

Local Challenges in Meeting Demand for Domiciliary Care in Thurrock

Sue Yeandle
Lucy Shipton
Lisa Buckner



Foreword

Over the past three years Thurrock Council has worked in partnership with the Centre for Social Inclusion at Sheffield Hallam University (SHU), as one of eleven local authorities taking part in the national **Gender and Employment in Local Labour Markets Programme** (GELLM).

In participating in this project Thurrock Council has made a firm commitment to disseminate and implement the SHU research findings by engaging with key stakeholders during all stages of the project.

This research study builds on the earlier work of the Council - as set out in the ***Gender Profile of Thurrock's Labour Market (2004)*** – by creating a better understanding of gender equality and the economic benefits of a diverse workforce. As one of Thurrock's largest employers, and as community leaders, we know it makes sense to ensure that both men and women are recognised. Our goal is to become an excellent authority, an employer of choice and to promote employment within Thurrock.

Through active participation in the GELLM research project, Thurrock 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 seeks to work with local employers to create gender equality throughout the borough.

Christine Paley.

Corporate Director for Community Well-Being

Acknowledgements

We are very grateful to Christine Paley, Director of Housing and Social Care, and to Rita Cheatle, Ade Fadare, Jan Hurn, Fran Leddra-Chapman, Vera Markos, Tania Sitch at Thurrock Council for their assistance in conducting this study.

We would also like to thank the staff within the private and voluntary sector organisations providing domiciliary care services in Thurrock, and within Thurrock Social Services Department, who took the time to complete our questionnaire, supply us with documentation, and participate in our interviews. 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:

Development and implementation of the study	Anu Soukas
Interviews with providers and stakeholders	Anu Suokas and Lucy Shipton
Survey work	Anu Suokas and Lucy Shipton
Statistical analysis	Lisa Buckner
Report writing, and overall direction of the research	Sue Yeandle, Lucy Shipton and Lisa Buckner

All Crown Copyright material is reproduced with the permission of HMSO.

Contents

Key findings	2
Introduction	4
The changing policy environment for domiciliary care	4
About the study	5
Domiciliary care in Thurrock - changes in supply and demand	6
Policy developments in Thurrock	8
Survey of Thurrock providers	10
Employment policies and practices in domiciliary care	11
Policy messages and recommendations	16
References	18
Appendices	
A1 Gender and Employment in Local Labour Markets	19
A2 Methodological approach	20
A3 Statistical information about older people in Thurrock and Care Assistants and Home Carers	21

Key Findings

This study is about the challenges faced by key agencies in responding to changes in supply and demand for domiciliary care in Thurrock. 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 Thurrock only. They are drawn from:

- analysis of official statistics relating to Thurrock
- a new survey and follow-up interviews with providers of domiciliary care in Thurrock (all sectors)
- interviews with key stakeholder managers
- documents supplied by respondents to our survey and by Thurrock's Social Services Department

Demand for domiciliary care in Thurrock

Thurrock's ageing population and continuing high levels of poor health and deprivation in parts of the borough mean that demand for domiciliary care is growing.

- 32% of households in Thurrock contain a person with a limiting long-term illness, including over 3,500 where the sick person is aged 75+.
- There is no co-resident carer in 88% of these households.
- Thurrock's population of very aged (85+) residents is expected to rise by over 2,600 people by 2028, with a particularly strong increase in the number of very aged men.
- 94% of very aged men, and 87% of very aged women in Thurrock live in their own homes.
- 41% of very aged men, and 63% 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 Thurrock.

- 900 Thurrock residents, 91% of them women, are already employed as care workers. 1 in

37 of all employed women in Thurrock is a care worker.

- In Thurrock, 56% of female care workers, and 19% of male carer workers, work part-time. Over 80% of care assistants and home carers are White British, although Thurrock's minority ethnic residents, especially men, are more strongly concentrated in care work than people of other ethnicity.
- Over a third of all Thurrock's care workers held no qualifications in 2001 – and two thirds (67%) of women care workers aged 50-59. However among care workers aged under 25, fewer than 1 in 8 (both sexes) were entirely without formal qualifications.

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. Thurrock has responded to these changes in a variety of ways, and re-shaping of the care market has affected all stakeholders.

- Thurrock's domiciliary care providers currently include small, medium and large organisations, across the public, private and voluntary sectors. Almost 80% of domiciliary care in the borough is purchased from the independent sector.

Employment challenges

Providers in Thurrock face many of the same challenges being addressed across the country, underscored by particular local circumstances, including proximity to the London labour market and, in Thurrock, very strong recent growth in employment in the distribution, hotels and restaurants sector. Employers in the domiciliary care sector reported both progress and concerns about the available supply of labour, the current composition of the domiciliary care workforce, and achieving 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 almost all cases.
- Providers reported progress in moving towards the National Minimum Standards

(NMS) qualifications targets, and some noted that the new qualifications and career frameworks were beginning to attract new applicants. There were a number of concerns in this area as well:

- Covering the workload when staff were released for training
 - Retaining staff once they had completed their training
 - Meeting the costs of NVQ training courses
 - Limited scope in some organisations for paying staff for the time spent on job training
 - Their ability to address the basic skills and confidence issues of some staff
- Rates of staff turnover varied considerably between providers: staff shortages were a minor issue for some, but an acute problem for others.
 - Some providers were experimenting with new recruitment arrangements (including internet advertising) but there was limited evidence of special initiatives, such as those targeting applicants from particular local communities or from different ethnic minority groups.
 - Providers were usually able to offer their staff some support with training costs (including in some cases giving staff study leave), but there was also evidence of some care staff having to pay their own NVQ costs, and being required to study in their own time.
 - 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.

Provider and stakeholder perspectives

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

- Supply and demand is a concern
- The image of the job remains a problem
- 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 (retail, restaurants etc.), which offer work environments, hours and work which some staff find more attractive.
- The flexible hours and working arrangements providers can offer are valuable 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 costs of training and workforce development were a concern for some employers.
- Some providers were concerned about very tight financial arrangements, and worried that price was sometimes put before quality.
- Some providers noted good partnership working across the sector; others reported less positive experiences.

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 UKHCA¹'s 2004 profile of the independent home care workforce in England (McClimont 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 2005².

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 Departments³ (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

¹ UK Home Care Association

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

³ Responsibility for the local delivery of social services has now been split between Adults' and Children's Services, in most cases involving restructuring and renaming of these departments.

grew by 90% between 1993 and 2004⁴, reflecting government policies promoting independent living and care at home, as well as substantial growth in the number of older people living in single person households. 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 Thurrock, 9,950 contact hours of domiciliary care per week were provided to 900 households in 2004, and 78% of this care was provided by independent providers⁵.

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 (DSS 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 National Service Framework for Older People* (2001)
- *Better Government for Older People* (2004)
- 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
- *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), and
- *Our health, our care, our say: a new direction for community services* (DoH White Paper 2006), which includes new arrangements for individualised care budgets'.

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.

