CENTRE FOR WORKFORCE INTELLIGENCE

WORKFORCE RISKS AND OPPORTUNITIES:

ADULT SOCIAL CARE

August 2011

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INTRODUCTION

As part of its core programme for 2010/11, the Centre for Workforce Intelligence (CfWI) was commissioned by the Department of Health (DH) to set out the major risks and opportunities facing the social care and healthcare workforce in 2011 and beyond. The Workforce Risks and Opportunities (WRO) project provides an assessment of current workforce issues and potential opportunities for improvement.

The CfWI's predecessor body, the NHS Workforce Review Team (WRT), previously carried out this type of work in relation to the healthcare workforce. This is, however, the first occasion a high-level analysis of risks and opportunities has been applied to social care. The focus is specifically on adult social care – services for children are out of the scope of this report.

Ideas for topics for inclusion in the report were generated by an expert group with representation across a number of key organisations working across adult social care. Further review of evidence and discussion with stakeholders informed this final report. The themes and perspectives presented are by no means exhaustive, but a preliminary step in starting the debate about the workforce risks and opportunities facing the sector.

The target audience is wide and encompasses those responsible for and interested in aspects of workforce planning, development and commissioning at all levels in the system. The report will sit alongside broadly similar papers relating to the healthcare workforce. Further information can be found at www.cfwi.org.uk.

1.OVERALL CONTEXT

The Coalition's programme for government set out its high-level agreement for, and approach to social and economic policy (Her Majesty's Government, 2010a). The agreement is dominated by an ambition to redistribute power from central government to local communities. A good example of this is the Government's vision for 'Big Society', which aims to empower communities, reform public services and encourage active participation in society. To support the realisation of this vision, the Department of Health (DH) has contributed £7 million to the Government Transition Fund, which was set up following the comprehensive spending review in October 2010 to support charities. Concurrently, the Coalition's agreement also emphasises deficit reduction above all commitments subsequently set out in the comprehensive spending review (Her Majesty's Treasury, 2010).

Since the Coalition set out its programme there have been significant changes to social care and healthcare policy agendas. The interconnections between social care and healthcare are widely recognised, both in policy and planning terms as well as from the perspective of people using services (Nuffield Trust, 2011). Thus any individual assessment of the workforce risks and opportunities facing the sector must be positioned within the context of the current transition within healthcare.

Following consultation and a period of 'pause, listen and reflect' (Field, 2011) the Health and Social Care Bill, first introduced in January 2011, seeks to provide the primary legislation required to take forward the Government's strategies and policies across healthcare and social care (Her Majesty's Government, 2011). Also relevant is the Localism Bill, introduced in December 2010 to devolve greater power to local communities (Her Majesty's Government, 2010b).

1.1 Government's vision for adult social care

A Vision for Adult Social Care set out the Government's agenda for adult social care (Department of Health, 2010a). The vision is underpinned by seven principles. In introducing these principles, at a high level, examples of workforce issues are drawn out. As these examples demonstrate, the principles are not mutually exclusive.

- **Prevention** – refers to empowering individuals to maintain independence and emphasises early intervention. For example, to prevent low-level care needs escalating to higher levels of dependency there should be an emphasis on reablement services and improved support to carers.

- **Personalisation** – is about people exercising choice and control in whatever social care services they use. The Government also wants to see much greater take-up of personal budgets and direct payments. These schemes set out how much money is available for someone's care and enable people who use services to agree and control how to spend it. This will mean less reliance on 'block contracting' by local authorities and an increase in the numbers of personal assistants, advocacy and brokerage services. This has significant implications for the workforce skills and numbers required.

- **Partnership** – all parts of the care system should be working to support individuals and communities, voluntary and private sectors, the NHS and local authorities. The Government will take measures to improve the linkage between services, making local authorities responsible for health and well-being (through joint strategic needs assessments) and ensuring priorities are shared with healthcare (for example on dementia care, end-of-life care, services for people with autism and support for carers). Partnership working also needs to address joined-up workforce planning.

- **Plurality** – diverse care needs should be matched by a mixed market of adult care and support. Introducing the prospect of 'any qualified provider' and social enterprises will be encouraged as a means of increasing choice for people using services and commissioners.

- **Protection** – refers to services that 'do no harm' and safeguard people from neglect and abuse. The vision emphasises that risk should not be used as a means of limiting individuals' freedom.

- **Productivity** – increasing local accountability for services as a means of driving improvements and innovation. The Government expects that commissioning and services should be fully separated. Local authorities must redesign their services to deliver efficiencies and those with substantial in-house provision are being asked to look to the market to replace them as the local provider.

- **People** – the vision requires a well-trained workforce with the right skills to lead the change set out by the Government. There will be new roles and responsibilities and new career pathways created by the vision for adult social care in England.

1.2 Think Local, Act Personal

Think Local, Act Personal (2011) is a sector-wide commitment to moving forward with personalisation and community-based support. It was published as the delivery vehicle for *A Vision for Adult Social Care* (Department of Health, 2010a)

and has since been finalised as the way forward since April 2011. The agreement underlines the importance of the connections between prevention, community-based approaches and personalised care and support. It also provides a framework for action. Various measures are emphasised to further develop the adult social care workforce, its capacity and capability, including:

- supporting staff development to enable staff to play their part in the shift to personalisation
- helping to further develop new types of workers and remove barriers to informal support
- assisting all providers, including smaller 'niche' providers, to recruit and train staff
- focusing local authority care management and social work resources on formal and legal aspects of care such as authorising support plans or safeguarding people in vulnerable circumstances
- supporting multidisciplinary working across healthcare and social care
- enabling information technology to support productivity.

