

The Future Care Workforce

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Summary and Recommendations

- Already a large employer, the adult social care sector in England will need to add approximately 1 million workers by 2025 in response to population ageing and the implied increase in the numbers of people with disabilities.
- The workforce will also have to be increasingly diverse in order to deliver a more personalised service to those in need of care and support.
- While there is evidence of good practice across the care workforce, there are a number of persistent challenges which could prevent the sector from evolving as required over the next decade. Many of these challenges are likely to be exacerbated by continued fiscal consolidation, which has resulted in local authorities reducing their expenditure on care services. These challenges include:
 - Workers are typically low paid and there is evidence of some providers curtailing minimum wage laws.
 - While working in the care sector can be rewarding it can also be emotionally challenging. The vast majority of care workers have faced verbal abuse (93%) and a significant proportion physical abuse (53%).
 - Staff turnover is generally high, with higher staff turnover linked to an increased chance of death for those in care.
 - The prevalence of training and qualifications across the sector is low adding to the perception that there are few learning and development opportunities.
 - Women make up the vast proportion of the care workforce (80%) and there is also a high proportion of non-British workers (18.2%). It will be difficult to meet expected demand for care if recruitment focuses solely on these demographic groups.
- In order to meet these challenges, this report makes a numbers of recommendations including:
 - While the funding of adult social care is beyond the scope of this report, it is clear that government funding must rise in line with the needs of the population to ensure that more individuals do not slip through the net and receive the care and support they deserve.
 - The abuse of national minimum wage regulations is clearly unacceptable. But rather than just penalising the guilty providers ex post, we must identify and address the underlying causes of this at an industry-wide level to prevent it from occurring in the first place.



1 million

England will need to add approximately 1 million workers by 2025.

- Reducing staff turnover is not just about pay and terms of employment, but also about ensuring that employees have the right support structures in place to drive career development as well as supporting them through times of stress or abuse in the workplace.
- As recommended by the Cavendish Review, a central quality assurance mechanism is required to verify the qualifications of care workers who undertake learning and development with different providers. Being able to take your qualifications with you from one employer to the next is a crucial part of building a social care profession.
- Men, older workers, the unemployed and the underemployed can all play a big role in filling the potential supply gap. In order to entice these individuals into the care sector, providers will need to use innovative promotional campaigns to address persisting stereotypes and target underrepresented groups.
- The care sector must learn from examples of best practice both from within the sector as well as from other low pay sectors to identify how it can improve staff morale and retention through relatively low cost measures.
- Building a strong reputation for quality of staffing must be seen as a key selling point that providers can use to take advantage of the expected increase in requirement for social care over the coming decades.

Introduction

This report is concerned with understanding how demand for adult social care is likely to change over the coming decades, whether the care sector and workforce is likely to be able to meet this demand, and finally, what we can do to increase the chances of delivering a care workforce consistent with expected need. In order to achieve these aims, we begin in **Section 1** by outlining demographic trends and the funding pressures facing the sector. **Section 2** looks at the current state of the workforce through a review of recent literature and analysis of relevant data. **Section 3** discusses the factors that could lead to increased demand for social care over the coming decades and evaluates past growth projections for the future care workforce. **Section 4** assesses some of the barriers that could prevent the workforce from evolving in line with expected demand and discusses how to address them. And finally, **Section 5** concludes the report and reiterates the recommendations outlined above. We are also fortunate to have been able to include case studies of positive experiences from those working in the care sector – both male and female, old and young - to help challenge some of the pre-existing stereotypes about this sector and highlight its benefits.

An interim version of this report was discussed by a roundtable group of social care experts in January 2014. We are extremely grateful for their comments which have helped to shape the report's content and recommendations. Nevertheless, the approach, contents and findings of the final report are solely the responsibility of the author.

Defining the social care workforce

The first problem to address in this research project is what or who determines the adult social care workforce and which regions of the UK we should look at. Neither issues are trivial. The rather arbitrary divide between health and social care is well known, while there are significant differences in the funding arrangements and provision of adult social care across UK regions. Ultimately, for reasons of expediency, our analysis refers to the social care workforce as defined by the National Minimum Data Set on Social Care (NMDS-SC) for England. This is a vast data source that contains detailed statistics on the state, size and structure of the workforce. Consistent with their methodology, the total care workforce of England encompasses a broad array of care-related occupations including:

- Social services managers and directors
- Residential, day and domiciliary care managers and proprietors
- Occupational therapists
- Social workers
- Welfare and housing associate professionals
- Nursing auxiliaries and assistants
- Houseparents and residential wardens
- Care workers and home carers
- Senior care workers

For the remainder of this report, when we refer to the care workforce we are predominantly referring to the people working amongst this diverse array of occupations.

1. Background:

The state of the social care sector in England

In contrast to the provision of health care which is free at the point of use, public funding of an individual's social care costs in England is decided using a means test. Those with wealth and assets above a certain threshold must cover their own costs of care (self-fund), while those who fall short will receive some financial support from their local authority.

There are currently 1.3 million people receiving state support for care services in England. The majority receive community based care, while some, particularly those aged over 65, are in residential or nursing care. The over 65s account for the largest proportion of publicly funded care users (67%), though the under 65s still account for a significant share (33%) (Health and Social Care Information Centre, 2013). There is limited data on those individuals who exclusively self-fund, but estimates from 2011 suggest that there are approximately 475,000 self-funders (68% domiciliary, 32% residential home) (Department of Health, 2013).

“...the number of people in England aged 85 or over will increase from 1.46 million today to 2.72 million by 2030”

While the number of people receiving publicly funded care has fallen since 2008, it is likely that demand for adult social care will rise in the coming decades, as the number of older people, and particularly the oldest old increases. The Office for National Statistics projects that the number of people in England aged 85 or over will increase from 1.24 million in 2013 to 2.3 million by 2030 (Office for National Statistics, 2013a). With the oldest old the most likely age group to have some form of disability, this demographic trend could drive a significant increase in the need for social care over the years ahead.