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 Thurrock 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, is also available (Yeandle et al 2006). *Local Challenges in Meeting Demand for Domiciliary Care* is one of the three locality studies conducted in Thurrock within the GELLM project, and builds on the project's earlier

⁴ Community Care Statistics 2004, Health and Social Care Information Centre, 2005

⁵ Community Care Statistics 2004, Health and Social Care Information Centre, 2005

statistical work, *The Gender Profile of Thurrock'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, independent and public 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 Thurrock – changes in supply and demand

Demographic projections in Thurrock

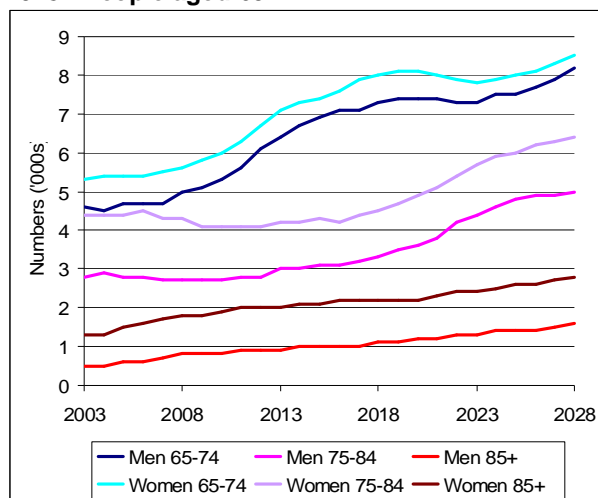
In 2001, Thurrock had 58,481 households, of which 18,627 (32%) contained a resident with a limiting long-term illness, including over 3,500 households where the resident with the illness was aged 75 or over. In almost 88% of these homes, there was no co-resident carer. As we showed in the *Gender Profile of Thurrock's Labour Market*, levels of poor health and disability in Thurrock for older women are high by national standards; almost two thirds of women aged 65+ in the district have 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 Thurrock also provide an important context.

Although only 1.2% of Thurrock's residents were aged 85 or older in 2001 (compared with 1.9% in England as a whole), this figure can be expected to rise. The population projections for older people in Thurrock are shown in Figure 1.

Between 2003 and 2028, Thurrock's population of residents aged 85+ is expected to grow very significantly. The latest estimate suggests that there will be 2,600 more people in this age group, of whom 1,500 will be women. This will *more than double* the number of very aged women, and will *more than triple* the number of very aged men living in Thurrock. There are also likely to be 2,000 more female and 2,200 more male residents aged 75-84. The expected rate of growth in Thurrock's population of older people is

considerably higher for both men and women than in England as a whole. For men aged 85+ the projection is 220%, and for women aged 85+ 115%, over the period 2003-2028.

Figure 1 Thurrock: 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 Thurrock about 87% of women aged 85+, and about 94% of men aged 85+, were living in their own homes, either owned or rented⁶ - well above the national average figures - and that a lower proportion of Thurrock residents live in 'communal establishments', such as residential homes. Most notably, Thurrock's very aged residents were much more likely than at the national level to live in social housing.

Almost 63% of all Thurrock women aged 85+, and almost 41% of men of this age, lived alone - also well above the national average. In 2001, the overwhelming majority of the borough's very aged women (80%) - and about 69% of its very aged men - had a limiting long-term illness, with a third of these men and women stating that their general health was 'not good'. Despite this, 8% of Thurrock's men aged 85+, and 2% of women of this age, were themselves providing regular unpaid care to a family member or friend - with 4% of these very aged men doing so for 50 or more hours each week.

Appendix 3 of this report includes a more detailed presentation of the main statistical evidence

⁶ These figures include those who were owner occupiers with a mortgage or loan

discussed above, together with some further 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 in Thurrock. This is likely to be very challenging for care providers in Thurrock, especially as the domiciliary care sector in the borough operates in a local labour market context which has particular features likely to affect the recruitment of staff.

The key local labour market issues are:

- Between 1991 and 2002, there was very significant job growth in Thurrock, with a net increase of almost 17,000 jobs (over 9,000 additional part-time jobs and over 7,700 additional full-time jobs) (Buckner et al 2004: 23). Total job growth in this period was +43.5% in the borough, compared with a national figure of 19.2%, and considerably outstripped Thurrock's population growth over the same period (+10,700 people of working age). A continuation of this trend would mean significant competition for workers, perhaps especially for those wanting to work part-time, between the social care sector and other sectors with high levels of part-time working – notably retail, hotels and catering, cleaning and various other forms of service sector employment. As we showed in the *Gender Profile of Thurrock's Labour Market*, by 2002, 43% of all jobs held by women in Thurrock were in the distribution, hotels and restaurants sector (compared with 27% in England), with almost 10,000 additional jobs held by Thurrock women in 2002 compared with 1991 (about two-thirds of them part-time), and with no major industrial sector recording net job losses among women (Buckner et al 2004:24-25).
- Although overall levels of unemployment and economic inactivity in Thurrock were a little lower than the national average among men aged 25+ and women aged 25-34, among young people, self-reported unemployment was high (over 8% for young men and over 5% for young women) (Buckner et al: 39-42). Our further research in some wards in the borough suggests that gaining access to paid employment remains a problem for some Thurrock residents (Grant et al 2006a and 2006b). For example, in the Grays Riverside and West Thurrock and South Stifford wards, over 12% of economically active women aged

16-24 were unemployed in 2001 (about double the national and Thurrock rates). There may thus be some people living in the borough who might welcome the opportunity to enter domiciliary care work⁷. The borough also has a relatively high proportion of 'economically inactive' women looking after their home and family full-time (60%, compared with 48% in England as a whole), and some of these women may wish to return to paid work in the future (Grant et al 2006a).

- Thurrock Council's ASPIRE Strategy noted that the Thurrock Urban Development Corporation hoped to achieve £62.8m of investment in the local economy by 2005/6, and to secure the creation of over 1,200 new jobs. The *Thames Gateway* development is also expected to bring significant economic changes to the borough.
- Thurrock has average levels of self-employment among men, and rather low levels of self-employment among women (2.7% of women and 13% of men, compared with 4.9% and 13.2% in England). This is unlikely to present a particular barrier in domiciliary care work, however, as very few care workers are self-employed (0.7% of female and 5.1% of male care workers in Thurrock in 2001).
- Given that, in England as a whole, some ethnic minority groups form a particularly important supply of caring labour⁸, Thurrock's relatively small ethnic minority population (7.5% of all male and 6.8% of all female residents in 2001⁹) may contribute to future labour supply. However, as the borough has only a very small population of Black Caribbean and Black African residents (just over 1% in 2001), and this group is already over-represented in care work, they are unlikely to provide much of the future labour supply needed for care assistant and care worker jobs (Figure 2).

⁷ Although it should be noted that current regulations prevent young people under 18 from working in domiciliary care.

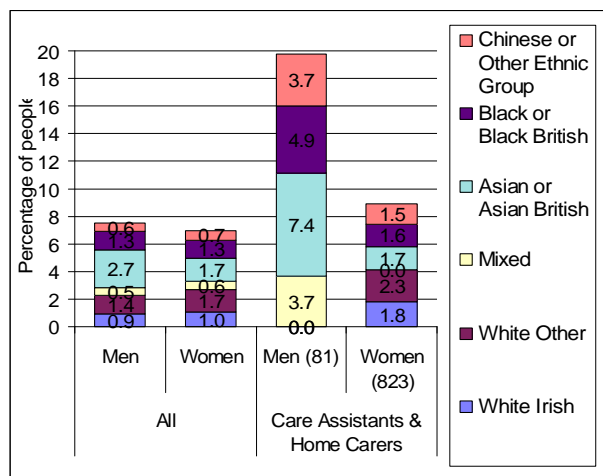
⁸ Notably women aged 25-59 in the Irish, Black, and Mixed ethnic groups, and men of all ages from the various Black and Mixed ethnic groups.

