

Local Challenges in Meeting Demand for Domiciliary Care in Birmingham

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Foreword

As Cabinet Member for Equalities and Human Resources for Birmingham City Council, equality of opportunity is at the heart of my vision for Birmingham, which means to ensure that all men and women have access to employment opportunities. This is achieved through fair recruitment processes and opportunities for both men and women to develop their careers. As one of the largest employers in the city, carrying out such an approach not only achieves fairness and improves morale but also results in better quality service delivery to the benefit of both employees and the communities they serve.

Over the last three years, Birmingham City Council, the largest local authority within the GELLM partnership, has worked closely with Sheffield Hallam University to undertake an important piece of research into *Gender and Employment in Local Labour Markets* (GELLM).

Following the successful launch of the *Gender Profile of Birmingham's Labour Market* last spring, I am now pleased to launch the three follow-up studies that have been carried out in Birmingham:

- *Challenges in Meeting Demand for Domiciliary Care in Birmingham*
- *Connecting Women with the Labour Market in Birmingham*
- *Addressing Women's Poverty in Birmingham: Local Labour Market Initiatives.*

These three studies have identified the aspirations of local women, what opportunities are available to them, and what constraints hold them back. The wider GELLM research programme has also explored some of the factors leading women to accept low-paid work and part-time work, and has examined how local employers' recruitment strategies have affected certain groups of women. These research studies, and the wider work of the GELLM partnership, provide us with a concrete base to bring any required changes. Therefore I commend the outcomes of these studies strongly.

Councillor Alan Rudge

Cabinet Member for Equalities and Human Resources

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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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Survey work	Anu Suokas and Lisa Buckner
Statistical analysis	Lisa Buckner
Report writing, and overall direction of the research	Sue Yeandle

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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 Birmingham. 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 Birmingham only. They are drawn from:

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

Demand for domiciliary care in Birmingham

Birmingham's ageing population and continuing high levels of poor health and deprivation in the borough mean that demand for domiciliary care is growing. In an ethnically diverse population, culturally sensitive home care will be particularly important in the future.

- 38% of households in Birmingham contain a person with a limiting long-term illness, including over 27,000 where the sick person is aged 75+.
- There is no co-resident carer in 86% of these households.
- Birmingham's population of very aged (85+) residents is expected to rise by over 10,000 people by 2028, with a particularly strong increase in the number of very aged men.
- 85% of very aged men, and 77% of very aged women in Birmingham live in their own homes.
- 40% of very aged men, and 58% 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 Birmingham.

- 7,600 Birmingham residents, 86% of them women, are already employed as care workers. 1 in 25 of all employed women in Birmingham is a care worker.
- In Birmingham, 51% of female care workers, and 21% of male carer workers, work part-time. Two-thirds of care assistants and home carers were White British, although Birmingham's Black Caribbean and Mixed ethnic group residents, especially men, are more strongly concentrated in care work than people of other ethnicity. The city's Asian residents are significantly under-represented in care worker jobs.
- Almost a quarter of Birmingham's care workers held no qualifications in 2001 – and almost a half (47%) of women care workers aged 50-59. However among care workers aged under 25, only about 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. Birmingham has responded to these changes in a variety of ways, and re-shaping of the care market has affected all stakeholders.

- Birmingham's domiciliary care providers now include small, medium and large organisations, across the public, private and voluntary sectors. Some two thirds of domiciliary care in the city is purchased from the independent sector.

Employment challenges

Providers in Birmingham face many of the same challenges being addressed across the country. They 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 usually formed less than half their workforces.
- 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.
 - Providers were experimenting with some new recruitment arrangements (including internet advertising) but there was limited evidence of special initiatives, such as those targeting applicants in different ethnic minority groups.
 - Many providers were offering 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 Birmingham 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 considerably improved partnership working across the sector.

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 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 2004³, reflecting government policies promoting independent living

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 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 Birmingham, 64,020 contact hours of domiciliary care per week were provided to 6,620 households in 2004, and 65% of this care was provided by independent providers⁴.

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)

The delivery of domiciliary care has become a key issue in contemporary public policy (Robinson and Banks 2005), 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 Birmingham City 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 Birmingham within the GELLM project, and builds on the project's earlier statistical work, *The Gender Profile of Birmingham's Labour Market* (Buckner et al 2004).

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

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 Birmingham – changes in supply and demand

