Local Challenges in Meeting Demand for Domiciliary Care
Synthesis Report

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Preface

The GELLM Partnership and Research Programme

Between 2003 and 2006, the Gender and Employment in Local Labour Markets (GELLM) Programme\(^1\) explored an extensive range of factors affecting the labour market situation of women in 11 local labour markets in England.

This unique programme of research, perhaps the most extensive study and analysis ever undertaken of the local labour market situation of women in England, was developed in a close and active partnership with 11 local authorities, and with support, guidance and additional investment from two national agencies, the Equal Opportunities Commission (EOC) and the Trades Union Congress (TUC). Working closely with its 13 external partners, the GELLM project team, comprising an experienced and diverse group of social scientists (with expertise in sociology, social policy, urban and regional studies, social statistics, and gender studies) produced 12 Gender Profiles of Local Labour Markets (Buckner et al 2004, 2005), each presenting a comprehensive picture of gender-disaggregated local labour market statistics\(^2\). The team then went on to develop, in 2004-5, six new Local Research Studies, each carried out in parallel fashion in up to six of the local labour markets which had been profiled, and designed and implemented in close collaboration with local policy-makers. The evidence from these studies was reported at the local level in 31 Locality Reports published (in spring 2006) with the support of the local authorities concerned, and disseminated in each of the English regions in a series of successful local events\(^3\).

Carrying out this research in partnership with a wide range of local authorities over a three year period was important in a number of ways:

**First**, it enabled us to focus our studies on topics which were of interest not only as subjects for academic study, but also as issues of major policy relevance and current concern to our partners. We debated the topics we should explore (and the precise focus of each study) with each of our partners in meetings of the GELLM Regional Project Groups (established by each local authority partner to support the project at local level), in consultations with the GELLM National Advisory Group (which comprised all our local and national partners, and also had the benefit of three external academic advisers with relevant expertise\(^4\)), and within the research team. This led to the decision to develop 6 multi-method Local Research Studies, with each local authority partner able to participate in up to three of the studies.

**Second**, it enabled us to design the studies so that they would draw on local intelligence and expertise about the issues involved. This was particularly important in those studies where there was thought to be existing research, or a body of knowledge about our topic, which had not previously been drawn together into a single report (and most notably in our study of ethnic minority women and their local labour markets).

**Third**, our partnerships made the process of securing research access (to organisations, documentation, agencies and individuals) both efficient and effective. Our various partners thus assisted in identifying suitable venues for focus groups, in contacting agencies and individuals who could provide a practitioner or policy-maker perspective at the local level, and supported us in accessing interviewees, workshop facilitators and the additional resources needed to support this type of research.

**Finally**, the partnership ensured that this body of research was not merely ‘policy relevant’, but achieved our wider aims for the GELLM programme. These were: to produce an evidence base fit for the purposes of local authorities and their partners; to deliver the research in a way which was ‘policy engaged’ and recognised the realities and challenges of addressing the entrenched local labour market problems which underpin women’s employment disadvantage; and to conclude the partnership, at the end of the three year

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1. The programme was based in the Centre for Social Inclusion at Sheffield Hallam University, and directed by Professor Sue Yeandle. It was made possible by a large core grant from the European Social Fund.
2. The Gender Profiles were launched at events hosted in each locality by our local authority partners in 2004-5, and were attended by a total of approximately 800 people.
3. A list of the 31 Locality Reports and details of the local dissemination events can be found at www.shu.ac.uk/research/csi.
4. Prof. Ed Fieldhouse and Prof. Damian Grimshaw, both of the University of Manchester, and Prof. Irene Hardill of Nottingham Trent University.
period, by supporting our local authority partners to *mainstream gender equality* in their planning, operations and strategic policy-making in relation to local labour market issues. Our Locality Reports were presented at well-attended conferences and workshops organised by our local authority partners in spring/summer 2006. These events were used to launch the reports, to debate the new evidence and recommendations, and to consider what actions should follow. Across the country, over 500 people attended these events, and at most of these meetings clear commitments were made to give further detailed consideration to the research findings, and to explore ways of addressing the issues identified at the local level.

### The GELLM Synthesis Reports

This *Synthesis Report, Local Challenges in Meeting Demand for Domiciliary Care*, draws together the findings from the local research study of domiciliary care providers’ recruitment, retention and workforce development policies and practices, which was carried out in Birmingham, Newcastle-upon-Tyne, Sandwell (West Midlands), Somerset, Thurrock (Essex), and West Sussex (Crawley and Mid Sussex). It provides a comparative analysis of some of the issues providers face in delivering social care to people living in their own homes in 6 local labour markets, and draws on the wider body of GELLM research of which it forms a part. As indicated above, it is one of the 6 GELLM *Synthesis Reports* published in summer 2006, and completes the study output as funded under the original research award.

In the 6 *Synthesis Reports*, we show how both gender and locality play out in the way local labour markets operate, and identify features which affect women’s labour market situation in similar ways across 11 very different local labour markets. We also show that in some cases, particular local labour market circumstances act as quite locally specific constraints and opportunities for the women living and working within them. In each case we explore the diversity of the female working age population, and take account of changes and developments which have affected the structure of the local labour market. In our analysis we have tried to tease out those factors which are within the sphere of influence of local authorities and their local partners - employers, trade unions, voluntary sector organisations and publicly funded agencies – as well as to identify those policy issues which require attention at the national level if local agencies are to achieve their objectives.

Because they offer a comparative analysis of data relating to different local labour markets, our *Synthesis Reports* present the research findings in ways which will be of particular interest to national and regional agencies with responsibilities for developing effective labour market policy, and for ensuring that the labour market operates in an inclusive manner, making full and fair use of the talents of both women and men across the whole economy. The research therefore contains messages of crucial importance to:

- those charged with seeking effective ways of **tackling local pockets of ‘worklessness’**
- those responsible for achieving a high level of **productivity** and making effective use of national **investments in education, skills and training**
- employers and trade unions seeking to create **modern workplaces** which can attract and retain staff and support employees to **achieve their full potential**
- employers and service providers concerned about **labour and skills shortages**

### The GELLM Research Studies

We developed the *GELLM programme* in a partnership in which all parties shared the view that local labour markets should aim to offer women (and men) equitable access to employment opportunities and a fair chance to realise their full potential as labour force participants - and that they should assist those who desire to enter the labour market to do so. Across the entire programme we have therefore:

i) explored the situation of women outside the labour market who wished to enter it (Grant et al 2006a; Escott et al 2006)
ii) examined the particular situation of women from minority ethnic groups (Stiell et al 2006)

iii) looked in detail at women's employment in the local authority sector (Bennett et al 2006)

iv) studied the situation of women in low-paid jobs and examined why so many part-time women workers are employed ‘below their potential’ (Escott et al 2006; Grant et al 2006b)

v) explored the recruitment, retention and workforce development policies of employers in the highly feminised domiciliary care sector (Yeandle et al 2006)

vi) through the Gender Profiles (Buckner et al 2004, 2005), provided the fullest possible statistical evidence for our topic of enquiry, making extensive use of the 2001 Census and other official statistics.

As we pointed out in the introduction to the Gender Profiles, given the importance of two critical factors - the gendered nature of labour force participation and the local nature of most employment - it is remarkable that previously so little attention has been given in analysis of labour force participation and behaviour to gender-disaggregated data at the sub-regional level. We believe the output from the GELLM Programme represents a major step forward in developing evidence-based policy in this field, makes it quite clear that such data is available, and shows that new evidence-based understanding of entrenched labour market problems and how to tackle them can be secured through a gender-sensitive approach to labour market analysis.

**Box 1 Policy Relevance of the GELLM Research Programme**

When we began the study, we could not know quite how close the fit between our research and new developments in public policy would be.

During the research period:

- The Women and Work Commission reported its findings (in 2006).
- The Prime Minister commissioned two major Equality Reviews (reporting in 2006).
- The Equality Act 2006, setting up the Commission for Equality and Human Rights and placing a new duty on public bodies to promote gender equality (from 2007), achieved the royal assent.
- The Equal Opportunities Commission conducted new GFls into:
  - occupational segregation
  - pregnancy discrimination
  - flexible and part-time working
  - ethnic minority women at work

- Important new developments occurred at the national level, affecting policy on:
  - skills and productivity - The Leitch Review of Skills 2005
  - access to the labour market - DWP Green Paper 2006 A New Deal for Welfare: empowering people to work
  - the delivery of health and social care - DoH White Paper Our Health, our Care, our Say: a new direction for community services
  - work and family life - Work and Families Act 2006

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5 GFls are the ‘General Formal Investigations’ which the Equal Opportunities Commission has statutory powers to conduct under the Sex Discrimination Act 1975.
1 Introduction

Local Challenges in Meeting Demand for Domiciliary Care: the study

This study was designed to explore

• the supply of and demand for domiciliary care in its local labour market context, recognising the extent of women’s employment in this highly feminised sector
• the characteristics of workers in social care, at the district level
• the organisations which provide domiciliary care in each district, and how they recruit, manage and develop their staff, with a particular focus on independent sector provision

The main research questions we hoped to answer through the study were:

➢ Demographic change:
  o What are the demographic trends underlying changes in demand for domiciliary care services, and how do they vary between localities?

➢ Workers in domiciliary care:
  o What are the characteristics of those providing social care in the local authorities selected, and do these differ from place to place? (This included analysing the age, sex, ethnicity, household circumstances, qualifications and unpaid care responsibilities of care workers.)
  o Both official statistics and data available from providers were used to explore these questions. We recognised at the outset that some data limitations would apply sixth.

➢ Providers of domiciliary care:
  o Which organisations are providing the labour supply in social care?
  o How are they recruiting, managing and developing their social care workforce?

➢ Employment policies in domiciliary care:
  o How similar or different are the recruitment and employment strategies of different providers of social care, both within and between local authorities?
  o To what extent are developments/ innovations in their practices proving effective?
  o What can be learned about women’s employment in local labour markets through a detailed focus on the domiciliary care sector?

Six of the local authority partners in the Gender and Employment in Local Labour Markets (GELLM) research programme chose to take part in this study seventh. They were:

➢ Birmingham City Council
➢ Newcastle City Council
➢ Sandwell Metropolitan Borough Council
➢ Somerset County Council
➢ Thurrock Council
➢ West Sussex County Council

 sixth This arises from the way social care occupations are defined in official surveys and statistics.
 seventh Each of these local authorities received a separate Locality Report drawing on the detailed qualitative data obtained through our interviews with domiciliary care providers working in the locality and summarising the local policy context and developments, in spring/summer 2006. Those interested in this detailed material can find it in the six Locality Reports relating to Local Challenges in Meeting Demand for Domiciliary Care. The reports were launched at events held in each of these six local authorities between April and June 2006 (Yeandle et al 2006a-f).
To explore the research questions we adopted the following study design and research methods:

- **Analysis of official statistical data** - primarily from the 2001 Census, but also including official statistics on social care. This work was designed to identify some of the demographic factors driving demand for domiciliary care, as well as to examine evidence about care workers which was available at district level from the Census of Population.

- **A new survey of independent sector domiciliary care providers** – this was developed in consultation with key stakeholders in the localities concerned and distributed to all providers registered with the local authority as providers/potential suppliers of domiciliary care services.

- **Follow-up telephone interviews** with a sub-sample of providers in the private, independent and public sectors – all providers who indicated on their postal questionnaire that they were willing to participate in an interview were approached for this purpose.

- **Interviews with key stakeholders** – these included local authority staff responsible for commissioning, planning and organising domiciliary care services and for managing their authority’s relationship with those contracted to provide services, as well as others in the locality who had operational or strategic roles relevant to our study.

- **Documentary analysis** of reports and information supplied by the research participants.

**Comparative analysis**

By drawing together evidence from all six of the local studies, in which a common research methodology and research instruments were used\(^8\), this *Synthesis Report* offers a comparative analysis of the policy and practical issues in delivering domiciliary care which are being faced at the national level in six very different localities. As we will show, some of the most important issues in delivering domiciliary care are challenges common to all of these localities, albeit challenges which are different in scale and degree in each case. Others are rather more specific, and relate to particular conditions in the local labour market, to the nature and volume of the available labour supply, and to the demographic features of its resident and projected population. We have also had the opportunity to review the different ways in which domiciliary care providers, local authorities and local agencies have recognised and begun to address the issues they face in recruiting and retaining staff in domiciliary care and in responding to the workforce development agenda which has been set out at national level. Relevant developments include the adoption of National Minimum Standards for qualifications, the phased introduction of care worker accreditation through the General Social Care Council, the work of the Commission for Social Care Inspection, and the activities of other agencies set up to promote good practice and effective policies in social care (see below).

In each case our local study of *Challenges in Meeting Demand for Domiciliary Care* was carried out after we had prepared a very detailed *Gender Profile* of the relevant local labour market (Buckner et al 2004-5). The study was also conducted alongside two other GELLM local research studies relevant to understanding gender and employment in each locality. This has enabled us to contextualise both our new research evidence about providers’ perspectives, and our analysis of the statistical evidence about supply and demand, within a detailed understanding of local labour market conditions.

**Report Structure**

The remainder of this *Synthesis Report* is structured as follows:

- A summary of the policy context and key themes in relevant literature (section 2)
- Comparative analysis of the study findings (sections 3 – 5)
- Examples of innovation and effective practice in the domiciliary care field (section 6)
- A concluding discussion of key policy issues (section 7)

\(^8\) Full details of the research methodology are given in Appendix 2.

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2  Policy Context

Introduction

In common with most of Europe, the UK is now experiencing significant growth in its population of older people, a trend which is expected to continue throughout the first half of the 21st century. This is happening at a time when smaller family size, more ethnically diverse populations, changes in geographical mobility, increased longevity, and new patterns of family life are also affecting daily living arrangements and creating additional and altered demand for personal social and care services delivered in private homes.

Almost all evidence suggests that older and disabled people, including those with considerable personal care needs, wish and prefer wherever possible to live in their own homes, rather than in residential settings. Longer lives are likely to mean more years in need of health or social care support (ONS 2004), creating significant additional demand for domiciliary care. In the past, care work in the domiciliary setting was often provided by women in the middle years of life – either unpaid within a family setting, or as unqualified, low paid workers, employed as ‘home helps’, a term now rarely used. The increased educational attainment and labour market participation of women in recent decades has diminished these traditional sources of caring labour, both low-waged and unpaid, and official attempts to up-skill and professionalise employment in social care have placed new demands on those responsible for planning and delivering services.

For many of the local authorities participating in the GELLM research programme, the future delivery of home care services, a key area of statutory local government responsibility, was already a cause of concern when we began our study. Demand for home care services was expected to continue growing, planning and purchasing arrangements had become more complex, and the recruitment and retention of care workers was becoming increasingly difficult – partly because not enough suitable individuals were coming forward to work in this field, and partly because the sector was facing competition for its workforce from other employers, most critically in the south-east and in other localities where alternative labour market opportunities were proving more attractive to job seekers. By 2006 this had resulted in an estimated overall vacancy rate of 11% in social care (and 15% average annual turnover) (Eborall 2005).

Domiciliary care has been and remains a highly feminised employment sector, and provides many women with paid employment which is relatively close to their homes, can often be done on a part-time basis, and involves tasks which have historically been strongly associated with feminine domestic roles. It remains a low paid occupation, and its low social status (despite recent changes in job content and in the skills and qualifications which care workers are expected to acquire), is proving hard to shift. Domiciliary care has thus been a particularly important sector for the GELLM project to study as part of its exploration of women’s employment in local labour markets.

