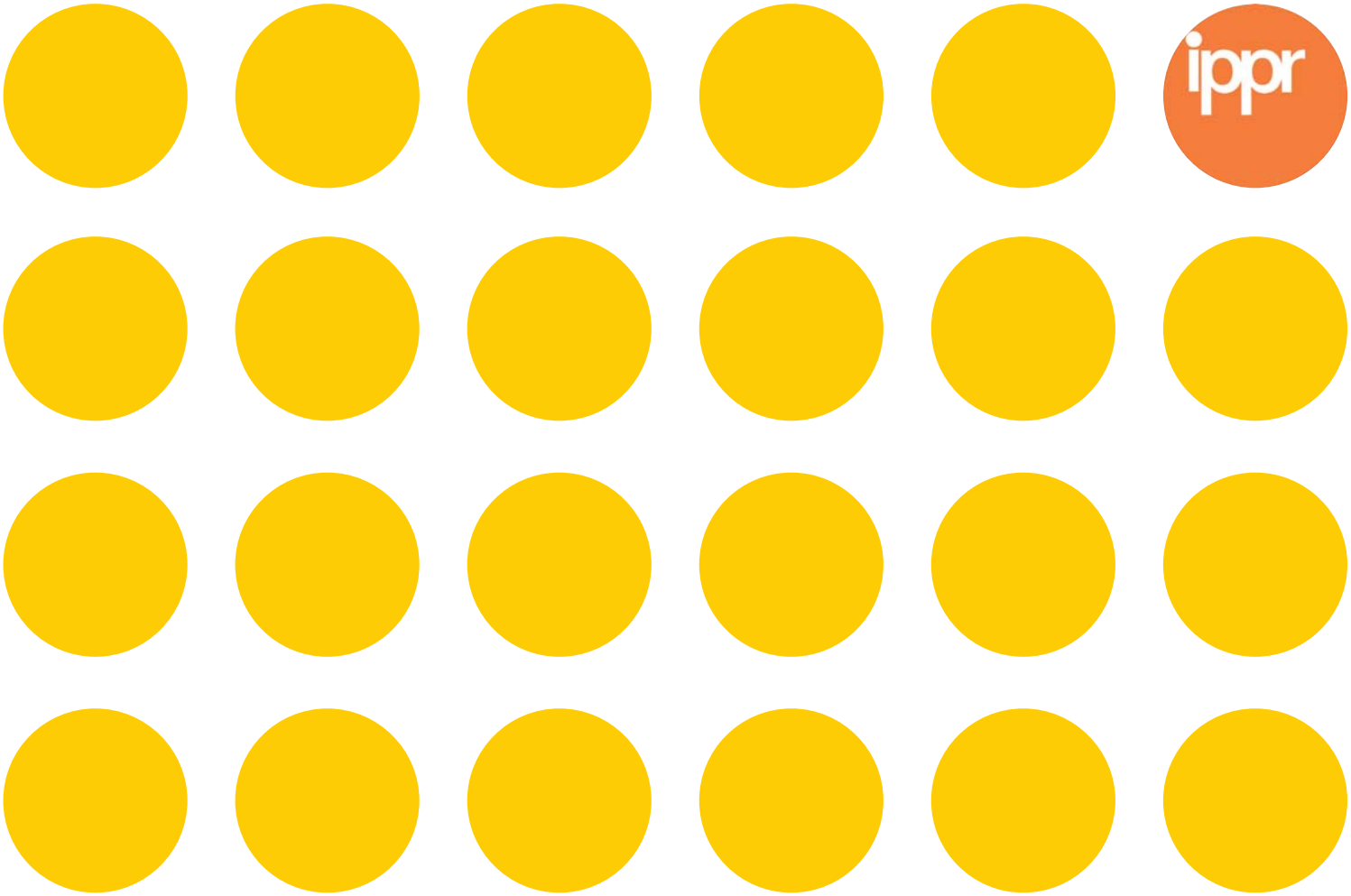
Who Cares?

Building the Social Care Workforce

Deborah Roche and **Jennifer Rankin**



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Introduction

Well over one and a half million people are in paid social care work in England. Despite this, relatively few people know what social care workers do and fewer still understand the important contribution they make to society. For many years personal social services were regarded as peripheral to the real economy and languished low down in the hierarchy of the welfare state (Camilleri and Jones 2001).

Yet social care has long been a pioneer of public service reform. Personalisation, choice, user empowerment and user involvement were aspirations for social care services many years before the current Government 'discovered' these tenets of public service reform. The fact that social care *does* operate at the boundaries of the welfare state, where state entitlements shade into charges and fees, might contribute to the extent to which its innovations have largely gone unnoticed. The public perception of social care is that it is not skilled, not well paid and not for them (COI 2001).

It is significant that social work has never had the same prestige as other male dominated professions (Trevillion and Beresford 1996). Difficulties are compounded by a hostile media and low public confidence in carers and particular professions such as social workers. One survey showed that 68 per cent of social workers thought that the image of their profession in the public eye would discourage people from joining (Audit Commission 2002). In comparison to other public sector workers, for example doctors and nurses in the National Health Service (NHS), social care workers face a highly critical press. In some tabloid newspapers negative coverage outnumbers positive by thirty eight to one (Eborall and Garmeson 2001). Social workers have an especially negative public image, and their portrayal divides into the stereotype of the authoritarian figure who splits up families versus the wimp who is both incompetent and ineffectual.

This perception, along with changes in population health and living arrangements, rising life expectancy and the number of people living with complex needs have created challenges in developing an adequately trained and supplied social care workforce. A workforce equipped to deliver effective and efficient social services in a timely and appropriate manner.

By the late 1990's there was a real need to address this widening gap between public expectations, and supply and demand for social care services. The current Government embarked on a major modernisation agenda aimed at professionalising social care and improving its public perception. This reform strategy commenced with the publication of *Modernising Social Services* (Department of Health 1998), which promised to raise standards across the workforce and to create opportunities for training and career progression. It also called for a more confident and flexible workforce continually engaged in updating knowledge and skills.

As part of this process, a raft of new bodies, systems and lines of accountability have been introduced. These are responsible for professionalising the workforce and promoting social care skills, services and knowledge in the wider community. The Training Organisation for Personal Social Services (Topss) and the Social Care Institute for Excellence (SCIE) were established to promote a skilled workforce, educated using evidence-based practice where possible. A new regulatory regime was introduced which, in line with similar moves in the health sector, split responsibility for regulating the workforce and services. The General Social Care Council (GSCC) was charged with regulating the workforce and the short-lived National Care Standards Commission (NCSC), later replaced by the Commission for Social Care Inspection (CSCI), were designated responsibility for service regulation[1].

1 Social care policy is fully devolved to each of the four nations of the United Kingdom (UK), England, Scotland, Wales and Northern Ireland. Thus, these different countries may have different training and regulatory bodies. SCIE's remit

Following this, children's services were reformed. The Green Paper *Every Child Matters* (DfES 2003), presented a new vision for improving children's welfare in England. A number of new programmes, such as Sure Start and Connexions, have been created and there is a drive to develop a specialised children's workforce. The reform of children's services has raised many questions about the future direction of adult services. Adult social care services are also subject to increasing integration with other public services, especially health. Care trusts, integrated health and social care services that share budgets and management, have been the most visible manifestation of this integration. In addition, joint education and working with the health and education sectors is set to increase. These changes have promoted some unease in the social care sector, that its distinctive contribution may become increasingly overshadowed by health and education. Ironically, just as social care has achieved the apparatus of a profession, its boundaries are becoming more blurred.