Demographic projections in Birmingham

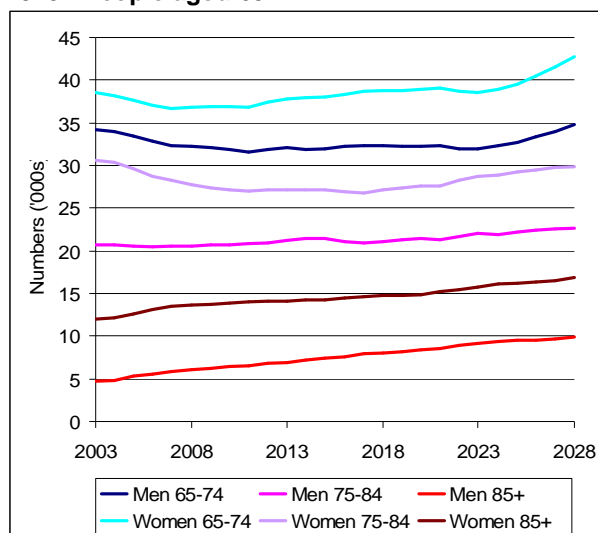
In 2001, Birmingham had 390,792 households of which 148,202 (38%) contained a resident with a limiting long-term illness, including over 27,000 households where the resident with the illness was aged 75 or over. In almost 86% of these homes, there was no co-resident carer. As we showed in the *Gender Profile of Birmingham's Labour Market*, levels of poor health and disability in Birmingham are high by national standards; almost 1 in 5 of all residents in the district 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 Birmingham also provide an important context.

1.7% of Birmingham'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 Birmingham are shown in Figure 1.

Between 2003 and 2028, Birmingham's population of residents aged 85+ is expected to grow significantly. The latest estimate suggests that there will be 10,100 more people in this age group, of whom 4,900 will be women. This is a significant increase in the number of very aged women, and will more than double the number of very aged men living in Birmingham. There are also likely to be 2,000 more male residents aged 75-84 (although in this age group the number of women is predicted to fall). While the expected rate of growth in Birmingham's population of older people is smaller for both men and women than in England as a whole, for men aged 85+ the

projection is nevertheless 111%, and for women aged 85+ 41% over the period 2003-2028.

Figure 1 Birmingham: 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 Birmingham about 77% of women aged 85+, and about 85% of men aged 85+, were living in their own homes, either owned or rented⁵. Seven per cent of very aged women, and 6% of very aged men in Birmingham were living 'rent free', slightly above the national averages (5% and 4% respectively for England)⁶. Almost 58% of all Birmingham women aged 85+, and almost 40% of men of this age, lived alone. The overwhelming majority of the city's very aged women (almost 80%) and about 70% of its men had a limiting long-term illness, with well over a third of these elderly men and women stating that their general health was 'not good'. Over 8% of Birmingham's men aged 85+, and 3% of women of this age, were themselves providing regular unpaid care – over 5% 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, 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

⁵ These figures include those who were owner occupiers with a mortgage or loan

⁶ 'Rent free' includes people living with friends or relatives or those who are provided with accommodation as part of their employment.

care services. While this is likely to be very challenging for care providers in Birmingham, the domiciliary care sector in the city 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:

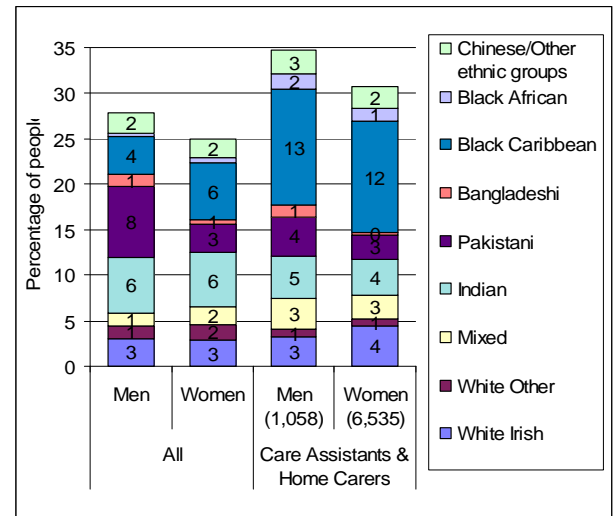
- Between 1991 and 2002, job growth in Birmingham occurred overwhelmingly in part-time employment, with a net increase of almost 40,000 part-time jobs and a net decline of over 19,000 full-time jobs (Buckner et al 2004: 22). A continuation of this trend is likely to mean significant competition for workers 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.
- Levels of unemployment and economic inactivity in Birmingham were significantly above average, however, (Buckner et al: 40-41), and some of our other research in the city suggests that gaining access to paid employment remains a problem for some Birmingham residents (Escott et al 2006; Grant et al 2006), who might welcome the opportunity to enter domiciliary care work.
- Birmingham has low levels of self-employment among both men and women of working age (2.7% of women and 9.4% of men, compared with 4.9% and 13.2% in England). This is unlikely to present a particular barrier in domiciliary care work, as very few care workers are self-employed (1.3% of female and 2.9% of male care workers in Birmingham in 2001).
- Given that, in England as a whole, some ethnic minority groups form a particularly important supply of caring labour⁷, Birmingham's large ethnic minority population (around one in 3 residents) may contribute to future labour supply; indeed the city's Black Caribbean residents are already strongly over-represented in care worker employment. However the Indian and Pakistani communities, which together make up a large proportion of the city's ethnic minority residents, are under-represented in care assistant and care worker jobs (Figure 2).

⁷ 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 Birmingham

Almost 7,600 Birmingham residents are people of working age in paid employment as care assistants and home carers - about 86% of them women⁸. Already 1 in every 25 women employed in Birmingham is a care assistant or home carer (as in England as a whole). Well over half (54%) Birmingham's care workers are women aged 25-49 (as across England), while about 19% are women in their fifties (compared with 22% in England as a whole).

