Who Cares Now?

An Updated Profile of the Independent Sector Home Care Workforce in England

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Please note: There may be minor formatting differences in layout between the printed version of this document and the on-line version available from www.ukhca.co.uk/pdfs/whocaresnow.pdf.

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Lesley Rimmer (UKHCA Chief Executive) directed the project.

Kim Grove of UKHCA compiled the database of home care providers, analysed the data and prepared the tables, with assistance from Michelle Berry.
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The responsibility for the report, its conclusions and any errors or omissions remains with the authors and does not necessarily represent the views of the UKHCA Board.

The report refers to England. A companion report is available for Scotland.

The report does not necessarily reflect the views of Topss or of the Department of Health.

Throughout the report the data from the surveys are presented in percentages, with base numbers given. Components may not total 100 percent because of rounding. Figures below one whole number are given to one decimal place. Figures shown in brackets are comparators drawn from 'Who Cares 2000', unless otherwise stated.

EXECUTIVE SUMMARY
Key Issues

Enabling people who require support to remain at home has now become a major policy area for Government. Although independent sector home care workers provide the majority of this support, there has been little research undertaken in this field. This survey adds to the limited information available on both the workers and the organisations through which they work.

Who Cares Now? (2000)[1] revisits the information provided by the previous United Kingdom Home Care Association (UKHCA) survey, explores new areas related to regulation, the motivations of home care workers for choosing to work in the sector and issues they consider important in employment. For the first time, the survey presents information on Registered Managers as a distinct group.

[1] Mathew, D. (2000) *Who Cares? A Profile of the Independent Sector Home Care Workforce in England*, UKHCA.

Direct comparisons between the two surveys must be viewed with caution because of differences in the sample of respondents but, where significant trends appear to be suggested, this identifies a need for more work to validate the results and, where possible, to identify underlying causes.

There are thought to be of the order of 4000 domiciliary care service units in England but until registration of home care services is complete, full and accurate numbers will not be available. Equally, inspection processes and compulsory annual returns to the Commission for Social Care Inspection (CSCI) would offer more accurate and universal data on staff numbers, the penetration of qualifications etc. It will be important for reliable data to be available, to inform the review of the National Minimum Standards (NMS) training targets in 2006.

The estimate of total home care provision by the independent sector and local authorities in England, is 3,800,000 hours weekly, less than 1.5% higher than in 2000. Local authority purchase from the independent sector increased by 33.5% over the period so that 72% of publicly funded home care is now provided by the independent sector, compared to 64% then.

The estimate of privately funded home care was just 500,000 hours, only 13% of total hours delivered (including in house provision). In 2000, the equivalent estimate was one million hours. The full reasons for this counter-intuitive change are not apparent.

35,000 fewer households were supported with home care services by local authorities, compared to 2000 and 139,000 fewer since 1993. Reduced use of residential care, tighter eligibility criteria, increased local authority charging and several other factors might have been expected to increase the number of people with home care needs who would now be purchasing their care privately from the independent sector.

It seems important to ask what has happened to those no longer receiving services. The change may also have wider significance for future market stability. A number of hypotheses are advanced in the report but we are not in a position to determine which, if any, are genuine reasons. UKHCA strongly recommends urgent further research to verify and establish the cause for the reduction in private purchase of home care.

The trend for more healthcare to be delivered to patients at home was reflected in the proportion of services reported as purchased by the NHS, that was more than double the level reported in 2000.

60% of providers were reliant on local authorities for more than three-quarters of their business (46% in 2000). 14.5% worked exclusively for local authorities, this included one-quarter of the small providers. Only 39% of providers delivered care to more than one local authority.

With the apparent reduction of private client work as a 'fall-back', these providers are vulnerable to the purchasing policies of social services departments, who are known to be reducing the numbers of providers from whom they purchase.

A healthy private market is important to the overall health of the home care sector. Providers over-dependent on one customer will be more vulnerable to changes in purchasing policy, less likely to innovate and may be less in touch with the real needs of service users. In the medium to long term this can be expected to result in poorer services and less choice for local authorities as well as for private purchasers themselves.

The estimated number of independent sector home care workers in 2004 was 97,500, (121,500 in 2000). Each worker is now delivering 25% more hours, on average. The number of workers in the statutory sector is also reported to have fallen as in-house provision has decreased, so the total number of people employed across all sectors of domiciliary care in England is now estimated to be 163,000, compared to 202,500 in 2000. The proportion of the home care workforce in the independent sector remains unchanged at 65%.

It is recognised that the figure for the independent sector is not directly comparable with 2000, as the estimate then contained an adjustment to include 'floating' workers; those who were on the books of home care providers but did not work in a given week. However, there is supporting evidence and reasoning to suggest that floating workers have at least significantly reduced, if not largely disappeared. For example, only 6% worked for more than one home care organisation, down from 14% in 2000 and only 11% percent had other types of paid work, down from 22%.

A reduction in prevalence of casual workers and those holding multiple jobs may be viewed as very positive, offering greater continuity and making investment in training and development more economic. However, the higher utilisation rate of worker time and the disappearance of the 'reserve' of casual workers could indicate loss of ability in the sector to absorb future increases in demand.

Only 14% of the care workers responding had been recruited to the sector within the preceding year, sharply lower than the 22% reported in 2000. This was in

marked contrast with the figure for those in home care between one and two years, that was almost unchanged and despite the Department of Health (DH) national recruitment campaign that preceded the survey by 4 months.

As with the lower overall headcount, this could be taken as a desirable reduction in turnover, improved continuity for service users and reduction in required cost per hour of training and other quality measures. It could also indicate a tighter recruitment market in which home care employers are increasingly unable to compete, giving early warning of impending capacity constraints.

However, the onset of the change appears to have been sudden and to have coincided with the introduction of regulation and National Minimum Standards. It is thought likely that one cause may have been an unwillingness (or inability) by employers to bear the higher costs of new worker recruitment (e.g. Criminal Records Bureau - CRB), induction and qualification training. It may also reflect an unwillingness by potential workers to make the equivalent personal investment.

Three-quarters of providers responding to the survey reported difficulty in recruiting home care workers or with retention. The most commonly cited problem was the general shortage of available labour in the market.

The social care workforce generally is expected to require continued growth over coming years to address the rise in demand. Home care might be expected to increase at a higher rate because of policies for increasing service user independence. It will be important to identify whether the reduction in recruitment in the 12 months leading up to the survey becomes a sustained trend.

The average age of the respondents remained at forty-two but workers aged 50 or over fell as a proportion to 25% (from 32%), the only age group where there was significant change. This appears to reflect reluctance to undertake training and qualifications since the proportion of people 'working towards' a qualification fell away very sharply at age 50 as did the importance workers place on qualifications, career progression etc.

Older service users generally express a preference for older care workers. Government policy is to encourage older people to extend their working lives. It will be important to undertake more detailed work to confirm whether the trends and attitudes identified for this cohort of the workforce are valid, their causes and potential solutions.

Workers holding an National Vocational Qualification (NVQ)2 in Care appear not to be paid any more than the 'all workers' average. This is likely to reflect the

absence of differentiation in price paid by purchasers based on either the individual worker's qualifications in a specific care package or on the proportions of qualified workers, within a service.

To address this, care sector representatives recently proposed to the Low Pay Commission (LPC) that the National Minimum Wage (NMW) should have a second, higher tier for workers who have demonstrated occupational competence at level 2 (or above) but we understand that such a recommendation would be beyond the remit of LPC. In the light of difficulties with recruitment, retention and achievement of training targets, we would recommend that any workforce strategy for the sector should introduce inter-related incentives for workers to undertake training and for employers to have a trained workforce.

At least two-thirds of home care workers do not receive pay specifically for travel time. Some of these will receive payment through premiums for service user contact time. Non-payment of travel time is increasingly reported as a problem seriously affecting retention. This is aggravated by increasing use of very short visits (15 minutes or less) where the proportion of paid, service user contact time can be as little as 40-50% of a working day.

It is not clear that allowance for this time is made, when calculating compliance with National Minimum Wage. Unless 'nominal' pay rates for contact time exceed £9 per hour for such work then NMW will not be achieved. Survey data from elsewhere (on average prices paid by purchasers) suggest such rates are extremely uncommon, while most providers report that visits of under half an hour constitute more than 50% of their work.

It is normal practice for purchasers to pay for contact time only. Where objective costing including allowance for this factor is not taken into account, prices are likely to preclude employers from paying travel time. This is therefore a particular problem where historic prices have only been uplifted by (or below) inflation, while visit times have decreased.

To address this, care sector representatives recently proposed to the Low Pay Commission that local authorities should have duty to ensure that prices paid cover all legal requirements, including National Minimum Wage.

One third of providers reported periods of induction that were below the legally required minimum, although the time most commonly reported was 20-21 hours. Given that the survey took place a year after the introduction of National Minimum Standards requiring effective induction, this response was discouraging. Further work is recommended to identify the reasons behind this failure of compliance in such a critical area for safety and quality.

Care workers responses on qualifications suggest dramatic rises in achievement of NVQ2 or above (26.6% compared to 8.5% in 2000) and those 'working towards' NVQs (50% from 8.9%). This might suggest that, after one year of regulation, the sector was halfway toward the five year qualification target and at least a third more workers have started working towards NVQs than required by NMS.

However, care worker respondents are likely to have been heavily selected or self-selected from among those who are most 'engaged'. Provider organisations, who might be expected to have a more reliable picture of the whole workforce, reported a much less positive picture with only 9.9% NVQs held and 18.1%. 'working towards'.
This would mean that, after one year of regulation, providers had barely reached one fifth of the five year qualification target and at least 17% fewer workers have started working towards NVQs than might have been expected under NMS. Given that some workers already held or were working towards qualifications when regulation was introduced, the recent activity rate appears wholly inadequate to achieve compliance with targets.

Respondents to the Registered Managers survey reported 18% holding the required NVQ4 and 42% studying. Provider organisations reported 12% of managers already holding and almost one third studying.

The implementation of training and qualifications requirements has presented practical difficulties. Capacity for training and competence assessment remains inadequate and the content of the qualifications has not historically been well adapted to domiciliary care services (this latter problem has been addressed in the new qualification structure and content launched in early 2005).

Funding streams have caused significant difficulty, with the majority directed either through Further Education (FE) colleges not accustomed to dispersed workforces, or through local authorities whose use of the grant money to develop the workforce of independent providers has been limited.

Only 2% of workers and 12% of employers reported any external funding, from all sources such as Topss, local councils, ESF, LSCs etc. The implication may be that such funding is not reaching independent sector providers to any degree.

SECTION ONE
Introduction

This report is based on the results of a survey of home care organisations in the independent sector in England, their Registered Managers and care workers. It throws light on an area of social care provision that delivers services to more people than any other type of service – around 500,000 are estimated to receive home care on any one day.

Remaining at home is recognised as the first choice of most people in need of care. Enabling more people to do so is a key priority of Government commissioning policy. Yet local implementation appears to be lagging behind the policy ambitions and the extent and value of the service are only now beginning to be recognised by the media and the public. It is still relatively neglected in terms of research and development.

The primary focus of this research was the qualifications and training of home care workers, but the report also contains other valuable information on the independent home care sector.

The UK Home Care Association (UKHCA) was established in 1989 as an organisation of mostly independent home care providers, with the purpose of leading and developing standards in the sector.

The last comprehensive survey of the domiciliary care workforce in the independent sector was 'Who Cares?' carried out by Mathew in 2000 (ref. 1). Since then, there have been substantial changes in the market environment that have major implications for the workforce. Some of the changes have continued previously identified trends. Others, like introduction of service regulation, have been long awaited and will continue to bring about change for some years to come. New factors, however, also continue to arise.

With regulation of domiciliary care just one year old, the 2004 survey offers an essential check on how the regulation is 'bedding-in' and examines the readiness of the workforce in the sector to meet the challenges placed on it. Specific new questions were incorporated into the 2004 survey to address this.

As well as being the last survey of the sector, 'Who Cares' (2000) (ref. 1) was also the first. Together with well established surveys of the local authority 'in-house' providers, it yielded valuable data to inform the setting of targets for National Minimum Standards (NMS) (2002) (ref. 2), and the first national training strategy, developed by Topss (England) (ref. 3). As both the NMS and the training strategy are due for review, it is hoped that the 2004 survey will once again contribute to the process. Whilst many questions are comparable in the two surveys, others were added to the changes identified above.

There are thought to be of the order of 4000 domiciliary care service units in England, of which the majority are in the independent sector and most are single

branch operations. Once registration of home care services is complete, more accurate numbers will become available.

Equally, inspection processes and compulsory annual returns to the Commission for Social Care Inspection (CSCI) could eventually offer more accurate and universal data on staff numbers, the penetration of qualifications etc.

It is our view that a high priority should be given to ensuring CSCI return data is collected in a form that can be readily aggregated, captures all necessary information, without the need for time consuming and wasteful separate surveys and is made widely available to those with a responsibility for workforce planning.

Data is routinely collected by the Department of Health (DH) about the hours of home care funded by local authorities, but there remains little information about the size of the private purchase market or about home care workers in the non-statutory sector.

Given the significance being attached to care at home within the policy process, this lack of information about a major sector of care provision needs to be remedied; information must be produced on a regular basis, not just through irregular 'one-off' surveys.

Surveys of the membership of UKHCA, commissioned from the Nuffield Institute in 1995, 1996 and 1997 had provided information about the burgeoning independent home care sector, the types of services provided, and developments in the commissioning practices of local authorities (ref. 4, ref. 5, ref. 6). A further survey around commissioning practices was carried out by Mathew in 2003, funded by the Department of Health Social Care Change Agent Team (ref. 7).

Laing and Buisson have followed the development of the home care market in their annual publications (ref. 8). There are a number of sources of information on local authority home care workers. Staffing returns provide data on the number and qualifications of the workers in local authorities, Social and Health Care Workforce Group (SCHWG) studies have reported turnover of staff, retention and vacancy rates (ref. 9), and the National Institute for Social Work (NISW) has explored in detail other aspects of work through interviews with staff (ref. 10).