1.3 Commission on Funding of Care and Support

It has long been recognised that adult social care in England is in need of reform and a number of reviews have been completed (Royal Commission on Long Term Care, DH, 1999; Wanless, 2006; Hirsch, 2006). The Coalition Programme for Government (Her Majesty's Government, 2010a) signalled a further review and in July 2010 established the Commission on Funding of Care and Support. A final report with recommendations was published in July 2011. It proposes an increase in the threshold of means-tested support, a new national eligibility threshold and improved joined-up working across the care and support system – health, housing, benefits and adult social care.

1.4 Law Commission review of adult social care

In 2008 the Law Commission began to review adult social care law in England and Wales and subsequently consulted on the matter in 2010. It was recognised that adult social care 'remains a confusing patchwork of conflicting statutes enacted over a period of 60 years' (Law Commission, 2010: 1). The Law Commission published its final report in May 2011, recommending a clear, modern and cohesive framework for adult social care (Law Commission, 2011a). Alongside the recommendations from the Commission on Funding of Care and Support, the Law Commission recommendations are expected to be considered as a White Paper for adult care and support is brought forward for 2012.

1.5 Broader policy developments in healthcare and support

Equity and Excellence: Liberating the NHS provides the starting point for a series of significant changes to the structure of the NHS (Department of Health, 2010b). This will involve the dissolution of primary care trusts (PCTs) and strategic health authorities (SHAs) with responsibility for commissioning services transferred to GP consortia accountable via the NHS Commissioning Board. *Healthy Lives, Healthy People* (Department of Health, 2010c) sets out more detailed reform of the system with regard to public health. An important theme running through these health strategies, and reading across to the social care vision, is the need to break down barriers between social care and healthcare to achieve better outcomes for people using services and the public. The workforce implications of breaking down barriers need to be carefully considered. Key proposals include:

- encouraging joint funding of preventive action from healthcare and social care
- separate outcomes frameworks for the NHS, for public health and social care, which provide clear lines of responsibility, enabling better joined-up care
- PCTs' responsibilities for local health improvement will transfer to local authorities, where a jointly appointed Director of Public Health will hold a ring-fenced public health budget
- each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement, including through the use of joint strategic needs assessments (JSNAs).

The Government has also published strategies for particular care groups. For example:

- *No health without mental health: a cross-government mental health outcomes strategy for people of all ages – a call to action* (Department of Health, 2011a) sets out six objectives to improve the mental health and well-being of the population. It emphasises the interconnections between services such as mental health, housing, employment and criminal justice.
- *Recognised, valued and supported: next steps for the carers strategy* (Department of Health, 2010d) identifies the priorities to ensure that outcomes for carers and those they support are maximised.

Transforming Community Services (Department of Health, 2011b) aims to provide better health outcomes for individuals, families and communities and promotes whole-system and integrated approaches, including with social care. The Department of Health's (2011c) Quality Innovation, Productivity and Prevention (QIPP) agenda which sets out to achieve the savings in *Equity and*

Excellence (Department of Health, 2010b) relies heavily on *Transforming Community Services*. Placing stronger emphasis on prevention and supported self-care, for example, requires greater join up between all services.

1.6 Key workforce reviews and policies

In considering recent reviews and strategy relevant to the social care workforce it is, of course, important to distinguish between qualified social workers and social care workers. 'Social worker' is a protected title in law, whereas 'social care workers' refers to people that are (typically) not professionally qualified but will hold vocational qualifications and undertake a wide range of care and support tasks. This includes individuals who provide care in people's own homes and other settings, such as care homes. It is also important to recognise the wide range of other qualified professionals who work in social care, including nurses and professions allied to health, for example, occupational therapists.

1.7 Independent Review of Higher Education Funding and Student Finance

The *Independent Review of Higher Education Funding and Student Finance* (Browne, 2010) is most relevant to social workers and professionals such as nurses working within the social care sector. The review recommends that public investment is targeted at the teaching of priority subjects that are considered most relevant to the well-being of society and the economy. Clinical medicine, nursing and other healthcare degrees attract attention, but social work is not considered. The review indicates that funding would be reduced from courses other than priority subjects. Bursaries for social work students have been paid for by the Department of Health and are demand led, and currently are not capped. These arrangements are being reviewed.

1.8 Liberating the NHS: Developing the Healthcare Workforce

The Government has just completed its consultation on proposals for the planning and developing of the NHS workforce (Department of Health, 2010b). The proposals, which were subject to a further listening exercise (Field, 2010), suggested that healthcare providers, including GP consortia, are grouped into 'skills networks' undertaking the functions currently held by SHAs. The networks will include representatives from local authorities, social care and education providers.

The NHS Future Forum listening exercise identifies a number of messages for Government, including the need for:

- stronger multi-professional advice to inform commissioning decisions

- user and public involvement to be 'hard-wired' into every part of the system
- a stronger emphasis on integrated care and the education and training of the workforce to be 'the single most important thing in raising standards of care. More time is needed to get this right – the effects of mistakes now will be felt for a generation' (Field, 2011).

