

**STAFF SHORTAGES AND IMMIGRATION IN THE SOCIAL CARE SECTOR**

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## **Project overview**

*“A set of review papers on the micro-level determinants of employer demand for migrant labour and the alternatives to immigration for responding to labour shortages in key sectors of the UK economy.”*

This paper is part of a research project commissioned by the Migration Advisory Committee (MAC), a body of independent economists set up by the UK Government in late 2007. The MAC has been tasked to advise the Government where in the UK economy there are skilled labour shortages that can be “sensibly” filled by migrant workers from outside the European Economic Area (EEA).<sup>1</sup> The MAC’s current remit focuses on skilled labour shortages. Specifically, the MAC has been asked to produce a list of “shortage occupations” for Tier 2 of the UK’s new points-based system. However, future work may also involve analysis of low-skilled labour markets. As explained in its recent report on “Identifying skilled occupations where migration can sensibly help to fill labour shortages” (February 2008), the MAC’s methods will include “top-down” approaches (including analysis of available data from employer skills surveys and the labour force survey) and “bottom-up” approaches which provide more detailed micro-level information about the nature and determinants of labour demand, supply, staff shortages and alternatives to immigration for filling vacancies in key sectors and occupations.

This research project contributes to the MAC’s bottom-up approach by providing an independent analysis and assessment of the nature and determinants of staff shortages in key sectors and occupations of the UK economy. Given the short time period within which the MAC needs to produce its first list of shortage occupations (July 2008), the main method of this project has been to mobilise existing information and research rather than to generate new data. To this end, academic experts provided an analytical research perspective on staff shortages and immigration in seven sectors of the UK economy: agriculture, food processing, financial services, construction, hospitality, health care and social care. Although taking a sectoral approach, the seven “sectoral review papers” highlight and discuss key occupations in each sector. All sectoral review papers were written during April-May 2008 and are based on a common template of questions. A separate paper discusses key concepts, selected empirical findings from the sector papers, and the implications for a skills-based immigration policy.

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<sup>1</sup> The EEA includes the EU 27 plus Iceland, Liechtenstein and Norway.

All papers in this research project were coordinated by Bridget Anderson and Martin Ruhs, with the assistance of Rutvica Andrijasevic and Karin Heissler (all at Centre on Migration, Policy and Society (COMPAS) at the University of Oxford). The full list of papers produced for this research project is:

*Concepts and overview:*

Anderson, B. and M. Ruhs (2008) "A need for migrant labour? The micro-level determinants of staff shortages and implications for a skills-based immigration policy", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

*Sectoral review papers:*

Bach, S. (2008) "Staff shortages and immigration in the health sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Chan, P., Clarke, L. and A. Dainty (2008) "Staff shortages and immigration in construction", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Geddes, A. (2008) "Staff shortages and immigration in food processing", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Jones, A. (2008) "Staff shortages and immigration in the financial services sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Lucas, R. and S. Mansfield (2008) "Staff shortages and immigration in the hospitality sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Moriarty, J., Manthorpe, J., Hussein, S. and M. Cornes (2008) "Staff shortages and immigration in the social care sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Scott, S. (2008) "Staff shortages and immigration in agriculture", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

All papers can be downloaded at the MAC's website: [www.bia.homeoffice.gov.uk/mac](http://www.bia.homeoffice.gov.uk/mac)

## **Executive summary**

### ***1. Overview of the sector***

Between four and six percent of the UK labour force are employed in social care and the size of the workforce is thought to exceed that of the NHS. The sector consists of two distinct labour forces. The larger workforce consists of direct care workers who are employed to give assistance to people needing support for reasons of disability or who need support to live independently. There is also a smaller professionally qualified workforce of social workers and occupational therapists who perform an important statutory role in undertaking assessments and acting as 'gatekeepers' to other services.

Major changes have taken place to the sector in recent years. These include a move away from publicly provided and funded services towards services that are mainly publicly funded but provided in the majority of instances by the private and voluntary sector. Levels of training within the sector have historically been low, but efforts have been made through regulation to increase skills levels within the workforce. The government's personalisation agenda assumes that further changes to the sector will occur with increased numbers of people given resources to arrange and pay for their own care. Closer working relationships with other services such as health, housing and education are envisaged and there is an expectation that 'new types of workers' will emerge in order to meet these changing roles. However, there are longstanding recruitment problems within the sector and this may act as a barrier to achieving these changes.

### ***2. Employer demand***

Demographic changes in the UK population and the need to comply with legislative requirements in terms of staffing levels and levels of training have created increased employer demand. The high proportion of publicly funded care recipients means that many employers are reliant upon fees paid to them by local councils for providing care. Limits on these fees have been tightly controlled, and employers argue that they have little flexibility in terms of the steps they can take to attract workers to the sector.

### ***3. Labour supply***

The sector has been extremely reliant upon women who want to combine part time paid employment jobs with other family or caring responsibilities. However, the pool of women in this

position is decreasing at a time when demand for care services is increasing. The low status of social care and poor pay are thought to make the sector increasingly unattractive when compared to alternatives. In addition, the gendered nature of the work has made it hard to attract men to work in the sector. There appear to be strong regional differences in labour supply, with London and the South East reporting the highest vacancy rates.

Shortages of social workers are thought to occur for different reasons. In the 1990s, there was a decline in the number of social work students, although this has been reversed somewhat as a result of government investment in the new social work degree. There is also some evidence suggesting that rates of stress and burnout are higher among social workers, meaning that some may choose to leave the profession.

#### ***4. Immigration and labour demand***

There is a strong demand for migrant labour as a way of dealing with recruitment problems. However, it has been suggested that migrant workers from different countries vary in their intentions to remain in the UK. While social workers recruited to work in the UK from Australia or New Zealand may intend to return home, those from India, South Africa, and Zimbabwe may wish to settle more permanently in the UK. Although there is evidence of increased recruitment of care workers from the European Economic Area (EEA), particularly Poland, it is uncertain how long they will remain both within the sector and in the UK. There are more migrant workers working in London and the South East, the areas in which recruitment problems have been reported to be greatest.

#### ***5. Immigration and alternative responses***

Employers have developed a number of initiatives designed to improve recruitment into the sector and these have been accompanied by central government initiatives, such as a national recruitment campaign. Employers have also reported that benefits such as key worker housing or care allowances have also been helpful, but most of these initiatives have not been formally evaluated. Developments in telecare have occurred but many of these remain at the pilot stage and have yet to be mainstreamed.

## **6. Conclusion**

The social care sector has faced increased demand for services at a time when there has been a decline in its traditional source of labour supply. However, the quality of information about the sector has only begun to improve recently and there are still considerable gaps in our knowledge about differences within the sector, in terms of region, between types of work, and between workers having diverse demographic characteristics. In particular, the large number of employers, and differences between the statutory, voluntary and private sectors mean that it is difficult to draw reliable and generalisable conclusions about the sector. However, this is likely to improve in the future with the further development of the National Minimum Data Set for Social Care (NMDS-SC). Both the Department of Health and the Department for Children Schools and Families have developed policies aimed at attracting more people to the sector. There are also important changes aimed at increasing the number of people managing their own care, including being given funds to employ their own workers. Major changes to immigration policy are likely to affect the stability of the sector and may even impact upon service quality.

