

# Local Challenges in Meeting Demand for Domiciliary Care in Somerset

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## Foreword

### Gender Equality

Somerset County Council has worked in close partnership with Sheffield Hallam University, and eleven other local authorities over the last three years to take part in the national *Gender and Employment in Local Labour Markets Programme* (GELLM).

In taking part, Somerset County Council has committed to disseminate and implement the research findings by engaging with key stakeholders at significant stages of the project. The findings will form a critical part of the way Somerset County Council understands the impact of its services and partnership working on Somerset's diverse communities. Each and every County Council service is responsible for delivering gender equality in their Service Plans.

Through active participation in this research project, Somerset County Council is well prepared for its new legal responsibility for implementing the 'Gender Duty' requirements of the Equality Act 2006 in all key service areas, and to effectively address gender inequality throughout the county.

**Alan Jones**  
Chief Executive

**Chris Bilsland**  
Corporate Equalities Champion

**Cllr Sam Crabb**  
Member Champion for Equalities





# Acknowledgements

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To protect the confidentiality we promised all those participating in the research, we cannot name the organisations or individuals who gave us this information; without their contributions the research could not have taken place.

## **Members of the GELLM Team contributed to the study as follows:**

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Statistical analysis	Lisa Buckner
Report writing, and overall direction of the research	Sue Yeandle, Lucy Shipton and Lisa Buckner

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## Key findings

This study is about the challenges faced by key agencies in responding to changes in supply and demand for domiciliary care in Somerset. It is one of 6 parallel studies of this topic conducted within the GELLM research programme in co-operation with partner local authorities. The findings in this report relate to Somerset only. They are drawn from:

- analysis of official statistics relating to Somerset
- a new survey and follow-up interviews with providers of domiciliary care in Somerset (all sectors)
- interviews with key stakeholder managers

### *Demand for domiciliary care in Somerset*

Somerset's large and growing population of very aged people, and the tendency for older people to prefer to live at home, often alone, mean that demand for domiciliary care is growing.

- 33% of households in Somerset contain a person with a limiting long-term illness, including over 16,000 households where the sick person is aged 75 or older.
- There is no co-resident carer in 70% of these households.
- Somerset's population of very aged (85+) residents is expected to rise by over 15,000 people by 2028, with a particularly strong increase in the number of very aged men.
- In Somerset, 85% of very aged men, and 75% of very aged women, live in their own homes.
- 33% of very aged men in the county, and 51% of very aged women, live alone.

### *Employment in the care sector*

Domiciliary care remains a strongly female-dominated segment of the labour market, and continues to be an important source of paid work for women in Somerset.

- 6,828 Somerset residents, 90% of them women, are already employed as care

workers. About 1 in 17 of all employed women in Somerset is a care worker.

- In Somerset, 59% of female care workers, and 18% of male care workers, work part-time. Most are White British women, although Somerset's small population of Black/Black British residents, especially men, are rather more concentrated in care work than people of other ethnicity.
- A large minority of Somerset's care workers had no formal qualifications in 2001 – 43% of women care workers aged 50-59, and one in five women care workers aged 25-34 years.

### *Organisation of domiciliary care*

The mixed economy of social care, developed in recent years as a consequence of government policy, has created complex issues for the organisation and delivery of crucial services. Somerset has responded to these changes in a variety of ways, and re-shaping of the care market has affected all stakeholders.

- All domiciliary care in the county is now purchased from the independent sector. Somerset's domiciliary care providers include small, medium and large organisations, across the independent (private and voluntary) sectors.
- Somerset County Council and its partners have already taken some steps to address issues of supply and demand in domiciliary care, notably through collaboration with the Somerset Learning and Skills Council and the activities of Care Focus (Somerset).

### *Employment challenges*

Providers in Somerset face many of the same challenges being addressed across the country. They reported both progress and some serious concerns about the available supply of labour and the current composition of the domiciliary care workforce. A few were concerned about their capacity to achieve targets for workforce development.

- All providers who responded to our survey had some older (50+) care workers on their staff – but these staff formed less than half their workforces in most cases.

- Some providers were using 'zero hours' and casual contracts; however two thirds of those responding to our survey reported that some of their staff were on permanent contracts.
- Providers reported progress in moving towards the National Minimum Standards (NMS) qualifications targets, but had a number of concerns in this area:
  - Covering the costs of training and the workload when staff were released for training
  - Retaining staff once they had completed their training
  - Limited scope in some organisations for paying staff for the time spent on job training
  - The challenge of addressing basic skills, motivation and confidence issues among some staff
- Rates of staff turnover varied considerably between providers: staff shortages were minor concerns for some, but acute problems for others. The worst affected providers reported that 13% of posts were unfilled at the time of the survey.
- Some providers were experimenting with new recruitment arrangements (such as internet advertising) and special initiatives, including television and other publicity to raise public awareness of the changed nature of domiciliary care work.
- Providers were mostly offering their staff some support with training costs (including giving staff study leave in some cases), and about half reported that they offered their staff membership of a pension scheme. Pay rates were low, only a little above the National Minimum Wage in most cases, although some providers paid premium rates, which could be a lot higher, for Sunday and night work.
- The image of the job remains a problem.
- The nature of the job has changed, involving more personal care and some challenging situations for staff. People outside the sector, including prospective applicants, do not always realise how much the role has developed.
- There is competition for staff from other sectors (e.g. supermarkets, factories and other health and social care employers) which offer work environments, hours and work which some staff find more attractive.
- Some domiciliary care workers are exceptionally committed to their jobs and the work they do.
- The flexible hours and working arrangements providers can offer are extremely important in attracting and retaining staff.
- Supporting staff, through regular contact, briefings, supervisions and praise for work well done, was critically important in motivating and keeping care workers.
- The hidden costs of training and workforce development were a worry for some employers.
- Revised tendering and procurement arrangements had impacted on the sector. Effects of the arrangements included:
  - Closer working relationships and more regular dialogue between the local authority and its contracted providers
  - Scope for better partnership working
  - Some providers had gone out of business or were diversifying into different areas of care and private work.
- Some providers expressed concerns about very tight financial arrangements, and worried that prices and resource constraints sometimes affected service quality.

### *Provider and other stakeholder perspectives*

Our sample of interviewees who were domiciliary care providers and other stakeholders in the development and delivery of services in Somerset reported that:

- Supply and demand is a major concern.

## Introduction

In common with most of Europe, the UK is now experiencing significant growth in its population of older people, a trend which is expected to continue throughout the first half of the 21st century. This is happening at a time when smaller family size, more ethnically diverse populations, changes in geographical mobility, increased longevity, and new patterns of family life are also affecting daily living arrangements and creating additional demand for personal social and care services delivered in private homes. All evidence suggests that older and disabled people, including those with considerable personal care needs, wish and prefer wherever possible to live in their own homes, rather than in residential settings. Since longer lives are likely to mean more years in need of health or social care support (ONS 2004), this will create significant additional demand for domiciliary care. In the past, care work in the domiciliary setting was often provided by women in the middle years of life – either unpaid within a family setting, or as unqualified, low paid workers, employed as ‘home helps’, a term now rarely used. The increased educational attainment and labour market participation of women in recent decades has diminished these traditional sources of caring labour, both low-waged and unpaid, and official attempts to up-skill and professionalise employment in social care have placed new demands on those responsible for planning and delivering services.

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

Our study of *Local Challenges in Meeting Demand for Domiciliary Care* has covered only some of the important issues which our local authority partners were interested in exploring, and should be read in the context of other research, notably the UKHCA<sup>1</sup>'s 2004 profile of the independent home care workforce in England (McCliment and Grove 2004), the Kings' Fund Inquiry into Care Services for Older People in London (Robinson and Banks 2005), *Skills for Care's* annual reports of 'The State of the Social Care Workforce' (Eborall 2005), and its new plans for a new National Minimum Data Set for Social Care (NMDC-SC), launched in October 2005<sup>2</sup>.

Conscious of the limited resources available to us, we chose to focus our study of care work in local labour market settings on providers of domiciliary care – across all sectors, private, public and voluntary – and on their experiences, understanding and difficulties as employers in developing and delivering the quantity and quality of home care needed, both now and in the future. The study was developed with the support of the Social Services Departments (SSDs) of the six local authorities involved, who have responsibility for commissioning and procuring essential domiciliary care services. Through these SSDs we were able to contact all the providers of domiciliary care who were registered with them, and to seek their co-operation in our study. We were especially interested in the supply and demand issues they faced, and how they were responding to these challenges, as we explain in more detail below.

### **The changing policy environment for domiciliary care**

The social care system in the UK has undergone some very significant changes in the past two decades, including changes in local authorities' own responsibilities as service providers and employers. The local authority's primary role in this field is now to commission and purchase social care services, and to contract with independent service providers. In England, the total number of hours of domiciliary care provided grew by 90% between 1993 and 2004<sup>3</sup>, reflecting government policies promoting independent living

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<sup>1</sup> UK Home Care Association.

<sup>2</sup> Some of the findings of these studies are discussed in the synthesis report of our study in all 6 localities (Yeandle et al 2006).

<sup>3</sup> Community Care Statistics 2004, Health and Social Care Information Centre, 2005.

and care at home, as well as substantial growth in the number of older people living in single person households. Packages of home care have become more intensive (with fewer households receiving care, for more hours per week), and more of these care services are now delivered by independent organisations. In Somerset, 52,490 contact hours per week of domiciliary care were provided to 4,120 households in 2004<sup>4</sup>. Since 1993, all domiciliary care has been contracted out to the independent sector in Somerset, and a number of major changes in care commissioning in Somerset (described below), were introduced in 2004-5.