It is within this context that ippr held a series of policy seminars in 2004 to examine the impact of recent changes and the challenges in professionalising, training and supplying a social care workforce able to meet current and forthcoming demand and expectations. Drawing on discussions from these seminars and current literature, this report examines how we can build the social care workforce and makes recommendations for achieving this.

In order to build an adequately trained and supplied social care workforce, it is necessary to identify the nature and breadth of social care. Spanning both the NHS and local authority social service departments as well as private and voluntary sector agencies, social care services are as diverse as the clients they support. Social care workers provide support for one and a half million people every day, including young children and families, vulnerable adults such as people with mental health problems or substance misuse, and older people.

Defining exactly what social care *is* continues to vex practitioners and policymakers alike. Increasingly, the clever answer is to say that social care is what social care workers do. The social care workforce is an amorphous one, which pulls both health and education professionals into its orbit. It is a term that generates neither recognition among the general public, nor affection among staff. Just as people choose to become teachers, rather than choose to work in the education sector, so people in the social care sector choose to work in a particular role rather than make a conscious choice to enter the sector. In particular, social work has its own distinctive practice and traditions. Thus, the lack of a 'brand identity' is not problematic itself.

However, the idea of a social care sector does have value once people are employed in the sector. Social care professionals share common values, whether they are a domiciliary care worker or social worker. These are centred on achieving social inclusion and better life opportunities for vulnerable people. While the idea of the typical social care worker is an artificial construct, it is one that can be utilised to deliver these values in practice, create further opportunities for people who work in social care, and provide better outcomes for people who use social services.

This diversity in the social care sector means it has a unique ability to wrap around other services and provide a flexible response to individual needs (Cozens 2004). Social care operates at the boundaries between the state, market and family (Daly and Lewis 2000). Frequently, social care workers find themselves caught between the Government and their clients. As this autobiographical account testifies 'social work is situated in the middle, pulled between the

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covers the whole of the UK. The Topss UK partnership has four different organisations, one for each of the devolved countries: Topss England, the Care Council for Wales, Northern Ireland Social Care Council, and the Scottish Social Services Council. The GSCC and CSCI are responsible for England. While this paper focuses on workforce issues in England, its findings may also be relevant to the other devolved countries.

individual and society, the powerful and the excluded' (Cree 2003). Thus, the workforce acts as a mediator between the state and vulnerable individuals, and needs to bridge the discord in public policy. For example *Every Child Matters* which emphasises happy children must be reconciled with Government policy on anti-social behaviour, which emphasises controlling deviance.

Despite, or perhaps because of, social care's range of roles, social care workers and commentators are divided as to whether or not it is headed in the right direction. Many consider that social care has developed the attributes of a real professio after many years when right-wing politicians questioned its existence (Colton 2002). Social care values have been rejuvenated in new settings and there is a promise of universalising them through the development of codes of practice and registering the workforce. Those who are directly involved in the Government's professionalisation project for social care are optimistic: 'So far, so good' (Eborall 2003).

On the other hand, there remains anxiety about whether enough is being done to counteract long-standing problems. In 2001, the King's Fund concluded that mounting pressures and workforce shortages signalled a developing crisis in care (Henwood 2001). Many consider that long-standing recruitment and retention problems are unresolved with capacity and workforce issues being the biggest threat to improvement and meeting service delivery requirements (Social Services Inspectorate 2003).

In addition to these broader concerns, many social workers have specific anxieties about the future of their profession. Some are nervous about seeing their profession subsumed into a wider social care profession and have expressed the view that the new managerialism is undermining traditional social work values (Jordan and Jordan 2000). The emergence of a plethora of Government services practicing social work under a different name, such as Sure Start and Connexions, is a trend that has caused unease to some within the profession.

Social care has been one of the fastest growing sectors of the economy in modern times and constitutes 15 per cent of the public sector workforce (DH 1998). As such, social care providers face ongoing challenges of recruitment and retention, heightened due to competition between statutory, private and voluntary care workers, as well as education and the National Health Service (NHS). Crucially, these challenges will be played out against a backdrop of a decline in the normal rate of growth of the personal social services following the outcome of the 2004 Spending Review, and rising demand for care. The evidence suggests demand and expectations will continue to grow, and as such will put greater demands on the social care labour market. One certainty about the future social care workforce is that it will need to successfully innovate and meet changes in the way that services are delivered, and maintain public trust while operating under some constraints.

1 Setting the scene

This section will consider the challenges that the social care workforce needs to meet in the years ahead.

Demographics and demand

Changes in demographics and demand for social care are affected by three interwoven trends: population ageing, ageing of the social care workforce, and shifting expectations of care. Thus, making predictions about future demand for services is a risky business, but one which needs to be addressed. It is expected that 40 per cent of the population will be aged over 50 years by 2020; and the proportion aged 60 years or over is projected to increase from around 20 per cent to around 30 per cent by 2030 (www.ifs.org.uk/cera). Given that many of these might live with chronic diseases and have a variety of care needs, it is reasonable to expect this will increase demand for social care workers.

However, due to data inadequacy it is necessary to be cautious about the more catastrophic claims sometimes made about the consequences of an ageing population. For instance, greater longevity will not necessarily mean greater demand for healthcare. Research from ippr has highlighted the compression thesis, which states that proximity to death is more important than longevity in explaining the demand for healthcare (Brooks et al. 2002). Yet, while it is likely that some observers may have overestimated the impact of an ageing population on health care services, the impact on social care services may have been underestimated. The Wanless report (Wanless 2002) predicts that demand for social care services will have increased from £6.4 billion to £10–11billion by 2022–3 (figures at 2002 prices). It argues that an ageing population will have a greater impact on social care services than on the health service.

The social care labour force is also an ageing force. A falling proportion of 16- to 24-year-olds now enter social care, and over the long run, the supply of informal carers has decreased as women have entered the labour market (Eborall 2003, Orme 2001a). However, this trend is not unique to social care, rather it reflects the rest of the public sector workforce. The Audit Commission has identified a 'demographic time bomb' across the public sector workforce, where twenty seven per cent of staff are over fifty years of age (Audit Commission 2002).

Who are the social care workforce?

- There is a core workforce in England of 929,000 (Eborall 2003). Adding in care workers in early years and the NHS, according to the Government, brings the total to 1.4 million (www.gscc.org.uk).
- Fifty per cent of the workforce work part time.
- There are 76,000 Social workers.
- Eighty per cent of care workers in England have no qualification for their work (EOC 2004a)
- Given a narrow definition, including healthcare assistants and occupational. therapists, there are 51,600 social care workers in the NHS. According to a broader definition, including all 'other support staff', for example support workers, there are 250,000 (Eborall 2003).
- Eighty-four per cent of the social care workforce is female (Simon et al. 2003).
- Ninety-eight per centof the child care workforce is female (EOC 2004a).
- Twenty-five of social care workers also care for a member of their own family (Balloch et al. 1999).

It is likely that the social care workforce will have to continue to meet rising expectations about what social care can do. There is some evidence to suggest that as social care services become better at identifying need, the demands on services will increase. For instance, some people have taken up direct payments, after years of not using community care services because of the constraints it put on their lives (Stainton 2002).

Furthermore, people have rising expectations about how their care will be delivered. For this generation, social care is expanding as an enabling force and people want social care services to enable them to live full socially integrated lives, rather than provide a standardised service. Almost three quarters (73 per cent) of people surveyed endorsed the concept of direct payments, when they stated that they preferred to receive money to choose their own services rather than to let the local council decide on what provision they should receive (CSCI 2004). But only 9600 people received direct payments in 2004, so the main challenge is still to come. People want to be treated as individuals, with services ready to respond to the full complexity of their need, and evidence suggests that while the current generation of old people prefer to be cared for by relatives, the older generation of tomorrow will demand more formal care (Brooks et al. 2002). If this holds, there will, in turn, be a further increase in demand for social care services.