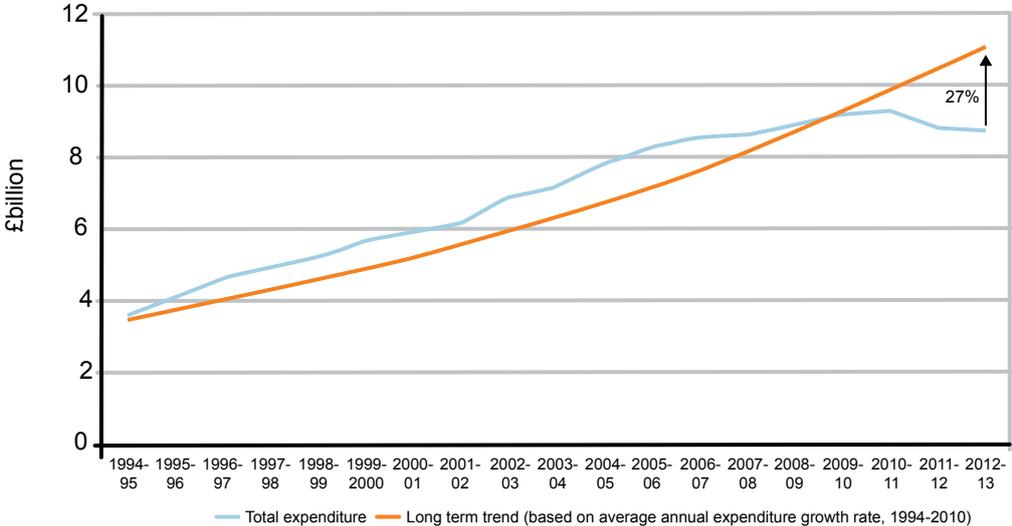
Ensuring individuals of all ages get the care that they deserve must be a key social policy goal. It is not just important for those in need of care, but also for family and friends who often form a bedrock of informal support, sometimes at the expense of their own health and wellbeing. Yet, a world class adult social care system is going to be a significant challenge to deliver, especially in light of continuing cuts to government expenditure.

“...If the long term average annual growth rate in total council spending had been extended over the last three years, expenditure would be 27% higher than it is today”

Total council spending on social care in support of older people rose steadily from 1994 to 2010 but it has since fallen by 6%. If the long term average annual growth rate in total council spending had been extended over the last three years, expenditure would be 27% higher than it is today (see Figure 1). Such a substantial downward shift

in spending poses immediate problems for councils in allocating resources to meet care needs, for the individuals requiring care and for the social care providers who receive a significant proportion of their revenues from the State. Ultimately this has contributed to an increasing number of people falling outside of the care system (Humphries, 2013).

Figure 1. Total council spend on 65+ care services and difference to the level implied by long - run trend



Source: The Health and Social Care Information Centre and Author's calculations

Against this backdrop is the important issue of the care workforce – the people who make a difference to the lives of those in care on a daily basis and therefore one of the most crucial stakeholders in the debate about the future of social care.

2. The social care workforce today: some stylised facts

Size and structure

The social care sector in England is relatively large, employing 1.5 million people (1.63 million jobs) (National Minimum Dataset for Social Care, 2013). To put this into perspective, this accounts for 5.5% of all employment across England (own calculations using Office for National Statistics, 2013b). Despite government cuts to social care expenditure, the workforce has grown by 13.5% since 2009 adding an extra 210,000 jobs. The majority of employees work in residential or domiciliary care, while smaller proportions work in the community or provide day care (see Table 1). Since we know that the majority of those receiving care do so in the community or at home, the high proportion of jobs in residential care highlights the labour intensive nature of this type of support. While the public sector was once the main employer, 77% of social care jobs are now with independent providers who, on the basis of evidence from NMDS-SC appear to be shifting resources away from residential care (Skills for Care, 2013).

Table 1. Number of jobs by service group

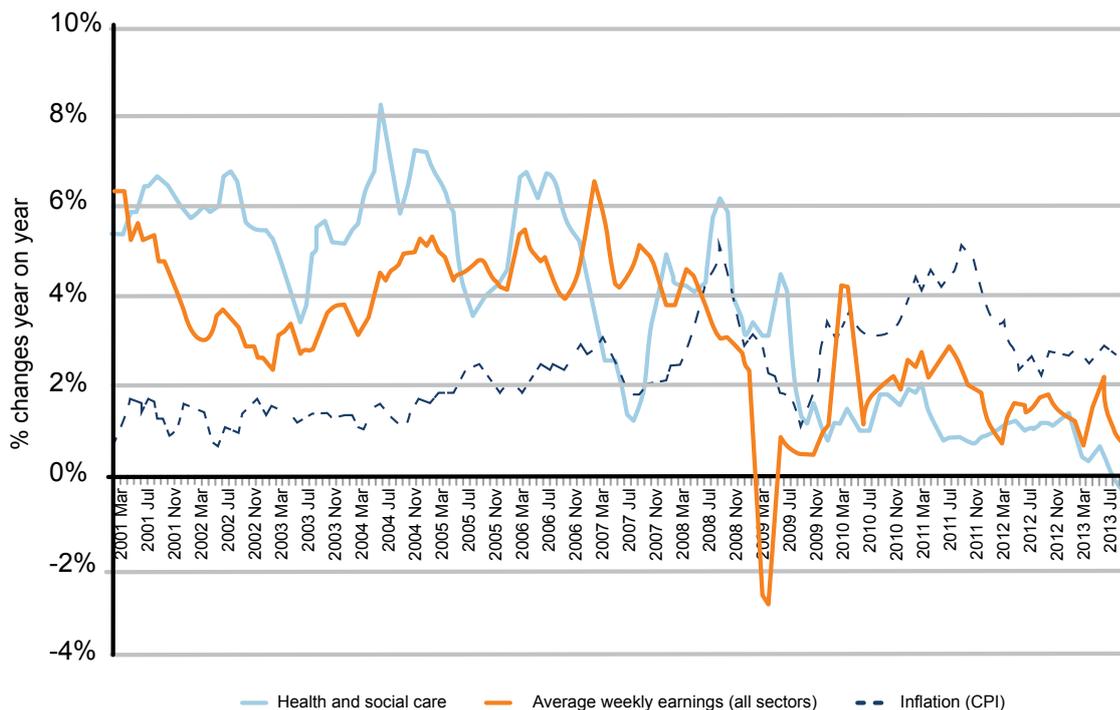
Main service	Number of jobs	Percentage of jobs
Residential	650,000	40%
Domiciliary	685,000	42%
Day	66,000	4%
Community	229,000	14%
Total	1,630,000	