The Community Care into Practice series published 'Creating Jobs?' The employment potential of domiciliary care (1998) (ref. 11), that provided valuable insight into the characteristics of the home care workforce and their employment conditions in the statutory and independent sectors of three local authority areas. However, the UKHCA surveys remain the only national studies of the independent sector workforce and one of very few sources of information on the extent of the private purchase market.

The primary aim of both the 2000 and the 2004 survey was to find out the following information about the independent home care sector:

- The size of the workforce
- The difficulties home care providers were facing with recruitment and retention of workers
- The qualifications held by home care workers and managers
- Training undertaken by home care workers

The Care Standards Act extended the scope of what is defined as domiciliary care from previously recognised types of service to also include dedicated care services provided within sheltered housing (ref. 12). 'Who Cares (2000)' (ref. 1) did not address that part of the sector. Attempts were made with the 2004 survey to ensure inclusion of these providers and it appears that they now constitute almost 10% of respondents. This is thought to be a slight under-representation of their numbers in the market.

A database of independent sector home care organisations was assembled from a variety of sources, including membership lists of representative bodies and the website listing of the CSCI. After purging duplicate entries the database stood at 4,515 entries.

Early in May 2004 a pre survey letter was sent out to 4,515 organisations alerting them to the imminent arrival of the survey, explaining the purpose of the survey and to ask whether the organisation did actually provide home care or housing support services. If organisations were not providing the above services they were asked to complete a slip at the bottom of the letter and return it to a freepost address.

Three questionnaires were distributed in May 2004 with a letter instructing the organisation what to do with the questionnaires. The questionnaires were sent as follows:

1) Organisational Questionnaire
This asked the organisation to provide information about hours of provision, the size of the workforce, training of workers and management qualifications. This questionnaire was coded so that reminders to return the questionnaire could be sent to the organisation.

2) Home Care Worker Questionnaire
Nine of these questionnaires were sent to each organisation with an instruction to give them to nine of their care workers to complete. This questionnaire asked about the skills and experience of the workers, hours of work, qualifications obtained, and training undertaken. The choice of these workers was left up to the employer and may or may not have introduced some selection bias eg. giving it to their most qualified/longest serving staff. To preserve anonymity, care worker questionnaires were not made identifiable to provider organisations.

3) Registered Manager Questionnaire
A third questionnaire (similar in content to the home care worker questionnaire) was to be given to the Registered Manager to complete. To preserve anonymity, Registered Manager questionnaires were not made identifiable to provider organisations. While it is likely, therefore, that the 561 responses received correspond closely with the 538 organisational responses, this is not certain.

Questionnaires were colour coded to make it easier for home care staff to differentiate between each of them.

After purging duplicate entries, organisations that had ceased trading and those who had responded stating that they did not provide home care, the list consisted of 3,584 service outlets. In the absence of a definitive list, this was taken as the statistical universe of service outlets for the survey. However, there may still be organisations on this list who do not provide home care and who did not respond at all.

538 Responses were received from organisations representing 727 of these outlets, a response rate of just over 20%.
2895 responses were received from care workers.
561 responses were received from Registered Managers.

In all 49,665 questionnaires were distributed, of which 39,424 were sent to the 3,584 organisations who were on the final purged list. Table 1 gives a breakdown of the questionnaires sent out and returned.

	Numbers sent out	After purging	Numbers returned	Outlets	Percent return
Organisational questionnaire	4,515	3,584	538	727	20%
Home Care Worker Questionnaire	40,635	32,256	2,895	n/a	9%
Registered Manager Questionnaire	4,515	3,584	561	n/a	16%
Totals	49,665	39,424	3,994	727	n/a

Respondents did not always complete all the questions or did not complete them fully. As a consequence, although care has been taken to ensure the data presented for each question are valid, caution should be exercised in cross-relating data between tables.

Because relatively little is still known about the sector, it is not possible to know how representative the providers and workers that responded to the survey are of independent home care. Nevertheless, it is hoped that this report will contribute to the understanding of a little-known area of social care and will assist policy makers identify further research that is required. More detail about the respondents is found in Appendix One.

This research, in conjunction with established data sources on local authority purchasing and direct provision, has been used to estimate the total hours of home care provided by the local authority and independent sectors in England and the number of people working as home care workers. The survey also provides information about the qualifications held by care workers in the independent sector and the training they receive in order to carry out their work.

SECTION TWO
Government Policy and the Home Care Market Context

Government policy has increasingly focussed on encouraging independence, especially by enabling people to live at home for longer. New regulation of care services is creating big challenges for providers in both independent and statutory sectors. Local discretion continues to mean that there is considerable variation in the way that these changes have been implemented. Although local authority use of independent sector providers has now become almost universal, genuine partnership working remains patchy. Increasing demand, tight financial constraints and limited workforce capacity appear likely to be key drivers for the market, over the next few years.

Independent domiciliary care providers have been around for at least as long as the NHS but their numbers and their volume of activity expanded dramatically, following the Government's Community Care reforms in the early 1990s (ref. 13).

These reforms led to a shift from solely local authority in-house provision of publicly funded home care to a position where more than two-thirds is now delivered by independent providers under various forms of contract.

This new access for independent providers to service users supported by public funds might have simply shifted work from one group of organisations to another. However, underlying demand for domiciliary care has also increased consistently over the last 10 years, with the result that local authority direct provision remains at over 60% of its 1993 volume.

This increased demand reflects the fact that there are more people in the population in need of care services, people are living to greater age, and those with disabilities or who suffer illnesses that used to be terminal are living longer and rightly demanding services that enable them to maximise their quality of life and their independence.

Over the same period there has been an increasing recognition that certain groups of people, such as those with learning disabilities or mental health problems for whom residential services were once considered the only option, can be effectively supported in community based settings.

A further factor in increasing demand may have been changes in patterns of family living and inter-generational care. Some evidence suggests that children are less often prepared or able to take on the care of parents or older relatives and, indeed, that the older people more often do not expect this to occur. This is attributed to various factors: Families living at greater geographic distance; expectations that Government should provide; or growth of the service industry culture.

Despite such evidence, it remains the case that informal carers – family, friends or neighbours of those in need of care – deliver considerably more care to more people than all 'formal' services put together.

Alongside such cultural change, recent legislation has explicitly recognised the rights of Carers to maintain their quality of life. This recognition brings with it clear entitlements for Carers to respite and other services that enable them, for example, to continue working and to maintain social contacts. Full implementation of this legislation could lead to further shifting of care from Carers to service providers.

The high cost of residential care; the consumer driven 'Independence Agenda'; and changed attitudes to institutionalisation have fuelled Government policy to reduce reliance on care homes and to have an explicit policy of increasing the role of domiciliary care, supported or very sheltered housing.

For those with needs that do not include personal care, a newly defined stream of housing-related services and funding has been brought together through the Office of the Deputy Prime Minister (ODPM) under the banner of 'Supporting People' (ref. 14). Though quite separate from Social Services funding, that now rarely offers the traditional 'home help' practical support in the absence of a substantial personal care need, Supporting People is often delivered by the same independent providers.

Government policy has also encouraged the bringing together of health and social care services. So called 'Health Act Flexibilities' enable local government and health bodies to pool funding, to set up multi-disciplinary services and to work together on joint commissioning of services (ref. 15).

A major opportunity for growth in home care services has been created by the political and economic imperative of reducing demand for hospital beds. This has culminated in the introduction of 'reimbursement', a system where local authorities are required to pay penalties to NHS trusts if patients are not discharged within a fixed time after they are assessed as ready.

Delayed discharges generally and reimbursement in particular have been drivers for innovation in home care, including increased use of 'Rapid Response' and 'Home from Hospital' services. The possibilities identified by these changes, as well as technological advances in medicines and medical equipment and fundamental reviews of patient care pathways have also highlighted opportunities for more people with long term conditions to be cared for and even clinically treated at home.

The combination of Government policy, demand factors and technological advance has led to a steady, year on year increase in the number of domiciliary care hours supported by public funds and the proportion of those cared for in their own homes who receive 'intensive' packages of care. This trend has appeared likely to continue and to become stronger.

The trend for more healthcare to be delivered to patients at home seems also likely to continue, moving towards a position where (as well as social care) most health care services, acute or long term, will be delivered while the service user remains in their normal place of residence.

Many independent home care providers originate from a health background and have worked in social care simply because it offered more opportunity for growth. Despite this, recent UKHCA research into commissioning practices – Commissioning Homecare: Changing Practice; Delivering Quality? (ref. 7) - shows that most 'joint' health and social care services are being created between NHS providers and local authority in-house teams.

The general growth trend in domiciliary care could probably have been far greater, had it not been for the application of stringent economic constraints. At the same time as volumes of publicly funded domiciliary care have risen, the actual number of people receiving those services has fallen consistently for several years. The constraint has been applied through raised thresholds of 'Eligibility Criteria' – rationing – applied by local authorities to keep expenditure within overall financial targets.

The trend for fewer, more complex cases seems to fit with the policy of focussing services on those in greatest need. However, in a context where greater numbers of people are believed to be in need of care, it is important to ask what has happened to those no longer receiving services.

It might be expected that people no longer eligible for local authority support would have shifted to self-funding their domiciliary care services to compensate for the restriction in public funding. At the same time, there have been widespread increases in the charges made by local authorities for the services they arrange. It might be expected that increased charges would also result in some shifting to private purchase.

However, this survey identifies a volume of self-funded services far lower than was reported in 2000. The proportion reported this time is less than half that in the 2000 survey. The higher representation of sheltered housing and voluntary sector providers among respondents to the 2004 survey will have contributed to this effect, as they tend to provide a smaller proportion of private care. *N.B. Please see warning on page 16.* However, the comparison may still be seen as valid, since the absolute number of privately funded hours reported in 2004 was 8% lower than in 2000, even though there were at least 50% more commercial

provider respondents to the survey and the average volume of hours per provider respondent also rose.

A number of hypotheses may be advanced to explain this very noteworthy change:

- The survey drew responses from a very different set of providers. For example, the proportion of voluntary and not for profit providers more than doubled. Many of these providers may offer services only to local authority contract.
- People in need of services but no longer eligible for public funding may not be able to afford to purchase their own care or are 'doing without' for other reasons.
- The cost of privately purchased care may have increased (as a result of regulatory standards, higher wages etc.) to a level where people are not prepared to buy it or are buying substantially less.
- People previously receiving publicly funded services may not actually have needed them.
- People may be becoming generally fitter and only need services for shorter, more intense periods, so local authority funding covers a greater proportion of the market need.
- There may have been an increase in the number of people relying on 'informal' care by friends and relatives.
- There may have been an increase in direct employment of care workers by service users.
- Providers may have been concentrating scarce labour resources on fulfilling contracts with local authorities, leaving less available capacity for privately purchased care.

We are not in a position to determine which, if any, of these possible reasons genuinely contributed to the unexpected and paradoxical findings. It is, of course, also possible that this survey or the earlier one or both yielded unrepresentative results. However, both surveys are thought to have drawn responses from a sufficient number of providers to be statistically robust.

Urgent further research is recommended to identify the real level of demand for services outside current public funding and the factors influencing that demand.

Increases in demand inevitably create considerable pressures on the capacity of domiciliary care and, in particular, on its workforce. At the same time as there are more older people and people in need of care, there are fewer people of working age to provide it and economic prosperity has brought almost full employment, in some areas.

There are more diverse work opportunities for women, who have traditionally been the majority of the care workforce, and more women are returning to full

time work, sooner after having children, rather than seeking part-time and flexible employment that home care has offered.

Pay and conditions for workers in independent sector home care have generally been very low. At the time of introduction of the National Minimum Wage (NMW), most independent providers reported pay as somewhat higher than the original NMW rate. As the NMW has increased (£4.50 at the time of the survey, rising to £4.85 in Oct 2004), many domiciliary care workers are now barely paid at the current level. Some care worker respondents reported being paid less than the current minimum.

One third of respondents to the survey reported that they were paid less than £5.50 per hour. Due to travel time and similar factors it is likely that real rates are lower than those reported.

Non-payment of travel time is increasingly reported as a problem seriously affecting retention. Historically with publicly purchased care and still in the privately funded care market, visit times were normally 1 or 2 hours so travel time was more easily absorbed. In local authority purchased work, there is now an increasing use of very short visits (15 minutes or less).

In such a regime, the proportion of paid, service user contact time can be as little as 40-50% of a working day. It follows that, unless 'nominal' pay rates for contact time exceed £9 per hour for such work then NMW will not be achieved. Only 5% of care workers responding to this survey report6(rt)-4.7(6(rt)-4.7(a09e)o.3(-6.5(u)-023(of r)8.v3(h£r

This agreement was re-launched by the Minister for Community Care Stephen Ladyman. Together with increased use of comprehensive costing models and dissemination work by the DH Change Agent Team, there is some evidence that the issue of realistic costing is beginning to be addressed by some authorities.

In order to meet budgetary constraints and to reduce the impact on service users of the resulting rationing, local authority purchasers have often tightly constrained prices paid to providers.

This pressure has generally been felt by providers to be without regard for costs of workforce development or local competitive pressures on pay and conditions. For example, introduction of statutory requirements such as NMW or annual leave under Working Time regulations were not always reflected in purchase prices.

This has historically made it difficult for many independent care providers to increase care worker pay, which is the largest element of their costs. Inevitably, uncompetitive pay makes the work attractive to fewer people and threatens provider capacity. However, this survey identifies use of improved pay and conditions, as incentives for recruitment and retention, by a substantial proportion of providers, suggesting that prices (and therefore worker pay) are not universally constrained.

Current commissioning and purchasing practice may have other negative effects on providers' ability to retain their workforce. Care plans are often extremely prescriptive on the tasks to be performed and allow insufficient time for even this limited work to be done with the dignity and flexibility to which service users are entitled and that are reflected in National Minimum Standards (ref. 2).

One of the key consequences of these short task-related visits is that the work becomes very unrewarding and unsatisfying for care workers and for their managers. Taken together with clear expressions of low job satisfaction in short visit work, 'contact time only' pay is increasingly unacceptable to many care workers.

More recently, there has been some recognition of the higher costs required to assure future capacity of the workforce but this remains patchy at best.