Figure 2 Ethnicity of care assistants and home carers in Birmingham



Source: 2001 Census Commissioned Tables, Crown Copyright 2003

In Birmingham, 51% of female, and 21% of male care workers work part-time (compared with 55% and 23% across England). Women care workers of all ages are much more likely to work part-time than other workers – and Birmingham's male care workers aged 25+ are much more likely to work part-time than other male workers. About two-thirds (69%) of female care workers in Birmingham are White British women, and 65% of the city's male care workers are White British men. However, Birmingham's Black residents (especially men) are significantly over-represented among care workers, while the city's

⁸ Data is 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.

Asian ethnic groups are under-represented in care work (Figure 2).

In Birmingham, male care workers, and 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. The picture in Birmingham reflects this national situation. 47% of Birmingham's female care workers aged 50-59 had no qualifications in 2001. Even among young care workers (aged 16-24) in Birmingham, about 13% of men and 12 % of women had not achieved NVQ level 2 (in 2001).

Policy developments in Birmingham

Responsibility for the commissioning and procurement of domiciliary care services to meet the assessed needs of Birmingham's residents lies with Birmingham City Council's Social Care and Health Directorate (formerly the SSD). In 2005, it purchased about two thirds of its domiciliary care from external agencies.

In recent years Birmingham City Council and other local / regional agencies have been called on to address a range of key issues and problems in relation to services for older people. These have focused on the 2001 'bed blocking crisis' (which arose from delayed hospital discharges as older people waited for home care packages or suitable residential placements) and a range of other health and social care services, often giving particular attention to residential provision. These reports have given very limited attention to the domiciliary care sector. Key recent developments in Birmingham since 2001 include:

The Knowles Report (2000)

Commissioned by Birmingham City Council, this Public Policy Review (chaired by Sir Richard Knowles) produced a report on The Implications of an Ageing Population. This report drew attention to the need to understand the city's demography, but did not, of course, have the benefit of the latest population data derived from the 2001 Census.

Joint Working Group for Older People/ Birmingham Older People's Partnership Board

This body produced its first report in November 2001. Subsequently it was followed up by the establishment of a city-wide partnership board, comprising older people, health agencies, social services, and independent and voluntary organisations.

They Deserve Better

The Independent Commission of Inquiry into Social Care for Older People in Birmingham reported in December 2001. The Commission, established by resolution of the City Council and chaired by the Rt. Hon. Terry Davis MP, called for much stronger partnership working in the city, pointing out in 'They Deserve Better', that:

The government's 'Building Capacity and Partnership in Care' agreement (October 2001), is predicated on local authorities assuming a greater responsibility for managing the market and building the capacity of private sector suppliers. Birmingham currently has neither the relationships nor the experience of partnership working with the private residential and nursing home and domiciliary care sectors to effectively manage this market. The Commission heard evidence from the Birmingham Care Consortium (and is) deeply concerned by the lack of a relationship between the Council and the Consortium. The current situation is untenable. (2001: 26.)

Birmingham Care Development Agency (BCDA)

This agency is the product of a partnership between *Birmingham City Council*, the *Birmingham and Solihull Learning and Skills Council*, and *Skills for Care* (formerly TOPSS, the *Training Organisation for Personal Social Services*). Set up in 2004, with three years' initial funding provided by the three partner agencies, BCDA funds training for qualifications required by

staff employed in social care occupations in private, independent and voluntary sector organisations within Birmingham. Its other activities include: workforce development within the independent sector; gathering and analysing workforce data; briefing sessions with its 460 registered providers; and the preparation of a detailed and comprehensive annual training directory of information about relevant training courses available in the city. By negotiating reduced cost advertising, BCDA also supports care providers with their recruitment, and has agreements with the Birmingham City Council newspaper *Birmingham Forward*, and the local free press, *Jobs and Training Weekly*. The agreed rates are well below normal advertising costs, and contribute to ensuring advertising by domiciliary care providers reaches the city's ethnic minority groups.

Report by Contract Consulting (2004)

Contract Consulting prepared a report to the Older People's Partnership Board on its strategic review of older people's services in Birmingham, focusing primarily on specialised accommodation for older people in the city, and related services. This report stressed the likely future pressure on domiciliary care in the city, commenting that '*maintaining current patterns of home care delivery into the future is just not sustainable*' (2004: 42-43). However the report had relatively little to say about the detail of domiciliary care provision, and its mapping of services for older people did not include home care. The report nevertheless called on the city to develop a more clearly articulated strategic vision for older people's services, in which it expected that domiciliary care would play its part.

Developments within Birmingham City Council

Birmingham City Council's *Social Care and Health Directorate* (SCHD)⁹ is one of the country's largest agencies responsible for delivering social care services, with over 7,500 staff and an annual budget of some £270m. It is committed to implementing the *Commissioning Strategy for Older People's Services 2005-2010*, adopted by Birmingham City Council in 2004. In line with central government policy, this strengthened the local authority's commitment to service user choice, and to the principles of

partnership and of enabling all older people who wish to do so to continue to live in their own homes for as long as possible.