Source: National Minimum Dataset for Social Care 2013

An earnings squeeze

The majority (76%) of social care jobs are direct care jobs which include care workers and home carers, senior care workers and support workers, many of which are low paid. Care workers and home carers (which account for 700,000 of the total care workforce) attract a median wage of £7.90 per hour but 40% of these individuals (approximately 350,000) are paid at or below £7 per hour (Office for National Statistics, 2013c). Like many other parts of the UK workforce, wages in the health and social care sectors have come under pressure in recent years from persistently high inflation which has acted to squeeze the disposable incomes of workers. Yet wages in the care sector have also come under pressure from cuts to government expenditure (outlined above) causing financial difficulties for providers. Perhaps this helps to explain why the squeeze on earnings has been felt more acutely across the health and social care sectors than across the rest of the labour market. Indeed, average earnings are not just continuing to fall in real terms (i.e. after accounting for inflation) but in nominal terms too (see Figure 2).

Figure 2. Average earnings growth in health and social care has fallen since 2008



Source: ONS Average Weekly Earnings and Author's calculations

“...firms using ruses to get round the minimum pay rate”

In late 2013, David Norgrove, Head of the Low Pay Commission, observed that in response to cuts in funding councils were “sometimes dramatically slashing the rates that they paid care companies to wash, feed and dress the elderly and frail; and this was happening so fast that the firms concerned were using ruses to get round the £6.31-an-hour minimum pay rate” (Ramesh, 2013). A report published shortly after by HM Revenue & Customs detailing the results of an investigation into 183 care providers confirmed these suspicions. It found evidence of non-compliance amongst 48% of the providers it assessed noting this was “the highest level of non-compliance since 2008”. According to the report, the most common reason for non-compliance related to deductions from workers’ pay and failure to pay for items deemed to be a business expense. Such deductions brought some workers’ pay below National Minimum Wage (NMW) rates (HM Revenue & Customs, 2013). Arguably, the latest episode of providers failing to pay NMW does not just stem from recent government cuts, but the “failure of successive governments to ensure that funding for social care keeps pace with rising demand”. This has “put pressure on local authorities as the commissioners of care, many of whom have responded by not only restricting access to care but by driving down the price they are willing to pay for it” (Pennycook, 2013). With the minimum wage set to rise, this may put additional financial pressures on providers.

“...carers do not just require adequate financial support from their employer but emotional support too”

While low pay is clearly a concern for the wellbeing of the workforce as well as those

in care, previous research implies that the social care sector may not be the worst offender – a number of other low pay sectors have a greater proportion of their employees working at or below minimum wage (Low Pay Commission, 2013). And broadly consistent with other low pay sectors, a large proportion of the care workforce is not employed on a full time basis (53%) and there are a significant number on zero hour contracts across the sector (30.5%). Research conducted by the Department for Business Innovation & Skills (2013) shows that the care sector is not alone in this regard - 30% of those working in distribution, accommodation and food are on zero hour contracts. In one sense then, employment and pay is roughly in line with other low paid industries. However, it could be argued that the significant prevalence of zero hour contracts across some parts of the sector (up to 60% for domiciliary care) combined with the often strenuous nature of the work and the substantial financial pressures facing social care providers, create their own unique set of challenges for the workforce.

It is worth emphasising that social care is intrinsically about the relationships between carers and those they care for, many of whom are often considerably vulnerable. Carers may therefore face high risk situations on a day to day basis which can be stressful (Burke, 2013). They may also be subject to abuse from those they care for. A survey undertaken by Skills for Care found that many social care and support staff have faced verbal (93%) and physical (53%) abuse (Skills for Care, 2013). In this regard, carers do not just require adequate financial support from their employer but emotional support too.

...zero hours (the good, the bad and the ugly)

Debate about the efficacy of zero hour contracts continues to gather steam. In short, while zero hour (and part time) working can provide flexibility for employees and employers alike, there is a risk that employers will exploit such arrangements for their own short term financial benefit to the detriment of employees who may prefer greater certainty about future employment and income. This may be a particularly acute problem for the care sector given current financial pressures on providers. Indeed, the Department of Business, Innovation and Skills has just released a consultation paper on zero hour contracts highlighting the issue of care providers failing to reimburse zero hour employees for travel time (Department for Business Innovation & Skills, 2013). As well as causing income pressures for employees, this is leading to poorer quality care through rushed home visits for those in need of support (Samuel, 2013).

Staff turnover

Given low levels of pay and other pressures on the care workforce, it is perhaps unsurprising that vacancy rates and staff turnover across the sector is high (3% and 19% respectively) with turnover having increased slightly since 2009 (+1 percentage point) (Skills for Care, 2012). Direct care roles (which are more likely to be lower paid with workers on part time/zero hours contracts), have the highest vacancy and turnover rates (4% and 22% respectively) while managerial roles have the lowest rates (3% and 11% respectively). The Chartered Institute of Personal Development puts median UK staff turnover at 11.9%, substantially below the average figure for the care sector, though the Institute notes that there is significant variation across, as well as within, different industry groups (Chartered Institute of Personal Development, 2013).

Crucially for those in care, the level of staff turnover can be a matter of life or death. The 2013 Annual Report from the Care Quality Commission (CQC) found a statistical

link between those care homes with increased rates of staff turnover and notifications of death - particularly in care homes without any nursing provision. This suggests that “too many changes in staff may result in gaps in care”. Across health and social care, continuity of care is recognised as being vitally important to those in need of support. The National Institute for Health and Care Excellence (NICE) for instance, highlights continuity of care as one of its Quality Standards. It states that patients should experience care “whenever possible, by the same healthcare professional or team throughout a single episode of care” (National Institute for Health and Care Excellence, 2012). While this is predominantly aimed at the NHS, the tenant of the statement is also applicable to the care sector. High levels of staff turnover make this impossible to adhere to.