This survey appears to identify a major reduction in the numbers of care workers employed by the independent sector, compensated for by an increase in the average number of hours that each worker delivers.

As a symptom of this, it appears that there has been a reduction in numbers of 'floating' workers; those who were on the books of homecare providers but did not work in a given week. Possible reasons for this include the higher cost of entry to home care work represented by more stringent recruitment checks, such as Criminal Records Bureau Disclosures, and by requirements for training. Such

investment may be considered too great for workers who are only delivering small numbers of hours.

However, there is an increased awareness of the need to address serious social issues such as the prevention of adult and elder abuse. This justifies a raising of the barriers to new entrants, even though it may discourage some of the more transient or casual workers on which the sector previously relied.

Concentration of home care work among fewer individual workers should offer benefits of improved continuity and may enable training targets to be met more rapidly. However, the higher utilisation rate of worker time and the disappearance of the 'reserve' of casual workers could indicate loss of ability in the sector to absorb future increases in demand.

Historically, domiciliary care has not made large demands on its workforce in respect of training and qualifications. There was an attitude in some quarters that no specific skills were needed for domiciliary care or that such skills as there were could not be imparted by training, being derived only from a 'caring attitude' and 'life experience'.

Inevitably, this absence of expectations resulted in a high proportion of workers with no relevant qualifications. Given that care is often a 'first entry point' for employment, workers in the sector are more likely to also have basic skills needs.

At the same time, service user dependency levels have risen. Services are more clinically complex, there is an increased focus on active programmes to re-establish and maintain independence and specialist work with user groups new to the market. This has meant that demands on the skills of home care workers have become rapidly greater, reinforced by new regulatory requirements to achieve formal qualifications.

The number of older people in the workforce had also contributed to concerns that home care would have a high proportion of workers who were resistant to 'going back to school'. It is interesting to note that this age group has appears to have reduced in the workforce, over the last four years.

There may still be some of the current workforce who will need considerable support or persuasion to engage with learning but it is a welcome result of this survey that a high proportion of worker respondents saw training as important or very important.

The implementation of training and qualifications requirements has presented practical difficulties. Capacity for training and competence assessment remains inadequate and the content of the qualifications has not been well adapted to domiciliary care services.

Funding streams have caused considerable difficulty, with the majority being directed either through Further Education (FE) colleges, who have not been accustomed to dealing with dispersed workforces, or through local authorities whose use of the grant money to develop the workforce of independent providers has been limited.

Following a complete review of the National Occupational Standards, planned changes to qualifications include introduction of specific units and other material applicable to domiciliary care. A change to the qualification structure will ensure that initial qualifications can be achieved more rapidly and set out clear paths and requirements for further specialist training, where required.

In April 2003, domiciliary care providers from all sectors became subject to regulation under the Care Standards Act (ref. 12). The regulator was initially the National Care Standards Commission (NCSC) but it has now been superseded by the Commission for Social Care Inspection (CSCI).

The wider remit of the new body, covering the commissioning and purchasing activities of local authorities as well as the service providers, offers hope to many that less confrontational relationships can be developed between all concerned parties.

The initial progress of service registration by NCSC was slow. The process remained incomplete, at the time of this survey, resulting in continued uncertainty as to the size and characteristics of the sector.

As registration is completed and the regulatory cycle of inspections and reports is established, a clearer picture is expected to emerge. In particular, there will be opportunities to collect and analyse universal data on providers, within routine reporting.

As might be expected with the introduction of complex new regulation with such wide applicability, a variety of detailed issues have arisen that have required careful consideration. Both providers and inspection staff are still working to become fully familiar with the new expectations on them. Positive relationships between the regulator and provider representatives have assisted greatly in resolving many issues.

Home nursing services are still not specifically regulated, either by CSCI or the equivalent regulator for healthcare (Commission for Healthcare Audit and Inspection - CHAI). Where such services include provision of personal care, they may be regulated by CSCI, as domiciliary care. However, there are no provisions to cover clinical aspects of the service. Given the rapid increase in this type of activity, it will be important to address this anomaly.

Many of the National Minimum Standards (NMS) relate directly to the workforce. Rigorous recruitment processes, clear, process-based requirements for training and minimum requirements for supervision are key areas.

Essential elements of the new recruitment requirements are obtaining Disclosures from the Criminal Records Bureau (CRB) and the Protection of Vulnerable Adults list (POVA), that will record those people identified as having caused harm to adults in their care and who are judged unsuitable to remain in the care workforce. POVA and the parallel list for children's services POCA, appear likely to be superseded by a proposed new 'banning' list operated by the Department of Education and Skills (DfES).

Substantial recruitment problems emerged for the domiciliary care sector, following the introduction of CRB checks, with workers unwilling to wait several weeks for a Disclosure to be processed. A change of process has been introduced to address this problem and improvements in CRB performance are ongoing, that should further reduce the problems.

The domiciliary care sector broadly welcomed the introduction of regulation for which they had campaigned over many years. Inevitably, some teething problems may be expected from the introduction of regulation to a completely new sector, but levels of goodwill and determination to make the new rules work remain high, for the present.

As previously discussed, regulatory requirements may create short or medium term challenges for the capacity of the workforce. However, there are real hopes that in the long term they will produce not only a safer, better qualified workforce, but also one that suffers less turnover, rewards workers appropriately and offers opportunities for career progression.

It will be important for reliable data to be available, to inform the review of the NMS training targets which is due to take place in 2006.

In addition to the regulation of care services by CSCI, individual domiciliary care workers became subject to a Code of Practice published by the General Social Care Council (GSCC) in 2002. This code sets out standards of conduct for workers. Uniquely for a workforce regulatory body, GSCC also published a companion Code of Practice for employers, including domiciliary care services, that sets out how they are expected to behave in relation to their workforce.

For the present, both Codes are enforced solely through CSCI. In the future, it is anticipated that all the 1.2 million individual care workers and care managers in social care are to be required to register with GSCC. In the event of behaviour judged to be misconduct under the Codes, such workers could then be 'struck off' the register and could then not be employed in the care sector.

Because of the clear opportunities for abuse offered by one-to-one care in private homes, a risk-based approach to priorities suggests that domiciliary care workers should be among the first to be registered.

In a logical and welcome extension of the principles of choice and independence for users of care services, Government has increased the emphasis on offering Direct Payments. This scheme offers cash payments, in place of care services being arranged by local authorities.

The intention is that recipients can choose to use the cash in any way they wish to meet their assessed needs. Guidance prohibits local authorities from requiring Direct Payments to be used in any specific way.

As a consequence of early models of such payments, there is a perception that Direct Payments are only intended to enable people to directly employ a care worker – usually known as a Personal Assistant or PA. In fact, recipients are equally entitled to buy physical aids or adaptations to their home or to buy service from a domiciliary care provider.

Local Authorities in England have had a duty, since April 2003, to offer Direct Payments to almost any person assessed as having eligible needs for care (other than long term residential care home placement). Implementation of the scheme remains slow, however, at around 2% of those eligible (ref. 17). Some commissioners have already set targets for the 50 – 70% of home care services to be replaced by Direct Payments within 5 years. This should represent a major opportunity for independent providers. However, there remains substantial debate over perceived quality and safety issues.

The implications for the workforce of well managed Direct Payments could be very rewarding and empowering, based as they are on close control by the recipient, rather than impersonal commissioning by a third party.

Recipients who choose directly to employ a PA will themselves need substantial training, education and support in order to discharge their legal obligations as employers. Care will be needed to ensure that these issues and others such as insurance for their liabilities are properly funded.

There is increasing focus on the need for statutory agencies to arrange 'the right services, at the right time and in the right place', including an increased emphasis on developing alternatives to bed-based care.

The Change Agent Team, was set up by the Department of Health to work directly with councils and their health care partners in reviewing practices. They identified better commissioning and the wider involvement of independent

providers in the development of services as being central to better services for older people.

The Change Agent Team commissioned UKHCA to carry out research in June 2003 (ref. 7), in order to gain a picture of home care provision in England and the methods used by local authorities to manage the market.

The problem of recruitment was identified as the principal issue of concern. Managers of independent services were concerned about unpaid travel time, particularly in light of the rise in the number of shorter visits.

Local authority home care workers continue to receive better pay and conditions than independent sector workers, including paid travel time and guaranteed minimum hours. It was recognised that pay and conditions were not the only reasons for recruitment problems: high employment: The demanding nature of the work; and the low status of home care; were cited as contributing factors.

Home care organisations were finding it difficult to provide cover for workers who were sick, on leave or training because of the shortage of care workers and because there were no contingency costs to retain workers on call. The shortage of workers was resulting in increasing pressure for home care providers, combined with:

- The demands for services to be put in place quickly to facilitate discharge from, or prevent admission to, hospital.
- The reduction in the length of visits specified by care managers may reduce job satisfaction for workers further impeding recruitment and retention.

SECTION THREE
Home Care Provision in England

An estimate has been made of the total home care hours provided in England, and the total number of home care workers providing that care, using information collected in the survey. The estimate is that 3.8 million home care hours are provided weekly, 72% of them supplied by the independent sector. Around 163,000 home care workers are estimated to be working for local authority and independent sectors in England.

The independent sector home care providers that responded fully to this question supplied 804,000 hours of care in one week, representing one-third of all local authority purchased care. This large sample gives confidence that the resulting statistics are broadly robust.

The breakdown of clients served showed 76% was provision to local authorities, 18% to private purchasers and 6% to the NHS. This represents considerable change from the results of the 2000 survey (shown in brackets in table 2). *N.B. Please see warning on page 16.* The result is even more dramatic than the reduction identified in the UKHCA 'Commissioning Homecare' survey carried out by at the end of 2003, that reported 27% private purchased hours.

The number of organisations responding rose by around 70% and the size of organisations (average total hours reported) was 20% larger. It is also known, from Government statistics that the number of hours purchased from independent providers by local authorities rose by 33.5%. Applying these factors to the 2000 figures offers an 'expectation' against which the actual 2004 figures may be compared.

- The most striking difference is that the reported volume of privately purchased care was less than half the figure that might have been 'expected', given the rise in numbers and size of respondents. Indeed, the absolute volume reported actually fell.
- The reported volume of hours purchased by local authorities was exactly in line with the 'expected' figure (< 0.6% variance) The proportion of total reported hours that this represented rose considerably, as a result of lower than expected private hours (see table 2).
- The reported volume of hours purchased by the NHS was more than double the 'expected' figure, and this change is reflected in the proportion of total hours reported. *N.B. Please see warning on page 16.*

	Hours (Figures in brackets are from 2000 survey)		Percent (Figures in brackets are from 2000 survey)	
Purchased by local authorities	607,961	(225,246)	75.6%	(57)
Privately purchased	146,855	(158,853)	18.3%	(40)
Purchased by NHS	49,365	(11,332)	6.1%	(3)
Total hours purchased	804,181	(395,431)	100%	

Number of respondents = 413 (255) (Missing Data 125)

The different profile of the 2004 sample, that includes many more non-commercial providers, clearly accounts for some of the reduction in the proportion of private purchase reported but is not sufficiently great to explain all of the change (see table 3).

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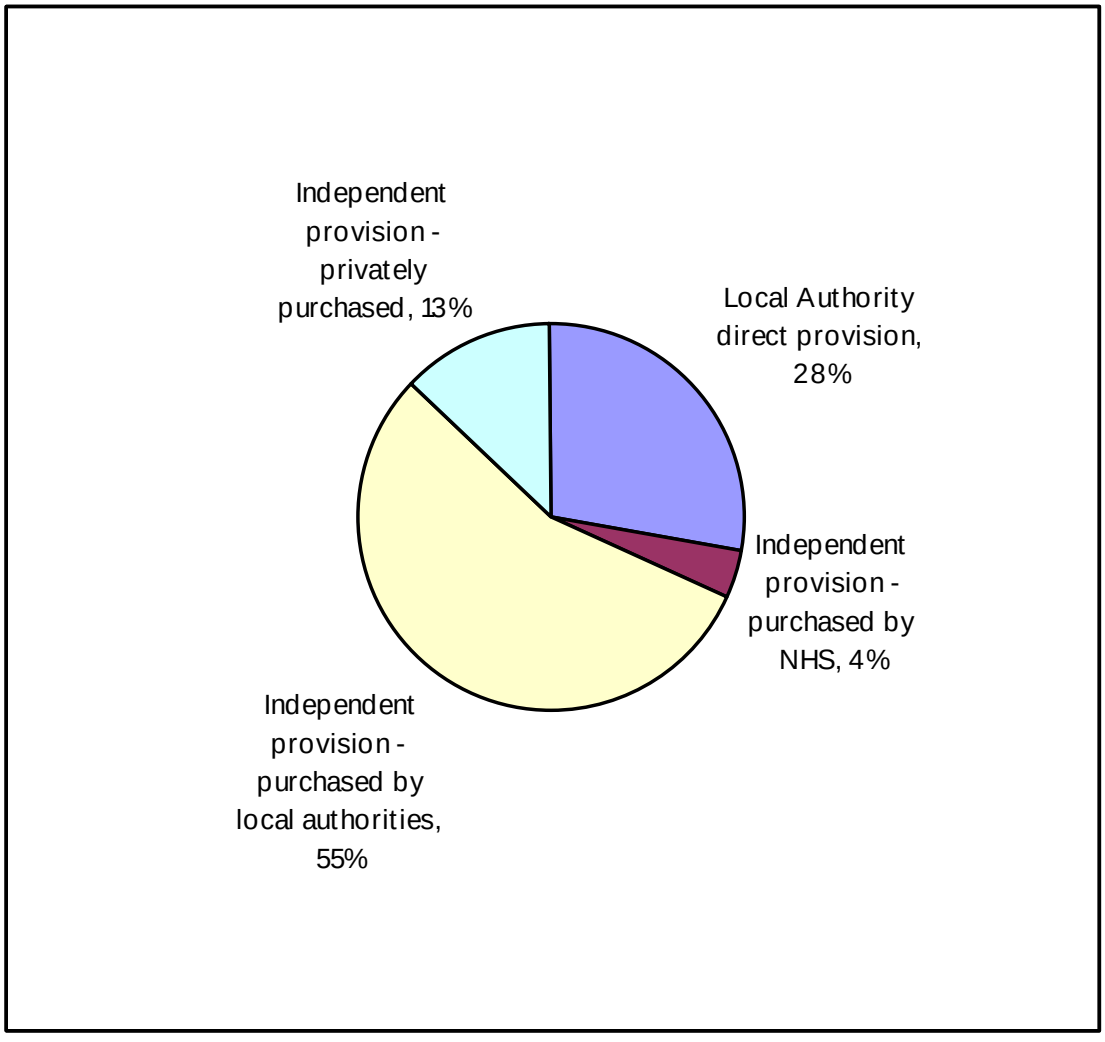
Sector	Hours (Figures in brackets from 2000 survey)		Percent (Figures in brackets from 2000 survey)	
Local authority direct provision*	1,043,200	(1,324,400)	28	(36)
Independent sector - purchased by local authorities*	2,069,800	(1,354,000)	55	(37)
Independent sector - privately purchased / other	499,970	(948,653)	13	(26)
Independent sector – purchased by the NHS	168,060	(66,373)	4	(2)
Total	3,781,030	(3,693,426)	100	

* Source: Department of Health statistical return (ref. 18)



Independent sector home care

Department of Health statistics demonstrate the dramatic growth of home care purchasing by local authorities from the independent sector. From a virtually zero base in 1993, in 1999 the number of independent sector hours was higher than hours provided by local authority in-house services for the first time and, in 2003, independent providers delivered two-thirds of all services commissioned.

