

Local Challenges in Meeting Demand for Domiciliary Care in Newcastle

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Foreword

Gender Equality

Newcastle City Council 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, Newcastle City Council is better 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.



Ian Stratford
Chief Executive



Peter Arnold
Leader of the Council

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

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Contents

Key findings	2
Introduction	4
The changing policy environment for domiciliary care	4
About the study	5
Domiciliary care in Newcastle - changes in supply and demand	6
Policy developments in Newcastle	8
Employment policies and practices in domiciliary care	11
Policy messages and recommendations	16
References	19
Appendix 1 Gender and Employment in Local Labour Markets	20
Appendix 2 Research methods	21
Appendix 3 Statistical information about older people in Newcastle and Care Assistants and Home Carers	22

Key findings

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

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

Demand for domiciliary care in Newcastle

Newcastle's ageing population, and continuing high levels of poor health and deprivation in parts of the city, mean that demand for domiciliary care is growing. In areas of the city where the population is ethnically diverse, culturally sensitive home care will be increasingly important in the future.

- 39% of households in Newcastle contain a person with a limiting long-term illness, including 8,000 households where the sick person is aged 75 or older.
- There is no co-resident carer in 88% of these households.
- Newcastle's population of very aged (85+) residents is expected to rise by 7,700 people by 2028, with a particularly strong increase in the number of very aged men.
- In Newcastle, 87% of very aged men, and 78% of very aged women, live in their own homes.
- 39% of very aged men in the city, 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 Newcastle.

- 2,500 Newcastle residents, 86% of them women, are already employed as care workers. 1 in 22 of all employed women in Newcastle is a care worker.
- In Newcastle, 46% of female care workers, and 25% of male care workers, work part-time. Most are White British men and women, although Newcastle's small population of Black/Black British residents, especially men, are more strongly concentrated in care work than people of other ethnicities.
- A large minority of Newcastle's care workers had no formal qualifications in 2001 – two thirds of women care workers aged 50-59, and almost a fifth 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. Newcastle has responded to these changes in a variety of ways, and re-shaping of the care market has affected all stakeholders.

- Newcastle City Council and its partners are making considerable progress in addressing issues of supply and demand in domiciliary care. Relevant activities include participation in the *Tyne and Wear Care Alliance*. Revisions have also been made to the approach to commissioning domiciliary care in Newcastle, through changes to the competitive tendering process in 2005.
- Newcastle's domiciliary care providers include small, medium and large organisations, across the public, private and voluntary sectors. About two-thirds of domiciliary care in the city is purchased from the independent sector.

Employment challenges

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

- All providers who responded to our survey had some older (50+) care workers on their staff – but these staff formed less than half their workforces in almost 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
 - Limited scope in some organisations for paying staff for the time spent on job training
 - The challenge of addressing 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.

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 Newcastle reported that:

- Supply and demand is a major 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 other public sector jobs) 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 hidden costs of training and workforce development were a worry for some employers.
- Revised tendering arrangements had impacted on the sector. Effects of the arrangements included:
 - More regular dialogue between the local authority and its contracted providers
 - Scope for better partnership working
- Some providers were concerned about very tight financial arrangements, and worried that price was sometimes put before quality.

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 Newcastle, 37,580 contact hours per week of domiciliary care were provided to 4,000 households in 2004, and 69% of this care was provided by independent providers⁴.

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

About the study

Local Challenges in Meeting Demand for Domiciliary Care is part of the national *Gender and Employment in Local Labour Markets (GELLM)* project 2003-6, in which Newcastle 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 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 Newcastle within the GELLM project, and builds on the project's earlier statistical work, *The Gender Profile of Newcastle'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 Newcastle – changes in supply and demand

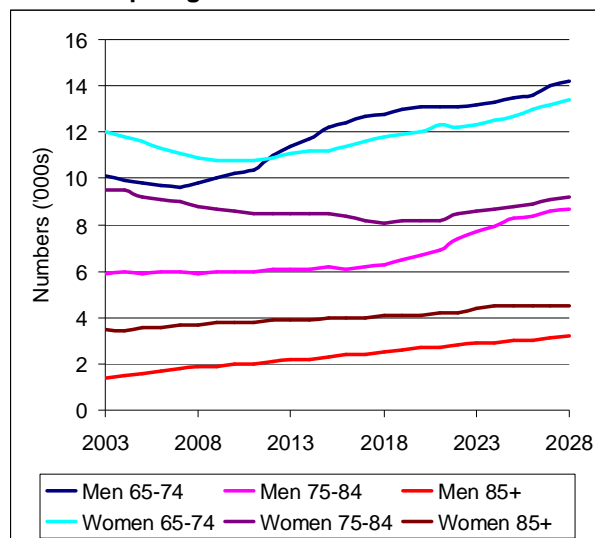
Demographic projections in Newcastle

In 2001, Newcastle had 111,243 households, of which 43,520 (39%) contained a resident with a limiting long-term illness, including over 8,000 households where the resident with the illness was aged 75 or over. In 88% of these homes, there was no co-resident carer. As we showed in the *Gender Profile of Newcastle’s Labour Market* (Buckner et al 2004), levels of poor health and disability in Newcastle 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 Newcastle also provide an important context.

1.9% of Newcastle’s residents were aged 85 or older in 2001 (which is the same proportion as in England as a whole). Population projections for older people in Newcastle are shown in Figure 1. Between 2003 and 2028, Newcastle’s population of residents aged 85+ is expected to grow significantly. The latest estimate suggests that by 2028 there will be 7,700 more people in this age group, of whom 4,500 will be women. This is 1,000 more very aged women and 1,800 more very aged men than in 2003 – and will more than double the number of very aged men living in Newcastle. By 2028 there are also likely to be 2,800 more 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 Newcastle’s population of older people is not as rapid as in some other localities, and is below the

national average for England, these figures represent a very significant challenge for the effective delivery of domiciliary care services.