“...the level of staff turnover can be a matter of life or death”

One of the reasons that continuity of care is so important is that it leads to better coordinated care – employees across the care sector have to work effectively together as well as with those in the health service. Greater continuity of staffing enables better relationships both within and across sectors to ensure that any health issues are quickly identified and well managed. Currently, there are significant coordination problems effecting health and social care, which according to the CQC, have resulted in an increasing number of older people arriving at A&E with avoidable conditions. This is increasing faster than the growth in the older population. (Care Quality Commission, 2013) Not only does this pose an immediate risk for the patient but it also creates an additional financial burden on the health service. While a high level of staff turnover is by no means the only factor behind poor levels of continuity and coordination, it is likely to play an important role.

The causes of high staff turnover

The National Minimum Dataset for Social Care (NMDS-SC) contains the most statistically robust analysis into the reasons why employees decide to leave their current employer as well as information on their subsequent workplace destination (Skills for Care, 2012). For the 2011 wave, 89,000 responses were collected making it possible to compare views across different parts of the industry.

“...pay not the main factor”

While the pay and nature of adult social care work has received a significant amount of attention, the vast majority of respondents do not cite either as their reason for leaving. The most common response was “personal reasons” (20.6%) followed by “transferred to another employer” (14.1%) and “resignation for other undisclosed reason” (11%). The “nature of work” accounted for 6.2% of leavers, “pay” accounted for just 4.2% and conditions of employment just 1.6%. In terms of the destination of leavers, the largest proportion stayed within the adult social care sector (29.7%) suggesting that there is significant churn across the industry as a whole. The second most common destination was “not another job immediately” (17.4%) followed by “the health sector” (12.2%). Responses were similar for those working in both residential and domiciliary care.

When interpreting these results, it is important to note that in reality, individuals are likely to have multiple overlapping reasons for moving on. For example, with 41% of the care workforce under the age of 39 (and with the vast majority of these being women), a lack

of employer support on childcare could be a significant factor in causing some to leave for personal reasons. In such a situation, the employer remains partly culpable for the decision taken by their employee. Whatever the actual combination of motives, the fact that so many move on to other jobs within the same sector, suggests that employers are not doing enough to encourage loyalty, and that, on the basis of the survey results, pay is only one small part of this equation.

Job churn is not only bad for those in care but also for the provider, since new employees may need (re)training which keeps labour costs artificially high. Indeed, it has been reported that many employers lack faith in the quality of some training on offer which has caused organisations to develop their own in-house training. According to the Cavendish Review of Healthcare Assistants and Support Workers in the NHS and Social Care “some of this [in-house training] is excellent, but it leads to duplication, with employers retraining new staff irrespective of what they have learned elsewhere” (The Cavendish Review, 2013). This is not only inefficient but also a safety risk.

Training and qualifications

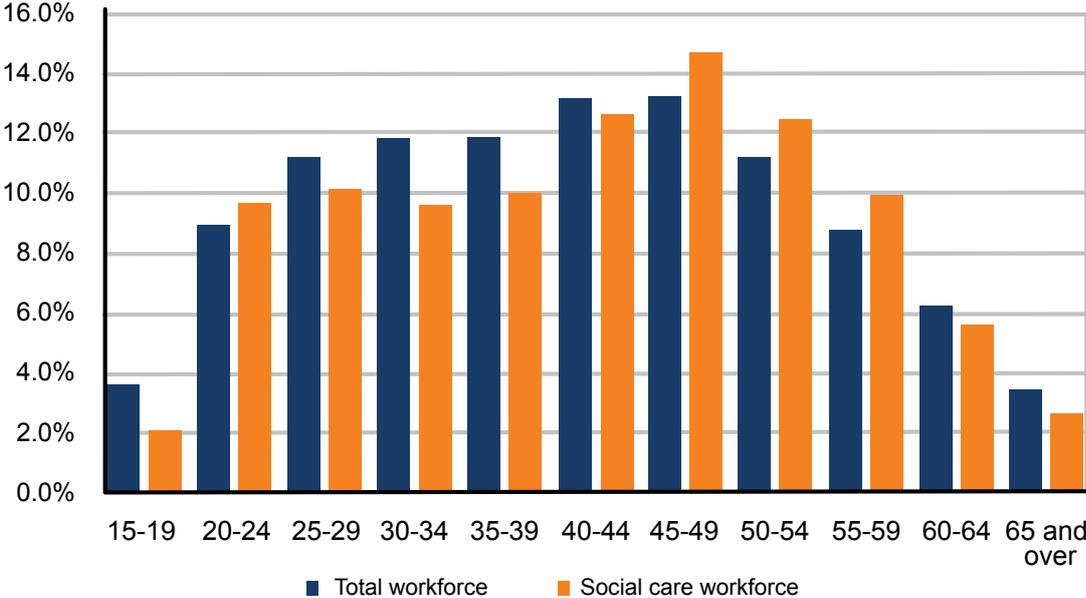
The prevalence of training and qualifications across the care sector is low. While the majority of staff have undertaken induction training (69.4%), care workers do not tend to be well qualified with the largest proportion (37.2%) having no relevant qualifications and just 6.7% of care workers holding qualifications at Level 4 or above. There is however significant variation across different job roles – 15.5% of those in management or supervisory roles have no qualifications by comparison to 37.6% of direct care staff. That equates to roughly two in every five carers who interact with patients on a daily basis having no relevant qualifications. The Cavendish Review highlighted this, and emphasised the problem that low-level staff have no incentive to train because of the widespread lack of faith in qualifications partly explained by the absence of a central quality assurance mechanism (The Cavendish Review, 2013).

Demographics

The social care workforce is dominated by women (82%) and this is similar across all types of care. The gender split is also relatively similar by seniority – women account for 79% of managers and supervisors and 84% of direct care staff. While the sector may be unrepresentative of the total UK workforce in terms of gender, its age structure is relatively similar. Figure 3 shows that the care workforce has a slightly higher proportion of its workforce amongst the older age groups and slightly lower proportion amongst the younger age groups than the labour market as a whole.