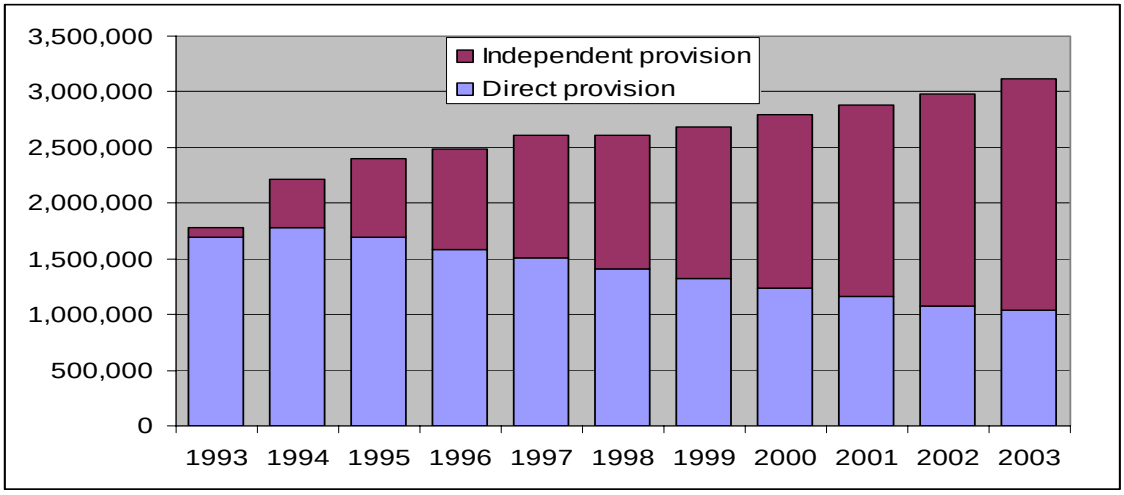
It is important to recognise, however, that the growth of independent provision has been driven primarily by the growth in commissioned volume, more than by replacing local authority in-house services. In 2003, local authority services still provided over 60% of the volume of service that they provided in 1993 (see table 6).

	Local Authority direct provision	Independent sector provision	Total
1993	1,696,000	86,600	1,780,800
1994	1,787,000	428,200	2,215,100
1995	1,688,900	706,800	2,395,700
1996	1,581,200	900,900	2,486,700
1997	1,506,500	1,101,000	2,607,500
1998	1,410,500	1,197,000	2,607,400
1999	1,324,200	1,360,100	2,684,200
2000	1,241,100	1,550,200	2,791,300
2001	1,161,700	1,719,800	2,881,600
2002	1,078,600	1,904,600	2,983,200
2003	1,043,200	2,069,800	3,113,000

Source: Department of Health statistical return HH1.

Total hours of home care arranged by local authorities rose by 25% between 1993 and 1994 and by a further 8% to 1995. Since then (with the exception of 1998, when there was no increase), overall hours have increased by 3-4% every year (see figure 2).

By contrast, after a slight rise in 1994, the number of households receiving home care has declined by a small percentage every year and now stands at just 73% of the figure for 1993 (see table 7).



	All Sectors		Local Authority direct provision	Independent sector provision
	Excluding double counting	Including double counting(1)		
1993	..	514,600	495,800	18,900
1994	..	538,900	479,300	59,600
1995	..	513,600	419,600	93,900
1996	..	491,100	370,200	121,000
1997	..	479,100	335,100	144,000
1998	..	447,200	284,500	152,700
1999	..	421,000	253,100	167,900
2000	398,100	415,800	225,800	190,000
2001	381,700	399,900	194,100	205,800
2002	366,500	383,100	167,600	215,600
2003	362,800	376,000	149,500	226,500

.. data not available Source: DH annual return HH1, Tables 2A, 2B & 3A (2000 onwards)
(1) Components may not add to totals because of rounding. Contains estimates for missing data.
N.B. Households receiving home care purchased with a direct payment are excluded.

The pattern of increasing hours and decreasing numbers of recipients reflects the steady trend for local authorities to focus services on those with the greatest levels of need, through the application of eligibility criteria (rationing).

The reduction of 139,000 households is set against demographic, cultural and policy trends that have been assumed to indicate an increasing number of people likely to need home care services:

- Greater numbers of older people
- More dispersed families
- Consumerism / service culture
- Caring at home for user groups previously resident in hospitals or long-term institutions, notably people with learning difficulties or mental health problems
- The rights of carers to enjoy respite and support
- Shorter hospital stays
- Greater use of supported / sheltered living solutions (also defined as home care)

It is not clear what has happened to the households that no longer receive services arranged by local authorities. Are they making alternative arrangements? Are they 'doing without'? Or is the true level of demand for home care decreasing, in spite of these apparent upward pressures?

In view of the implications for future public health and public expenditure, we recommend detailed independent research to establish the social and economic trends underlying these statistics.

Community care policies have fostered a growth in independent sector home care, but little accurate data yet exists for the private purchase market. There remains considerable debate about the size of this market and about its ongoing significance.

The 'Who Cares?' (2000) (ref. 1) survey reported a level of private purchase that, at 25% of the total hours provided (including in-house provision) and 40% of the care delivered by independent sector providers, was slightly higher than the estimates or 'guesstimates' that had been the only indication previously available.

The UKHCA survey 'Commissioning Homecare' carried out by at the end of 2003 (ref. 7), reported private purchase at 27% of the care delivered by independent sector providers. However, this had been thought to be an understatement, since providers serving only the private market are unlikely to have responded (the survey addressed local authority commissioning and purchasing patterns).

This 'Who Cares Now?' survey in 2004 estimates private purchase at less than half the 2000 figure and only two-thirds of the figure for 2003, a picture that is very different from that which might have been expected, given known market conditions. *N.B. Please see warning on page 16.*

	2000	2003	2004
Private purchase as a percentage of all home care delivered by independent providers	40%	27%	18%
Private purchase as a percentage of total home care delivered by all sectors	25%	No estimate	13%

The higher representation of sheltered housing and voluntary sector providers among respondents will have contributed to this effect, as they tend to provide a smaller proportion of private care (see table 8). *N.B. Please see warning on page 16.* However, the comparison may still be seen as valid, since the absolute number of privately funded hours reported in 2004 was 8% lower than in 2000, even though there were at least 50% more commercial respondents to the survey and the average volume of hours per respondent also rose.

On a similar technical point, 'Who Cares Now?' aimed to reach all organisations meeting the regulatory definition of home care. This now includes care provided in sheltered housing. Department of Health statistics on home care contact hours do not appear to have incorporated sheltered housing care provision (inclusion might be expected to have shown as a substantial 'step-change'). This suggests that the Government's figures for home care may be considerably understated, that in turn would have an effect on the grossed up estimates of hours in this survey.

However, these technical statistical factors are not thought sufficient to account for more than a small part of a very large apparent shift that may have significance for future market stability.

It can be argued that a healthy private purchase market is important to the overall health of the home care sector. Providers who are over-dependent on one (local authority) customer, or even 2-3 in an area, will be more vulnerable to changes in purchasing policy, will be less likely to innovate and may be less in touch with the real needs of service users. In the medium to long term, this might be expected to result in poorer services and less choice for local authorities as well as for private purchasers themselves.

Private care has been purchased from the independent sector since before the NHS began or community care policies were introduced, but a number of factors have come into play, in recent years, that might have been expected to lead to increases in this market.

The emphasis in community care policy guidelines on targeting people most in need has resulted in a steady fall in the number of people supported by local authorities after 1994, in spite of the increase in hours of care (see table 6 above).

Charging policies of local authorities have increased the number of people required to make a financial contribution towards the cost of their home care. Such contributions are now almost universal, are higher year on year and are reported sometimes to exceed the 'market rate' at which a private individual

could purchase care directly. At the same time, the financial resources of older people are said to be ever increasing.

There is continuing anecdotal evidence from providers that people are 'topping up' care purchased by local authorities by paying the home care provider directly for additional care, above the level eligible for support by social services departments. This also reflects an increasing tendency of social services departments to limit the tasks that care workers are permitted to carry out, and the time that they are allotted to carry out the remaining tasks.

The Department of Health statistics relating to the intensity of local authority arranged services reveal that the independent sector continues to provide a slightly higher average number of hours to service users than is provided by local authority direct services.

The difference has steadily reduced, since 1994, a statistical picture that might be expected, given that the intensity delivered by both sectors has increased and that an increasing proportion of services previously provided directly are now being purchased from independent providers.

A factor that continues to influence the figures for intensity of service is that overnight and live-in services, that involve very much higher than average hours, are almost exclusively provided by the independent sector (see table 9). This was apparent from previous Department of Health figures and has been confirmed by the UKHCA survey 'Commissioning Homecare' (2003) (ref. 6).

	All Sectors (1)	Local Authority direct provision	Independent sector provision
1993	3.5	3.4	4.6
1994	4.1	3.7	7.2
1995	4.7	4.0	7.5
1996	5.1	4.3	7.4
1997	5.4	4.5	7.6
1998	5.8	5.0	7.8
1999	6.3	5.2	8.1
2000	7.0	5.5	8.2
2001	7.5	6.0	8.4
2002	8.1	6.4	8.8
2003	8.6	7.0	9.1

Source: HH1 form, Tables 1, 2A, 2B and 3A (for 2000 onwards)
(1) Figures for 2000 onwards for All Sectors exclude double counting.
N.B. Households receiving home care purchased with a direct payment are excluded.

The results of the research confirm that independent sector home care remains a major employer of labour. The total number of people employed across all sectors of home care in England is thought to have fallen, over the last four years and is now estimated to be around 163,000. The proportion of these who work in the independent sector remains at 65%.

This survey appears to identify a reduction in the numbers of care workers employed by the independent sector, compensated for by an increase in the number of hours that each worker delivers.

The care worker numbers are calculated using the estimates of total home care hours and the average hours per worker reported by provider organisations. The local authority figures are drawn from 2003 staffing returns. The total comes to 163,000, including management and administrative staff.

The estimated number of independent sector home care workers (97,500) is not directly comparable to the number reported in 2000, when an adjustment was made for workers on providers' books but not working in the survey week, adding around 25% to that estimate.

However, it is believed that many of these 'irregular' or 'spare' workers available in 2000 will have already been pressed into service or will have left the sector. This presumption is supported by various factors:

- There was a reduction in the number of workers delivering small numbers of hours, suggesting that each available worker is being utilised more fully.
- Fewer than half the number of workers held more than one job, showing that fewer workers are moving from one provider to another to get work.
- Providers reported difficulty in recruiting adequate numbers of staff to maintain capacity to deliver service, suggesting that there are no 'spare' workers.
- Investment in more stringent recruitment checks and requirements for training may be considered too great, for workers to be only delivering small numbers of irregular hours.

In the light of the uncertainty, it was decided that the number of workers actually delivering care in the survey week was likely to be the more reliable basis for the current estimate.

The independent sector figures also include adjustment for workers working for more than one provider. The survey found that 6.5% of independent sector workers held more than one home care job. A handful (0.6%) of workers reported working for 3 or more providers. The total number of independent sector workers has therefore been abated to correct for this double counting. In 2000, the proportion holding 2 or more home care jobs was 14%.

The average care worker's week reported by provider organisations was 26 hours. The care worker respondents themselves reported a slightly higher figure of 30 hours . In 2000 provider organisations reported an average of 21 hours and care worker respondents, 27 hours

In the earlier survey, this difference was taken to indicate that the care worker respondents tended to be drawn more from among the 'full-timers' in the workforce. While this may again be true, travel time could be another relevant factor, with employers counting only service user contact hours and workers counting total time out working.

The variation of hours worked appears to have narrowed. Only 55% of workers reported working less than 30 hours per week, compared to 60% in 2000 and only 6% reported working more than 50 hours, compared to 10% in 2000. A handful of workers still reported extremely long hours (1.3% greater than 70 hours) but it should be remembered that this includes live-in workers, who may report hours on site, rather than hours actually worked. *N.B. Please see warning on page 16.*

In contrast to the reduction in care worker numbers, there appears to have been a slight increase in numbers of administrative staff, and a marked reduction in the numbers of people holding the title of manager (see table 10). It is suspected that these roughly compensatory shifts reflect a tendency to report only the Registered Manager, as a manager and to describe anyone else as 'administrative', even if their duties include managerial responsibilities.

