community services
Manage complexity, commission services	Front line and supervision	Front line, solo working	Front line, generally self or user employed	Usually personal, not regulated
Proper jobs with benefits and career structure	Established job with career progression	Flexible jobs but prospects limited	Casual employment with limited options	Intrinsic rewards only

Data taken from DH, 2009a

The demarcation of the future workforce could look as described in Box 3 above. The group of skilled and professionally qualified employed by local authorities (or perhaps the health service, DWP or a specialist service provider) with a particular brief to manage risk and people perceived as having very high needs or without the ability or inclination to manage their own care and without a family able or willing to do this for them. Vocationally qualified staff would be found almost entirely in

regulated services, or those where a high degree of operational skill was recognised as being required. They would manage their own progression together with their employers, and constitute the future management as well as provide the professional leadership for these services. Their workforce providing direct care would be in the next group. The route is valuable to some workers (and their employers) because it is casual and flexible, but it is generally without opportunities for professional development (National Skills Academy, 2009) and does not provide a role model for career development in the local community.

Finally, always there, and an essential component in the range of social resources, are family carers and community volunteers offering their services because of personal motivation. They are invaluable to the system, and likely in times of resource pressure to feel it keenly. Care and support provided by family already makes a major contribution to social care contributing some support estimated at some £57 billion each year. Carers have also been entitled since 2000 under the Carers and Disability Act to an assessment of their own needs for support, but implementing this is very variable (Carers UK, 2003). The availability of family care is already a part of the resource assessment process carried out by local authorities.

Future scenarios

The outcome of these shifts could be as summarised in Box 4 below.

BOX 4

The social care workforce

The most likely scenarios:

- The costs of regulated care will outweigh public and private resources for the majority
- More casualised care will become the norm from choice or necessity
- Funding for middle range care may come through social security rather than “expensive” assessments adding little value
- Lots of “middle” roles generating extra costs in commissioning, advocating, brokering etc may not be sustainable
- Differences in care options between self-funded and those dependent on public funds will be very evident. Already 50% plus of older people wholly or partly fund their own care
- Lifetime differences in career options between the qualified and the casualised will be very evident, and could exacerbate social divisions and undermine community and economic regeneration

Data taken from DH, 2009a

The current social care workforce recruits primarily from a narrow group of the population irrespective of where they are employed. The Department of Health’s recruitment strategy (DH, 2009b) recognises that this base must be broadened to meet future demand for social care. This will require increasing public knowledge about working in social care, easy access to information about local jobs and all year round campaigning.

Understanding employment choices

There is growing evidence that understanding why people choose to work in social care is complex. Pay and conditions of service are determined locally, and for front-line posts achieving a recognised qualification is generally recognised with only a modest premium above the minimum wage. Rewards tend to rise only with promotion to a more senior role. Some employers proactively support professional development; others are not willing or able to do so. Self-reports indicate this includes employers of personal assistants who do not believe that they have the skills, personal resources or financial leeway to do this.

Choice of employer was thought to be determined by pay and working hours, but retention rates vary widely and most social care staff movement is between social care employers rather than between sectors such as retail or hospitality (Skills for Care, 2007). Workers chose to stay in social care because of the inherent appeal of the work. There are significant gaps in the evidence about the motivation of staff, how their decisions about employment are made, or the employment portfolios of social care workers with a range of part-time jobs in different sectors.

Direct employment by people using services

The rise in demand for the social care workforce may be partially met by more people being employed directly by a user-employer. The unregulated part of social care, represented particularly through personal assistants, is growing fast. In 2007, the Commission for Social Care Inspection (CSCI) found that there were some 152,000 personal assistants compared with 113,000 in 2006-7 (CSCI, 2008). 87% of these are women, two thirds have had previous experience in working in health or social care and 42% hold a relevant qualification (Petch, 2008). The choice of personal assistant is currently for service users alone to make. They are free to take whatever risks they choose when doing so, but are bound by the regulations relating to being an employer as with any other small business. Tough targets have been imposed on local authorities to increase the number of people managing their own budgets and services, so this trend will certainly accelerate. The indication from Petch’s review indicates that only a third of these workers are new to social care or health care.