1.9 Enabling Excellence

The regulation of unregulated social care workers has long been debated, as it has in health with assistant practitioner and healthcare assistant roles. *Enabling Excellence* (Department of Health, 2011d) sets out the Government's plans to reform workforce regulation. For workers currently unregulated, a system of assured voluntary registration is proposed. The Government's view is that existing safeguards, such as the Vetting and Barring Scheme, the Criminal Records Bureaux and the Independent Safeguarding Authority, are sufficient at a national level. The emphasis should be placed on employers assuring themselves that staff are adequately trained and competent at a local level.

The Government is exploring whether the Health Professionals Council can establish a voluntary register of social care workers by 2013. It is also signalling to commissioners of social care that services may wish to give priority to services that include registered workers when procuring services. Similarly, direct employers – referring to people who are given control to pay for and/or arrange their own care through the use of personal budgets and direct payments – will also be encouraged to give preference to registered individuals. The voluntary register could also be used in the new system for rating excellence currently being developed by the Care Quality Commission (CQC) – the social care and healthcare regulator for England.

Enabling Excellence recognises that much of the unregulated workforce is employed across both social care and healthcare services; some funded by local authorities, others by the NHS, and in some instances both sectors. The Government plans to develop common standards for both social care and healthcare. Children's services are, however, excluded due to the different context in which the staff work.

1.10 Financial context

Economic priorities require public service costs to be reduced and constrained. To meet these priorities, the Government has set out a programme of reform and efficiency savings, which will involve significant change to the system landscape and the delivery of services.

To support social care during this period of financial stringency, the Government has allocated £2 billion per year of additional funding by 2014–15 in the Comprehensive Spending Review (Her Majesty's Treasury, 2010). The £2 billion allocation comprises £1 billion of additional funding through Department of Health grants to local authorities (via the general local government formula grant) and up to £1 billion available within the NHS to support social care, of which up to £300 million a year is earmarked for reablement. It is expected that total grant funding from the Government for social care will reach £2.4 billion by 2014–15. However, the local authority revenue grant will reduce from £28 billion in 2011 to £21.9 billion in 2014–15 and this now also includes the personal social services (PSS) grant (Department of Health, 2011e). These monies are not ring-fenced.

Despite the allocation of additional resources for social care, many services are facing reductions. Some estimates put the funding gap at least £1.4 billion by 2014 as local government faces a 27 per cent real reduction in overall funding (The King's Fund, 2011a). The Local Government Spending Review places the decrease in funding at around 14 per cent (Her Majesty's Treasury, 2010). Analysis by the Health Select Committee indicates that the social care sector will need to deliver efficiency gains of up to 3.5 per cent per annum throughout the Spending Review period to avoid reducing their levels of care (House of Commons Health Committee, 2010). Although many local authorities are focusing on reablement to make the savings required, the actual overall effect of this strategy is yet to be quantified.

2.OVERVIEW OF THE ADULT SOCIAL CARE WORKFORCE

> By adult social care, we mean the responsibilities of local social services authorities towards adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems and carers. Adult social care services include the provision of care homes, day centres, equipment and adaptations, meals and home care. It also includes the mechanisms for delivering these services, such as community care assessments, carers' assessments, personal budgets and direct payments, and adult protection procedures. (Law Commission, 2011b).

The adult social care sector covers care homes, domiciliary (home) care, day care, a wide range of community-based services and social work with all its specialities. Social care is delivered by a wide range of public, private and voluntary sector organisations and involves a workforce of over a million and a half people. The analysis prepared in this part of the report draws on joint briefing prepared by Skills for Care and the CfWI based on the National Minimum Data Set for Social Care (NMDS-SC).

2.1 Workforce

In contrast to healthcare, where a single large employer (the NHS) predominates, social care is provided by thousands of different organisations of varying size and complexity. Consequently, the size of the adult social care workforce is complex to calculate due to incomplete data in some areas and the difficulty of integrating several data collections. We also need to distinguish between the number of jobs – which is what the data collections mostly provide – and the number of people doing these jobs. Some people may do more than one job.

The number of jobs in adult social care in 2009 was estimated at 1.75 million, with 1.61 million being directly employed, and 143,000 not directly employed, for example volunteers. These jobs are delivered by a workforce of 1.6 million, with 1.46 million in directly employed roles (Skills for Care, 2010).

The types of job in the adult social care workforce can be divided into:

- management and supervisory
- professional (jobs requiring a professional qualification such as nursing or social work)
- direct care and support
- other, including administrative, ancillary posts such as catering, transport, maintenance, and jobs not involved in direct care and support.

Table 1 below gives the percentages of people involved in each of these jobs and the total number of people. There is a near match between people and jobs in all areas apart from direct care, where having more than one social care job is not uncommon.

Table 1. Types of jobs and workforce numbers (2009)

	Private sector	Voluntary sector	Councils (2008 data)	NHS	Direct payments users	Total people
Management and supervisory	44%	35%	20%	1%		**157,000**
Professional	53%	10%	20%	17%		**108,000**
Direct care and support	49%	23%	9%	5%	14%	**1,113,000**
Other jobs	43%	34%	22%			**225,000**
Total people	**770,000**	**396,000**	**204,000**	**73,000**	**160,000**	**1,603,000**

Source: Skills for Care, 2010

Job Centres reported 26,742 vacancies for care occupations in England for March 2011, with 21,694 for care workers (care assistants and home carers). To put this into perspective, health and social care work makes up about 13 per cent of all jobs, but vacancies for care workers alone make up about 9 per cent of all job vacancies, with all care services covering about 11 per cent of vacancies. In the UK, public sector employment is decreasing, whilst private sector employment is increasing (Office for National Statistics, 2011).