The parameters set by the 2004 Spending Review put further constraints on social care. After 2006 the average real rate of growth in the personal social services budget will fall to 1.3 per cent a year (for 2006–7 and 2007–8), slower than the overall economy. In order to meet the constraints imposed by this spending review, it is likely there may be no development of new services and possible cuts to existing services. This could have a negative impact on social services delivery, and by extension the NHS. It is a striking fact that no Government in the last twenty years has succeeded in holding down growth in spending on the personal social services below the underlying rate of growth in the economy (Robinson 2004). On the ground the workforce will have to respond to growing demands for more personalised care in the face of tight financial constraints.

Juxtaposed with this rising demand for social care and concurrent spending constraints, is the falling supply of social care workers. Without consistent increases in the workforce, it is claimed that social care services will be caught between the demographic scissors of increasing demand for social care and a decreasing supply of care workers (Daly and Lewis 2000, Henwood 2001). In 2000, the Social Services Inspectorate and the Audit Commission suggested that the workforce needed to grow by three per cent every year. Arguably, demographic and demand challenges can only be overcome by making better use of the existing workforce, and by drawing in sections of population who are not currently involved in social care.

Recruitment and retention

Recruiting and retaining staff in social care is a difficult and complex challenge. Social care is so diverse that managers compete with, and need to retain staff from, other parts of social care as well as from other sectors such as health, education and retail. It has been argued in many places that social care is experiencing a crisis in recruitment and retention. Anecdotally, the tight labour market is believed to have an adverse effect on the supply of social care workers. In the main, recruitment and retention problems are local issues, shaped by the local social and labour markets. However, in the absence of long term recruitment and retention data that covers the whole sector (public, private and voluntary) it is difficult to draw any definitive conclusions.

The following figures (based on the most current statistics available at time of writing) present a snapshot of these issues.

Statutory Sector

- The average gross vacancy rate increased from 8.4 per cent in 2002 to 10.7 per cent in 2003.
- In local authorities vacancy rates were highest for occupational therapy posts (18.7 per cent, down from 20 per cent) and residential home workers 12.5 per cent up from 10.7 per cent.
- Average annual turnover fell from 14.1 per cent in 2002 to 13.2 per cent in 2003.

Regional Variation

- For occupational therapists there was a 32.9 per cent vacancy rate in London, compared to 4.5 per cent in the Eastern region in 2003.
- London consistently experiences more severe recruitment and retention problems than the English average.
- Yorkshire and Humberside had fewer problems than the national average.

Occupational variation

- There are lower vacancy rates for home care staff than for occupational therapists.

Sector based variation

- Children's services have higher vacancy rates than adult services, for example, there was a 12.5 per cent vacancy rate for residential care staff in children's homes, compared to 9.2 per cent among staff in elderly people's residential homes in 2003.

Source: Social Care and Health Workforce Group (2004) *Social Services Workforce Survey 2003*: Employers Association for Local Government

Independent Sector

- The vacancy rate for 2001 was 6.9 per cent and the annual turnover rate was 21.8 per cent for private sector employees.
- In the West Midlands in 2001, vacancy rates for home care managers were 11.1 per cent, compared to the North West with 2.5 per cent.

Turnover

- Average turnover among home care workers stood at 35.8 per cent in 2001 and for home care managers at 22.9 per cent.
- London homecare workers had the highest turnover in 2001 at 50 per cent.

Source: Social Care and Workforce Group (2002*) Independent Sector and Care Home Survey 2001*: Employers Association for Local Government.

This data shows the extent to which the statutory and independent sectors have difficulty recruiting staff with significant sectoral, regional and occupational disparities.

In the voluntary sector, recruitment and retention problems are considered to be a significant problem. In a survey of 65,000 workers, average annual turnover was 22 per cent in 2004 (Social Care Employers Consortium 2004). However, there is no comparable data for previous years. Eighty one per cent of recruiters in Local Authorities reported difficulties in recruiting staff (Social Care and Health Workforce Group 2003), with their residential homes having an average vacancy rate of 6.9 per cent.

A variety of reasons have been offered as to why this is the case. A lack of suitably qualified applicants and unattractive pay were the most commonly cited reasons for difficulties in recruiting and retaining social workers. For home care staff, the most common reasons were pay levels, competition from the wider economy and the nature of the work (Social Care and Health Workforce Group 2003). Many voluntary sector operators considered pay and a lack of recognition as key workers for housing and other benefits, as barriers to recruitment.

The social care workforce has about an average participation of non-white workers with 7.5 per cent from non white ethnic minorities, compared to 8 per cent of the overall population. There is an obvious gender imbalance with at least 80 per cent of the workforce being female, up to 96 per cent in some parts (Eborall 2003). It is also a gender segregated workforce with more men than women in managerial positions (Orme 2001a).

However, gender discrimination is rarely direct and is not a straightforward causal relationship. Rather, it flows from the fact that women, due to parenthood and other caring responsibilities, are also more likely to work part time and to follow a more fragmented employment pattern. Frequently, management arrangements often prove to be incompatible with domestic responsibilities. In recent years, the issues of paternity leave and fathers' rights have opened up important questions about how we divide our caring responsibilities in the home. Yet on the whole, the majority of formal and informal care responsibilities continue to be undertaken by women (Orme 2001a, Camilleri and Jones 2001). This has important repercussions for how staff may be retained within the social care sector.

Mainstreaming equalities within the workforce falls under part of a broader agenda of improving the lived experience of work. The nature of the work means that social care will always be challenging. However, recent developments mean that social care workers are under more pressure than ever. Users need more responsive services, policymakers demand more integrated services. Often, it is the lowest paid staff who feel the least valued, for example home care workers (Kett 2000). Stress is widely recognised by Social Service Departments as a leading cause of absenteeism. However, in the view of one expert it remains something that is often ignored (Morris 2003).

Complaints about working days overloaded with paperwork have long been made by social care workers at all levels (Balloch et al. 1999). Government evidence shows that children's social workers can spend less than 30 per cent of their time with children and their families, and that some administrative tasks would be better done by others (DfES 2003). In response to these findings, the Children's Workforce Unit is conducting a workforce survey to determine how paper work can be cut, and how to make better use of information and communications technologies (ICT).

Historically, social care workers have received low wages. Care workers, paid an average £5 an hour in the independent sector could, in affluent areas, earn more than twice as much working behind a bar (EOC 2004a). Since 1992, local government workers have seen their gross pay decline against both average pay and private sector pay (Thornley 2003). These low wages may have contributed to difficulties in recruiting and retaining staff.

The Social Services Inspectorate has estimated that an extra 50,000 people are needed to meet new Local Authority requirements, and to reduce vacancy rates from 11 to 5 per cent (Social Services Inspectorate 2003). In the mean time agency staff help fill the gap. Eighty two per cent of respondent Social Services Departments used agency staff, primarily for filling children's social worker and home care positions. In London, two-thirds of agency staff were employed by these departments (Social Care and Health Workforce Group 2003). Various measures to address recruitment and retention problems, including advertising on the internet and in the press, and joint recruitment with the NHS have also been employed.

Education and Training

Traditionally, the social care workforce was known for its low skill base and lack of training opportunities. At the time of writing, there were no up to date statistics available in the public domain to show how many people in the social care workforce were trained and qualified. As such, it is difficult to determine progress since 1998. There are positive signs emerging, for example greater numbers of disabled people are entering education and training programmes than ever before. Despite this, currently there is a lack of evidence on the overall impact of the training strategy, or whether, as was feared by some, the training strategy alienates sections of the workforce who don't recognise the need for training or have a long term commitment to a career.