⁹ In 2001, the female population of Thurrock (all ages) included: White Irish (1.1%); White Other (1.4%); Mixed Ethnic Group (0.9%); Black or Black British (1.1%), Asian or Asian British (1.7%); Chinese/Other Ethnic groups (0.6%).

The social care workforce in Thurrock

The 2001 Census showed that 900 Thurrock residents were people of working age in paid employment as care assistants and home carers - about 91% of them women¹⁰. At that date, about 1 in every 37 women employed in Thurrock was a care assistant or home carer (compared with 1 in 25 in England as a whole). This suggests both that it may be possible to draw additional workers into the social care sector, and that many women have found work in other parts of the local or regional economy. Well over half (56%) Thurrock's care workers were women aged 25-49 (compared with 54% across England), while about 27% were women in their fifties (compared with 22% in England as a whole).

Figure 2 Ethnicity of care assistants and home carers in Thurrock



Source: 2001 Census Commissioned Tables, Crown Copyright 2003

In Thurrock, 56% of female, and 19% of male care workers worked part-time (compared with 55% and 23% in England). Women care workers (all ages) were much more likely to work part-time than other workers. Over 90% of female care workers in Thurrock, and 80% of the borough's male care workers were White British. This means that Thurrock's ethnic minority residents (especially men) were over-represented among

¹⁰ Data are not available at district level for domiciliary care workers only. The 'care assistants and home carers' category is the closest available definition. Some care workers are employed in residential and day care facilities, with some working 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.

care workers (Figure 2), although the numbers of men were very small.

In Thurrock, female care workers aged under 50, are considerably more likely than other comparable workers to have unpaid caring responsibilities for a sick, disabled or frail relative or friend alongside their paid jobs.

Across England, female care workers are much more likely to lack formal qualifications than other women workers (29% of female care workers, 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 employed women in their fifties. This difference in level of qualification is much less marked for men. In Thurrock, a higher proportion of care workers have no qualifications, compared with the national situation. 67% of Thurrock's female care workers aged 50-59 had no qualifications in 2001. However, among the small number of young care workers (aged 16-24) in Thurrock, 13% (of 73) young women, and 31% (of 13) young men had no qualifications.

Policy developments in Thurrock

Responsibility for the commissioning and procurement of domiciliary care services to meet the assessed needs of Thurrock's residents lies with Thurrock Council's Housing and Social Care Directorate (formerly the SSD). In 2005, it purchased about 78% of its domiciliary care from external agencies. Key recent developments in Thurrock and the Essex region include:

Essex Care Training Partnership (ECTP)

This employer-led partnership was set up in 2001 to offer a brokerage service for all Social Care providers in Essex, Southend and Thurrock, with support from Essex County Council, Thurrock Council, Southend Borough Council and the independent and voluntary sector. ECTP aims to increase care provider participation in workforce development activity, and supports employers to meet the National Minimum Standards in training and development.

At the time of our research, ECTP was developing its activities in consultation with the

Essex Social Care Workforce Strategy Group, and was assisting care providers to equip their staff with 'the knowledge and skills they need to provide high standards of service'. Established to share ideas and experiences across the social care sector, the partnership supports organisations who wish 'to share training resources and ensure cost-effective use of resources'. Organisations wishing to share a training course with other local social care providers can submit on-line to find suitable partners, and is accessible to individuals wishing to identify local training opportunities. The website also offers information and guidance on:

- workforce planning
- a directory of training providers
- training and awareness raising events
- funding streams to support brokerage activities
- and the ESOL¹¹ training audit of social care staff (being conducted in Essex by *Skills for Care Eastern* and the region's *Learning and Skills Councils*)

Thurrock Ageing Strategy Steering Group

This group, formed in 2004, is a multi-agency forum including a number of departments within Thurrock Council, the local PCT and NHS Trust, the Pension Service and local voluntary agencies supporting older people. Building on the *Independence Strategy* agreed in 2001, this group commissioned an analysis of Thurrock's 50+ population, using data from the 2001 Census and from local surveys (*The 50+Local Profile*, produced in 2004) to provide a comprehensive picture of the quality of life and aspirations of older people in Thurrock. As part of this development, Thurrock Council has supported 'a new holistic approach to wellbeing', developing an *Older People at the Centre* group (OPAC) and employing an Older People's Planning Officer. The council has also made other commitments to providing support for active and healthy ageing in the Borough, through its ASPIRE strategy and other developments. Recent activities include the 2006 on-line survey of Social Care Home Care Service Users.

Essex Independent Care Association

In 2004, Essex Independent Care Association prepared a report for the Social Care Workforce

Planning Team within Thurrock Council, drawing on a new survey of independent providers of social care. The survey collected information in line with draft guidance on the National Minimum Data Set for Social Care. Analysis of the survey, which examined data relating to 675 staff, 74% of whom were care workers, found that:

- 50% of workforce were under 40
- Turnover was very high, with 40% of workers in post for less than one year
- The NVQ2 50% target was not yet deliverable – fewer than 10% had already achieved it
- Average hours per care worker were 27 per week

In relation to recruitment, retention and partnership working, the report's author noted:

Recruitment remains a problem within social care – and retention would seem to be more so. The 40% of staff recently recruited are not all from service growth. Many of them have replaced former colleagues.

Only at the more senior levels was the benefit of working together in a mutually beneficial supplier relationship realised.

Developments within Thurrock Council

Thurrock Council's *Housing and Social Care Directorate* (HSCD)¹² is responsible for delivering social care services, with 485 staff (including 117 working in its Home Care/Crisis Support/Extra Care teams) and an annual budget for Older People's Services of almost £13m. For 2005/6, the Council produced a very detailed 'Social Care Adult Services Plan' which recognised the scale of recruitment challenges in the social care field and drew attention to the implications for social care of the population growth expected in the Borough as a consequence of the UDC-led regeneration programme (+70,000 people over a twenty-year period).

Plans for improved co-ordination of health and social care services, through a new Care Trust between Thurrock Council and Thurrock Primary Care Trust were developed during 2004-5, but put 'on hold' in autumn 2005 pending national decisions about PCT restructuring. In its place, a Joint Partnership Board between Thurrock Council and Thurrock PCT has been created. This Board aims to achieve co-ordinated

¹¹ English as a Second Language.

¹² This replaced its Social Services Department in 2005.

decision-making on changes impacting on the future of health and social services in Thurrock.

HR Strategies

The HSC Directorate produced a new *HR Strategy and Workforce Plan* in 2004/5. Its recommendations included an emphasis on the following:

- Work-life balance for staff
- Commitment and quality in front-line practice
- Front-line management
- Working in teams
- Equal Opportunities and Diversity

The Directorate also produced a detailed *Learning, Development and Quality Training Plan for 2004-5* setting its vision and priorities, summarising data on its current workforce and setting out its plans for achieving national and local targets in relation to:

- workforce development
- workforce regulation
- workforce performance

with the overall of securing an effective 'working partnership of local government, service users and support agencies'.

Survey of Thurrock providers

In Thurrock, our survey of providers of domiciliary care had a 50% response rate and produced 8 responses, from the voluntary/community sector (1); the for-profit sector (2); and the not-for profit private sector(4)¹³. Thurrock Council's Housing and Social Care Directorate also responded to the survey.