Adult social care jobs have increased by 363,000 since 2006–7, primarily due to the rise in jobs for users of direct payments which have increased by an estimated 150,000 over the same period (Skills for Care, 2010).

The data suggests that the proportion of men in the workforce is increasing, but only by one or two per cent across the different job areas. People directly employing their own care and support staff are likely to be one of the main drivers of this.

Analysis of the NMDS-SC demonstrates, as might be expected, a high number of women working in adult social care, particularly in direct care, providing jobs where the proportion is over 85 per cent (Skills for Care, 2010). Men account for up to a quarter of the workforce in day care, support roles and management, rising to over 30 per cent in senior management (Skills for Care, 2010). This suggests a higher success rate of men with regards to promotion prospects into higher positions.

The cross-section of people who use social care services should, ideally, be reflected in the workforce. Whilst gender is often examined with reference to the underrepresentation of women in higher positions such as senior management,

it is important to consider the future recruitment of men into the less senior levels of social care.

With regard to equality issues, 85 per cent of the workforce are White, with the remaining 15 per cent coming from Black and ethnic groups. The proportion of Black and ethnic staff is not uniform across the sector – an estimated 25 per cent of staff working in independent care homes with nursing are from Black and ethnic groups, whilst in day care the same group drop to nine per cent of all staff.

2.2 Organisations

A large number of organisations and enterprises are involved in providing or organising adult social care. The total number registered for PAYE/VAT in England in 2009 was approximately 17,320, an increase from the 2008 estimate of 13,500 (although this is partly due to better data). It is likely that 17,320 is an underestimate since it excludes, for example, local authorities' central operations, government departments, non-departmental public bodies and other organisations whose main activity is not social care, and voluntary organisations that are entirely staffed by unpaid workers. If sole traders, partnerships and other organisations not registered for PAYE or VAT are included, the number rises to an estimated 54,232.

The estimated number of local units or establishments is higher, as many enterprises operate over several workplaces. For PAYE/VAT registered establishments it is 40,626, and including unregistered ones 77,536 (Skills for Care, 2010).

Although trends are difficult to quantify, there is likely to be expansion in this sector, and numbers given above will be underestimates.

2.3 Care providers

There were 18,462 residential care homes for adults and older people registered with the CQC in 2009. Over three-quarters are care only; the remaining ones provide nursing or other non-medical care as well. These homes provide 457,537 places between them, of which 260,162 are care only. In addition, an estimated four to five thousand non-regulated establishments are providing residential care, for example staffed hostels.

Day care is not regulated by the CQC, and the numbers can only be estimated. Almost all local authorities operate day centres, and based on their staffing structures a total of 1,120 local authority day care centres are in operation for adults and older people. Estimates for the independent day care sector put the number at 8,200 establishments, with some 6,700 operated by the voluntary sector, and 1,500 by the private sector.

There were 5,319 domiciliary care agencies and 759 nurses' agencies registered with the CQC in 2009. Unregistered independent sector establishments are estimated at 2,400.

Although local authorities provide community services, there are estimated to be an additional 6,700 establishments, mostly in the voluntary sector, providing services in the community.

In the residential sector, the number of care-only homes has fallen by nearly 9 per cent since 2004, although homes with nursing or non-medical care have increased by 4 per cent over the same period. The number of care-only places has fallen by nearly 6 per cent, while the number of care places with nursing or non-medical care has increased by 10 per cent since 2004. This reflects growing demand for nursing care, a trend which is likely to continue as people live longer and tend to develop more complex needs in later life, including dementia.

The trends in care-only homes and domiciliary care reflect increased provision of care and support in the home rather than in residential care. The number of home care agencies has increased by 29 percent since 2004 (Skills for Care, 2010).

2.4 People employing their own staff

Increasing numbers of people are employing their own staff, driven by the numbers of users of direct payments for adults' services. In 2008–9, some 114,500 adults and older people were using payments from local authorities' social services departments, including for children's services. About 75 per cent were for their own care and 25 per cent of these payments were to carers. Skills for Care estimates that in 2009–10, some 150,000 adults and older people were using direct payments (Skills for Care, 2010).

There are people using funds from streams other than direct payments, and self-funding, but there is limited information available at present. The most recent estimate (2006) is that there are 145,000 older people (aged 65+) in England funding their own domiciliary care, but this estimate was based on a narrow definition of need (King's College London and Social Care Workforce Research Unit, 2010).

The number of users of direct payments has increased rapidly since 2002, when there were only 7,882. Payments rose nearly 50 per cent in the period 2008–9 and a further 30 per cent in the period 2009–10 (Skills for Care, 2010).

3.WORKFORCE RISKS

3.1 Imbalance between workforce supply and demand

An imbalance exists when the quantity (or quality) of the available workforce and the quantity (or quality) required by employers diverge in existing market conditions. Labour market supplies and demands fluctuate frequently and sometime continuously, so there will always be imbalances. Risks occur when adjustments cannot be made quickly, leaving an imbalance that cannot be easily corrected. There are several factors driving an imbalance between supply and demand in the adult social care sector.