## **1. Overview of the sector and its labour markets**

### **1.1 Background**

The social care sector covers all the occupations providing services to people with a disability or needing support for independent living. Responsibilities include care provided in people's own homes, at drop-in centres, and in care homes. The provision of meals and day services are also included. These services also include support for carers giving unpaid help to members of their family or friends. They are often provided in conjunction with other public services such as health care and education (Commission for Social Care Inspection 2007), meaning that developments in these sectors often have implications for social care provision. However, in contrast to education and health, the social care workforce is characterised by a distinction between the smaller professionally qualified workforce, of whom the majority are social workers but who also include other professionals such as occupational therapists, and the larger direct care workforce, such as care assistants or home care workers, the majority of whom have vocational qualifications or who do not possess any type of formal qualification.

This paper summarises what is currently known about the social care workforce and the factors that may have implications for its ability to deliver the government's aim of achieving a 'highly skilled, valued and accountable workforce drawn from all sections of the community' by 2020 (Department of Health/Department for Education and Skills 2006). It is drawn from a review of existing literature and from ongoing unpublished research funded by the Department of Health. It will concentrate mainly upon social care services for adults since this is the sector in which employment of migrant workers seems to be highest (Experian 2007), although 28 percent of local councils are thought to use international recruitment to attract social workers to work in children's services (Evans et al. 2006b).

### **1.2 Key features**

#### *Size of sector and funding*

It is estimated that between four and six percent of the UK labour force is employed in social care (Cole 2007; Ewijk et al. 2002). Changes in the demographic structure of the population, in particular, the proportion of the population aged 80 and over, and women's increased

participation in paid employment (Cameron et al. 2002; Cameron and Moss 2007) mean that demand for social care is expected to increase. Thus, it is widely assumed that the sector will play an increasingly important role within the UK economy. The latest comprehensive spending review for 2008-2011 earmarked almost £26 billion pounds to local councils for expenditure on social care, with a further £1.5 billion to come from the Department of Health (Samuel 2007). However, entitlement to social care is means tested and comparatively few people, of whom older adults comprise the largest proportion, have the resources to fund their own care entirely. For instance, only around a third of people living in care homes are funding their own care and, in most cases, this has been financed through the sale of their home (Wright 2003). The debate around funding long term care for older people has proved to be particularly contentious (for a summary of the arguments see, for example, Caring Choices 2008; Joseph Rowntree Foundation 2006). Overall, the gap between public funding for social care and current and projected demands has led to widespread concerns that social care is under funded (Davies 2007). In response, the government has launched a public consultation about how best to meet the gap between the public funds available to pay for these services and the projected increase in demand for them (HM Government 2008).

#### *Policy developments impacting on the sector*

The state's role in the provision of social care services means that the need to recruit staff can be affected radically and rapidly by changes in national policy and funding (Dobson and Salt 2006). *Options for Excellence* (Department of Health/Department for Education and Skills 2006) outlined the government's concerns that "not enough people were attracted to work in the sector" and sketched out plans for improving the training and status of workers in the area. In particular, it highlighted the challenges of meeting the tensions between increased demand for services through demographic changes and the increasing reliance upon internationally recruited workers and agency workers as a way of dealing with shortages.

Since the contracting out of social care services in the 1990s (Glasby 2007; Lewis and Glennerster 1996; Wistow et al. 1992), the workforce has shifted from one primarily employed by local councils to one in which the majority of workers, especially those whose roles do not involve statutory work (such as undertaking assessments), are employed in the private or voluntary sectors.

Further changes to the nature of paid work in social care are anticipated because of the government's plans (HM Government 2007) for more personalised adult social care services.

These are intended to increase in the proportion of people receiving direct payments or personal budgets, meaning that many more people will, in effect, become the employers of those providing support to them.

Regulation has been an important policy lever aimed at improving the quality of the social care workforce. The key developments affecting the sector include:

- legislation setting out national minimum standards (NMS) for care services, which include guidelines on staff qualifications and training;
- registration of social workers and planned expansion of the social care register to provide a database of people who work in social care and who have been assessed as trained and fit to be in the workforce; and
- establishment of vetting and barring schemes as a result of the Care Standards Act 2000 to be followed by implementation of the Safeguarding Vulnerable Groups Act 2006.

The first two points have had implications for the levels of training required for employees. The third will have implications in terms of the backgrounds of those that can be recruited. Once the Independent Safeguarding Authority becomes operational in 2009, all employers will have powers to check that no employee has been deemed unsuitable to work with children or vulnerable adults.

#### *Constraints on quality of information about the sector*

Until comparatively recently, the importance of the social care sector was overlooked and few attempts were made to provide reliable national estimates quantifying the size of the sector and to analyse recruitment and retention patterns. This means that until publication of the first *State of the Social Care Workforce* report (Eborall 2003), good quality information indicating trends over time was lacking, beyond the surveys collected by the former Employers' Organisation for Local Government and successor surveys undertaken by the Local Government Association which only accounted for a proportion of those employed in the public sector.

Secondary analysis of subsets of nationally collected data such as the Labour Force Survey and the Annual Population Survey (Simon and Owen 2005; Simon et al. 2007) have provided some information on the sector but it has been suggested that these datasets do not include all those employed in care work and the Standard Occupational Classifications (SOC) provide insufficient

information to analyse different types of care worker in detail (Eborall 2003). However, the establishment of the National Minimum Data Set for Social Care (NMDS-SC) has made it possible to produce better information on the adult social care workforce in England (Eborall and Griffiths 2008a). It is likely that similar developments will occur in the other UK countries. Thus, while the quality of information will improve in the future, there are shortcomings in the data which are currently available.

At the same time, devolution and the separation of children's and adults' services in England have had implications for obtaining a UK perspective on the sector. Although there is still a single sector skills council, Skills for Care and Development, it is comprised of five organisations. Of these, the following three; the Care Council for Wales; the Northern Ireland Social Care Council, and; the Scottish Social Services Council cover the devolved administrations. The remainder, the Children's Workforce Development Council and Skills for Care are responsible for the children and young people's workforce and adult social care in England, respectively. Differences exist in the workforce priorities of each organisation and the amount and type of information that they collect. There are also differences resulting from the varying arrangements for care in each of the UK countries. For example, Scotland has a different system for funding long term care (Bell et al. 2007), and proportionally fewer people living there receive direct payments (that is, the system of cash payments made to individuals who have been assessed as needing services, in lieu of provision arranged through the local authority) (Davey et al. 2007). This means that the UK social care sector is likely to become increasingly differentiated.

#### *Current workforce characteristics*

Using data from the Labour Force Survey, Simon and colleagues (2007) estimated that the social care sector accounted for more than a million workers in England and Scotland (refer to Table 1).