Almost all the organisations completing the survey questionnaire regarded older people, people with dementia, disabled adults and people with sensory impairment as among their key client groups, although completed questionnaires were also returned by a few organisations specialising in support for people who are ill, recovering from an illness or terminally ill. The responses we received came from organisations of differing size

- 4 were organisations employing fewer than 50 care staff, 1 had between 50 and 99 employees, and 1 had 100 or more care workers. Consequently, some (4) had contracts to provide between 500-2000 hours of care per week, while a few had smaller contracts, providing less than 500 hours of care per week. All of the providers who answered the question supplied personal care and made regular visits to clients in their own homes, and most also supplied domestic help and shopping services. Four said they provided a night sitting service, and four provided escorting/accompanying services.

Six providers told us that between 10 and 50 per cent of their staff were employed for fewer than 16 hours per week, and most had some staff with this type of short hours part-time working arrangement. However, 6 providers said half or more of their staff worked full-time (30+ hours per week). Most providers who responded had some care workers aged 50 or older (although in all cases except one these older staff formed less than half their workforce).

When surveyed in 2005, almost all providers said they were currently employing some staff without qualifications at NVQ level 2¹⁴. Two said less than a quarter of their domiciliary care workers had reached this level, while two reported that more than half had achieved this standard. Three providers indicated that the majority of their care supervisory staff now had qualifications at NVQ level 3. All had some care workers registered for training and accreditation at NVQ2 level or above at the time of our survey, and 3 had over 50% of their care staff in this situation.

The providers' survey showed that staff turnover and staff shortages were matters of real of concern to some, but not all, employers. In the previous 12 months, staff turnover had ranged between 0% and 71%, and although some organisations reported no staff shortages in the previous 12 months, the worst affected employer considered that at times up to 29% of posts were unfilled.

The most common method of recruiting care workers was via local newspaper advertisements or through a personal recommendation; almost all also said they appointed new staff through the local Jobcentre. However some Thurrock

¹³ 2 respondents did not answer the relevant question. In the data which follows, total numbers below 8 indicate missing data.

¹⁴ 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.

providers had been experimenting with other approaches. Some (5) were now also using the internet to recruit staff, and 2 were using the trade or professional press. One had run special recruitment initiatives in recent months, and others had used community or other recruitment events to encourage applications. Providers said staff who left their organisation often gave up their jobs for 'personal and family reasons', and because of the 'unsociable hours'. Some also felt staff were leaving to further their careers, for better pay, or because of ill health or injury¹⁵. A minority of providers said that internal job moves and retirement were also factors causing some staff to leave their posts.

Only one of the 8 providers had staff on permanent contracts. Three providers said they were using fixed term contracts, and 3 were using casual contracts. However, no providers in Thurrock reported using zero hours contracts for their staff. Wages ranged from £5.66 to £7.00 per hour for weekdays during the day time to £6.05 to £65.00+ per hour for Sunday nights. Only 3 of the 8 providers said they reimbursed the costs staff incurred while travelling to visit clients, although 6 offered staff mileage allowances. All the providers claimed to pay holiday benefits, and 2 said they paid sickness benefits above statutory requirements. Two providers said they offered their staff membership of a pension scheme. Seven of the 8 providers said they met or partially covered staff training costs in attaining NVQ target levels, although only a minority (3) reported giving staff study time for this.

Most of the Thurrock providers said they had some difficulty in meeting the costs of training their staff, and the majority said they found it hard both to release staff for training and to meet the costs of replacing staff while they were being trained. Most providers had some difficulty finding the resources needed for assessment and funding, and reported some problems in the quality of training. Over half of the providers also reported that some of their employees' lacked confidence, and expressed some concerns about retaining staff once they were trained.

Employment policies and practices in domiciliary care

Six of the providers in Thurrock who responded to our survey agreed to be interviewed about the challenges they faced in responding to changes in the demand for domiciliary care. The key points made by those who were interviewed as part of this study are highlighted in the following section of the report.

Supply and demand is a concern

Although a few domiciliary care providers reported no difficulties in recruiting, most reported ongoing difficulties in this area. Some of our interviewees mentioned that the need for staff to have their own transport could be a problem, and others faced dilemmas about recruiting people in advance of securing contracts for delivering care work:

We do have a lot of difficulty recruiting. Recruiting staff...is a problem in this field.

I do the adverts for care workers for agencies that I know are active in the borough. Continually, every single week, they say. 'Care workers urgently required', so obviously the work is there.

We've never really got vacancies, unless our work increases a great deal, because we have limited funds to do that.

At the moment we do have more capacity to do more work than we have.

[Demand for] services is going up. We are dealing with children who get older, then they're adults. They go on to Adult Services, so it's a never ending sort of circle, really. I had 29 children on our case load - and I've got 80+ at the minute - so it's gone up and up and up. When we run our summer play scheme, it's open to any child in the borough that is disabled, so we target the special schools. There are loads and loads and loads of names that we've never heard of come through to us - the children of different ages that obviously manage on their own without any help.

It is difficult for a care worker in Thurrock, with the buses and the trains, which aren't very frequent. They will usually always run late to the service users, if they can't drive, because of public transport. So we don't take carers who can't drive

Our business is definitely going up and we would consider taking on more staff. We have the

¹⁵ Non work-related ill health or injury

'chicken and egg' scenario - what comes first? Do I wait for ten enquiries by Direct Payment, then take on the staff in the hope that the work is still going to be there? Or do I employ the staff in the hope the work comes along?

Recruiting and the image of the job

Part of the difficulty in recruiting staff lies in the way the job has changed, and in the image of the job. The quality of the applicants, as well as their ideas about the job, can both make it hard for providers to attract suitable applicants:

People tend to see it as a temporary job. I don't think people see it as a full time career move. I don't think care has the status that it deserves. They don't realise sometimes what it involves.

People think that care is wiping arses, and that's it, they don't see it as anything else. With the CSCl and NVQ coming in, it's making it more of a profession, and people are beginning to realise that there's a damn sight more to it.

I would say maybe 50% of them are quite good. But we might not be able to offer them employment for one reason or another, like they might not be able to work the hours that we need.

We do get some (very poor applicants), but I don't interview them. I have a pre interview questionnaire, and if they cannot answer the questions on my sheet, ten simple questions, then they are not worth interviewing.

Some providers felt that a further problem in recruiting staff was the desirability of having people with particular characteristics working in the sector. This meant that some potential applicants were considered unsuitable for domiciliary care work. Our interviewees included providers who felt that mature female workers were the most appropriate candidates:

We did state on one of our adverts recently 'mature applicants welcome'. We do find that our mature staff have been the more reliable - because they don't have those family commitments nowadays - their children are grown up. If they see it in black and white, that mature applicants are welcome, I think it did encourage a lot of people. Generally the older ladies we have are very reliable and very capable, and they enjoy the job - and that's all we ask.

Our retirement age is 70, and that's optional, but they can stay on. Our insurance company say they can work till 70; they do have to have medicals at varying stages, to say that they're fit for the job.

We've got a problem when it comes to male carers, because service users prefer a female carer - it's a problem within the whole industry. Even the male service users prefer a female carer.

I feel [young people] might be a bit unstable, to be honest, and may be not so caring - not having that much experience.