People with learning disabilities, long-term conditions and older people are living longer. These are positive and welcome trends in society and a result of advances in medicine and clinical practice, health technologies and people enjoying healthier lives. However, demand on services is growing:

- By 2026 there are expected to be 1.7 million more adults who need social care and support. In the next 20 years, the number of people over 65 will increase by just under half, those over 85 in England will double, and the number over 100 will quadruple (Her Majesty's Government, 2010c).

- People with mental health needs are increasing and represent a significant contributor to the overall extent of ill health. Almost one in five (17.6 per cent) of the adult population have mental health needs at any one time and the number of people with significant neurotic symptoms has increased since 1993 (Department of Health, 2010e).

- The number of younger people with learning disabilities is expected to rise by 20.6 per cent, from 203,000 in 2005 to 245,000 by 2041 (Personal Social Services Research Unit, 2008).

There are other factors that contribute to this. People rightly have growing expectations for personalised care and support. This is also supported by the continuing policy push towards personalisation as described in part one.

The number of regulated social care services is increasing (this includes services such as care homes, home care, shared lives schemes, etc.). In 2004 there were 22,467 services which had risen to 24,716 services by 2010. Trends within the market include:

- Reduction in the number of residential care homes but an increase in the number of places. This suggests that smaller care home providers are being acquired and consolidated by larger organisations. The other

dynamic in the sector is that smaller homes are being replaced by larger homes.

- Rise in the number of nursing homes, and the places in them reflecting an increase in the demand for nursing care.
- Year-on-year increase in the number of home care (domiciliary) services which demonstrates both increased demand and a shift towards community-based support through measures such as Direct Payments (Care Quality Commission, 2010a).

The regulator signals the need for commissioners and providers to develop the market if future long-term care needs are to be anticipated. As the market grows, so too will the need for the workforce to develop via effective workforce commissioning.

Workforce simulation models suggest that the number of paid adult social care jobs in 2025 could increase from 1.54 million to between 2.1 million and 3.1 million depending on the assumptions made. The number of people working in adult social care would increase from the current 1.6 million to between 1.8 million and 2.6 million according to the scenarios employed (Skills for Care, 2010).

3.2 Smaller state sector and public funding 'gap' for adult social care

The policy and financial context, described in part one, emphasise the Government's ambition for a smaller state sector. Reductions in funding risk producing a further 'gap' in resources for the provision of adult social care. This could mean that people's care needs will not be met.

Social care services are means tested and local authorities may increase their eligibility criteria through the Fair Access to Care Services framework (Department of Health, 2003). In 2009–10 three local authorities set their eligibility threshold at critical – the most restricted level whereby someone's care needs have to be critical before they get social services support – and a further 107 local authorities at substantial – meaning that access to services is restricted to only those people whose needs are assessed to have substantial consequences. These thresholds are expected to remain broadly similar (Care Quality Commission, 2009).

With the loss of funding to services, local authority spending on adult social care is vulnerable. Indications from the sector are that services are being decommissioned and some are being outsourced to other organisations. The Local Government Association (LGA, 2011) has reported that 61 per cent of local authorities were in the process of renegotiating or changing contracts. This is likely to squeeze fees to providers. More than two thirds (71 per cent) of local

authorities were sharing services with another local authority and more than half reported sharing services within their own organisation.

Workforce reductions will see potential loss of skills, knowledge and experience. As services are redesigned and reconfigured, the challenges of managing employment within new 'networked' organisations will need to be overcome (Marchington, Rubery and Grimshaw, 2011). These challenges include, for example, the need to establish trusting, collaborative relationships among partner organisations. Where different priorities and policy objectives exist, inconsistencies and uncertainties can arise over how services are managed and delivered, which could ultimately affect quality of care.

3.3 Social care workforce characteristics

Analysis of the NMDS-SC demonstrates, as might be expected, a high number of women working in adult social care, particularly in direct care, providing jobs where the proportion is over 85 per cent. Men account for up to a quarter of the workforce in day care, support roles and management.

Just as social care is seen to be polarised by gender, notably the lack of men working in the sector, it also tends to be characterised by older workers. Analysis of the NMDS-SC on the age of the workforce shows a fairly even distribution across all age bands with the peak being 40 to 44. There are increasing numbers of older people in senior positions, while some areas such as occupational therapists have a younger age profile. Similarly, the average age for social workers is 44.8. There is a need to attract younger people into social care, which could be assisted by more clearly defined career pathways, and clearer understanding of the factors making choices to work in social care.

3.4 Recruitment and retention

Job Centres reported some 26,742 vacancies for care occupations in 2011, with 21,694 for care workers (care assistants and home carers). In 2010 health and social care work made up about 13 per cent of all jobs, but vacancies for care workers alone made up about 9 per cent of all job vacancies, with all care services covering about 11 per cent of vacancies (ONS, 2011). In the UK, public sector employment is decreasing, whilst private sector employment is increasing (ONS, 2011).

Vacancy levels of around 25 per cent in social care are about 13 per cent higher than the level for all industrial, commercial and public sector employment in England (Skills for Care, 2010).