Other research

This study has covered only some of the important issues which our local authority partners were interested in researching, and should be read in the context of other research and investigations, notably:

- The UKHCA’s 2004 profile of the independent home care workforce in England (McClimont and Grove 2004)
- The Kings’ Fund’s investigations, including its 2001 Inquiry Future Imperfect (2001), its Inquiry into Care Services for Older People in London (Robinson and Banks 2005), and the Wanless Social Care Review (2006)
- Skills for Care’s annual reports of ‘The State of the Social Care Workforce’ (Eborall 2005), and its plans for a new National Minimum Data Set for Social Care (NMDC-SC), launched in 2005
- The PSSRU’s estimates of the future demand for long-term care (Wittenberg et al 2006)
- Estimates of future workforce needs in the social care sector produced by the Institute for Employment Studies (IER) for the Sector Skills Development Agency (SSDA)

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9 UK Home Care Association.
10 Some of the findings of these studies are discussed in the synthesis report of our study in all 6 localities (Yeandle et al 2006).
11 Personal Social Services Research Unit
These studies, and other research, have led to the following conclusions:

In the decade 2004-2014 there will be very significant demand for labour in the social care sector, particularly in personal service occupations such as care assistants working in domiciliary care. The IER’s projections identify two types of demand – ‘expansion demand’ (which represents additional ‘new’ jobs in the sector) and ‘replacement demand’ (which represents jobs which have become vacant because job holders have left through retirement, job changing or illness/death). Noting that, in terms of both the male/female employment ratio and the level of part-time employment in the sector, ‘the composition of employment in the sector is projected to remain fairly constant over the next decade’ (Dickerson et al 2006: 200), the IER has estimated that from 329,000 personal service jobs in the social and health care sector in 2004, employment will grow to around 530,000 jobs – a very large net increase of over 200,000 jobs – by 2014. This estimate includes about 68,000 new ‘expansion demand’ jobs, and 134,000 ‘replacement demand’ jobs. Given other labour market projections (which show increased demand for labour in a number of other sectors), this is likely to be extremely challenging for employers in the social care sector. It implies an urgent need to locate additional sources of labour, and the likelihood that employers in the social care field will face significant additional recruitment costs in future. As the IER authors point out, in the area of employment covered by the Skills for Care Sector Skills Council:

> Amongst Managers and Senior Officials, Professionals and Personal Service Occupations, total requirements are in excess of 60% of current employment levels.

It is worth noting that in the specific localities studied in this report, employment in personal services occupations was already at a high level in 2003. In Somerset and Birmingham it exceeded 8% of all employment (8.3% in Somerset; 8.2% in Birmingham and Solihull); while in the wider regions in which the West Sussex and Newcastle local authorities are located it approached 8% (7.9% in Sussex; 7.8 in Tyne and Wear). In both our other study localities, Sandwell and Thurrock, the figure was close to 7% (Black Country 7.2%; Essex 6.9%) (Hogarth and Wilson [eds.] 2004).

The Health and Social Work sector as a whole already has a relatively high level of vacancies. Although this sector represents 10.5% of all employment in the economy, its share of all job vacancies is higher, at 13.3%. In the most recent published survey, employers reported that a very high number of these vacancies, just over 50%, were ‘hard to fill’ (LSC 2004).

In 2003, shortly before our study began, the UKHCA drew attention to what it considered a ‘workforce crisis’ in home care (UKHCA 2003), describing this as ‘an unprecedented crisis in recruitment and retention’. It also pointed out that ‘regulation is imposing new costs on the industry’ and that the independent sector was, increasingly, having to pay ‘non-contact time’ costs, including time spent travelling between service users, time undertaking training, and time spent on supervision. To assist independent providers and commissioners of services in producing sound information about costs and prices in the sector, the UKHCA developed a costing model designed to be consistent with the principles which had been set out by the Department of Health in 2001. This model facilitated accurate calculation of ‘the actual cost of an hour of home care’, taking into account direct hours of care, the staff resources needed to provide the service, and indirect costs. As we shall see, our new survey of domiciliary care providers reported here suggests that a significant minority are still not paying employees for time spent on required study or travelling to clients’ homes, and believe they face financial barriers in doing so.

Sir Derek Wanless’s Social Care Review (Wanless 2006), designed to ‘determine how much should be spent on social care for older people in England over the next 20 years’, examined trends ‘likely to affect demand for and the nature of social care for older people in England’. It noted that:

- Overall, the number of people with impairment and dependency will increase significantly over the next 20 years.
- Over the 20 years to 2025, the Review predicts a rise in the number of older people who do not require care of 44%, a 53% increase in those with some need, and a 54% increase in those with a high level of need. (xxiii)

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12 In the Wanless Review, older people are defined as people aged 65 and older.
The Wanless Review drew attention to existing ‘evidence of unmet need’, which was ‘particularly high among moderately dependent people’. It reported that in 2004/5 local authorities spent £8 billion on personal social care services\textsuperscript{13}, but that total expenditure is impossible to calculate as ‘there is no reliable data for the total amount of private spending on … self-funded domiciliary care’. Summarising its assessment of ‘who will do the caring?’ the Review noted:

An estimated 559,000 people in 2003/4 were formally employed in England providing ‘core’ social care for older people, not including some 120,000 NHS staff doing some care work. … Care assistant wages average just over half the unit costs of local authority commissioned care services….. Since 2002, pay rates for social care jobs have risen faster than inflation, but vacancy rates remain high.

In common with most other investigations in this field, the Wanless Review focused primarily on trends and developments at the national level, and on their implications. In its case, the key focus was on the cost implications of the anticipated changes. In this study, we have explored selected aspects of the current and future situation in six localities in England, with a view to supporting planning and policy-making in the domiciliary care field at the local level in our six partner authorities. This level of analysis is needed, as there are very important variations in the key factors affecting this planning and policy-making:

- local labour market conditions and structures are highly variable between localities
- the composition and characteristics of the available workforce differ significantly between localities
- the size and neediness of the older population varies considerably between localities

One recent study which explored local labour market conditions was the King’s Fund Inquiry into Care Services for Older People in London (Robinson and Banks 2005). This detailed investigation\textsuperscript{14} of the care system in London drew attention to growth in London’s older population, and to the fact that in the future it will comprise more people from ethnic minority groups, reporting that:

\textit{Care services operate within distinctive local care markets, where individuals and public bodies buy goods and services from the private, voluntary and statutory organisations that provide them … (These) are subject to pressures in the labour market and in land and property markets – all of which affect staff recruitment and retention…... (2005: xv)}

The authors noted that distinctive features of London’s economy included that: migration in and out of London affects the availability of care workers; London has high rates of mental illness and of some kinds of social problems; the capital experiences labour shortages in many areas of the economy; and the ethnic composition of London’s population brings both benefits and challenges. The Inquiry’s London focus (conceptualised as ‘a laboratory’) treated London as ‘a microcosm of a wider world’. This approach, its authors claimed, produced findings ‘echoed across England as a whole’, but also put a ‘spotlight’ on a local area, identifying some challenges ‘bound to be quite specific to London’.

Our study has sought to provide a local evidence base about some of the key issues identified in other research, and to support local authorities and their partners in adapting their policy-making and implementation to local demographic and labour market conditions. As our study shows, these differ considerably between one place and another. We do not claim that these localities are ‘representative’ of England as a whole, or of the English regions in which they are located, although many of the issues we identify are likely to be relevant to other localities experiencing similar demographic or labour market conditions. Ours is primarily a study of the demographic and labour market context in which domiciliary care is being delivered in 6 localities, and of the way independent sector providers in those localities are experiencing supply and demand pressures. Since labour market factors ‘appear to have an effect on (service) quality’ (Netten et al 2004: x), these are clearly important issues. It has not been possible, for resource reasons, to include in this study the perspectives of home care workers (or those trade unions and others who represent them), or the views of users of home care. A range of insights into care worker perspectives (Francis and Netten 2003b; UKHCA 2003) and users’ views (Netten et al 2004; Patmore and McNulty 2005) is available from other research.

\textsuperscript{13}£1.6 billion of this is recouped through means-tested charges to users (xxiv).

\textsuperscript{14}This King’s Fund Inquiry was a more detailed investigation than could be attempted within the GELLM project in our 6 localities. It explored a range of evidence, including: written submissions; responses to a call for evidence; focus group data and hearings.
The policy environment for domiciliary care

The social care system in the UK has undergone some very significant changes in the past two decades, including changes in local authorities’ own responsibilities as service providers and employers. Local authorities’ primary role in this field is now to commission and purchase social care services, and to contract with independent service providers.

In England, between 1993 and 2005, the total number of hours of domiciliary care provided grew by 100%, reflecting government policies promoting independent living and care at home, as well as substantial growth in the number of older people living in single person households (Figure 1). There has been a clear trend towards delivery of more intensive packages of care, with far fewer households receiving only a single visit or less than two hours of care each week (NHS 2006). Packages of home care have become more intensive (with fewer households receiving care, for more hours per week), and more of these care services are now delivered by independent organisations. Table 1 shows the position in 2005 in our selected localities.

Figure 1 Number of contact hours per week by type of provider

<table>
<thead>
<tr>
<th>Locality</th>
<th>Contact hours of domiciliary care per week</th>
<th>Number of households where domiciliary care was provided</th>
<th>% of hours of domiciliary care provided by independent sector providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>60,810</td>
<td>5,840</td>
<td>67%</td>
</tr>
<tr>
<td>Newcastle</td>
<td>39,050</td>
<td>3,360</td>
<td>82%</td>
</tr>
<tr>
<td>Sandwell</td>
<td>22,380</td>
<td>2,160</td>
<td>82%</td>
</tr>
<tr>
<td>Sandwell</td>
<td>50,420</td>
<td>3,390</td>
<td>82%</td>
</tr>
<tr>
<td>Somerset</td>
<td>8,880</td>
<td>800</td>
<td>81%</td>
</tr>
<tr>
<td>Thurrock</td>
<td>39,740</td>
<td>3,620</td>
<td>77%</td>
</tr>
<tr>
<td>West Sussex</td>
<td>354,500</td>
<td></td>
<td>73%</td>
</tr>
</tbody>
</table>

Source: Community Care Statistics 2005: Home Help and Care Services for Adults, England
* This is the officially published figure; Somerset CC contracted out all domiciliary care services for older people in 2005, however.
These developments were set in train in the 1989 White Paper, ‘Caring for People’, which outlined radically
different funding arrangements for social care, stressed that care should be tailored to individuals’ needs,
and required local authorities to make use of private and voluntary sector provision. The 1990 NHS and
Community Care Act took this policy forward, and the now familiar ‘mixed economy’ of care has been one
of its most important effects. Developments since 1997 have included:

- The Royal Commission on Long-Term Care for the Elderly, set up by the government in 1997 to
  examine the funding of long-term care in the context of population ageing. The Commission took a wide
  range of evidence and made its recommendations in 2000. The latter included that (in addition to
  providing ‘nursing care’ free of charge) ‘personal care’ should be free in response to assessed need. In
  England, the government rejected the Commission’s recommendations on this point, arguing that, in
  the long term, free personal care would be excessively costly for the public purse and unsustainable. A
  different view was taken in Scotland, and there free personal care has been introduced. According to
  some, this development in Scotland is beginning to generate significant funding problems15. This issue
  is again debated in the Wanless Review mentioned above.

- The White Paper Modernising Social Services (Department of Health 1998) sought to ‘modernise’ social
care services to improve provision and make it fit for the 21st century. It called for more co-operation
between health and social care agencies, highlighting the need to reduce geographical variations in
performance/quality of care. Greater promotion of independence was advocated, to be achieved in part
by the extension of Direct Payments to people over 65. National objectives, standards and targets for
quality and efficiency were set for Social Services Departments.

- The Care Standards Act 2000 established the National Care Standards Commission (from April 2002,
later incorporated into the Commission for Social Care Inspection (see below). This had responsibility
for setting, regulating and inspecting all regulated care services, including domiciliary care.

- The General Social Care Council (2001) is the workforce regulator for social care in England. It was
established as the independent regulatory body responsible for overseeing social care training, and is
tasked with raising standards of conduct and practice by setting requirements for training, qualifications
and professional development as well as by registering domiciliary care staff (in a phased development
which began in 2005).

- The Social Care Institute of Excellence was launched in October 2001 and is an independent registered
charity. Its role is ‘to develop and promote knowledge about good practice in social care’. SCIE runs a
free on-line resource, Social Care Online, targeted at practitioners, researchers, service users and
policy makers. It aims to highlight good practice and to identify additional information about the sector,
and has a remit which includes adults’, children’s and family services.

- The National Service Framework for Older People (2001) was established to improve the quality of care
services by exploring the problems that older people encounter in accessing and receiving care. The
Framework includes plans to eliminate age discrimination and to support person-centred care with
newly integrated services.

- Better Government for Older People (2004) is a networking partnership in which older people are the
key partners. It forms part of the wider Modernising Government agenda. The partnership aims to
ensure that older people are engaged at all levels of decision making, and in the development of the
strategies and services supporting an ageing population.

- The Commission for Social Care Inspection was launched in April 2004 as the ‘single, independent
inspectorate for all social care services in England’, as part of the implementation of the Health and
Social Care (Community Health and Standards) Act 2003. The CSCI ‘brings together the inspection,
regulation and review of all social care services’ and aims to provide a ‘complete picture’ of social care
in England.

15 Most recently in the Minister for Social Care’s speech to the Carers’ Week Conference, Carers UK, July 12th 2006.
• The *Fair Access to Care Services* initiative (introduced following a consultation in 2001 with implementation required by April 2003) has addressed inequalities in how eligibility criteria are defined and applied for adult social care services. Its framework is based on individual needs and associated risks to independence. It aims to achieve fairer and more consistent eligibility decisions across the country.

• *Skills for Care* is a new body established in April 2005, led by employer networks and other care interests. It is part of the Sector Skills Council for Care and Development, and replaced TOPSS (the Training Organisation for Personal Social Services). Concerned specifically with adult social care, Skills for Care aims to support employers by improving the quality of care provision through training and development, workforce planning and workforce intelligence.

• At the end of January 2006, a Department of Health White Paper *Our health, our care, our say: a new direction for community services* set out plans for a ‘radical shift in the way services are delivered’ and established a new direction for the health and social care system. Government intends that, in future, services will be more personalised, and will ‘fit into people’s busy lives’, with the client being the major driver of service improvement. This development followed the Green Paper *Well-being and Choice - our vision for the future of social care for adults in England* (Department of Health 2005), which made new proposals about introducing ‘individual care budgets’ and brokerage arrangements to support care users.

The above provides an indication of the extent to which the policy arena in which domiciliary care work is situated has been, and continues, to change. These policy developments are in part reflections of some of the demographic and labour market developments explored elsewhere in this report and in the wider *Gender and Employment in Local Labour Markets Research Programme*. We return to the significance of contemporary and projected policy developments in the closing section of the report.

### The evidence base about domiciliary care

The delivery of domiciliary care has become a key issue in contemporary public policy (Robinson and Banks 2005). This is to be expected, as it affects the well-being of millions of older and disabled people and their carers, involves about 163,000 domiciliary care workers (McClimont and Grove 2004), and demands resourcefulness and innovation of the many organisations involved. These include: employers and providers of domiciliary care - companies, local authorities and charities, including the 3,684 domiciliary care agencies registered with CSCI in November 2004 (Eborall 2005); the local authority SSDs who now purchase a very large volume of services from these providers; and the many sector/professional bodies, trade unions, regulatory and/or advisory agencies and training providers in this field. The quality, adequacy and reliability of domiciliary care is of critical importance for the welfare of many vulnerable older and disabled people, relies heavily on the organisational standards and effectiveness of providers, and impacts on a wide range of other social and economic issues.

When we began our study, the most detailed account of the workforce providing domiciliary care was that which had very recently been produced for *Skills for Care* by the UKHCA (McClimont and Grove 2004). Unlike our study, which lacked the resources to collect data from home care workers, and was focused specifically on independent sector domiciliary care providers’ perspectives in our selected localities, the UKHCA study used a nationwide survey (sent to over 4,500 providers). It invited each of these organisations to distribute additional questionnaires to a sample of care workers, and used a separate research instrument to seek responses from Registered Managers$^{16}$.