Continuing to attract the older woman worker

The age profile of the current workforce appears to suggest stability rather than a potential problem. Women make up 83% of the workforce and two thirds of workers begin employment in social care when they are over 30, with about a third aged 45 or over. The evidence is that older workers are attracted to social care because of the flexibility it offers, job satisfaction and a growing awareness of social care as they grow older (Skills for Care, 2008a). The risks associated with this age profile in social care may reduce in future. The retirement age for women moves from 60 to 65

between 2010 and 2020 and the age for state pension entitlement will rise to 68 between 2024 and 2046. More people continue to work past retirement either from choice because they wish to remain engaged, or from necessity because of the level of their retirement income and the erosion of stable pension schemes. Older women with different ethnic and cultural heritages are the bed rock of social care workers and were targeted in the 2009 Department of Health recruitment campaign (DH, 2009b).

Improving the gender balance

Recruitment initiatives could also support a re-balancing of the predominately female workforce. Women make up 83% of the workforce, and predominately work at the operational level, whilst 35% of the men work in more senior posts. The percentage of men joining the workforce each year has increased from 13% in 1995-9 to 18% in 2007-8 (Skills for Care, 2008a). Little is known in general about career choices, so what influences men to work in social care can only be surmised. Historically there is a higher proportion (still a minority overall) of men working in learning disability and mental health services. This may be because these services could be characterised as providing more emphasis on rehabilitation, employment and development compared with the more physical, intimate personal care provided for older people. In addition, most of the older users of service are female, reflecting the actuarial realities of life expectancy. In local authorities higher rates of pay, fewer anti-social hours and clearer career structures in learning disability and mental health services may have attracted men, and more male role models would provide more encouragement to other men. Segmented roles, involving less direct physical care, which can be organised around a team of personal assistants, may also be more attractive work to men.

Attracting younger people into social care

The 2009 DH campaign also targeted women in their early 20s as part of the strategy to diversify the composition of the social care workforce. The 2010 campaign will target 18-24 year olds who have been unemployed for over nine months. 15% of this group were recorded as unemployed between July and September 2009, the highest since 1997 (Audit Commission, 2009). This age group is very under-represented in the social care workforce; that is 9% of the workforce (Skills for Care, 2009). The 14-19 Diploma in Society, Health and Development is an opportunity to interest young people in social care work, but diplomas may not survive a change in national political control.

The Care Ambassadors Scheme, managed by Skills for Care, supports front-line workers – originally young people, now of all ages, in talking to learners in school and college and other audiences about their work. Social care has become part of the government's strategy for reducing unemployment among young people.

The Minister, Phil Hope, announced in April 2009 that apprenticeships in social care will be increased by approximately 1,300 and targeted on groups of young people who do not usually look to social care for a career (Hope, 2009). Care First apprenticeships are available for up to 50,000 young people and offer employers subsidies worth a total of £75 million to support the scheme. The National Skills Academy for Social Care runs a Graduate Management Trainee Scheme, offering recent graduates from any discipline a twelve month period of learning with employer hosts from the public, private and voluntary sectors. Trainees receive a bursary as well as learning and development support, and it is hoped that they will make a career in social care at the end of their learning phase. This is a first for adult social care.

Recruiting culturally competent workers

England's population is ethnically and culturally diverse. Expectations about intimate personal care have cultural components and the workforce must reflect the composition of the population. In September 2009 the NMDS recorded 62% of the workforce as white; 6% as black, 4% as Asian, 1% as mixed, 2% as other and for 26% ethnicity was unrecorded (Skills for Care, 2009). This information is at a high level of generality in terms of ethnic and cultural heritage and no information is available for over a quarter of the workforce. A heavy emphasis has to remain on ensuring that the workforce is representative of the local population, that all workers are sufficiently trained to be able to provide sensitive cross cultural personal care and that equality is actively promoted for the workforce as well as for people using services.