(Figures in brackets from 2000 survey)

LA home care workers	49,500	(64,500)
Independent sector home care workers	97,500	(121,500)
LA home care managers and administrative staff	7,000	(7,000)
Independent sector home care managers and administrative staff	9,000	(9,500)
Total workers	163,000	(202,500)

N.B. Figures have been rounded to the nearest 500

Local authority numbers (2003 survey) – source; Local Authority Employers Organisation

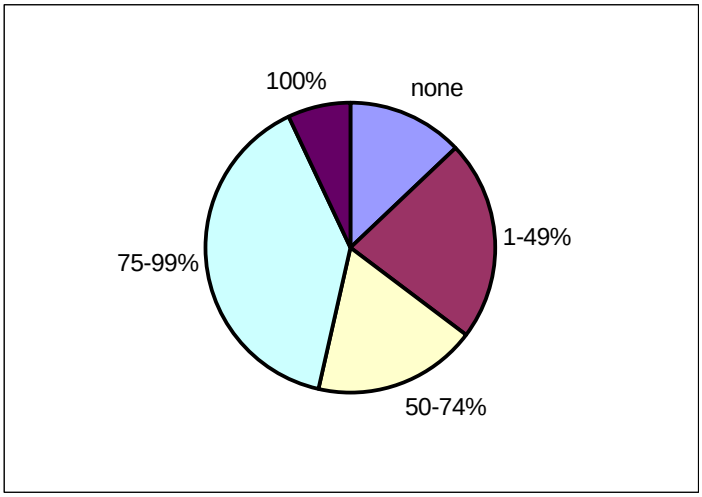
SECTION FOUR
Independent Sector Home Care Providers

The providers that responded to the survey varied widely in size and the service user groups they worked with. The extent to which respondents were dependent on local authority purchasing was substantially greater, compared to 2000. However, it should be remembered that the profile of the sample was very different, including many more not-for-profit organisations, including sheltered housing providers.

The number of small providers remained

60% of the providers were reliant on local authorities for more than three-quarters of their business. Indeed, 14.5% worked solely for local authorities and this included a quarter of the small providers (see figure 3). The equivalent figure was 46% in 2000. *N.B. Please see warning on page 16.*

The UKHCA survey 'Commissioning Homecare' in 2003 (ref. 7) reported that only 39% of independent providers provided care to more than one local authority. With the apparent reduction of private client work as a 'fall-back', a good proportion of these providers are vulnerable to the purchasing policies of their local social services departments, who are known to be reducing the numbers of providers from whom they purchase.



See table 12 below (all providers) for data on numbers of respondents

The smallest providers (those providing fewer than 500 hours a week) were still the most likely not to work with local authorities at all but the proportion was reduced to 13% compared to 19% in 2000 (see table 12).

	Size of provider (hours of care provided)			
Percent of hours that are LA purchased	fewer than 500 hours (Frequency)	500-999 hours (Frequency)	1000 hours and over (Frequency)	All providers (Frequency)
None	13% (27)	4% (4)	3% (4)	8% (35)
1-24%	4% (8)	3% (3)	3% (4)	3% (15)
25-49%	13% (27)	6% (6)	6% (8)	9% (41)
50-74%	19% (39)	21% (21)	13% (16)	18% (76)
75-99%	27% (563.3( )-464.6(2)4.6(1)l08-1.2(%)-656.3(()TJ24.098 0 TD0.0007 Tc0.0061			

Table 13 provides the same data but presented with the same breakdown as given in the 2000 survey report, to enable comparison. *N.B. Please see warning on page 16.*

	Size of provider (hours of care provided) (figures in brackets from 2000 survey)			
Percent of hours that are LA purchased	fewer than 500 hours	500-999 hours	1000 hours and over	All providers
None	13% (19%)	4% (10%)	3% (8%)	8% (13%)
1-49%	17% (18%)	9% (27%)	9% (23%)	12% (22%)
50-74%	20% (20%)	21% (22%)	13% (16%)	18% (18%)
75-100%	50% (44%)	66% (42%)	75% (52%)	62% (46%)
Base numbers	206	97	129	432

Number of respondents = 432 (Missing Data 106)

Voluntary / not-for-profit providers were even more reliant on local authority purchasing than the commercial providers. Almost 90% of the total hours delivered by the voluntary / not for profit sector were for local authorities and three quarters of the organisations who reported working exclusively for local authorities were voluntary / not for profit (table 14).

	Private/commercial 357 respondents	Voluntary/not for profit 168 Respondents
Purchased by local authorities	73%	87%
Privately purchased	21%	9%
Purchased by NHS	6%	4%
	100%	100%

Number of Respondents = 525 (Missing Data 13)

Regional variations were more apparent than in 2000, with providers in the South East least likely to be heavily dependent on local authority purchase. (see table 15) Those reporting no work at all with local authorities were quite evenly spread across all regions. *N.B. Please see warning on page 16.*

	Respondents heavily dependent on local authority purchase - defined as 75-100% of total hours (N=359)	
Region	Proportion of Respondents	Number of Respondents
South East	45%	74
West Midlands	51%	39
South West	54%	50
East of England	61%	36
North East	68%	22
Yorks & Humber	75%	24
North West	76%	49
London	78%	40
East Midlands	80%	25

Providers were asked to indicate whether the care they provided was practical or personal care. It is acknowledged that home care workers often provide a mix of services and it may not have been easy to quantify how many hours were provided for each category of care. However, it is clear that most providers participating in the survey still work predominantly with people requiring personal care.

Practical care hours represented 22% of total hours reported, compared to 15% in 2000. This increase might have been expected to be greater, given the introduction of the 'Supporting People' initiative and the appearance of sheltered housing providers (only recently included in the definition of home care) as a more substantial group of respondents (ref. 14). *N.B. Please see warning on page 16.*

Respondents were asked which groups of service users they provided care for and whether they would describe their service as 'specialist' to a particular client group (see table 16).

A wide range of service user groups were identified and, in most cases, respondents provided service to several groups. Services for older people and those with physical disabilities were the most commonly provided, at around 85%. Children (24%), people with infectious or contagious diseases (27%) and those who abuse drugs or alcohol (30%) were less often served.

The numbers of respondents reporting that their service provision constituted 'specialist' care was considerably lower, on average less than 37% of the number offering generic services. This response was remarkably consistent between all the groups. Indeed the lowest proportions of specialist services seemed to occur where provision to a particular group might be expected to be 'specialist' by definition, such as substance abuse (27%) and communicable diseases (26%). The response also confirms previous concerns that people with sensory impairment, while very commonly offered service, are unlikely to receive specialist care.

Older people	86%	(n=465)	Older people	41%	(n=222)
People who are elderly, mentally infirm	74%	(n=399)	People who are elderly, mentally infirm	29%	(n=157)
People with dementia	79%	(n=426)	People with dementia	32%	(n=174)
People with a physical disability	85%	(n=459)	People with a physical disability	33%	(178)
People with a learning disability	64%	(n=346)	People with a learning disability	30%	(n=164)
People with mental health problems	62%	(n=333)	People with mental health problems	22%	(n=118)
People who abuse drugs, alcohol etc.	30%	(n=161)	People who abuse drugs, alcohol etc.	8%	(n=43)
People with infectious / contagious diseases	27%	(n=144)	People with infectious / contagious diseases	7%	(n=39)
Children	24%	(n=130)	Children	11%	(n=61)
Young offenders	2%	(n=11)	Young offenders	1%	(n=4)
People who have a sensory impairment	65%	(n=349)	People who have a sensory impairment	18%	(n=99)
People from minority ethnic groups	52%	(n=279)	People from minority ethnic groups	16%	(n=88)

N=538 NB. More than one category will have been ticked by each organisation

37% of providers used fewer than 20 home care workers in the survey week, compared to only 25% in 2000. The number of providers deploying over 50 workers fell sharply (see table 17). This is further evidence that the overall number of workers may be lower but that each one is busier. *N.B. Please see warning on page 16.*

Number of workers deployed	Percent of providers 2004	Number of providers 2004	Percent of providers 2000
1-19	37%	186	25%
20-49	37%	186	36%
50-99	16%	85	24%
100 and over	10%	53	15%

Number of Respondents = 510 (Missing Data 28)

23 organisations reported that they used unpaid volunteers to deliver home care services, including one organisation with 5 branch outlets and 600 volunteers, delivering 6000 hours a week. These responses suggest that as many as 7,500 unpaid volunteers may be working in home care services nationally.

Providers were asked what other care services they provided, in addition to personal home care (see table 18). Half (262) of the respondents identified one or more additional service. It is acknowledged that some of the services mentioned have considerable 'crossover' with home care generally. For example, 'short breaks and respite' may simply mean a short period of home care service.

Service	Number of providers	Percent of providers
No additional services	266	50%
Nursing Agency	50	9%
Meals on wheels	25	5%
Care Home	68	13%
Care home with nursing	36	7%
Short breaks/respite	102	19%
Sheltered/very sheltered/extra care	48	9%
Day care	94	18%
Other – the most prominent		
Carer support	16	6%
Other housing support	19	7%
Information & advice services	15	6%
Domestic services – all types	26	10%

Number of Respondents = 528 (Missing Data 10)
NB: Some respondents reported more than one additional service

SECTION FIVE
The Home Care Workers and Registered Managers

The home care workers who responded to the survey had a wide range of experience in paid and unpaid care work. Less than 10% were male and the average age was 42. 55% worked part time.

In comparison, slightly more Registered Managers were male (10.5%) the average age was slightly higher at 44 and only 13% of them worked part time. The average week worked was reported at 40 hours.

Much of the care that independent sector home care workers now provide is highly skilled, and would have been provided by qualified nurses in the past. The workers often provide this care in difficult conditions, working in isolation with people who are vulnerable and highly dependent, with limited time to undertake the tasks assigned.

They may have to handle the challenging behaviour of service users, and cope with emergencies that arise, including the death of people they care for. However, little is known about this group of workers, who are providing such an important service.

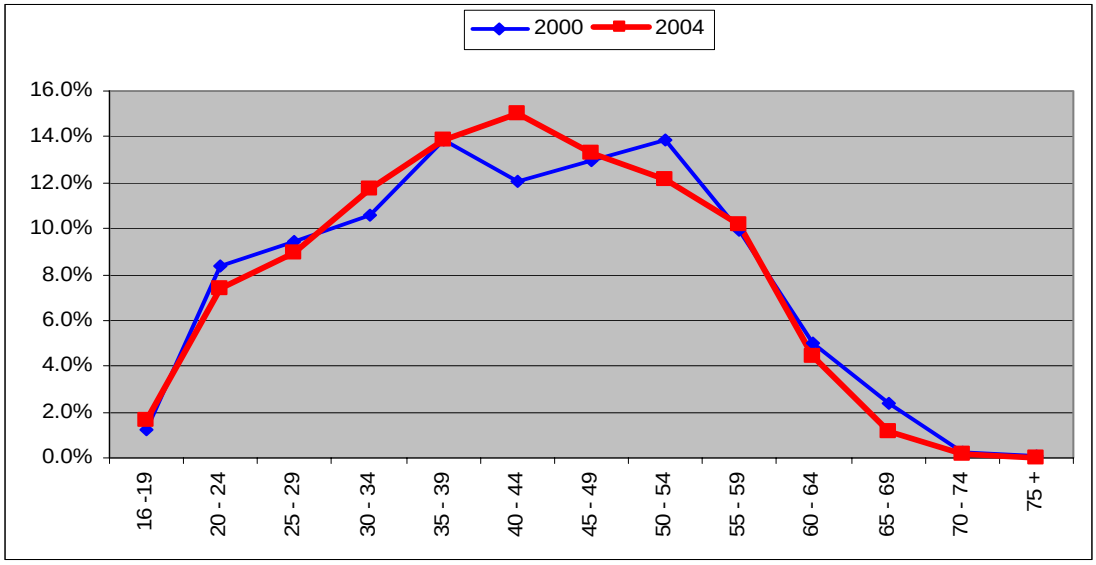
The vast majority of respondents to the care worker survey (91%) were women, although the proportion of male care workers has almost doubled, since 2000 (see table 19). A slightly higher proportion of respondents to the Registered Manager survey (10.5%) were men.

Gender	Care workers 2004 (n=2861)		Care Workers 2000 (n=1287)		Reg. Managers 2004 (n= 551)	
Male	248	(8.7%)	70	(5.4%)	58	(10.5%)
Female	2613	(91.3%)	1217	(94.6%)	493	(89.5%)

The average age of the home care workers who responded to the survey was unchanged, at forty-two years. The age distribution was roughly normal, with workers under 30 years old at 20% and those 50 or over at 25% (see table 20 and figure 4). N.B. The choice of these workers was left up to the employer and may or may not have introduced some selection bias eg. giving it to their most qualified/longest serving staff.

Age group	Percent of workers 2004 (n=2820)	Percent of workers 2000 (n=1278)	Number of workers 2004	Number of workers 2000
16 -19	1.6%	1.3%	46	16
20 - 24	7.4%	8.4%	209	107
25 - 29	8.9%	9.5%	252	121
30 - 34	11.7%	10.6%	330	135
35 - 39	13.9%	13.8%	391	177
40 - 44	15.0%	12.1%	423	154
45 - 49	13.3%	13.0%	374	166
50 - 54	12.2%	13.8%	343	177
55 - 59	10.2%	9.9%	287	127
60 - 64	4.5%	5.0%	126	64
65 - 69	1.2%	2.3%	33	30
70 - 74	0.1%	0.2%	4	3
75 +	0.0%	0.1%	1	1

Number of Respondents 2004 = 2820 (Missing Data 75)



See table 20 above for data

This 'steady-state' could be taken to suggest that fears of an 'ageing' workforce were unfounded. However, there is some suggestion in the data that the proportion of workers over the age of 50 has reduced, especially those of pensionable age.

Older service users generally express a preference for older care workers and Government policy is to enable and encourage older people to extend their working lives or to re-enter economic activity. Other evidence from this survey suggests that the workforce is suffering a reduction in overall size.

