

Local Challenges in Meeting Demand for Domiciliary Care in Sandwell

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Foreword

Gender Equality

Sandwell MBC has worked in close partnership with Sheffield Hallam University, and eleven other local authorities over the last three years to take part in this national research study, the *Gender and Employment in Local Labour Markets Project* (GELLM).

In participating in this Project the organisation has made a firm commitment to disseminate and implement the research findings by engaging with key stakeholders during all stages of the project. The philosophy for implementing change in relation to gender equality has been based on the commitment that each Service Area will continue to be instrumental in taking forward the responsibility for aligning their service priorities for gender equality in their Business Plans.

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

A handwritten signature in black ink, appearing to read "PH".

Cllr Pauline Hinton
Deputy Leader of the Council

A handwritten signature in black ink, appearing to read "Allison Fraser".

Allison Fraser
Interim Chief Executive

A handwritten signature in black ink, appearing to read "Iris Boucher".

Cllr Iris Boucher
Cabinet Member
Adults Service & Health

A handwritten signature in black ink, appearing to read "Andrea Pope-Smith".

Andrea Pope-Smith
Interim Director
Adult Services & Health

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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:

Development and implementation of the study	Anu Soukas
Interviews with providers and stakeholders	Anu Suokas and Lucy Shipton
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 Sandwell. 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 Sandwell only. They are drawn from:

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

Demand for domiciliary care in Sandwell

Sandwell'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.

- 41% of households in Sandwell contain a person with a limiting long-term illness, including 9,000 where the sick person is aged 75 or older.
- There is no co-resident carer in 70% of these households.
- Sandwell's population of very aged (85+) residents is expected to rise by 3,100 people by 2028, with a particularly strong increase in the number of very aged men.
- In Sandwell, 85% of very aged men, and 70% of very aged women, live in their own homes.
- 42% of very aged men in the borough, and 60% 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 Sandwell.

- 3,000 Sandwell residents, 90% of them women, are already employed as care workers. 1 in 20 of all employed women in Sandwell is a care worker.
- In Sandwell, 52% of female care workers, and 22% of male care workers, work part-time. Most are White British men and women, although Sandwell's Black residents, especially men, are more strongly concentrated in care work than people of other ethnicities (including people of Indian and Pakistani origin).
- A large minority of Sandwell's care workers had no formal qualifications in 2001 – half of women care workers aged 50-59, and almost a third of women care workers aged under 25 years.

Organisation of domiciliary care

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

- Sandwell MBC and its partners are making considerable progress in addressing issues of supply and demand in domiciliary care. Relevant activities include *Carelink/Learning 2 Care*, and a recently established *Care Training and Care Work Taster Programme*. A completely new approach to the commissioning of domiciliary care in Sandwell was introduced, using a new competitive tendering process, in 2005.
- Sandwell's domiciliary care providers include small, medium and large organisations, across the public, private and voluntary sectors. Some 67% of domiciliary care in the borough is purchased from the independent sector.

Employment challenges

Providers in Sandwell 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 formed less than half their workforces in every case.
- Providers reported progress in moving towards the National Minimum Standards (NMS) qualifications targets, but had a number of concerns in this area:
 - 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 minor concerns for some, but acute problems for others.
- Providers were experimenting with new recruitment arrangements (such as internet advertising) and special initiatives, including community events targeting prospective applicants in different ethnic minority groups.
- Providers were mostly offering their staff some support with training costs (including giving staff study leave in some cases), and a majority reported that they offered their staff membership of a pension scheme. Pay rates were low, only a little above the National Minimum Wage in most cases, although some providers paid premium rates, which could be a lot higher, for Sunday and night work.
- Supply and demand is a concern.
- The image of the job remains a problem.
- The nature of the job has changed, involving more personal care and some challenging situations for staff. People outside the sector, including prospective applicants, do not always realise how much the role has developed.
- There is competition for staff from other sectors (e.g. retail and manufacturing) which offer work environments, hours and work which some staff find more attractive.
- Some domiciliary care workers are exceptionally committed to their jobs and the work they do.
- The flexible hours and working arrangements providers can offer are 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 worry for some employers.
- Sandwell's new tendering arrangements had impacted on the sector. While a few providers were thought to have gone out of business following these changes, benefits of the new arrangements included:
 - Less 'migration' of care workers between agencies and different parts of the care sector
 - Greater stability and more opportunity to plan service improvements
 - Scope for better partnership working
- Some providers were concerned about very tight financial arrangements, and worried that price was sometimes put before quality.

Provider and other stakeholder perspectives

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

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 (McCliment and Grove 2004), the Kings’ Fund Inquiry into Care Services for Older People in London (Robinson and Banks 2005), *Skills for Care*’s annual reports of ‘The State of the Social Care Workforce’ (Eborall 2005), and its new plans for a new National Minimum Data Set for Social Care (NMDC-SC), launched in October 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 and care at home, as well as substantial growth in

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

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 Sandwell, 20,940 contact hours per week of domiciliary care were provided to 2,130 households in 2004, and 78% 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 (DETR 1998)
- *The Care Standards Act 2000*, establishing the *National Care Standards Commission* (from April 2002) with responsibility for setting, regulating and inspecting all regulated care services, including domiciliary care
- the *General Social Care Council* (2001) tasked with regulating the conduct and training of social care staff
- the *Social Care Institute of Excellence* (2001) an independent registered charity whose role is to promote knowledge about good practice in social care
- the *Commission for Social Care Inspection* (2004), the independent inspectorate for all social care services in England
- new measures to support staff development, and to create a more skilled workforce (DoH, 2000a)
- the *Fair Access to Care Services* initiative, clarifying eligibility for adult social care services
- *Skills for Care*, established in 2005 as one of the new sector skills councils, charged with tackling skills and productivity needs in the care sector, and replacing TOPSS (the

Training Organisation for Personal Social Services).