Workers diverted into social care

Fluctuations in the economy also have an impact on recruitment into social care through steadily increasing unemployment. Some people will be diverted into social care from their earlier job choices, including more men. Intensified pressure on length of entitlement to social security benefits will support the drive into alternative employment.

Migration

Migrant workers are a significant proportion of the adult social care workforce in England. In 2009 they represented nearly a fifth of the workforce in services for older people and were 28% of the workers hired in 2007 (Cangiano, Shutes, Spencer and Leeson, 2009). The low status, low pay and lack of career opportunities make social care jobs less attractive to UK residents. The evidence is that migrant workers in social care are at risk of exploitation, being expected to work long and unsocial hours for inadequate recompense (Oxfam, 2009). Given the targets set for local authorities to increase the number of people using personal budgets and the proposal for free personal care at home for those with highest needs, migrants may well provide a

source for this increased demand. There are no restrictions on recruitment from most EU member states, but some remain on new members, currently Romania and Bulgaria. Tighter controls have been put in place by the Border Agency for non-EU migrants, on eligibility and on becoming a recognised employer. Only anecdotal evidence exists about the impact of workers from outside the UK on the experiences of users of service. Some is positive, citing a cultural appreciation of the social value of older people, a stronger work ethic and the ability to provide a responsive service for diverse communities. Others are more negative, reporting poor language skills and an instrumental attitude to the work. But all of these factors could apply to a worker raised in the UK, supporting the need for careful recruitment and clear management.

Improving pay and conditions

Occupations with a predominately female gender balance tend to have lower pay.

'Minimum wage jobs are more likely to be held by women, young workers, those of retirement age, ethnic minorities, those with a disability, and those with no qualifications. They are also more likely than better-paid jobs to be part-time and temporary. Higher instances of minimum wage jobs are found in small firms, in the private sector, in particular areas of the UK, and in certain industries and occupations.'

Low Pay Commission, 2009, para 7

'Social care is labour intensive, predominantly locally based, low paid work. It is one of ten low paying industries that provide over 8.4 million jobs, almost a third of all jobs in the UK in December 2008. Social care accounted for the largest rise in the number of jobs in these low-pay industries.'

Low Pay Commission, 2009, paras 11 and 12

The emergence of the consumer society and acceleration of technology have made some changes in this pattern in retail and administration, where more men are now employed. Where the barriers to entry remain low, the effect on wages of a shift in gender has not been reflected in improved pay or conditions. Only where entry barriers have been raised, such as in nursing and teaching which now require degree level qualifications and professional development, have reward and career pathways improved. In social care these conditions apply only to social workers and to registered managers of care services who require a recognised qualification. For all other social care workers decisions about qualification are made by individual employers.

The impact of personal history

The possession of a criminal record is likely to be a serious impediment to employment in most of the sector. Although the gap is closing, men are statistically more likely than women to acquire a criminal record during or before early adulthood (Home Office, 2009). In contrast to the regulated sector, Criminal Record Bureau checks for the growing unregulated sector are not a requirement. Some convictions, if linked with a record on the Protection of Vulnerable Adults List (POVA) or Protection of Children Act List (PoCA), are a complete bar to employment with vulnerable adults or children. In other cases the decision is that of the employer, although few are likely to take great risks. The exception is in services such as working with offenders and in drug misuse, where a view is that people who have ceased offending or drug abuse have a valuable contribution as role models and bring a unique knowledge and understanding to the work.

Improving job satisfaction

The value that society places on social care work is unclear, but if it were highly valued this could compensate for these factors. Department of Health research on their national recruitment campaigns found respondents saw social care as important work that had to be done by someone, but not by them (DH, 2009b). There are other rewards than the material gained from social care work, not least the satisfaction of providing support for others. The issue is whether these are sufficient to counterbalance the sector wide employment conditions. This satisfaction could be undermined if the economic recession intensifies pressure on resources which further reduces time with users of service, and general employment conditions are further eroded.