Comparing its results with those obtained in an earlier (2002) survey, the UKHCA study found an increase in the proportion of providers reliant on local authorities for their business, with a large minority of small providers entirely dependent on this source. It also reported an ‘apparent reduction’ in the number of home care workers (from 121,500 in 2002 to 97,500 in 2004), with each worker on average delivering 25% more...

---

$^{16}$ The UKHCA survey had a 20% response rate among organisations (producing data from 727); a 9% response rate among care workers (with nearly 3,000 care workers questionnaires returned); and a 16% response rate from Registered Managers (561 returned).
hours (McClimont and Grove 2004), and 65% of the home care workforce employed in the independent sector. Warning that this did not necessarily indicate a long-term trend, it noted that in 2004:

> Only 6% worked for more than one home care organisation, down from 14% in 2000, and only 11% had other types of paid work, down from 22%. A reduction in the prevalence of casual workers and those holding multiple jobs may be viewed as very positive, offering greater continuity and making investments in training and development more economic. However, the higher utilisation rate of worker time and the disappearance of the ‘reserve’ of casual workers could indicate loss of ability in the sector to absorb future increases in demand. (2004: x)

Compared with the position a few years’ before, the study also found a reduction in the number of new recruits entering the sector (14% compared with 22% in 2000). This was a further development which was difficult to interpret – possibly indicating a desirable reduction in turnover within the sector, but also potentially arising from a ‘tighter recruitment market’. The authors observed that:

> Three-quarters of providers... reported difficulty in recruiting home care workers or with retention. The most commonly cited problem was the general shortage of labour in the market. (2005: xi)

The UKHCA study also found that across the country as a whole:

- At least two thirds of home care workers did not receive pay specifically for travel time.
- It was normal practice for purchasers to pay for contact time only.
- One third of providers were offering induction training below the legally required minimum.
- Despite ‘dramatic’ improvements in the proportion of care workers achieving or ‘working towards’ NVQs, barely one fifth of the five-year target had been reached.
- There were practical difficulties and capacity problems in implementing training and qualifications requirements.
- Providers had experienced a range of difficulties with funding streams, notably those delivered through the FE system.
- Only 2% of workers, and only 12% of employers, were receiving external funding. (2005:xiii)

With a wider remit, across the whole social care sector, TOPSS England had also produced relevant statistics in the First Annual Report of its Workforce Intelligence Unit in 2004. In April 2005 these were updated by the newly formed Skills for Care, in its report on The State of the Social Care Workforce 2004 (Eborall 2005). This identified the following key data about the domiciliary care segment of the social care workforce:

- In 2004, about 3,700 branches of agencies providing domiciliary care staff were registered with CSCI.
- Of total registrations, 77% were private sector and 5% voluntary sector/not-for-profit organisations; most of the remainder were local authorities.
- An estimated 922,000 people worked in ‘core’ social care in 2003-4, 61% of whom were delivering services for older people.
- The independent sector domiciliary care workforce was estimated at 106,500, of whom 97,500 were care workers.
- Vacancy rates in social care were about twice as high as for private/public sector business activity generally.
- Little was known about vacancy and turnover rates in the independent sector, but in the local authority sector, vacancy rates for domiciliary care workers were estimated at 11%, and turnover rates at 15% (13% when retirements were excluded).
- In April 2004, the median gross pay of female care workers was £6.40 per hour. This ranged from £4.80 per hour or less (the bottom 10%) to over £8.30 per hour (the top 10%). Care workers in the public sector earned on average 22% more than those in the independent sector.
- Knowledge of the independent sector workforce, and about levels of qualification and training in the workforce remained inadequate. A new National Minimum Data Set for Social Care was launched in October 2005 by Skills for Care; this nation-wide workforce information project will

17 TOPSS (Training Organisation for Personal Social Services) England was incorporated into the newly formed Sector Skills Council for Care and Development in 2005.
gather detailed data from employers and provide an overview of the whole sector. The social care sector will be able to access this information and use it to benchmark their services; identify skill needs; identify recruitment and retention issues; and to create training plans that meet the needs of the National Minimum Standards.

As we will see, many of the issues identified in this existing research and in the emerging evidence base about the domiciliary care workforce were familiar to the providers who participated in our own study. In consultation with our partners, we chose to focus our study of care work in local labour market settings on providers of domiciliary care – particularly those in the private, not-for profit or voluntary sectors – and on their experiences, understanding and difficulties as employers in developing and delivering the quantity and quality of home care needed, both now and in the future. The study was developed with the support of Social Services Departments in the six local authorities involved, which had responsibility for commissioning and procuring essential domiciliary care services. These SSDs enabled us to contact all providers of domiciliary care who were registered with them, and to seek their co-operation in our study. We were especially interested in the supply and demand issues they faced, and how they were responding to these challenges.

This new study is unique in contextualising providers’ perspectives in a detailed examination of local data about the local demographic and labour market context in six English localities. The study also draws on the new evidence we have gathered about women’s employment in local labour markets through the other studies we have conducted within the GELLM research programme. These have explored the particular situation of women in low-paid part-time work (Grant et al 2006a), the difficulties many women in deprived communities have in accessing paid work (Grant et al 2006b; Escott et al 2006) and the constraints affecting the labour force participation of women from ethnic minority communities (Stiell et al 2006). We hope this report will encourage those responsible for commissioning and procuring domiciliary care, and those who design and implement the wider social care policies which are continuing to reshape the experiences of employers, providers and care users in the domiciliary care sector, to pay close attention to local conditions and their implications. We also hope it will provide evidence of some of the good practice we have observed, and enable other agencies to emulate some of the innovations which are proving effective in meeting some of the challenges in matching supply and demand for domiciliary care. In the rest of the report we present our comparative analysis of our findings in the six localities studied; our detailed locality reports are available separately.
Supply and Demand for Domiciliary Care in 6 localities

To understand what lies behind the difficulty in reconciling supply and demand in the field of domiciliary care, it is necessary to know the magnitude of the demographic shifts projected to occur in coming decades at the local level, and to know something about the current workforce delivering domiciliary care in specific localities. In this section of the report we therefore examine some of the data available at local level on the characteristics of the very aged population, an important source of demand for domiciliary care. We then go on to review what is known about the characteristics of care workers in our selected localities.

Demographic trends

In 2001, 16% of the total resident population of England was aged 65 or older, and 1.9% was aged 85+. These figures represent about 7.8 million people aged 65+, and about 936,000 people aged 85+. As would be expected, the 85+ age group have poorer general health, a higher incidence of limiting long-term illness and greater care support needs than other age groups (Figure 3). In this section of the report we therefore examine the most recent available data on these topics in our selected localities, noting that services to older and especially very aged people are a major (although not the only) element in the work delivered by domiciliary care providers.

Living alone

Among the very aged, women are considerably more likely than men to live alone. Well over half of very aged women, and more than a third of very aged men are in this position. By definition, those who live alone do not have a co-resident carer available to them should they require support and assistance, and they are thus a group who may be particularly likely to require domiciliary care. The proportion of very aged men who live alone is well above the national average in some of the localities we have studied (42% in Sandwell) but considerably lower in others (33% in both Somerset and West Sussex) (see Table 2). This pattern is similar for very aged women, although Thurrock has a much higher percentage of very aged women living alone than any of the other localities we examined.

Living in residential care

West Sussex and Somerset stand out in this study as the localities in which very aged men and women are more likely than at the national level to live in a ‘communal establishment’, such as a residential care or nursing home (where, by definition, residents do not require domiciliary care). Thurrock is the study district in which very aged residents are least likely to be living in an establishment of this type.

Carers

In West Sussex and Somerset 9% of very aged men are themselves carers, compared with 3% of very aged women in these two counties. This is very similar to the national pattern, and we found only a small amount of variation between the localities we studied. This reflects the fact that in extreme old age, men often become the carers of their sick or disabled wives, whereas women are more likely than men to be widowed before they reach age 85.

Limiting long-term illness

By age 85+, the majority of men and women have a limiting long-term illness (LLTI). At the national level the figures are 70% for men and 78% for women. This indicator is strongly related to other factors associated with socio-economic deprivation and well-being, and as a result there are marked regional and local variations. Among men, compared with the national average, the proportions who have a LLTI are much higher in Newcastle and in Sandwell and a little lower in West Sussex. The pattern is similar for women, although the proportions of very aged women with a LLTI are also very high in Thurrock.

Poor health

The Census records everyone’s own assessment of their general state of health, and this indicator also provides important information about the situation of older people. Among the very aged, 32% of men in England, and 36% of women, report that their health is ‘not good’. Here again there is quite a large gap

18 The term ‘very aged’ is used throughout this report to refer to people aged 85+. 
between the ‘best’ and ‘worst’ localities in our study. In Sandwell, 38% of very aged men and 45% of very aged women report poor health, compared with 27% of men and 30% of women in West Sussex. We should note, however, that there is considerable variation within the county of West Sussex. Thus in the Crawley district within West Sussex, the health of very aged men is slightly worse than the national average (with 34% saying their general health is ‘not good’), and a very high percentage of men have a LLTI (75%).

Table 2  Men and women aged 85+ by living circumstances and health status, 2001

<table>
<thead>
<tr>
<th></th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men (numbers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lives alone</td>
<td>4,580</td>
<td>1,372</td>
<td>1,242</td>
<td>3,748</td>
<td>496</td>
<td>6,593</td>
<td></td>
</tr>
<tr>
<td>Lives in a Communal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment</td>
<td>40</td>
<td>39</td>
<td>42</td>
<td>33</td>
<td>41</td>
<td>33</td>
<td>37</td>
</tr>
<tr>
<td>No central heating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health ‘not good’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a Limiting Long-Term Illness</td>
<td>71</td>
<td>74</td>
<td>72</td>
<td>69</td>
<td>69</td>
<td>68</td>
<td>70</td>
</tr>
<tr>
<td>Provides unpaid care</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Women (numbers)</td>
<td>12,485</td>
<td>3,512</td>
<td>3,613</td>
<td>9,066</td>
<td>12,841</td>
<td>16,541</td>
<td></td>
</tr>
<tr>
<td>Lives alone</td>
<td>58</td>
<td>58</td>
<td>59</td>
<td>51</td>
<td>63</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>Lives in a Communal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment</td>
<td>16</td>
<td>21</td>
<td>16</td>
<td>25</td>
<td>13</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>No central heating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health ‘not good’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a Limiting Long-Term Illness</td>
<td>79</td>
<td>80</td>
<td>82</td>
<td>76</td>
<td>80</td>
<td>74</td>
<td>78</td>
</tr>
<tr>
<td>Provides unpaid care</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: 2001 Census Theme Tables, Crown Copyright 2003

Projected increase in the very aged population

As the very aged population is an important source of the demand for domiciliary care, it is important to consider how this population is likely to change in the future. Official projections enable us to review likely change over the 25-year period between 2003 and 2028, and these are shown for the study localities in Table 3.

Table 3  Population change 2003-2028: men and women aged 85 and over

<table>
<thead>
<tr>
<th></th>
<th>Population aged 85+</th>
<th>Projected change in population aged 85+</th>
<th>2003-2028</th>
<th>Numbers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2003</td>
<td>2028</td>
<td>5,200</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birmingham</td>
<td>4,700</td>
<td>9,900</td>
<td>5,200</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Newcastle</td>
<td>1,400</td>
<td>3,200</td>
<td>1,800</td>
<td>129</td>
<td></td>
</tr>
<tr>
<td>Sandwell</td>
<td>1,300</td>
<td>2,900</td>
<td>1,600</td>
<td>123</td>
<td></td>
</tr>
<tr>
<td>Somerset</td>
<td>3,700</td>
<td>10,500</td>
<td>6,800</td>
<td>184</td>
<td></td>
</tr>
<tr>
<td>Thurrock</td>
<td>500</td>
<td>1,600</td>
<td>1,100</td>
<td>220</td>
<td></td>
</tr>
<tr>
<td>West Sussex</td>
<td>6,500</td>
<td>16,400</td>
<td>9,900</td>
<td>152</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>267,450</td>
<td>729,385</td>
<td>461,934</td>
<td>173</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birmingham</td>
<td>12,000</td>
<td>18,900</td>
<td>6,900</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Newcastle</td>
<td>3,500</td>
<td>4,500</td>
<td>1,000</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Sandwell</td>
<td>3,500</td>
<td>5,600</td>
<td>1,500</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Somerset</td>
<td>9,000</td>
<td>17,400</td>
<td>8,400</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>Thurrock</td>
<td>1,300</td>
<td>2,800</td>
<td>1,500</td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>West Sussex</td>
<td>15,600</td>
<td>23,700</td>
<td>8,100</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>668,890</td>
<td>1,128,470</td>
<td>459,580</td>
<td>69</td>
<td></td>
</tr>
</tbody>
</table>

Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005

At the national level, the expected growth of the very aged population is expected to be large. Among men the expected increase is a remarkable 173%, close to trebling the numbers, and among women (who form the existing overwhelming majority of very aged people), the projected increase is 69%. In England as a whole this will mean an additional 922,000 people aged 85+ (to be added to the 936,000 in 2003, bringing their total to 1.85 million). In all, the very aged population group will become considerably more male in the
future – by 2028 about 39% of very aged people will be men, compared with less than 29% in 2003. These changes, and their implications for demand for domiciliary care, arise mainly from very marked improvements in life expectancy, especially for men, in recent decades. Male deaths from lung cancer, in large part attributable to reduced smoking among men, have declined sharply, and the management of a number of diseases and conditions commonly experienced by very aged people (notably coronary heart disease and hypertension) has also improved very significantly.

While these welcome developments are enabling many people to enjoy more years of ‘healthy life’, it is important to recognise that, overall, greater longevity (as well as more successful treatment of many illnesses and types of disability at younger ages) is increasing the number of years of life in which health will not be good. To give only some examples, mental illness, some forms of cancer, and poor health associated with obesity have all been increasing in recent decades. Recent calculations indicate that higher male life expectancy at birth (now standing at 75 years) is likely to include almost 16 years in poor health, with the comparable figure for females 80 years of life, of which almost 19 will be in poor health. Service planners also need to note the large disparity in the figures for expected years of life in poor health between the most and least deprived localities. Bejekal (2005) has estimated that the gap is as great as an additional 11 years in poor health for men and almost 14 years for women. It has also been estimated that over a 35-year period the number of weekly hours of home care needed in England will rise by 48%, from just under 2 million in 1996 to 2.9 million in 2031 (Wittenberg 2001:10).

Changing age structure of the population
The changing balance of the population between older and younger age groups also has very important implications for service delivery. By 2028 it is expected that the proportion of people aged 85+ in England will have increased from 1.9% to 3.4%. In Somerset and West Sussex this very aged group will be approaching 5% of the total population (Table 4) by that date. When these figures are considered alongside changes in the proportion of older people in the population19 (which is set to increase from 16% to 21% over 25 years), the challenges of finding the labour supply able to deliver the additional domiciliary care services likely to be required become very apparent. Again, our comparative analysis suggests that, because these changes will be experienced very differently in different localities (with much higher percentage increases in localities like West Sussex and Somerset compared with Birmingham where this percentage is expected to fall), the implications of these changes will be different in different places.