These developments were set in train some 15 years ago in the 1989 White Paper, 'Caring for People', which outlined new funding arrangements for social care, stressed that care should be tailored to individuals, and required local authorities to make use of private and voluntary sector provision. The 1990 *NHS and Community Care Act* took this policy forward, and the now familiar 'mixed economy' of care has been one of its most important effects. Developments since 1997 have included:

- the *Royal Commission on Long-Term Care for the Elderly* (1997-9)
- the White Paper *Modernising Social Services* (DoH 1998)
- the *Supporting People* review and policy programme (DETR 1998)
- *The Care Standards Act 2000*, establishing the *National Care Standards Commission* (from April 2002) with responsibility for setting, regulating and inspecting all regulated care services, including domiciliary care
- the *General Social Care Council* (2001) tasked with regulating the conduct and training of social care staff
- the *Social Care Institute of Excellence* (2001) an independent registered charity whose role is to promote knowledge about good practice in social care
- the *Commission for Social Care Inspection* (2004), the independent inspectorate for all social care services in England
- new measures to support staff development, and to create a more skilled workforce (DoH, 2000a)
- the *Fair Access to Care Services* initiative, clarifying eligibility for adult social care services

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<sup>4</sup> Community Care Statistics 2004, Health and Social Care Information Centre, 2005

- *Skills for Care*, established in 2005 as one of the new sector skills councils, charged with tackling skills and productivity needs in the care sector, and replacing TOPSS (the Training Organisation for Personal Social Services)
- *Our health, our care, our say: a new direction for community services* (DoH White Paper 2006)

The delivery of domiciliary care has become a key issue in contemporary public policy (Robinson and Banks 2005; Wanless 2006), affecting the well-being of millions of older and disabled people and their carers, involving about 163,000 domiciliary care workers (McClimont and Grove 2004), and demanding resourcefulness and innovation of the many organisations involved: the employers and providers of domiciliary care - companies, local authorities and charities, including the 3,684 domiciliary care agencies registered with CSCI in November 2004 (Eborall 2005); the local authority SSDs who now purchase a very large volume of services from these providers; and the many sector/professional bodies, trade unions, regulatory and/or advisory agencies and training providers in this field. The quality, adequacy and reliability of domiciliary care is of critical importance for the welfare of many vulnerable older and disabled people, relies heavily on the organisational standards and effectiveness of providers, and impacts on a wide range of other social and economic issues. Most recently, the Kings Fund report by Sir Derek Wanless, published in March 2006, provides a new and comprehensive analysis of the demand for social care, including estimates for future spending requirements and an examination of factors affecting demand.

### **About the study**

*Local Challenges in Meeting Demand for Domiciliary Care* is part of the national *Gender and Employment in Local Labour Markets (GELLM)* project 2003-6, in which Somerset County Council is one of the 11 local authority partners. Parallel studies relating to domiciliary care have also been conducted in 5 other local authorities, and are published separately. A synthesis report, drawing together evidence from all six local studies (Yeandle et al 2006) is also available. *Local Challenges in Meeting Demand for Domiciliary Care* is one of the three locality studies conducted in Somerset within the GELLM

project, and builds on the project's earlier statistical work, *The Gender Profile of Somerset's Labour Market* (Buckner et al 2004).

Our study of domiciliary care has included analysis of official statistical data, a new survey of domiciliary care providers, and interviews with a sample of providers in the private and independent sectors, and with key stakeholders. Further details of the methodology are given in Appendix 2. The focus of this study has been on:

- the supply of and demand for domiciliary care in its local labour market context
- the characteristics of workers in domiciliary care, at the district level
- the organisations which provide domiciliary care in each district, and how they recruit, manage and develop their staff

## Domiciliary care in Somerset – changes in supply and demand

### Demographic projections in Somerset

In 2001, Somerset had 210,586 households containing a resident with a limiting long-term illness, including over 16,000 households where the resident with the illness was aged 75 or over. In almost 85% of these homes, there was no co-resident carer. As we showed in the *Gender Profile of Somerset's Labour Market* (Buckner et al 2004), levels of poor health and disability in Somerset are approximately in line with the national pattern; about 1 in 6 of all residents in the county has a limiting long-term illness.

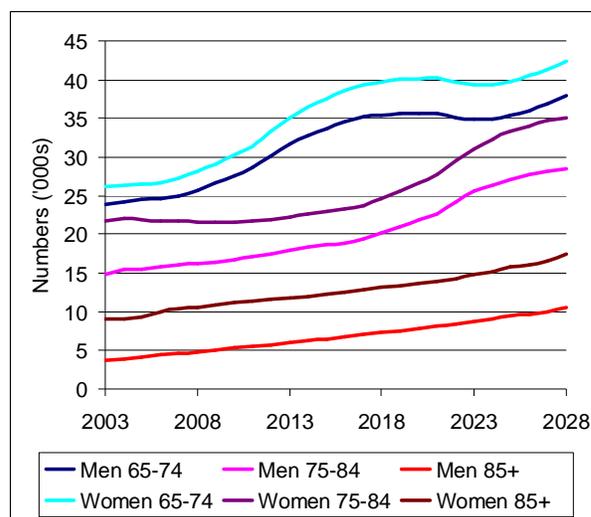
As much of the social care provided to those living in their own homes supports older people, the demographic profile and projections for Somerset also provide an important context.

2.6% of Somerset's residents were aged 85 or older in 2001 (compared with 1.9% in England as a whole). The population projections for older people in Somerset are shown in Figure 1, and, as this shows, the figures are set to rise rather sharply.

Between 2003 and 2028, Somerset's population of residents aged 85 or older is expected to grow very significantly. The latest estimate suggests there will be 15,200 more residents aged 85+ (of

whom 8,400 will be women) by 2028. This will virtually double the number of very aged women, and will almost treble the number of very aged men in the county. There are also likely to be 26,800 more residents aged 75-84 (13,300 of them women). This expected growth in Somerset's population of older people is considerably greater than that projected for England as a whole (+184% for men and +93% for women aged 85+, compared with 173% and 67% across England). The projected increase among very aged men is even more marked in Mendip, Sedgemoor and Taunton Deane than in other parts of the county, and for very aged women in South Somerset. These figures thus represent a very significant challenge for the effective delivery of domiciliary care services.

**Figure 1 Somerset: Population projections 2003-2028 - People aged 65+**



Source: 2003-based sub-national population projections, Government Actuary Department, Crown Copyright 2004

The last Census (in 2001) showed that in Somerset about 75% of women aged 85+, and 85% of men aged 85+ were living in their own homes, either owned or rented<sup>5</sup>. Over half of all Somerset women aged 85+, and almost a third of men of this age, lived alone. Three quarters of these women (76%) and 69% of the men had a limiting long-term illness, with about a third of both sexes stating that their general health was 'not good'. Almost 9% of Somerset's men aged 85+, and almost 3% of women of this age, were themselves providing regular unpaid care – over

<sup>5</sup> These figures include those who were owner occupiers with a mortgage or loan.

4% of these very aged men for 50 or more hours each week.

Appendix 3 of this report includes a presentation of the main statistical evidence discussed above, including the relevant district-level data, together with other relevant information likely to be of interest to specialists in this field.

These figures suggest a future in which there will be considerably increased demand for domiciliary care services. This is likely to be challenging for care providers in Somerset, as the domiciliary care sector can expect to face difficulties in recruiting sufficient additional staff.

The key local labour market issues are:

- Between 1991 and 2002, there was significant job growth in Somerset, dominated by the distribution, hotels and restaurants sector, especially in relation to part-time employment, and by additional jobs across the public administration, education and health sector (Buckner et al 2004: 29). Particularly notable were the 94% increase in part-time jobs among women in West Somerset, the 28% increase in full-time jobs among women in Sedgemoor, and the fact, overall, that over two-thirds of job growth in the county was in part-time employment (+ almost 28,000 part-time jobs). A continuation of this trend is likely to mean significant competition for workers between these segments of the labour market and the social care sector.
- Somerset has comparatively low levels of unemployment, on all available measures, and fairly low rates of economic inactivity (Buckner et al: 45-56). Despite this, some of our other research in the county, (including our investigation into women's poverty and economic regeneration in Bridgwater) suggests that gaining access to paid employment remains a problem for some Somerset residents (Escott et al 2006), who might welcome the opportunity to enter domiciliary care work. It can also be noted that in Sedgemoor, Mendip and West Somerset, the proportions of working age women who are looking after their home and family full-time (at over 14%) are slightly above the national and county averages. Some of these women may in the future wish to re-enter paid employment.

- Somerset has high levels of self-employment among both women and men of working age (7.4% of women and 17.2% of men of working age in the county, compared with 4.9% and 13.2% in England). The scope for successful working on a self-employed basis in the county may also reduce the pool of labour available for domiciliary care work, in which few care workers have in recent times been self-employed (2.5% of female and 3.9% of male care workers in Somerset in 2001) – although this could change if there is significant future take-up of care policies such as Direct Payments and Individual Care Budgets.
- Girls in Somerset are comparatively well qualified. In 2002/3, 61% achieved 5 or more GCSEs at grade A\*-C (compared with 58% in England). Their average point score per candidate at A/AS level was 272 (compared with 256), and over 74% of Somerset girls achieved grades A-C at A level in 2002/3, compared with 68% nationally (and with 66% of Somerset boys). Higher achieving pupils are likely to choose other jobs and careers at the labour market entry point (unless new measures are taken to attract them into social care), and in a relatively tight labour market requiring more skilled labour, at later life stages they may also have a good range of other employment opportunities.
- Given that, in England as a whole, some ethnic minority groups form a particularly important supply of caring labour<sup>6</sup>, Somerset's small ethnic minority population (about 3% of residents, more than half of whom identified themselves as White Irish or White Other in the 2001 Census) may continue to contribute to the supply of caring labour – however this group is certainly not large enough to meet the likely increase in demand.