Analysis of the NMDS-SC demonstrates turnover rates across staff in the private and voluntary sectors (those sectors where information is available) average 18 per cent across all jobs, peaking at nearly 23 per cent for care workers, and falling to below 6 per cent for senior managers. Turnover rates are lower in the

voluntary sector; higher pay rates probably contribute to this (Skills for Care, 2010). A survey of National Care Forum (2011) member organisations – which represent not-for-profit social care and health providers, found 33.7 per cent of care home workers leave within 12 months and 54.2 per cent within two years (compared with 40.8 per cent and 59.6 per cent in 2010). For home care workers, 44.9 per cent leave in the first 12 months, and 64.3 per cent leave within two years (compared with 48.9 per cent and 65.3 per cent respectively in 2010). The economic situation provides one possible explanation for these improvements in recent years.

Many social care workers receive low pay – around minimum wage levels – and competition from other industries (such as retail) may cause problems in recruiting and retaining staff. Poor terms and conditions coupled with demanding yet sensitive tasks make social care a difficult area to recruit and retain staff. We need a better understanding of why people leave the sector.

The status of social care has long been cause for concern (Platt, 2007). The sector continues to be little understood by the general public. The work can be seen as unfavourable and there are not clearly defined career pathways. Similarly, the Social Work Task Force (SWTF, 2009) stated that the role of social workers is unclear and that there are poor images of the profession among the general public.

> Social workers have left the Task Force in no doubt regarding their concern about the way in which the profession is reported on in the media and the impact this is having on recruitment, morale and public perception (SWTF, 2009).

3.5 Reduced training and development

Funding reduction will impact on training and development budgets and could undermine performance of services on training and development standards. Successive reports from the regulator have, for example, highlighted staffing and workforce development as a key area of concern for all types of provider and commissioner (CQC, 2010b, 2011). For example:

- staff training, qualifications, knowledge and commitment were key strengths in just over a quarter of local authorities, and 22 per cent of local authorities need to improve (CQC, 2011)
- performance against minimum standards varies across regulated services, for example,
    - care homes for younger adults: 84 per cent compliant
    - care homes for older people: 83 per cent compliant
    - home care: 85 per cent compliant
    - shared lives schemes: 87 per cent compliant.

Staff training is a key area of concern, especially with regard to the provision of safe and effective care. Safeguarding training was noted as a strength in only 40 per cent of local authorities, and as an area for improvement in 41 per cent (CQC, 2011).

Workforce development is less well resourced and led in adult social care when compared with the NHS. In social care, people are retained while they are being trained but are more likely to leave when they stop training. This has implications for training schemes.

Training and development budgets are likely to be reduced further in light of the economic and financial priorities for local authorites and providers. This could have a negative effect on the quality of services, especially when the needs of the people who use services, their families and carers are more complex.

Reduction in budgets also impacts the ability of organisations to offer placements to students training to be social workers, in terms of the staff required for effective supervision. There are already concerns that the quality of training for social workers does not meet the requirement of employers, and lack of quality placement opportunities is an issue.

3.6 Sector complexity and uncertainty

The social care sector is highly complex and driven by powerful economic, health and social forces. It involves large numbers of people and interactions, multiple skills, and diverse processes and services.

It is widely accepted that the greater the degree of uncertainty in a system, the more dynamic and unpredictable are the situations that may occur; uncertainty can make predictions around supply and demand more difficult, for example.

The complex system also places demand on getting quality evidence for decision making. In the past, social care was described as a 'data desert' and concerns had been raised about the under-management of research, highlighting the absence of a research and development strategy for the sector. The work of the Social Care Institute for Excellence, for example, has enabled the sector to develop evidenced-based practice (Social Care Institute for Excellence, 2003) and the National Institute for Health Research School for Social Care Research (2010) is seeking to raise the status of social care research.

The NMDS-SC provides the sector with extensive and reliable data about social care providers and their workforce. The NMDS-SC, operated by Skills for Care, enables detailed analyses to be performed at national, regional and local levels. It also allows other datasets to be combined, such as data from the Office for National Statistics. The data set provides a vehicle for employers, planners and

policymakers to evidence what is known about the workforce, rather than what we think is known.

The NMDS-SC provides quantitative intelligence and is currently partially complete. Coverage of private sector care homes is over 60 per cent complete, and homes run by the third sector over 75 per cent complete. Well over half of domiciliary care services complete the NMDS-SC but workforce data is less complete for nursing agencies and shared lives schemes (formerly known as adult placement schemes) (Skills for Care, 2010). The NMDS-SC is a voluntary return and is therefore unlikely to achieve total coverage. The current coverage allows for generalisation following sampling, and in workforce planning terms can provide excellent information about services, their capacity, worker demographics and current levels of skill mix. The missing data on the NMDS-SC potentially represents a risk in that workforce data is not complete and non-respondents could hold different characteristics to those of NMDS-SC respondents – there is however no evidence to suggest this to be the case. There is also an opportunity to improve future social care workforce planning when employer participation in the NMDS-SC is improved.

4.KEY WORKFORCE OPPORTUNITIES

4.1 New and changing workforce roles

Traditional worker roles within social care are evolving and new roles are emerging as a result of changes in government policy, system reform and changing societal needs. Recent government publications including *A Vision for Adult Social Care* (Department of Health, 2010a) and the Public Health White Paper *Healthy Lives, Healthy People: our strategy for public health in England* (Department of Health, 2010c) are driving change across the system as a response to new demographic trends and the growing demands of an older population with increasingly complex needs. There is a move to greater personalisation of care and closer integration with healthcare and other services. Such changes are resulting in new approaches to both the commissioning and delivery of social care, and in turn are impacting on the workforce.