Figure 1 Newcastle: 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 Newcastle almost 78% of women aged 85+, and about 87% of men aged 85+, were living in their own homes, either owned or rented. 58% of all Newcastle women aged 85+, and 39% of men of this age, lived alone; these percentages are higher than the national figures. The overwhelming majority of the city’s very aged women (80%) and 74% of its men had a limiting long-term illness, with well over a third of both sexes stating that their general health was ‘not good’. About 9% of Newcastle’s men aged 85+, and about 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 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 Newcastle, 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.

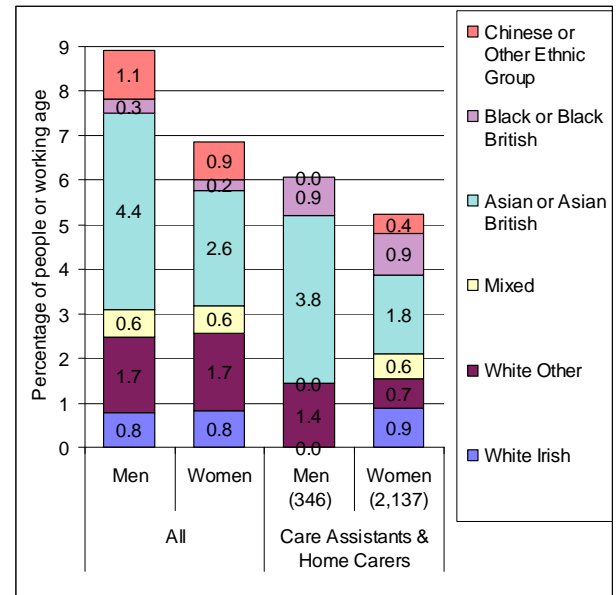
The key local labour market issues are:

- Between 1991 and 2002 Newcastle's working age population decreased by 1,200. Over the same period, more than 18,000 new jobs were created, over 14,000 of them part-time positions (Buckner et al 2004) creating an increasing demand for labour in the city. A continuation of this trend is likely to involve some competition for workers wanting to work part-time between the social care sector and other sectors with high levels of part-time working – notably the distribution, hotels and restaurants sector.
- Levels of unemployment and economic inactivity in Newcastle were above average, however (Buckner et al: 42-43), and our other research in Newcastle suggests that gaining access to paid employment remains a problem for some of Newcastle's residents (Escott et al 2006).
- Newcastle has low levels of self-employment among both men and women of working age (3.1% of women and 8.2% of men, compared with 4.9% and 13.2% in England). This is unlikely to present a particular barrier in domiciliary care work, however, as very few care workers are self-employed (1.0% of female and 2.0% of male care workers in Newcastle in 2001).
- Given that, in England as a whole, some ethnic minority groups form a particularly important supply of caring labour⁵, the fact that Newcastle has a relatively small ethnic minority population may also contribute to future labour supply shortages.

The social care workforce in Newcastle

Nearly 2,500 Newcastle residents are people of working age in paid employment as care assistants and home carers - 86% of them women⁶. Already 1 in every 22 women employed in Newcastle is a care assistant or home carer (4.5% compared with 4% of women in England as a whole). More than half (52%) of Newcastle's care workers are women aged 25-49 (compared with 54% across England), while 22% are women in their fifties (the same figure as for England as a whole). Almost 12% of care workers in Newcastle were young women aged 16-24.

Figure 2 Ethnicity of care assistants and home carers in Newcastle



Source: 2001 Census Commissioned Tables, Crown Copyright 2003

In Newcastle, 46% of female, and 25% of male care workers work part-time (compared with 55% and 23% across England). Care workers aged 25 and over were more likely to work as part-time employees than other workers, and this was especially true for men. The overwhelming majority (94%) of female care workers in Newcastle are White British women, and 91% of the city's male care workers are White British

⁵ 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.

⁶ 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.

men. However, people from ethnic minority groups, especially women and men of the Black/Black British group, were disproportionately clustered in care work (Figure 2).

In Newcastle, care workers of both sexes, especially those under 50, were considerably more likely than other workers to have unpaid care 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 most evident among 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 Newcastle was particularly striking. 66% of Newcastle's female care workers aged 50-59, and 44% of male care workers aged 50-64 were unqualified in 2001. When compared with England as a whole, Newcastle has high levels of unqualified care workers in all age groups.

Policy developments in Newcastle

Responsibility for the commissioning and procurement of domiciliary care services to meet the assessed needs of Newcastle's residents lies with Newcastle City Council's Social Services Department (SSD). In 2005, the SSD purchased about two-thirds of its domiciliary care from external agencies⁷. 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 meeting national targets and standards, and improving the reliability and quality of service delivery. The most recent *Commission for Social Care Inspection* rated Social Services performance in Newcastle 'good' in respect of performance relating to the number of older people helped to live at home. Key local developments in the social care sector include the following initiatives.

⁷ The balance between independently contracted domiciliary care and in-house public sector provision is closer to 50:50 if the city's large commitment to supporting the independent living of residents with learning difficulties is excluded (information supplied in key stakeholder interview).

Tyne and Wear Care Alliance

The *Alliance*, which grew out of an earlier project in Sunderland and continues to be hosted by Sunderland Council, secured a major European Social Fund award (£6.4m) in 2003. Its funding, lasting over three and a half years, supports an employer-led partnership between local providers of adult social care, local authorities in the region (including Newcastle City Council), and the Tyne and Wear Learning and Skills Council. By 2005, the Alliance was working in partnership with over 20 providers of domiciliary care, many based in the city, and, building on existing infrastructure, was delivering the following key activities:

- *Development of a Workforce Learning and Development Toolkit*
- *Support towards training costs*
- *Help with workforce development planning*
- *Action research into current learning provision in the sector, and other workforce development issues*
- *NVQ registrations*
- *Establishing local partnerships*
- *An annual conference for the sector*

Care and Share Associates (CASA)

This group aims to replicate the expertise and experience of Sunderland Home-Care Associates in Newcastle, where a pilot project is running. Working in partnership with One North East and the North East Social Enterprise Partnership (NESEP), CASA operates as an employee owned and controlled business, which invests its surplus in the service it delivers with the aim of rewarding 'the loyalty and professionalism of its whole staff team'. CASA has identified the economic and demographic pressures affecting the care sector as key elements underpinning its business rationale; its own research has revealed that among the procurement problems affecting local authorities, the following are key features⁸:

- *Dealing with a large number of small, independent and private providers of various quality, with some unable to offer consistency of service*
- *Recruitment of carers and independent/private providers*
- *Servicing rural locations*
- *In the light of intentions to reduce 'in-house' provision, concerns about capacity in the independent/private sectors*

⁸ Cited in CASA's proposal to NESEP Inspire,

Supported by a £700,000 award to NESEP from the European Union's Equal programme, CASA has been set up with staff from Sunderland Home Care Associates, a cooperative providing home care to older people. CASA has established North Tyneside Home Care Associates, employing over 30 people, and funding has been secured to establish Newcastle Home Care Associates (with other projects in development elsewhere in the UK). CASA aims to secure long term funding through each business it sets up paying a share of profits to federate the businesses together to enable effective lobbying and shared services. CASA itself will ultimately be owned by its member coops.

Contractual and tendering procedures

Revised tendering procedures, developed in 2005 for generalist domiciliary care supporting adult clients, required comprehensive information from organisations seeking to secure block contracts for this work within the city. In the first part of 2005, Newcastle City Council (NCC) had contracts with 12 generalist domiciliary care providers and 3 'domestic only' providers, as well as 28 specialist service providers.

The 2005 open tendering process sought bids from providers willing to tender for generalist work 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. For those bidders who had existing contracts, recent evidence about complaints and how they were handled, and the views of staff and service users, were also taken into account.

Developments within Newcastle SSD

Connected to the new tendering arrangements, the SSD has also made adjustments to its own commissioning and procurement arrangements, and has actively encouraged partnership working. Contracted providers have bi-monthly meetings with the SSD, and a forum of domiciliary care providers, often attended by these organisations' selected representatives, meets quarterly to discuss shared issues and concerns.

Newcastle's *Social Care for Adults Business Plan 2004-5* stressed the importance of a number of strategic priorities, and set out the authority's

arrangements for meeting these. In respect of domiciliary care, the key commitments were to:

- *Support vulnerable people to live in their own homes wherever this is their wish and is practical.*
- *Involve users and carers in planning services and in tailoring individual packages of care.*
- *Meet legislative requirements for health and social care while remaining within budget.*

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 Newcastle providers

In Newcastle, our survey of providers of domiciliary care had a 49% response rate and produced 21 responses: 8 from the voluntary/community sector; 8 from the for-profit sector; and 4 from the not-for profit private sector. Newcastle City Council's Social Services Department also responded to the survey and took part in the interviews.

➤ Services Provided

Around half of the organisations completing the survey questionnaire regarded older people as one of their key client groups; in Newcastle many of the providers were also supporting people with mental health problems, learning disabilities, physical disabilities and sensory impairments. Ten of the organisations supported people suffering from dementia or people who are ill/recovering from an illness or who were terminally ill.

The responses we received came from organisations of differing size - 10 were organisations employing fewer than 50 care staff, 7 had between 50 and 99 employees, and 2 had 100 or more care workers⁹. 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 escorting/accompanying services, and most also supplied shopping, night sitting services and client support concerning engaging in activities. Three-quarters of the providers said they provided regular visits to clients in their own homes, domestic help, help with managing the household and help to (re)gain independent living skills.

⁹2 respondents did not answer the relevant question

➤ Staff and Working Conditions

Four providers told us that between 25 and 50 per cent of their staff were employed for fewer than 16 hours per week, and most had some staff with this type of 'short hours' part-time working arrangement. However, 16 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 but one case these older staff formed less than half their workforce).

Nineteen of the 21 providers had some staff on permanent contracts, six providers were using casual contracts and four providers were using 'zero hours' contracts for some of their staff. Wages ranged from £4.90 to £7.94 per hour for weekdays during the day time and from £4.85 to £35.00 per hour for Sunday nights. The majority of providers (19) said they reimbursed the costs staff incurred while travelling to visit clients, and 17 providers offered staff mileage allowances. Most providers claimed to pay sickness and holiday benefits above statutory requirements, and 17 said they offered their staff membership of a pension scheme. All 21 providers said they met or partially covered staff training costs in attaining NVQ target levels, and 16 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 63%, and although some organisations reported no staff shortages in the previous 12 months, the worst affected employer considered that at times up to 42% of posts were unfilled.

The most common method of recruiting care workers was via local newspaper advertisements, the local Job Centre, or through recommendations, and three-quarters of providers used in-house promotion methods. However some Newcastle providers had been experimenting with other approaches. Most (15) were now also using the internet to recruit staff, and 7 were using the trade or professional press. Nine 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', to further their careers or because they had moved house. Many leavers

also mentioned the unsociable hours involved, not being comfortable with the job, and better pay elsewhere. Retirement, challenging situations with clients and health problems were also mentioned by around half of the employers as reasons for their staff leaving.

➤ Qualifications and Training

Some providers said they were currently employing staff without qualifications at NVQ level 2¹⁰. Six said less than a quarter of their domiciliary care workers had reached this level, while 3 reported that more than half had achieved this standard. Twelve 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 5 had over 50% of their care staff in this situation.

Most of the Newcastle providers said that some of their staff lacked the confidence needed to train, 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 motivation and noted some difficulties in retaining staff once they were trained. Smaller numbers of providers had difficulties finding the resources needed for assessment, and some reported low completion rates among staff undertaking NVQ training, as well as the variable quality of training.

¹⁰ 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

Eleven of the providers in Newcastle 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, and comments made by key stakeholders in the city, are highlighted in the following section of the report:

Supply and demand is a major concern

Most domiciliary care providers stressed that they face regular and ongoing difficulty in ensuring a regular supply of adequate and suitable labour.

The market has shrunk, you know, there's fierce competition.

There is a lot of work out there, there is a high demand. If only we could recruit, we'd be running twice as many hours as we are now.