The care sector is ethnically diverse with black and minority ethnic groups accounting for 17.8% of the total workforce. It is also reliant on non-British workers, with 18.2% of the workforce accounted for by non-British workers though managers are significantly more likely to be British (92.4% are British) compared with professional care workers (64.5%) and direct care workers (80.6%). The fact that so many care professionals are non-British may reflect a skills gap across British born workers, while British born workers may perceive direct care roles more negatively than migrant workers.

Figure 3. Age profile of social care workforce versus total workforce of England *



* The census data only show 16-19 employment whereas care workforce data shows 15-19 data

Source: NMDS-SC (2011) and ONS Census 2011

3. Future demands of the care workforce

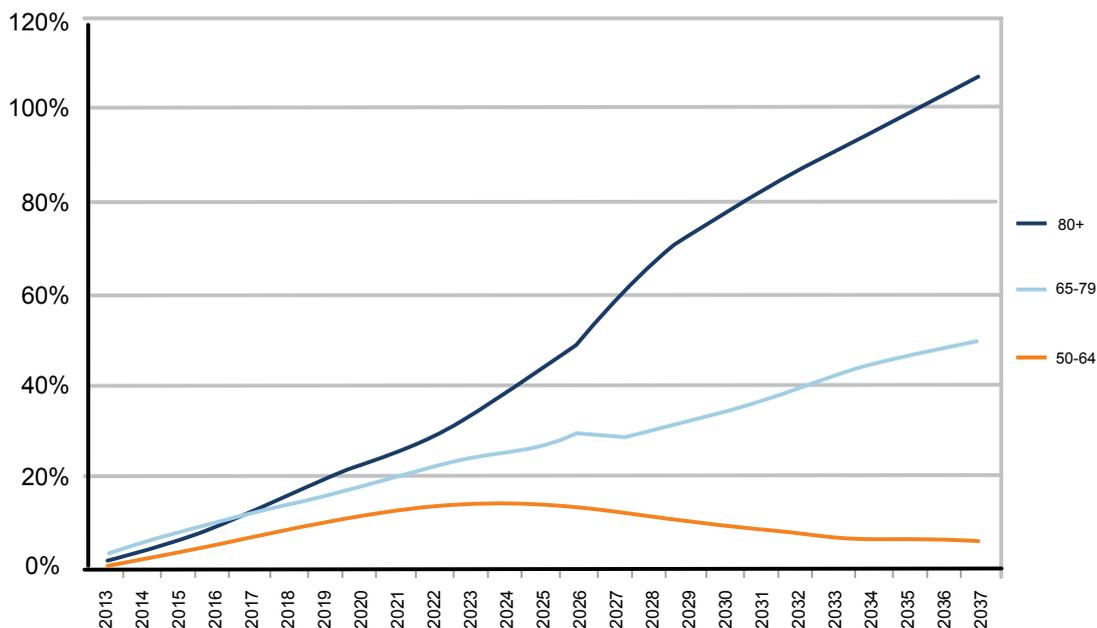
Future demand for care will depend on a number of different elements including demographic and health trends, scientific developments and individuals' preferences for the type of care they receive. Complicating things somewhat, these elements are interrelated. Advances in medicine for example could change peoples' life expectancies and reduce incidences of severe disability which could, in turn, shift preferences. With this in mind, we briefly review and critique each element.

Demographic and health trends

The need for long term care often arises as a result of an individual with a chronic illness or disability. In general, the more severe the illness or disability, the more care the individual is likely to require. The Family Resources Survey has provided measures of disability across the population for a number of years. It has found that rates of disability have remained relatively constant over the last decade (both overall and by age cohort). Assuming that disability rates by age remain the same over the next twenty years it is possible to predict future numbers of people in England with a disability through the use of ONS population projections.

According to these methods, from 2013 to 2037 the number of people with a disability in England will rise from 10.56 million to 13.93 million (33.4%). The main driver of this increase, is the projected growth in population of the over 65s and the over 80s in

Figure 4: Projected percentage increase in numbers of people with disabilities by age group (2013-2037)



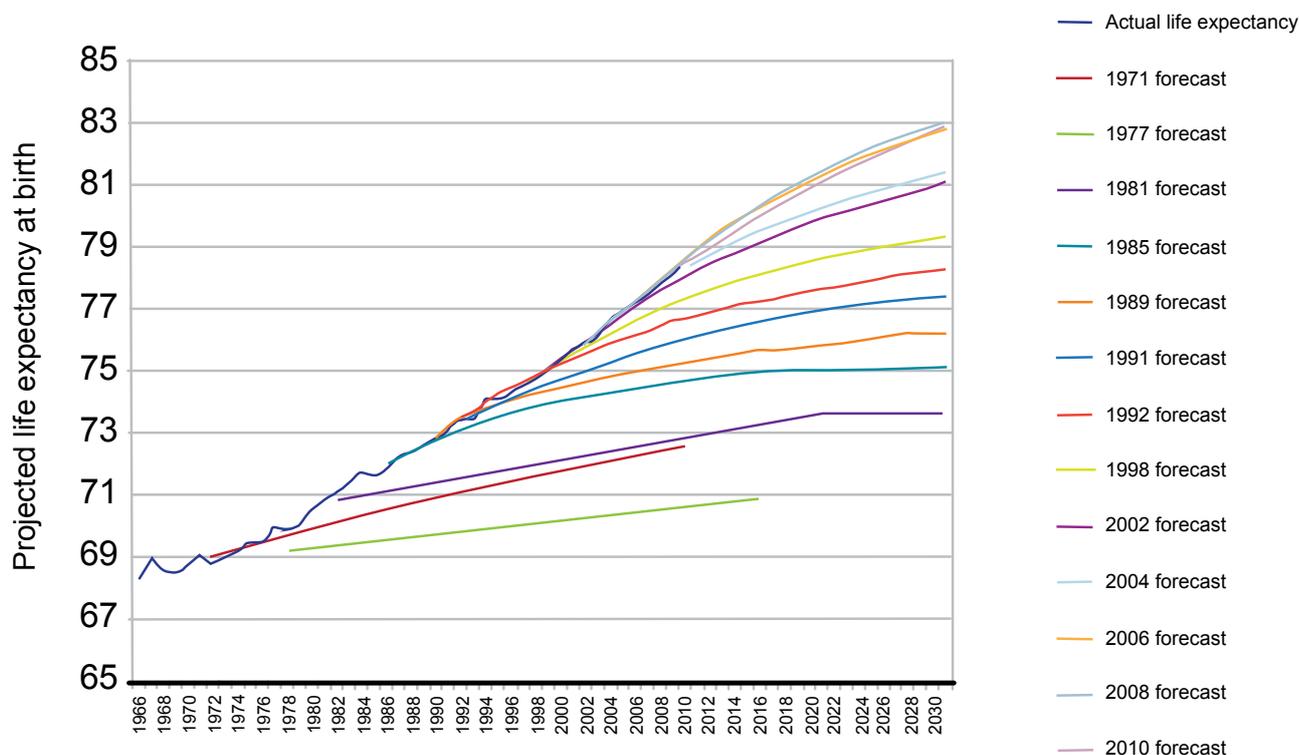
Source: ONS population projections, Family Resources Survey and Author's calculations