The SCH Directorate established a *Providers Representative Group* for domiciliary care in 2001, which met regularly during 2001-3 when revised contracting arrangements were under discussion. This group was reconvened in June 2005 as a forum for debate with the City Council about possible future changes to contracts with domiciliary care providers. The group consists of about eight private sector providers, from small, medium and large organisations; the City Council invited all 50 contracted independent providers to indicate their interest in joining this group in March 2005, and selected the representative group from those interested in taking part. The group meets approximately once a month, and minutes of its meetings are circulated to all contracted providers.

Recently, the local authority has indicated its intention to shift more of its resources for older people and other adults requiring social care into domiciliary and day services, as expenditure on residential care is reduced. Key stakeholders have also confirmed that Birmingham is planning to reconfigure its domiciliary care services during the lifetime of its current commissioning strategy (2005-10), with the public (in-house) sector expected to reduce its share of service delivery. The intention in Birmingham is for the public sector to retain mainly specialist service provision, and services supporting those recently discharged from hospital, with the majority of generic and longer-term service provision contracted out to the independent sector, via private and voluntary sector organisations.

Survey of Birmingham providers

In Birmingham, our survey of providers of domiciliary care had a 38% response rate and produced 17 responses: 4 from the voluntary/community sector; 11 from the for-profit sector; and 2 from the not-for profit private sector¹⁰. Birmingham Council's Social Care and Health Directorate also responded to the survey.

Almost all the organisations completing 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

⁹ This replaced its Social Services Department in 2005.

¹⁰ 1 respondent did not answer the relevant question.

support for younger disabled people. The responses we received came from organisations of differing size - 9 were organisations employing fewer than 50 care staff, 3 had between 50 and 99 employees, and 1 had 100 or more care workers¹¹. Consequently, some (7) had contracts to provide fewer than 500 hours of care per week, while a few 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 sitting services. Nine said they provided a 24-hour on call service, 4 provided 'rapid response', and 3 offered 24-hour live-in care services. Nine of the providers also offered a 24-hour on-call service.

Three 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 short hours part-time working arrangement. However, 10 providers said half or more of their staff worked full-time (30+ hours per week). All 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).

Almost all providers said they were currently employing some staff without qualifications at NVQ level 2¹². Five said less than a quarter of their domiciliary care workers had reached this level, while 8 reported that more than half had achieved this standard. Seven providers indicated that the majority of their care supervisory staff now had qualifications at NVQ level 3. Almost all had some care workers registered for training and accreditation at NVQ2 or above at the time of our survey, and 7 had over 50% of their care staff in this situation.

The providers' survey showed that staff turnover and staff shortages were of concern to some, but not all, employers. In the previous 12 months staff turnover had ranged between 0% and 53%, and although some organisations reported no staff shortages in the previous 12 months, the worst affected employer considered that at times up to 27% of posts were unfilled.

The most common method of recruiting care workers was via local newspaper advertisements or the local Job Centre; almost all also said they

appointed new staff on the basis of recommendations. However some Birmingham providers had been experimenting with other approaches. A few (5) were now also using the internet to recruit staff, and 1 was using the trade or professional press. Six 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 they were 'not comfortable with the job'. A minority of providers said that work-related stress and challenging situations with clients were factors causing some staff to move on. Work-related injuries and health problems, and 'too much responsibility' were also mentioned by a few of the employers, although the majority did not believe these had been relevant factors for staff who had left their own organisation.

Fourteen of the 17 providers had some staff on permanent contracts, and 8 providers were using zero hours contracts for some of their staff. Wages ranged from £5.00 to £10.00 per hour for weekdays during the day time to £5.30 to £12.00 per hour for Sunday nights. Only 8 of the 17 providers said they reimbursed the costs staff incurred while travelling to visit clients, although 12 offered staff mileage allowances. Most providers claimed to pay sickness and holiday benefits above statutory requirements, and 9 said they offered their staff membership of a pension scheme. Sixteen of the 17 providers said they met or partially covered staff training costs in attaining NVQ target levels, and most (14) reported giving staff study time for this.

Most of the Birmingham providers said they had some difficulty in meeting the costs of training their staff, and the majority said they found it difficult 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 reported some problems in retaining their trained staff. About half of the providers also reported that some of their employees' lacked basic skills and confidence, and expressed some concerns about low completion rates among staff undertaking NVQ training.

¹¹ 4 respondents did not answer the relevant question.

¹² 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

Eight of the providers in Birmingham 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 staff, most said they faced regular and ongoing difficulty in ensuring a regular supply of adequate and suitable labour, as indicated here in comments made by independent sector providers in the city:

It's difficult, very difficult.

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

It's very difficult to attract quality people. Staff work largely unsupervised in the community, and you've got to have people who can work competently at that level. Initially we had quite an interest in our (recent) job adverts. We sent out application packs, and probably 30% of those will come back –out of those 30% you'll probably choose to interview ten people – and then some will drop out or just not arrive for interview.

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. Job image and job content can both make it hard for providers to attract suitable applicants.