If you talk to care managers, they're really stressed out, most of them - they've got too much work and not enough people to do it.

I have concerns. The demand for the business will always be there, I have no doubt about that, but the problems around recruitment concern me enormously.

In the public sector 'in house' provision the situation was just as serious.

We're having a real problem with staffing levels - it's not because the vacancies aren't there. We've got senior workers visiting clients because the situation is so desperate - and I don't think it is any different for the private companies.

Recruiting staff

Providers also reported problems concerning the recruitment of good quality staff.

Very mixed, very mixed, some people are really, really, excellent - and some people really haven't got a clue. So I suppose on average I would say that the overall quality is not as good as you might hope.

There seem to be a lot more people wanting jobs - I think as the factories and other workplaces are closing down, we seem to be getting people - but it's getting the right people and the right quality of

staff that we want. It's difficult, and you find people are coming from hospitals as the hospitals are closing down. They might be highly trained, they might have got a lot of experience, but it's not necessarily the right skills that we want for the work.

Some providers were addressing their recruitment problems by employing people who did not fit the stereotypical white, middle-aged, female care worker.

We get a lot of overseas students from the two universities.

Over the summer we've just employed a couple of students, but they are from Manchester University, to work for a few months, a few weeks - 3 months altogether during the holidays. But that's not particularly usual. The more mature students, not the young ones.

Over the last few years, (we've taken on) quite a lot of women from Africa - north Africa- a lot of Nigerian women as well. We have had quite a few Chinese applicants over the last years as well - there is a large population of Chinese students in Newcastle. Because they've been students, they can't do contracts. Sometimes the language has been a barrier, because their English hasn't been good enough, so the service users wouldn't understand them. We've had to be careful on that.

I could foresee that as our people are drying up that we would have to take on a lot more people from abroad, but I suppose they are coming into the country from all over the place now, so it's a free market isn't it? They must speak English - they need to because of the record keeping and giving of medication. Sometimes their English is sometimes better than the people we are actually employing from this country.

Providers noted a number of problems with their recruitment activities.

(There's been a) drastic reduction over the last 3 or 4 years. I don't think it's just me - in the last 12 months it's getting worse. We used to literally advertise in the local paper on a Thursday night and be inundated with phone calls - and now you're lucky if you get 10, 20 calls.

When we recruit, it's advertised in the local evening paper, it's automatically sent to the Jobcentre and places like that. I find the applicants that come to me from the Jobcentre are not suitable.

We're spending a lot of money putting advertisements in the newspaper. A few weeks ago

we had only 3 replies and only one turned up for interview. It's getting that way, it's just happening more and more.

There have been a couple of campaigns on the television, to try to get people to go into social care - that didn't help.

School leavers – it's not really been much of a success, going to the colleges. Because they have to be 18 - so that doesn't work.

[The Jobcentre] were sending people who had very limited English skills.

Domiciliary care providers welcomed the opportunity to meet as a group to address recruitment issues, but there were also some problems with this.

Local initiatives - no,(a) lot of talk about it, a lot of meetings...[but] no action. All the providers get together regularly as a group to discuss their issues and problems, and that's very useful because we are all facing the same problems - but at the end of the day we are all aware we are all competitive, and we are all fighting for the labour market.

The image of the job

Another issue raised by providers was that since the nature of the job has changed, new applicants do not always have an understanding of what domiciliary care work involves.

What is asked of the support worker is greater than it used to be, and is greater than if you are simply going in to do somebody's shopping and cash their pension. That's fairly straightforward, but if you're going to try to empower somebody, and make a decision that they can control their life - that requires a higher degree of thoughtfulness and supervision and training.

The domiciliary care model has its roots in something akin to the old home help - and there hasn't been enough thinking about how that translates into learning disability services. Social Services seem to want to contract at the same price as the home help, with the same flexibility as the home help - but they ask for a totally different, more professional, sort of service to be delivered - and there is real tension between those two.

The government's introduction of care standards through the NMS framework was nevertheless thought by some providers to have significantly improved the image of care work:

It's uplifted the whole profile, and I think it is making people feel more confident about what they are doing and about the need for what they are doing.

Competing demand for labour

As suggested above, competition for the available labour is a problem in Newcastle. This competition for the available labour supply comes both from other industries and sometimes from within the care sector. Providers commented particularly on the jobs available in local supermarkets:

Carers are practically trained to nursing level, you know, for some types of care - and they are not getting the pay that goes with it. So they're looking elsewhere, I mean if they can get £7 for filling a shelf at Asda, they're not going to come to us for £5.

At the end of the day, they're going to look at what the salary is, and then they are going to look at Tesco's, where they can make a hell of a lot of money without the responsibility, without being out in the community by themselves, in charge and having to be the first person in there in an emergency. It's an awful lot of responsibility.

There's not only competition between the private and voluntary sector, there's enormous competition from the local authority, who have the same problems recruiting.

I've had a lot of staff poached...two of them have gone on to the ambulance service - two of them have gone on to the police. I think the police had spotted how very good they were with our clients while they were in custody, and they get poached all over the place. It's not usually to other care places, it's usually to other professions.

This idea that people get poached once they've got their NVQ and they go to an organisation that pays people that's got NVQs - I hear that as a theoretical issue, but I am not sure that we experience it very much.

Some providers felt staff who were dedicated to their jobs were less likely to be poached by other sectors:

There are certainly people who are really committed, and who want to make a career out of it. Those people won't go and work in a supermarket - but the volume of staff that we need in the sector is enormous, and we also have the people who are more there for the wage, and they are likely to drop out and go into what they would consider to be easier jobs.

We get a lot of overseas students from the two universities now. I don't think those people are particularly interested in a philosophical motivation, I think that they are looking for just some part time work that will possibly give them a little bit of income and possibly give them a foot in the labour market. But I think that people who come to us for contract, full and part time jobs, on the whole I think they want to help people.

Retaining and supporting staff

Some providers felt retention was the main problem, not recruitment:

We only provide services south of the Tyne, and Newcastle area, and I think there's an unending pool of workers who are prepared to come into care. But sometimes because of the work and because of the hours and because of the psychological stress that brings we do have a good turnover of people. We don't have a problem with recruitment, we have a problem with retention.