particular which account for 50% (1.6 million) of the overall increase in disability (see Figure 4). This group currently has the highest rates of disability across the population and its size is expected to more than double by 2037. It is also this age group that currently has the highest incidence of severe or multiple disabilities requiring the most labour intensive care.

“...life expectancy and disability are notoriously hard to predict”

While the projections for future disability are based on assumptions using current information, the reality may differ significantly from this picture. For example, assumptions around life expectancy which underpin the population projections may be underestimates or overestimates. If a greater proportion of people live longer than expected, this will put additional pressure on the care sector (especially if disability rates by age remain constant). We have a track record of underestimating life expectancy - over the last 40 years the ONS has consistently revised life expectancy upwards (see Figure 5). These revisions have been substantial; in 1981, forecasters projected male life expectancy at birth in 2016 to be 73. Using 2010 –based life expectancy projections, men born in 2016 are expected to live at least 10 years beyond that with male life expectancy shifting closer to female life expectancy. Disability rates are also difficult to predict. For example, although numbers with dementia is currently on the increase, advances in the medical treatment of dementia could be a “game changer” in reducing disability rates across older cohorts, while on the other hand obesity could be the next big public health crisis necessitating an increase in the size of the social care workforce (National Obesity Forum, 2014). In short, while the big picture may seem clear in terms of rising longevity, the social care workforce will have to remain flexible enough to absorb unexpected shifts in demographics, public health and healthcare.

Figure 5: Upward revision to projected life expectancy at birth for males by year of forecast



Source: Office of National Statistics and International Monetary Fund

People's care preferences

There appears to be consensus that a one size fits all approach to social care is not acceptable. Instead, individuals require personalised services that meet their needs and promote independent living (Lucas, 2012). For many this may mean a shift towards care in their own home facilitated by improvements in technology. But there will still be demand for residential and nursing care when more extensive support is required. There will need to be greater choice for different types of care and support as the sector evolves. We are not there yet - in the latest Adult Social Care Services Survey by HSCIC just 32 per cent of those in care agreed that they have as much control as they would want over their daily life (Health and Social Care Information Centre, 2013b). Shifting this percentage upwards must be a key objective going forwards. But greater choice and control may require a larger and more varied social care workforce.

Future size of the workforce

The workforce projections outlined in this section were based on projections of demand made in 2008 by the Personal Social Services Research Unit (PSSRU) for the Department of Health. These in turn were based on government projections of the future population of England. The "base scenario" assumes that the same patterns of service which existed in 2008-9 continue at a constant rate while demand for services increase as anticipated. Under this scenario the care workforce increases by 765,000 (47%) from 2012 to 2025. The second scenario, "maximising choices", assumes that all who wish to have their publicly funded-social care provided in a highly personalised way in their own homes can do so. Under this scenario, the number of jobs would increase by 965,000 (59%) and most jobs will be personal assistants. Such an overall increase in workforce numbers equates to average annual growth in the workforce of 4.6% over the period. Skills for Care provide two additional scenarios which assume a reduction in resources going into care and greater voluntary and community support (Skills for Care, 2013).

"...the crisis of unmet need"

While the projected increases in the care workforce under the "base" and "maximum choices" scenarios look substantial, the current degree of unmet need across the 65+ age cohort suggests there is an immediate requirement to increase the size of the care workforce. The annual Health Survey undertaken by the HSCIC found that 30% of women and 22% of men aged over 65 who needed help to complete one or more activities of daily living failed to receive help with any. This increased with age to 44% of women aged over 85 and 43% of men. The increase in unmet need by age reflects the fact that the oldest old are more likely to be widowers – with spouses/partners being the main single source of care and support amongst retirees. The most common activities where help was required but not received was getting up and down stairs, having a bath or shower and getting around indoors (Whalley, 2012). Over the medium to long term, some of these problems can be solved by increased investment in new homes and adaptations to existing homes that better cater for those with chronic illness and disability. But in the short term, many of these individuals will need daily support from a care worker.

How many more workers do we need?

According to our calculations based on the Health Survey, there are approximately 750,000 people aged over 65 who require help with one or more activities of daily living but receive no help at all. To provide care for all of these individuals would require a

substantial increase in the size of the care workforce. The current ratio of care workers to those in care (both public and private) is 0.92 care workers for every person in care. If one assumes that all those with unmet need today start to receive care services tomorrow this would imply that the care workforce must increase by 690,000 for the ratio of care workers to those in care to remain the same. Clearly such a sudden increase is impractical but it demonstrates the size and immediacy of the task at hand. It also helps demonstrate that we may need an increase in workforce numbers above and beyond those projected under the maximum choices scenario. And this increase will need to be front loaded – with the majority taking place within the next five years.

4. Barriers to workforce growth and how they might be overcome

Labour supply

Attracting at least 1 million additional workers into the care sector (after taking account of current projections as well as unmet need) over the next decade is going to be a significant challenge. The sector currently attracts women and migrants but the extent to which these two groups can drive such a substantive increase is likely to be limited. From 2013 to 2025 there will be a 1.56 million increase in the number of working age women but even if a high proportion of this group (let us assume 20% for argument's sake) find jobs in the care workforce this will only account for 31.2% of the total increase required. Net migration is expected to fall over the next decade relative to the levels experienced over the last ten years. Across the UK as a whole, average annual net migration is expected to fall from 202,000 per annum during the years 2003-2013 to 168,000 from 2014-2025. Unless the proportion of migrants going into the care sector substantially increases, migration is only going to be a small part of the answer.