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<sup>6</sup> Notably women aged 25-59 in the Irish, Black, and Mixed ethnic groups, and men of all ages from the various Black and Mixed ethnic groups.

### The social care workforce in Somerset

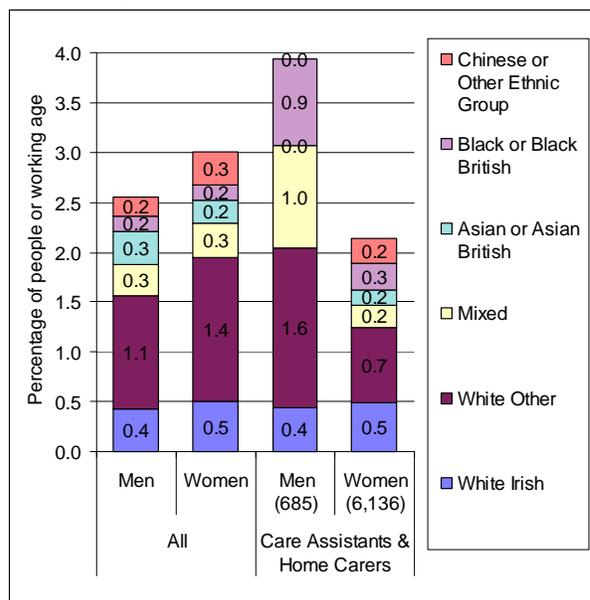
Almost 7,000 Somerset residents are people of working age employed as care assistants and home carers<sup>7</sup> - about 90% of them women. Already more than 1 in 17 of all women employed in Somerset (compared with 1 in 25 of those in England as a whole) is a care assistant or home carer. Over half (53%) of all care workers in Somerset were women aged 25-49 (compared with 54% across England), and almost a quarter (24%) were women in their fifties (compared with 22% in England as a whole). A slightly higher proportion of care workers in Somerset were young women aged 16-24 (15%) than in England as a whole (13%).

Within the county, there are some variations to this picture. For example:

- In West Somerset, 30% of all female care workers were in their fifties - compared with just 22% in Taunton Deane.
- 28% of female care workers in Mendip have no formal qualifications - compared with 20% in Taunton Deane.
- 48% of female care workers in Taunton Deane were full-time employees - compared with just 34% in South Somerset.
- In Somerset, 57% of female, and 17% of male care workers were employed part-time (compared with 55% and 23% across England). Care workers aged 25 and over are much more likely to work as part-time employees than other workers - this was true for both men and women.
- 98% of female care workers in Somerset were White British women, and 96% of male care workers in the county were White British men. This is not surprising in a county where less than 4% of the employed population belongs to any other ethnic group. Nevertheless, even in Somerset men (but not women) from ethnic minority groups were disproportionately clustered in care work.

<sup>7</sup>Data is not available for domiciliary care workers only. The 'care assistants and home carers' category is the closest available definition. Some care workers are employed in both domiciliary and other settings, either simultaneously or sequentially. In this report we use the term 'care workers' to cover all in the care assistants and home carers category, as defined in the Standard Occupational Classification. Another recent study suggests that at least 3,500 of these workers are employed in independent residential and nursing care homes (Waterlow 2001).

Figure 2 Ethnicity of care assistants and home carers in Somerset



Source: 2001 Census Commissioned Tables, Crown Copyright 2003

- In all age groups, male care workers in Somerset (as elsewhere) were considerably more likely than other workers to have unpaid care responsibilities alongside their jobs, and this was also true of women care workers aged 16-49.

Across England, female care workers are much more likely to lack formal qualifications than other women workers (29%, compared with 16% of all working age women in employment in England, have no qualifications at all). This is particularly true of older workers; at the national level, 50% of female care workers aged 50-59 have no qualifications, compared with only 35% of all women employees of this age. This difference in level of qualification is much less marked for men. The picture in Somerset was rather better, with just 43% of female care workers aged 50-59 unqualified in 2001. Among those aged 16-24, one third of both male and female care workers in Somerset had not achieved NVQ level 2.

## Policy developments in Somerset

Responsibility for the commissioning and procurement of domiciliary care services to meet the assessed needs of Somerset's residents lies with Somerset County Council's Social Services Department (SSD). The SSD has since 1993 purchased all of its domiciliary care from independent, external agencies, and undertook a major new commissioning and procurement exercise in 2004-5, resulting in new 5-year contracts with providers, starting in October 2005.

In recent years, Somerset County Council has been operating with a revised Strategy and 5-year plan for older people's services, with homecare a key strand within the overall strategy. Its aim has been to reduce expenditure on residential care, to develop and improve community services, and to target home care provision on the most vulnerable older people.

The revised commissioning arrangements were introduced with the aim of enabling external suppliers to develop and provide high quality services, including those needed by people on discharge from hospital, and others requiring intensive support, through revised contract specifications.

The local authority and other local and regional agencies have also put considerable effort into trying to develop effective partnership working. The stated aims of the local authority's partnership approach include:

- Sharing key objectives
- Collaborating for mutual benefit
- Communicating clearly, honestly and regularly
- Sharing information, expertise and plans, and avoiding duplication
- Monitoring performance
- Resolving conflicts quickly at the local level
- Working together to get the most from resources
- Promoting partnership at all levels, including through joint training and induction activities

In its documentation, Somerset County Council emphasises that its 'ideal providers' of domiciliary care services have attributes which include 'strong workforce planning capabilities', a 'flexible and responsive structure', and a commitment to 'anti-discriminatory practice, openness, inclusion and best value'.

## Service Inspections

In November 2004 the *Commission for Social Care Inspection* (CSCI) announced star ratings for social services authorities and awarded Somerset the maximum of three stars. The judgements leading to this rating included the assessment that adult services 'serve people well and have excellent capacity for improvement'. In relation to older people helped to live at home, the latest performance assessment (autumn 2005) noted that

- *The council continues to effectively provide a good range of quality services, demonstrating year on year improvement on performance.*
- *The council has successfully achieved their target of no waiting times for home care services.*
- *Careful monitoring will be required to ensure the current strategy successfully reflects the revised national target. This will need to take into consideration the significant projected increase, over the next five years, of Service Users aged 85+ (projected increase between 2003-2010 = 29%).*

Key developments in the social care sector in Somerset include the following initiatives.

## LSC Somerset

The Learning and Skills Council in Somerset has identified the health and social care sector as a priority focus, noting in its Statement of Priorities 2006-7 that it intends to:

*Achieve a step change in our actions to engage employers across the county through sector strategies (which include) health and social care.*

The LSC has also commissioned new research on the care sector, focusing specifically on the residential care segment (Waterlow 2001). This report identified a range of barriers and issues in achieving NVQ training targets in social care. Although the study did not explore the particular situation of domiciliary care providers and care workers, its findings are likely to be relevant for home care also:

- Care assistants working part-time had lower levels of NVQ achievement
- Female care assistants were slightly less likely than male care assistants to have achieved a Care NVQ
- Older care assistants (55+) were the least likely to have NVQ
- Being near retirement and having family responsibilities were both barriers to achieving NVQ

- The cost of training, and difficulties in releasing staff to train, were also impeding training progress
- 80% of the care assistants included in the survey were aged 25+ and ineligible for zero-cost government funded NVQ programmes

### **Care Focus (Somerset)<sup>8</sup>**

Care Focus Somerset, formerly the Somerset Industry Group for Care, was established in 1993 to support and develop the social care workforce in Somerset. It is an employer-led organisation funded by Somerset County Council and Skills for Care. The organisation is responsible for distributing government funding for health and social care training (ensuring fair access), and for identifying other resources available for workforce development in the sector. Its services to the social care sector include:

- Information on careers, training and qualifications, for employers and applicants
- Conferences and events addressing key sector issues (most recently in March 2006)
- Support for providers on workforce development and planning
- Publicity about careers and opportunities within the sector.

Care Focus has close links with the national Care Ambassadors scheme, originally set up in the South West (Dorset) in 2003. This innovative scheme works with care workers to encourage the recruitment of younger people into social care.

### **Recruitment campaigns**

In 2005, Somerset County Council provided £50,000 for a county-wide recruitment drive linked to the national campaign on social care recruitment being mounted at the same time. The campaign has also been linked to the 'Care Ambassadors Scheme', targeting especially young people and college students, and outlining the new career pathways available to those now entering social care.

### **Contractual and tendering procedures**

Somerset's 2004 *Selective Tendering* process sought bona fide competitive tenders from independent providers across the county's 13 zones. Tenderers could bid for care and support at home (including sitting services) block contracts, home support contracts, extra care housing contracts, and children and families contracts. The application documentation required information which closely reflected the National Minimum Standards relating to the delivery of domiciliary care, and collected detailed information about each potential provider's employment structure and training arrangements. All tenderers were required to supply their self-assessment of performance, which included information on their approach to recruitment and retention, and to training and staff development. In 2005-6, Somerset County Council had contracts with just 8 providers of domiciliary care. Senior staff within the authority reported that the new arrangements were working well, although with some providers experiencing initial capacity problems in the more rural parts of the county.

### **Survey of Somerset providers**

In Somerset, our survey of providers of domiciliary care had a 46% response rate and produced 19 responses: 1 from the voluntary/community sector; 12 from the for-profit sector; and 6 from the not-for profit private sector. As indicated above, Somerset no longer provides domiciliary care directly from within its own workforce.

### **➤ Services Provided**

Almost all the organisations responding to the survey questionnaire regarded older people and disabled adults as among their key client groups, although completed questionnaires were also returned by a few organisations specialising in support for younger disabled people.