Care work staff are leaving care work, and it's not just care workers – organisers, managers, it's right up the chain. They are all leaving. I've had the same team of home care organisers here, we've all worked closely for 15 years, and in the last 2 years I am now down to only 3 of my original people out of 7.

However, many providers in Newcastle 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. Commenting on why people stay in the job, providers noted:

(The large) majority of staff have been with us for quite some time. I think it's the conditions of work – supervisions, appraisals, being valued, being respected and understood, views taken into consideration. I think it's the relationship, from the support worker right up to myself as general manager.

They are usually quite amazed at the level of support. A lot of the time they have come from agencies who won't invest in them, and they won't give them the time to train or pay them to train. Because our organisation is small it's very, very easy to manage this level of support, because we have a very, very good structure.

It's the type of job where they can select when they want to work. It's the sheer flexibility of it - but you see a lot of that flexibility has now been taken away because of the Care Standards.

Our contract is a zero hours contract, so we don't guarantee any hours. But the thing that appeals to them, it's so flexible. You know, a mother could come into work and work 9 till 3, not work weekends; someone else could come into it, and just work after 3, and so it's very flexible.

Not everybody wants that [permanent contracts] mind, because they want to retain that control and flexibility when they can work - especially if they have young children.

By contrast, pay was widely regarded as low for the work involved.

I think you might attract more people back into the profession if it was a decent salary. When you think about how important the work is, you see other jobs in the paper in the private sector for people on forty grand to do sales jobs that don't seem important - there is something wrong with society - but that's my personal opinion.

We lose staff to other providers who are paying a little bit more, so the fact that it's a low paid sector has an impact, undoubtedly.

Now the carers are starting to say, 'Look, I'm doing a nurse's job here, but I am not getting paid for that.' And they are walking away because of that.

Workforce development and training

Few providers reported any major problems meeting the requirements of the National Minimum Standards framework, although for some it had intensified their workload

We were already meeting most of the standards anyway.

It doesn't come anywhere close to where we train our staff. Our training was much higher than any minimum standards.

From the management point of view and home care organisers, they now have all these extra requirements. The workload has almost doubled.

The problems we find are actually having the time to do the assessments. What we've brought up several times in meetings is for the company to take on their own assessors, and that's their job. Because of the size of the company now we feel we should just have assessors to assess and do nothing else.

Some providers also noted that candidates with no prior experience or qualifications were sometimes more suitable for the job.

They don't need qualifications at all, they don't even need experience of this type of work - and sometimes, some of our best care workers have come because it's been a complete career change. They've had no experience. And I like to think they come with a clean slate and you can train them up. You're not having to deal with perhaps bad habits they learned elsewhere.

I would rather have somebody that's not coming from a care home background, because I find it easier to train somebody with no experience than to change somebody round.

Some of those we interviewed were concerned about meeting the costs of training and developing their workforce. Some reported that they had not been able to retain those they had trained.

We are paying those workers to do the training, and then it doubles our costs because we then have to pay the workers to do the visits.

We'd always had fairly well trained staff. The cost implications have been terrible for all of the independent sector in care. Even with the funding - because the funding only covers the cost of the courses, it doesn't cover the fact that you are paying people to be on the courses. In fact some of the independent sector don't pay their staff to go on courses, they just can't afford it.

Certainly all our competitors, and there's a lot of them - you can find staff move, you can find that you get staff trained up and then they move on for a few pence more an hour, which is most infuriating. Seems to be common everywhere.

Although care workers' attitudes to training were generally considered to be quite positive, there were sometimes problems encouraging care staff to train.

They are very keen to do it as quick as possible, because obviously the more highly qualified you are, the better job you're going to be able to get, which means you're going to have better financial gain at the end of it. So they're keen to get through it - and the fact that it's going to help you work with the people that you're working with.

There are one or two of the older staff members who feel, you know, at 50, 55 they've passed all that sort of studying and educational side of things. So it's difficult to convince them to actually complete it.

A lot of people have said things like 'I am 56 years old, there is no way I am going to do an NVQ, I

would rather leave care'. [We have tried to support these people], but they will leave when it comes to the crunch, when it's compulsory they will leave. But at the moment its only 50% have to have it, so we are getting around those people who are adamant they are not going to do it. [In the future] I think that people will leave.

Those responsible for in-house provision felt some very good progress had been made in the training and career development of their staff.

We've looked at training and totally changed that round - it's quite a commitment for us - 90 staff currently doing NVQ, all of our senior workers - 20 of them - and every team leader. All care workers are doing level 2, seniors have to do level 3, team leaders are doing level 4. Before, we'd taken for granted that all our staff have very good basic skills, but (we found) we have quite a number who can't read or write, or where English isn't their first language. We had them basic skills tested - we worked with the trade union, kept the tests confidential. We identified the support needed, and everybody had a week's basic skills training, and support for further needs. A number have achieved level 2 in basic skills - we are working with the black and minority ethnic group carers, really trying to bring their English and maths up to standard, so they can take advantage of training. We are committed to staff training - out of 20 seniors, 17 were formerly care staff, so we are recruiting from within our own ranks. We are quite new at it, but I think it lifts the profile of the job, and that's what may help attract people in.

Contracting arrangements in Newcastle

Key stakeholders reported that there had been some significant changes affecting contracting in recent years. Prior to 1999-2000, one interviewee felt the 'traditional home help role' had been part of the service but since that time,

We have concentrated our efforts on personal care. That's when we put out the tenders and got the contracts, and you had lots of new agencies springing up.

Most of the domiciliary care providers we interviewed felt that they were working in partnership with the local authority.

We understand each other...we have meetings and we talk to each other - well, we are always talking to each other on the phone. If there are any complaints they'll ring us and we ring them - we do have pretty good communication with them.

We definitely work in partnership with the local authority. Right from the start my view was that we

are all working towards the same goal, which is the quality reliable service for frail old people. And we do very much work in partnership, to have a good relationship - not just with the contract unit, but with the social work teams that we deal with on a day to day basis. We do joint visits, we discuss any problems, and how best to overcome them - that's what working in partnership is about.