Some of our interviewees felt more could be done to develop an active recruitment policy:

If you look at the employment rates in Thurrock, you are looking at something like 96%, so the area is just 3% or 4%. If you do any recruitment fairs or advertise, you're not likely to get a good response.

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

Others, however, had experienced rather more success using the local newspapers and word of mouth as their main method of recruiting staff:

When I advertise I usually get a really good response.

I have had people ring, leave their names and say, 'if you want staff, can you contact me?' So word of mouth does go round - that we are quite a good organisation. If we treat our staff really well, that goes before us. So if one of my members of staff says to a friend 'Oh, if you want to work in care, [organisation name] is really good to work for,' then you're liable to get a better quality of staff come through.

A lot of our people come through word of mouth. We very rarely have to advertise for anything other than specialists. But domiciliary care workers tend to come through word of mouth.

Competing demand for labour

In Thurrock, the providers we interviewed were particularly conscious of being in competition with other parts of the domiciliary care sector when recruiting and retaining staff. Some also highlighted competition from the retail sector, which has expanded very significantly in recent years, and includes the major Lakeside shopping centre development. These providers also

pointed out that they faced particular challenges in Thurrock because of the comparatively ready access to alternative employment in London – although, as indicated in the comments below, London also offers an additional supply of labour.

I've got staff from everywhere, you know - but there are only four agencies up this way, and we were the new agency on the block. We had a good reputation in London - and when we came, everybody made a mass exodus to come to us - what they heard, the sort of service we provide.

It's difficult at the moment to recruit, because of the competition with the retail industry. They pay better rates and people prefer it. [We have] a bit of a difficulty in recruiting, particularly in Thurrock - but from the Greater London areas, we seem to have a good supply of people who want to work

Retaining and supporting staff

Domiciliary care providers in Thurrock identified the flexible working arrangements they offer, and the one-to-one support they give their staff as key reasons why people enter and remain in domiciliary care. Some providers felt they had managed to retain their staff by offering better pay than was usual in the sector, and good terms and conditions of employment. Commenting on why people stay in the job, providers noted:

Well, we're quite fortunate, with everybody leaving other agencies and coming to us - because we're a fairer company, and a more approachable director. I am very 'hands on' myself, and because I prepare a much shorter profit margin for myself, I am finding it very easy to recruit and retain staff. I haven't had a staff member leave me in four years.

You need to supervise your staff. They need to be able to off-load. Our job is quite distressing at times, and for staff to be able to off-load and not take their work home is quite important. We retain our staff (through) supervision and annual appraisals. I am at the end of a phone. They know that, on a 24-hour basis.

Our rates of pay are the same as (Thurrock) Council's, we pay NJC¹⁶ rates. And we base them on their pay scale, so they lose nothing by working for us. The only thing we don't do is pay enhancements for out of hours working, but they're told that at the beginning.

(Staff say), 'I don't want to work after four o'clock, because my children come home', 'I don't want to

work before 7 because my husband's in bed'. Whatever reason, that's why people temp - and if you can provide them with the hours that they want, and work around that, then they'll stay, providing the money is right.

I understand that agencies do find it very difficult to recruit and retain staff, but this [organisation] has never had that problem. I wonder if that is because our terms and conditions of employment are better. We are flexible; we pay travel - agencies don't normally. So when I advertise, I usually get a really good response - and when we take on staff I retain them as well. I took on staff in 2001, and the four staff we took on are still with us.

Workforce development and training

Most of the providers we spoke with in Thurrock were optimistic that they would reach the targets for the National Minimum Standards by 2008. This contrasts with the evidence gathered in 2004 (Essex Independent Care Association 2004), and it should be noted that only 2 of the 8 Thurrock providers in our survey reported that 50% or more of their care workers had already achieved NVQ2. Nevertheless, some recent progress has evidently been made in this area, in part due to the training opportunities available locally.

The private sector tell us that they just haven't got the resources - but there are actually now more resources out there for them. There's the national training strategy grant – it's expected that (local authorities) spend 50% of that in the private/voluntary sector- in some areas 75%, because of the size of the private/voluntary sector. We've decided on 50%. An independent provider can apply through TOPPS¹⁷ for project money. There's the Learning Resource Centre Network as well, and the Learning and Skills Council funding streams. It's so complicated (now) that people won't know where to go and get the money – that's been another complaint from the independent sector.

The comments from Thurrock independent sector providers included below probably do not reflect the position in those agencies which declined to be interviewed, however, and in our survey a number of Thurrock employers reported some difficulty in meet the costs of training or accessing funds for staff development:

I think at the moment I have 3 members of staff out of the 18 that have no qualifications.

¹⁶ National Joint Council.

¹⁷ The Training Organisation for Personal Social Services. The work of this former agency has subsequently been transferred to Skills for Care.

We're doing really well. We're at 73% at the moment.

We offer NVQ training at the moment, but I think if I'm taking on staff in future, we will be asking for the NVQ qualification. All our staff have to have it. We've trained our staff to NVQ level 2, and it's been paid for out of a government initiative, but in future - will we get that?

It all comes down to finance. Replacing staff on training is the issue - it's costing us to replace that member of staff. We're a small company, so it has a major financial impact, which it wouldn't do in a large company. It costs us a lot of money.

The downside is the girls have to have time off to do their training, which I cannot pay them for. I cannot pay them, because we are an agency. I have to pay someone to replace them in the workplace, so I cannot pay them to have time off. So the downside is that they lose money while they are doing this training - and they are also having to pay for some of this training while they are losing money.

Some providers nevertheless mentioned that, in their view, candidates without prior experience or qualifications were sometimes more suitable for domiciliary care jobs than those who had previously worked in care:

I had a lady who had applied, and all she had done was worked at Tesco's. She said she hadn't any prior experience and she didn't know how she'd get on. But she came across as a really caring person, and she answered the questions really well, and we took her on. She has been very, very successful. She is still with us, just about to finish her NVQ2 in Care. So I think at times personality, and how they answer our questions, comes through far more than qualifications

People don't have to have experience. In some respects it's better if they haven't worked anywhere else, because to be honest each agency and each home works to different standards. And you find that people - especially if they've worked in a residential home - have got into bad habits with regards to moving and handling and using the equipment. So we don't expect people to have experience, because we train them fully ourselves.

Other employers said they had experienced difficulty in persuading some of their staff to undertake or complete training, and in some cases that they had found it difficult to retain those they had trained:

The two that haven't done their NVQ have said that they feel it's not appropriate to them - they only work ten hours for us a week.

I think some people get a bit panicky - a lot aren't particularly comfortable with writing. They think they're going to have to write essays and things like that. But once they realise what it entails, they are normally quite comfortable with it.

We had a few problems. Some of the staff would start the course and then half way through they don't want to finish. That's one of the main problems we've been having. They are quite eager at the beginning, they see it as a positive thing, but then finishing - that's a problem. We are having to encourage them to finish the course.

We couldn't possibly pay for everything ourselves, we just couldn't, because we do get a lot of people, and we do train very thoroughly ourselves as well when people start with us. We find that people tend to apply for the hospital jobs and residential homes - and it's just hard sometimes.

I don't know where they expect us to get the money to pay for it all. Some of the training we cannot get free. I have to get a consultant in, which costs me £500 a day. That has to come from somewhere. I charge some of the girls who have not long been with me for their training - I am not going to pay £50 a head for them to take their certificate and go somewhere else. So I would charge them. But if they are my regular girls, who have been with me from day one, and I know they're coming back all the time week in week out, I will absorb the cost.