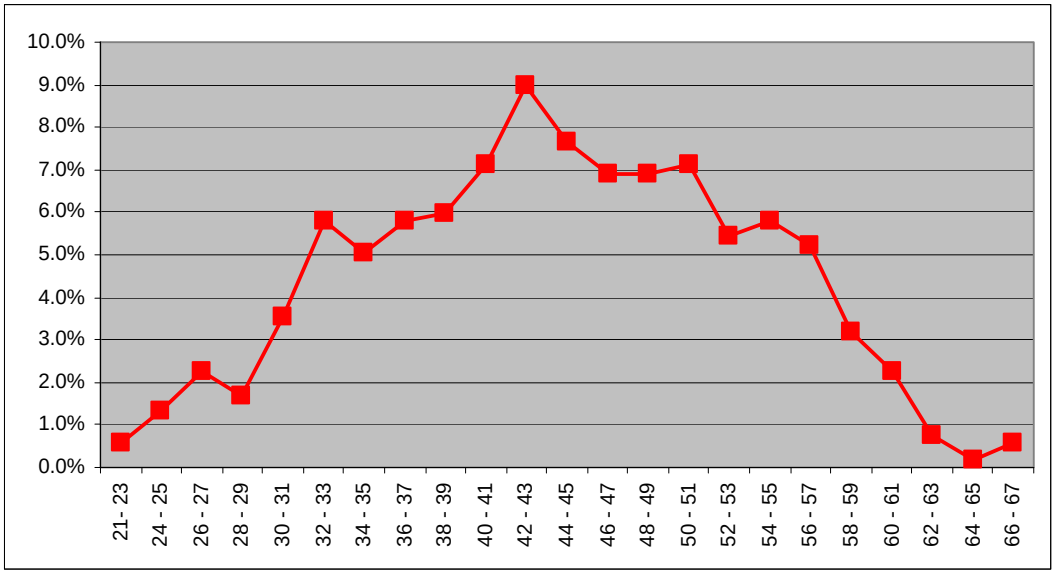
In this context, reduction in any group of workers should not be viewed with equanimity and it will be important for more work to be undertaken to confirm whether older workers are indeed leaving.

One generally perceived factor is the introduction of mandatory qualification based training - a resistance to 'going back to school'. This perception is supported by the lower prevalence of over-50s, compared to other age groups, among respondents who were 'working towards' an NVQ and by the somewhat lower importance placed by over-50s on training. If this factor is indeed significant, care providers will need strong support to overcome the resistance.

The average age of Registered Managers was only slightly higher than for care workers at 44 (see table 22). Again, there was an even distribution of age, with an equal 15% more than ten years above and below this average figure (see figure 5). The youngest Registered Manager respondent was 21 and the oldest 66.

Age group	Number of Registered Managers 2004	Percent of Registered Managers 2004
Under 30 years	31	5.8%
30-39 years	140	26.2%
40-49 years	201	37.6%
50 years and over	20	3.7%

Number of Respondents 2004 = 535 (Missing Data 26)



11.5% of the care workers who responded were from black and minority ethnic backgrounds, an increase over the 6.5% reported in 2000. The new result

suggests that such workers are rather over-represented in the care workforce, compared to the proportion of the national population (7.9%). *N.B. Please see warning on page 16.*

Table 23 offers further detail, showing a slight under-representation of Asian and Asian-British workers but a proportion of Black and Black British workers that is three times the national average.

Ethnic origin	2004 % of workers (Frequency)		2000 % of workers (n=1281)	(Census data 2001 - ONS)
Asian / Asian British	3.2%	(90)	0.9%	4.0%
Black / Black British	6.1%	(172)	3.7%	2.0%
Mixed	1.3%	(38)	0.9%	1.2%
Chinese / Other	0.8%	(23)	0.9%	0.8%
White	88.6%	(2,520)	93.5%	92.1%

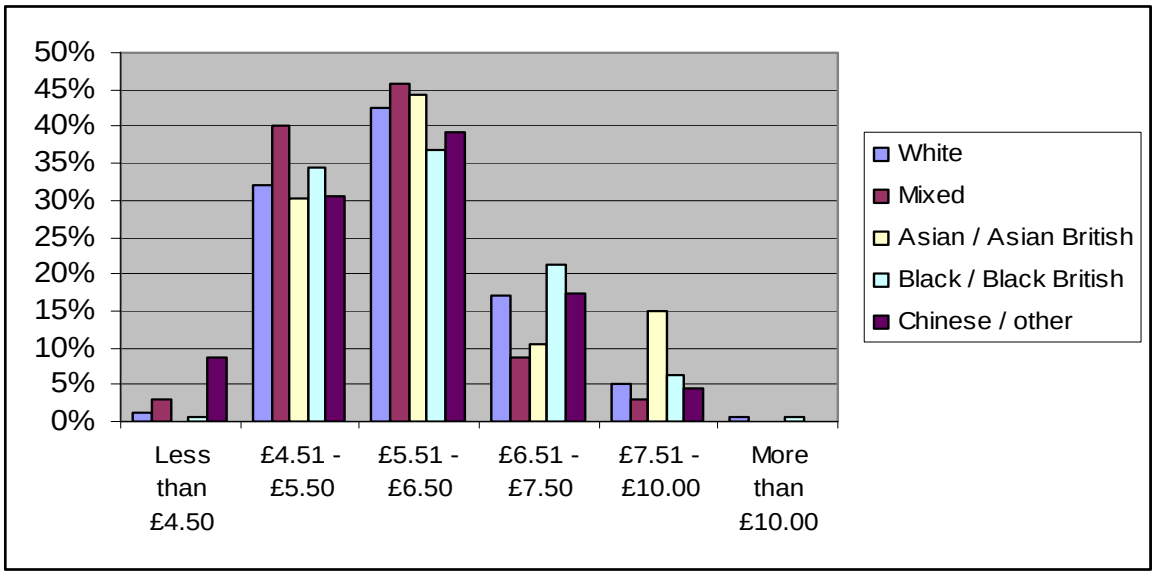
Number of Respondents = 2843 (Missing Data 52)

These national averages, however, are an oversimplification. There was a relatively lower response rate from London and other metropolitan areas where the proportion of the population from black and minority ethnic backgrounds is known to be higher. In spite of this, 60% of all respondents identifying themselves as from an ethnic minority were from the London region alone (see table 24).

Region	Mixed	Asian /Asian British	Black / Black British	Chinese / other	White
North West	0.93%	0.93%	0.62%	0.62%	96.89%
North East	0.44%	0.00%	0.00%	0.00%	99.56%
Yorkshire and Humberside	0.00%	1.31%	1.96%	0.00%	96.73%
East Midlands	1.18%	2.96%	1.78%	0.00%	94.08%
West Midlands	3.11%	4.44%	4.89%	0.44%	87.11%
East	0.40%	4.84%	5.24%	0.40%	89.11%
London	5.37%	14.05%	36.78%	4.13%	39.67%
South East	0.25%	0.50%	1.50%	0.25%	97.50%
South West	0.67%	0.00%	0.67%	0.67%	97.99%
Base numbers	30	68	129	17	2041

Number of Respondents = 2285 (Missing Data 610)

There was little connection between black and minority ethnic background and pay rates (see figure 6). An apparent feature was that low pay rates were reported by a higher proportion of respondents from Mixed Origins than the average for all groups and high pay rates correspondingly less often. Caution should be exercised with this result, however, due to the large statistical impact of one or two responses on the small number of respondents in each minority group. See table 25 below for the relevant data.



White	30	768	1021	410	119	17	2395
Mixed	1	14	16	3	1	0	35
Asian / Asian British	0	26	38	9	13	0	86
Black or Black British	1	55	59	34	10	1	160
Chinese or other ethnic group	2	7	9	4	1	0	23
Total	34	900	1143	460	144	18	2699

The average age of respondents from Black and Asian minorities was identical to the overall average at 42. Respondents identifying with Mixed Origins and 'Chinese or other' averaged only 35, seven years younger.

The proportion of workers reporting that English was not their first language does not, of course, directly compare with those reporting minority ethnic origins,

although there will be a degree of connection. 7.6% of workers reported a total of 34 different 'first' languages, the most frequently cited being from the Indian sub-continent or southern Africa.

Around 1.6% reported European first languages, the most common being Spanish, French and German. Only 0.25% of respondents cited languages from the new EU accession countries, suggesting that home care providers are not yet actively recruiting from those areas, as speculation had suggested. Languages from another commonly discussed source of labour for the care sector, the Philippines, accounted for 0.4% of respondents.

People from all black and minority ethnic groups were less well represented among respondents to the Registered Manager survey, only 7% in total, compared to 11% among care workers (see table 26). The smaller numbers of respondents make analysis by region unreliable.

Ethnic origin	% of Registered Managers (n=549)		National Population (Census data 2001 - ONS)
Asian / Asian British	2.4%	(13)	4.0%
Black / Black British	3.3%	(18)	2.0%
Mixed	0.9%	(5)	1.2%
Chinese / Other	0.7%	(4)	0.8%
White	92.7%	(509)	92.1%

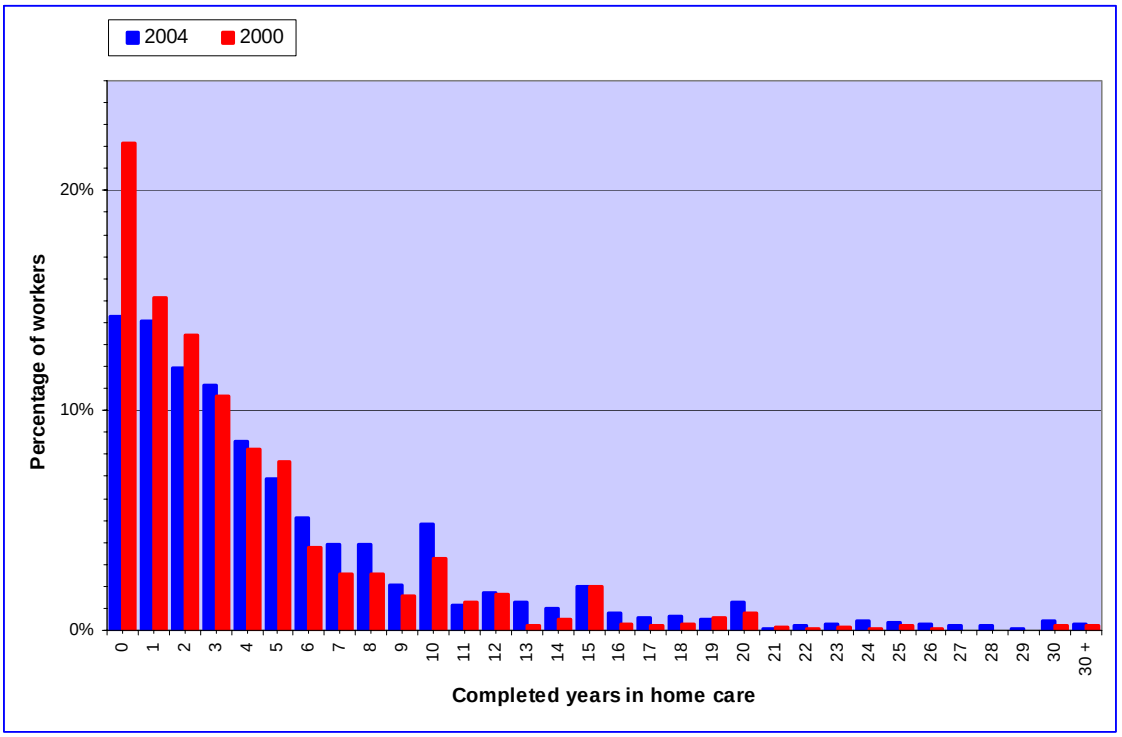
Only 3% of Registered Managers identified first languages other than English. Only two of the language groups were specified by more than one of the respondents.

1.5% of care workers considered themselves to have a disability. Less than half specified the nature of the disability. Of those, half had hearing difficulties, and a quarter had problems with joints, limbs or muscles. Nothing else was reported by more than 2 care workers. A similar proportion of Registered Managers considered themselves to have a disability, of which half reported difficulties with walking. *N.B. Please see warning on page 16.*

The average length of time that respondents had worked as a care worker was considerably greater, at 5.3 years, (4 years in 2000) and a higher proportion, at 35%, had completed 5 years (30% in 2000). The median figure, at just under 3 years, reflected the 40% of workers who had been in home care for fewer than two years.

The welcome nature of the changes in these proportions should be seen in context, however. They are largely a statistical consequence of the large fall in the number of new recruits.

There remained a long 'tail' of workers with many years experience, a handful of the respondents reporting over 30 years and two over 40 years (see figure 7). The longest time reported was 46 years – a working life worthy of congratulations in any sector!



In interpreting this data, it is important to recall that the introduction of the Community Care Act, just over 10 years ago, heralded the start of a major expansion in independent sector home care. The numbers of workers recruited in the years since then may be expected to have grown accordingly.

This should account for the 'step change' in numbers of workers reporting 10 years or less in home care, even ignoring the impact of those who clearly reported round numbers of 10, 15 or 20 years.

Completed years	Percentage of workers 2004	Percentage of workers 2000	Number of workers 2004	Number of workers 2000
Less than 1	14.3%	22.1%	402	283
1	14.0%	15.1%	395	193
2	11.9%	13.5%	336	172
3	11.1%	10.6%	313	136
4	8.6%	8.2%	242	105
5	6.8%	7.7%	193	98
Total 0 - 5	66.7%	77.2%	1881	987
6 - 10	19.7%	13.8%	556	176
11 - 15	7.1%	5.6%	199	71
16 - 20	3.6%	2.2%	102	28
21 - 25	1.3%	0.7%	37	9
26 - 30	1.1%	0.3%	31	4
Over 30	0.2%	0.2%	7	3
Total			2813	1278

Only 14% of the workers had been working in the sector for less than a year, sharply down from the 22% reported in 2000 (see table 27). These most recent recruits were the only cohort for whom there was any substantial change. For example, the figure for those in home care between one and two years was almost unchanged at 14% (15% in 2000). *N.B. Please see warning on page 16.*

This may be further evidence that the number of new workers being recruited by providers has dropped very recently, coinciding with the introduction of new standards for recruitment and training. Whether this is due to reluctance on behalf of the workers or of the employers (or whether there are other causes) cannot yet be identified. It could, for example, be worrying further evidence that recruitment is becoming more difficult.

It will be important to identify whether the reduction in recruitment in the 12 months leading up to the survey becomes a sustained trend. If it feeds through to decreasing rates of turnover and if all that is lost are those workers who would otherwise have left inside the first year, then it will be taken as a welcome improvement for continuity. However, the sector can ill afford to lose any source of capacity.