The responses received came from organisations of differing size -12 were organisations employing fewer than 50 care staff, but 4 said they had 100 or more care workers. Consequently, some had contracts to provide fewer than 500 hours of care per week, while others had large contracts for 2,000 or more hours per week. All the providers supplied personal care to clients in their own homes, and most also supplied domestic help, shopping, and night-sitting or sleeping-in services. 11 of the providers said they provided a 24-hour 'on call' service, and a small number

<sup>8</sup> [www.carefocussomerset.org.uk](http://www.carefocussomerset.org.uk)

provided 'rapid response' and 24-hour live-in care services.

➤ *Staff and Working Conditions*

Five providers told us that between 25 and 75 per cent of their staff were employed for fewer than 16 hours per week, and most had some staff with this type of working arrangement. However, six providers reported that half or more of their staff worked full-time (30+ hours per week). Five providers said that between a quarter and a half of their care workers were aged 50 or older, and all had some staff in this older age group.

About two-thirds of the providers surveyed had some staff on permanent contracts. 7 providers reported using 'zero hours' contracts, and 2 used casual contracts for some of their staff. Wages ranged from £5.30 to £7.75 per hour for weekdays during the day time, to £6.20 to £60.00+ per hour for Sunday nights. While about half the providers (10) reimbursed the costs staff incurred while travelling to visit clients, only two offered staff mileage allowances. Most reported paying sickness and holiday benefits above statutory requirements, and 10 offered staff membership of a pension scheme. 15 of the 19 providers said that they met, or partially covered, staff training costs in attaining NVQ target levels, and 9 reported giving staff study time in support of this.

➤ *Recruitment and Staff Turnover*

The providers' survey responses on staff turnover and staff shortages suggested that these issues were of concern to some, but not all employers. Thus staff turnover in the previous 12 months had ranged between 0% and 59%, with a median value of 20%. Some organisations reported no current staff shortages, but the worst affected employers considered that 13% of posts were currently unfilled.

For these providers, the most common method of recruiting care workers was via local newspaper advertisements or the local Job Centre. Only 4 were currently using the internet to recruit staff, and only 2 were using the trade or professional press. 5 reported that they had run special recruitment initiatives in the recent past, and a few others had used community or other recruitment events to encourage applications.

Providers felt that most staff who left gave up their jobs for 'personal and family reasons', but the majority also considered that work-related

stress, work-related injuries and unsociable hours were other key factors affecting care workers' decisions to leave. About a third of providers felt some staff were also leaving jobs in domiciliary care for better pay elsewhere, or because of challenging situations with clients or having to accept too much responsibility. However, the majority of employers did not think these were factors affecting their own staff who had left.

➤ *Qualifications and Training*

Many of these providers were currently employing staff who lacked qualifications at NVQ level 2<sup>9</sup>: 11 reported that fewer than a quarter of their domiciliary care workers had this level of formal qualification. Only one provider said that over 50% of its care workers had achieved NVQ2, and only 4 had more than half of their care supervisory staff qualified to NVQ3. Most of the providers had some care workers currently registered for training and accreditation at NVQ2 or above, and 4 reported that over 50% of their care staff were in this situation. As we have already seen, the wider context for this is that 24% of all care assistants in Somerset were without any formal qualifications in 2001, a little below the national figure (for more detailed data, see Appendix 3).

Most of the Somerset providers reported some difficulties in meeting the costs of training staff, and a majority also reported difficulties in releasing staff for training, in covering the cost of replacing staff, in finding the resources needed for assessment, and in retaining trained staff. Most felt that they also faced issues here because staff lacked motivation and confidence, although the majority of providers did not judge this to be a basic skills problem among their own staff. Some concerns were also reported about low completion rates among staff undertaking NVQ training.

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<sup>9</sup> By April 2008, 50% of the care arranged by each provider should be delivered by a care worker holding at least NVQ2 in care, under the National Minimum Standards Regulations.

## Employment policies and practices in domiciliary care

Seven of the providers in Somerset who responded to our survey agreed to be interviewed about the challenges they faced in responding to changes in the demand for domiciliary care. Some of these providers are registered block providers with the Social Services Department. The key points made by those who were interviewed as part of this study, and comments made by key stakeholders in the county, are highlighted in the following section of the report.

### **Supply and demand is a major concern**

Most domiciliary care providers in Somerset stressed that they face regular and ongoing difficulty in ensuring a regular supply of adequate and suitable labour. Some providers, however, said they did not face problems in terms of recruitment and retention. Providers felt that the demand for more care services in the local area had increased in recent years, partly because more people tend to remain in their own homes. They thought that this situation was likely to continue (and increase) in the future.

*When we advertised several years ago for staff, we'd probably get 12, 15 responses. Now we're fortunate maybe to get 4 or 5.*

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

*Well, we don't really have a problem getting people, to be quite honest. We are very lucky - we can be very, very choosy. Things have changed so much over the years, and I've seen that change. But we really haven't got a problem employing quality staff - we can afford to choose.*

*Our work seems to be always increasing, so we need, obviously, to keep that recruitment process up.*

*In the last eight months our work has probably quadrupled - and for Dorset Social Services, where we had a very small contract, that's also probably quadrupled since the changeover.*

### **Recruiting staff**

The domiciliary care organisations that we spoke to in Somerset were mainly employing either women with young children, or middle-aged women who were returning to work.

*It tends to be people with young children, because they can work evenings and weekends, when their husbands are home. Or it tends to be people in their forties that want to go back to work, and think they can make a career of it. [Mothers] see it as a short term stop-gap.*

The providers also reported problems in recruiting good quality staff. Issues included difficulties with some staff who joined with previous care work experience, as well as problems with older people who were reported sometimes to be reluctant to train:

*The problem I've found with domiciliary care is that, unless you've looked after perhaps family, friends, or relatives - even if you come as a nursing auxiliary - the fact that you have worked in residential nursing homes doesn't mean that you are suitable to work in the community.*

*The nice thing about the older woman or man, they tend to have fewer commitments, and they tend to be more available, and they're old school. I suppose they can relate a little, they probably had elderly relatives themselves, so know the type of care that they would like their own mother to have, and provide that sort of care themselves. So it is a good era to look at, but I know a lot of them are very daunted with the training that is required now by governing bodies.*

Providers in Somerset had experimented with, or had adopted, a number of initiatives to support recruitment. Despite this, many still had problems with staffing levels, and some activities seemed to have worked better than others:

*We just advertise in the local paper, the Job Centre - but that doesn't bring us anything very much at all. Actually the newspapers are far more successful. I did a recruitment day in the local shopping centre, just to raise our profile, really. I think we probably got something back from that.*

*We try to do that [advertise in newspapers] - it's fairly limited, because it's so very expensive. We have found that our best, cost-effective, way is to deliver leaflets to people's houses.*

*We've done some joint recruitment initiatives with the NHS as well, so we are not alone in this - it's across the board.*

*We're quite involved with Care Focus (Somerset), they rolled out Care Ambassadors in Dorset. One*

of our carers has gone down to look at what they are doing down there, with a view to helping in Somerset. Our carers (have been) going into schools. We've been asked to become involved with the Modern Apprenticeships as well, that's with Care Focus (Somerset), part of the LSC.

We've had conferences that have involved people like Connexions and other professionals within the employment sector. Making them aware of what is available. We've got a PR chap working with us, and we've had television cameras following a carer around, and just anything and everything that we can think of to try and make people aware of just what goes on within the care sector.

### **The image of the job**

Another issue raised by providers was that because the nature of the job has changed, new applicants do not always have an understanding of what domiciliary care work or the training may involve:

*If they haven't done care before, (it's important to) make it quite clear that it's not going round making little old ladies cups of tea. That actually they will be doing some quite hard work, and will need quite a lot of training.*

*We are not what used to be traditionally called home helps.*

*It's just the nature of the work. Domiciliary care is very close to - bordering on - nursing, district nursing, now. So it does make it very difficult for us to recruit.*

Some providers also thought that people who, in the past, might have come into domiciliary care work on a temporary basis may no longer consider working in the sector because of the changed nature of the job and the new training requirements:

*I think the nature of the business has always been high turnover of staff. People used to come into care for a job that they could just do for a few months and then go off, just to get some money. But they can't do that any more, because there is a lot of assessment, from the employer's point of view, to be able to get a new staff member in.*

Providers in Somerset nevertheless felt that a lot was being done in the local area to raise the profile of domiciliary care work, and gave examples:

*Within Care Focus (Somerset) they are certainly promoting care as a career, and really upping the profile of the care worker. For me, that's the most key element to try and work on - by making the*

*general public aware of the huge range of responsibilities that we have.*

*I think what's helped us really is, especially in Somerset, they've been doing a campaign to actually raise the profile of the care worker, and they've been highlighting that people can come into social care as a career. I think that's helped tremendously. Because we are no longer the old fashioned home help, and I think people now see that the caring industry is a much wider business. There is a clear direction for people if they want to progress - it was on the telly, it was on the milk bottles, and all sorts of things.*

### **Competing demand for labour**

As indicated above, conditions in the local labour market mean that competition for labour is a problem in Somerset. This competition for the available labour supply comes both from other industries and sometimes from within the care sector itself. Providers commented on this situation, and particularly on the jobs available in local supermarkets and factories:

*With the [range of care] agencies around... they know damn well that they could leave us and get another job tomorrow.*

*The supermarkets. We are also competing against the NHS as well, because they are looking for similar type staff.*

*Last year it wasn't very good, we had an enormous ASDA open in town, and I would imagine they probably recruited about 200 people. So I don't think that helped us.*

*In Yeovil, it's a big town and the wages are the draw for people. They tend to go to factories. Factories generally pay more [and offer the same kind of shift patterns].*