- *Our health, our care, our say: a new direction for community services* (DoH White Paper 2006).

The delivery of domiciliary care has become a key issue in contemporary public policy (Robinson and Banks 2005), affecting the well-being of millions of older and disabled people and their carers, involving about 163,000 domiciliary care workers (McClintont 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 Sandwell 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 in a synthesis report, drawing together evidence from all six local studies (Yeandle et al 2006). *Local Challenges in Meeting Demand for Domiciliary Care* is one of the three locality studies conducted in Sandwell within the GELLM project, and builds on the project's earlier statistical work, *The Gender Profile of Sandwell'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.

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

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

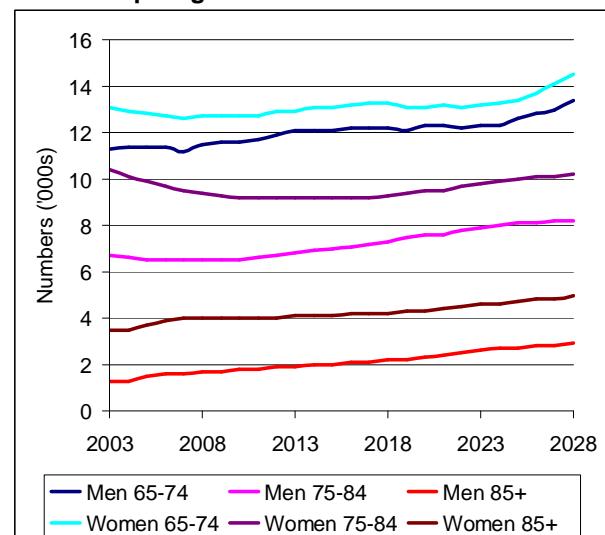
Domiciliary care in Sandwell – changes in supply and demand

Demographic projections in Sandwell

In 2001, Sandwell had 115,423 households, of which 47,427 (41%) contained a resident with a limiting long-term illness, including almost 9,000 households where the resident with the illness was aged 75 or over. In more than 70% of these homes, there was no co-resident carer. As we showed in the *Gender Profile*, levels of poor health and disability in Sandwell are high by national standards; about 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 Sandwell also provide an important context.

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

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



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

Between 2003 and 2028, Sandwell's population of residents aged 85+ is expected to grow significantly. The latest estimate suggests that there will be 3,100 more people in this age group, of whom 1,500 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 Sandwell. There are also likely to be 1,500 more male residents aged 75-84 (although in this age group the number of women is predicted to fall slightly). While the expected rate of growth in Sandwell's population of older people is smaller for women than in England as a whole, for men aged 85+ it is significantly above the expected increase at national level.

The last Census (in 2001) showed that in Sandwell almost 70% of women aged 85+, and about 85% of men aged 85+, were living in their own homes, either owned or rented⁵. One in 8 very aged women, and one in 10 very aged men in Sandwell were living 'rent free', a much higher level than at national level⁶. Almost 60% of all Sandwell women aged 85+, and almost 42% of men of this age, lived alone. The overwhelming majority of the borough's very aged women (80%) and over 70% of its men had a limiting long-term illness, with over a third of these elderly men and almost half of the women stating that their general health was 'not good'. About 7% of Sandwell's men aged 85+, and about 2% of women of this age, were themselves providing regular unpaid care – over 4% of these very aged men for 50 or more hours each week.

Appendix 3 of this report includes a presentation of the main statistical evidence discussed above, together with some further presentation of 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. While this is likely to be very challenging for care providers in Sandwell, the domiciliary care sector in the district 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 Sandwell occurred primarily in part-time

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.

employment, with a net increase of around 5,000 part-time jobs and a net decline of almost 4,000 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 Sandwell were significantly above average, however (Buckner et al: 42-43), and our other research in Sandwell suggests that gaining access to paid employment remains a problem for some Sandwell residents (Grant et al 2006).
- Sandwell has low levels of self-employment among both men and women of working age (2.2% of women and 8.1% 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 (1.1% of female and 2.0% of male care workers in Sandwell in 2001).
- Given that, in England as a whole, some ethnic minority groups form a particularly important supply of caring labour⁷, Sandwell's large ethnic minority population (around one in 5 residents) may contribute to future labour supply. However the Indian and Pakistani communities, which together make up more than half of the borough's ethnic minority residents, are under-represented in care assistant and care worker jobs (Fig 2).

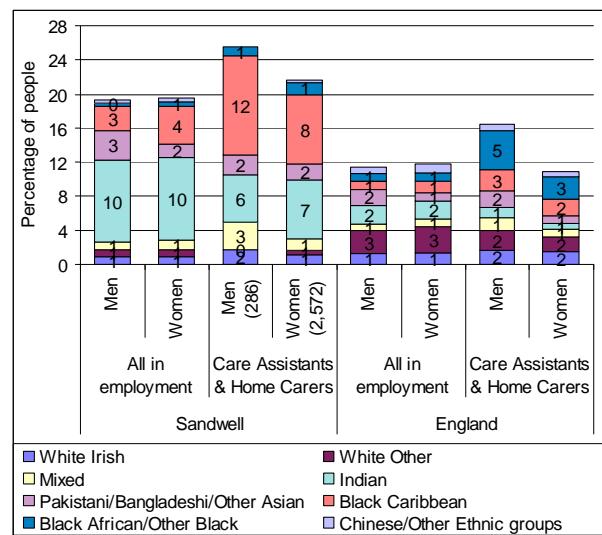
The social care workforce in Sandwell

Nearly 3,000 Sandwell residents are people of working age in paid employment as care assistants and home carers - almost 90% of them women⁸. Already 1 in every 20 women employed in Sandwell is a care assistant or home carer (5% compared with 4% of women in England as a

whole). Well over half (57%) Sandwell's care workers are women aged 25-49 (compared with 54% across England), while just under 20% are women in their fifties (compared with 22% in England).