New ways of working may lead to changes in both the shape and size of the social care workforce. The personalisation agenda is likely to drive demand for personal assistants as the number of people using direct payments and personal budgets increases. There will also be a need for brokerage and coordination roles to facilitate the creation of tailored care packages. In parallel, the role of people who use services will change as they themselves, or their carers, become employers or trainers of their staff.

In future, and in common with its role in relation to healthcare professions, the CfWI will review and make recommendations about the number of, primarily, social worker training places with higher education institutions.

With the drive to strengthen the relationship between social care professionals and the health service, new roles are also being developed encompassing both support and clinical skills. This blend of care will be delivered primarily in community settings in line with the Government's Transforming Community Services agenda. Roles such as community support workers enable a holistic approach to care delivery and may result in reduced hospital admissions. New clinical roles for care home staff, involving clinical tasks usually carried out by nurses, are emerging. This development may lead to improved outcomes for people, as care staff are better equipped to provide support across the spectrum of support – from reablement to end-of-life care. It may also increase job satisfaction among care workers and, in turn, staff retention rates.

Within social work, structures are also changing. Proposals for key areas of reform are described in *Building a safe and confident future: one year on* (Social Work Reform Board, 2011). This aims to formalise roles in social work by setting standards for both social workers and their employers. It sets out proposals for continuing professional development, education and partnership working. In

particular, changes to the social work degree, including the selection criteria, curriculum, placements and regulation, aim to improve the quality of qualified social workers with a view to them taking on more complex cases, particularly around safeguarding and mental health, and acting as mentors to those in other supporting roles. Social workers may also require greater managerial and technical competencies as they take on more specialised roles in new models of care delivery. Such changes may result in a shift in the balance of qualified social workers and social work assistants.

There is also a growing number of combined children's and adults' departments. Community Care (2010) reports that 14 per cent of adult social services directors plan to merge their posts with another within six months. This can include merging with children's social services.

Social work practice pilots have been established to give front-line workers more flexibility in how they do their jobs. The scheme, supported with £1 million funding, is said to reduce bureaucracy, allow social workers to do their jobs effectively including through improved joined-up working, and free staff to spend more time with people (Department of Health, 2011f). Following on from initial successful pilots, a second wave of practice pilots has been offered to local authorities (Department for Education, 2011).

Within both social care and social work, there will need to be much greater flexibility in the workforce and an ability to deliver a much broader range of services. To achieve more integrated models of care delivery, there will need to be greater understanding between hospitals, community and care home staff, for example about respective roles and responsibilities. Traditional patterns of work will change, with roles being extended or merged to gain the required skill mix. The development and broadening of skill sets will empower workers and improve continuity of care and, potentially, quality of care and outcomes. The development of clearer career pathways may also help the movement towards the professionalisation of social care workers. However, this will need to be reflected in education, training and recruitment and retention strategies. New skill sets will also be needed for unqualified staff and, in particular, the increasing number of personal assistants to respond to the changes in service requirements that arise as a result of personal budgets. The introduction of basic training may help to address this. Developments in information technology and the use of assisted technology in care may also help to alleviate pressure on the workforce, and contribute to service improvements and efficiencies.

4.2 Integration with healthcare and wider services

Although health is the main focus of the Health and Social Care Bill (Her Majesty's Government, 2011), the direct impact on and opportunities for social care could be extensive through a range of structural and organisational changes.

Several provisions offer potential to develop integration between the two sectors, including:

- **Public health** – Part 1 of the Bill underpins the creation of a new public health service, Public Health England, to be located within the Department of Health. It transfers local health improvement functions from PCTs to local authorities. Directors of Public Health will be appointed by local authorities acting jointly with the Secretary of State.

- **Economic regulation** – Part 3 proposes expansion of the role of Monitor (currently known formally as the 'Independent Regulator of NHS Foundation Trusts) with responsibility for promoting integrated care.

- **Patient involvement and local authorities** – Part 5 includes measures intended to increase local democratic legitimacy in health and social care. It would give local authorities the function of coordinating the commissioning of local NHS services, social care and health improvement. Other measures in the Bill include, for example:

    - Establish HealthWatch England as a statutory committee within the Care Quality Commission. In particular, HealthWatch England will 'champion' the interests of people who use services across health and social care and create a network of local HealthWatch organisations in each local authority.

    - Introduce a statutory duty for all upper-tier local authorities to create a health and well-being board, and develop a new joint health and well-being strategy. It also sets out their role in preparing the joint strategic needs assessment and in promoting integrated working between the NHS, public health and social care.

Although there are attendant risks with any major programme of change, the development of new arrangements such as health and well-being boards and commissioning consortia offer some opportunities to further develop integration of care services and the workforce.

The Government has made clear its commitment to the integration of healthcare and social care in its proposals for reform, arguably even more important in the context of the intense financial and demographic challenges facing social care and health.