The picture remains that a substantial section of the workforce is in home care for relatively short periods and reinforces the information from providers about the difficulties with recruitment and turnover.

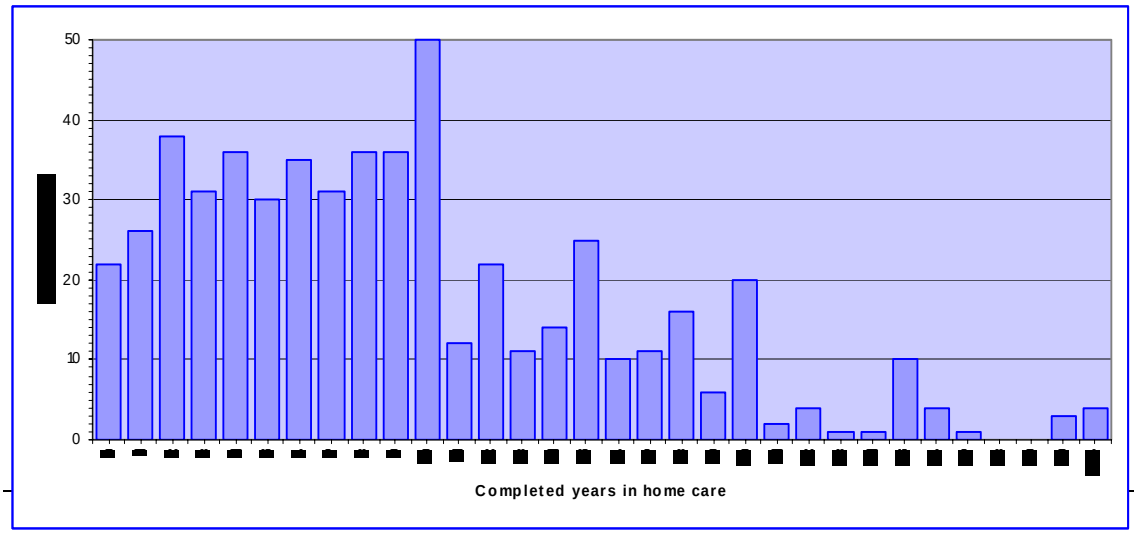
However, many workers new to home care had previous experience in other types of formal or informal care, as we will see below, so new recruits to home care do not necessarily represent unqualified or inexperienced workers. It is also important that 70% of workers had worked in home care for another organisation, prior to their current job.

The average length of time that Registered Manager respondents had worked in home care was 10 years and the distribution was substantially different from that for care workers (see table 28 and figure 8).

A far smaller proportion had been in home care for 2 years or less (4% compared to 40% for care workers. Two thirds of Registered Managers reported having been in home care for 10 years or less. This group were quite evenly spread across the years.

Completed years	Percentage of Managers	Number of Managers
Less than 1	4.0%	22
1	4.7%	26
2	6.9%	38
3	5.7%	31
4	6.6%	36
5	5.5%	30
Total 0 - 5	33.4%	183
6 - 10	34.3%	188
11 - 15	15.3%	84
16 - 20	11.5%	63
21 - 25	3.3%	18
26 - 30	1.5%	8
Over 30	0.7%	4
Total		548

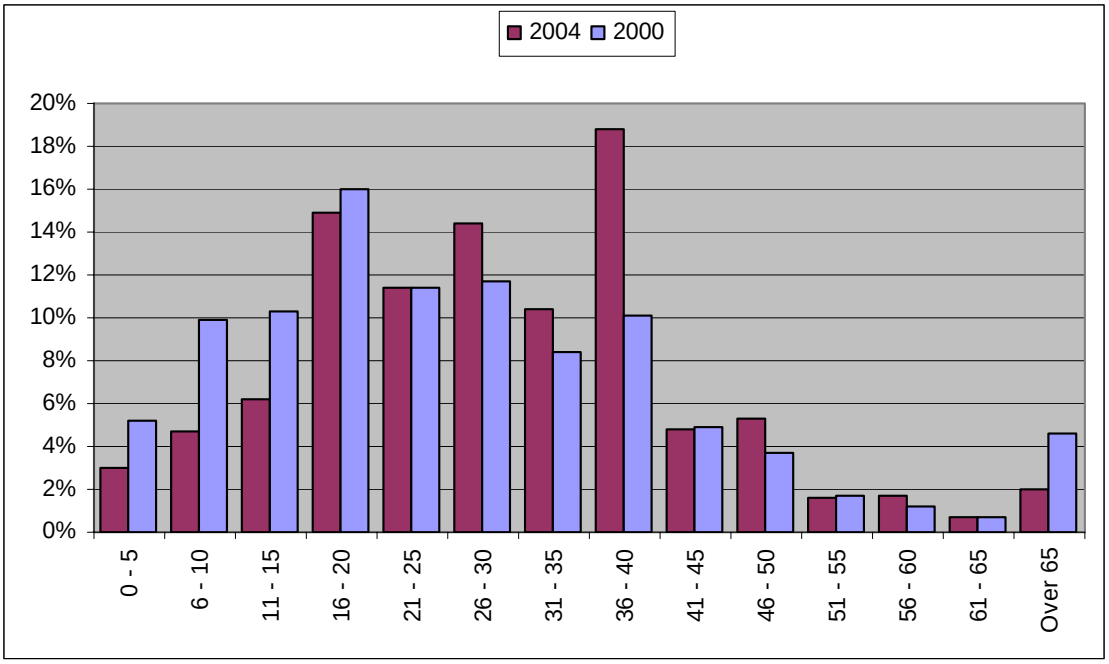
Even more noticeably than with care workers, the introduction of the Community Care Act (1990) created a 'step change' with substantially lower numbers of Registered Managers reporting 10 years or more in home care. Again, there was a tendency to report round numbers of years.



The care worker respondents reported working an average of 30 hours (27 in 2000) in the last seven days (see table 29). The provider organisations reported a slightly lower figure of 26 hours (21 in 2000). In the earlier survey, the difference was taken to indicate that the care worker respondents tended to be drawn more from among the 'full-timers' in the workforce. While this may be true, travel time could be another relevant factor, with employers counting only service user contact hours and workers counting total time out working.

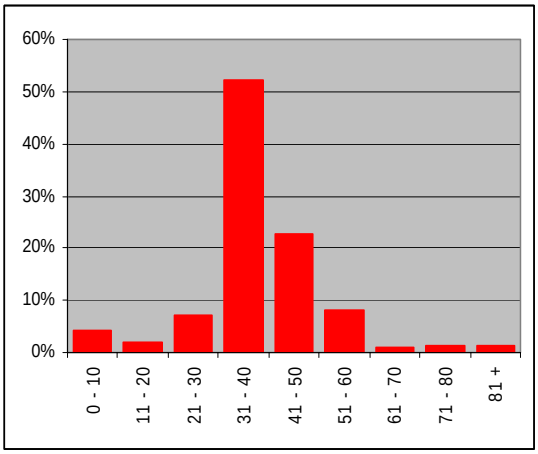
Hours worked	2004 care workers (%)	2000 care workers (%)	2004 care workers (frequency)	2000 care workers (frequency)
0 - 5	3.04%	5.21%	80	63
6 - 10	4.72%	9.92%	124	120
11 - 15	6.24%	10.33%	164	125
16 - 20	14.95%	16.03%	393	194
21 - 25	11.41%	11.40%	300	138
26 - 30	14.42%	11.74%	379	142
31 - 35	10.38%	8.43%	273	102
36 - 40	18.75%	10.08%	493	122
41 - 45	4.75%	4.88%	125	59
46 - 50	5.29%	3.72%	139	45
51 - 55	1.60%	1.74%	42	21
56 - 60	1.75%	1.16%	46	14
61 - 65	0.68%	0.74%	18	9
Over 65	2.02%	4.63%	53	56
Total			2629	1210

The variation of hours worked appears to have narrowed (see figure 9). Only 55% of care workers reported working 30 hours in the week or less, compared to 65% in 2000; only 6% reported working more than 50 hours, compared to 10% in 2000. A handful of workers still reported extremely long hours (1.3% greater than 70 hours) but it should be remembered that this includes live-in workers, who may report hours on site, rather than hours actually worked. *N.B. Please see warning on page 16.*



Registered Managers, averaged 40 hours in the week but this average obscures a surprising reported range, from 0 – 99 hours (see table 30 and figure 10). 13% of Registered Managers fell below the official definition of 'part-time', working less than 30 hours. In fact, 21 managers (4% of those who responded to this question) reported working less than 10 hours in the week. Some of these may have reported days of leave very literally - as not working. In contrast, 12% reflected the stereotype of small business managers, working more than 50 hours.

Hours worked	% of Reg. Managers	Number of Managers
0 - 10	4.09%	21
11 - 20	1.95%	10
21 - 30	7.02%	36
31 - 40	52.24%	268
41 - 50	22.81%	117
51 - 60	8.19%	42
61 - 70	0.97%	5
71 - 80	1.36%	7
81 +	1.36%	7
	Total	513



Only 6.5% of the workers had delivered home care for more than one provider in the previous week, down from 14% in 2000 (see table 31). Of these, only 0.6% of the total worked for three or more organisations (2% in 2000). This is evidence that more people are concentrating their care work with just one provider, rather than signing on with a number of organisations and taking hours on a casual or ad-hoc basis, supporting the view that 'floating' workers are largely disappearing.

Type / number of additional job(s)	Care workers 2004 (%) (n=2895)	Care workers 2004 (frequency)	Care workers 2000 (%) (n=1292)	Care workers 2000 (Frequency)
2 home care jobs	5.9%	171	12%	155
3 or more home care jobs	0.6%	18	2%	26
Other health / care jobs	3.2%	92	9%	120
Non-health / care jobs	1.1%	31	8%	97
Not specified	6.6%	192	3%	37

11% of respondents indicated that they had second paid jobs (not counting second home care jobs). Again, this was less than half the figure reported in 2000. The majority of second non-home care jobs specified were in health or social care, although many respondents did not specify the type of work. The most frequently reported second jobs included:

- NHS worker / nurse etc
- Care coordinator / assistant / agency care work
- Cleaning / domestic help
- Supervisor / manager / administrator
- Support worker

Respondents were asked to indicate categories of work or experience they had gained that were relevant to home care work. Over one-half of the workers indicated that they had past experience as a care assistant, one-third had experience of caring for a relative or friend, one-eighth had worked as a hospital auxiliary and 30% had other relevant experience that might be considered relevant. Fewer reported being qualified nurses. At 3.2% this was down from 8% in 2000. *N.B. Please see warning on page 16.*

SECTION SIX
Recruitment and Turnover

With reductions in unemployment and in the number of people of working age in the general population, it is becoming increasingly difficult for all employers to recruit sufficient staff. Changes in requirements around recruitment checks and training have complicated the picture for home care providers. We continue to receive reports of organisations unable to take on work because they do not have sufficient numbers of home care workers.

Problems with recruitment are affecting all sectors, especially in areas of high employment. Of particular importance to home care, is that women who want flexible working patterns have a greater range of choices available to them. For example, the NHS has responded to the shortage of nurses by launching recruitment campaigns and by introducing flexible work patterns to encourage women with families to return to nursing.

Shortly before this survey was undertaken, there was a high profile Department of Health campaign to attract people into social care, in which the work shown was predominantly home care. This campaign is known to have drawn interest from tens of thousands of potential recruits but it is not yet clear what impact it has had on provider recruitment.

In the National Minimum Standards for home care and in the Topss England National Training Strategy for the social care workforce, there is recognition that workforce planning is central to any recruitment, retention and training programme. For largely historical reasons, much of the home care sector has not previously undertaken such planning.

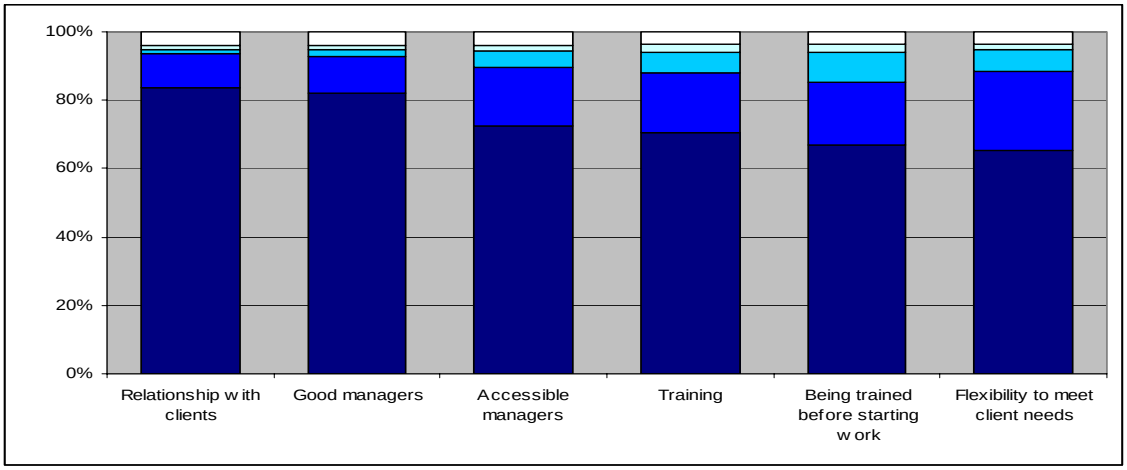
In home care provision, there is no fixed number of workers needed and the concept of a 'vacancy' is largely meaningless. Providers recruit on a continuous basis to get as many workers as possible, especially when the labour market is so restricted. They utilise all their available workers.

Often, they have not kept a 'headcount' of workers used. The most common performance indicators are based on service user contact hours and it has been seen as irrelevant whether the workers deliver one hour or a hundred per week. Such extremes were not uncommon in the past but it is notable, from this survey, that both very long and very short hours are becoming rarer.