In Sandwell, 52% of female, and 22% of male care workers work part-time (compared with 55% and 23% across England). Women care workers aged 25+ are considerably more likely to work part-time than other workers – although there are very few Sandwell men of this age in part-time care work. The majority (78%) of female care workers in Sandwell are White British women, and 75% of the borough's male care workers are White British men. However, Sandwell's Black residents (especially men) are significantly over-represented among care workers, while the borough's Asian ethnic groups are under-represented in care work (Figure 2).

Figure 2 Ethnicity of care assistants and home carers in Sandwell



Source: 2001 Census Commissioned Tables, Crown Copyright 2003

Male and female care workers in Sandwell, in all age groups, are more likely than other 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 formal 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,

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.

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.

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 Sandwell reflects this national situation. 50% of Sandwell's female care workers aged 50-59 were unqualified in 2001 – and even among young care workers (aged 16-24) in Sandwell about a third of both men (33%) and women (31%) had not achieved NVQ level 2.

Policy developments in Sandwell

Responsibility for the commissioning and procurement of domiciliary care services to meet the assessed needs of Sandwell's residents lies with Sandwell MBC's Social Services Department (SSD). In 2005, the SSD purchased about two-thirds of its domiciliary care from external agencies. In recent years the SSD and other local and regional agencies have put considerable effort into identifying and addressing issues and problems, with the aim of improving the reliability and quality of service delivery. Key local developments in the social care sector include:

Carelink / Learning 2 Care

Carelink was set up in November 2000 within Sandwell MBC's Economic Regeneration Unit, and is now led by Sandwell MBC as the Black Country-wide *Learning 2 Care* project, following an additional funding allocation. It offers a free recruitment service in social care specifically targeting unemployed people aged 24-59 who might not otherwise consider employment in social care, and uses a range of innovative approaches:

- Open Days at the four local colleges
- 'Floor Walking' and *ad hoc* interviewing at local Job Centres
- Networking Days for employers and providers in the sector, and outreach employer support
- Outreach work targeting different ethnic minority communities, via local voluntary and faith organisations and Ethnic Minority Careers events
- Innovative approaches to job advertising, using campaigns in the local press, on buses and radio, with links to national TV advertising campaigns

Carelink recruited around 700 unemployed people into care work between 2000 and 2005, and has a target to place a further 1000 people into care sector jobs by 31 December 2007. Its other aims include training 1500 people to NVQ1 level, 190 to NVQ2 (Care) and 400 to Skills for Life Level 3. *Carelink/Learning 2 Care* has been

identified by *Skills for Care* as a potential model project in recruitment and retention, and involves extensive partnership working throughout the Black Country, involving care sector employers, colleges, local authorities, Jobcentre Plus, NHS bodies and the West Midlands Care Association.

Care Training & Care Work Taster Programme

This new (18-month) programme was introduced in 2005 at a cost of £80,000. It aims to attract local unemployed and economically inactive people into social care employment within Sandwell SSD, and is targeting Sandwell's ethnic minority community. Sandwell MBC has developed this programme in response to the high costs of recruiting care assistants and related staff. In the year prior to introducing the programme, the local authority had advertised 275 care assistant vacancies, at an average cost of £2,756 per post recruited to, taking the costs of advertising, management time spent on recruitment and induction, CRB checks⁹ and initial training into account ($275 \times £2,756 = \text{over } £750,000$). Through this new programme, the SSD also hopes to reduce expenditure wasted on applicants who drop out between expressing initial interest and job start.

Research into social care workforce issues

Developments here include:

- a review of staffing in the independent and local authority health and social care sector (EKOS 2004) in the Black Country and West Birmingham area. This mainly explored issues in the residential sector, but a number of its key findings are relevant to the domiciliary care sector, including:
 - the high annual turnover reported in care assistant posts (21%);
 - difficulties in recruiting care assistants (noted by 53% of Sandwell providers);
 - employers' concerns about the lack of applicants with necessary skills (31%) and their inability to offer competitive rates of pay (24%).
- Research within Sandwell MBC (Wray 2004) which identified the recruitment of suitable home care staff as a major concern for providers: 81% of respondents in this area of social care reported having to recruit candidates with no experience of the care industry.

⁹ Criminal Records Bureau.

New contractual and tendering procedure

A new tendering procedure introduced in 2005 for non-specialist domiciliary care supporting adult clients, 'rationalised the market basis of providers' used by Sandwell SSD, replacing the previous system (based on an approved list of providers and *ad hoc* contracting of business on the basis of 2 quotes), which involved 'doing business with an inordinately large number of people, which was difficult to manage'. In 2005, contracts were agreed with 12 main providers, recruited via an open tendering process, with applications sought from providers willing to tender at a fixed price per hour. Tenders were assessed on the basis of quality: staff; references; health and safety, equal opportunities and other policies in place; training; financial stability and security. Contracts were offered to the top 12 bidders, scored on quality factors. This process drew a few new providers into commissioning arrangements, and other successful bids came from existing local suppliers of domiciliary care. These included some smaller organisations, including 'proprietor owned' or 'sole trader' providers. At the end of 2005 there were few contracts with 'national organisations'.