Table 4  Percentage of total population aged 85 and over

<table>
<thead>
<tr>
<th></th>
<th>% population aged 85+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2003</td>
</tr>
<tr>
<td>Birmingham</td>
<td>1.7</td>
</tr>
<tr>
<td>Newcastle</td>
<td>1.8</td>
</tr>
<tr>
<td>Sandwell</td>
<td>1.7</td>
</tr>
<tr>
<td>Somerset</td>
<td>2.5</td>
</tr>
<tr>
<td>Thurrock</td>
<td>1.2</td>
</tr>
<tr>
<td>West Sussex</td>
<td>2.9</td>
</tr>
<tr>
<td>England</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005

Table 5  Percentage of population aged 65 or over: England and selected localities

<table>
<thead>
<tr>
<th>Population aged 65+</th>
<th>Percentage of total population aged 65+</th>
<th>Predicted change in the population aged 65+ (2001-2025)</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
<td>2005</td>
<td>2015</td>
<td>2025</td>
</tr>
<tr>
<td>Birmingham</td>
<td>141,956</td>
<td>15</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Newcastle</td>
<td>41,370</td>
<td>16</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Sandwell</td>
<td>46,571</td>
<td>16</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Somerset</td>
<td>96,680</td>
<td>19</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Thurrock</td>
<td>18,679</td>
<td>13</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>West Sussex</td>
<td>152,825</td>
<td>19</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>England</td>
<td>7,808,000</td>
<td>16</td>
<td>16</td>
<td>18</td>
</tr>
</tbody>
</table>


19 Older people are taken to be the group who are aged 65+.
Care workers’ characteristics in the 6 localities

In England as a whole, the 2001 Census recorded almost 445,000 people of working age who were in employment as care assistants and home carers. Table 6 shows that this included about 200,000 people working in full-time jobs and over 225,000 in part-time employment. There were also about 9,000 self-employed people in England working in this occupation. Table 6 also gives the detailed figures for our selected localities. Not surprisingly, given the large variations in overall population size between these localities, the numbers of care workers also varies considerably in each place. However the number of care workers per 1,000 people in the population, 9.1 in England as a whole, also varies from a high of 13.7 in Somerset to just 6.3 in Thurrock.

Table 6  People of working age employed as care workers and care assistants (2001)  

<table>
<thead>
<tr>
<th></th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time</td>
<td>3,265</td>
<td>984</td>
<td>1,326</td>
<td>3,473</td>
<td>446</td>
<td>3,758</td>
<td>215,383</td>
</tr>
<tr>
<td>employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>3,185</td>
<td>1,132</td>
<td>1,215</td>
<td>2,508</td>
<td>365</td>
<td>2,845</td>
<td>170,613</td>
</tr>
<tr>
<td>employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>89</td>
<td>18</td>
<td>28</td>
<td>155</td>
<td>6</td>
<td>169</td>
<td>7,354</td>
</tr>
<tr>
<td>Total women</td>
<td>6,539</td>
<td>2,134</td>
<td>2,569</td>
<td>6,136</td>
<td>817</td>
<td>6,772</td>
<td>393,350</td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time</td>
<td>214</td>
<td>86</td>
<td>59</td>
<td>118</td>
<td>15</td>
<td>124</td>
<td>11,636</td>
</tr>
<tr>
<td>employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>817</td>
<td>256</td>
<td>223</td>
<td>539</td>
<td>59</td>
<td>524</td>
<td>38,153</td>
</tr>
<tr>
<td>employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>31</td>
<td>6</td>
<td>6</td>
<td>27</td>
<td>4</td>
<td>26</td>
<td>1,797</td>
</tr>
<tr>
<td>Total men</td>
<td>1,062</td>
<td>348</td>
<td>288</td>
<td>684</td>
<td>78</td>
<td>674</td>
<td>51,586</td>
</tr>
<tr>
<td>ALL</td>
<td>7,601</td>
<td>2,482</td>
<td>2,857</td>
<td>6,820</td>
<td>895</td>
<td>7,446</td>
<td>444,936</td>
</tr>
<tr>
<td>Number per</td>
<td>7.8</td>
<td>9.6</td>
<td>10.1</td>
<td>13.7</td>
<td>6.3</td>
<td>9.9</td>
<td>9.1</td>
</tr>
<tr>
<td>1,000 people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Age and Sex

As is well known, the workforce in social care is highly feminised, with approximately 90% of all positions as care assistants and home carers in England held by women. This picture varies a little between the study localities, with a rather higher proportion of these jobs held by men in Newcastle (12%) than in Thurrock (9%). When the age and sex of all those working in this occupational category is examined (Figure 2) it can be seen that there are other differences which are of interest too. Thurrock not only has fewer men employed as care workers, it also has fewer young women aged 16-24 in these jobs (8%), especially when compared with West Sussex, where 15% of these positions are held by young women. In all the study localities, a little over half of all care worker jobs are held by women aged 25-49, the age group in which most women have quite demanding maternal responsibilities. Here the figures hover around the national average (54%), rising to 57% in Sandwell and dropping to 52% in West Sussex. There is a little more variation in the proportion of care worker jobs held by older women workers - those aged 50-59. In Thurrock 27% of care workers are older women, considerably more than the national average of 22%, while in Birmingham this figure is much lower, at 19%.

As can be seen in Figure 3, older women workers are rather disproportionately concentrated in care work. In England as a whole, women aged 50-59 hold only about 9% of all jobs in the economy, but women of this age occupy 22% of all care worker jobs. This gap is even wider in Thurrock, where women aged 50-59 hold 8% of all jobs, but 27% of care worker jobs, and is striking when compared with Birmingham, where this gap is considerably smaller (8% and 18%).

30 This includes those who are self-employed.
Figure 2  Age-sex distribution of Care Assistants and Home Carers

![Age-sex distribution chart](chart.png)


Figure 3  Women aged 50-59 in work as a % of all in employment

![Women 50-59 employment chart](chart.png)


**Ethnicity**

There is a very uneven representation of ethnic groups in the care work sector, mirroring the rather sharp divisions by ethnicity seen in many other parts of the economy. In care work there are also some very interesting gender divisions. Among women, just over 10% of care worker positions are held by women from ethnic minority groups. This figure rises to 30% for Birmingham, and is highly variable between our study localities, in part reflecting the size of the ethnic minority population in each area. However as Figure 4 shows, women from ethnic minority groups (considered together) are more concentrated in care work.
than in all jobs in some localities (such as Birmingham and Thurrock), and are less concentrated in this form of employment in others (such as Newcastle).

**Figure 4** Care Assistants and Home Carers by ethnicity - Women of working age

![Bar chart showing the percentage of women in care work by ethnicity in different localities.


**Figure 5** Care Assistants and Home Carers by ethnicity - Men of working age

![Bar chart showing the percentage of men in care work by ethnicity in different localities.


The explanation for this variation lies in the precise composition of the ethnic minority population in each locality. Black African and Black Caribbean women are disproportionately concentrated in care work almost everywhere, and in Thurrock the 'White Other' group (which includes people from other European countries, as well as a number of other categories) is also highly concentrated in this occupation. By
contrast the Indian, Pakistani and Bangladeshi population groups of women tend to be under-represented in care work, irrespective of the locality in which they live.

At first sight, an examination of men and ethnicity in relation to care work seems to reveal a rather different picture, with ethnic minority men disproportionately concentrated in care work almost everywhere – except in Newcastle (Figure 5). At the local level the figures behind this data in some localities are quite small, but the picture is nevertheless rather similar. Men from the Black and Black British groups are rather strongly concentrated in care work, whereas men of Asian origin (grouped into a single category here because of small numbers, and because at national level they share this characteristic) are rather less likely than other groups to take up employment in this sector.

**Part-time employment**

Among both men and women care workers, there is a comparatively high level of part-time employment. This is shown very clearly in Figure 6. This characteristic of care work is at least as strong a feature of the sector among male workers as for female workers. The variations between the study localities here reveal some interesting gender differences. For example, while (of all the localities studied) Newcastle has the highest level of part-time working among male care workers, it has the lowest level of part-time working among female care workers.

![Figure 6 Care Assistants and Home Carers – percentage who are part-time employees](image)


**Qualifications**

There has been a strong policy steer at national level to create a more demonstrably skilled workforce in social care, with national targets set, as already discussed earlier in this report. The data in Figure 7, from the 2001 census, do not capture more recent developments, but are of interest because they demonstrate the degree to which different localities have faced rather different challenges in this area.

In 2001 about 40% of Thurrock’s care workers, both male and female, had no qualifications at all, compared with only about 15% of male care workers and about 24% of female care workers in Somerset. These figures need to be set in the context of the national average, which shows that less than 20% of all male care workers, and less than 30% of all female care workers were unqualified. From this we can perhaps deduce that the challenge of meeting national targets for up-skilling the care workforce has been a rather more difficult one for care providers in some localities than in others.
Local labour market context

Although some of the challenges of recruiting staff, retaining them and achieving effective workforce development are similar for all providers in the domiciliary care sector, the local labour market circumstances in which they operate are extremely important factors - affecting who may be seeking work in the social care sector, and how difficult it will be to hold on to employees after they have been recruited. The next section of the report therefore outlines some of the key local labour market factors which are relevant to understanding the challenges of securing a good supply of caring labour.

Employment change

All local labour markets experience some degree of continuous change, with new jobs being created, organisations restructuring or ceasing to trade, and shifts and changes in the focus and scale of public and private sector spending and investment. At the national level, the decade or so preceding our research was, overall, a positive period for employment and jobs, with a net increase of over 3,566,900 additional jobs between 1991 and 2002, representing an overall increase in England of over 19%. At this national level, both male and female employment increased, and there were positive trends in both full and part-time employment – although in percentage terms job growth was much more impressive for part-time employment than for full-time.

Table 7 shows that these national trends were experienced in very different ways in the different localities studied. Over this period, both Birmingham and Sandwell experienced significant net losses of full-time employment, especially for men. At the same time both these areas, like Newcastle, also experienced small net losses of working age population. By contrast there was a significant increase in the working age population in Somerset, Thurrock and West Sussex, accompanied by large numbers of additional jobs. The West Sussex and Thurrock economies were especially buoyant, as can be seen in Table 7.

Industrial re-structuring

While these jobs trends were, in some localities, extremely positive for the local economy as a whole, large increases in the jobs available create a more challenging situation for those employers seeking to recruit labour. Their difficulties can be particularly acute if they lack any significant freedom to respond to a tighter
situation in the local labour market by raising wages and funding their higher wage costs by increasing the price of their goods and services. Because much social care is publicly funded, with public sector spending on social care subject to rather tight limits, employers in the domiciliary care sector mostly feel they are unable to tackle any difficulties they encounter in recruiting labour by raising rates of pay. There is also a long history of low pay in this area of work, which almost certainly has a strong influence on the way all relevant agencies and decision-makers think about pay in the sector.

Table 7 Changes in employment 1991-2002 by full-time part-time status and sex

<table>
<thead>
<tr>
<th>1991-2002</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in number of jobs</td>
<td>+20,679</td>
<td>+18,628</td>
<td>+1,058</td>
<td>+36,947</td>
<td>+16,869</td>
<td>+93,447</td>
<td>3,566,931</td>
</tr>
<tr>
<td>Female full-time</td>
<td>-1,657</td>
<td>-126</td>
<td>+1,509</td>
<td>+4,843</td>
<td>+3,527</td>
<td>+13,559</td>
<td>+632,389</td>
</tr>
<tr>
<td>Male full-time</td>
<td>-17,661</td>
<td>+4,332</td>
<td>-5,447</td>
<td>+4,220</td>
<td>+4,207</td>
<td>+44,047</td>
<td>+819,143</td>
</tr>
<tr>
<td>Female part-time</td>
<td>+20,588</td>
<td>+6,891</td>
<td>+1,358</td>
<td>+19,558</td>
<td>+6,208</td>
<td>+21,821</td>
<td>+1,231,606</td>
</tr>
<tr>
<td>Male part-time</td>
<td>+19,409</td>
<td>+7,531</td>
<td>+3,638</td>
<td>+8,326</td>
<td>+2,927</td>
<td>+14,020</td>
<td>+883,793</td>
</tr>
</tbody>
</table>

| Percentage change | +5 | +12 | +0.8 | +24 | +44 | +36 | +19 |
| Female full-time | -1 | -0.3 | +5 | +13 | +45 | +19 | +13 |
| Male full-time | -8 | +7 | -8 | +6 | +20 | +39 | +9 |
| Female part-time | +24 | +21 | +6 | +53 | +73 | +35 | +31 |
| Male part-time | +116 | +118 | +89 | +108 | +214 | +98 | +103 |
| Total jobs in 2002 | 484,913 | 171,721 | 129,312 | 190,474 | 55,634 | 355,509 | 22,175,234 |
| Change in working age population | -1,000 | -1,200 | -5,000 | +21,100 | +10,700 | +29,400 | +1,241,000 |


All the localities studied had experienced some loss of jobs in the manufacturing sector, resulting in a common pattern in which the share of all jobs in manufacturing was falling. This is shown, for women’s jobs only, in Table 8. As this reveals, while there was a particularly large decline in the importance of the manufacturing sector as a source of employment for women in Sandwell, this situation was far from unique.

The other major development which affected all our study areas was the increased importance of the distribution, hotels and restaurants sector as a source of female employment. Here Thurrock saw the most marked change, with the 6% increase noted in Table 8 taking this sector’s share of all female jobs in Thurrock to around 43% by 2002. This has been particularly important for the domiciliary care sector, since - as almost every provider we interviewed pointed out - this sector (which includes jobs in retail such as those at the major Lakeside Shopping Centre development a few miles from the town of Grays in Thurrock) competes very directly for labour with the social care sector, especially at the lower levels of employment, such as domiciliary care work.

Table 8 1991-2002 Change in the industrial distribution of jobs held by women

<table>
<thead>
<tr>
<th>Increase/decrease in share of jobs in selected sectors</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturing</td>
<td>-5.3</td>
<td>-1.7</td>
<td>-10.1</td>
<td>-3.6</td>
<td>-2.1</td>
<td>-7.2</td>
<td>-4.8</td>
</tr>
<tr>
<td>Construction</td>
<td>-0.4</td>
<td>0</td>
<td>-0.9</td>
<td>+0.1</td>
<td>+1.6</td>
<td>-0.4</td>
<td>-0.1</td>
</tr>
<tr>
<td>Distribution Hotels and Restaurants</td>
<td>+1.7</td>
<td>+0.4</td>
<td>+0.1</td>
<td>+2.2</td>
<td>+6.0</td>
<td>+2.1</td>
<td>+2.0</td>
</tr>
<tr>
<td>Transport and Communications</td>
<td>+0.2</td>
<td>-0.2</td>
<td>+1.1</td>
<td>0</td>
<td>+0.1</td>
<td>+0.3</td>
<td>+0.3</td>
</tr>
<tr>
<td>Banking Finance and Insurance</td>
<td>+3.6</td>
<td>0</td>
<td>+1.5</td>
<td>-1.9</td>
<td>-1.5</td>
<td>+2.7</td>
<td>+2.3</td>
</tr>
<tr>
<td>Public Administration, Education and Health</td>
<td>-1.5</td>
<td>+1.2</td>
<td>+6.8</td>
<td>+3.3</td>
<td>-2.0</td>
<td>+2.1</td>
<td>+0.1</td>
</tr>
<tr>
<td>Other Services</td>
<td>+1.8</td>
<td>+0.6</td>
<td>+0.7</td>
<td>+0.3</td>
<td>-1.8</td>
<td>+0.8</td>
<td>+0.1</td>
</tr>
</tbody>
</table>

Local wages
Average hourly pay for women working full-time (measured across all occupations) was below the national level in all of our study localities with the exception of Thurrock (Table 9). This was also true of the average hourly pay of men working full-time, except in Thurrock and West Sussex, where male earnings were higher. Hourly pay rates for part-time work, especially for women, are very much lower than in full-time jobs (a topic explored in detail in another of the GELLM studies [Grant et al 2005, 2006a]). Where the data was available at local level, we examined part-time hourly pay rates, and found these to be particularly low in Thurrock and in Newcastle.