### **Retaining and supporting staff**

Many providers in Somerset identified the flexible working arrangements they offer, the one-to-one support they give their staff, the rewards of the job, and the career paths now available, as the key reasons why people enter and remain in domiciliary care. Commenting on why some people stay in the job, providers noted:

*They could earn more money and have less stress if they went to work in Tesco's. (But) I think what attracts them is the flexible working. It can fit in around their children and things like that.*

*It's about making sure that they feel confident, about what they are doing. That they've got the necessary back-up training, and support. In the early days you don't keep chopping and changing*

*their work around, they need a bit of consistency. It's quite important that they're kept to their regular shift and also - trying to get to know your care staff.*

*There's a great deal of support... you've got to listen to people and treat them as you would expect to be treated yourself. The only reason they move on is personal circumstances, not because they are unhappy with the job.*

*I think pay, to a certain extent. There are (now) so many opportunities for them to earn more money (in care work). If they do an NVQ2, they get an extra 50p on their hourly rate. If they become an assessor they get another 50p. We've just built in an extra grade of carer called a Skill Plus Carer, and they are the people who are recognised by service users as giving outstanding service, or are nominated by their team leader as being particularly flexible and helpful. I think far more important is their relationship with their team leader, and being listened to when they've got concerns. It's when they have their supervisions and appraisals - just make them feel part of the team, because they are lone workers. It's about having regular team meetings.*

*We've improved our recruitment no end by having all these schemes and being able to provide a career path. We also run our own training company, so we can move our staff on through the training route. So many of them have become assessors and verifiers and moved up. But for us that's absolutely crucial, because you need to be able to move people and develop them - and if you don't they leave.*

### **Workforce development and training**

Few of the providers who gave us interviews reported any major problems in meeting the requirements of the National Minimum Standards framework, although for some it had intensified their workload:

*We were already very close. The only thing that we've increased is the amount of NVQ staff going through. But the rest of it was all very close, there are a couple of things that we are doing extra now, dementia training and things like that, but we weren't a million miles away.*

*It's just something that we've always done. It's probably improved - with not quality, but quantity. Obviously we're mindful that we have to have 50% of our staff through NVQ2 by a certain date, so it's probably made us keep on top of it more, and speed it up - but it's always been there.*

*We had the CSCI requirement that 50% of our staff have to have NVQ level 2 by 2006, so we have targets to meet anyway. I know we are nowhere*

*near our 50% at the moment, so maybe if you said 15% to 20%.*

*Personally it hasn't affected me much, simply because to most of the members of staff we are only a second employer. Most of the training is carried out by their first employers.*

Some providers faced problems with staff working at different speeds to complete their NVQs, although it was explained that this could be overcome by rewarding staff upon completion of their qualification:

*I've got about 12 carers that registered on NVQ2 at the same time. One has finished, and we've got a couple that haven't completed the first unit yet. So that's quite difficult - and that's all about them, and the speed at which they work, and the amount they can access their assessors, and that type of thing. Most of the assessors are senior carers or team leaders, and sometimes it's quite difficult for them to free up the time.*

*When somebody gets through an NVQ, and we do make a fuss of them when they get through, there is normally some sort of an award or social event. We might just keep the certificate back for that, and one of the senior managers will come, and we will order flowers and they'll be presented with their certificate in front of everybody.*

Although care workers' attitudes to training were generally considered to be quite positive, there were also some problems encouraging care staff to train:

*The younger workforce are very keen in gaining their NVQs, but our older workforce are not. They feel it's going back to school, and they don't want to do it.*

*We've got several staff that have been with us for several years who haven't done their NVQ, and they're sort of more mature ladies and they've chosen that they do not want to do their NVQ. They've been with us for several years and are care staff with vast experience that you wouldn't want to lose.*

*It's older ladies that have just said, 'This is my part-time job, I really don't want to be doing this.' But it's only a couple - they just really don't want to do that. [When the regulations go up to 100% needing an NVQ2] they will leave. They'll just say, 'Well, thanks, but no thanks - I'm going', which is a shame. We just replace them with younger people who are quite eager to do it. They get more money - the incentive is that they get more money once they've passed their NVQ.*

*A lot of people (like) the professional image – they don't want to be part of a lower profile (occupation), they want to be part of something that's really good.*

Some domiciliary care providers also faced a number of challenges with their external training providers:

*It's not a problem for us to access NVQs - our problem is that the training company has a problem with assessors at the moment, which has a knock-on effect with us.*

*Since we started going through the college - they were very, very slow in actually taking our staff on. That was because they had their own issues - staff off sick, staff that had left. So that's been a frustration. That staff were looking to start - they were desperate to start - and then they weren't able to for several months, because of staff shortages at the college.*

*In the early days when we were wanting to get people through NVQs, they went to college, and then only came out with the underpinning knowledge. They didn't have the certificate, because the college couldn't provide proper assessment. The staff didn't like having to go for 5, 6 hour sessions - whereas we now do our NVQs holistically, and they have a fortnightly meeting with their assessor and move it on, and they are assessed in the workplace that they are more comfortable with. It's minimised the disruption.*

The challenge facing the sector in this field was summed up by one of the key stakeholders we interviewed:

*We're working with a workforce generally that hasn't been qualified, looking at a whole workforce being changed, and that's our problem. If you have people who historically haven't gone through the training process, it will be costly.*

### **Contracting arrangements in Somerset**

As indicated above, Somerset Social Services Department has recently implemented significant changes in its tendering processes, and since 1993 has outsourced all domiciliary care work from independent providers. The authority now has just 8 block providers and, according to our interviewees, some local providers who previously contracted with the local authority have gone out of business. Those providers who tendered successfully now work in 13 dedicated geographical 'zones' within the Somerset area.

*There were 35 providers in Somerset before the tender and there are now 8 providers.*

*If we were going to go through this contracting process, contracts for 1, 2 or 3 years weren't terribly sustainable, and you couldn't really plan your business very well. So the County Council took that on board and said they would go for longer contracts, and that was why there was such a huge consultation process.*

*It's recently just changed, because of the tendering process that Social Services did last October. There are now only 8 block providers within Somerset. The spot providers didn't get their contracts renewed, many of them have either sold up or gone out of business. So it has been a time of considerable change. The block providers will be working with Social Services as part of the strategic partnership, so things will change.*

Changes in the procurement process have affected the providers in Somerset in a number of ways:

*It was a huge upset, and we are still - I mean it's worked very well - but there is still some fall out - it's not all settled yet.*

*The experience of the last several months (is) that the people that were actually awarded the contracts didn't have enough infrastructure manpower in place to be able to take them on - so they were lacking in the manpower. One of the large companies had to go out and use agency staff, that they actually brought down from afar. Quite a few of the staff actually left the industry completely, which was very upsetting from our side, and then quite a few other staff chose to stay with us.*

*We lost a big contract last year with Somerset Social Services, so we went from having 170 staff to only retaining about 30 staff. The staff that we retained were all excellent staff, so we were able to pick and choose a little bit the staff that stayed with us.*

*Because we haven't got a block contract with Social Services now we are doing more private caring, and going into learning disability, which is a totally different type of care.*

*Because the other agencies are so busy with Social Services we are getting more and more private work. They don't want to do it, because they haven't got the capacity to do it.*

*The block providers have got a different agenda now to the spot providers, and although we could have done some work together, maybe around regulation or that type of thing, we didn't. We couldn't have the same discussions about our work, and a lot of the block providers want to work together around contract issues, and the spot providers don't have those issues.*

There was also some concern expressed about the way the new procurement arrangements were impacting on how domiciliary care was delivered to clients:

*It's certainly changed in my view, the quality of the care that's now being given. I feel that their quality has actually gone down, and we've actually seen that. Because the people that actually went over to them with the contracts, quite a few of them have actually come back to us, to pay for their care privately, or through the Direct Payments.*

Some providers also commented that they had found the new tendering process in Somerset time-consuming and complicated:

*Complicated, stressful [and took] months, because of all the preparation. It was more cut-throat this time, because you knew there was a possibility that some other big players could have been tendering for the same thing.*

*Blooming hard...it was really hard.*

*It was a really long, drawn-out process here, and started about a year before the tendering process began, with a consultation workshop run by Social Services about the specifications, and how the block contracts would be allocated. I was involved in a huge amount of that, so I was attending 2 workshops a week for about a year. There wasn't total agreement on all of that for everything, but at least you did feel that you'd had your say, and you were listened to. But it was hugely time consuming.*

Key stakeholder interviews confirmed that a very thorough and detailed procedure had been put in place. Following initial expressions of interest (from about 20 providers) and subsequent submissions of detailed documentation by about 12 of these, tenderers were interviewed both by a panel of service users and carers, and by a panel of local authority officers:

*We probed very hard on diversity and equal opportunity. A lot of it was focused on the company's ability to manage change and be flexible. There was a focus on their approaches to workforce planning, and on their quality of service and how their policies track through into practice. It was quite a rigorous, long-haul process, and the ones that were still standing at the end and scored highly enough were the ones who now have the five-year rolling contracts with us. We have an annual review process, and also do quality monitoring during the year.*

Providers and stakeholders dealing with the reality of delivering domiciliary care in Somerset thus confirmed that many of the issues facing the

sector nationwide are part of their everyday experience of delivering home care services in the county.

Our study has shown a variety of ways in which the local authority and independent providers are tackling these problems, and confirms that efforts are already under way to monitor, understand, and address some key issues. The very recent major changes to procurement and commissioning in Somerset were, not surprisingly, at the forefront of many providers' minds, perhaps deflecting their attention from longer-term planning issues and future recruitment challenges.

Stakeholders and providers in Somerset reported some progress in addressing staff training and workforce development issues, and had introduced some new measures and innovations, but tended to have less to say about medium to longer term plans. Current and short-term issues tended to dominate providers' responses – especially in relation to recruiting and retaining staff, meeting NMS targets and complying with the increasingly complex, if necessary, regulation and monitoring of the sector in a context of budgetary constraint and some uncertainty about future contracting arrangements.