Emerging findings are that personal assistants find more job satisfaction, as do their employers, because of their closer working relationship and the removal of some organisational constraints on, for example, the tasks to be performed or time limits in which to do them. These are negotiated directly with their immediate employer, rather than being dictated or mediated through an employing agency. Evidence to date indicates that employers of personal assistants are often unable to provide improved pay or other tangible rewards and these may be less favourable than a larger employer able to support learning and training, or provide a pension scheme. As with any employer there is scope for poor practice by both parties and the first cases at industrial tribunals are beginning to be heard.

Local authority roles in future

The role of social care in social cohesion

Low status and low pay impacts on local communities. Higher parental aspirations are associated with improved educational achievement in their children (Li and Mumford, 2009). These parents act as role models and can encourage young people to consider a wider range of employment choices. The achievement of NVQs by social care workers could potentially have a positive impact not only on the worker's professional confidence but on the expectations of their wider family.

The role of local government becomes of particular significance as employer and a commissioner of services which employ large numbers of people. Resource pressures on local authorities will intensify as public finances are re-balanced and demand for social care services increases, but a social care model which weighs cost as the major determinant, risks the further erosion of social cohesion. Communities will feel they have little stake in the growing economy and diminishing prospects for their families and themselves if they face a round of minimum wage paid work, shift patterns covering any hour and day of the year, and limited career and qualification opportunities. At its most basic level, this description fits social care work.

The presence within communities of a personal and an organised resource is known to strengthen those communities and allow others to make a contribution where they may not wish to or be able to through formal employment. Mobilising and supporting these voluntary and community resources will need to be a key role for local authorities seeking to balance resource demands with availability.

The roles for a local authority in the future will be consolidated as shown in Box 5 below:

BOX 5

The social care workforce

The future social care role for a local authority:

- Managing risk, individual and public protection
- Gate-keeping and funding for complex needs
- Maximising individual well-being, voluntary and community effort
- Helping people realise their assets and maximise their incomes to help self-fund
- Signposting regulated services and casualised support

Data taken from DH, 2009a

Workforce responsibilities

The local authority role already includes responsibility for the workforce needs of adult social care within the geographic area of that authority. The Integrated Local Area Workforce Strategy (InLAWS) system introduced in 2009 is a joint Association of Directors of Adult Social Services and Skills for Care initiative to support this. In March/April 2009 it identified two key barriers to developing an integrated workforce strategy within a local authority boundary: complexity of working with multiple stakeholders and data management. Local authorities are also supporting national and local recruitment initiatives, and are encouraging the development of the personalised workforce and of volunteers and family carers through learning and training – and this will need to be enhanced. Local authorities could also offer a form of endorsement for personal assistants, a mid-way point for those with personal budgets wary of an absence of regulation but wishing to employ their own staff.

Box 6 sets out how this would translate in workforce terms.

BOX 6

The social care workforce

The future workforce role for the local authority:

- Employing and training professional staff providing complex services
- Supporting raising standards for the casualised and workforce and volunteers through learning and training
- Offering local “endorsement” schemes
- Encouraging young people to consider a career in care (rather than casualised work)
- Supporting apprenticeships – multiple benefits

Data taken from DH, 2009a

Adult social care provider responsibilities

Organisations, whether private or voluntary, will need to ensure their familiarity with the needs of their customers and their markets for a more consumerist generation. Personal budgets will increase their contract management requirements as:

- each home care package will need to be tailored to a person's priorities rather than carrying out a narrow range of very basic, though essential personal care tasks within a certain time limit
- group care services will need to be more tailored to individual choice and need, and offer facilities expected by users in their own homes, such as access to personal entertainment and ICT
- appealing to individuals will require more sophisticated marketing, including the use of ICT.