Table 9  Men’s and Women’s Average Hourly pay in the study localities in 2005: all occupations

<table>
<thead>
<tr>
<th>Average hourly pay*</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women working full-time</td>
<td>9.68</td>
<td>9.40</td>
<td>8.64</td>
<td>8.74</td>
<td>10.11</td>
<td>9.59</td>
<td>9.96</td>
</tr>
<tr>
<td>Men working full-time</td>
<td>10.69</td>
<td>10.42</td>
<td>9.38</td>
<td>10.17</td>
<td>11.65</td>
<td>12.12</td>
<td>11.50</td>
</tr>
<tr>
<td>Women working part-time</td>
<td>6.44</td>
<td>6.38</td>
<td>6.67</td>
<td>6.17</td>
<td>6.04</td>
<td>7.44</td>
<td>6.73</td>
</tr>
<tr>
<td>Men working part-time</td>
<td>6.09</td>
<td>6.28</td>
<td>7.02</td>
<td>6.08</td>
<td>..</td>
<td>7.04</td>
<td>6.53</td>
</tr>
</tbody>
</table>

Source: ASHE 2005, via NOMIS, ONS, Crown Copyright Reserved  * Excluding overtime

Potential labour supply
When demand for labour is high, and the labour supply is not large enough to meet this demand, employers may look to identify latent labour supply in the economy which can be drawn into employment. This has been happening for some years in the wider national economy, where the labour force participation rate of women has been rising. This has involved some women entering paid work more quickly than they might otherwise have done (for example reducing the period of time they take out of paid employment to raise children), some women remaining in the paid labour force who might otherwise have withdrawn from paid work, and some women choosing paid employment rather than full-time management of their own homes or engaging in other activities. Despite this, we know (from our other GELLM work [Escott et al 2006; Grant et al 2006]) that in 2004 there were about 900,000 women in England who were outside paid employment who wanted a paid job.

As we can see in Table 10, rates of ‘economic inactivity’, both for men and for women, varied considerably between our localities. The rate for men in Newcastle was 10 percentage points above the national average, while in West Sussex and Thurrock it was 5 percentage points below. Among women, the highest rate of economic inactivity in the localities selected was found in Birmingham (9 points above the national average) and the lowest in West Sussex, where it was almost 5 points lower.

The ‘economically inactive’ working age population includes four main categories: students (although those students who have paid jobs are counted as economically active); people who have retired from paid work (but have not yet reached state pension age); people who are long-term sick or disabled and unable to work; and those who are looking after their home or family full-time. This last category is highly gendered, as the data in Table 10 confirm. In England, 14% of all women of working age are in this situation, compared with just 1% of men. As the figures show, there is a little variation between our localities among men. However it is very unlikely that there is any significant latent labour supply among this group. Among women, the figures range from almost 17% in Birmingham and Sandwell to 13% in Newcastle. The ethnic composition of the female population is one of the relevant underlying factors here, but (as our other research has shown), many women in the ethnic minority groups with the highest economic inactivity rates (notably the Bangladeshi and Pakistani groups) would like to obtain paid employment. As we have already seen, these women are under-represented in social care, and so perhaps provide one potential source of new labour supply.

Most of the women in this ‘looking after home and family’ category, however, are White British women. This is the case in Thurrock, where we see a gendered pattern of economic inactivity which is not explained by
local labour market opportunity. In Thurrock’s buoyant labour market situation, men’s economic inactivity rates are very low, while women’s are quite high. Again, there may be a latent source of labour here which could be drawn into paid employment in the care sector using an appropriate recruitment strategy.

Table 10  Economic inactivity of men and women of working age, study localities and England %

<table>
<thead>
<tr>
<th></th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men economically inactive</td>
<td>25</td>
<td>29</td>
<td>20</td>
<td>15</td>
<td>13</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Of whom looking after home and family</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Women economically inactive</td>
<td>39</td>
<td>37</td>
<td>35</td>
<td>26</td>
<td>27</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Of whom looking after home and family</td>
<td>17</td>
<td>13</td>
<td>17</td>
<td>14</td>
<td>16</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>


Travel to work patterns
As we showed in the Gender Profiles of our selected local labour markets, there are important differences in men’s and women’s travel to work arrangements and patterns. Compared with men, women tend to work closer to home, are more likely to get to work on foot or by using public transport, and are less likely to drive a car to work. These gendered patterns were seen in all the localities studied. Table 11 shows that there are major differences by locality as well. Women in Sandwell are especially likely to work very close to home; on this indicator, there are almost 20 percentage points of difference between these women and women in Thurrock. In Somerset, 17% of all women in employment walk to work (compared with fewer than 10% in Thurrock), and public transport is barely used at all by Somerset women. By contrast almost a third of Newcastle women go to work by bus or metro. Given that domiciliary care has to be delivered in the service user’s home, and that the logistics of getting domiciliary care workers to and from service users’ homes is so important to care providers in terms of cost, efficient use of time and resources, and the planning of service delivery, it is particularly important to bear these differences in mind when assessing the challenges of meeting demand for domiciliary care in different localities.

Table 11  Women’s travel to work patterns in the study localities %s

<table>
<thead>
<tr>
<th></th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of women who work at or within 5kms of home</td>
<td>57</td>
<td>63</td>
<td>65</td>
<td>60</td>
<td>46</td>
<td>57</td>
<td>56</td>
</tr>
<tr>
<td>% of women who travel to work on foot</td>
<td>12</td>
<td>14</td>
<td>14</td>
<td>17</td>
<td>10</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>% women who travel to work by bus/metro</td>
<td>26</td>
<td>31</td>
<td>22</td>
<td>3</td>
<td>8*</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>% of women who drive to work</td>
<td>45</td>
<td>39</td>
<td>46</td>
<td>59</td>
<td>53</td>
<td>59</td>
<td>51</td>
</tr>
</tbody>
</table>

Note:* that a further 14.8% of Thurrock women in employment travel to work by train

This part of the report has shown some of the variations in local demographic and labour market conditions. Particularly relevant to the provision of domiciliary care are the variations in the expected rate of growth of the very aged population, and the much higher rates of living alone and of poor health and limiting long-term illness in some localities compared with others. We also saw locality variations in the proportion of care worker jobs held by older workers and men, differences in patterns of employment by ethnicity, and differences in the share of care workers who in 2001 were unqualified. We have emphasised the very different labour market structures and trends apparent in each locality, and the importance of taking these into account when addressing supply and demand issues. The report now turns to recruitment and retention issues in domiciliary care, and to evidence from our new survey of providers.
4 Recruitment and Retention in Domiciliary Care

In Sections 4 and 5 of the report, we explore the survey and interview data provided by the 88 independent sector providers of domiciliary care which participated in the study. Although there were five local authorities in our study which retained ‘in-house’ provision of domiciliary care services, and these also participated in the research, the statistical data presented below relate only to the independent sector providers. They included small, medium and larger organisations across all parts of the independent sector (Table 12). Just over half were operating on a ‘for-profit’ basis, and about the same proportion were organisations with fewer than 50 employees.

Table 12 Domiciliary Care Providers: survey respondents by size of workforce and sector

<table>
<thead>
<tr>
<th>Size of provider’s workforce</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer than 50 employees</td>
<td>9</td>
<td>10</td>
<td>2</td>
<td>12</td>
<td>6</td>
<td>9</td>
<td>48</td>
</tr>
<tr>
<td>Vol/com</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Private for-profit</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Private not-for-profit</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>50-99 employees</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>Vol/com</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Private for-profit</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Private not-for-profit</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>100+ employees</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Vol/com</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Private for-profit</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Private not-for-profit</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Missing data</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>All</td>
<td>17</td>
<td>20</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td>88</td>
</tr>
</tbody>
</table>

Source: GELLM Survey of Domiciliary Care Providers 2005

Staff Turnover and Vacancies

To explore the issues faced by these providers in recruiting and retaining staff, we collected evidence in the survey and asked our interviewees what steps they were taking to address the problems they identified. Although 15% of providers said domiciliary care worker staff turnover was at or below 5%, almost a quarter had an annual turnover rate of 25% or above, and about half had a turnover rate mid-way between these two extremes. This last group, 51% of providers, said that between 10% and 25% of their domiciliary care workers had left their employment in the past year (Table 13).

The picture with regard to current vacancies was also mixed. While 42% of providers did not have any current vacancies, more than one in 5 (22%) said that 25% or more of their current domiciliary care posts were unfilled, and in 9 cases (out of 64) 75% or more of all posts were reportedly unfilled (Table 13).

The problems of recruiting staff were highlighted by some respondents in the interviews, and confirmed by other local research[21], and it was clear that for many employers in the sector, supply and demand were key concerns:

The sector is diminishing in terms of the number of people available to work, but expanding in terms of the number of jobs available. So there are not enough people to fill the jobs.

(Independent sector provider, Birmingham)

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[21] Essex Independent Care Association (2004), which found that ‘40% of workers had been in post for less than one year’; EKOS (2004) which reported 21% annual turnover in care assistant posts and difficulties in recruiting care assistants (noted by 53% of Sandwell providers) in West Birmingham and the Black Country; Wray (2004) who found 81% of providers in Sandwell had recruited candidates with no experience of the care industry.
I have concerns. The demand for the business will always be there, I have no doubt about that, but the problems around recruitment concern me enormously.

(Independent sector provider, Newcastle)

I think it’s very difficult throughout Somerset to recruit and retain staff. There is a vast need for care staff, and only a very small pool to draw on. So all the companies are vying for a very small pool of staff, and alongside the very low unemployment rate in Somerset, it makes it quite difficult.

(Independent sector provider, Somerset)

---

Table 13  Staff turnover and vacancy rates in previous 12 months\(^{22}\)

<table>
<thead>
<tr>
<th>Staff turnover rate</th>
<th>Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of providers</td>
<td>%</td>
</tr>
<tr>
<td>N=88</td>
<td></td>
</tr>
<tr>
<td>0-5%</td>
<td>10</td>
</tr>
<tr>
<td>5-10%</td>
<td>8</td>
</tr>
<tr>
<td>10-25%</td>
<td>34</td>
</tr>
<tr>
<td>25-50%</td>
<td>10</td>
</tr>
<tr>
<td>50-75%</td>
<td>5</td>
</tr>
<tr>
<td>75+</td>
<td>0</td>
</tr>
<tr>
<td>Information missing</td>
<td>21</td>
</tr>
<tr>
<td>Valid responses</td>
<td>67</td>
</tr>
</tbody>
</table>

Source: GELLM survey of Domiciliary Care Providers 2005

As can be seen from Table 14, when recruiting domiciliary care staff, these providers were primarily relying on traditional modes of recruitment such as local newspaper advertisements (used by 94% of providers in our survey), the local job centre (used by 77%) and personal recommendations (Table 14). However almost half our respondents were also using the internet to recruit staff, about a third used special recruitment initiatives and events, and about one in five were using community events to advertise vacancies and encourage new applicants. In a small number of cases, more innovative approaches had been adopted, such as radio advertising.

---

Table 14  Methods used to recruit staff into care assistant positions  \(\text{numbers}\)

<table>
<thead>
<tr>
<th>Method of recruitment</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>n =</td>
<td>17</td>
<td>20</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td>65</td>
</tr>
<tr>
<td>Personal recommendations</td>
<td>14</td>
<td>18</td>
<td>9</td>
<td>3</td>
<td>8</td>
<td>13</td>
<td>65</td>
</tr>
<tr>
<td>Local newspaper advertisements</td>
<td>17</td>
<td>19</td>
<td>10</td>
<td>16</td>
<td>7</td>
<td>14</td>
<td>83</td>
</tr>
<tr>
<td>Radio advertising</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Internet</td>
<td>5</td>
<td>14</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>42</td>
</tr>
<tr>
<td>Special recruitment initiative</td>
<td>6</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>29</td>
</tr>
<tr>
<td>Recruitment events</td>
<td>6</td>
<td>9</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Jobcentre Plus</td>
<td>14</td>
<td>18</td>
<td>10</td>
<td>11</td>
<td>6</td>
<td>9</td>
<td>68</td>
</tr>
<tr>
<td>Community events</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: GELLM Survey of Domiciliary Care Providers 2005

\(^{22}\) Respondents were asked to calculate their own turnover and vacancy rates for Care/Support worker positions in the previous 12 months, or (if these were unavailable) to supply information about staffing levels and vacancies/leavers on which these rates could be calculated by the research team.
A number of providers reported that response to recruiting through job centres and conventional forms of advertising, such as local newspaper advertisements, had recently been very disappointing. Some also commented on difficulties in attracting applicants for domiciliary care positions who were of the right calibre.

*We've had no response – nobody from the Jobcentre at all.* (Independent sector provider, West Sussex)

*We do have dealings with the Jobcentre. We held an open day there recently and we are in touch with them quite a lot. We have an ongoing advert there. It's hit and miss, really. You find a lot of people, if they are speaking to us from the Jobcentre, they'll make an appointment to come and see us, but then cancel. So you do get the feeling that they are trying to show willing in front of their advisors, but really have no intention of accepting a position. That happens quite a lot.* (Independent sector provider, Thurrock)

*There are problems recruiting the right people – as an organisation we have got a standard we expect, and even if we are desperate we will not recruit below that standard.* (Independent sector provider, Sandwell)

Others mentioned having to commit considerable resources to supporting applicants and employees with weaknesses in basic skills.

*We are tending to get more and more people now who are struggling with the Basic English skills. We refer them to the LSC to boost their language skills and their writing, because there is so much now that they have to write – we have to make sure they can actually do that.* (Independent sector provider, Birmingham)

This situation had led some providers to experiment with alternative recruitment approaches (see Table 14), some of which they had found effective.

*I think what's really helped us is they've been doing a campaign to raise the profile of the care worker, and they've been highlighting that people can come into social care as a career. I think that's helped tremendously. There is a clear direction for people if they want to progress – it was on the telly, it was on the milk bottles, all sorts of things.* (Independent sector provider, Somerset)

*We are part of the Birmingham Care Development Agency – there is a lot going on to try and develop the social care sector.* (Independent sector provider, Birmingham)

Most employers were also very conscious of competing for labour in a local labour market where there were other vacancies attracting potential applicants away from domiciliary care work. Almost all mentioned competition from the retail sector and from employers in hotels and catering, but in some areas it was also manufacturing sector employers, and other employers in the health and social care sector, who were thought to be diverting existing or prospective employees away from work in domiciliary care.

*I've had a lot of staff poached. Two of them have gone on to the Ambulance Service; two of them have gone on to the Police. It's not usually to other care places, it's usually to other professions.* (Independent sector provider, Newcastle)

*In Yeovil, the wages are the draw for people. They tend to go to factories. Factories generally pay more.* (Independent sector provider, Somerset)

*Obviously we are very close to Gatwick airport, and Gatwick is the high competition.* (Independent sector provider, West Sussex)

*I think 50% of our recruiting has come from people working in the independent (social care) sector. I feel awful about that – but you can't say no to people – 'Stay where you are.'* (Local authority provider)

Some other local authority interviewees with responsibility for recruiting care staff also felt local authorities were finding it significantly easier than many independent sector providers to recruit staff (although this was not everyone’s experience):

*Last time we advertised for homecare assistants we were overwhelmed with applications.* (Local authority provider)

---

23 Newcastle City Council has successfully introduced basic skills testing and training for care workers, in consultation with local trade union representatives (Yeandle et al 2006: 14).
Many providers also mentioned that the image of the job was hampering effective recruitment. Most people outside the sector were thought to be unaware of recent changes in the content of the job of a domiciliary care worker, or of the opportunities for training, development and progression which had been introduced.