Developments within Sandwell SSD

Connected to the new tendering arrangements, the SSD has also made adjustments to its own commissioning and procurement team, and encouraged a new approach to partnership working, including monthly meetings with its 12 providers. Within the local authority, 'work groups' have been established to explore further options for 'modernising home care'. These are likely to have both internal and external ramifications, and involve discussions with external agencies and collective bargaining (re in-house developments).

These developments form the context in which the results from our survey of providers and our interviews with providers and stakeholders need to be understood.

Survey of Sandwell providers

In Sandwell, our survey of providers of domiciliary care had a 67% response rate and produced 10 responses: 2 from the voluntary/community sector; 5 from the for-profit sector; and 2 from the not-for profit private sector¹⁰. Sandwell Council's Social Services Department also responded to the survey.

➤ Services Provided

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 support for younger disabled people. The responses we received came from organisations of differing size - 2 were organisations employing fewer than 50 care staff, 6 had between 50 and 99 employees, and 2 had 100 or more care workers. Consequently, some had contracts to provide fewer than 500 hours of care per week, while others had large contracts for 2,000 or more hours per week. All the providers supplied personal care to clients in their own homes, and most also supplied domestic help, shopping, sitting services and help with managing the household. Four said they provided a 24-hour on call service, and 2 provided 'rapid response' and 24-hour live-in care services.

➤ Staff and Working Conditions

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, 5 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 these older staff formed less than half their workforce).

Seven of the 10 providers had some staff on permanent contracts, and four providers were using 'zero hours' contracts for some of their staff. Wages ranged from £4.90 to £6.50 per hour for weekdays during the day time to £5.00 to £14.00 per hour for Sunday nights. Only 3 providers said they reimbursed the costs staff incurred while travelling to visit clients, although 5 offered staff mileage allowances. Most providers claimed to pay sickness and holiday benefits above statutory requirements, and 7 said they offered their staff membership of a pension scheme. Nine of the 10 providers said they met or partially covered staff training costs in attaining NVQ target levels, and 3 reported giving staff study time for this.

➤ Recruitment and Staff Turnover

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 30%, and although some organisations reported no staff shortages in the previous 12 months, the worst

¹⁰ One respondent did not answer the relevant question.

affected employer considered that at times up to 60% of posts were unfilled.

The most common method of recruiting care workers was via local newspaper advertisements or the local Job Centre. However some Sandwell providers had been experimenting with other approaches. Most (8) were now also using the internet to recruit staff, and 3 were using the trade or professional press. Three had run special recruitment initiatives in recent months, and a few 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', for better pay, or to further their careers. Many leavers also mentioned the unsociable hours involved, work-related stress, and challenging situations with clients. Some employees found the job involved too much responsibility. Work-related injuries and health problems 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.

➤ Qualifications and Training

Some providers said they were currently employing staff without qualifications at NVQ level 2¹¹. Two said less than a quarter of their domiciliary care workers had reached this level, while 5 reported that more than half had achieved this standard. Four providers indicated that the majority of their care supervisory staff now had qualifications at NVQ level 3. Most also had some care workers registered for training and accreditation at NVQ2 or above at the time of our survey, and 4 had over 50% of their care staff in this situation.

Most of the Sandwell 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 also reported that some of their employees' lacked basic skills and confidence. A minority had difficulty finding the resources needed for assessment, and a few said they were struggling to retain their trained staff. Some concerns were also reported about low completion rates among staff undertaking NVQ training.

¹¹ 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

Four of the providers in Sandwell 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

Most domiciliary care providers face regular and ongoing difficulty in ensuring a regular supply of adequate and suitable labour:

There are lots of people out there whose needs aren't being met.

At the end of the day you do run out of people who really want to do the job and live in the right area.

There is adequate supply at the moment, because I know other providers who haven't got enough work for their care workers, because of the budget implications at the moment with Social Services.

The image of the job

Part of the difficulty in recruiting staff lies in the image of the job. Job image issues mean it can be very hard for providers to attract suitable applicants.

The job itself has no appeal. It's not well advertised, it's not marketed well, there is no opportunity for career moves for a lot of people doing this work. It's for reasons like that it's very, very, very difficult to recruit. The pay is low, the responsibility is high and - if you weigh everything up - for a lot of people it's just not worth it for them, there are far easier things to do to earn a living.

In the press (...) inevitably it's always the bad care workers and what they've done. No-one promotes it as a good job. All you see in the press (is) the bad side of the job.

There are problems recruiting people - problems recruiting the right person. As an organisation we have got a standard that we expect, and even if we are desperate we will not recruit below that standard.

In addition, the nature of the job has changed, and applicants do not always have an understanding of what domiciliary care work now involves.

It has changed dramatically - responsibilities are (much greater). Home help work (was) doing the breakfast, doing the tea, doing the shopping and the pension. People have still got this vision of home help. Domiciliary care is now bordering on nursing. Nurses used to do the washing and dressing and any personal care - now it's the care workers.

Competing demand for labour

Competition for the available labour is a problem in Sandwell, both from other industries and sometimes from within the sector. Reference was made to jobs in retail and in local manufacturing firms:

They can get higher wages by working in Tesco. It's there and it's available to them - they are doing a full shift all in one go.

The only people that we've had move are to go to Social Services' own providers - obviously they pay a lot more than we do - and the hospitals, to improve their career path.

All you need is a big ASDA – we've got 2 of those – they pay slightly more than the home care rate. It's inside, it's warm. The competition is there. There are lots of manufacturing units on the Express Way, and people will drive to work and go there. The rate of pay may not be brilliant, but it's better than what they're getting.