There is a lot required of care assistants now. They are a low paid part of the market, but they are expected to do a highly professional sort of domiciliary care work. It's not housework any more, it's bathing, caring – having knowledge of benefits.

Sometimes we get people who have come from nursing homes... and ... they rely heavily on the fact they've got a group of people around them. So although they might come to you with years of experience of care, it's whether it's the right experience, and whether they can transfer that and are going to be comfortable working on a one-to-one basis.

We are tending to get more and more people now who are struggling with the Basic English skills. We refer them to the LSC to boost their language skills and their writing, because there is so much now that they have to write – we have to make sure they can actually do that. That's not to say we turn people away – we will do that extra work with them.

The independent sector has a lot of problems in retaining staff – I think 50% of our recruiting (in the local authority) has come from people working in the independent sector. I feel awful about that, but we can't say no to people – stay where you are.

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

Other councils that I've worked for have done joint care awareness days – to say, care is not a 2-bit part-time job, it's a career. I don't think the Job Centres and other agencies where we advertise realise just how big working in the care environment is, and what scope they can have to improve their career.

However, others were full of praise about the strategies in place:

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

The BCDA are doing some recruitment for us at the moment – they are looking at the market, and seeing where we need training and other stuff.

We did a Jobs Fair in one of our local parks, and we got a lot of people from that – we do provide training for people who have never done care before, so we were able to do that for a lot of those people.

The City Council has put some money into a care partnership of home care providers, and that means we all sort of work together, and we're given opportunities to access training for staff funded through the local authority, so there are developments in that way.

Competing demand for labour

Competition for the available labour supply is a problem in Birmingham, both from other industries and sometimes from within the sector. Reference was made to losing staff to nursing and other parts of the health service, and to alternative jobs in retail firms and restaurants:

When we are setting pay, we look at what the retail people are paying – we do class them as a

competitor, especially the large Tescos, and places like Pizza Hut.

Obviously we're in competition with the private sector supermarkets – paying £8 an hour, and far less demanding work than we're asking for.

In November and December we do struggle – people leave us – we have people who have children who want to do 9 to 5 Monday to Friday, which is more convenient in retail than in this job.

We can't compete with the Social Services home care, or indeed with auxiliary nurses with the PCT. They're paid at a higher rate and also they've got attractive things like lease cars and pensions.

Retaining and supporting staff

Providers in Birmingham 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. By contrast, pay was widely regarded as low for the work involved. Commenting on why people come into the job, providers noted:

We do tend to get staff and keep them fairly well. But we pay a higher rate – we only do specialist care. It's a very difficult situation, because it's such a devalued profession. I consider my staff low paid, although they are higher paid than the majority – they average between £7.50 and £8.50 an hour.

We do things like get them every other weekend off, and 1 in 4 is a long weekend.

We do a 2-week induction programme - so it's a very gradual process – they won't be in situations that are beyond their capabilities. They feel they are going to be well supported and supervised in their job role.

It's an approach of the management team, to try to get to know people as individuals, and support them according to what their level of need is. We try to offer them hours that are compatible with their own lifestyle and commitments, so if somebody only wants to work part-time, that's what we'll give them. Experience tells us that if you're asking someone to do what they are not able to do, they simply won't stay.

We contribute towards a stakeholder pension; we put them into a health plan; and put them in for training. We half fund them (they pay half their fee), but we pay all their hours at college, or if they are an assessor.

A lot of people are attracted by the flexibility and the hours – with early shift, the job is finished by 1 o'clock – the evening shift starts at 4 or 5 o'clock – I think people are attracted by that.

We've got a company benefits scheme – childcare - insurance. Care worker of the Month, newsletters, thank you cards, flowers, birthday cards, Christmas cards. We invited all the people who had just passed their NVQ2, with families and children – we put on a buffet and the MD presented their certificates and a bottle of bubbly. Going that extra mile to say thank you has really paid off for us.

Workforce development and training

Some providers found it difficult to meet the costs of training and developing their workforce in line with the government's National Minimum Standards requirements. Not all were paying staff for the time spent training, and some found it hard to retain those they had trained.

I don't think it's been so much of a trauma for us as for some of the smaller private organisations. We have national back-up, which has been very useful.

Quite often I find that people who are doing a training course with us aren't actually being paid by their employer – they are doing it in their own time.

The TOPSS standards have been a bit of a nightmare – it's the terminology that staff are struggling to understand.

It's been difficult. We don't actually fund the NVQs for our workers, and I think that's because it's a transient workforce – we find out that we give them NVQ, we pay for it, and then they disappear. We've sourced lots of free funding for them, so we are getting them through on that basis, that's been extra work for us.

Others were much more positive about training and staff development:

We are working alongside Care Connect, who do the NVQs online for us, so people can do them on the distance learning, which is a lot easier for us. A lot of people are going to college and doing their NVQs as well, so it's not too bad. We've got our 50% at the moment going through them, and we've got a waiting list of people who want to start.

I am an example – I went from home help, to clerical organiser, assistant team manager, team manager. I took the pathway, and in that pathway I've studied my social work qualifications, my management qualifications, and I've recently done my NVQ5 in operational management. So there are opportunities in social services if people are

interested in that. If you bring that commitment, it does pay rewards – I've been given loads of opportunities for training and other things to develop, and opportunities to develop services as well.