*It has changed dramatically – the responsibilities are much greater. Home help work (was) doing the breakfast, doing the tea, doing the shopping and the pension. People have still got this vision of home help. Domiciliary care is now bordering on nursing. Nurses used to do the washing and dressing and any personal care – now it’s the care workers.*  

(Independent sector provider, Sandwell)

**Retaining Staff**

As we have seen, many providers were having some difficulty in retaining staff. The survey data revealed that about a quarter of providers considered that the ‘unsocial hours’ of domiciliary care work, and the existence of better paid jobs and alternative career development opportunities elsewhere were factors affecting staff retention ‘very much’ (Table 15). More than a quarter of providers reported that ‘personal and family reasons’ were also very important factors causing staff to leave. A much larger group of providers felt that these factors were affecting staff retention and turnover ‘to some extent’. Although (on this broader measure) ‘personal and family reasons’ were again cited most frequently (by 83% of respondents), the unsocial hours of the job were mentioned by 64%, other career opportunities by 63%, better pay elsewhere by 52% and work related stress by 36%. 47% of providers also reported that ‘not being comfortable with the job’ played a role in staff decisions to leave their jobs as domiciliary care workers. Comments in the interviews on this topic included:

*They can get considerably more income from working in a shop or fast food outlet – any other services industry really.*  

(Independent sector provider, West Sussex)

*Care work staff are leaving care work, and it’s not just care workers – organisers, managers, it’s right up the chain. They are all leaving.*  

(Independent sector provider, Newcastle)

*At the end of the day, they are going to look at what the salary is, and then they are going to look at Tesco’s where they can make a hell of a lot of money without the responsibility, without being out in the community themselves, in charge, and having to be the first person in there in an emergency. It’s an awful lot of responsibility.*  

(Independent sector provider, Newcastle)

**Table 15  Reasons staff leave care assistant positions in the domiciliary care sector**

<table>
<thead>
<tr>
<th>Factors considered to be affecting retention ‘very much’</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>N =</td>
<td>17</td>
<td>20</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Job factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees ‘not comfortable’ with job</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unsocial hours of job</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>20</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Too much responsibility in job</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Challenging situations with clients</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Work-related stress</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Work-related injuries</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Labour market factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better pay elsewhere</td>
<td>0</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>19</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Career/development opportunities elsewhere</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>20</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td><strong>Employee factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal/family reasons</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>25</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Moving house</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Retirement</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

*Source: GELLM Survey of Domiciliary Care Providers 2005*
Retirement was also mentioned as a ‘very’ important factor by 8% of providers, and as a factor having ‘some’ impact by 38%. This is not surprising given the age profile of the sector (discussed above) and the fact that in our survey, 10% of providers reported that more than half of their domiciliary care workforce were aged 50 or older (Table 16).

Some providers felt that older employees were especially well suited to the job.

*The middle aged woman is the ideal person for this profession. Life experience counts for a lot, and is better received by clients.*
  
  (Independent sector provider, West Sussex)

*We have lost some people who have been with us a long period of time, doing their 20 hours a week. They love their job, they love the people they work with, and they like the continuity in their own life. And when they have to leave – maybe because of ill health – you can really see how it tears them apart.*
  
  (Independent sector provider, Sandwell)

*The nice thing about the older woman or man, they tend to have fewer commitments, and they tend to be more available, and they’re ‘old school’. So it is a good (group) to look at – but I know a lot of them are very daunted with the training that is required now by governing bodies.*
  
  (Independent sector provider, Somerset)

Table 16  Domiciliary Care Providers by proportion of workforce aged 50+

<table>
<thead>
<tr>
<th>Share of workforce aged 50+ is</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25%</td>
<td>11</td>
<td>10</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>44</td>
<td>57</td>
</tr>
<tr>
<td>25-49%</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>More than 50%</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Missing data</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>All valid responses</td>
<td>15</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td>7</td>
<td>14</td>
<td>77</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: GELLM Survey of Domiciliary Care Providers 2005

Other points made in the interviews we conducted included:

- concerns about the costs of recruiting and advertising, which some providers found very high;
- the bureaucracy associated with drawing new entrants into social care work, which was time-consuming and sometimes put interested applicants off;
- some providers were trying to improve their workforce planning and were gaining support from regional agencies set up to support them in doing this;
- in most localities, some new ways of advertising vacancies had been tried, with innovative campaigns to interest new job applicants. Some of these are highlighted in section 6 of the report.

We also asked providers what they had found effective in retaining staff. Most emphasised the importance of flexible working arrangements and of offering part-time positions. Others stressed that the supervisory and managerial support given to employees, and especially to new recruits, was critically important. Almost all felt that while pay rates were a potentially valuable tool in retaining staff, they had very limited room for manoeuvre in the area of employees’ rewards and benefits, because of the very tight costing and pricing regimes operated by local authority commissioners of domiciliary care. The following are some examples of the comments providers made:

*The support superiors give to them (is crucial). It can be a very alienating job working out there by yourself. You may get (praise) from the service user, but staff also need recognition from their superiors, people in the office, other professionals.*
  
  (Independent sector provider, Sandwell)

*It’s about making sure that they feel confident about what they are doing - that they’ve got the necessary back-up, training, and support. In the early days you don’t keep chopping and changing their work around - they need a bit of consistency. It’s quite important that they’re kept to their regular shift, and also - getting to know your care staff.*
  
  (Independent sector provider, Somerset)

*Supervision is of the utmost importance. We keep our staff through lots of one-to-one meetings, and they quite often drop in – so it’s a very friendly caring sort of atmosphere. It’s a very close-knit team because we are a small company.*
  
  (Independent sector provider, West Sussex)
A lot of people are attracted by the flexibility and the hours – with early shift, the job is finished by 1 o’clock. The evening shift starts at 4 or 5 o’clock – I think people are attracted by that. (Independent sector provider, Birmingham)

Summary

Some of these issues, as they affect the design and structuring of jobs in domiciliary care, are discussed further in section 5. Overall, across the six localities, our interviews with providers and stakeholders thus highlighted the following key issues affecting recruitment and retention in the sector:

- Supply and demand issues are a concern everywhere.
- Competition for staff is experienced mainly in relation to the retail sector, the hotels and restaurants sector, manufacturing, and elsewhere in the health and social care sector.
- The nature of the domiciliary care job has changed – but this is not well understood outside the sector, and misperceptions about the work involved are holding back recruitment.
- The image of the job as low paid, low skilled, and suitable mainly for those without career ambitions is misplaced but proving rather hard to shift.
- For some providers, the costs of frequent, protracted and sometimes rather ineffective recruitment are very high.
- Some providers’ experience was that many job applicants were unsuited to the job.
- The drawn-out processes involved in recruiting, security checking and initial training of new staff were deterrents to potential applicants.

Examples of good practice and innovation in addressing these issues are included below in section 6 of this report.
5 Working Conditions, Workforce Development and Job Design

In this section we discuss the way domiciliary care providers were addressing workforce development, and explore how far they were considering alternative ways of designing jobs in the sector to tackle mismatches between supply and demand. We begin by reviewing our data about hours of work and employment contracts in domiciliary care, and then go on to examine the survey responses and our interviewees’ comments about staff development and training. It is important to stress that all providers were aware of the national agenda relating to the development of the social care workforce, and of the targets set by government for National Minimum Standards in social care. Most providers were confident that they had made some progress towards achieving these standards, although many were not yet on target to fully meet the requirement that, by April 2008, 50% of care workers should be qualified to NVQ level 2 in care.

Hours of work and contracts of employment

Our survey of providers revealed that although most (almost two thirds) employed only a small number (less than 25%) of their domiciliary care workers to work very short weekly hours (under 16 hours per week), for a few providers this was a much more common arrangement. Two providers said more than 75% of their staff worked 16 hours or less per week, and one in 4 providers had at least a quarter of their domiciliary care workforce in this situation (Table 17).

Table 17 Domiciliary Care Providers by proportion of staff who are employed for less than 16 hours per week

<table>
<thead>
<tr>
<th>Share of workforce employed for less than 16 hours per week</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL</th>
<th>numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>n =</td>
<td>17</td>
<td>20</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Under 25%</td>
<td>12</td>
<td>14</td>
<td>5</td>
<td>11</td>
<td>5</td>
<td>9</td>
<td>56</td>
<td>64</td>
</tr>
<tr>
<td>25-74%</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td>75% or more</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Total valid responses</td>
<td>16</td>
<td>19</td>
<td>8</td>
<td>16</td>
<td>8</td>
<td>14</td>
<td>81</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: GELLM Survey of Domiciliary Care Providers 2005

The working conditions of staff varied a great deal between providers, as can be seen in Table 18. Although the large majority of our respondents had some staff on permanent contracts, more than a third were also using ‘zero hours’ contracts with some staff. Well over half reimbursed the travelling costs which staff incurred when travelling to clients’ homes – but, rather strikingly, 43% did not do this. 61% paid mileage allowances to some staff working in domiciliary care, but again this practice was far from universal.

One provider explained:

Our contract is a zero hours contract, so we don’t guarantee any hours. But the thing that appeals to them, is it’s so flexible. You know, a mother could come into work and work 9 till 3, not work weekends; someone else could come into it, and just work after 3. So it’s very flexible.  (Independent sector provider, Newcastle)

Others emphasised the non-contractual benefits they offered which, in their opinion, were important in creating a welcoming and supportive working environment:

We’ve got a company benefits scheme – childcare – insurance. ‘Care worker of the month: newsletters; thank you cards; flowers; birthday cards; Christmas cards. We invited all the people who had just passed their NVQ2, with families and children - we put on a buffet and the MD presented their certificates and a bottle of bubbly. Going that extra mile to say thank you has really paid off for us.  (Independent sector provider, Birmingham)
Our rates of pay are the same as the Council’s, we pay NJC\textsuperscript{24} rates. And we base them on their pay scale, so they lose nothing by working for us. The only thing we don’t do is pay enhancements for out of hours working, but they’re told that at the beginning.

(Independent sector provider, Thurrock)

Table 18  
Domiciliary Care Providers by proportion of staff with selected working conditions

<table>
<thead>
<tr>
<th>Working conditions</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>n =</td>
<td>17</td>
<td>20</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td><strong>Contract type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some staff have permanent contracts</td>
<td>14</td>
<td>18</td>
<td>7</td>
<td>13</td>
<td>1</td>
<td>8</td>
<td>61</td>
</tr>
<tr>
<td>Some staff have zero hours contracts</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>0</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td><strong>Allowances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel costs in attending clients are reimbursed</td>
<td>8</td>
<td>18</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Mileage allowances paid</td>
<td>12</td>
<td>16</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td><strong>Training costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff given free induction training</td>
<td>16</td>
<td>19</td>
<td>10</td>
<td>17</td>
<td>8</td>
<td>14</td>
<td>84</td>
</tr>
<tr>
<td>NVQ training is free or partially funded by employer</td>
<td>16</td>
<td>20</td>
<td>9</td>
<td>15</td>
<td>7</td>
<td>13</td>
<td>80</td>
</tr>
<tr>
<td>Staff given study time to prepare NVQs</td>
<td>14</td>
<td>15</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>8</td>
<td>52</td>
</tr>
</tbody>
</table>

Source: GELLM Survey of Domiciliary Care Providers 2005

Staff training and development

Almost all the providers reported that they gave free induction training to new staff in domiciliary care, and 91% said that they paid all or some of the costs of staff training in respect of NVQs in social care. However only 59% were giving staff paid time off to study for NVQs.

NVQ training and qualifications were very important issues for the providers at the time of our survey, as all were working to meet the national target that 50% of their staff should have achieved level 2 of NVQ by April 2008. As can be seen in Table 19, this was quite a challenging situation for many of the providers. 43% reported that fewer than 25% of their domiciliary care staff were qualified to NVQ2, and only 26% had at least half their staff qualified to this level.

Table 19  
Domiciliary Care Providers by proportion of staff who have NVQ2

<table>
<thead>
<tr>
<th>Share of workforce with NVQ 2 is</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>N =</td>
<td>17</td>
<td>20</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Less than 25%</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>11</td>
<td>2</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>25-50%</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>More than 50%</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Missing data</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>All valid responses</td>
<td>13</td>
<td>16</td>
<td>9</td>
<td>17</td>
<td>8</td>
<td>14</td>
<td>77</td>
</tr>
</tbody>
</table>

Source: GELLM Survey of Domiciliary Care Providers 2005

The costs of training staff were among the most important factors troubling these providers (Table 20). 24% reported that they could not offer the training they desired because they lacked available funds, and 27% said the cost of NVQs was a major issue. Much larger numbers of providers expressed some concern (saying that these factors were affecting them ‘to some extent’). On that wider measure, a clear majority felt

\textsuperscript{24} National Joint Council.
they were affected by cost constraints, over two-thirds were experiencing some difficulty in releasing staff for training, and over half had encountered problems in accessing training of appropriate quality. Half reported that they had faced some difficulty in providing NVQ training because some of their staff lacked basic skills, almost three-quarters felt some of their staff lacked confidence in approaching NVQ training, and well over half reported some concerns about completion rates and retaining staff once they were qualified.

### Table 20 Difficulties reported by Domiciliary Care Providers in meeting the training needs of their workforce

<table>
<thead>
<tr>
<th>Factor affecting providers ‘very much’</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n =</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of NVQs</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>5</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Cost of replacing staff</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Difficulty in accessing funding</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>No available funds</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Operational issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty releasing staff for training</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Difficulty finding resources for assessment</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Availability/quality of training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of spaces</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Variable quality</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Complexity of assessment</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Staff issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stack lack basic skills</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Staff lack confidence</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Staff lack motivation</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Low completion rates</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Difficulty retaining trained staff</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: GELLM Survey of Domiciliary Care Providers 2005

Some providers were clearly unhappy about not being able to pay staff while they were training, but felt their hands were tied:

(‘It’s been) a terrible strain, because we don’t pay our staff when they get trained – which is something that has been pointed out by CSCI. I’ve checked out with other companies – they don’t pay their staff, because the money is not there from the hourly rate that Social Services give us. If we paid our staff when they are training, the business would just go bankrupt.

(Independent sector provider, Sandwell)

The problems we find are actually having the time to do the assessments.

(Independent sector provider, Newcastle)

(NMS has had) two big impacts. One is financial, and, second, the logistics of getting it done. Financially, it’s quite an expense to ensure that all of the training is carried out within the timescales. We’ve approached this by becoming self-sufficient as far as the training’s concerned. We have our own in-house trainers – but it’s a bit of a strain at the moment.

(Independent sector provider, West Sussex)

In the localities studied, a number of industry-led bodies had been established to promote and support workforce development. Examples of the innovative approaches to workforce development put in place in some localities are outlined in our Locality Reports of this study and in Section 6 of the report.
The commissioning process

Responsibility for the commissioning and procurement of domiciliary care services to meet the assessed needs of local residents lies with CSSRs25. As we saw in section 2, official data show that in 2005 local authorities in England purchased 73% of the hours of domiciliary care they were responsible for delivering from independent sector providers.

In recent years, the local authorities involved in this study had all made important changes in the way they commissioned and procured domiciliary care services (outlined in the Locality Reports of this study). Somerset County Council had taken the decision to outsource all its domiciliary care services in 1993, and in the five other authorities the trend had also been towards reducing ‘in-house’ provision and procuring a higher proportion of hours of domiciliary care from the independent sector. In most cases, local authorities were shifting the balance of service provision towards the delivery of more specialist and hospital discharge services by their own domiciliary care workforce, with most of the commissioning from independent sector providers relating to other types of domiciliary care.

Below we present some brief insights into independent sector providers’ views of the commissioning, procurement and tendering processes, mainly in relation to its impact on job design. Local authorities’ approaches to the commissioning process in the six localities included: annual (and longer-term) planning of social care within adult services26; major revisions to procurement arrangements; new tendering exercises, often following extensive consultation with prospective or existing providers of domiciliary care; and the implementation of guidance from national agencies, notably CSCI, in some cases in response to advice received in inspection reports. Broadly, the trend was towards a more thorough and systematic commissioning process, with independent sector providers’ workforce development arrangements and employment policies being placed under scrutiny as part of the appraisal of the tenders submitted.

Many of the independent sector providers which took part in this research commented that the process of tendering for domiciliary care contracts could be very time-consuming, and that it absorbed considerable resources. This is probably inevitable, given the importance of service quality. While our study was unable to examine all stakeholders’ perspectives on the processes involved, it is worth noting that many providers who had succeeded in securing domiciliary care contracts spoke positively about the thoroughness, professionalism and clarity of the processes involved. By the same token, some interviewees felt the processes they had been involved with were unnecessarily drawn-out, repetitive and frustrating.