Worker commitment

Despite these problems, it was emphasised that many domiciliary care workers in Sandwell were doing a difficult job with great sensitivity, and were considered to be exceptionally committed to their jobs:

We have got some people who have been with us a long period of time, doing their 20 hours a week. They love their job, they love the people they work with, and they like the continuity in their own life. And when they have to leave – maybe because of ill health – you can really see how it tears them apart.

Retaining and supporting staff

Providers in Sandwell 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:

It's certainly not the pay. We've always said our carers deserve £10 an hour for what they do and the responsibilities they've got.

We have them from all walks of life - recently a lot of students who want extra money to get them through university - it's predominantly evenings and weekends that they can do.

We do support our staff. If you've got a small child at school and school phones, we will allow you to go home. If you've got no annual leave left and something happens, we can bring it forward from the next year. We'll support you to get overtime so you can make your money. If you split up from your husband or wife and your childminding changes, we'll change your shift pattern. We look after the individual as long as it's not detrimental to the organisation or the service user. The service user comes first. As long as that balance is there, we will juggle and shift and shuffle and do anything to support you.

[You retain staff] with support. The first 3-6 months, they need an awful lot of support, because they are going to see a varied range of clients. They are going to see old ladies that you are just doing breakfast for, but also younger women with MS with no mobility at all, speech very slurred, having to be hoisted. Some wouldn't be able to go to the lady with MS; they wouldn't be able to cope with it. It's getting to know the carers when they first come, gradually introducing it. If they can't cope, bring them back to the cases they can cope with - because other carers can do that while they are doing the easier ones.

The support superiors give to them (is crucial). It can be a very alienating job working out there by yourself. You may get (praise) from the service user, but staff also need recognition from their superiors, people in the office, other professionals. It's a very undervalued job, - and a very negative sort of job as well, because at the end of the day there is not an awful lot of hope there for people that you are looking after.

Workforce development and training

Providers were concerned about meeting the costs of the training and development of their workforce. Some were not paying staff for the time spent training, and not all were able to retain those they had trained.

Initially we were paying for our NVQs £365 per care worker. Probably the ones that we paid for have now left, to further their career. There is funding now for NVQ2s, but it still (takes) a lot of our time, the management of it.

It's been very costly...companies have had to pay for that themselves. I really think it's just a government strategy to get care on the cheap.

(It's been) a terrible strain, because we don't pay our staff when they get trained - which is something that has been pointed out by CSCI. I've checked out with other companies, they don't pay their staff, because the money is not there from the hourly rate that Social Services give us. If we paid our staff when they were training, the business would just go bankrupt.

Key problems here included covering the workload during staff training, although care workers' attitudes to training were generally considered to be quite positive. Some providers had found constructive ways of responding when they encountered care workers who were apprehensive about preparing for NVQs:

It does restrict what you can do within your business and (affect) the availability of your managers. There have been times when the care co-ordinator and I have actually gone out and done care work, because we've allocated the time for the carers to train, and the carers who were covering, something's happened. So we've gone out and covered it ourselves.

A lot of staff want recognition. In the very, very beginning I assumed that the older carers wouldn't want to take part in it - but I was wrong. Not all of them, but most of them - wanted that recognition.

The only staff who are reluctant, are some of the older staff, where training is a threat and we've had to support them. We've had a couple of issues where the literacy skills aren't very good, and we've had a word with the trainer and they've done...a little test at the end - and they've done it on their own, verbal rather than writing. A lot of it is childminding problems, like if our training is during the day - so we've had to revisit how we do it. You have to have some groups where it's of an evening, and we have got a good training provider who will do that now.

Contracting arrangements in Sandwell

Domiciliary care providers, most of whom obtained the vast majority of their business through contracts with the SSD, were very conscious of the new contracting arrangements recently put in place locally. Some felt these developments had provided scope for developing more effective partnerships within the sector, and were helping them resolve some of their labour supply problems:

The new contracts have reduced the amount of domiciliary care agencies, and we've got contracts in two areas of Sandwell - before we used to compete for all areas. There were 36 agencies in Sandwell and it's been reduced to 12 main providers. I know 2 companies have closed because they hadn't got a contract.

The new contracts we've got actually stop carers migrating from one agency to the other. In this area, we've only got three agencies at the moment, so if they live locally they've only got three agencies to go to. We've had less staff move to other agencies.

It is a competitive market - but we don't need to compete too much, because we have a good reputation. We pride ourselves on giving a good quality service at a reasonable rate and we're renowned for that.

It's getting to be partnership, to be fair. Since the new contracts have been given out we have monthly meetings, the contracts manager and the providers. People are now openly discussing problems they are having, whereas before they tended not to voice it openly. We have got a forum where the 12 providers have got together.

It's both [partnership and business]. As we're going on we're improving our standards - I don't think they are as much as we are. The partnership is becoming a bit strained, so it's (been) more of a business than a partnership in the past year.

There was some concern about the way cost restrictions and new tendering arrangements were impacting on how domiciliary care was delivered to clients, however, and the price set for the tasks involved was putting some providers under pressure:

The care workers are actually doing more time in the client's house to be able to provide the duties needed. Wash, dress, breakfast, make bed, empty commode - all in half an hour. Sometimes that takes more than half an hour - but try and go back to Social Services and tell them! 'We've got no budget, you'll just have to do it in half an hour - and if you can't make the bed, then you leave the bed.' But that's part of our duties - and who is going to make the bed? Will the client struggle to try and tidy her bed up or end up in hospital with a hip replacement and a bigger package when she comes out? And how much is it costing to have that hip replacement in hospital?