To meet demand, the care sector will need to tap into other parts of the labour market including working age men (expected to increase by 960,000) and those over 65 (expected to increase by 2 million). Particularly for the over 65s, the greater flexibility of working part time in the care sector may be an advantage. In addition, it may be beneficial to target underemployed workers – those who are in work but wish to work more hours. 10.6% (or 3 million) of the UK's workforce is currently underemployed – the highest level since the ONS started collecting data on underemployment in 2000 (Office for National Statistics, 2013d). For these individuals, entering the care sector could provide a welcome income boost while also doing something that helps the local

Case Study

Ann Headland (Bilton Court): 69, who is the activity co-ordinator and has worked at Anchor for nine years.

She said: “When I left the health service I had a desk-based job and I wanted to give something back to the local community. My job had helped keep the wheels moving but it wasn't a hands-on job and you didn't have any contact with patients.

“I would recommend care to anyone who is looking for a career change in their 50s because the job is very rewarding. I have worked for Anchor for 9 years and have always been happy doing the job I do.”

community. And finally, the care sector must try to reduce the numbers of people leaving the care workforce each year (73% of those that leave their current employer leave the care workforce altogether).

Profitability of the sector

“...for those providers that have the financial means to reinvest in their workforce – both in terms of numbers and skills – it is vital that they take a long term view.”

An adequate supply of labour is not the only type of supply constraint likely to impact on the market. Many providers will be reluctant to expand their businesses and take on more staff during a time of cuts to Government expenditure and with the future state of social care funding still uncertain, particularly with a General Election looming. Even without these issues however, the financial sustainability of care providers would likely have come under the spotlight in the wake of the collapse of Southern Cross. While the specific problems at Southern Cross were an exception, a report by Corporate Watch in association with The Independent, found evidence of financial mismanagement as well as strange corporate governance arrangements in a number of leading providers; 3 out of 10 of the largest care home providers are rated as risky by leading credit rating agencies over concerns about their ability to pay off large debts in a tough economic climate (Corporate Watch, 2012). The domiciliary care sector does not appear to be doing any better - estimates suggest that **net** profit margins across independent and voluntary home care providers are as low as 3% (Angel, 2013). However, it is worth noting that not all providers are the same. For those providers that have the financial means to reinvest in their workforce – both in terms of numbers and skills – it is vital that they take a long term view. Building a strong reputation for quality of staffing must be seen as a key selling point that providers can use to take advantage of the expected increase in requirement for social care over the coming decades.

High level views on ways to address supply barriers

...tackling turnover: improved support networks and terms of employment

Earlier this paper noted that pay was not the most important driver of staff turnover implying that raising earnings is only a small part of the challenge and there is a need to find more creative solutions to keep people motivated in the workforce. One important theme worth exploring is how we can **improve the support networks** to help carers deal with the types of practical and emotional issues they face on a day to day basis. Increased support from providers for coaching and mentoring may be one way of addressing this. Consistent with the concept of mentoring set out in the National Skills Academy, these individuals would not just help care workers improve their core competencies but also support them on more personal issues such as stress and relationships while also acting as important role models for junior members of staff (The National Skills Academy, 2014). In addition, there needs to be a more consistent and rigorous processes in place for **preventing and tackling incidences of physical and verbal abuse** against care workers, as well as clear lines of support for those that have been abused. Enhanced training in prevention, avoidance and de-escalation may be part of the answer to this (McGregor, 2013).

Alongside improved support networks, it is vital that the **terms of employment** are clear to all of those concerned and that they are rigorously adhered to. While the care industry is not alone, it has a reputation of failing to pay the minimum wage and exploiting those on zero hour contracts which is not just impacting on those working in the industry but also acts as a deterrent to prospective employees. For those that do leave the industry for a prolonged period of time – i.e. due to childcare – there are interesting examples from other countries of **measures put in place to entice them back** later on. In the healthcare sector in Malta, for example, nurses and midwives leaving the sector remain on a reserve list should they wish to return, ensuring that they can have their previous service accumulated, which is then reflected in their salary and calculation of total length of service (Weber, 2011).

...Clearer paths for career progression: increased reputation and motivation

To make the sector more attractive for all groups in society there must be clearer paths for career progression and the introduction of **more creative initiatives to raise morale and performance**. Take the restaurant chain Nandos for example, which also operates in an industry which is characterised by low pay and high turnover. Nandos' workers, of which 60% are under the age of 25, have **clear opportunities for career advancement**, with over 40% of grillers and waiters moving up the ranks to managerial status (Sawyer, 2010). But any new management must go through an assessment process where they have to be approved by 80% of kitchen staff (The Startups Team, 2013). This gives even the most junior employees real buy-in to the way in which a branch is run. In addition, members of staff are taken on regular away days and other social events to boost morale and team spirit. These measures appear to be working - Nandos won the *Sunday Times* Best Place to Work (Big Companies) category in 2010 and reportedly has a high level of staff retention relative to the rest of the sector. While this has come at a cost - 75% of Nandos human resources budget is spent on learning and development - the reputation of the firm as an employer as well as its overall brand image has grown as a result.

Improved opportunities for career progression must be repeated at an industry-wide level. One likely deterrent to career development is the fact that the qualifications awarded by some providers are not trusted by others. Such a scenario is likely to put-off many from even attempting to attain qualifications and other forms of training and development outside of what is already considered compulsory by their employer. As recommended by the Cavendish Review, there is **an urgent need for a trusted third party to provide standardised verification of training and development** in order to address this problem. Being able to take your qualifications with you from one employer to the next is a crucial part of building a strong social care profession.

Attracting men and older workers

“...the use of effective male role models will be important as will focusing on the different sorts of roles on offer within the care sector”

One of the most significant challenges will be to attract more men and older people into the care workforce. There is undoubtedly stigma attached to the care sector with the very word “caring” often perceived to be “feminine” in some way (Lombard, 2012).