**Table 1: Estimates of the social care workforce in England and Scotland using the Labour Force Survey**

Occupational group	Individual occupations	SOC codes	Estimated population numbers
<i>England</i>			
<b>Social care workers</b>	Social workers	2442	68,000
	Youth and community workers	3231	67,000
	Housing and welfare officers	3232	105,000
	Houseparents and residential wardens	6114	28,000
	Care assistants/home carers	6115	463,000
<i>Subtotal</i>			732,000
<b>Childcare workers</b>	Nursery nurses	6121	128,000
	Childminders and related occupations	6122	101,000
	Playgroup workers	6123	51,000
<i>Subtotal</i>			280,000
<b>Total for England</b>			<b>1,012,000</b>
<i>Scotland</i>			
<b>Social care workers</b>	Social workers	2442	11,000
	Youth and community workers	3231	9,000
	Housing and welfare officers	3232	16,000
	Houseparents and residential wardens	6114	4,000
	Care assistants/home carers	6115	57,000
<i>Subtotal</i>			97,100
<b>Childcare workers</b>	Nursery nurses	6121	12,000
	Childminders and related occupations	6122	8,000
	Playgroup workers	6123	5,000
<i>Subtotal</i>			25,000
<b>Total for Scotland</b>			<b>122,000</b>

Source: (Simon et al. 2007: 8, 37).

This study only covered England and Scotland, but the most recent published estimates of the social care workforce in Northern Ireland and Wales are, 40,000 (Department of Health Social Services and Public Safety 2006) and 89,000 (Care Council for Wales Undated), respectively.

However, using a combination of different sources of data, including early results from the NMDS-SC; the Health and Social Care Information Centre's analyses of council social services workforces SSDS001 returns; the NHS Non-medical Workforce Census; the Local Authority Workforce Intelligence Group (LAWIG); the 2006 Adult Social Care Workforce Survey, and; the Commission for Social Care Inspection (CSCI) Self Assessment Survey for Councils, Eborall and Griffiths (2008) estimated that the adult social care workforce in England alone, amounted to 1,390,000 million people (refer to Table 2). This was a substantial increase on their previous estimate of 922,000 (Eborall 2005) and was largely attributable to having improved data on people working in the independent sector and the inclusion of workers employed by people using direct payments about whom previously there was no information. In addition, there are an estimated 168,340 social care workers in the Children's workforce (Children's Workforce Development Council 2008b). Taken together, these totals exceed the 1.3 million people currently employed in the NHS (Information Centre for Health and Social Care 2008).

While this estimate is thought to include some degree of double counting as some workers may work for more than one employer, it also excludes people who are recruited and paid for privately without any support from statutory services. These include those working as home care workers or as live-in companions providing care, many of whom are anecdotally reported to be migrant workers. There has been very little published empirical research on this group of workers since the since the 1990s (Baldock and Ungerson 1994; Gregson and Lowe 1994; Wilson 1994), so it is difficult to know whether these reports are verifiable.

**Table 2: Estimated size of the adult social care workforce in England 2006-2007**

	Private and voluntary sector	Local Authority	NHS	Direct payments	Total
Residential care	584,000	51,000	-		635,000
Domiciliary (home) care services	274,000	48,000	-		322,000
Day care services	29,000	28,000	-		57,000
Community incl. NHS and the organisation and management of care	34,000	90,000	60,000	113,000	297,000
Workers not directly employed (e.g. agency, 'bank' staff and students)	67,000	11,000			78,000
<i>% of total workforce</i>	<i>71</i>	<i>16</i>	<i>4</i>	<i>8</i>	<i>100</i>
<b>Total workforce</b>	<b>988,000</b>	<b>228,000</b>	<b>60,000</b>	<b>113,000</b>	<b>1,389,000</b>

Source: (Eborall and Griffiths 2008: 27). Because of rounding, individual components may not sum up to the totals provided. NHS estimates include healthcare assistants but not support workers, nursing assistants and helpers except in social services and occupational therapy areas.

### *Gender*

As is well-known, the social care sector is characterised by extreme occupational segregation; while men comprise around 54 percent of the UK economically active population (Self and Zealey 2008), they make up only 16 percent of those working in social care (Skills for Care 2007a). In some occupations, , such as nursery nurses or childminders, the proportion is even smaller (Rolfe 2005; Rolfe et al. 2003).

### *Age structure*

Over 60 percent of social care workers are estimated to be aged 35 and over (Skills for Care 2007a) and, like its counterpart in health, the social care sector is often described as having an 'ageing workforce' (McNair and Flynn 2006). However, Eborall and Griffiths (2008a) take a differing view, arguing that, in the case of care workers at least, there is a fairly even age distribution among them. Staff working with children tend to be younger than their counterparts working with adults. For instance, staff working in nurseries have an average age of 24 years-old (Cameron et al. 2002).

### *Ethnic composition*

Social care represents a sector in which some ethnic groups are over-represented while others are under-represented. Seventeen percent of staff employed in the independent sector (Eborall and Griffiths 2008a) and 11 percent of all whole time equivalents (WTE) staff employed by local councils in England are from a minority ethnic group (Information Centre for Health and Social Care 2007), compared with eight percent in the population as a whole (Office for National Statistics 2004). Among staff employed in the independent sector, seven percent are of Black or Black British ethnic origin, and of that, five percent are employed by local councils (Information Centre for Health and Social Care 2007). Black people, however make up only two percent of the UK population (Office for National Statistics 2004). However, ethnic background represents an unreliable way of estimating the share of migrant care workers in the social care workforce, as many staff from a minority ethnic group are UK citizens from a Black British or British Asian background.

### *Share of migrants in the workforce*

The arguments about inadequacies in current data about immigration and migrants are well known (House of Lords Select Committee on Economic Affairs 2008). Furthermore, until comparatively recently, little information was collected about migrant workers working in social care (Evans et al. 2006b). This task also presents methodological challenges in that employers who are engaged in illegal working practices or who regard such details as commercially sensitive are unlikely to co-operate (Evans et al. 2006b). Recent press reports (Leppard 2008) have suggested that there is a high level of illegal working in care homes, although the care homes sector would dispute this. Taken as a whole, these factors contribute to making it difficult to establish the precise numbers of migrant workers in the sector.

Notwithstanding this, one report that uses a sub-set of data from the Annual Population Survey suggests that migrant workers (defined as those who were born outside the UK) made up around 12 percent of employees in the care sector (Experian 2007), although as Table 3 shows, there is some variation in the proportion of migrant workers within different occupations.

**Table 3: Employment in the UK care related sector by main job, April-June 2006, using the Annual Population Survey (APS)**

SOC Code	Occupation	UK born		Non UK born		Total
		N	%	N	%	N
2442	Social workers	90,000	81	22,000	19	111,677
3222	Occupational therapists	28,000	91	3,000	9	30,563
3231	Youth and community workers	89,000	95	5000	5	93865
3232	Housing and welfare officers	158,000	89	19,000	11	177,666
6111	Nursing auxiliaries and assistants	197,000	90	23000	10	219,796
6114	House-parents and residential wardens	35000	95	2000	5	37,398
6115	Care assistants and home carers	535,000	84	105,000	16	640,686
6121	Nursery nurses	151,000	95	7,000	5	157,949
6122	Childminders and related occupations	99,000	81	23,000	19	122,197
6123	Playgroup leaders and assistants	51,000	98	1,000	2	52,040
6124	Educational assistants	353,000	92	29000	8	382389
<b>Total</b>		<b>1,787,000</b>		<b>240,000</b>		<b>2,026,220</b>

Source: (Experian 2007: 3).