There was evidence in all the localities that, for some providers at least, effective partnership working was being achieved, and that this was valued. But not everyone felt equally involved in these partnerships, and some providers felt very acutely their lack of power, especially in regard to costing and pricing issues. An aspect of the commissioning process which attracted considerable comment was the purchasing of care in tightly specified time slots, a point also highlighted in other research (Francis and Netten 2003a; Robinson and Banks 2005:62). As this has obvious implications for job design and workforce management, we include some of these observations below:

I won’t take on half hour work; it just isn’t cost effective for us. In that half hour, what interaction can you have if you’re doing half hour personal care? You run in the door, ‘Good morning’, whip through their personal care - and gone. Whereas if we do an hour, we can chat and make sure everyone’s happy with what is going on - and talk through what we are actually doing on the day. (Independent sector provider, Thurrock)

There is a lot of pressure on us to provide a more quality service, but they want it done cheaper. So it’s Catch-22. It’s very difficult to provide what they’re asking for within the cost and provisions that they are asking for. (Independent sector provider, Newcastle)

My worst gripe is that Social Services are purchasing care in half hour slots. I tell my staff they’ve got to do the full half hour – talking, making them a drink, seeing if there’s anything useful they can do. I explain, we’re paid for half an hour, you do half an hour. A lot of the agencies are being booked for half hour calls, but they’re doing 10 minutes in the household. Social Services know it’s a fiddle. It’s horrible at the moment – the climate is pretty unkind. It’s money, it’s budgets. (Independent sector provider, Birmingham)

The care workers are actually doing more time in the client’s house to be able to provide the duties needed. Wash, dress, breakfast, make bed, empty commode - all in half an hour. Sometimes that takes more than half

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25 Councils with Social Services Responsibility.
26 Separate organisation of local authority services for adults and children took place during the research period.
an hour - but try and go back to Social Services and tell them! ‘We’ve got no budget, you’ll just have to do it in half an hour - and if you can’t make the bed, then you leave the bed.’ But that’s part of our duties - and who is going to make the bed? Will the client struggle to try and tidy her bed up or end up in hospital with a hip replacement and a bigger package when she comes out? And how much is it costing to have that hip replacement in hospital?  
(Independent sector provider, Sandwell)

Some providers expressed their concerns about the different wages paid in the public and independent sectors, and about the financial viability of current arrangements:

The local authority pay their staff a hell of a lot more than we are able to, simply because it’s linked into what they pay us for each hour of service provision, and they set the ceiling on that. There is no way we can compete with that, and in Newcastle we’ve had several meetings with the contract unit to express our concerns over this uneven playing field. How on earth can we compete, if they are paying their staff £7.35 or £7.50 an hour, when you know for some packages of care we have to fight to even get £7 an hour from them. The figures just don’t add up - and then of course you haven’t got any extra money for all the hidden costs, the care standards legislation. Because there’s been a huge cost attached to that registration - you know, you’re charged for the privilege of inspection.  
(Independent sector provider, Newcastle)

The side that does worry me is the money side of it. We are not a charity, so we do need to make a profit. The costing of running a domiciliary care agency has escalated over the last 3 years - probably tripling our costs for the training side, CSCI and everything else. Yet the costs we are getting from Social Services aren’t reflecting this. 2-3% increase – nothing. We are getting less from Social Services on a weekend as an agency than they actually pay their in-house carers.  
(Independent sector provider, Sandwell)

Some went so far as to suggest that procurement arrangements were now putting price before quality of service to the client:

They want a first class service, but only paying an absolute minimum. We’ve been through an exercise in Newcastle where they asked us to identify the true cost of our care, and we all did that, all the providers did that, and we all came out at round about the same figure, which was about £13 an hour, and then they offered us £10 something an hour. So we were like, well, what’s the point of us all doing that? And we weren’t fixing the figures, because we all came out with the average figure. I don’t know how they expect anyone to run a business.  
(Independent sector provider, Newcastle)

It’s price unfortunately. We have service users whose health deteriorates - obviously we say they need more support, and this is the new cost. ‘We can get it cheaper in a nursing home - we’ll move them to a nursing home’. Where are the rights with that? We’ve had to involve advocacy groups a lot of times - some we’ve won, some we haven’t.  
(Independent sector provider, Sandwell)

Price has got far more to do with it than anything else. You do hear some horrendous stories of things going on with private agencies which don’t meet National Care Standards criteria, which have problems passing their inspections, and yet are still being given work because they’re cheap.  
(Independent sector provider, Birmingham)

Summary

In this section we have shown some of the variability in working conditions in the independent domiciliary care sector, reported some of the issues providers raised about the problems they face in achieving their training and workforce development targets, and outlined some of their views about commissioning arrangements. Key points include:

- Some providers were making quite extensive use of workers employed for under 16 hours per week
- 43% of providers did not reimburse the travel costs incurred by staff travelling to clients’ homes
- Providers placed considerable emphasis on the non-contractual benefits they offered staff
- Only 26% of providers said that 50% or more of their care workers were qualified to NVQ2 level
- Most providers felt resource constraints were affecting progress towards workforce development targets
- Some providers were concerned about the practice of commissioning ‘half-hour work’, which they felt affected both employee working conditions and service quality
6 Innovation and Effective Practice in Recruiting, Retaining and Developing Domiciliary Care Staff

In this part of the report we briefly draw attention to a few of the examples of effective practice and innovation which were identified in the six study localities. These were not the only examples found, and further evidence of innovation and good practice is presented in the Locality Reports. We highlight here: some of those developments which were helping local agencies to tackle issues of supply and demand by adopting or enhancing their recruitment policies and practices; some innovations which were improving care worker training and workforce development; and some of the local and regional partnership arrangements which were operating across the domiciliary care sector, bringing together domiciliary care providers, those involved in planning, commissioning and procuring domiciliary care, and local agencies providing training to providers and care workers.

Recruitment initiatives

Local authorities and other local agencies were in some cases very actively trying to address difficulties in recruiting domiciliary care workers. Birmingham, which identified this as a long-standing problem it needed to tackle, and Sandwell, which needed to significantly reduce the high recruitment costs associated with repeated and often unsuccessful advertising, have both put major effort into modernising and streamlining their approach.

**Birmingham City Council’s Home Care Recruitment Initiatives**

Recognising that its traditional approach to recruitment had not been yielding sufficient applicants, and that recruitment difficulties had been a factor in past difficulties with ‘bed blocking’, Birmingham City Council’s Corporate Recruitment Team, working with managers in the BCC Social Care and Health Directorate, reviewed and refocused its approach. Noting that the image of the job was among the difficulties it faced, the Team updated its job descriptions and ‘re-branded’ the image of the job role, highlighting the importance of domiciliary care work for service users and the wider community, and introducing clear and accessible ‘occupational information sheets’ which proved very popular with jobseekers.

*Home Care Discovery Days* were developed to enable applicants to ‘discover more about home care vacancies within their neighbourhood’. These were well-publicised locally, and conducted using community venues, health centres and libraries. Applicants attend either group presentations or one-to-one information sessions, led by staff who perform the role and who can answer questions about the day-to-day activities of the job. During the event, the application process is ‘de-mystified’, and jobseekers can complete an application in a ‘supported and positive environment’. Application form assessment and short-listing are carried out ‘on the spot’, and suitable candidates are interviewed immediately. The event also includes tests and exercises, and is flexible to meet the needs of both managers and applicants - forms can also be completed outside the event with interviews conducted later. Those interviewed at the event can supply references and complete medical forms, and Criminal Record Bureau paperwork and ‘right to work’ checks can be commenced immediately, streamlining the recruitment process and significantly reducing delays. The outcome of these events has been impressive – for example, following three events held in just one month (February 2005), 31 people were appointed to home care positions.

*Pre-Employment Courses* have also been introduced very successfully to support the recruitment of care workers. These are customised training courses (with additional funding from Jobcentre Plus and the European Social Fund), held in areas where there are 10 or more home care vacancies. These short (5 -10 day) courses include job-specific training, confidence building, employability, rights and responsibilities, and other support in making the transition from unemployment into work. Applicants are helped to assess their own suitability for home care work, and supported in preparing for a job interview in home care. In one case (a partnership activity undertaken jointly with Aston Pride and Working Links), four open days were held in the Aston and Perry Barr areas, where unemployment was very high (28%). 103 local residents attended the open days and 45 were offered course places. The courses were successfully completed by 39 of those who attended, and 17 people were offered Home Care Assistant posts in the local area.

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27 We have space here to include only one example from each locality. Further examples are given in the Locality Reports.
28 Aston Pride is a local NDC (New Deal for Communities) initiative in Birmingham. Working Links is a private sector employment organisation.
Learning 2 Care (Sandwell)

Originally set up as the Carelink initiative within Sandwell MBC’s Economic Regeneration Unit in 2000, Learning to Care is now led by Sandwell MBC as the Black Country-wide Learning 2 Care project, following an additional funding allocation. It offers a free recruitment service in social care specifically targeting unemployed people aged 24-59 who might not otherwise consider employment in social care, and uses a range of innovative approaches:

- Open Days at the four local colleges
- ‘Floor Walking’ and ad hoc interviewing at local Job Centres
- Networking Days for employers and providers in the sector, and outreach employer support
- Outreach work targeting different ethnic minority communities, via local voluntary and faith organisations and through Ethnic Minority Careers events
- Innovative approaches to job advertising, using campaigns in the local press, on buses and radio, with links to national TV advertising campaigns

Carelink recruited around 700 unemployed people into care work between 2000 and 2005, and Learning to Care has a target to place a further 1,000 people into care sector jobs by 31 December 2007. Its other aims include training 1500 people to NVQ1 level, 190 to NVQ2 (Care) and 400 to Skills for Life Level 3. Learning 2 Care has been identified by Skills for Care as a potential model project in recruitment and retention, and involves extensive partnership working throughout the Black Country, involving care sector employers, colleges, local authorities, Jobcentre Plus, NHS bodies and the West Midlands Care Association.

Workforce development initiatives

In a number of localities, local or regional organisations were running projects and schemes designed to support providers, especially those in the independent sector, to access funding support, training courses, advice and guidance which would help them meet their targets for training and qualifications and enable them to improve workforce planning. We cite here two county-wide examples.

Essex Care Training Partnership (ECTP)

ECTP was set up in 2001 to offer a brokerage service for all Social Care providers in Essex, Southend and Thurrock, with support from Essex County Council, Thurrock Council, Southend Borough Council and the independent and voluntary sector. This partnership aims to increase care provider participation in workforce development activity, and supports employers to meet the National Minimum Standards in training and development. At the time of our research, ECTP was developing its activities in consultation with the Essex Social Care Workforce Strategy Group, and was assisting care providers to equip their staff with ‘the knowledge and skills they need to provide high standards of service’. Established to share ideas and experiences across the social care sector, the partnership supports organisations who wish ‘to share training resources and ensure cost-effective use of resources’. Organisations wishing to share a training course with other local social care providers can submit on-line to find suitable partners, and service offered by the partnership can also be accessed by individuals wishing identify local training opportunities. The ECTP website also offers:

- Information and guidance on workforce planning
- A directory of training providers
- Notice of training and awareness raising events
- Guidance on the funding streams available to support brokerage activities
- Information about developments relating to ESOL for social care staff
Care Focus Somerset

This is an employer-led organisation which supports and develops the social care workforce in Somerset, with financial support from Somerset County Council and Skills for Care. It distributes government funding for health and social care training and identifies other resources for workforce development in the sector. Its services to the social care sector include:

- Information on careers, training and qualifications, for employers and individual applicants
- Conferences and events addressing key sector issues
- Support from providers on workforce development and planning
- Publicity about careers and opportunities within the sector

Speaking at the 2006 Care Focus Annual Conference, Andrew Larpent, Chairman of Care Focus noted:

The care sector is Somerset’s biggest employer, and our key objective is to promote a highly-skilled workforce in order to maintain and improve our services. To coincide with the Government’s advertising campaign we have launched a new website showing career opportunities in care, and we are encouraging job shadowing of care workers. We focus our attention on the people who actually deliver care, building their reputation and esteem as key members of society. Somerset can justifiably be proud of what it is doing to support the care industry. Additional support secured this week from Somerset County Council to enable us to take forward the Care Ambassadors project is a very positive development.

Local Partnerships

Partnership activity, in most cases bringing together independent sector providers of domiciliary care, in some cases supported with funding from local authorities, regional and national agencies, and the European Social Fund was proving an effective way of supporting employers to address the challenges they face in meeting the challenges they face in recruiting, retaining, developing, managing and accrediting their domiciliary care workforce.

Tyne and Wear Care Alliance

In the North-East, the Tyne and Wear Care Alliance had been set up on with a major European Social Fund award (£6.4m) secured in 2003. Building on an earlier project in Sunderland, and hosted by Sunderland Council, the Alliance operates as an employer-led partnership between local providers of adult social care, local authorities in the region (including Newcastle City Council), and the North Tyneside Learning and Skills Council. By 2005, the Alliance was working in partnership with over 20 providers of domiciliary care, many based in the city, and building on existing infrastructure, was delivering a wide range of workforce development activities.

The Alliance, which grew out of an earlier project in Sunderland and continues to be hosted by Sunderland Council, secured a major European Social Fund award (£6.4m) in 2003. Its funding, over three and a half years, supports an employer-led partnership between local providers of adult social care, local authorities in the region (including Newcastle City Council), and the North Tyneside Learning and Skills Council. By 2005, the Alliance was working in partnership with some XXX providers of domiciliary care, many based in the city, and building on existing infrastructure, was delivering the following key activities:

- Development of Workforce Learning and Development Toolkit
- Support towards training costs
- Help with workforce development planning
- Action research into current learning provision in the sector, and other workforce development issues
- NVQ registrations
- Establishing local partnerships
- Annual conference for the sector

Formerly the Somerset Industry Group for Care
The Care Training Consortium (CTC) is a not-for-profit, employer-led organisation set up by West Sussex County Council (WSCC) Social & Caring Services to assist the independent care sector in West Sussex access information and funding support for quality training and development provision. The Consortium is a not-for-profit, employer-led and candidate-centred organisation. It provides a single point of access for training information, and acts as a broker to secure training and funding to support the independent care sector.

In response to requests from local independent sector providers, the Consortium was set up in 2002 to help providers meet their National Minimum Care Standards obligations. It receives infrastructure funding from WSCC Social and Caring Services, and works in partnership with, but independently from, the local authority. Through the consortium, providers can access funding from Skills for Care, the Sussex Learning and Skills Council, the European Social Fund and the Department of Health. CTC has an Executive Board which includes representatives of all parts of the independent care sector, the LSC, Skills for Care, CSCI, Unison, City & Guilds and statutory agencies. It focuses on local needs and priorities, and works with training providers and care services across West Sussex. Activities include:

- **Research** - to provide a clearer picture of the training needs within the West Sussex independent care sector.
- **Building Quality Training Capacity** - through CTC’s links with training providers, its website facilitating providers’ access to information, and its work with proprietors, managers and care staff to develop training and development plans.
- **Funding** Supporting providers to develop bids, and disbursing funds. CTC works very actively with funding bodies and the independent care sector to access resources to support staff training and development.
- **Quality Training**: CTC has developed an Assessor’s Network and has piloted the ‘Light Touch Learning’ APEL programmes which aims to make NVQ awards more accessible to care staff. Working closely with colleges and independent training providers, CTC encourages sharing of best practice and the development of learner-centred approaches, and works with employers to highlight the business benefits of staff training and development. It has highlighted the need for training beyond NVQ level 2, stressing the extent to which direct care workers are now undertaking more specialised clinical procedures, and identified the need for specialist training in areas such as palliative care and loss and bereavement.

These are just some of the innovations, effective practices and examples of good practice identified in the localities studied. There was evidence everywhere that collaborative working and new arrangements to address shared issues and concerns had begun to develop, often in response to the new requirements placed upon providers in the sector through the national policy developments outlined earlier in this report.

In most cases the agencies involved were addressing immediate and medium-term issues, in some cases achieving considerable impact. Here the importance of meeting the NMS qualifications targets for domiciliary care workers by April 2007 was clearly a key background factor. Some of the local developments we encountered in our study had arisen in response to local experience of the recruitment and retention issues which, as we saw earlier in the report, the UK Homecare Association described in 2003 as an ‘unprecedented crisis’.