Asa Lehane-Johnson, 25, formerly of The Beeches Leatherhead, Surrey - he was an activity co-ordinator but is now responsible for improving activities across the whole of Surrey, working as a Customer Engagement Advisor. He has worked for Anchor for two years.

He said: "I was looking for a career change, and specifically wanted to find a role that meant I worked with older people.

"I found Anchor's approach to care, 'Happy Living for the Years Ahead', to be extremely positive, and felt that they were the company for me. There was a role for an Activity Co-ordinator available at one of Anchor's homes and the rest, as they say, is history.

"My initial role as Activity Co-ordinator was so rewarding, knowing that I was offering a program of activities and social events that had a positive impact on the older people living within the care home.

"Anchor also encourages career development, and that has worked wonderfully for me, as I have been able to develop my career – I'm now working in my new role as a Customer Engagement Advisor.

"Care is an ever increasing and developing sector. Working in care can be so rewarding, and there is so much to learn from the older generation."

England is not an exception in this regard – looking across European countries care workforces are dominated by women. To improve the ratio of men to women, social care must be portrayed and actively promoted as work that men as well as women can and do find interesting and fulfilling requiring the use of attractive modern promotional methods (Munday, 2007). The use of effective male role models will be important in this regard, as will focusing on the different types of roles on offer within the care sector. In this regard, the Skills for Care initiative ***...Care Ambassadors*** is a strong move forwards because prospective employees can identify male ambassadors across the workforce (Skills for Care, 2014).

But more also needs to be done to ensure that care jobs are presented as viable opportunities for men using employment agencies as well as being seriously considered by career advisory services in schools and universities. Central to achieving this objective will be to challenge the basic assumptions that many people hold about the care sector which can be supported by measures to improve career progression and raising the overall reputation of the industry. Given that attracting more carers into the sector is ultimately a public health issue, Government must also play an important role –

whether this is through better information provided by job centres, schools and colleges or even some form of public information campaign.

...adapting the working environment for older people

While there are some jobs within the social care sector that can be physically demanding, this does not mean that older people are unable to contribute. On the contrary, older individuals often have a wealth of previous experience - whether or not they have been in the care sector - and are typically more loyal to their employers than younger workers. They must be actively encouraged to join the care sector and the industry must make similar promotional efforts to attract older workers as they will have to with prospective male employees. Indeed, given that the care sector has a greater number of older employees as a proportion of total workforce than the rest of the labour market, it may be particularly fruitful to find older role models to encourage older workers into the sector. It will also be important to grow initiatives such as “Grey Pride” aimed at pinpointing and counteracting ageism within the workforce and to cause employers to make necessary adaptations to working practices (Grey Pride, 2014). This may include, amongst other things, an increased push for more flexible working for older people in the sector.

Case Study

Stephen Pritchard Chichester (Augusta Court): Steve, 64, who has worked at Augusta Court in Chichester for several months, joined the care sector at the age of 62.

After he retired, he wanted to help others especially as he had been caring for his father into his 90s at Steve’s home.

“It provides me with the ability to continue to contribute to the community and to individuals.

He said he liked working in the care sector because it provides me with the enjoyment of working in a team with colleagues from diverse backgrounds and a wide range of skills.

He said: “Being an Activity Co-ordinator provides me with the opportunity to use my skills as a musician and an artist and a communicator. It provides me with the opportunity to learn new skills and to continue to contribute those I came with.

“I wanted to work for Anchor because it is a recognised leader in the sector with good staff, good provision of services and good educational facilities. At Anchor, I am able to enhance my contribution through the structured provision, education, monitoring and managerial/colleague assistance.

“With the level of media attention comment daily concerning standards and governance in the sector, I needed to be sure I was making my contribution where it was appreciated, valued, and valid.”

5. Conclusions and recommendations

The adult social care sector is facing a number of significant challenges. Alongside demographic change, it is facing significant financial pressure in the wake of local government spending cuts, and continued uncertainty about how proposed reforms to social care funding are likely to impact business models. At the same time, the sector's reputation as an employer has taken a reputational hit over allegations about failing to adhere to minimum wage law, the fall of Southern Cross and zero hour contracts. But despite all of these issues and more, as the case studies in this report show there are women and men working in the sector who care deeply about providing care and support for older people and it is a shame that these types of examples tend to attract little media attention. These individuals' experiences help to counter some of the pre-existing stereotypes about what working in care is actually like. As was suggested by one member of the roundtable that helped to shape this report, is it time to have a programme called "Caring for Yorkshire" in the style of "Educating Yorkshire" to show the positive impact that front line staff can have on those in care? But this is just one of a host of measures required to deliver the future care work force that our ageing population deserves. In this regard, our report recommends the following:

- While the funding of adult social care is beyond the scope of this report, it is clear that government funding must rise in line with the needs of the population to ensure that more individuals do not slip through the net and receive the care and support they deserve.
- The abuse of national minimum wage regulations is clearly unacceptable. But rather than just penalising the guilty providers ex post, we must identify and address the underlying causes of this at an industry-wide level to prevent it from occurring in the first place.
- Reducing staff turnover is not just about pay and terms of employment, but also about ensuring that employees have the right support structures in place to drive career development as well as supporting them through times of stress or abuse in the workplace.
- As recommended by the Cavendish Review, a central quality assurance mechanism is required to verify the qualifications of care workers who undertake learning and development with different providers. Being able to take your qualifications with you from one employer to the next is a crucial part of building a social care profession.
- Men, older workers, the unemployed and the underemployed can all play a big role in filling the potential gap in labour supply. In order to entice these individuals into the care sector, providers will need to use innovative promotional campaigns to address persisting stereotypes and target these underrepresented groups.
- The care sector must learn from examples of best practice both from within the sector as well as from other low pay sectors to identify how it can improve staff morale and retention through relatively low cost measures.
- Building a strong reputation for quality of staffing must be seen as a key selling point that providers can use to take advantage of the expected increase in requirement for social care over the coming decades.

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Appendix – List of roundtable attendees

The following people attended the roundtable held on the 22nd of January 2014 to discuss an interim version of this report. We are extremely grateful for their comments which have helped to shape the report's content and recommendations. Nevertheless, the approach, contents and findings of the final report are solely the responsibility of the author and ILC-UK.

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