While key stakeholders were certainly aware of demographic pressures and trends, there was little mention in our interviews of the wider structural changes affecting Somerset's local labour market, and no mention at all of the difficulty which some Somerset residents, especially women, face in entering the labour market (as revealed in our companion studies *Addressing women's poverty in Somerset: local labour market initiatives* [Escott et al 2006] and *Ethnic minority women in Somerset and access to the labour market* [Stiell et al 2006]), or of these groups of women as potential recruits for the sector.

Enhanced awareness and understanding of the labour market situation local women face, arising in part from Somerset's participation in the *Gender and Employment in Local Labour Markets* research programme, may assist in the development of a longer term perspective on supply and demand in domiciliary care, and in identifying possible local solutions to labour supply problems.

## **Policy messages and recommendations**

Somerset's new approach to contracting and commissioning domiciliary care services has been, in part, a response to some of the important supply and demand and workforce development issues highlighted in this report. Here we summarise key developments in Somerset which need to be monitored, encouraged and maintained, and recommend some actions which Somerset County Council and other local agencies may wish to consider.

### ***Partnerships and dialogue between agencies***

In Somerset, a range of partnerships are in place, and were operating during our research. This approach needs to be maintained and enhanced, to create further opportunities for regular dialogue and for exploring and sharing good practice about service development and enhancement.

Further clarification of existing partnerships and opportunities for dialogue would be welcomed by some local independent providers, and in view of recent changes in contracting arrangements, detailed assessment of their impact on the recruitment and retention of care workers could now be undertaken. The aim of this process should be: to strengthen the network of agencies with domiciliary care responsibilities; to identify any weaknesses in forward planning; and to contribute to effective development of services in the context of Somerset's large and growing population of older people.

### ***Recruiting staff***

Given the difficulty reported in recruiting suitable staff, further outreach work is needed to ensure that new sources of labour supply are identified and that the changes being made, both locally and nationally, to create career structures in social care and to accredit and professionalise the care sector, succeed in attracting new people, from all ethnic groups and both sexes, into the domiciliary care workforce.

#### ➤ **New sources of labour**

In some parts of the county, it may be helpful to pay particular attention to attracting applicants from local communities where economic activity rates are relatively low (and where some women are finding access to employment very difficult (Buckner et al 2004; Escott et al 2006). Women

in these communities often find re-entry to the labour market particularly hard, but would welcome the opportunity to access jobs where training and progression routes are available. New domiciliary care workers from these communities may be particularly keen to access employment which includes opportunities for up-skilling and career development.

#### ➤ **Attracting applicants**

Like other parts of the country, Somerset faces some problems with the 'migration' of domiciliary care staff between different parts of the social care sector, and across different sectors of the economy. Key stakeholders are now beginning to recognise this as a potential strength rather than a weakness of the sector, however, with social care positions offering points of entry to a wider range of employment and career opportunities than previously.

Providers stressed the limited scope in the system for reallocating costs, and the difficulty they currently face in competing for the available labour supply using higher rates of pay. Local agencies nevertheless need to find ways of addressing the problem of low pay in this field of work, and have a role to play in highlighting this issue at the national, strategic level. Providers also need to recognise and promote the advantages of the employment they offer in new ways. There are encouraging signs that some applicants are beginning to come forward in response to the enhanced opportunities for training, accreditation and progression which domiciliary care work now offers, but much more could be done to reshape the image of the job, and some further work could be developed to tackle this at the local level, in continuing partnership with other relevant agencies.

### ***Strategic planning and the longer term***

Providers in Somerset are undoubtedly aware of the need to continue to focus on recruitment and retention issues; however, it is unclear how far they have fully understood the implications of the major demographic challenges ahead, or have considered their local ramifications in the medium to long term.

It is crucial that the strategic planning and review process continues to address capacity issues, and that further activity is undertaken to reshape the local social care market and ensure that an effective network of businesses and organisations is available locally to deliver on

future demand for domiciliary care services. The role played by Care Focus (Somerset) is a good example of proactive development of the training and skills development work required. As the most important commissioner of domiciliary care services in the county, Somerset County Council will continue to have a key role to play here, and can contribute to the necessary local awareness-raising by working actively with other key agencies, including *Skills for Care* with its brief to connect skills development and labour supply issues, and the *UK Home Care Association*, as an advocate of good practice from within the sector.

### ***Resource issues***

Those organisations which participated in the research in Somerset are already aware of the benefits employers gain by supporting and rewarding their staff, particularly in terms of retaining personnel who might otherwise be attracted by alternative opportunities elsewhere. The scope local agencies have for developing this support is constrained by the tight financial situation in the sector. The allocation of substantial additional resources to support domiciliary care is likely to remain a matter primarily for public policy, public opinion and central government to resolve, although heightened awareness of key issues at the local level, and pressure from key agencies in the decision-making process, can contribute to the debate needed about the funding of social care.

### ***Domiciliary care and the local labour market***

Other research within the GELLM programme has shown the critical importance of women's employment in local labour markets. This is particularly true of Somerset's labour market, where employers across the public sector, and in the independent health and social care sectors, rely heavily on women to fill the available jobs, with women now occupying more than half of all jobs in the county (around 35% of all full-time jobs and about 78% of all part-time jobs).

In this other work (Buckner et al 2004; Escott et al 2006; Stiell et al 2006) we have emphasised the importance of key features of the labour supply provided by women, many of whom prefer to work part-time and flexibly, but who often pay a heavy price for this in terms of their rates of pay, accepting positions which involve working below their potential, and delivering services which are both socially and economically undervalued.

Domiciliary care – the essential support services for those who are frail, disabled and ill, whose quality ought to be a hallmark of a modern, decent society – is perhaps the prime example of this type of work. Many steps have already been taken to address problems in delivering domiciliary care, at both local and national level. However, given the difficult challenges facing Somerset, in terms of its ageing population, its rural/urban mix, and its proximity to other centres of employment in the South West, it seems likely that reconciling supply and demand for domiciliary care will continue to be an important challenge for key agencies in Somerset for some years to come.

In committing to existing partnerships in this field, and to exploring ways of drawing new sources of labour into this form of work, Somerset County Council has already begun to address local challenges in reconciling supply and demand in domiciliary care. Within the sector, job image and job design, resource planning, employment and working conditions, training and workforce development will continue to need energetic attention in the years to come if older people and others in need of home care in Somerset are to receive the quality of service they deserve and will require.

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## Appendix 1 Gender and Employment in Local Labour Markets

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

### The GELLM project output comprises:

- new statistical analysis of district-level labour market data, led by Dr Lisa Buckner, producing separate **Gender Profiles** of the local labour markets of each of the participating local authorities (Buckner, Tang and Yeandle 2004, 2005, 2006) - available from the local authorities concerned and at [www.shu.ac.uk/research/csi](http://www.shu.ac.uk/research/csi)
- 6 **Local Research Studies**, each involving between three and six of the project's local authority partners. Locality and Synthesis reports of these studies, published spring-summer 2006 are available at [www.shu.ac.uk/research/csi](http://www.shu.ac.uk/research/csi). Details of other publications and presentations relating to the GELLM programme are also posted on this website.
  1. *Working below potential: women and part-time work*, led by Dr Linda Grant and part-funded by the EOC (first published by the EOC in 2005)
  2. *Connecting women with the labour market*, led by Dr Linda Grant
  3. *Ethnic minority women and access to the labour market*, led by Bernadette Stiehl
  4. *Women's career development in the local authority sector in England* led by Dr Cinnamon Bennett
  5. *Addressing women's poverty: local labour market initiatives* led by Karen Escott
  6. *Local challenges in meeting demand for domiciliary care* led from autumn 2005 by Professor Sue Yeandle and prior to this by Anu Suokas

### The GELLM Team

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

### The GELLM Partnership

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

## Appendix 2 Research methods

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

### ***Analysis of 2001 Census data***

Data from the 2001 Census for England and from the sub-national population projections<sup>10</sup> were used to produce a statistical profile relating to domiciliary care in Somerset. This explored:

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

### ***Postal survey of providers***

A postal questionnaire was sent to all 41 domiciliary care providers registered with Somerset's SSD in 2005. The purpose of the survey was to explore providers' employment, training and human resources practices and policies and to recruit providers to take part in telephone interviews. 19 providers responded to the survey in Somerset, a response rate of 46%. They included 1 from the voluntary and community sector, 12 private for-profit organisations, and 6 private not-for-profit organisations. Somerset no longer provides domiciliary care directly from within its own workforce. Data from the survey were analysed using SPSS to produce frequencies, cross tabulations and bar charts.

### ***Interviews with key stakeholders and a sample of providers***

Follow-up in-depth interviews were conducted with 10 key stakeholders and providers in Somerset. The interviews with key stakeholders were conducted with managers responsible for Care Focus (Somerset), training/staff development, and the in-house management of domiciliary care within the Somerset County Council's Social Services Department, using specially designed interview schedules, which included a request for relevant documentation. The interviews with providers explored workforce management, planning and recruitment practices, and interviewees were asked to supply relevant supporting documentation (e.g. examples of contracts of employment, policy documents relating to flexible working, training etc.). These interviews were tape-recorded and transcribed prior to being analysed by the research team.

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<sup>10</sup> 2003 based sub-national population projections, Government Actuary Department, Crown Copyright 2004.