In 2010, The King's Fund held two seminars that brought together senior policy experts and NHS and social care leaders to discuss the barriers and aids to integration at national and local levels, and the financial challenges facing all services (The King's Fund, 2011a). The proceedings of the seminars suggest that

the success of social care and health integration will depend on a number of factors, including

- the scale and pace of change, which in some places could undermine local achievements in bringing services closer together
- the extent to which GP consortia are committed to partnership working and can be supported in their new roles
- the ability of health and well-being boards to promote integration
- how far financial pressures will help or hinder shared planning and use of resources
- the unknown impact of extension of choice and competition
- whether three separate outcomes frameworks for the NHS, adult social care and public health will offer sufficient incentives for aligning services around the needs of people rather than organisations.

There is some evidence of effective integrated working at the front line, but the strategic approach to integration can be hampered by factors such as organisational turbulence and rapid turnover of leaders (King's Fund, 2011b).

4.3 Improving the status of social care

There is acknowledgement across the sector that the profile of social care should be raised. Public perceptions of the system, and also of people using services and their carers, have been marred by high-profile media coverage focusing on extreme cases of neglect and service shortfalls.

In response, reviews have been undertaken outlining areas for improvement, most notably the review by Platt, commissioned by the Secretary of State, *The status of social care – a review 2007* (Platt, 2007). As the system continues to undergo structural change, there is a unique opportunity for greater systemic and behavioural transformation.

In its *Vision for Adult Social Care* (Department of Health, 2010a), the Government set out plans for system reform, as discussed in part one. One of the key changes outlined is the devolution of decision making and leadership in adult social care from the state to the community and individuals. This shift in power may facilitate improvements in quality and productivity by enabling resources to be targeted where they are really needed, creating a more diverse market to meet local demand and stimulating innovation. In addition, the Government's commitment to the personalisation of the service through the provision of personal budgets will empower people using services to choose and control their own care arrangements on an individual basis. Both of these moves will necessitate operational and cultural change among employers, staff and people using services. It is particularly important for people who use services to have access to information on the implications of the changes and their choices. This

will serve not only to raise awareness among the public of the range and availability of social care services, but also to manage expectations.

Strong local leadership in line with the changes under the Government's vision may also help to improve the recognition of social care workers, particularly with regard to their terms and conditions. The low levels of pay associated with care work can make it difficult to recruit and retain staff with sufficient skills to deliver high-quality care. In addition to focused leadership, the introduction of basic training at all levels, coupled with clearer career pathways, could help to improve job satisfaction and standards of care. The increasing volume of unregulated care work, however, makes it difficult to track and monitor staff working in social care. The lack of workforce data also limits the strength of any recommendations in this area. Currently, social workers and social worker students are legally required to register with the General Social Care Council, but this requirement does not apply to social care workers. The proposed requirements for individual assured voluntary registration, as set out in *Enabling Excellence* (Department of Health, 2011d), along with more effective use of information technology, would enable greater tracking and monitoring of both care workers and could potentially help to improve the provision of safe care and outcomes for people.

The Comprehensive Spending Review (Her Majesty's Treasury, 2010), as discussed in part 1, provides an additional £2 billion to social care to support the transformation of social care. System reform through

- targeted funding
- the localisation and personalisation of care
- strong leadership
- staff development
- service integration

has the potential to improve the status of social care and raise standards, which will be of enormous benefit to people using services and the workforce.

Work by the Department for Business, Innovation and Skills and the Department of Health reviews the whole social care sector and is beneficial in having wide scope that includes unregulated care, including personal assistants and carers, as well as including a remit on people who pay for their own care. The value of social care, and the workforce in particular, to economies, either at a national or local level, has remained unexplored. Councils, for example, have no clear means of quantifying the economic benefits for local economies arising from market shaping and workforce commissioning. Similarly, providers need to ask what benefits services bring to local economies and whether these benefits can be realised during commissioning and for the purposes of local economic plans. Could, for example, people who find themselves out of work – especially younger people who may lack work experience – begin to see social care as a positive

choice and an important stepping stone in building their careers. Further work in this area is warranted.

5. SUMMARY

The social care and health system is currently facing a period of unprecedented change. This in itself presents both risks and opportunities as new structures and ways of working emerge. Social care faces increasing levels of demand, which need to be met at a time of reduced levels of public funding overall. This impacts on the capacity for training and development within the sector, which itself has an ageing workforce with high turnover rates.

Building the capacity of third sector groups and organisations to provide support provides one means of meeting the growing need for social care. There will also be closer integration of services. The continuing trend to offer personal budgets will enable people to design and purchase services according to their own needs and preferences. The impact of personalisation on the social care sector, and its workforce in particular, warrants further research. The new worker roles emerging present an opportunity for skill mix changes and staff development. Greater professionalism within the service, along with strong leadership, may also help to bring about improvements in service delivery and standards of care, with workers earning greater respect and positively influencing their own working conditions.

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ACKNOWLEDGEMENTS

We are grateful to representatives from the following organisations who have met with us to discuss the issues contained in this report and commented on an earlier version of this report:

Ceretas

Coventry City Council

Department of Health

English Community Care Association

General Social Care Council

Greenwich Council

Local Government Association

NAAPS (Shared Lives)

Registered Nursing Homes Association

Skills for Care

Social Care Institute for Excellence

National Care Forum

Some of the material presented in this report draws on joint briefing prepared by the CfWI and our partners including Skills for Care and the Institute for Public Care. Part two in particular draws on the National Minimum Data Set for Social Care (NMDS-SC) as reported by Skills for Care in *The State of the Adult Social Care Workforce in England, 2010*.

Responsibility for this report rests with the CfWI.

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