Contracting arrangements in Birmingham

Some of the domiciliary care providers we interviewed, all of whom obtained the vast majority of their business through contracts with Birmingham City Council, commented on the contracting and tendering arrangements in place locally, and on the opportunities which had been created to develop partnerships in social care. Many providers found the tendering process time-consuming and onerous:

It's very, very stressful. It's a hell of a lot of paperwork, and it's a huge time commitment. I didn't sleep for nights and nights and nights.

It's a very lengthy process and everybody wants the same information – you repeat yourself frequently – each council wants something different.

I had to ring at least 6 or 7 people to get the name of the person – it was very, very difficult. Once the information came through it was pretty standard stuff – but it has taken a long time.

It's clearer now the National Standards are in place – there are clearer guidelines that everybody is working to.

Some – not all - providers felt cost restrictions and tendering arrangements were impacting on how domiciliary care was delivered to clients, and that price setting in some elements of their work was putting them under inappropriate pressure:

I think they are looking to buy quantity rather than quality.

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

My worst gripe is that Social Services are purchasing care in half hour slots. I tell my staff they've got to do the full half hour – talking, making them a drink, seeing if there's anything useful they can do. I explain, we're paid for half an hour, you do half an hour. What is actually happening with a lot of the agencies is they are being booked for half

hour calls, but they're doing 10 minutes in the household. Social workers and Social Services know it's a fiddle. The problem is, it's not the minority, it's the majority. It's horrible at the moment – the climate is pretty unkind. It's money, it's budgets.

Some providers took a very positive view of recent developments in partnership working in the city:

I have a good relationship with Birmingham Social Services – I'm on their Providers' Representative Group. I think it's very good they've done that, because we are working directly with the council to have a look at the new contract – some of the providers have actually got input into how the contracts should go forward, so it shouldn't be a big surprise to us when it comes out. I don't know of any other council I work with which does that.

Others had rather more mixed feelings:

They recognise and respect what we do and what we stand for – but at the same time they've got the accountants on the other side, telling them to cut corners, they are so many million pounds in debt. And so they have to compromise – but there is a lot of goodwill there, and they do try to involve the voluntary sector, certainly in planning what sort of services should be available.

Providers and stakeholders dealing with the reality of delivering domiciliary care in Birmingham thus confirmed that many of the issues facing the sector nationwide are part of their everyday experience of delivering home care services in the city.

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 being made to address key issues. Nevertheless, in Birmingham, we heard relatively little from either key stakeholders or providers about medium to longer term plans.

This is perhaps not surprising given the current situation they face in relation to budget constraints and their consequences for recruiting and retaining staff, in meeting NMS targets, and in complying with the increasingly complex, if necessary, regulation and monitoring of the sector.

However, we found it striking that there was very little mention in our interviews of the structural changes affecting Birmingham's local labour

market, or of the difficulty which some Birmingham residents, especially women, face in entering the labour market (as revealed in our companion studies *Connecting women with the labour market in Birmingham* (Grant et al 2006) and *Addressing women's employment in Birmingham: local labour market initiatives* (Escott et al 2006).

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

There was only limited evidence in Birmingham of recent activities and innovations in recruiting domiciliary care workers, or in commissioning home care services. This may be because attention has been drawn to the importance of redeveloping residential and related services in recent years. 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 Birmingham City Council and other local agencies may wish to consider.

Partnerships and dialogue between agencies

In Birmingham, some potentially very valuable 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 in part reflects recent budgetary circumstances which have constrained recruitment opportunities. Given the common experience among independent sector providers

of difficulty in recruiting staff, it seems likely additional outreach work will be needed in future 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 new people, from all ethnic groups and both sexes, into the domiciliary care workforce.

In Birmingham, particular attention could be given to attracting applicants from the Asian origin communities. There is likely to be increased demand for care from within the Indian and Pakistani communities in coming years, and already providers are noting difficulty in recruiting staff with relevant language skills. Our other research has shown that some women in these communities are finding re-entry to the labour market very difficult. New domiciliary care workers from these communities would be particularly well equipped to support a population of older people which will be ethnically and culturally more diverse, and special recruitment initiatives are needed to draw women and men from these groups into domiciliary care work.

Strategic planning and the longer term

While providers in Birmingham are aware of the need to continue to focus on recruitment and retention issues, it is unclear how far they are aware of the implications of the major demographic challenges ahead, or have considered their local ramifications in the medium to long term. Some awareness-raising at the local level by key agencies, including Birmingham City 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 Birmingham 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.

to receive the quality of service they deserve and will require.

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 Birmingham'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, 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 socio-economic circumstances of some of Birmingham's residents, and the likely changes in the city's population of very aged residents, it seems likely that reconciling supply and demand for domiciliary care will continue to be an important challenge for key agencies in Birmingham 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 Birmingham City 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 Birmingham are

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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
- 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, Birmingham 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 Birmingham 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 Birmingham.