We've got a very, very good working relationship with contracts and with social services. They are very good, and they're very professional.

This view was shared by key stakeholders:

Wherever possible we don't hit them with a stick, but we try and work with them, and I think we have quite a good relationship with them. They tend to respect me, and I respect them – I know a lot of them have problems with staffing, and sometimes you've just got to be a bit flexible – a bit of give and take, really.

A few providers nevertheless did not share the view that the relationship between themselves and the local authority was a 'partnership'.

I think it's more on a business level really. Certainly in the last few years, with the standards and everything coming in. There are times when I feel that working together as a partnership would benefit both parties.

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 local authority pay their staff a hell of a lot more than we are able to, simply because it's linked into what they pay us for each hour of service provision, and they set the ceiling on that. There is no way we can compete with that, and in Newcastle we've had several meetings with the contract unit to express our concerns over this uneven playing field. How on earth can we compete, if they are paying their staff £7.35 or £7.50 an hour, when you know for some packages of care we have to fight to even get £7 an hour from them. The figures just don't add up - and then of course you haven't got any extra money for all the hidden costs, the care standards legislation. Because there's been a huge cost attached to that registration - you know, you're charged for the privilege of inspection.

The complexity of the task, compared to the price that they want to buy it for, becomes more difficult as they ask for more from us.

There is a lot of pressure on us to provide a more quality service, but they want it done cheaper. So it's Catch-22. It's very difficult to provide what they're asking for within the cost and provisions that they are asking for.

Reduced time slots in care packages had intensified this problem further for some:

If I go back 7 or 8 years I would say that the normal visit was one hour. That was the least that one got per visit to get them up of a morning, get them dressed. Now the majority only get half an hour. People can feel really rushed. Social Services will tell you they only purchase a range of tasks, so you can forget the interaction.

As specialist care we won't do less than an hour, because obviously sometimes it can take you 20 minutes to get into somebody's home if they've got dementia. Sometimes we get referrals and it's like, what we would like you to do is help them get up, get dressed, get washed, make a meal, in under say 30 minutes, and we just say, no thank you. We do half hour calls, but not specialist calls.

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

They want a first class service, but only paying an absolute minimum. We've been through an exercise in Newcastle where they asked us to identify the true cost of our care, and we all did that, all the providers did that, and we all came out at round about the same figure, which was about £13 an hour, and then they offered us £10 something an hour. So we were like, well, what's the point of us all doing that? And we weren't fixing the figures, because we all came out with the average figure. I don't know how they expect anyone to run a business.

Providers made a range of comments about the tendering process in Newcastle. Several found it very time-consuming and complex, whereas others found it relatively straightforward.

A huge amount of information, and they are always very long winded, and we have to do them for up to half a dozen different local authorities, each of whom want something different - the time consumed doing all those is enormous.

Fraught...The tender documents are extremely bulky, the legal documents. There is an awful lot of evidence you have to submit on policies, procedures - everything from equal opportunities to making a complaint, to all the sorts of training and information and supervision you will give care

workers, and how you will meet this care standards legislation, and insurance details and there is mountains of it. It never ever runs to timescale - ever in all the years I've been doing it. It's always the start of the contract, without fail, is deferred at least three months.

It is easy, but there can be something quite small which would have a major impact, a major change. A few years ago, for example, they suddenly inserted all the usual tasks, but then to clean up after any household pets - so if you've got somebody with six dogs...who were never let out and who were just messing all over the house - now that makes a hell of a difference - if you miss it, it's your responsibility.

It's fine actually, to be honest in the past I've dealt with the services, with the changes in processing, they're all much the same. Obviously you've a lot of work to gather all the information, but once you've gathered it the first time, it's there.

It was extremely easy, but most of it was done by email and then we got hard copies that we signed and sent back and got back days later. It was extremely straightforward and easy.

Providers and stakeholders dealing with the reality of delivery domiciliary care in Newcastle 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.

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 Newcastle, stakeholders and providers reported considerable progress, especially in addressing staff training and workforce development issues, although providers had less to say 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 in a context of budgetary constraint and some uncertainty about future contracting arrangements.

While key stakeholders were certainly aware of demographic pressures and trends, there was little mention in our interviews of the structural changes affecting Newcastle's local labour

market, or of the difficulty which some Newcastle residents, especially women, face in entering the labour market (as revealed in our companion study *Addressing women's poverty in Newcastle: local labour market initiatives* [Escott et al 2006]). Enhanced awareness and understanding of the labour market situation local women face, arising in part from Newcastle'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

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

Partnerships and dialogue between agencies

In Newcastle, a range of partnerships are in place, 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, assessment of their impact on the recruitment and retention of care workers could now be undertaken. The aim of this process should be: to strengthen the network of agencies with domiciliary care responsibilities; to identify any weaknesses in forward planning; and to contribute to effective development of services in the context of Newcastle's large population of older people.

Recruiting staff

Given the difficulty reported in recruiting suitable staff, further outreach work is needed to ensure that new sources of labour supply are identified

and that the changes being made, both locally and nationally, to create career structures in social care and to accredit and professionalise the care sector, succeed in attracting new people, from all ethnic groups and both sexes, into the domiciliary care workforce.

➤ **New sources of labour**

In some parts of the city, it may be helpful to pay particular attention to attracting applicants from the city's ethnic minority communities (where some women are finding access to employment very difficult (Stiell et al 2006). Women in these communities often find re-entry to the labour market particularly hard, but would welcome the opportunity to access jobs where training and progression routes are available. New domiciliary care workers from these communities would be particularly well equipped to support Newcastle's increasingly diverse population of older people.