When the current Government came into office, less than one in five people in this workforce had a relevant qualification. However, when considering this, there is a need to make the distinction between using education and training to develop and further a career, and for the opportunity to gain new skills. Older workers may be less interested in the notion of a career, but this doesn't mean they don't want to learn new skills or take on new responsibilities (Eborall 2003). In response, the Government promised to deliver a 'better trained, more confident and flexible workforce' (Department of Health 1998). The intention to meet this commitment has resulted in the development of new education and training schemes and new bodies.

Most of the new awards in social care have been developed around parts of the workforce that are already skilled, for example the new social work degree. Previously, social work had a body to regulate education and training – the Central Council for Education and Training in Social Work (CCETSW) – although it did not regulate the workforce or have a remit to raise standards. However, this was widely regarded as an ineffective advocate for the profession and criticised for failing to preserve social work values (Lyons 1999). A three year degree in social work rolled out in September 2003, and is regulated by the GSCC. While it is accepted that this new degree will bring social work into line with other professions, it is recognised that in itself it is no guarantee of status.

There are also new requirements for staff at the less experienced end of the skills ladder. Recent Government policy has aimed to help low-skilled individuals get a Level 2 qualification which is judged to be the necessary minimum for successful labour market experience (Dearden et al. 2004). As such, the Department of Health has set a requirement that 50 per cent of residential staff should attain this level by 2005. Following this, enrolments in the Care NVQ Levels 2, 3 and 4 have increased since 1999. Presently, there are no statistics on the total number of staff in social care with NVQs. However, staff who work in the statutory sector are more likely to have a qualification (Eborall 2003).

Gaining an NVQ in the health and social care sector has been an opportunity to learn new skills, as well as to certify existing skills, and is regarded as a chance to better career prospects (Dearden et al. 2004). Interestingly, women in the social care sector who have a level 2 NVQ qualification experience a positive wage premium, whereas men get a negative premium. (The latter experience fits with the impact of level 2 NVQs across all other economic sectors) (Dearden et al. 2004). So, although, training pays for women, there needs to be further investigation into how it can pay for men as well. In addition, it needs to be ensured that staff in the non-statutory sector have the same opportunities to take up training through adequate financial support.

Topss England developed the first National Training Strategy for Social Care in England in 2000, which set out the major skills gaps and shortages in social care. In 2004 Topss became the

sector skills council[2] for social care. Sector skills councils are charged with promoting skills, and reducing skills gaps and shortages.

To address knowledge and skills for new starters, Topss have set out induction standards that new employees must be trained in during their first few weeks in post. Following this are Topss foundation standards that must be completed within the first six months of employment, addressing issues around communicating with service users, physical contact and record keeping. Other new developments include a greater role for service users in developing training courses. In addition, The National Occupational Standards (NOS) set out the skills and knowledge that make up best practice for social care.

In 2002, on average, local authorities spent the equivalent of two per cent of their pay roll costs on training (Social Care and Health Workforce Group 2003). There is a perception that the cost of training has risen since the introduction of the Care Standards Act 2000. Many small voluntary providers cite this as a particular problem (Social Care Employers Consortium 2004). There is evidence to suggest that there were modest increases in training activity in numbers of students studying for the Diploma in Social Work before it was replaced by the social work degree (Eborall 2003).

In the future employers will be expected to become more active commissioners of training and awards. Topss have acknowledged that they will need to consider how to offer and implement knowledge and support for providers. In particular those who operate on a small scale as smaller providers, with less than twenty staff, are significantly more likely to rely on unqualified workers (Eborall 2003).

Developments in the children's workforce strategy broadly reflect overall trends. There is an increasing emphasis on developing a skilled workforce that is flexible and attractive to would be employees and that sets common occupational standards. A new post-qualifying award for social workers working with children has been created.

These changes hallmark the development of the social care profession through more established education and training routes. However, it is too early to judge how far the Government's professionalisation project still has to go.

Regulating the social care workforce

Recent regulatory policy has been characterised by greater awareness as to what regulation is for and how it works. Regulatory regimes now include inspection from national bodies alongside professional self-regulation. Registration of the workforce is now required and there is an explicit emphasis on using regulation to drive up standards and improve quality of care, as well as the more traditional role of regulation in protecting service users and staff.

Alongside these developments has been a more widespread introduction of title protection, as in the health sector. Title protection, in this case for social work, aims to offer the public a guarantee on what they can expect from these professions.

Set up in 2001, the GSCC was entrusted as the guardian of standards in social care in England. It was assigned the task of building a register of all social care workers specified by Government, with the eventual goal of registering all workers in social care sector. In order to register, social care workers need to meet requirements about their good character, health and training. Given that there are over one million workers, working at varying levels and in diverse roles, this is a formidable task. In 2003, the GSCC set about registering the social care workforce, beginning with the most visible group, social workers. The next groups of the

2 Sector Skills Councils are UK organisations. The sector skills council for social care is led by the Topss UK Partnership.

workforce to be registered and the requirements they will need to meet in order to register are yet to be set.

In 2002, the GSCC developed the first ever codes of practice for social care workers**.** Signing up to these codes is a key requirement for registration and means that every individual worker agrees to be accountable for maintaining high standards of conduct and care. Workers have a duty to point out when their employers break these codes. The codes state that workers must 'bring to the attention of your employer or the appropriate authority, resource or operational difficulties that might get in the way of the delivery of safe care', or where 'the practice of colleagues may be unsafe or adversely affect standards of care' (GSCC 2002). They reveal the distinctiveness of the social care regulation system, in that it seeks to instil values, as well as to count qualifications. The codes are relatively unique in comparison to other sectors, as the rights and responsibilities of workers are mirrored by a matching code for employers. At the time of writing, 1.5 million copies have been distributed to the sector. Given their short time in operation it is too early to establish their full impact, but this level of individual regulation should have a powerful impact in guaranteeing standards in social care. Across the workforce people believe regulation will be a force for good (Winchester 2004). In a survey conducted with 47,000 care workers and employers, 96 per cent rated the codes as good-excellent (GSCC 2004). However, while many social care workers have heard of the GSCC, relatively few are aware exactly what it does and more needs to be done to embed the codes in everyday practice.

Service regulation was first assigned to the National Care Standards Council, established in 2002. However, this body had a short life and was quickly swallowed up by structural reform. The function of regulating services was passed on to the Commission for Social Care Inspection (CSCI), which came on-stream in April 2004. CSCI are responsible for deciding how providers in different care settings will meet the national minimum standards set out by the Care Standards Act. To compliment these measures, new lines of accountability have been developed within local social service departments. These include annual reports to councillors and agreed measures across councils to deal with poor quality staff (DH 2000).

Given this raft of changes, and the short time-frame they have been in operation, it is difficult to establish the extent to which they have been successful in ensuring a safe and appropriate social care workforce, and helping regain public trust. Only in time will we establish an evidence-base that supports or questions these measures.

The integrated care landscape

Social care workers need to navigate their way through a changing and complex landscape of care. Care is managed between social care, the NHS and housing departments and social care services are now being delivered in new settings (Kendall and Lissauer 2003). The social care workforce is expected to take on new roles and work with a variety of professionals across a wide range of agencies. For example, social care staff are taking on the roles of community nurses (Henwood 2001). Integration has implications for professional education, competence, career paths, authority and autonomy of practice.

For workers in the social care sector, the issue of integration has opened up the risk that the unique perspective of social care will be lost. In recent years, social care professionals have feared the prospect of a takeover by the NHS, as Care Trusts, or education departments in the guise of Children's Trusts. Undeniably, these partnerships fragment the traditional local authority social services departments. Furthermore, there is a perception among the workforce and its representatives that integration has been all one way, and some complain that hospitals do not have to make the same efforts and meet them half-way.