Analysis of 2001 Census data

Data from the 2001 Census for England and from the sub-national population projections¹³ were used to produce a statistical profile relating to domiciliary care in Birmingham. 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 45 domiciliary care providers registered with Birmingham'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. 17 providers responded to the survey in Birmingham, a response rate of 38%. They included 4 from the voluntary and community sector, 11 private for-profit organisations, and 2 private not-for-profit organisations. 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 12 key stakeholders and providers in Birmingham. The interviews with key stakeholders were conducted with managers responsible for contracting and commissioning, HR, and training/staff development within the Birmingham'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.

¹³ 2003 based sub-national population projections, Government Actuary Department, Crown Copyright 2004

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

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

	Men			Women		
	65-74	75-84	85+	65-74	75-84	85+
Population in 2001 (numbers)¹⁴	34,553	20,243	4,580	39,324	30,771	12,485
Tenure (%):						
Owns	70 (77)	63 (69)	57 (59)	68 (74)	58 (62)	47 (45)
Rents from council/social landlord	23 (17)	28 (21)	24 (20)	25 (20)	29 (25)	26 (22)
Private rented	4 (5)	3 (6)	4 (9)	3 (5)	4 (8)	4 (9)
Lives in communal establishment	1 (1)	3 (3)	9 (12)	1 (1)	4 (5)	16 (23)
Living arrangements (%):						
Lives alone	22 (17)	29 (26)	40 (37)	34 (33)	52 (52)	58 (55)
Lives with a partner	70 (76)	59 (65)	39 (41)	50 (56)	28 (31)	9 (8)
Health and care (%):						
General Health 'not good'	24 (19)	30 (25)	36 (32)	25 (19)	32 (27)	38 (36)
Limiting long-term illness	47 (42)	59 (56)	71 (70)	47 (40)	63 (58)	79 (78)
Provides unpaid care	14 (14)	13 (12)	8 (8)	14 (14)	8 (8)	3 (3)
Population Change¹⁵						
Population 2003 (numbers)	34,200	20,700	4,700	38,600	30,600	12,000
Per 1,000 people of Working age in 2003 (20-64)	60 (74)	37 (44)	8 (10)	68 (83)	54 (64)	21 (25)
Population 2028 (numbers)	34,800	22,700	9,900	42,800	29,900	16,900
Per 1,000 people of Working age in 2028 (20-64)	54 (104)	35 (71)	15 (27)	66 (109)	46 (85)	26 (40)
Change 2003- 2028:						
Increase (number)	600	2,000	5,200	4,200	-700	4,900
Percentage change (%)	2 (45)	10 (69)	111 (173)	11 (40)	-2 (38)	41 (69)

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

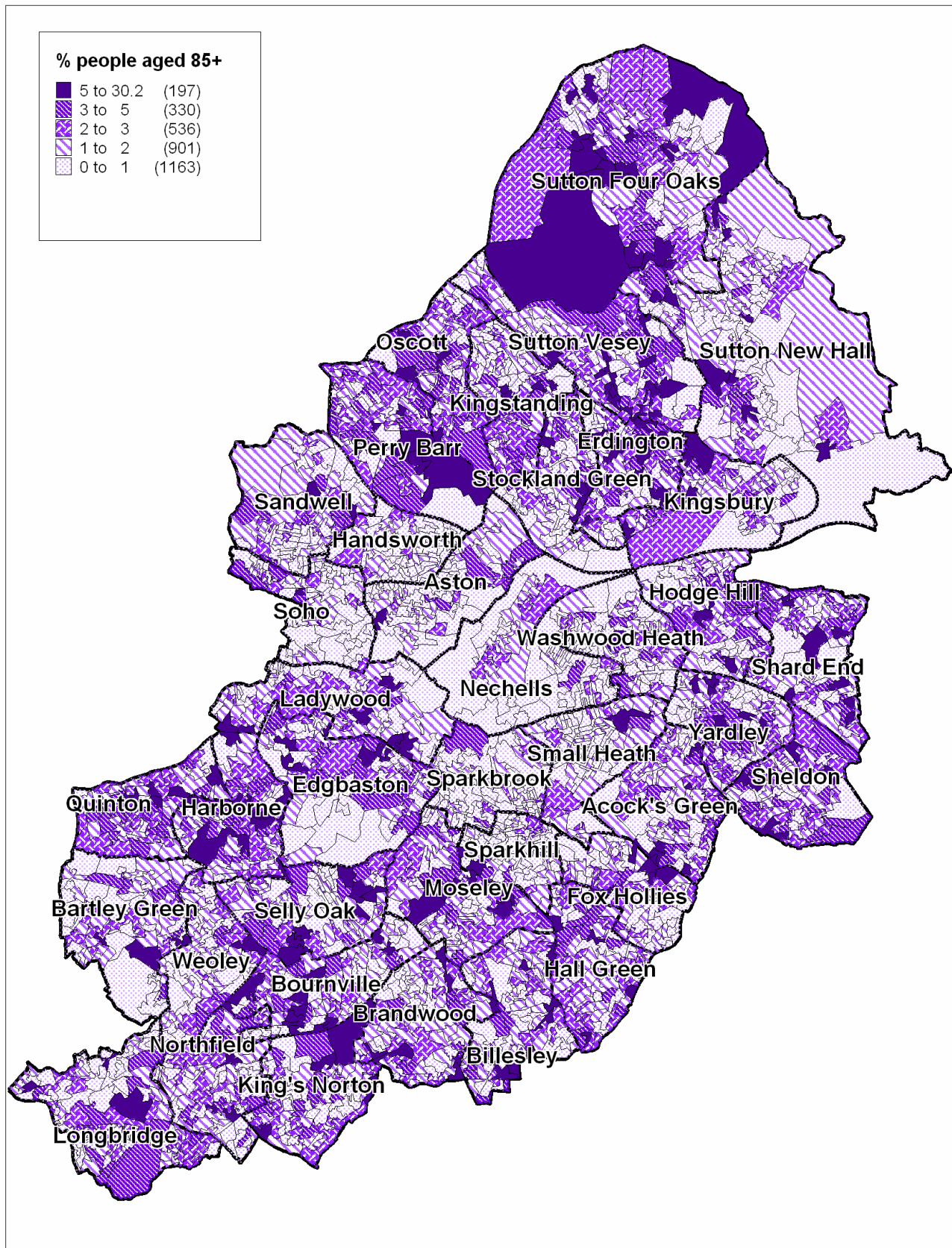
	All households (390,792)	Age of resident with LLTI	
		65-74	75+
Number with resident with LLTI	148,202	19,084	27,377
% of all households	38 (34)	5 (5)	7 (7)
% with no carer in household	70 (71)	82 (82)	86 (86)