Pay

It was widely recognised that pay in the sector was low, and half the Thurrock providers in the survey reported that 'leaving for better pay' elsewhere was an important reason they were that losing staff. There were also 'hidden costs' carried by domiciliary care workers, including, in more than half of cases in the Thurrock survey, having to pay any fares incurred in visiting service users. As one explained:

It's pay - without a doubt, without a doubt. Thurrock is one of the lowest paying boroughs. We would love to be able to pay them more, but we physically cannot. That is without a doubt an issue, especially when you take into account petrol is so expensive. They can claim it back, but that's at the end of the financial year - so pay is definitely the main issue.

Contracting arrangements in Thurrock

Some of the domiciliary care providers we interviewed, all of whom obtained most of their business through contracts with Thurrock Council, commented on the contracting and tendering arrangements in place locally. While some providers found the tendering process very time-consuming, others valued the thoroughness of the process:

It's quite a laborious job, it's really long and the paperwork that we need to submit - it's a lot.

It's lengthy. It's comprehensive, but lengthy. To get the contract here, it took me a year and two months from start to completion. To actually get any work, it took a year and two months! They are very good, the people we deal with - this is why it takes so long, because the process is very clear and every step of the way we know what we're getting into, what they are getting from us, what they expect from us. That's why it took so long, because I don't go jumping in with both feet until I know what I'm doing.

Positive aspects of the relationship with the Thurrock Social Services were emphasised by some providers:

I think it's more of a partnership relationship, because we need to work together in order to meet the needs of the service users. I think that is being achieved.

Others had rather more mixed feelings:

I would hope that we work in partnership...although I feel at times they take us for granted. 'Oh, [organisation] will do that'- without even thinking where the money is coming from. They expect us to work miracles, and the caseload is going up and up and up with no more money. So how do they think that we are going to do this work?

Half hour time slots also caused difficulties for a number of providers, although some noted that Thurrock Council had responded to this issue:

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

If it's only a half hour call, the girls are only going to earn £3.25. It means they have got to fit in 16 half hour calls in a day, to make 8 hours.

I find that a client needs an hour to have a shower and get dressed and have breakfast in the morning, and they are only down for half hour. I can ring up the council and say 'Look, I have actually been there and assessed this client myself. It took a good 15 minutes to get him showered, (then more) to get dressed, and fed, and another 5-10 minutes to do my notes. So it's an hour, clearly'. And they would up the rate. Whereas before, they would say 'Well, I'm sorry, half an hour is all you can have because of our budget.' But now they are actually listening to what the service user needs.

Some of our interviewees involved in purchasing domiciliary care work nevertheless felt that some calls could be completed in very short time slots:

Some service users have difficulty taking their medication, so somebody needs to go in and monitor that. I mean, how long does it take for someone to swallow a tablet? You are looking at 15 minutes at the most. So if a carer goes in for those 15 minutes, we cannot charge for 15 minutes, we have to give them a charge for half an hour.

As the issues raised in our interviews with domiciliary care providers have shown, employers and other stakeholders dealing with the reality of delivering domiciliary care in Thurrock were dealing with many of the issues which face the sector nationwide in their everyday experience of delivering home care services in the borough. There were also specific local circumstances which presented particular local challenges in meeting rising demand for domiciliary care, and it is likely these will continue to put pressure on all key stakeholders in the future as the borough's population continues to change and to age.

This study has shown some of the ways the local authority and individual providers are beginning to tackle the problems they face, and confirms that efforts are already being made to address key issues. Nevertheless, in Thurrock, we heard relatively little providers about medium to longer term plans. It is not clear whether this arises from

their understandable focus on short-term and immediate staffing issues, or arises from a lack of awareness – and possibly some complacency - about the likely recruitment challenges ahead.

As they were very well aware, all stakeholders in Thurrock face difficult budget constraints and are regularly dealing with the consequences of these. These constraints inevitably impact on their ability to recruit and retain staff, and to meet National Minimum Standards targets. Providers are also having to comply with the increasingly complex, if necessary, regulation and monitoring of the sector, and this places significant demands on them in terms of both financial and staff resources.

We nevertheless found it striking that there was very little mention in our interviews of the structural changes affecting Thurrock local labour market, or of the difficulty which some Thurrock residents, especially women, face in entering the labour market (as revealed in our companion study *Connecting women with the labour market in Thurrock* (Grant et al 2006).

Enhanced awareness and understanding of the labour market situation local women face, arising in part from Thurrock'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

While there was evidence of serious attention to workforce development issues in Thurrock and the wider Essex region, few examples of co-ordinated activities and innovations in recruiting domiciliary care workers were found. The expected sharp increase in the numbers of very aged residents in the Borough in coming years means further developments are needed in response to some of the important supply and demand issues affecting the domiciliary care sector highlighted in this report. Here we summarise key developments which Thurrock Council and other local agencies may wish to consider.

Partnerships and dialogue between agencies

In Thurrock some significant partnerships have already been developed and are working across the statutory and independent sectors. This approach needs to be maintained and enhanced, to create continuing opportunities for regular effective dialogue, and for exploring and sharing good practice in service development and enhancement.

Recruiting staff

There was quite limited evidence of innovative approaches to recruiting additional domiciliary care staff in our study. This may reflect the uneven experiences of providers in different parts of the sector, and movement of staff between different segments of the social care market. As elsewhere, the tight budgetary situation in Thurrock constrains some providers' recruitment activities. Evidence about labour demand in the locality suggests there may in future be increasing difficulty in recruiting staff, and that additional outreach work will be needed to ensure new sources of labour supply are identified, and that changes being made at national level to create career structures in social care and to accredit and professionalise the care sector, succeed in attracting a wide range of new people into the domiciliary care workforce.

In Thurrock, our other research has shown that some women in particular localities within the Borough are finding entry or re-entry to the labour market very difficult. There may be ways of supporting these groups, and others, to enter the social care field, using special recruitment initiatives and highlighting the changed nature of domiciliary care work, and the progression opportunities now available within social care.

Strategic planning and the longer term

While providers in Thurrock were continuing to focus on workforce development, it is unclear how far they are aware of the implications of the major demographic challenges ahead, or if they have considered their local ramifications in the medium to long term. Some awareness-raising at the local level by key agencies, including Thurrock Council, but also involving *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, would be beneficial.

Resource issues

Many of the organisations which participated in the research in Thurrock 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 however 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.

Central government has recently indicated its intention to further reshape the delivery of community care services, through the 2006 Department of Health White Paper *Our health, our care, our say: a new direction for community services*. While the detailed implications of the changes involved remain unclear, the government has emphasised its commitment to the introduction of Individual Budgets for social care. These will give individual care users much greater control over both their own budgets and their care plans. If taken up widely, this development (like the earlier introduction of Direct Payments for older people), could have major implications for the social care market. For example, large numbers of care users could select to go straight to the marketplace for their caring labour, or to recruit this indirectly. The implications of these developments for skills, training and quality assurance in the delivery of domiciliary care remain unclear, and whether there are enough care workers willing or able to work in this way, and offering more flexible hours, must be, at the least, an open question. It is important that evidence about the experiences of care providers in recruiting, developing and retaining domiciliary care staff is drawn on, by central and local agencies, at both the strategic and operational levels, as the practical consequences of the changes planned are addressed.