The workforce also faces the added challenge of making partnership working a reality. The Health Act 1999 established the legal framework for health and social care partnerships. This

was followed by the development of some 'real' partnerships in the form of Care Trusts. The Green Paper paved the way for 'virtual partnerships' in some forms of Children's Trusts. Whatever form the partnership takes staff have to invest time and resources in making them work. Arguably, cultural change is the most challenging aspect of these partnerships and the biggest unknown for staff. Partnerships might falter without consideration as to what cultural change means in practice (Peck 2001).

However, this is not straightforward. There is some evidence to suggest that social care remains invisible to many health professionals (McLeod 2002). On the one hand, social care's lack of institutional identity may contribute to this. On the other hand, this very fact gives social care the freedom to provide services when and where necessary. To complicate matters further, integration can present particular challenges when different professionals are guarding different aspects of government policy. For example, the objectives of housing and social work professionals have come into collision over anti-social behaviour policy. The Government's policies on anti-social behaviour call on the housing association to take the role of enforcer in evicting tenants, while social workers need to represent the interests of children and families (Young et al. 2004). This may lead to tensions between colleagues who are pulled in different directions as a result of Government, department or professional edicts and expectations.

In this complex care environment, it is unlikely that any one sector will dominate, however, some argue that the health sector does dominate. Social care struggles from being poorly promoted and insufficiently understood among other professions.

2 Meeting the challenges

Recruitment and retention

Recruitment and retention challenges are particularly acute in social care. This is due to two key factors, diversity and competition both from within and beyond the sector. First, the diversity of roles, and freedom to redesign staffing alongside service innovations and job specifications, create multiple entry and exit points for the workforce, and may make it difficult for people to identify career pathways and progression. Second, the nature of the social care market, split between many small providers, creates competition within the social care labour market. Both the health service and education compete with this sector for staff with social care skills. Moreover, staff may exit the sector altogether.

Recruitment and retention may be aided by effective human resource policies. Some councils have developed active human resources policies, for example in 2001 Kent County Council overhauled their processes and implemented a whole-systems approach to recruitment and retention. They offered incentives such as signing-on bonuses and sabbaticals, promoted development of unqualified staff, and developed grow-your-own-social-worker policies. As a result, both vacancy rates and staff turnover declined (Eborall 2003).

Too often job satisfaction is undermined by factors in the working environment. Pay and conditions are undeniably important, but need to be seen in context of other factors, such as a manageable workload, support from managers, and the feeling that they have working conditions to enable staff to make a difference. The Audit Commission (2002) has argued that pay only becomes a retention issue when people are demoralised for other reasons. Topss concluded that 'a high level of inbuilt job satisfaction is one of social care's greatest strengths and differentiates it from other types of work where it is competing for staff' (Eborall 2003). Thus, the lived experience of work plays a key role in contributing to retention of staff.

Job satisfaction in the public sector can be undermined by a variety of different factors including paperwork, lack of autonomy, excessive workloads and lack of resources, a sense of not being valued and the imposition of change agendas without explanation (Audit Commission 2002). All these factors can contribute to the sense among social care workers that they are not making a positive difference to people's lives, thus the key selling point of social care work is diminished. There is some evidence to suggest that within the UK care workforce, levels of stress have been rising while job satisfaction has been declining (Eborall 2003).

Some have predicted that workforces that rely on low-skilled women workers will find it increasingly difficult to attract people into these sectors of the labour market (Moss 2003). This gender inequity at the heart of the social care workforce has negative consequences for men who want to enter caring professions, and for women who want to move ahead in them. In view of the falling supply of labour for low-skilled jobs, the need to offer more skilled work and career paths becomes more pressing. 'Wherever the present standard for any category of job is low-qualified women around the age of 30' (Coomans 2002) there will unmistakably be a strong need to improve the quality of the job so it will be acceptable to people with higher educational attainments.

There is a risk for any profession relying on only half of the potential workforce: 'if, and when, women change their employment patterns who will do this work in the future?' (Moss 2003). Gender-segregated workforces sustain the gender pay gap, subordinate individual choices to outmoded stereotypes and provide barriers to closing vital skill gaps (EOC 2004b, Miller 2004). It would seem that the traditional gender inequity in the social care workforce may be unsustainable.

A related issue is the extent to which gender representation is, and is perceived to be, equitable in the workforce. A report from the Equal Opportunities Commission (2004a) shows that men are deterred from child care due to low pay and status. Care is considered to be a female domain, most suited to older women with families. Caring jobs are not viewed as a career option for younger people or men (COI 2001, EOC 2004b). However, if men do enter the social care workforce, they are more likely to become managers, whereas women are more likely to be in menial 'caring' positions (Camilleri and Jones 2001, Orme 2001a).

Encouraging more men into caring professions is not an easy task, nor is it a panacea for ending occupational inequality, but can be seen as a necessary first step. Arguably, making the profession gender neutral will make the demanding nature of the work more visible (Orme 2001a). It will also help the workforce to become more representative of the people it serves and help redress the future issues of demand and supply. However, this is not unique to the UK, nor is it an easy task. Continual occupational segregation is problematic in many countries. In Scandinavian countries, with the some of the highest rates of female employment in the world, levels of gender segregation are at some of the highest levels (OECD 2002).

Aligned to a sense of job satisfaction is a need to have clear paths to progress along. As the structure of the social care sector is diffuse, cutting across many different settings, these may be hidden, or even absent. For some people this may be a barrier to entry or a reason to leave social care. In research conducted by the Department of Health among the general public, social care was associated with low pay and limited career opportunities. It was commonly perceived as work done by the unskilled for the undesirable. When questioned about social work, the majority were unclear as to whether it constituted a real career (COI 2001). Clearly, the social care workforce needs to have clearer lines of progression, and recruitment practices need to highlight these.

This might prove a tough challenge as the public perception of social care as a career is not favourable. The COI (2001) study also found that social care workers, in particular domiciliary workers with the least skills, were characterised as '"salt of the earth" types', hardworking, but unskilled. There was an expectation that women were naturally suited to this work and most people didn't consider this to be suitable work for them or their families.

Some have raised concerns that new agencies, bolstered by political prestige and funding, for example Sure Start, have taken skilled staff away from existing providers, thereby threatening these services. It is too soon to identify whether or not there is a causal link, however, when designing and implementing such programmes, their potential effect on local labour markets needs to be considered prior to implementation. While indeed, it might not be in the interest of a specific employer to lose staff, when considering the overall workforce, it is better that staff are supported in moving to a new role within social care, or be able to return to their previous position, than be lost to the sector altogether.

Due to variation in education and training, and the diversity of skills required across roles, aligning skills and pay in social care is difficult. It is tempting to look to the NHS for answers. 'Agenda for Change' (Department of Health 2002) offers NHS staff the opportunity (in theory) to climb the skills ladder from porter to doctor. However, the NHS is characterised by a centralised command and control system, and its workforce is largely based in the statutory sector. Furthermore, it is the recipient of sustained resource increases that will have tripled its budget between 1997 and 2010. None of these conditions hold for the social care sector. As such, a social care Agenda for Change is not appropriate. It becomes necessary to examine other ways of resolving this dilemma.

Looking forward: a Wanless report for social care?

With spending on social care as a proportion of national income due to fall, it is timely for the Government to conduct a long term review of spending on adult social care. This Wanless style review would need to undertake a detailed examination of the future demand for social care and its potential effects on the workforce, including the supply of care workers and possibly modelling best and worst case scenarios. As health and social care are inextricably connected, it would need to examine the impact of future demand and supply on this relationship. Social care plays a vital role in helping people live in their own homes, and in helping prevent admissions to primary and secondary care. Arguably, any cuts to social care may impact on the attempt to transform the NHS from a sickness service into a health service. A Wanless style review would bring benefit through providing a clearer understanding of the mutual dependency between health and social care, and the particular funding pressure points.