Managing numerous personal budgets is also likely to increase costs, at least initially compared with managing block or spot contracts with large organisations that are well used to working within a contract culture. They will need to demonstrate an increased assurance of the relevance and quality of support for people choosing their services over unregulated or personally controlled options. Recruitment will have to be as vigorous as now, and work directed to reducing workforce turnover in the early weeks of employment. Managers will need to ensure the horizons of their staff are expanded to understand their roles in accord with the philosophy of personalisation. The outcomes for their customers will need to be more than the alleviation of their care needs if their services are to continue to be chosen in a more open market. Box 7 summarises the implications for providers of regulated services.

BOX 7

The social care workforce

The implications for social care providers:

- Meeting the requirements of more consumerist people and their families
- Negotiating more individual funding streams and mixed funding
- Maintaining standards through registration
- Making visible the personal rewards from working in social care (and from using regulated services)
- Expanding horizons

Data taken from DH, 2009a

This has implications for their workforce too:

BOX 8

The social care workforce

The future workforce role for care providers:

- Providing personalised services within registered settings
- Connecting services with communities
- Training staff who require vocational qualifications
- Developing the next generation of managers and leaders
- Supporting the learning of PAs to maintain standards

Data taken from DH, 2009a

There is the potential for registered providers to see personal assistants as something other than rivals for custom locally. They could include them as members of the local care community, given that social care will have a damaged reputation which will impact on them as providers if personal care goes badly astray. The public and media may not differentiate between providers of service and personal assistants in the event of care scandals. Evidence from personal assistants is that some would welcome developing and improving their skills as essential, and this could be a new form of partnership – or even income generating role – for registered providers (National Skills Academy for Social Care, 2009). Developing relationships with personal assistants could be a source of recruitment when arrangements with personal budget holders end as some personal assistants move between working for providers and for personal budget holders (Petch, 2008). Some providers will undoubtedly feel unable or unwilling to take on a broader community role. Others, particularly smaller providers, may see this as a market enhancer in the localities where they operate, extending the public knowledge of their services. This could be particularly useful as care needs change, and individuals may wish to choose an option for living providing more support than living at home.

conclusions

By 2020 the evidence indicates that:

- 1 Much of the day to day social care workers' role will remain the same - providing support and personal care for people in daily living, safeguarding those at risk and maintaining their quality of life
- 2 A substantial minority of workers will be employed and paid for directly by people using services and working on outcomes set by them. This will be the enduring policy objective, and a proven way for people to maximise control and choice over their own care which also helps society cope with the resource implications of demographic changes
- 3 Significant employment in registered services will remain from user choice, to manage risk to individuals with high levels of need, including older people with critical care needs, and to reduce risks to the public purse where the choice of a personal budget is refused or has persistently failed
- 4 Personal budgets, and hence assessments, could be administered by the DWP, providing a simplified and lower cost system
- 5 Social care will remain in the low pay group of industries and this will perpetuate poorer conditions of service and pay among women, ethnic minorities and people with disabilities unless there is specific action to address this. Pay and conditions of service are unlikely to improve if there is a decision not to specify qualifications for, or to regulate, social care workers in England
- 6 The gender and age distribution of the workforce is likely to be less skewed towards older women workers and there will be more evidence of men and younger adults in the workforce
- 7 The role of local authorities in strategic planning and community development will continue to include developing the workforce locally and could extend to offering to people using services an assurance scheme for personal assistants
- 8 Promoting conditions in which family carers, friends and volunteers can continue to care for individuals at home will remain essential to reduce the burden of care on families and on the state
- 9 Thinking will have to accelerate on the implications of increased longevity, the rising proportion of older people in the population and a working generation who face a future old age of financial uncertainty
- 10 Policies on the future of adult social care provide sparse information on the impact that demographic trends and raised expectations will have on the future of the workforce. Models similar to those developed for the future funding of adult social care (DH, 2009a) will need development for workforce planning.

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