The side that does worry me is the money side of it. We are not a charity, so we do need to make a profit - why would the owner carry the business on if it wasn't making a profit? When we put the

tender in last year, it was take it or leave it - you either tender at this price, or you don't. And there were quite a few agencies that just left it, didn't bother tendering because of the rates.

The costing of running a domiciliary care agency now has escalated over the last 3 years -probably tripling our costs for the training side, CSCl and everything else - yet the costs we are getting from Social Services aren't reflecting this. 2-3% increase – nothing. We are getting less from Social Services on a weekend as an agency than they actually pay their in-house carers.

We are costed out in 1hour units, 3/4 of an hour, ½, ¼ of an hour. We have to get the tasks to sit into the units of care, but still work within that restrictive amount of money to give care to people. A lot of people feel they are being rushed, because we are only contracted to provide X amount of care and we have to do that within those restrictions. Someone who is on their own all day can feel they are being rushed. But if you only have ¼ of an hour to do a call, you may spend 5 minutes trying to get into the property, then you only have 10 minutes - and you still have to move on to your next person. Nobody pays you for moving from one house to another.

Some went so far as to suggest that procurement arrangements were now putting price before quality of service to the client:

It's price unfortunately. We have service users whose health deteriorates - obviously we say the need more support, and this is the new cost. 'We can get it cheaper in a nursing home - we'll move them to a nursing home'. Where are the rights with that? We've had to involve advocacy groups a lot of times - some we've won, some we haven't.

While the providers we spoke to stressed that they never compromised on standards, some felt other providers sometimes did:

If we don't think the level of care is right, we have to say no, although we're sorry about that service user, we will not put a cheap care package in if it's not going to meet the needs adequately - [although another provider will often be willing to do it].

Providers made a range of comments about the tendering process in Sandwell. Several found it very time-consuming and complex and some felt those involved in setting the procedures were rather remote from the practicalities of the job.

It took me 4 days to do the tender and that was two of us working on it... 4 days of doing nothing else.

A little far removed from what goes on at grassroots. They don't have an empathy with what is real life, the ones who are coming from the money angle

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

Our study has shown a variety of ways in which the local authority and independent providers are tackling these problems, and shows that efforts are already being made to monitor, understand, and address key issues.

In Sandwell, we did not hear much from stakeholders and providers about medium to longer term plans. This is perhaps not surprising given the current and short-term issues they face in recruiting and retaining staff, meeting NMS targets and complying with increasingly complex, if necessary, regulation and monitoring of the sector.

There was very little mention in our interviews of the structural changes affecting Sandwell's local labour market, or of the difficulty which some Sandwell residents, especially women, face in entering the labour market (as revealed in our companion study *Connecting women with the labour market in Sandwell* [Grant et al 2006]).

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

Sandwell's recent innovations in recruiting domiciliary care workers and in commissioning home care services are responses to some of the important supply and demand issues highlighted in this report. Here we summarise key developments in Sandwell which need to be monitored, encouraged and maintained, and recommend some actions which Sandwell MBC and other local agencies may wish to consider.

Partnerships and dialogue between agencies

In Sandwell, partnerships have already been developed, and were operating across the statutory and independent sectors during our research. This approach needs to be maintained and enhanced, to create further opportunities for regular dialogue and for exploring and sharing good practice about service development and enhancement.

Further clarification of the existing partnership arrangements would be welcomed by local independent providers, and in view of recent changes in contracting arrangements, a revised assessment of the effectiveness of partnership arrangements could now be undertaken. The aim of this process should be: to strengthen the network of agencies with domiciliary care responsibilities; to identify any weaknesses in forward planning; and to contribute to effective development of services in the context of Sandwell's large and diverse population of older people.

Recruiting staff

Innovative approaches to recruiting additional domiciliary care staff have been developed in Sandwell, in response to staffing problems and to the high and wasteful costs involved when agencies have to cope with high staff turnover.

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

➤ New sources of labour

Particular attention could be given to attracting applicants from the Indian origin community

(where many women have been displaced from manufacturing employment) and from the Pakistani and Bangladeshi communities (where women are finding re-entry to the labour market particularly difficult). New domiciliary care workers from these communities would be particularly well equipped to support Sandwell's growing population of older people, which will be ethnically and culturally more diverse.

➤ Streamlining the recruitment process

The lengthy process involved when domiciliary care workers are recruited, with its essential but somewhat protracted vetting and checking procedures for new domiciliary care workers, appears to be contributing to a waste of resources (especially when applicants withdraw at a late stage in the recruitment process), and effort should continue to be committed to addressing this problem.

➤ Attracting applicants

Like other parts of the country, Sandwell faces some problems with the 'migration' of domiciliary care staff between different parts of the social care sector, and across different sectors of the economy. Providers stressed the limited scope in the system for reallocating costs, and the difficulty they currently face in competing for the available labour supply using higher rates of pay. Local agencies nevertheless need to find ways of addressing the problem of low pay in this field of work, and have a role to play in highlighting this issue at the national, strategic level. Providers also need to find ways of highlighting the advantages of the employment they offer in other ways. There are signs that applicants are beginning to come forward in response to the enhanced opportunities for training, accreditation and progression which domiciliary care work now offers, but much more could be done to reshape the image of the job, and some further work could be developed to tackle this at the local level.

Strategic planning and the longer term

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

It is crucial that the emphasis on strategic planning and review is continued, and that further

activity is undertaken to reshape the local social care market and ensure that an effective network of businesses and organisations is available locally to deliver on future demand for domiciliary care services. The lead role played by Sandwell MBC in the Learning 2 Care project is a good example of this type of work. As by far the most important commissioner of domiciliary care services in the district, Sandwell SSD has a key role to play here, and can contribute to the necessary local awareness-raising by continuing to involve other key agencies, including *Skills for Care* with its brief to connect skills development and labour supply issues, and the *UK Home Care Association*, as an advocate of good practice from within the sector.