➤ **Attracting applicants**

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

It is crucial that the strategic planning and review continues to address capacity issues, and that

further activity is undertaken to reshape the local social care market and ensure that an effective network of businesses and organisations is available locally to deliver on future demand for domiciliary care services. The role played by Tyne and Wear Care Alliance is a good example of proactive development of the training and skills development work required, and is already providing an example which other regions are keen to emulate. As by far the most important commissioner of domiciliary care services in the city, Newcastle City Council will continue to have a key role to play here, and can contribute to the necessary local awareness-raising by working actively with other key agencies, including *Skills for Care* with its brief to connect skills development and labour supply issues, and the *UK Home Care Association*, as an advocate of good practice from within the sector.

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

Resource issues

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

Domiciliary care – the essential support services for those who are frail, disabled and ill, whose quality ought to be a hallmark of a modern, decent society – is perhaps the prime example of this type of work. Many steps have already been taken to address problems in delivering domiciliary care, at both local and national level. However, given the difficult socio-economic circumstances of some of Newcastle's 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 Newcastle for some years to come.

In committing to existing partnerships in this field, and to exploring ways of drawing new sources of labour into this form of work, Newcastle City Council has already begun to address local challenges in reconciling supply and demand in domiciliary care. Within the sector, job image and job design, resource planning, employment and working conditions, training and workforce

development will continue to need energetic attention in the years to come if older people and others in need of home care in Newcastle 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 Stiehl
 4. *Women's career development in the local authority sector in England* led by Dr Cinnamon Bennett
 5. *Addressing women's poverty: local labour market initiatives* led by Karen Escott
 6. *Local challenges in meeting demand for domiciliary care* led from autumn 2005 by Professor Sue Yeandle and prior to this by Anu Suokas

The GELLM Team

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

The GELLM Partnership

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

Appendix 2 Research methods

The study was conducted in Newcastle 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 Newcastle.

Analysis of 2001 Census data

Data from the 2001 Census for England and from the sub-national population projections¹¹ were used to produce a statistical profile relating to domiciliary care in Newcastle. This explored:

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

Postal survey of providers

A postal questionnaire was sent to all 41 domiciliary care providers registered with Newcastle'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. 20 providers responded to the survey in Newcastle, a response rate of 49%. They included 8 from the voluntary and community sector, 8 private for-profit organisations, and 4 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 17 key stakeholders and providers in Newcastle. The interviews with key stakeholders were conducted with managers responsible for contracting and commissioning, training/staff development, and the in-house management of domiciliary care within the Newcastle'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.

¹¹ 2003 based sub-national population projections, Government Actuary Department, Crown Copyright 2004

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

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

	Men			Women		
	65-74	75-84	85+	65-74	75-84	85+
Population in 2001 (numbers)¹²	9,843	5,653	1,372	11,846	9,144	3,512
Tenure (%):						
Owns	60 (77)	54 (69)	47 (59)	58 (74)	47 (62)	34 (45)
Rents from council/social landlord	34 (17)	37 (21)	33 (20)	36 (20)	41 (25)	38 (22)
Private rented	4 (5)	4 (6)	7 (9)	4 (5)	5 (8)	6 (9)
Lives in communal establishment	1 (1)	4 (3)	11 (12)	1 (1)	6 (5)	21 (23)
Living arrangements (%):						
Lives alone	24 (17)	32 (26)	39 (37)	39 (33)	56 (52)	58 (55)
Lives with a partner	68 (76)	56 (65)	39 (41)	49 (56)	24 (31)	8 (8)
Health and care (%):						
General Health 'not good'	26 (19)	31 (25)	36 (32)	25 (19)	33 (27)	40 (36)
Limiting long-term illness	51 (42)	62 (56)	74 (70)	48 (40)	64 (58)	80 (78)
Provides unpaid care	14 (14)	12 (12)	9 (8)	14 (14)	8 (8)	3 (3)
Population Change¹³						
Population 2003 (numbers)	10,100	5,900	1,400	12,000	9,500	3,500
Per 1,000 people of Working age in 2003 (20-64)	63 (74)	37 (44)	9 (10)	75 (83)	59 (64)	22 (25)
Population 2028 (numbers)	14,200	8,700	3,200	13,400	9,200	4,500
Per 1,000 people of Working age in 2028 (20-64)	96 (104)	59 (71)	22 (27)	91 (109)	62 (85)	30 (40)
Change 2003- 2028:						
Increase (number)	4,100	2,800	1,800	1,400	-300	1,000
Percentage change (%)	41 (45)	48 (69)	129 (173)	12 (40)	-3 (38)	29 (69)