As can be seen, these figures differ from the estimates reported by Simon and colleagues (reported in Table 1), partly because they offer data for the UK as a whole, and partly because they include additional occupations such as nursing and education assistants. For the purposes of this paper, we will concentrate upon care workers<sup>2</sup> who comprise the majority of staff working in residential and domiciliary settings shown in Table 2, and social workers, who comprise the majority of staff employed centrally by local councils. As Tables 1 and 3 show, social workers are not the largest part of the social care workforce in numerical terms, but this is outweighed by their importance in undertaking statutory duties such as assessments or child protection

<sup>2</sup> Other terms used to describe care workers are support workers, care assistants and carers. This last term is unhelpful as it makes it hard to distinguish people providing care on a paid basis from family carers.

investigations and as 'gatekeepers' to other social services (Moriarty and Murray 2007). Although the Children's Workforce Development Council (2008b) has identified international recruitment as an emerging issue in the Children's social care workforce, the comparative size of the adult social care workforce and the varying proportions of workers 'born abroad' within different occupations, as shown in Table 3, suggest that the majority of migrant workers are employed in adult services.

### *Labour costs and shortages*

Labour costs make up around half the costs of providing home and residential care and between half and two thirds of the costs of providing care in nursing homes (Wanless 2006).<sup>3</sup> This presents two difficulties for employers. First, the impact of regulatory requirements for minimum levels of staffing means that social care providers cannot reduce overall levels of staffing in order to raise wage levels. Second, many social care providers have limited opportunities to raise charges for their services in order to absorb increased staffing costs because they are reliant upon contracts with local authorities that set strict ceilings on the amounts they will pay for services (Low Pay Commission 2005, 2007).

Social care is the third largest low-paying sector in the UK economy, with over a million jobs being paid at or around the level of the minimum wage (Low Pay Commission 2008). Currently, based on data from the NMDS-SC, the median gross hourly pay rate in the private sector is £5.73 for care workers and £6.00 for senior care workers (care workers with an average of three years experience and/or vocational qualifications at NVQ level 3 or higher) (Skills for Care 2007c). Rates of pay for care workers are higher in the voluntary (£6.19) and statutory sectors (£7.53) (Eborall and Griffiths 2008a) but this represents only a minority of workers. They are also higher in London and the South East.

Wage levels are also comparatively low among social workers. Data from the Annual Survey of Hours and Earnings (ASHE), suggests that with a median wage of around £500 per week, social workers earn, on average, around 80 percent of the average wage for other professionals in the other SOC 'Group 2' professional occupations, such as teachers or psychologists. However, they earn more than nurses or occupational therapists (Eborall and Griffiths 2008a).

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<sup>3</sup> This differential exists because nursing home residents require higher levels of staffing and because of the different skill mix in nursing homes including nurses.

Indeed, women social workers are comparatively well remunerated when compared with women in other public sector jobs (Nickell and Quintini 2002). By contrast, there is a larger differential in favour of other professions for men employed in social work (Eborall and Griffiths 2008a). On average, social workers in children's services earn more than their counterparts working with adults (Curtis 2007).

Labour shortages are regularly reported in the sector. Vacancy rates in the social care sector are running at around 4-5 percent compared with a national average of 2.7 percent (Eborall and Griffiths 2008a). The vacancy rate in the social care sector is double that for all types of industrial, commercial and public employment (Learning and Skills Council 2006) and compares with less than one percent for secondary school teachers and qualified nurses (Department of Health/Department for Education and Skills 2006). The Commission for Social Care Inspection (CSCI), the body responsible for regulating and inspecting adult social care services, has described recruitment and retention problems in social care as "chronic" (Commission for Social Care Inspection 2006).

Using the NMDS-SC which currently includes data collected directly from 7,461 independent sector establishments (around a fifth of all the estimated 35,000 social care employers), Eborall and Griffiths (2008) estimated that the vacancy rate across all staff in the independent sector was 3.4 percent. Among home care workers it was 5.5 percent, compared with 3.3 percent in care only homes and 1.8 percent in care homes with nursing. Measured in terms of the number of vacancies notified to job centres, these also show a high number of vacancies; between January-June 2007, there were 70,576 vacancies for care workers and 5,000 vacancies for social workers (Eborall and Griffiths 2008a).

Vacancy rates in the statutory sector are even higher. Based on a survey of local authority employers with a response rate of 70 percent, the average vacancy rate in local councils in 2005 (the latest published data) was 10.5 percent<sup>4</sup> (Local Authority Workforce Intelligence Group 2006). Other data collected by CSCI in 2007 suggested that the vacancy rate in statutory sector (those employed by local councils in England) is eight percent (Eborall and Griffiths 2008a).

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<sup>4</sup> They defined vacancy rates as the number of vacant posts at 30th September each year which authorities are seeking to fill or will seek to fill, as a percentage of the total establishment.

The most likely explanation for the difference between vacancy rates in the independent and statutory sector is that most council vacancies are for qualified posts such as social workers and occupational therapists, which are deemed to be 'hard to fill' because they demand higher levels of skills or because of the nature of the work (Learning and Skills Council 2006), although the latest survey suggests that some of these pressures have eased (Learning and Skills Council 2008). There were steep declines in the number of students studying social work in the 1990s (Moriarty and Murray 2007) and it is possible that the number of social workers qualifying each year was insufficient to replace those who were retiring or leaving the profession for other reasons. This may improve, as has been mentioned already, with the increase in the number of social work students.

In addition, vacancy rates can vary considerably between councils, with rates in London and the South East approaching 30 percent compared with less than one percent in Yorkshire and the Humber. Housing costs are a key reason for this variation and the availability of key worker housing has been put forward as an important reason by employers for helping with recruitment problems, along with other initiatives such as 'grow your own' schemes for helping unqualified workers achieve qualifications and better workforce planning (Local Authority Workforce Intelligence Group 2006).

Turnover rates in the public sector are better. This is possibly because they are higher in less skilled jobs where reasons for leaving often include wanting to improve pay or for reasons of career progression (Skills for Care 2007b). The average turnover rate among those employed by local councils is 11.5 percent, compared with 13 percent in the voluntary sector and almost 20 percent in the private sector (Eborall and Griffiths 2008a). Contrary to anecdotal evidence, it is the NHS which attracts most staff leaving social care, rather than the retail sector (Skills for Care 2007a).

Although low rates of pay are often cited as a reason for difficulties with recruitment and retention, other factors may play a part. These include the need to work unsocial hours and the risk of violence or abuse from people using services (Balloch et al. 1998). Set against this, levels of job satisfaction may be high, especially among care workers (McLean 1999; Rose 2003). However, this is far less true of social workers, and a series of studies have suggested that they experience lower levels of job satisfaction and higher levels of stress, possibly because of the demanding nature of much statutory work (Coffey et al. 2004; Evans et al. 2006a; McLean and Andrew 2000; Parry-Jones et al. 1998).