Alongside these issues, the review needs to analyse recruitment and retention issues, and the thorny question of pay. It could help set out clear benchmarks for how people who work in the caring professions should be rewarded. A related issue is rewards and remuneration within the different sectors of social care. Voluntary sector providers have complained that the current system of commissioning and contracts institutionalises lower wages for staff in the voluntary sector when compared with the statutory sector (SCEC 2004). A national review offers an opportunity to test these claims and ensure competing for contracts does not mean cut-price wages.

However, in the short term it is necessary for more immediate action to design local pay bands and skills ladders. Some local authority social service departments have already begun to develop workforce strategies. Commissioners are ideally placed to develop local pay bands for different skill levels with comparators to related sectors such as education and housing. Thus a skills ladder, without replicating the NHS model, offers a way forward for aligning social care pay and development.

In order to tackle recruitment and retention issues in the children's workforce, the Children's Workforce Unit at the DfES is undertaking a workforce survey and creating a package of measures to tackle these issues. Social care as a whole would benefit from a similar, joined up strategy.

It is evident that achieving the eventual goal of recruiting and retaining a skilled and qualified workforce is not straightforward. There is a need to mobilise skills and resources towards designing attractive remuneration and retention policies and practices in social care. These could include incentives and rewards, as well as clarification and development of career pathways. Such efforts may help meet local, as well as national, staffing needs, identify how staff are best organised within existing and evolving service arrangements and improve their lived experience at work. Through such efforts an adequately trained and supplied social care workforce could be built that is responsive to current and emerging demands. This will have implications for the way in which they are educated, trained and regulated.

Education and Training

The social care workforce is characterised by a diversity of roles and skill requirements. As such, the education and training requirements are as varied as the roles themselves. Thus, education and training needs to address the distinct issues around the training of staff coming into the workforce, and the development of existing staff. It is necessary to consider education and training in the broadest sense as not all education will be driven by the concept of a career.

As such, when considering training, there has been a tendency to consider that education and training need to promote the development of two kinds of workers: 'critical thinkers' and 'fixers' (Preston-Shoot 2004). However, these are not separate components of two different parts of the workforce, but need to be developed throughout the workforce.

All social care workers need to develop skills such as empathy, more interventionist and entrepreneurial skills, as well as the ability to reframe a problem (Rankin and Regan 2004, Smale et al. 2000). Rather than overload health professionals, some workers, for example domiciliary care workers, need to have the opportunity to train to perform care assessments (Kendall and Lissauer 2003). All social care qualifications and training need to be underpinned by the idea that they prepare workers to fulfil both functions as 'thinker' and 'fixer'. Ultimately, social care workers will do many varied jobs but all need support and training to be both critical thinkers and fixers.

Encouragingly, the trend towards a better trained and more professional workforce is welcomed by most providers, although there are concerns that access of support, such as the Training Support Grant is too complex. However, it appears that the social care sector continues to struggle in facilitating further education and training of existing staff. There are examples of good practice, but social care providers of all scales need to be more proactive in promoting knowledge in the workforce. It has been suggested that electronic dissemination of SCIE's findings is not the most effective way to share knowledge or to engage with users, carers and care workers (Eborall 2003). Education and training staff to develop a culture of seeking out new evidence on the efficacy of care interventions would be a useful step forward.

A related issue are the limited arrangements for qualified staff, such as social workers, for retraining on returning to work after a career break. There is no nationally approved course for people returning to work after a career break, in contrast with teaching, nursing and midwifery (Leason 2004). Similarly, many social care workers in employment already have caring responsibilities, for children and older relatives, although the exact numbers are unknown (Simon et al. 2003). The education and training strategy needs to consider the needs of the workforce across the life cycle.

Any education and training strategy will also need to find the right balance between the specialist and the generic. It is too much to expect every social care worker to master knowledge of all the different aspects of social care, let al.one housing and benefits policy and the NHS in this new care landscape. Thus, it is necessary to be realistic about the capacity of social care workers, and indeed any professional, to take on a multiplicity of roles.

Likewise, it is essential to ensure service users are able to understand and steer through the plethora of services and institutions available to them. In past publications, ippr has recommended the creation of a social care navigator (Rankin and Regan 2004). This role would be located in different health and social care environments, according to local need. The navigator would help people with a variety of needs to negotiate their way through the network of public services, for example health, social care, the voluntary sector, and the tax and benefits system. The social care navigator is also a realistic response to the limited time and capacity available for social care workers to master all aspects of the complex integrated care landscape.

Competency development, as represented by the National Occupational Standards, is an integral part of professional status. However, social workers have given the education and training strategy, in merging social work into the broader care workforce, a mixed welcome. Some involved in social work education have criticised the new regulatory and training structures for both lacking coherence and for impinging on professional autonomy (Orme 2001b). These fears may yet be overdrawn. The professionalisation project offers an opportunity

to raise the status of social work and to encourage more people to enter the profession through the development of skills ladders.

Regulation and inspection

It has been widely anticipated that regulation would help put social care on an equal footing with other key public sector professions, such as health and education. In many respects, it is too soon to judge the impact of the new regulation and inspections system. However, it is necessary to understand whether the existing policy direction does facilitate the broadest aspects of regulation, from public protection, to raising the status of the workforce, to being a tool to drive up standards and raise quality.

There is a general consensus that the new regulatory structures need time to mature as organisations if they are to lead on promoting quality through regulation. It would be inopportune to reorganise social care regulation again. Rather, these new bodies need time to develop their role as a champion for high standards, as well as becoming a national voice for the promotion of social care to governments and the public.

The new regulatory regime faces tough challenges. It has to play a part in making good on the new contract between the service and service users and carers. Arguably, politicians have led the public in expectations of a perfectly preventative regime. This perception has been sustained by the Health Select Committee report into elder abuse (House of Commons Health Committee 2004). This influential report draws attention to a topic that for too long has been hidden and ignored by policymakers and practitioners alike. It suggests that up to half a million older people in England are being abused at any one time and calls for national minimum standards in domicilary care to guard against abuse. This report recommends that the Government, through the GSCC, should act to register domiciliary care workers and their managers without further delay. An alternative option would be to make care homes responsible for registering their staff to a minimal level and reporting this to the GSCC. However, in itself, full registration of an entire workforce is no guarantee of public safety.

The Better Regulation Taskforce has argued that the social care sector is too diverse to be subject to a single form of universal regulation. Yet the notion that the GSCC offers a preventative system drives the policy goal of total registration for all social care workers. While all social care workers must be responsible for ensuring high standards (and liable for failure to meet them), given the nature of social care work it is a misplaced goal to aim to set the entry requirements to the register at the same level, that is, to make all registrations subject to formal qualifications. For instance, the principle of proportionality suggests that it is inadvisable to advocate full registration of personal assistants who are hired under the auspices of direct payments. This requirement could impinge on individual choice and freedom to take risks that the policy is designed to promote.

For some components of the social care workforce, such as social workers and child and adult protection workers, it is appropriate for full registration requirements. Indeed, for staff who have successfully completed recognised and validated education and training courses this is helpful from a regulatory standpoint. However, some have suggested that there is an over reliance on qualification as the path to registration in the approach taken with social worker regulation (Henwood 2001). In recognising that a large proportion of the social care workforce do not possess any formal qualifications in the field, and that many of them work part-time, they would be better suited to a form of registration not based around qualifications, unlike the requirements for social workers. For some workers, such as personal assistants hired with direct payments, commissioners and employers may be better placed to conduct a more streamlined registration process, if they have information at their disposal, such as names and addresses, references and a police check, to be passed on to the GSCC for reference. Alternatively, the GSCC could invite these workers to join a register, which notes name and address and provides

social care codes in return. Inclusion on this register may give them some advantages in the personal assistants market.