## Appendix 3 Statistical information about Older People in Somerset and about Care Assistants and Home Carers

**Figure A1 Statistical information about older people in Somerset**  
(figures for England are presented in brackets)

	Men			Women		
	65-74	75-84	85+	65-74	75-84	85+
<b>Population in 2001 (numbers)<sup>11</sup></b>	23,161	14,000	3,748	25,870	20,895	9,006
<b>Tenure (%):</b>						
Owns	82 (77)	76 (69)	64 (59)	79 (74)	68 (62)	49 (45)
Rents from council/social landlord	12 (17)	15 (21)	14 (20)	14 (20)	18 (25)	16 (22)
Private rented	5 (5)	7 (6)	8 (9)	6 (5)	8 (8)	10 (9)
Lives in communal establishment	1 (1)	3 (3)	14 (12)	1 (1)	5 (5)	25 (23)
<b>Living arrangements (%):</b>						
Lives alone	15 (17)	21 (26)	33 (37)	31 (33)	51 (52)	51 (55)
Lives with a partner	81 (76)	71 (65)	44 (41)	61 (56)	34 (31)	10 (8)
<b>Health and care (%):</b>						
General Health 'not good'	15 (19)	22 (25)	30 (32)	15 (19)	24 (27)	33 (36)
Limiting long-term illness	38 (42)	53 (56)	69 (70)	35 (40)	55 (58)	76 (78)
Provides unpaid care	14 (14)	12 (12)	9 (8)	15 (14)	8 (8)	3 (3)
<b>Population Change<sup>12</sup></b>						
<b>Population 2003 (numbers)</b>	23,900	14,900	3,700	26,100	21,800	9,000
Per 1,000 people of Working age in 2003 (20-64)	84 (74)	52 (44)	13 (10)	91 (83)	76 (64)	32 (25)
<b>Population 2028 (numbers)</b>	37,900	28,400	10,500	42,400	35,100	17,400
Per 1,000 people of Working age in 2028 (20-64)	119 (104)	89 (71)	33 (27)	133 (109)	110 (85)	55 (40)
<b>Change 2003- 2028:</b>						
Increase (number)	14,000	13,500	6,800	16,300	13,300	8,400
Percentage change (%)	59 (45)	91 (69)	184 (173)	63 (40)	61 (38)	93 (69)

**Figure A2 Households with one resident with a Limiting Long-Term Illness**

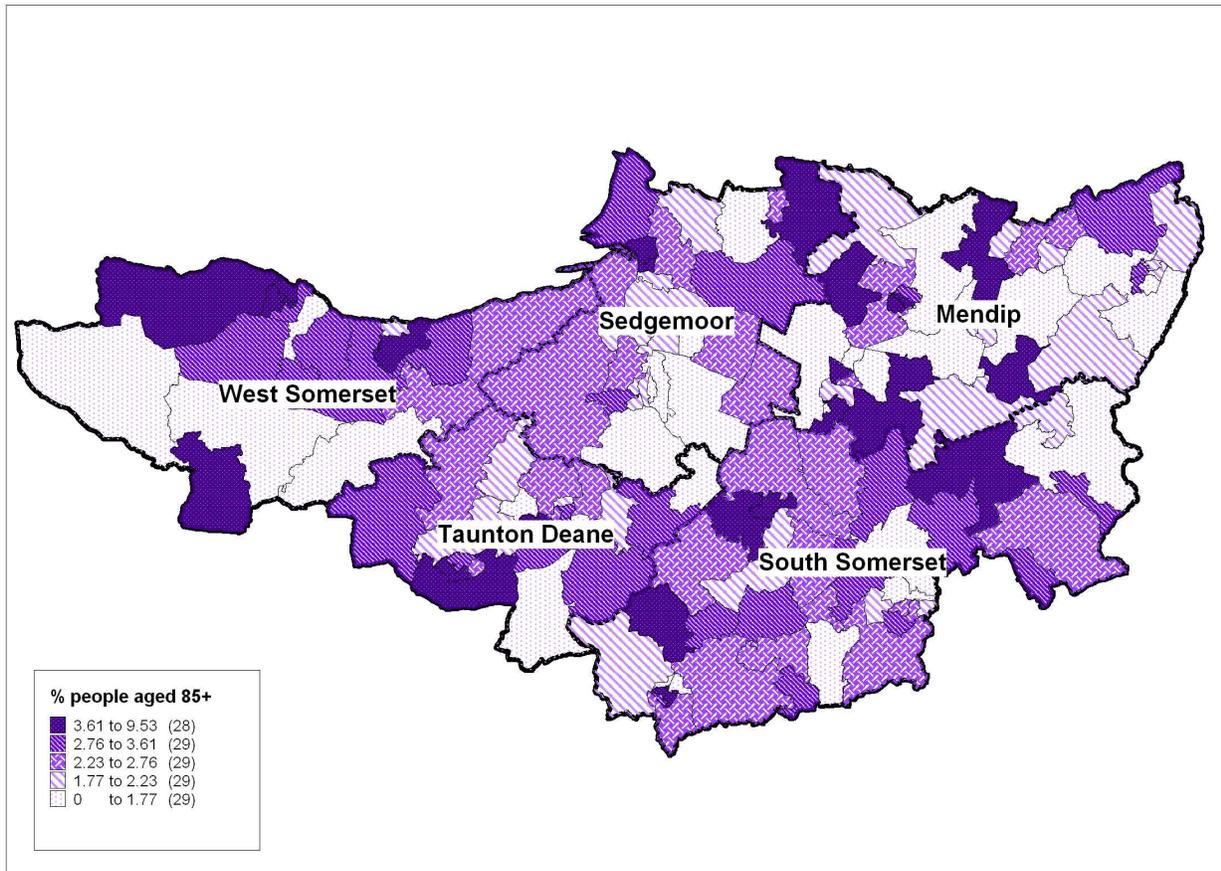
	All households 210,586	Age of resident with LLTI	
		65-74	75+
Number with a resident with a LLTI	69,799	10,025	16,094
% of all households	33 (34)	5 (5)	8 (7)
% with no carer in household	70 (71)	81 (82)	85 (86)

Source: 2001 Census Standard Tables, Crown Copyright 2003

<sup>11</sup> Source: 2001 Census Theme Tables, Crown Copyright 2003.

<sup>12</sup> Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005.

Figure A3 Percentage of people aged 85 and over in Somerset



Source: 2001 Census Key Statistics, Crown Copyright 2003. 2001 Census Output Area Boundaries, Crown Copyright 2003. This work is based on data provided through EDINA UKBORDERS with the support of the ESRC and JISC and uses boundary material which is Copyright of the Crown

**Figure A4 Care Assistants and Home Carers (CA&HCs), Somerset**  
(figures for England are presented in brackets)

	Men				Women			
	16-64	16-24	35-49	50-64	16-59	16-24	25-49	50-59
<b>Number:</b>								
All CA&HC	122,898 689	16,106 108	71,494 426	35,298 155	99,475 6,140	10,074 924	61,759 3,597	23,642 1,619
<b>% in employment who are CA&amp;HC</b>	0.6(0.4)	0.7(0.5)	0.6(0.4)	0.4(0.4)	6.2(4.0)	6.6(3.8)	5.8(3.8)	6.8(4.9)
<b>% across all age groups:</b>								
All in employment CA&HC		13 (13) 16 (16)	58 (62) 62 (62)	29 (25) 23 (22)		14 (15) 15 (14)	62 (65) 59 (61)	24(20) 26(25)
<b>% across all age-sex groups:</b>								
All in employment CA&HC	55 (55) 10 (12)	7 (7) 2 (2)	32 (34) 6 (7)	16 (14) 2 (3)	45 (45) 90 (88)	6 (7) 14 (13)	28 (29) 53 (54)	11(9) 24(22)
<b>Employment Status:</b>								
<b>All in employment</b>								
Employee full-time	73 (76)	75 (74)	77 (80)	62 (68)	46 (55)	59 (62)	46 (56)	40(47)
Self-employed full-time	18 (15)	4 (4)	18 (15)	25 (21)	5 (4)	1 (0)	5 (4)	8 (6)
Employee part-time	6 (7)	20 (22)	3 (4)	7 (6)	43 (38)	39 (37)	44 (37)	45(42)
Self-employed part-time	3 (2)	1 (1)	2 (2)	5 (4)	5 (4)	1 (1)	5 (4)	7 (5)
<b>Care Assistants &amp; Home Carers</b>								
Employee full-time	79 (74)	79 (69)	82 (77)	70 (68)	41 (43)	59 (56)	39 (42)	35(40)
Self-employed full-time	3 (2)	0 (0)	3 (2)	5 (5)	1 (0)	0 (0)	1 (1)	2 (2)
Employee part-time	17 (23)	21 (30)	14 (20)	23 (25)	57 (55)	41 (44)	58 (54)	61(57)
Self-employed part-time	1 (1)	0 (1)	1 (1)	2 (2)	2 (1)	0 (0)	2 (1)	2 (3)
<b>Qualifications:</b>								
<b>All in employment</b>								
No qualifications	19 (19)	10 (11)	14 (14)	34 (35)	16 (16)	7 (6)	12 (12)	33(35)
Lower level	52 (49)	80 (74)	57 (51)	30 (28)	58 (54)	82 (76)	61 (55)	37(34)
Higher level	29 (33)	10 (15)	29 (35)	36 (37)	26 (30)	11 (18)	27 (32)	30(30)
<b>Care Assistants &amp; Home Carers</b>								
No qualifications	15 (19)	10 (11)	12 (16)	27 (36)	24 (29)	7 (11)	20 (24)	43(50)
Lower level	63 (58)	84 (79)	65 (60)	46 (36)	64 (58)	89 (81)	68 (62)	41(34)
Higher level	22 (23)	7 (10)	23 (24)	27 (28)	12 (13)	4 (8)	11 (13)	16(16)
<b>Unpaid care:</b>								
All in employment CA&HC	10 (10) 17 (17)	3 (4) 12 (11)	8 (8) 15 (16)	16 (17) 26 (26)	14 (13) 17 (18)	4 (5) 9 (10)	12 (12) 17 (17)	23(24) 24(25)