### *Employment relations*

The government's modernisation agenda for public services has had clear implications for employment relationships with the social care workforce employed in the public sector. On the one hand, there is emphasis on the need for pay modernisation, job redesign, and better performance management. On the other, it advocates creating 'partnership paradigms' in which employee involvement is incorporated into decision making (Bach et al. 2005). Many councils are trying to incorporate these changes into equal pay reviews. Equal pay reviews have proved to be an extremely controversial area because of councils' concerns that they will be faced with large bills to compensate workers deemed to have been discriminated against (Curtis 2008) and there is now a large, and increasing, backlog of cases waiting to go before a tribunal (Equality and Human Rights Commission 2008). Social care workers and social care ancillary staff, such as cooks, are among the groups most affected by equal pay reviews because they are predominantly women.

Negotiations over pay and conditions for social care workers in the publicly funded sector are arranged through the Local Government Employers, which represents local authorities in negotiations with trade unions and the government. However, not all employees are members of a union or professional organisation; only one in eight social workers is reported to be a member of the British Association of Social Workers (Williams 2008), although some may be members of other trade unions, such as Unison. While local strikes are not unknown (News Item 2007), they are rarely protracted. For example, a dispute in Liverpool in 2005 (Shifrin 2005) was thought to be the first strike specifically of social workers for over 20 years since a protracted dispute in Camden in the 1980s (Ironside and Seifert 2000). At the time of writing, UNISON members working in local government, including social care workers, have balloted to take strike action (Lombard 2008) but it is not yet known whether an agreement will be reached with employers.

Levels of unionisation in the private and voluntary sector are historically low (Cunningham 2008) but are increasingly the focus of union recruitment strategies. The GMB (Britain's general trade union) now represents over 600,000 care workers in the voluntary and private sector (GMB 2008) while Unison tends to recruit among workers in the public sector.

### *Types of paid employment*

Among care workers and other staff providing direct care, around a third of staff work part time for less than 30 hours per week, although few work less than eight hours per week (Hall and Wreford 2007). By contrast, only about a quarter of social workers and a fifth of managerial staff work part time (Eborall and Griffiths 2008a). A high proportion of care workers have childcare (Hall and Wreford 2007) or family caring (McFarlane 2001) responsibilities and this is their main reason for only choosing part time paid employment. Until now, self-employment has not been a feature of the sector beyond the very small numbers of social workers working in adoption or as counsellors or therapists. However, the government's personalisation agenda which aims to increase the number of individuals managing their own budgets to purchase care may offer potential for an increase in the number of own-account care workers. There are also opportunities for people using direct payments to establish co-operatives to employ support workers.

### *Agency and temporary working*

As Table 2 shows, agency workers comprise a small proportion of those employed in the private sector but around five percent of those employed in local authorities. Local authorities have made substantial use of agency staff to cover social worker vacancies, particularly in the London area where social worker recruitment has been most difficult (Kirkpatrick and Hoque 2006). While expenditure is thought to be unlikely to revert to the negligible levels found in the mid-1990s (Kirkpatrick and Hoque 2006), there have been concerted efforts to reduce the amount of money local councils spend on agency workers in recent years, for example, through the managed vendor scheme.

Some social workers are thought to prefer agency working because of its opportunities to work as a 'free agent' (Kirkpatrick and Hoque 2006) or because it is seen as a way of avoiding some of the pressures faced by permanent staff or because it is a way of compensating for reductions in local councils' terms and conditions of employment (Carey 2007; Kirkpatrick and Hoque 2006). By contrast, staff shortages in the private sector are more often dealt with by the use of paid or unpaid overtime (Hall and Wreford 2007).

Interviews with managers of recruitment agencies undertaken as part of a wider Department of Health-funded project looking at migrant workers in adult social care (Hussein et al. 2008) found that agency work in social care was seen to be particularly attractive to migrant workers who

were already in the UK with any type of visa that allowed them to work for a limited period of time. It was seen as a way of gaining experience in a variety of jobs without the difficulties of obtaining a more permanent position.

### *Regional differences*

Recruitment is reported to be more difficult in London than in other parts of the country. However, there are differences in vacancy rates between different councils in the same region, suggesting that some councils are better at retaining their staff than others (Eborall and Griffiths 2008a).

Recruitment difficulties in London would appear to account for a large part of the regional differences in the use of migrant workers. In London, 48 percent of social workers and 68 percent of care assistants were born abroad. At the other extreme, the North East and Wales had no social workers who were not British born and fewer than six percent of care assistants were born abroad (Experian 2007).

### *Other factors impacting upon employment*

The nature of social care means that many workers are working unsocial hours. Apart from care homes and other establishments providing 24 hour care, the increase in the number of people living at home with disabilities that would in the past have required them to live in a care home means that home care workers are also expected to work unsocial hours. Even among local authorities, few employers pay enhanced rates for this type of working (Eborall and Griffiths 2008a) so this may be one explanation for difficulties in recruitment and retention. Social workers working in child protection or mental health may also be involved in emergency visits and may accrue considerable amounts of unpaid overtime. Home care workers also report that they regularly do unpaid overtime (Hall and Wreford 2007).

## 2. Characteristics, dimensions and determinants of employer demand

The chief impact on employer demand has been the effects of regulation aimed at improving the levels of skills and qualifications within the workforce.

The low rates of pay in care work have meant that it has tended to be seen as a low skilled occupation, whereas the work itself does require skills (Kaplanis 2007). In addition to working in a low paid industry, until comparatively recently many care workers would not have held a vocational qualification that would provide an objective measure of their skills to people outside the sector.

*Options for Excellence* (Department of Health/Department for Education and Skills 2006) outlined the government's view that improved levels of training would be an important way of improving recruitment and retention. Employers now face increased expectations of the levels of skills and qualifications in the workforce. Most notably, the government has set a target that 50 percent of staff in care homes (Department of Health 2003a) and home care (Department of Health 2003b) would hold NVQ (National Vocational Qualifications) level 2 in health and social care by 2005 (later revised to 2008 for home care providers). While some providers have met, or even exceeded, this target; others have not. Data from the NMDS-SC suggests that only around a quarter of care workers have NVQ level 2 qualifications or above (Skills for Care 2007d). Concerns have been expressed that smaller providers and workers without basic literacy skills find it particularly difficult to access suitable training and support (Balloch et al. 2004; Cameron and Moss 2007).

By contrast, there has been more success in ensuring that 50 percent of registered managers have achieved a level 4 qualification. Using the NMDS-SC, over 50 percent of managers were reported to have achieved a level 4 qualification. Around 15-20 percent had NVQ level 2 or 3, and another 20 percent had other relevant qualifications (Skills for Care 2007d).

However, NVQs do not fully capture the full range of skills required in care work. Social care requires 'soft' skills, such as ability to work as a member of a team, a sense of responsibility, and good interpersonal skills to help support people who may be undergoing difficult life experiences or changes. Workers may also be called upon to provide support with technical tasks formerly undertaken by nurses, such as PEG (percutaneous endoscopic gastrostomy) feeding or administering medication. Care workers may acquire skills in complementary

therapies, such as aromatherapy or massage (Fisher and Moriarty 2005) to help people who are terminally ill or in discomfort. They may also develop their skills in activities such as photography (Mitchell 2005) so that they can help people using services to maintain hobbies or interests. These sorts of support are seen as providing value added in care homes and day centres and so workers with these skills are likely to become increasingly desirable. They are also highly valued by people using services and this highlights how 'employer demand' in social care does not simply consist of the expectations laid out by those responsible for commissioning or providing services. Workers are increasingly expected to provide care in partnership with people using services.