Source: 2001 Census Standard Tables, Crown Copyright 2003

¹⁴ Source: 2001 Census Theme Tables, Crown Copyright 2003

¹⁵ Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005

Figure A3 Birmingham: 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 Birmingham (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	195,449	29,258	123,815	42,376	161,764	28,194	105,391	28,179
CA&HC	1,067	144	707	216	6,539	960	4,127	1,452
% in employment who are CA&HC	0.5 (0.4)	0.5 (0.5)	0.6 (0.4)	0.5 (0.4)	4.0 (4.0)	3.4 (3.8)	3.9 (3.8)	5.2 (4.9)
% across all age groups:								
All in employment		15 (13)	63 (62)	22 (25)		17 (15)	65 (65)	17 (20)
CA&HC		14 (16)	66 (62)	20 (22)		15 (14)	63 (61)	22 (25)
% across all age-sex groups:								
All in employment	55 (55)	8 (7)	35 (34)	12 (14)	45 (45)	8 (7)	30 (29)	8 (9)
CA&HC	14 (12)	2 (2)	9 (7)	3 (3)	86 (88)	13 (13)	54 (54)	19 (22)
Employment Status:								
<i>All in employment</i>								
Employee full-time	77 (76)	72 (74)	80 (80)	73 (68)	59 (55)	61 (62)	60 (56)	52 (47)
Self-employed full-time	12 (15)	3 (4)	13 (15)	17 (21)	3 (4)	1 (0)	3 (4)	4 (6)
Employee part-time	8 (7)	24 (22)	5 (4)	7 (6)	37 (38)	38 (37)	35 (37)	41 (42)
Self-employed part-time	2 (2)	1 (1)	2 (2)	3 (4)	2 (4)	1 (1)	2 (4)	3 (5)
<i>Care Assistants & Home Carers</i>								
Employee full-time	77 (74)	77 (69)	78 (77)	73 (68)	49 (43)	54 (56)	48 (42)	46 (40)
Self-employed full-time	2 (2)	0 (0)	3 (2)	4 (5)	1 (0)	0 (0)	1 (1)	1 (2)
Employee part-time	20 (23)	23 (30)	19 (20)	23 (25)	50 (55)	45 (44)	51 (54)	52 (57)
Self-employed part-time	1 (1)	0 (1)	1 (1)	0 (2)	1 (1)	1 (0)	1 (1)	1 (1)
Qualifications:								
<i>All in employment</i>								
No qualifications	24 (19)	14 (11)	21 (14)	43 (35)	18 (16)	7 (6)	15 (12)	41 (35)
Lower level	45 (49)	69 (74)	47 (51)	24 (28)	52 (54)	73 (76)	52 (55)	30 (34)
Higher level	30 (33)	17 (15)	32 (35)	34 (37)	29 (30)	20 (18)	32 (32)	29 (30)
<i>Care Assistants & Home Carers</i>								
No qualifications	20 (19)	13 (11)	15 (16)	41 (36)	26 (29)	12 (11)	21 (24)	47 (50)
Lower level	60 (58)	76 (79)	62 (60)	42 (36)	62 (58)	79 (81)	66 (62)	42 (34)
Higher level	20 (23)	11 (10)	23 (24)	18 (28)	12 (13)	9 (8)	13 (13)	11 (16)
Unpaid care:								
All in employment	11 (10)	5 (4)	10 (8)	18 (17)	14 (13)	6 (5)	14 (12)	24 (24)
CA&HC	22 (17)	10 (11)	22 (16)	30 (26)	18 (18)	11 (10)	18 (17)	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