Our examination of the demographic and local labour market context in these localities suggests that a longer-term agenda needs also to be embraced. The 20-year horizon adopted in the Wanless Review, and the demographic, employment and labour market projections cited at the start of this report, suggest that local agencies will need to work very proactively to identify their longer-term strategies for meeting the local challenges in meeting demand for domiciliary care which they can expect to face. We turn in our final comments to some of the expected forward developments in the policy context for domiciliary care, and to their implications for those responsible for commissioning and providing domiciliary care services in the future.
7 Policy Issues

To close this report, we offer some concluding comments about local challenges in meeting demand for domiciliary care in the light of the evidence drawn together in our study. Our research has shown that all six of our selected localities confront a future in which there is likely to be very significant additional demand for care in the home of the care user. In the report, we have indicated some of the local implications of the official projections relating to numbers of very aged people, emphasising that in the future this group will include far more men than previously. To illustrate the links between our demographic, policy and labour market data, it is useful to briefly focus on the combined significance of these factors. Two very different localities in our study – Thurrock and Somerset – face the most marked growth (in percentage terms) in their very aged populations; this will be very challenging in both cases, although it is important to stress that every locality is likely to experience growth in its very aged population and important shortages of paid caring labour, albeit with different configurations of underlying factors in each case.

Although its currently population is relatively young, Thurrock already has a rather high proportion of very aged people living alone. The borough has indicators of poor health among older people close to the national average, but only just over 6 care workers (91% of them women) per 1,000 residents in its total population. The local labour market factors in Thurrock are particularly challenging, as a high percentage - 27% - of Thurrock’s care workers were aged 50-59 in 2001, its relatively small ethnic minority population was already over-represented in care work, and the percentage of the jobs on offer in Thurrock which were in the fast growing distribution, hotels and restaurants sector, a major competitor with the domiciliary care sector for labour supply, had grown to 43% by 2002. This suggests that it will be extremely important in Thurrock to retain the existing domiciliary care workforce, to attract new sources of labour, including men and women currently outside paid employment, and to make conditions of employment in domiciliary care as attractive as possible.

In Somerset, where the number of men aged 85+ will almost treble between 2003 and 2028, the very aged population already represented 2.5% of all residents in 2001, and in that year, across the county, there were almost 14 care workers per 1,000 residents. While health indicators in Somerset among very aged people were better than the national average, at district level there were localities where this was not the case, for example in Taunton Deane (where 1 in 10 men aged 85+ was providing unpaid care to a relative or friend). The sheer size of the elderly population in Somerset, together with a marked increase in demand for female part-time labour in recent years, including additional demand for labour in the distribution and tourism sectors, also suggests a very challenging future. In 2001, 1 in 17 of all employed women in Somerset was a care worker, and between 1991 and 2002 the county saw job growth significantly outstrip the increase in its number of people of working age.

A changing operating environment

Many of the organisations which participated in this study are already aware of the benefits employers gain by supporting and rewarding their staff, particularly in terms of retaining personnel who might otherwise be attracted by alternative opportunities elsewhere. Our respondents included some employers who were strongly committed to creating the best possible conditions of employment for their staff. The scope local agencies have for developing such support is nevertheless constrained by the tight financial situation in the sector. While the allocation of substantial additional resources to support domiciliary care is likely to remain a matter primarily for public policy, public opinion and central government to resolve, heightened awareness of key issues at the local level, and pressure from key agencies in the decision-making process, can contribute to the debate needed about the funding of social care. It will be important that local decision-makers engage with this debate, drawing on the full range of available evidence, including the detailed information about the financing of care presented in the Wanless Review (2006).

During the course of our research, central government indicated its intention to further reshape the delivery of community care services, through the 2006 Department of Health White Paper Our health, our care, our say: a new direction for community services and the 2005 Green Paper which preceded it. While the detailed implications of the changes involved remain unclear, the government has emphasised its

30 Total female part-time employment in Somerset grew by +53% between 1991 and 2002, compared with +31% nationally.
commitment to the introduction of Individual Budgets for social care, and the importance it attaches to the provision of services which accord with care users’ personal preferences, empower them to remain active citizens, and deliver choice and independence to older and disabled people and their carers. These planned developments will give individual care users much greater control over both their own budgets and over their care plans. If taken up widely, this could have major implications for the social care market. If large numbers of care users select to go straight to the marketplace for their caring labour, or recruit their caring labour indirectly, the implications of these changes for skills, training and quality assurance in the delivery of domiciliary care will be significant. Furthermore, the White Paper does not specify where the flexible domiciliary care labour which will be needed is to be found, and the question of whether there are enough care workers (or potential recruits into care work) willing or able to work in this way (or in the sector more generally) remains unresolved. We would expect the composition of the domiciliary care labour force to change quite significantly if individual care budgets and direct payments come into widespread use. As these changes take shape, and their practical consequences are addressed, it will be very important to draw on evidence about the experiences of care providers in recruiting, developing and retaining domiciliary care staff, by central and local agencies, at both the strategic and operational levels, and we hope the evidence in this study and in our Locality Reports will make a useful contribution to this. There are important roles for those commissioning services, for providers of domiciliary care, and for the representative bodies and trade unions in the sector in preparing for these changes.

Domiciliary care, women’s employment and the local labour market

Our other research within the much wider Gender and Employment in Local Labour Markets research programme has shown the critical importance of women’s employment in local labour markets. Employment in social care, whether in the public sector or in the delivery of care through independent providers of health and social care, relies heavily on women to fill the available jobs. This has been the case historically, from the first development of paid employment in this field, and remains true today in the localities we have studied.

In our other GELLM work (Buckner et al 2004, 2005; Grant et al 2005, 2006a) we have emphasised the importance of key features of the labour supply provided by women, many of whom prefer to work part-time and flexibly, but who often pay a heavy price for this in terms of their rates of pay, accepting positions which involve working below their potential, and delivering services which are both socially and economically undervalued. In a comparatively tight labour market, and with female labour market entrants better qualified than ever before, competition for female labour will be significant, and employers, especially in those parts of the country where job growth has significantly outstripped growth in the working age population, or where the working age population is shrinking, will need to offer attractive conditions of employment to secure an adequate labour supply. This has important implications for wages, working conditions, workforce development and workforce planning in social care. Some of the providers consulted for this study believe that the development of career progression routes in social care and the greater emphasis on accreditation and professionalisation is beginning to draw new labour into the sector. It will be essential to ensure that the job roles on offer remain attractive to job seekers as well as to those already working in domiciliary care.

It can be argued that domiciliary care – the essential support services for those who are frail, disabled and ill, whose quality ought to be a hallmark of a modern, decent society – is a prime example of strongly feminised employment in which job occupants are poorly rewarded, both in terms of their pay and in terms of the social evaluation of the work they do. As we have seen, many steps have already been taken to address problems in delivering domiciliary care, at both local and national level. However, the near certainty that reconciling supply and demand for domiciliary care will continue to be an important challenge well into the future means that efforts at all levels will need to be strengthened. This will involve further commitment to new innovative projects, particularly those which draw new sources of labour into social care. Throughout the sector, job image and job design, financial and human resources planning, employment and working conditions, training and workforce development will continue to need energetic attention in the years to come if older people and others in need of home care are to have access to the support they will need, and to be able to rely on the availability of high quality service delivery.
References


Department of Health (2001) Building Capacity and Partnership in Care: an agreement between the statutory and the independent social care, health care and housing sectors London: DoH.


Patmore, C and McNulty, A (2005) Making Home Care for Older People more Flexible and Person-Centred (Ref DHP 2069 CP) York: SPRU.


Appendix 1  Gender and Employment in Local Labour Markets

The Gender and Employment in Local Labour Markets project was funded, between September 2003 and August 2006, by a core European Social Fund grant to Professor Sue Yeandle and her research team at the Centre for Social Inclusion, Sheffield Hallam University. The award was made from within ESF Policy Field 5 Measure 2, ‘Gender and Discrimination in Employment’. The grant was supplemented with additional funds and resources provided by a range of partner agencies, notably the Equal Opportunities Commission, the TUC, and 12 English local authorities.

The GELLM project output comprises:

- new statistical analysis of district-level labour market data, led by Dr Lisa Buckner, producing separate Gender Profiles of the local labour markets of each of the participating local authorities (Buckner, Tang and Yeandle 2004, 2005, 2006) - available from the local authorities concerned and at www.shu.ac.uk/research/csi

- 6 Local Research Studies, each involving between three and six of the project's local authority partners. Locality and Synthesis reports of these studies, published spring-summer 2006 are available at www.shu.ac.uk/research/csi. Details of other publications and presentations relating to the GELLM programme are also posted on this website.

1. Working below potential: women and part-time work, led by Dr Linda Grant and part-funded by the EOC (first published by the EOC in 2005)
2. Connecting women with the labour market, led by Dr Linda Grant
3. Ethnic minority women and access to the labour market, led by Bernadette Stiell
4. Women’s career development in the local authority sector in England led by Dr Cinnamon Bennett
5. Addressing women’s poverty: local labour market initiatives led by Karen Escott
6. Local challenges in meeting demand for domiciliary care led from autumn 2005 by Professor Sue Yeandle and prior to this by Anu Suokas

The GELLM Team
Led by Professor Sue Yeandle, the members of the GELLM research team at the Centre for Social Inclusion are: Dr Cinnamon Bennett, Dr Lisa Buckner, Ian Chesters (administrator), Karen Escott, Dr Linda Grant, Christopher Price, Lucy Shipton, Bernadette Stiell, Anu Suokas (until autumn 2005), and Dr Ning Tang. The team is grateful to Dr Pamela Fisher for her contribution to the project in 2004, and for the continuing advice and support of Dr Chris Gardiner.

The GELLM Partnership
The national partners supporting the GELLM project are the Equal Opportunities Commission and the TUC. The project's 12 local authority partners are: Birmingham City Council, the London Borough of Camden, East Staffordshire Borough Council, Leicester City Council, Newcastle City Council, Sandwell Metropolitan Borough Council, Somerset County Council, the London Borough of Southwark, Thurrock Council, Trafford Metropolitan Borough Council, Wakefield Metropolitan District Council and West Sussex County Council. The North East Coalition of Employers has also provided financial resources via Newcastle City Council. The team is grateful for the support of these agencies, without which the project could not have been developed. The GELLM project engaged Professor Damian Grimshaw, Professor Ed Fieldhouse (both of Manchester University) and Professor Irene Hardill (Nottingham Trent University), as external academic advisers to the project team, and thanks them for their valuable advice and support.
Appendix 2   Research Methods

The study was conducted between spring 2005 and spring 2006, and involved new statistical analysis of the 2001 Census of Population, a new survey of domiciliary care providers with follow-up telephone interviews, and interviews with key stakeholders involved in commissioning and delivering domiciliary care services in each of the 6 study areas.

Analysis of 2001 Census data
Data from the 2001 Census for England and from the sub-national population projections were used to produce statistical profiles relating to domiciliary care in each locality. These explored:

- population structure and key labour market indicators;
- demographic and employment characteristics
- demographic/housing/health related indicators for older people
- population and household projections for 2004-2028, and
- provision of unpaid care by people working as care assistants or home carers

Postal survey of providers
A postal questionnaire was sent to a total of 190 domiciliary care providers who were registered with the SSDs in the selected localities. The purpose of the survey was to explore providers’ employment, training and human resources practices and policies, and to recruit providers to take part in telephone interviews. 88 providers responded to the survey, a response rate of 46%. They included 17 from the voluntary and community sector, 51 private for-profit organisations, and 17 private not-for-profit organisations. Data from the survey were analysed using SPSS to produce frequencies, cross tabulations and bar charts. The survey distribution and response rates in the individual localities are indicated in Table A2.

<table>
<thead>
<tr>
<th>Survey Respondents</th>
<th>Birmingham</th>
<th>Newcastle</th>
<th>Sandwell</th>
<th>Somerset</th>
<th>Thurrock</th>
<th>West Sussex</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacted</td>
<td>45</td>
<td>41</td>
<td>15</td>
<td>41</td>
<td>16</td>
<td>32</td>
<td>190</td>
</tr>
<tr>
<td>Responded</td>
<td>17</td>
<td>20</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td>88</td>
</tr>
<tr>
<td>Response rate</td>
<td>38%</td>
<td>49%</td>
<td>67%</td>
<td>46%</td>
<td>50%</td>
<td>44%</td>
<td>46%</td>
</tr>
</tbody>
</table>

| Sector:            |            |           |          |          |          |             |       |
| Vol/com            | 4          | 8         | 2        | 1        | 1        | 1            | 17    |
| Private for profit | 11         | 8         | 5        | 12       | 4        | 11           | 51    |
| Private not-for-profit | 2       | 4         | 2        | 6        | 1        | 2            | 17    |
| Unknown            |            |           |          |          |          | 2            | 2     |
| SSD                | ✓          | ✓         | ✓        | n/a      | ✓        | ✓            | 5     |
| Independent provider interviews | 7   | 11        | 3        | 7        | 6        | 8            | 41    |

| Key Stakeholder Interviews | 4 | 5 | 4 | 3 | 5 | 4 | 25 |

Interviews with key stakeholders and a sample of providers
Follow-up in-depth interviews were conducted with 41 independent sector providers and with 25 key stakeholders in the selected localities. The interviews with key stakeholders were conducted with managers responsible for contracting and commissioning, HR, and training/staff development within the local authorities concerned, using specially designed interview schedules, which included a request for relevant documentation. The interviews with providers explored workforce management, planning and recruitment practices, and interviewees were asked to supply relevant supporting documentation (e.g. examples of contracts of employment, policy documents relating to flexible working, training etc.). These interviews were tape-recorded and transcribed prior to being analysed by the research team.

31 The authors of this report would like to thank Anu Suokas for her contribution to this research in its early stages.
32 2003 based sub-national population projections, Government Actuary Department, Crown Copyright 2004
Appendix 3  Additional data on Care Assistants and Home Carers

Figure A1  Care Assistants and Home Carers – percentage who are part-time employees by age

![Bar chart showing percentage of part-time employees by age and gender for different regions.](chart.png)

Source: 2001 Census Commissioned Tables, Crown Copyright 2003

Figure A2  Care Assistants and Home Carers with unpaid caring responsibilities, by age %

<table>
<thead>
<tr>
<th></th>
<th>All in employment</th>
<th>Care Assistants and Home Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Birmingham</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>11 5 10 18 14 6 14 24</td>
<td>22 10 22 30 18 11 18 24</td>
</tr>
<tr>
<td>Women</td>
<td>10 4 9 17 14 5 14 26</td>
<td>16 14 15 23 21 14 21 26</td>
</tr>
<tr>
<td>Sandwell</td>
<td></td>
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<tr>
<td>Men</td>
<td>11 5 10 17 15 6 14 25</td>
<td>16 10 15 23 20 14 18 27</td>
</tr>
<tr>
<td>Women</td>
<td>10 3 8 16 14 4 12 23</td>
<td>17 12 15 26 17 9 17 24</td>
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<td>Somerset</td>
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</tr>
<tr>
<td>Men</td>
<td>10 3 8 16 14 5 12 22</td>
<td>15 ** ** ** 21 18 19 24</td>
</tr>
<tr>
<td>Women</td>
<td>9 3 8 16 13 4 11 23</td>
<td>15 10 15 21 16 8 16 24</td>
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<td>West Sussex</td>
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<tr>
<td>Men</td>
<td>9 4 8 17 13 5 12 24</td>
<td>17 11 16 26 18 10 17 25</td>
</tr>
<tr>
<td>Women</td>
<td>10 4 8 17 13 5 12 24</td>
<td>17 11 16 26 18 10 17 25</td>
</tr>
</tbody>
</table>

Source: 2001 Census Commissioned Tables, Crown Copyright 2003

Note ** Small number of men working as Care Assistants and Home Carers in Thurrock
Figure A3  No qualifications: Men and women aged 16-24


Figure A4  No qualifications: Men and women aged 25-49


Figure A5  No qualifications: Men and women aged 50-64/59