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 Thurrock'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.

In this other work (Buckner et al 2004; Grant et al 2005, 2006b) 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, the socio-economic circumstances of some of Thurrock's residents, and the likely changes in the city's population of very aged residents, make it likely that reconciling supply and demand for domiciliary care will continue to be an important challenge for key agencies in Thurrock for some years to come.

A commitment to new innovative projects in this field, and to drawing new sources of labour into this form of work, would enable Thurrock Council and its partners 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 Thurrock to receive the quality of service they deserve and will require.

References

- ADSS Audit Commission (2004) *Better Government for Older People*. London: Local Government Association, Nuffield Institute, Joseph Rowntree Foundation Public Services for Tomorrow's Older Citizens.
- Buckner, L. Tang, N. and Yeandle, S. (2005) *Gender Profile of Thurrock's Labour Market* Sheffield: Centre for Social Inclusion, Sheffield Hallam University.
- DSS (1989) *Caring for people: community care in the next decade and beyond*, HMSO, Cmnd 849.
- DoH (1998) *Modernising Social Services: promoting independence, improving protection, raising standards* HMSO, Cmnd 4169.
- DoH (2001) *The National Service Framework for Older People*, London:DoH
- DoH (2006) *Our, Health, Our Care, Our Say*, HMSO Cmnd 6737.
- DETR (1998) *Supporting People: A new policy and funding framework for support services*, London:DETR.
- Eborall, C. (2005) *The State of the Social Care Workforce 2004* London: Skills for Care.
- Essex Independent Care Association (2004) *Survey of the Independent Sector Social Care Workforce* (unpublished).
- Grant, L., Price, C. and Buckner, L. (2006a) *Connecting Women with the Labour Market in Thurrock* Sheffield: Centre for Social Inclusion, Sheffield Hallam University.
- Grant, L., Yeandle, S. and Buckner, L. (2006b) *Working Below Potential: Women and Part-time Work in Thurrock* Sheffield: Centre for Social Inclusion, Sheffield Hallam University.
- Grant, L., Yeandle, S. and Buckner, L. (2005) *Working Below Potential: women and part-time work* Working Paper series No. 40, Manchester: Equal Opportunities Commission.
- Grant, L, Price, C. and Buckner, L. (2006) *Connecting women with the labour market* Sheffield: Centre for Social Inclusion, Sheffield Hallam University.
- McClimont, B. and Grove, K. (2004) *Who Cares Now? An Updated Profile of the Independent Sector Home Care Workforce in England* London: UKHCA (United Kingdom Home Care Association) and Skills for Care.
- NHS (2005) *Community Care Statistics (2004) Home care services for adults England* NHS Health and Social Care Information Centre.
- ODPM (2004) *What is Supporting People?* London: ODPM.
- ONS (2004) *Focus on Health* London: Office for National Statistics.
- Robinson, J. and Banks, P. (2005) *The Business of Caring: King's Fund Inquiry into Care Services for Older People in London* London: King's Fund.
- Wanless, D (2006) *Securing Good Care for Older People: taking a long-term view* London: King's Fund.
- Yeandle, S. Shipton, L. and Buckner, L. (2006) *Local Challenges in Meeting Demand for Domiciliary Care: synthesis report* Sheffield: Centre for Social Inclusion, Sheffield Hallam University.

Thurrock Council Documents consulted during the research

- The 50+ Local Profile
- HR Strategy and Workforce Plan 2004/5
- Learning, Development and Quality Training Plan for 2004/5 (Housing and Social Care Directorate)
- Procurement Strategy 2004-7
- Social Care Adult Services Service Plan 2005/6
- Staff Care (Thurrock Social Services) 1999
- A Strategic Analysis of Recruitment and Retention for Housing and Social Care (nd)
- Supervision Policy (Thurrock Social Services) 2001
- Thurrock Home Care Guide (Home Care Business Unit)

Appendix 1 Gender and Employment in Local Labour Markets (GELLM)

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

The GELLM project output comprises:

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

The GELLM Team

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

The GELLM Partnership

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

Appendix 2 Research methods

The study was conducted in Thurrock 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 Thurrock.

Analysis of 2001 Census data

Data from the 2001 Census for England and from the sub-national population projections¹⁸ were used to produce a statistical profile relating to domiciliary care in Thurrock. 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 18 domiciliary care providers registered with Thurrock's SSD. 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. 8 providers responded to the survey in Thurrock, a response rate of 50%. They included 1 from the voluntary and community sector, 4 private for-profit organisations, and 1 private not-for-profit organisations, 2 organisations did not reveal what type of organisation they ran. 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 5 key stakeholders and providers in Thurrock. The interviews with key stakeholders were conducted with managers responsible for contracting and commissioning, HR, training/staff development, and in-house domiciliary care within the Thurrock 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.

¹⁸ 2003 based sub-national population projections, Government Actuary Department, Crown Copyright 2004

Appendix 3 Statistical information about older people in Thurrock and care assistants and home carers

Figure A1 Older people in Thurrock (figures for England are presented in brackets)

	Men			Women		
	65-74	75-84	85+	65-74	75-84	85+
Population in 2001 (numbers)¹⁹	4,513	2,639	496	5,462	4,285	1,284
Tenure (%):						
Owns	76 (77)	63 (69)	57 (59)	75 (74)	55 (62)	45 (45)
Rents from council/social landlord	20 (17)	30 (21)	30 (20)	24 (20)	36(25)	34 (22)
Private rented	2 (5)	3 (6)	4 (9)	2 (5)	3 (8)	4 (9)
Lives in communal establishment	0 (1)	1 (3)	6 (12)	1 (1)	3 (5)	13 (23)
Living arrangements (%):						
Lives alone	16 (17)	27 (26)	41 (37)	33 (33)	56 (52)	63 (55)
Lives with a partner	79 (76)	65 (65)	44 (41)	56 (56)	28 (31)	8 (8)
Health and care (%):						
General Health 'not good'	18 (19)	25 (25)	33 (32)	19 (19)	27 (27)	33 (36)
Limiting long-term illness	44 (42)	56 (56)	69 (70)	43 (40)	61 (58)	80 (78)
Provides unpaid care	14 (14)	12 (12)	8 (8)	13 (14)	7 (8)	2 (3)
Population Change²⁰						
Population 2003 (numbers)	4,600	2,800	500	5,300	4,400	1,300
Per 1,000 people of Working age in 2003 (20-64)	52 (74)	32 (44)	6 (10)	60 (83)	50 (64)	15 (25)
Population 2028 (numbers)	8,200	5,000	1,600	8,500	6,400	2,800
Per 1,000 people of Working age in 2028 (20-64)	80 (104)	49 (71)	16 (27)	83 (109)	63 (85)	27 (40)
Change 2003- 2028:						
Increase (number)	3,600	2,200	1,100	3,200	2,000	1,500
Percentage change (%)	78 (45)	79 (69)	220 (173)	60 (40)	46 (38)	115 (69)

Figure A2 Households with one resident with a limiting long-term illness (LLTI)