Since the 1990s, the emergence of the disability movement (Campbell and Oliver 1996) and one associated with people who saw themselves as 'survivors' of mental health services (Beresford 2000), together with the impact of theories around normalisation for people with mental health problems or a learning disability (Walmsley 2001) have combined to create a strong movement of people with experience of using social care and health services (Beresford 2001). This has had an important influence on expectations about the sort of support that social care services will provide (Beresford and Branfield 2006). Service user views are increasingly being incorporated into inspections of services undertaken by regulatory bodies (Klee and Manthorpe 2006). Service users and carers set particular importance on qualities such as friendliness, being treated with respect, and reliability (Beresford et al. 2005; Moriarty and Webb 2000; Qureshi 2001). They may find these personal qualities more important than other aspects of providing care.

In addition to regulation aimed at raising skill levels among care workers, the government has also made changes to social work education. In 2001, it announced that social work was to be a degree level qualification (Department of Health 2001a). Previously, while it was possible to acquire a social work qualification through undergraduate or postgraduate study, the majority of social workers qualified by undertaking a diploma-level qualification. This announcement was accompanied by substantial expenditure which provided bursaries for students and increased funds for programme providers (Orme et al. BJSW advance access doi:10.1093/bjsw/bcm095). These changes would appear to have had a positive impact in terms of the numbers of students enrolling on degree programmes. In 2006-2007, 5,470 students enrolled in social work degree programmes in the UK (General Social Care Council 2007), this represents an increase of around 20 percent when compared with earlier years (Evaluation of the Social Work Degree Qualification in England Team 2007).

Efforts are also being made to improve retention among social workers once they qualify. The Children's Workforce Development Council is running pilot newly qualified social worker schemes aimed at providing better induction and support for social workers in their first year of practice (Children's Workforce Development Council 2008a). A new range of post-qualifying awards has also been developed for all social workers, irrespective of the field in which they work (General Social Care Council Undated).

### **3. Characteristics and segmentations of labour supply**

The next section of this paper summarises some of the factors that make the social care workforce distinctive when compared with the UK labour market as a whole.

First, within the workforce of UK citizens, proportionally few men work in social care. The main explanation for the reluctance found among many men to seek employment in this field centre around the perception that it is gendered work associated with women, (Christie 1998; Christie 2006; McLean 2003). Thus, while traditional occupations for men have declined, this has not been accompanied by a move by men into 'non-traditional' areas of work such as social care. Studies of men in social work and social care have suggested that they may have specific reasons for choosing to work in the field. For example, some enter social care as a second career (Balloch et al. 1999; McLean 2003), and for others it is a way of demonstrating rejection of traditional ideals of masculinity (Christie 2006; McLean 2003). Once employed in the sector, retention may also be an issue. Some studies have suggested that they face barriers in terms of how their predominantly female colleagues perceive them (Owen 2003). Secondly, the gender pay gap means that occupations in which women predominate tend to be paid less (Anderson et al. 2001). This means that average earnings in social care and social work are lower for men than for women, meaning that although men tend to achieve better career progression than women, particularly in professional occupations such as social work (Davey, 2002) they may be more reluctant to enter the sector in the first place.

Second, a substantial proportion of workers have family or caring commitments that prevent them from undertaking full time employment or that may impact upon the hours that they work (Hall and Wreford 2007; McFarlane 2001). This means that it is important to make clear distinctions between the actual *numbers* of people in the workforce and the number of whole time equivalents needed to meet the demand for care.

Third, the status of social care is low and members of the public are unclear about what the work involves, or have negative impressions of it (Platt 2007). This may be a barrier to people choosing to work in social care if vacancies are available in other areas of work.

Fourth, the regulatory framework aimed at improving public confidence in the service means that, even if a person has not committed an offence that would preclude him or her from working with vulnerable adults, employers have to consider carefully whether or not to employ a person with a criminal record. In addition, potential applicants may decide not to apply for a job because of the need for disclosure (Perry 2004). This means that social care employers are faced with decisions about applicants' suitability that are not shared by employers in most other fields.

#### **4. Immigration and labour demand**

It is important to recognise that the quality of information on the sector needs improvement and that different sources of information can produce different data. The review completed by Evans and colleagues (2006b) concluded that existing knowledge about international recruitment of social care staff was inadequate for planning purposes. There are various reasons for this:

- Data on country of birth is in itself insufficient to identify migrant workers, especially in a sector that has always employed a high proportion of people born outside the UK as many of these people may have acquired British citizenship.
- Data from the Worker Registration Scheme does not record movement within the labour market nor subsequent departure (Markova and Black 2008), meaning that the overall numbers of people working in a particular occupation may not be the same as the total number of people actually working in it.
- It is difficult to assess the extent of undocumented working, for example, people with student permits or 'overstayers'.
- The sector itself consists of over 35,000 employers (excluding people using direct payments) and most of these are micro- and small businesses so there are challenges both in collecting data and ensuring that they are generalisable.

#### **4.1 Reasons for using migrant labour**

Recruitment and retention difficulties are a key reason for the employment of migrant workers. Twenty eight percent of councils use international recruitment for social workers in children's services and 21 percent use it to recruit for other social work posts. Explanations for using international recruitment include: using it to supplement other local initiatives, such as open days because of perceived shortages in domestic supply, especially social workers, and as a way of attracting people to certain localities, such as rural areas (Evans et al. 2006b).

As mentioned earlier, migrant workers are estimated to constitute over 10 percent of the workforce (Experian 2007). The gendered nature of care work and its low status mean that care work has always attracted higher proportions of migrant workers than some other sectors. Many people from Commonwealth countries, the Irish Republic, and the Philippines came to work in the health and social care sector in the 1960s and 1970s (Wanless 2006). Migrant women, in particular, are concentrated in a small number of jobs such as care work, hospitality, and cleaning (Dumont and Leibig 2005). In this sense, vacancies in the sector and the ethnic patterning of the workforce may operate as 'push and pull' factors (Mejia et al. 1979) behind the numbers of migrant workers working in the sector.

#### **4.2 Country of origin**

Analysis of data from the Labour Force Survey in 2002-2003 (Spence 2005) found that migrant workers from Jamaica, Nigeria, Ghana, Mauritius, and the Philippines were all over represented among those working in health and social care in London, although this study did not report on their citizenship status and many of these workers may have acquired British citizenship.

Since 2004, citizens from the A8 European Union accession countries have joined the care workforce. Analysis of the Worker Registration Scheme (WRS) for migrants from the A8 show that between May 2004 and September 2006, 14,090 applicants out of a total of 364,240 people were working as care assistants and home carers, making it ninth out of the top 20 occupations in which registered workers are employed (Blanchflower et al. 2007).

In addition to WRS applicants, between 2003 and 2004, 24,473 work permits were granted for senior carers. Of these, 4,847 were granted to people from the Philippines (Dobson and Salt 2006).