Resource issues

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

Domiciliary care and the local labour market

Other research within the GELLM programme has shown the critical importance of women's employment in local labour markets. This is particularly true of Sandwell'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 many Sandwell residents, and the district's growing 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 Sandwell for some years to come.

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

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Appendix 1 Gender and Employment in Local Labour Markets

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

The GELLM project output comprises:

- new statistical analysis of district-level labour market data, led by Dr Lisa Buckner, producing separate **Gender Profiles** of the local labour markets of each of the participating local authorities (Buckner, Tang and Yeandle 2004, 2005, 2006) - available from the local authorities concerned and at www.shu.ac.uk/research/csi
- 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 Methodological Approach

The study was conducted in Sandwell 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 Sandwell.

Analysis of 2001 Census data

Data from the 2001 Census for England and from the sub-national population projections¹² were used to produce a statistical profile relating to domiciliary care in Sandwell. 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 15 domiciliary care providers registered with Sandwell'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. 10 providers responded to the survey in Sandwell, a response rate of 67%. They included 2 from the voluntary and community sector, 5 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 8 key stakeholders and providers in Sandwell. The interviews with key stakeholders were conducted with managers responsible for contracting and commissioning, HR, and training/staff development within the Sandwell'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.

¹² 2003 based sub-national population projections, Government Actuary Department, Crown Copyright 2004

Appendix 3 Statistical information about older people in Sandwell and Care Assistants and Home Carers

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

	Men			Women		
	65-74	75-84	85+	65-74	75-84	85+
Population in 2001 (numbers)¹³	11,271	6,494	1,242	13,590	10,361	3,613
Tenure (%):						
Owns	63 (77)	55 (69)	47 (59)	62 (74)	47 (62)	36 (45)
Rents from council/social landlord	30(17)	36 (21)	31 (20)	31(20)	38 (25)	32 (22)
Private rented	2 (5)	2 (6)	4 (9)	2 (5)	4 (8)	5 (9)
Lives in communal establishment	1 (1)	3 (3)	9 (12)	1 (1)	4 (5)	16 (23)
Living arrangements (%):						
Lives alone	21 (17)	28 (26)	42 (37)	35 (33)	54 (52)	59 (55)
Lives with a partner	72(76)	60 (65)	38 (41)	51 (56)	27 (31)	8 (8)
Health and care (%):						
General Health 'not good'	25 (19)	32 (25)	38 (32)	26 (19)	34 (27)	45 (36)
Limiting long-term Illness	51 (42)	62 (56)	72 (70)	49 (40)	66 (58)	82 (78)
Provides unpaid care	14 (14)	12 (12)	7 (8)	14 (14)	7 (8)	2 (3)
Population Change¹⁴						
Population 2003 (numbers)	11,300	6,700	1,300	13,100	10,400	3,500
Per 1,000 people of Working age in 2003 (20-64)	69 (71)	41 (44)	8 (10)	80 (83)	64 (64)	21 (25)
Population 2028 (numbers)	13,400	8,200	2,900	14,500	10,200	5,000
Per 1,000 people of Working age in 2028 (20-64)	81 (104)	50 (71)	18 (27)	88 (109)	62 (85)	30 (40)
Change 2003- 2028:						
Increase (number)	2,100	1,500	1,600	1,400	-200	1,500
Percentage change (%)	19 (45)	22 (69)	123 (173)	11 (40)	-2 (38)	43 (69)