Not only is such an approach more reflective of different working requirements, it can be seen as fulfilling the Better Regulation Taskforce criteria of targeting and proportionality. Acknowledging that the GSCC is a curative system, designed to set standards and restore abuses rather than prevent all bad practice might set more realistic expectations about its aims and how it should go about achieving them.

The other issue, which the legislation has not fully resolved is whether regulatory structures and systems for social care will be used to set national minimum standards only, or whether it should become a tool to raise standards across the workforce. The answer is that it should be doing both. In the short term, it must attend to getting the basics right, namely, providing safe and appropriate care for all who use social care services. In the long term, the culture of regulation and standards promotion needs to be embedded in the workforce to drive quality improvements and ensure innovative and timely personal services for all. Regulation should be seen as a positive tool for staff development and rights in the workplace.

There are a number of measures which could be employed to help promote regulation as an enabling force to promote quality improvement. It can be used to strengthen an individual worker's position in the workplace, for example by enshrining their rights to training courses. Examples of good practice, as identified by SCIE, could be disseminated more widely. Uptake of these suggestions could be tied to staff's performance review where appropriate.

As with many public services, for many years service users were infrequently consulted by those who regulated and monitored social care services (House of Commons Health Committee 2004). Service users need to be at the heart of regulatory systems, so their experiences can influence future developments. Encouragingly, a report published by the CSCI during its first week demonstrates its commitment to ensuring views of service users are an integral part of their operations (CSCI 2004). Such activities might also help to improve public opinion of the profession.

Given the integrated care market, it is likely the social care workforce will be regulated across different sectors. Workers will derive identity from both their training home and their current employer. This should help promote and embed universal social care values and assist in embedding the codes in everyday practice.

All regulatory regimes are concerned with getting the right balance between liberating an individual's creativity within service delivery and protecting those who use them. Social care is no exception. However, as with any system of regulation, it runs the risk of living up to the impossible promise that regulation can always prevent abuses and bad practice. Regulatory regimes need to take appropriate and balanced action to ensure safety, rather than guarantee the impossibility of a risk-free human system.

The enabling state: towards a new contract with users and carers

New public expectations of care reveal something fundamental about how care will need to be delivered in the twenty first century welfare state. The social care workforce needs to get to grips with a new contract between service users, carers and the state. Early on in the welfare state, receiving care signified second class citizenship and it was expected that people should gratefully accept what the state provided. However, now, and more so in the future, the social care workforce needs to become a powerful force to change this perception and promote the model of the state as an enabling force in people's lives.

In order to become allies of service users and carers, social care workers will need to embrace this new agenda. This means respecting service users' rights to choice and promoting service user involvement in the design of services. Whereas it was once expected that the state would provide, now it must enable people to provide where it cannot. The philosophical starting point is that the role of the state is to enable citizens to achieve equal autonomy.

Involving the public in making decisions about services has been an underlying theme of the current Government, as part of its strategy to make public services more accountable at the local level. The NHS and Community Care Act 1990 made consultation of service users a legislative requirement. More recently, moves to involve service users have deepened beyond consultation towards co-production of services. Increasingly, service users are involved in the design and delivery of services. Evidence suggests that participation increases self confidence and helps users develop skills (Carr 2004).

Involving the public in decision-making is not always a straightforward exercise. Service user involvement has been criticised for being tokenistic (Henwood 2001). Part of the problem is that the systems and structures that support user involvement don't allow for feedback on user participation (Carr 2004). One study found that a third of initiatives were not providing any feedback to the disabled children and young people involved (Franklin and Sloper 2004). Service users have also drawn attention to these issues. Recalling her experience of serving on the board of Somerset Partnerships NHS and Social Care Trust as non executive director, one user doubted at times whether the post had any real influence. Ultimately, she concluded that her role had helped to challenge the dominant medical perspective and the stereotypical view of service users (Brodie 2003). However, sometimes service users can feel their opinions and suggestions are not valued, and this further undermine's their participation in decision-making processes.

Increasingly, service users will become their own commissioners. Direct payments represent one of the first steps towards a rights-based model of care. Yet, so far the uptake of direct payments has been in inverse proportion to the amount of interest that it has generated. Take up remains insubstantial: with just 9,600 people in receipt of direct payments in 2004 (www.dh.gov.uk). In some sectors, such as mental health, direct payments are underused (Social Services Inspectorate 2003). Despite statutory duties, many Local Authorities are reluctant to promote them. Moreover, there is evidence to suggest that lack of awareness among professionals and professional resistance to the concept pose obstacles to further take up (Carr 2004; Stainton 2002). The social care workforce needs to be prepared for an increase in direct payments, extending into new areas such as mental health services (Social Exclusion Unit 2004).

In future, a human rights agenda should also have an impact on setting expectations about what social care is for. It is expected that the Human Rights Act, which came into force in 2000, will, in time, have a large impact on people's right to freedom from abuse and privacy, and to family life. This may also act as another guarantee of good practice when regulating social care.

The future social care worker will need to have the training and the skills to respond to users as co-producers of their own services. This may require support and an active programme of skills development. It will entail developing a better understanding of the objectives of public involvement whether seeking comment on service improvements or deciding new priorities (Roche 2004).

Recommendations

A 'Wanless' review for social care

A systematic review of the challenges and demands facing social care and a better conception of its relationship with the NHS would help to promote an understanding of what social care can achieve and the resources and commitments needed to do so.

Establish an adequately trained and supplied workforce for social care across the spectrum

We recommend the following steps towards achieving this.

Improving the lived experience of work

- Place a statutory duty on Local Authorities to develop a workforce strategy to cover recruitment and retention of staff, and measures to improve the lived experience of work.
- Conduct an annual workforce survey on morale and motivation involving staff from all levels to ensure their input into decision-making about the shape and direction of services (Roche 2004).
- Develop formal structures for uptake of user and public suggestions to ensure they are responsive to local needs (Roche 2004).
- Continue support for eliminating/minimising abuse and violence against staff.

Pay should reflect local need as well as level of skills and training required

- Commissioners should develop a ladder of pay bands for different skill levels taking into account local market factors, such as supply, as well as nationally benchmarking some roles.
- Align financial incentives to promote the best outcomes for users, and for managing local demand, for example when commissioning services.
- When rolling out new programmes, their potential impact on staff movements in the local social care economy need to be considered.

Targeted recruitment schemes within and beyond the social care sector

- Recognise contributions of workforces from public, private and voluntary sectors.
- Design retention incentives desirable to existing staff.

Ensure workforce diversity

- Tackle diversity as part of a wholesale equalities agenda that includes disabled people, gender and race.

Education that encourages responsiveness

- Current and future workforce needs to be prepared and trained to respond to new policy developments, for example, an increase in direct payments.
- Appoint a social care navigator/care manager: training needs to address the balance between specialist and generic.

Rethink individual and organisational registration and regulation

Esure clarity in the goals and processes of regulation

- The Government's long term goal is full registration of the social care workforce, but at present there is not enough clarity as to what the demands of regulation and registration

actually mean in practice. Given the breadth and variety of social care roles there is a need to review the regulatory framework to ensure that it is appropriate for these.