The General Social Care Council (GSCC) has reported that of the approximately 80,000 social workers registered with the GSCC at the end of 2007, about 6,400 (eight percent) were social workers who trained outside the UK. Of these, 85 percent came from the following countries: Australia, Canada, German, India, New Zealand, Philippines, Romania, South Africa, USA, and Zimbabwe (Hussein et al. 2008). This figure differs substantially from that reported in Table 3, possibly because many social workers born outside the UK trained here. The other explanation is that the Annual Population Survey classifies people not actually registered with the GSCC as social workers.

#### ***4.3 Country of origin and type of work undertaken***

The figures provided in the section above give an important indication of the differences between different types of workers and their country of origin. Workers from Australia, New Zealand, Canada, and the USA are more likely to be social workers whereas proportionally more people from India, the Philippines, and Nigeria are working as care workers (Experian 2007).

In this sense, it appears that two different markets for migrant social care workers are emerging (Hussein et al. 2008). The first is for the qualified and more skilled migrant workers, such as social workers and occupational therapists. The second is for care workers and senior care workers who will carry out direct care work in home care or in care homes. This second group, however, may include qualified workers from countries such as Poland and some parts of Africa who often seek care work due to non-recognition of their qualifications, or because of language problems or because of a need to secure paid employment quickly (Cuban 2008; Datta et al. 2006; Hussein et al. 2008). With support, these workers have potential to join the group of professionally qualified workers.

#### ***4.4 Comparisons with UK born workforce***

Analysis of the NMDS-SC (Hussein et al. 2008) shows that workers whose previous paid employment was 'working abroad' (a proxy measure in the absence of specific NMDS-SC questions asking about country of birth and citizenship) suggested that migrant workers tended to be better qualified, younger and included a slightly higher proportion of men (20 percent). They were also more likely to be working full time and to have higher qualifications than their British counterparts (Hussein et al. unpublished). Thus, 83 percent of workers recruited from

abroad worked full time, compared with 38 percent of their British counterparts. Table 4 also shows that these workers tended to be more qualified.

**Table 4: Comparison of qualifications between workers recruited ‘from abroad’ and those who were not**

Highest qualification recorded	Recruited from abroad				Total
	No		Yes		
	N	%	N	%	
Entry level or NVQ1	244	<1	5	<1	249
NVQ2+	16651	48	194	21	16845
NVQ3+	12660	37	575	63	13235
NVQ4+	4977	14	135	15	5112
<b>Total</b>	<b>34532</b>		<b>909</b>		<b>35441</b>

Source: (Hussein, Manthorpe and Stevens, unpublished). This is based on NMDS-SC data.

Interviews with agency managers as part of this same project suggested similarities with US research on the evidence for ‘hiring queues’ (employers’ hierarchical preferences for certain employees) (Waldinger and Lichter 2003). Thus, social workers from Australia and New Zealand were seen as preferable to social workers from other countries because their child protection systems showed greatest similarities with those in the UK. Migrant workers were also seen to be more ‘hardworking’ and ‘willing to do anything’ than some of their British counterparts. Set against this, difficulties with written and spoken English were seen as problematic and it was observed that it sometimes took time for workers to adjust to UK ways of working (Hussein et al. 2008). One advantage possessed by migrant workers working in ethnically diverse areas is that they may possess the language skills and knowledge about cultural and religious practices that enable them to work with people using services who share a similar background.

Interviews with migrant workers (Datta et al. 2006) have suggested that some migrant workers feel that they possess other advantages over their counterparts born in the UK in that they see themselves as having a more caring ethos and a greater willingness to help others.

#### **4.5 Intentions to remain in UK**

Different groups of migrant care workers may have different intentions about how long they intend to stay in the UK. Evans and colleagues (2006b) suggest that there are two different

groups of migrant *social workers* and a third group of migrant *care workers*. The first group may be joining the UK workforce in an early stage in their careers; they usually come from countries such as Australia and New Zealand, and plan to return to their country of birth in the future. The second group, often from South Africa or Zimbabwe, may be slightly older with some family commitments, but have been in social work for a longer period. While permanent resettlement may not be an overt goal, it may become a reality. A third group of social care workers is arriving from the A8 accession states who enter the UK to obtain better labour opportunities and who may start in social care work as an entry point. At this point, there is no evidence as to whether they stay in social care, or indeed that they will work in parts of the country or in areas where there are job shortages (Coombes et al. 2007).

## **5. Alternatives to immigration for responding to perceived labour shortages**

There are a number of examples where alternatives to immigration have been explored as a way of dealing with social care labour shortages. They range from national to local initiatives but all share a common aim of widening the 'workforce pool' by employing people who have not traditionally been recruited to this sector. Although most of these schemes remain unevaluated, the potential for telecare is possibly greatest but will also require greatest investment. Improving terms and conditions in the form of car or travel allowances or developing 'grow your own schemes' are likely to produce the greatest benefits in the short term given that these workers are already in the post and will not require basic induction or training. National recruitment initiatives are more expensive than local advertising but may achieve more in helping to change public attitudes. Training for former service users is most likely to receive the support of users.

### **5.1 Recruitment campaigns**

In 2001, the Department of Health launched the first national recruitment campaign for social work and social care (Department of Health 2001b), which involved setting up new websites and a telephone helpline for people considering a career in social care. Although advertisements from these campaigns have won awards, the funding has not been available to identify how many of these contacts result in people taking up a post in social care or social work. However, if the recruitment campaign is considered as part of the wider investment in social work

education, then this development has proved to be successful in terms of increasing the number of people enrolling on social work programmes in England (Evaluation of the Social Work Degree Qualification in England Team 2007).

For those not considering a career in social work but who want to work in social care, Skills for Care has developed the Care Ambassador (Care Ambassador 2004-2008) initiative based on using experienced social care professionals who can act as role models to encourage young people to consider careers in social care. Similarly, these schemes have not been formally evaluated but have won support from local employers.

### **5.2 Support for employers**

Although social care employers include local councils and national and multinational providers, the majority of providers are small and medium enterprises that may lack the resources to acquire specialist support for recruitment and retention. The Social Care Institute for Excellence has set up a website (Undated) aimed at informing employers about best practice in issues such as recruitment and retention.

### **5.3 Career change and 'grow your own' schemes**

Other initiatives include efforts directed to helping professionals change their career and become qualified social workers (Scottish Institute for Excellence in Social Work Education 2006) or other 'Grow your own' schemes aimed at helping unqualified staff acquire a social work qualification. (This is the subject of yet to be published work funded by the Department for Innovation Universities and Skills as part of its *Gateways to the Professions* project). The Open University has become a substantial provider in this area with a focus on helping people to acquire, or 'top up' existing professional qualifications.

### **5.4 Role of people with experience of using services**

The unique contribution made by people with experience of using social care services is also increasingly recognised. For example, the evaluation of Support Time and Recovery (STR)

Workers (Huxley et al. 2005) has demonstrated that people with experiences of using mental health services are able to provide highly valued support to others.

### ***5.5 People who have had limited training, education or employment opportunities***

Some but not all of these attempts to increase the pool of labour in social care are integrated with other wider public policy goals, such as efforts to increase the life chances of young people who have limited training, education or employment opportunities. Granville and Laidlaw (2000) explore the potential for young people serving sentences to become involved as part of community service with the social care sector and the benefits to all concerned if this is well prepared and supported.