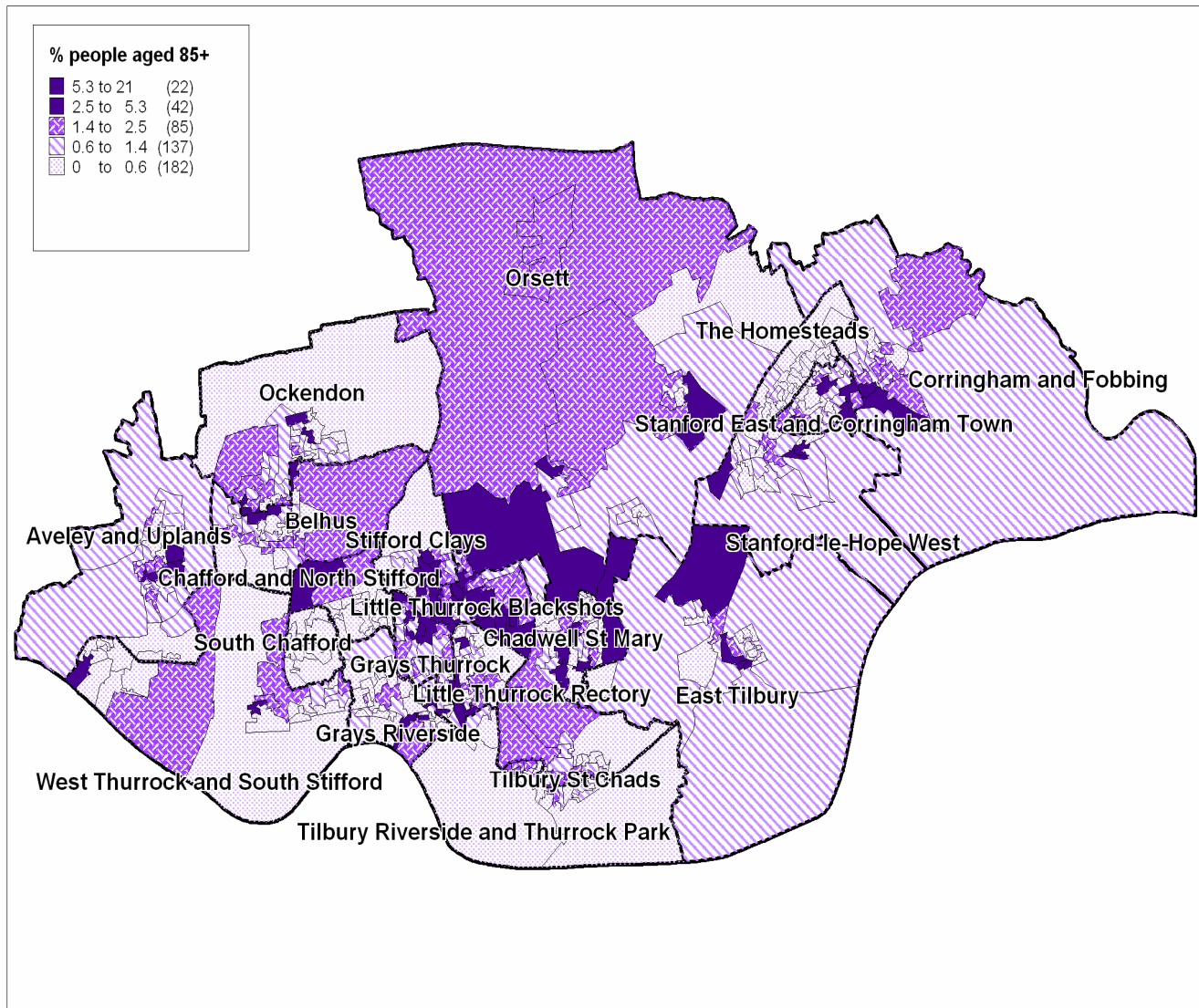
	All households (58,481)	Age of resident with LLTI	
		65-74	75+
Number with resident with LLTI	18,627	2,466	3,515
% of all households	32 (34)	4 (5)	6 (7)
% with no carer in household	71 (71)	82 (82)	88 (86)

Source: 2001 Census Standard Tables, Crown Copyright 2003

¹⁹ Source: 2001 Census Theme Tables, Crown Copyright 2003

²⁰ Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005

Figure A3 Thurrock: percentage of people aged 85 and over



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&HC) in Thurrock
(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
Number:								
All in employment CA&HC	37,713 81	5,330 13*	23,825 43*	8,558 25*	30,354 819	5,413 73	19,338 504	5,603 242
% in employment who are CA&HC	0.2 (0.4)	0.2 (0.5)	0.2 (0.4)	0.3 (0.4)	2.7 (4.0)	1.3 (3.8)	2.6 (3.8)	4.3 (4.9)
% across all age groups:								
All in employment CA&HC		14 (13) 16 (16)	63 (62) 53 (62)	23 (25) 31 (22)		18 (15) 9 (14)	64 (65) 62 (61)	19 (20) 30 (25)
% across all age-sex groups:								
All in employment CA&HC	55 (55) 9 (12)	8 (7) 1 (2)	35 (34) 5 (7)	13 (14) 3 (3)	45 (45) 91 (88)	8 (7) 8 (13)	28 (29) 56 (54)	8 (9) 27 (22)
Employment Status:								
All in employment								
Employee full-time	80 (76)	77 (74)	82 (80)	76 (68)	57 (55)	68 (62)	56 (56)	51 (47)
Self-employed full-time	14 (15)	6 (4)	16 (15)	16 (21)	2 (4)	1 (0)	2 (4)	2 (6)
Employee part-time	5 (7)	16 (22)	2 (4)	5 (6)	39 (38)	31 (37)	40 (37)	45 (42)
Self-employed part-time	1 (2)	1 (1)	1 (2)	3 (4)	2 (4)	0 (1)	2 (4)	2 (5)
Care Assistants & Home Carers								
Employee full-time	76 (74)	* (69)	* (77)	* (68)	45 (43)	53 (56)	42 (42)	48 (40)
Self-employed full-time	5 (2)	* (0)	* (2)	* (5)	1 (0)	0 (0)	1 (1)	0 (2)
Employee part-time	19 (23)	* (30)	* (20)	* (25)	55 (55)	47(44)	57 (54)	52 (57)
Self-employed part-time	0 (1)	* (1)	* (1)	* (2)	1 (1)	0 (0)	0 (1)	0 (1)
Qualifications:								
All in employment								
No qualifications	25 (19)	13 (11)	20 (14)	48 (35)	21 (16)	7 (6)	16 (12)	49 (35)
Lower level	53 (49)	77 (74)	59 (51)	22 (28)	62 (54)	83 (76)	65 (55)	30 (34)
Higher level	22 (33)	10 (15)	22 (35)	30 (37)	17 (30)	10 (18)	18 (32)	21 (30)
Care Assistants & Home Carers								
No qualifications	39 (19)	* (11)	* (16)	* (36)	40 (29)	13 (11)	31 (24)	67 (50)
Lower level	39 (58)	* (79)	* (60)	* (36)	47 (58)	83 (81)	56 (62)	18 (34)
Higher level	21 (23)	* (10)	* (24)	* (28)	13 (13)	4 (8)	13 (13)	14 (16)
Unpaid care:								
All in employment CA&HC	9 (10) 15 (17)	4 (4) * (11)	8 (8) * (16)	16 (17) * (26)	13 (13) 21 (18)	5 (5) 18 (10)	12 (12) 19 (17)	22 (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

*Note: Data in this column are based on very small numbers and should be treated with caution