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

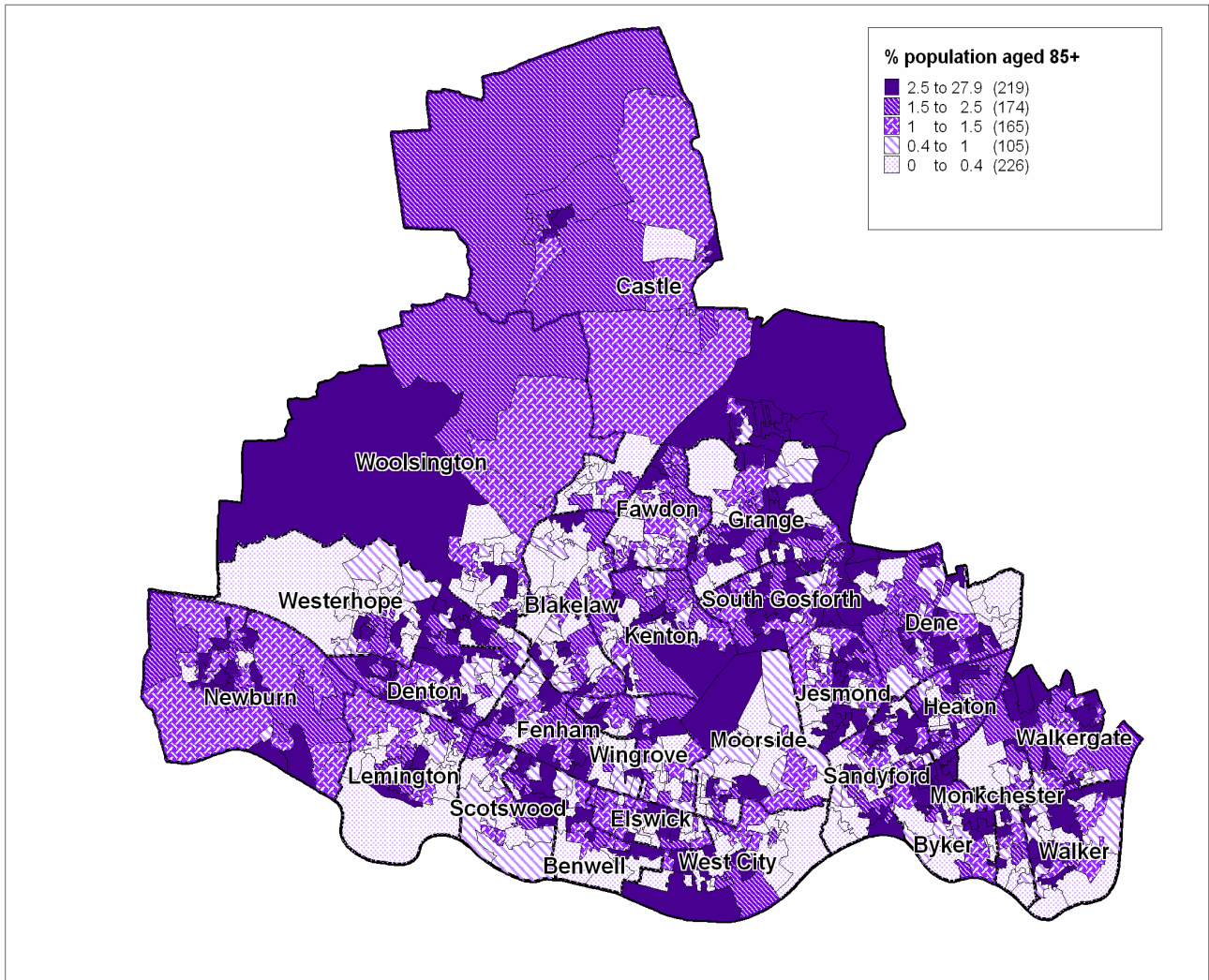
	All households 111,243	Age of resident with LLTI	
		65-74	75+
Number with resident with LLTI	43,520	6,108	8,029
% of all households	39 (34)	6 (5)	7 (7)
% with no carer in household	72 (70)	84 (82)	88 (86)

Source: 2001 Census Standard Tables, Crown Copyright 2003

¹² Source: 2001 Census Theme Tables, Crown Copyright 2003

¹³ Source: 2003-based Sub-national Population Projections, Government Actuary Department, Crown Copyright 2005

Figure A3 Percentage of people aged 85 and over in Newcastle



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

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

	Men				Women			
	16-64	16-24	25-49	50-64	16-59	16-24	25-49	50-59
Number:								
All in employment	52,341	8,092	33,360	10,889	47,009	8,512	30,787	7,710
CA&HCs	352	65	218	69	2,133	295	1,301	537
% in employment who are CA&HC	0.7 (0.4)	0.8 (0.5)	0.7 (0.4)	0.6 (0.4)	4.5 (4.0)	3.5 (3.8)	4.2 (3.8)	7.0 (4.9)
% across all age groups:								
All in employment		16 (13)	64 (62)	21 (25)		18 (15)	66 (65)	16 (20)
CA&HCs		19 (16)	62 (62)	20 (22)		14 (14)	61 (61)	25 (25)
% across all age-sex groups:								
All in employment	53 (55)	8 (7)	34 (34)	11 (14)	47 (45)	9 (7)	31 (29)	8 (9)
CA&HCs	14 (12)	3 (2)	9 (7)	3 (3)	86 (88)	12 (13)	52 (54)	22 (22)
Employment Status:								
All in employment								
Employee full-time	77 (76)	66 (74)	80 (80)	75 (68)	56 (55)	53 (62)	58 (56)	51 (47)
Self-employed full-time	11 (15)	2 (4)	12 (15)	15 (21)	3 (4)	1 (0)	3 (4)	3 (6)
Employee part-time	10 (7)	31 (22)	6 (4)	7 (6)	39 (38)	46 (37)	36 (37)	41 (42)
Self-employed part-time	2 (2)	1 (1)	2 (2)	4 (4)	2 (4)	1 (1)	3 (4)	4 (5)
Care Assistants & Home Carers								
Employee full-time	74 (74)	61 (69)	77 (77)	75 (68)	53 (43)	56 (56)	52 (42)	54 (40)
Self-employed full-time	2 (2)	0 (0)	1 (2)	4 (5)	0 (0)	0 (0)	0 (1)	0 (2)
Employee part-time	25 (23)	39 (30)	22 (20)	20 (25)	46 (55)	43 (44)	47 (54)	46 (57)
Self-employed part-time	0 (1)	0 (1)	0 (1)	0 (2)	1 (1)	1 (0)	0 (1)	1 (1)
Qualifications:								
All in employment								
No qualifications	19 (19)	9 (11)	15 (14)	38 (35)	17 (16)	6 (6)	15 (12)	42 (35)
Lower level	45 (49)	70 (74)	46 (51)	23 (28)	49 (54)	71 (76)	48 (55)	26 (34)
Higher level	36 (33)	21 (15)	39 (35)	39 (37)	34 (30)	23 (18)	38 (32)	32 (30)
Care Assistants & Home Carers								
No qualifications	24 (19)	15 (11)	21 (16)	44 (36)	38 (29)	17 (11)	32 (24)	66 (50)
Lower level	51 (58)	74 (79)	51 (60)	31 (36)	48 (58)	74 (81)	53 (62)	21 (34)
Higher level	25 (23)	11 (10)	28 (24)	25 (28)	13 (13)	10 (8)	15 (13)	13 (16)
Unpaid care:								
All in employment	10 (10)	4 (4)	9 (8)	17 (17)	14 (13)	5 (5)	14 (12)	26 (24)
CA&HCs	16 (17)	14 (11)	15 (16)	23 (26)	21 (18)	14 (10)	21 (17)	26 (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