### ***5.6 Improvements to terms and conditions of employment***

As mentioned at the beginning of the paper, social care employers are unlikely to be able to raise wage levels substantially. However, it has been suggested that more attention could be paid to finding other ways of improving employment conditions (Eborall and Griffiths 2008a). For example, Leicester Council is reported to have had more success in retaining home care staff by enabling them to be classified as essential car users, giving them access to a car leasing scheme and parking permits that had previously only been available to more senior staff or those working for the NHS settings (Improvement and Development Agency for Local Government 2007).

### ***5.7 Potential for 'downward substitution' and telecare/assistive technology***

The role of 'downward substitution' in care (Challis 1992) through providing different care from a more highly qualified provider to a lower qualified one as is envisaged, for example, in a paper from Demos (the think tank) looking at the implementation of personal budgets (Leadbeater and Gallagher 2008) has yet to be evaluated. There is evidence that councils are applying ever stricter eligibility criteria for services (Commission for Social Care Inspection 2006) and so the needs of those currently receiving services are increasingly severe. It is also important to recognise that the benefits of downward substitution are more likely to be seen in countries with higher proportions of people in more expensive forms of care, such as nursing homes (Challis 1992), who might suitably be offered less expensive forms of care, which is not the case in the UK.

Some potential for responding to labour shortages might be through the greater use of assistive technology and telecare. Assistive technology has been shown both to reduce care costs and to be acceptable to older people (McCreadie and Tinker 2005). However, the study on which this work was based and the cross-national ENABLE project (Löfqvist et al. 2005) identify that currently 'high level' assistive technology is only currently available to a minority of older people in the UK and that there are gaps in the provision of even low level forms of assistance. Existing data on telecare installation and operational costs are limited. In addition to the costs of installation, they may also include monitoring costs. There are also indirect costs, which may be substantial in the form of training existing care staff on how to develop a care package that includes the appropriate use of telecare (Curtis 2007). It has also been suggested (Woolham et al. 2006) that returns on any investment in telecare will take some time to be achieved and that there is a risk that it will be seen as a substitute for social care instead of a means of complementing it. The Department of Health (2008) has recently assigned £31 million for the evaluation of innovative technologies in supporting people with complex needs but it will take three years before the results from the pilots are available. However, a review of telecare interventions (Broens et al. 2007) suggests that for schemes to be implemented successfully beyond the pilot stage, arrangements need to be in place for the financing of services and that legislation may be required to ensure that services are of sufficient quality.

## **6. Assessment of optimal response to alleged staff shortages**

### ***6.1 Quality of information currently available***

The limitations in the quality of information on the workforce as a whole and on the migrant workforce in particular makes it important to retain a degree of flexibility in implementing decisions that could have implications for the recruitment of migrant workers within the sector.

### ***6.2 Longstanding nature of the problem***

Recruitment difficulties in social care are longstanding and there is a long history of local initiatives taken to attract more people into the workforce. Many of these difficulties are thought to originate in the low status of social care (Platt 2007), in gendered assumptions about the nature of the work (McLean 2003), and in the comparatively low levels of remuneration within

the sector (Low Pay Commission 2007, 2008). Disadvantages can accrue from being overly reliant upon a workforce that may decide to leave and return home (Pollard et al. 2008) or where there is a strong degree of occupational polarisation (May et al. 2007) where certain occupations are associated with a particular ethnic group or gender. The social care workforce has always contained a high proportion of migrant workers and this reflects longstanding issues to do with pay and status. However, recruitment difficulties can vary considerably within the sector. This suggests that, in addition to differences between employers, there are other as yet unidentified local labour market factors impacting upon the sector which may be affected by decisions to implement policies on a UK-wide basis. The evidence for the difficulties that might ensue from restricting employers' access to workers outside the EEA is strongest for London (Experian 2007) but rural areas with comparatively high proportions of older people, such as Cumbria (Cuban 2008) may also have problems.

### **6.3 Finding alternatives**

The increase in the number of social work students (Evaluation of the Social Work Degree Qualification in England Team 2007) suggests that it is possible to increase the supply of social workers through measures designed to increase its popularity among applicants to higher education and to improve its professional status. However, it will take time before there is sufficient evidence showing whether this will result in long term improvements to the future supply of social workers that would obviate the need to employ social workers from outside the UK. The potential for similar approaches to work in increasing the number of UK born social care workers is even more uncertain. There is little evidence of the factors attracting people into social care and on competition with other employers. More understanding is needed of people's motivations to do care work. Furthermore, there is a degree of competition within the sector, with different types of employers seeking to attract the same workers.

### **6.4 Interfaces with other services**

Many targets in the health sector, such as reducing the number of people whose discharge from hospital is delayed, are dependent upon good partnerships with the social care sector. To our knowledge, no work has yet been undertaken linking delayed discharges to labour shortages in the care home or home care sector, but decisions to restrict employers' access to areas outside the European Economic Area would need to be considered in terms of their impact upon the NHS, as well as social care.

### **6.5 Potential impact on quality of care**

As mentioned earlier, care workers can experience high levels of job satisfaction (Rose 2003) (McLean 1999). This often means that some workers have a level of commitment, despite working unsocial hours for comparatively low rates of pay (Datta et al. 2006). They may also acquire skills that are not measured through the conventional NVQ framework. The importance that many people using services give to their personal relationships with individual workers (Beresford et al. 2005; Qureshi 2001) means that long term relationships can develop between workers and people using services. The benefits of continuity in care are why turnover rates in social care are often seen as a better indicator of the quality of the service than vacancy rates.

### **6.6 Relationships between paid care and unpaid care**

One of the difficulties in the sector is that there is so little work looking at differences between UK born and migrant care workers in terms of their family responsibilities. There is some evidence that UK born workers have high levels of family and caring responsibilities (Ginn and Sandell 1997; Hall and Wreford 2007; McFarlane 2001). By contrast, migrant care workers may have left family members overseas (Cuban 2008). This may mean that they are more willing to have different patterns of work than their UK born counterparts.

### **6.7 Future demand for care**

Wittenberg and colleagues (2004) have estimated that to keep pace with demographic pressures over the next 50 years in the UK, residential and nursing home places in the UK need to expand by around 150 percent, and numbers of hours of home care by around 140 percent. Work also undertaken by the Personal Social Service Research Unit on behalf of Skills for Care (Eborall and Griffiths 2008b) has estimated that by 2025 the size of the workforce required is projected to increase to between 2-2.5 million workers. This range was based on three different assumptions: the 'base case' (broadly the status quo), 'maximising choice' (an increase in direct payments for all those who wish to receive them) and 'reining in' (reduced access to care and greater use of family care and self funding). This work has highlighted that the key issue in terms of assessing current and future demand for care workers has to include both long and short term planning. Ultimately, much is dependent upon the interaction of different policy aims within government. Developments in the social care sector over the past 10 years have occurred within a context of expansion both in the NHS and in children's services (for example,

through initiatives such as *Sure Start*). Future plans for personalisation in social care (HM Government 2007) are likely to result in increases in the workforce, although the jobs they do may change. This highlights the need to consider how changes to immigration rules would impact upon the government's ability to meet other policy objectives.

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