- Such a review should include different forms of regulation which give different duties to employers and will require the active involvement of the Commission for Social Care Inspection (CSCI). The other component of this review will look at different forms of group regulation though the General Social Care Council (GSCC). For some occupational groups, registration through qualification will be inappropriate. For example, it is important not to make regulation of personal assistants hired under the auspices of direct payments too onerous. They should only be regulated through their commissioners and/or employers and be registered in a minimal way to ensure public safety, that is names and addresses; other groups, such as social workers and child and adult protection workers should be regulated individually through the GSCC.
- Given the size of the task to register all social care workers, an agreed priority list needs to be developed. [3]

No re-structuring of regulatory bodies

- There is a general consensus that as some are new they need time to mature as organisations and define their interactions and boundaries with other organisations.

Regulation as a positive tool

- promote regulation as an enabling force for improving standards and driving up quality, not reinforcing boundaries.
- promote regulation as strengthening individual's position within the workplace and wider community, such as schemes for staff development as well as complaints procedures, thereby strengthening accountability while moving away from a culture of blame.

The social care workforce plays a vital role in promoting a more progressive society, and in supporting more opportunities for the most vulnerable people. Yet the personal social services have not shaken off their reputation as a Cinderella service. If the social care workforce can successfully meet current and future demands, respond to users as co-producers of their own services, and promote its role more effectively with the public, we may yet achieve a renewed respect for, and commitment to, the social care workforce.

3 At the time of writing the GSCC is in the process of consulting to define the next groups for registration.

References

- Audit Commission (2002) *Recruitment and Retention: A Public Sector Workforce for the Twenty-First Century*: Audit Commission
- Balloch J, McLean J , Fisher M (1999) *Social Services Working Under Pressure* : Policy Press, Bristol
- Brodie D (2003) 'Partnership Working: A Service User Perspective', in Glasby J, Peck E (2003) *Partnership working in action*: Radcliffe
- Brooks R, Regan S, Robinson P (2002) *A New Contract for Retirement*: ippr
- Camilleri P, Jones P (2001) 'Doing women's work? Men, Masculinity and Caring', in Pease, B Camilleri P (2001) *Working With Men in the Human Services*: Allen and Unwin
- Carr S (2004) *Has Service User Participation Made a Difference to Social Care Services?* : Social Care Institute for Excellence
- Colton M (2002) Editorial in a special issue on social work and social justice, *British Journal of Social Work* 32, 6 2002
- Commission for Social Care Inspection (2004) *What People Want From Social Care Services and Inspections as They Get Older*: Commission for Social Care Inspection
- COI Communications on behalf of the Department of Health (2001) *Perceptions of Social Work and Social Care*: Department of Health
- Coomans G (2002) 'Labour supply issues in a European context', European Conference on Employment Issues in the Care of Children and Older People, Sheffield Hallam University, 21–22 June 2002
- Cozens A (2004) 'Our social secret': *Guardian* 10 March 2004
- Cree V (2003) *Becoming a Social Worker*: Routledge, London
- Daly M , Lewis J (2000) 'The concept of social care and the analysis of contemporary welfare states', *British Journal of Sociology* 51, 2, 2000
- Dearden L et al. (2004) *An All-in-depth Analysis of the Returns to National Vocational Qualifications Obtained at Level 2* :Institute for Fiscal Studies
- Department for Education and Skills (2003) *Every Child Matters*: Department for Education and Skills
- Department of Health (2002) *A Modernised NHS Pay System*: Department of Health
- Department of Health (2000) *A Quality Strategy for Social Care*: Department of Health
- Department of Health (1998) *Modernising Social Services*: Department of Health
- Eborall, C (2003) *The first Annual Report of the Topss England Workforce Intelligence Unit*, Volumes 1-3 :Topss England
- Eborall C, Garmeson K (2001) *Desk Research on Recruitment and Retention in Social Care and Social Work COI Communications*: Department of Health
- Equal Opportunities Commission (2004a) *Supporting Parents and Carers*: Equal Opportunities Commission
- Equal Opportunities Commission (2004b) *Plugging Britain's Skills Gap : Challenging Gender Segregation in Training and Work*: Equal Opportunities Commission
- Frankin A, Sloper P (2004) *Participation of Disabled Children and Young People in Decision Making Within Local Authority Social Services Departments in England*: Social Policy Research Unit
- General Social Care Council (2002) *Codes of Practice for Social Care Workers and Employers* : GSCC, London.
- General Social Care Council (2004) 'Codes of Practice Get Strong Support From Social Care Workers': GSCC press release19 July 2004
- Henwood M (2001) *Future Imperfect? Report of the King's Fund Care and Support Inquiry*: The King's Fund
- House of Commons Health Committee (2004) *Elder Abuse*: volume 1: HC 111-1
- Jordan B, Jordan C (2001) *Social Work and the Third Way*: Sage
- Kendall L, Lissauer R (2003) *The Future Health Worker*: ippr

- Kett R (2000) 'Supporting home carers' *Community Care* May 2 2000
- Leason R (2004) 'Looking for a way back' *Community Care* 12 March 2004
- Lyons, K (1999) *Social Work in Higher Education: Demise or Development*: Ashgate, Wiltshire
- Miller L et al. (2004) *Occupational segregation – Working Paper Series Number 15*: Institute of Employment Studies
- McLeod E (2002) 'Social work in primary health care settings', *British Journal of Social Work* 32, 6, 2002
- Morris L (2003) 'Research into practice' *Community Care* 12 June 2003
- Moss P (2003) *Beyond caring: The Case for Reforming the Childcare and Early Years Workforce*: Daycare Trust
- Organisation for Economic Co-operation and Development (2002) *OECD Employment Outlook*: OECD
- Orme J (2001a) Gender *and Community: Social Work and Social Care Perspectives*: Palgrave, London
- Orme J (2001b) 'Regulation or fragmentation? Directions for social work under New Labour', *British Journal of Social Work* 31, 2001
- Peck E (2001) 'The meanings of 'culture' in health and social care', *Journal of Interprofessional Care* 15, 2001
- Preston-Shoot M (2004) 'Education and Training for the Social Care Workforce': a PowerPoint presentation at an ippr seminar 28 June 2004: www.ippr.org
- Rankin J, Regan S (2004) *Meeting Complex Needs: The Future of Social Care*: ippr
- Robinson P (2004) *Tough Choices: The 2004 Spending Review*: ippr
- Roche D (2004) *PCTs: An Unfinished Agenda*: ippr
- Simon A et al. (2003) *Mapping the Social Care Workforce; Supporting Joined-up Thinking*: Thomas Coram Research Institute at Institute for Education
- Smale G, Tuson G , Stratham D (2000) *Social Work and Social Problems*: MacMillan
- Social Care and Health Workforce Group (2003) *Social Services Workforce Survey 2002*: Local Government Employers Association
- Social Care and Workforce Group (2002) *Independent Sector and Care Home Survey 2001*: Employers Association for Local Government
- Social Care Employers Consortium (2004) *The Growing Crisis in Care:* Social Care Employers Consortium
- Social Exclusion Unit (2004) *Mental Health and Social Exclusion*: ODPM Publications
- Social Services Inspectorate (2003) *Modernising Social Services – a commitment to the future 12th Annual Social Services Inspectorate Report*: Social Services Inspectorate
- Stainton T (2002) 'Taking rights structurally: Disability, Rights and Social Work Responses to Direct Payments', *British Journal of Social Work* 32, 6, 2002
- Thornley C (2003) *More Cold Comfort: A Unison Briefing for the National Joint Council for Local Government Public Services*: Unison
- Trevillion S, Beresford P (ed) (1996) *Meeting the Challenges: Social Work Education and the Community Care Revolution*: National Institute of Social Work
- Wanless D (2002) *Securing our Future Health*: HM Treasury
- Winchester (2004) 'Sector registers approval' *Community Care* April 1st 2004
- Young F et al. (2004) 'No room for nuisance' *Community Care* April 22nd 2004