Source: 2001 Census Commissioned Tables, Crown Copyright 2003

Note: Lower level qualifications are equivalent to 'A' level and below and higher level qualifications are equivalent to first degree and above

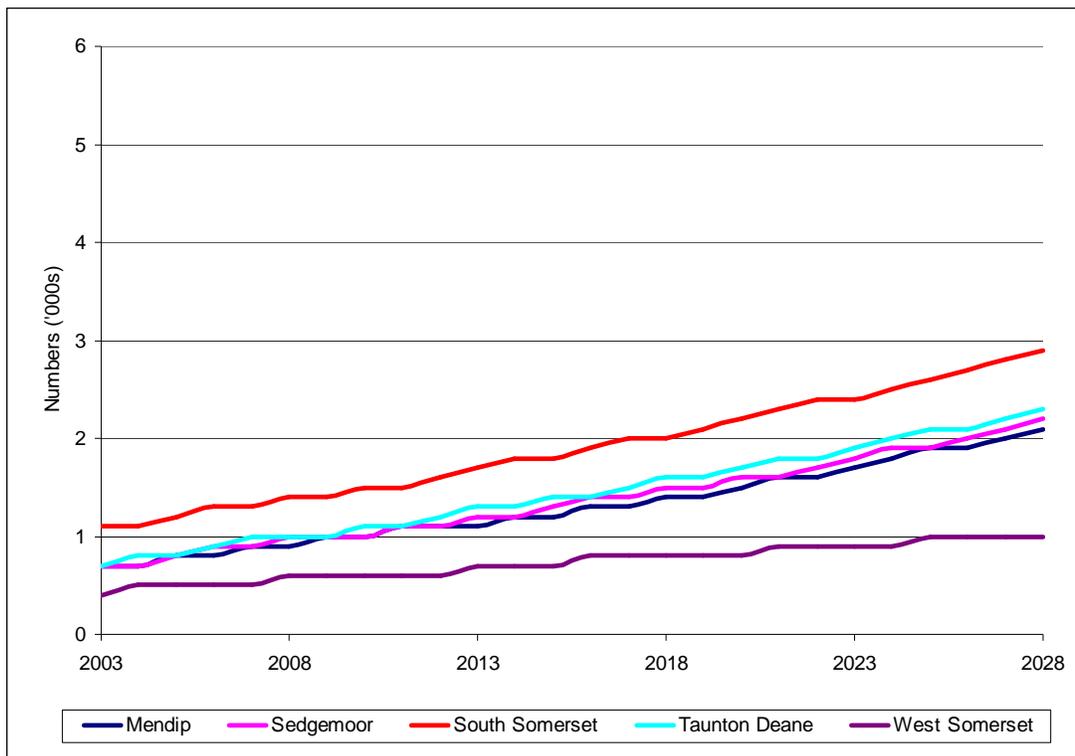
**Figure A6 Information on people aged 85+ in the Somerset districts**

	Mendip		Sedgemoor		South Somerset		Taunton Deane		West Somerset	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
<b>Population in 2001 (numbers)<sup>13</sup></b>	700	1,743	724	1,799	1,148	2,692	746	1,884	430	888
<b>Tenure (%):</b>										
Owns	63	46	63	52	67	49	60	46	67	49
Rents from council/social landlord	13	14	13	15	14	17	16	18	11	16
Private rented	6	5	3	3	4	3	2	3	6	6
Lives in communal establishment	15	29	16	24	11	23	17	26	14	24
<b>Living arrangements (%):</b>										
Lives alone	29	49	33	49	36	53	32	53	34	51
Lives with a partner	45	9	41	10	45	10	41	9	45	11
<b>Health and care (%):</b>										
General Health 'not good'	28	31	28	34	32	34	33	33	26	29
Limiting long-term illness	68	77	68	77	69	75	73	79	66	73
Provides unpaid care	9	3	7	4	9	3	10	2	9	3
<b>Population Change<sup>14</sup></b>										
<b>Population 2003 (numbers)</b>	700	1,700	700	1,700	1,100	2,700	700	1,900	400	900
<b>Population 2028 (numbers)</b>	2,100	3,200	2,200	3,200	2,900	5,700	2,300	3,600	1,000	1,700
<b>Change 2003- 2028:</b>										
Increase (number)	1,400	1,500	1,500	1,500	1,800	3,000	1,600	1,700	600	800
Percentage change	200	88	214	88	164	111	229	89	150	89

<sup>13</sup> Source: 2001 Census Theme Tables, Crown Copyright 2003.

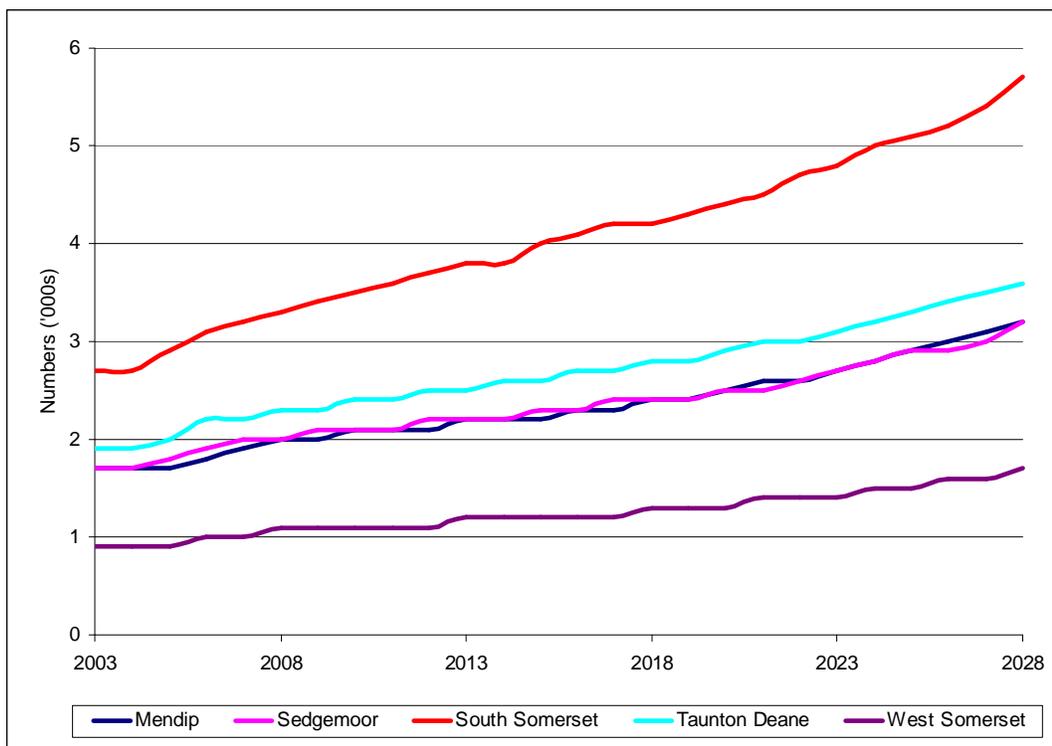
<sup>14</sup> Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005.

**Figure A7 Population projection for men aged 85+ in the Somerset Districts**



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

**Figure A7 Population projection for women aged 85+ in the Somerset Districts**



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

**Figure A8 Care Assistants and Home Carers (CA&HCs), Somerset districts**

	Mendip		Sedgemoor		South Somerset		Taunton Deane		West Somerset	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
<b>Number:</b>										
All CA&HC	26,129	21,088	25,793	20,641	38,690	30,349	24,870	21,530	7,419	6,618
	108	1,141	147	1,267	141	1,751	229	1,480	67**	501
<b>% in employment who are CA&amp;HC</b>	0.4	5.4	0.6	6.1	0.4	5.8	0.9	6.9	0.9	8.1
<b>% aged 50-64/59:</b>										
All in employment	29	26	30	24	28	24	27	23	33	27
CA&HC	24	29	28	26	22	28	18	22	24	30
<b>% across all age-sex groups aged 50+:</b>										
All in employment	16	11	17	11	16	10	14	10	18	12
CA&HC	2	26	3	23	2	26	2	19	3	27
<b>Employment Status:</b>										
<b>All in employment</b>										
Employee full-time	70	46	73	46	76	46	73	49	60	42
Self-employed full-time	20	6	18	5	17	5	17	4	26	11
Employee part-time	6	43	6	44	5	44	7	42	8	40
Self-employed part-time	3	6	3	5	2	5	3	4	5	8
<b>Care Assistants &amp; Home Carers</b>										
Employee full-time	75	41	75	43	78	34	83	48	78	38
Self-employed full-time	3	1	8	1	2	1	1	1	0	2
Employee part-time	19	57	16	5	20	62	15	50	22	59
Self-employed part-time	3	1	2	2	0	1	1	1	0	1
<b>Qualifications:</b>										
<b>All in employment</b>										
No qualifications	20	17	22	18	17	17	17	14	22	17
Lower level	51	56	52	59	54	59	53	57	51	59
Higher level	29	27	27	24	29	24	30	28	26	25
<b>Care Assistants &amp; Home Carers</b>										
No qualifications	16	28	23	25	14	25	11	20	7	26
Lower level	56	58	53	64	69	64	71	69	59	64
Higher level	28	13	25	12	17	11	18	11	34	10
<b>Unpaid care:</b>										
All in employment	9	14	10	14	9	14	10	13	10	14
CA&HC	19	18	14	15	14	20	14	16	28	16

Source: 2001 Census Commissioned Tables, Crown Copyright 2003

Note: Lower level qualifications are equivalent to 'A' level and below and higher level qualifications are equivalent to first degree and above