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

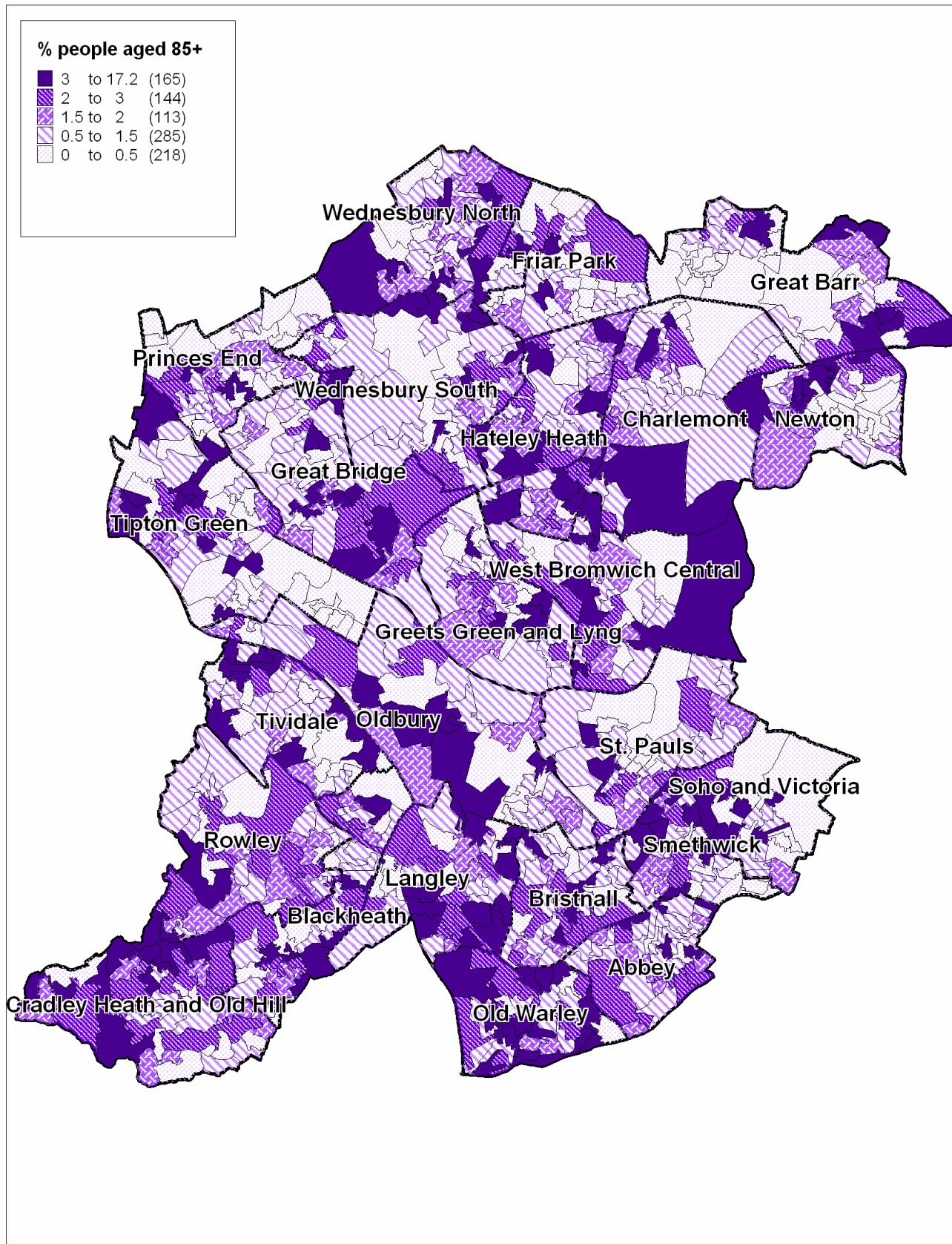
	All households 115,423	Age of resident with LLTI	
		65-74	75+
Number with a resident with a LLTI	47,427	6,590	8,978
% of all households	41 (34)	6 (5)	8 (7)
% with no carer in household	70 (71)	82 (82)	86 (86)

Source: 2001 Census Standard Tables, Crown Copyright 2003

¹³ Source: 2001 Census Theme Tables, Crown Copyright 2003

¹⁴ Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005

Figure A3 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 Sandwell (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	61,573 290	8,397 49*	38,719 179	14,457 62	49,425 2,570	7,740 361	32,976 1,640	8,709 569
% in employment who are CA&HC	0.5 (0.4)	0.6 (0.5)	0.5 (0.4)	0.4 (0.4)	5.2 (4.0)	4.7 (3.8)	5.0 (3.8)	6.5 (4.9)
% across all age groups:								
All in employment CA&HC		14 (13) 17 (16)	63 (62) 62 (62)	24 (25) 21 (22)		16 (15) 14 (14)	67 (65) 64 (61)	18 (20) 22 (25)
% across all age-sex groups:								
All in employment CA&HC	56 (55) 10 (12)	8 (7) 2 (2)	35 (34) 6 (7)	13 (14) 2 (3)	45 (45) 90 (88)	7 (7) 13 (13)	30 (29) 57 (54)	8 (9) 20 (22)
Employment Status:								
All in employment								
Employee full-time	83 (76)	80 (74)	84 (80)	80 (68)	58 (55)	66 (62)	59 (56)	49 (47)
Self-employed full-time	10 (15)	3 (4)	11 (15)	13 (21)	2 (4)	1 (0)	2 (4)	3 (6)
Employee part-time	6 (7)	17 (22)	5 (4)	5 (6)	39 (38)	33 (37)	38 (37)	46 (42)
Self-employed part-time	1 (2)	1 (1)	2 (2)	2 (4)	2 (4)	0 (1)	2 (4)	2 (5)
Care Assistants & Home Carers								
Employee full-time	77 (74)	78 (69)	76 (77)	82 (68)	47 (43)	62 (56)	47 (42)	39 (40)
Self-employed full-time	1 (2)	0 (0)	0 (2)	5 (5)	4 (0)	0 (0)	1 (1)	1 (2)
Employee part-time	21 (23)	22 (30)	23 (20)	13 (25)	52 (55)	38 (44)	52 (54)	60 (57)
Self-employed part-time	0 (1)	0 (1)	2 (1)	0 (2)	1 (1)	0 (0)	1 (1)	0 (1)
Qualifications:								
All in employment								
No qualifications	33 (19)	19 (11)	27 (14)	57 (35)	27 (16)	9 (6)	23 (12)	57 (35)
Lower level	45 (49)	70 (74)	50 (51)	18 (28)	53 (54)	76 (76)	55 (55)	25 (34)
Higher level	22 (33)	11 (15)	24 (35)	25 (37)	20 (30)	15 (18)	22 (32)	18 (30)
Care Assistants & Home Carers								
No qualifications	24 (19)	16 (11)	22 (16)	38 (36)	31 (29)	13 (11)	27 (24)	53 (50)
Lower level	57 (58)	84 (79)	58 (60)	36 (36)	58 (58)	76 (81)	62 (62)	36 (34)
Higher level	18 (23)	0 (10)	21 (24)	26 (28)	11 (13)	10 (8)	11 (13)	11 (16)
Unpaid care:								
All in employment CA&HC	11 (10) 16 (17)	5 (4) 10 (11)	10 (8) 15 (16)	17 (17) 23 (26)	15 (13) 20 (18)	6 (5) 14 (10)	14 (12) 18 (17)	25 (24) 27 (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