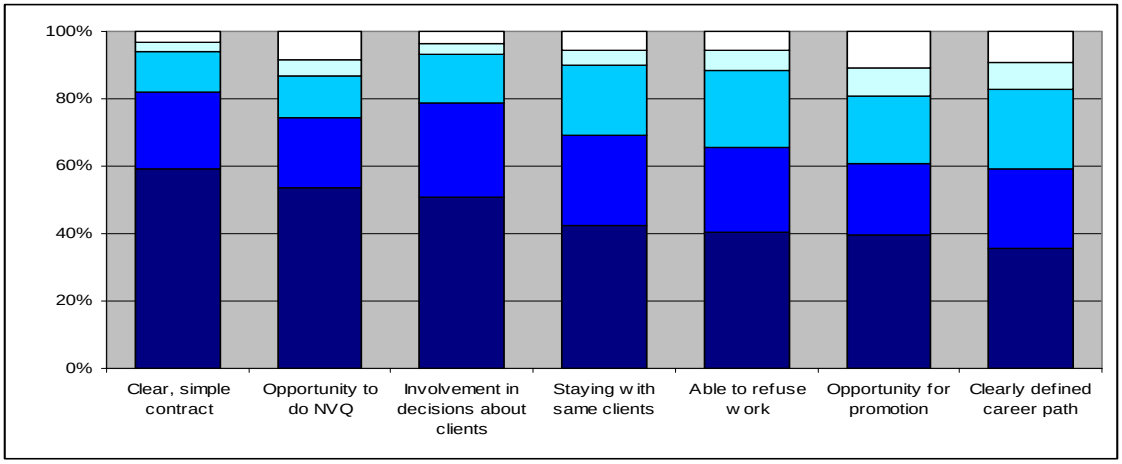
The situation was further confused, for some parts of the sector, because of their origins in provision of temporary staff. For these organisations, workers routinely swap between hospital, care home and home care work, as work is available. As a result, even payroll data is unhelpful in identifying numbers of workers or hours of work in a particular role.

The social care sector workforce generally is expected to require continued growth over the next few years to address the rise in demand. Home care might

1. Your relationship with your clients
2. Good managers
3. Being able to get hold of managers easily
4. Training
5. Being trained before you start work
6. Flexibility to do what your client wants or needs
7. Clear and easily understood contract
8. Opportunity to undertake an NVQ/SVQ qualification
9. Being involved in decisions about clients or work
10. Staying with the same clients
11. Being able to say 'no' to work
12. Opportunity to progress to senior care worker or higher
13. Clearly defined career path



Factors offered were scored by importance on a scale of 1 to 5. In figures 12 and 13, higher scores are represented by darker colours.



Of all these pre-employment and in-work motivation factors, only a few showed any real relationship with the age of the respondents. Of those few factors, it will be seen from the list below that several had not scored highly, anyway.

- Younger workers tended to value the opportunity of a pathway into nursing more highly (second lowest importance score of the pre-employment set).
- After the age of 35, a progressive reduction in importance began to be assigned to the opportunity to progress to a more senior position (lowest importance score of the in-work set).
- At age 40, a slight reduction in importance is observed in the importance assigned to a clearly defined career path and this becomes rapidly less important after age 55 (second lowest importance score of the in-work set).
- At age 50, a steady reduction in importance began to be assigned to the opportunity to do an NVQ.
- At age 55, the same reduction in importance began to be assigned to the importance generally of training, although this group still rated training before starting work in home care just as highly as other age groups.

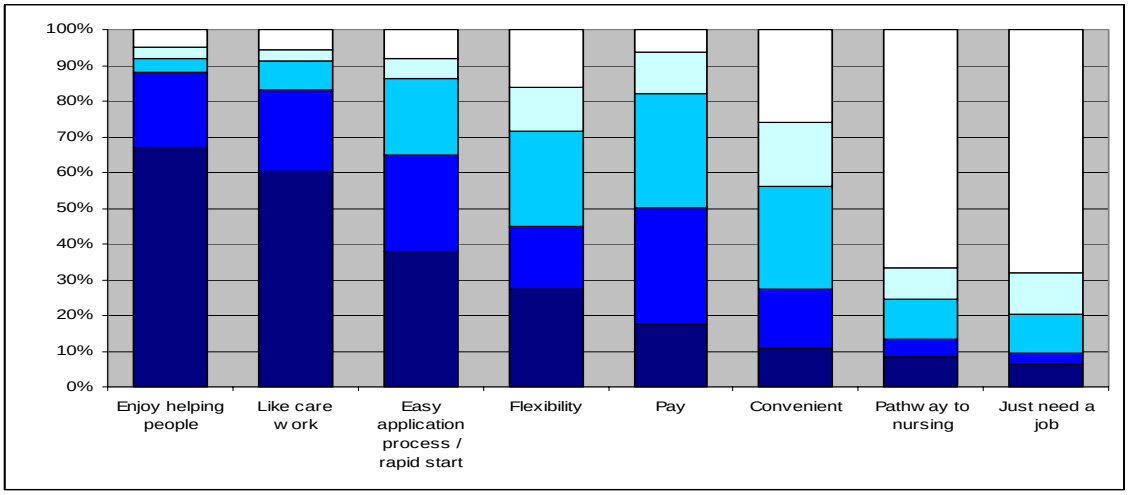
These last two factors reinforce the concern that older workers are less willing to undertake training.

We are unable to resist commenting that the only age related link that appeared across all motivation factors was the tendency for 16-20 year olds not to place as much importance on anything as the other respondents.

The data on which the figures above are based appear in Appendix 2.

Registered Managers were asked the same questions about how important various factors had been, in choosing their job (see figure 14). Some of the factors were clearly of less importance to managers, than they had been to care workers but the order was almost identical. Managers ranked the factors offered in the following order:

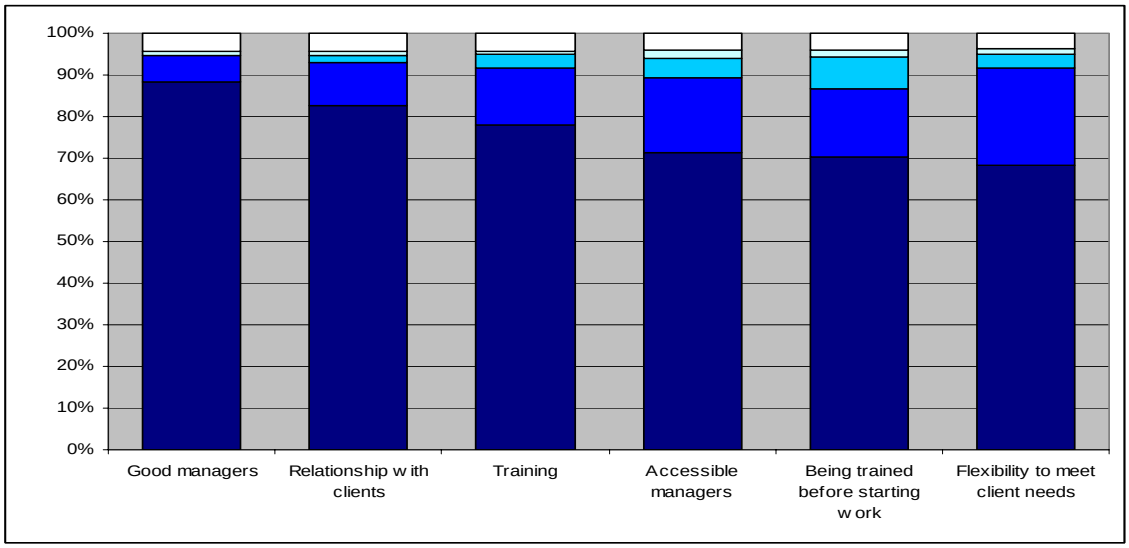
1. Enjoy helping people
2. Like care work
3. Easy, quick application process and a rapid start to work
4. Flexibility to fit around other commitments
5. Pay
6. It was convenient
7. It provides a way into a career in nursing
8. Just needed a job



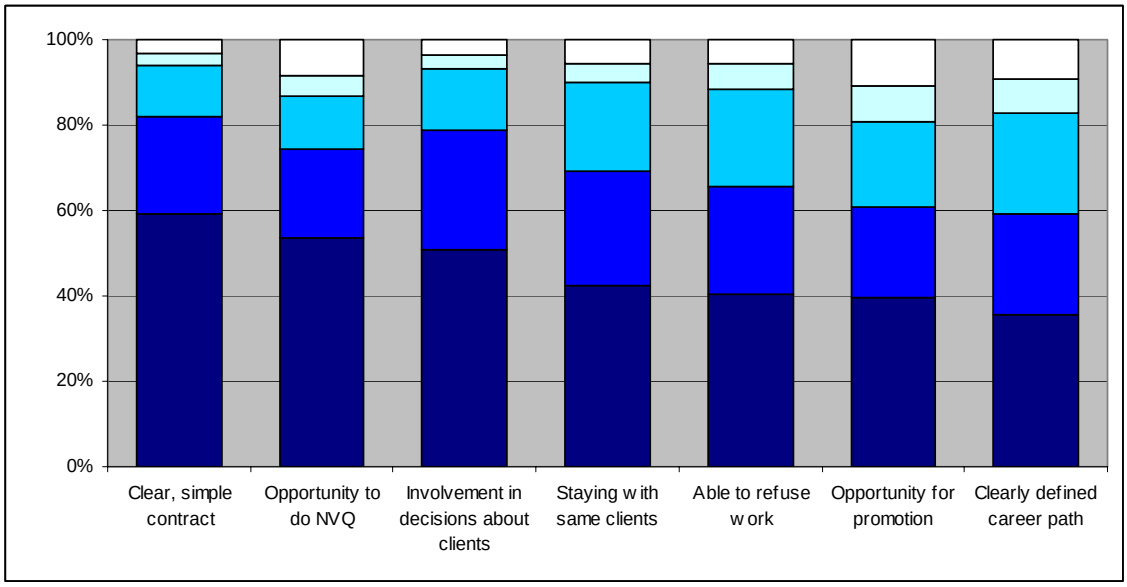
Factors offered were scored by importance on a scale of 1 to 5. In figure 14, higher scores are represented by darker colours.

The managers were then asked about the importance of the various factors applicable now that they were working in home care. It is uncertain whether some of the answers given may have reflected the managers' views on what is important for others in home care, rather than simply what was important to them personally (see figures 15 and 16). Managers again ranked these factors in a very similar order to that given by care workers, giving the following order:

1. Good managers
2. Your relationship with your clients
3. Training
4. Being able to get hold of managers easily
5. Being trained before you start work
6. Flexibility to do what your client wants or needs
7. Clear and easily understood contract
8. Opportunity to undertake an NVQ/SVQ qualification
9. Being involved in decisions about clients or work
10. Staying with the same clients
11. Being able to say 'no' to work
12. Opportunity to progress to senior care worker or higher
13. Clearly defined career path



Factors offered were scored by importance on a scale of 1 to 5. In the figures 15 and 16, higher scores are represented by darker colour.



The data on which the figures above are based appear in Appendix 2.

Overall, three-quarters of providers responding to the survey had found difficulty in recruiting home care workers. This almost unchanged national average figure obscures considerable regional variation and some important changes since 2000.

The highest proportions of providers reporting recruitment problems for this survey were in the North East and North West (see table 32). These areas reported much lower levels of difficulty in 2000 (68%). In contrast, the area of greatest difficulty in 2000 was the South East, including London, at 86%. It will be seen from the table below that these areas are now reporting substantially less difficulty. *N.B. Please see warning on page 16.*

Region	Percentage reporting difficulties	Numbers reporting difficulties	Numbers of respondents
North East	88.5%	45	55
North West	81.8%	23	26
East Midlands	80.8%	23	30
Yorks &Humber	76.7%	21	26
South West	75.4%	30	41
West Midlands	73.2%	34	48
East	70.8%	30	45
South East	69.9%	58	83
London	66.7%	52	69
Total	74.4%	316	423

The problem is often reported to be so severe that some providers are unable to find or to retain care workers and are turning down business. Many causes were cited. The most common was a general shortage of available labour in the market. Poor response to advertisements, poor pay and conditions and competition with other employers were also blamed.

Previously cited problems such as the poor image of care work, short visits and travel problems, the inability to guarantee hours and the lack of security in the work were still evident but did not feature as strongly.

Providers were asked whether recruits coming to them already possessed the skills and competences required to meet the needs of service users fully, partly or not at all. A surprising 72% responded that new recruits were fully skilled and competent and a further 27% were partly so.

This survey suggests that 70% of current home care workers have worked for other organisations before their current job. However, given other data on the prevalence of qualifications, this reported level of competence among new recruits would appear to say more about providers' expectations than about any objective measure. It may, indeed, represent a form of 'protest' over qualifications requirements.

Care workers were asked how they had found out about their current job. Table 33 shows the responses received.

	Percent	(Frequency)
Newspaper or other advertisement	40%	(1,158)
Word of mouth	35%	(1,011)
Knew through working for another organisation	11%	(323)
Jobcentre	9%	(255)

Number of respondents = 2895

No other source of information was identified by more than 1% of care worker respondents. Registered Managers, when asked the same question, also reported advertisements and word of mouth as important sources but more than 50% had come into their role through internal promotion or move from another role in the organisation.

Providers were asked whether they had taken any special measures to tackle recruitment / retention problems. 56% of all respondents said they had done so, perhaps a surprisingly small number, given that 75% were reporting difficulty with recruitment.

Regular / specialist advertising	75	29
Increased pay rates	68	26
Leavers interviews	46	18
Training initiatives	44	17
Job fairs/open days / campaigns / recruitment drives	40	15
Improved working practices	35	14
Bonuses and other incentives	31	12
Increased induction / supervision / management support	22	8
Communication with local orgs	18	7
Good/improved working terms and conditions	15	6
Working in partnership with LA's/others	15	6
Referral bonuses	10	4
Looked overseas	9	3
Guaranteed hours	7	3
Career opportunities	5	2
Provision of uniforms etc	4	2
Other	26	10

NB Respondents commonly reported more than one action taken.

As can be seen in the above table, a range of measures was cited among providers identifying actions taken:
The most common action (regular or specialist advertising) corresponds to the most common source of job quoted by care workers. Whether this is cause or effect is not evident but given that workers overwhelmingly cited advertising, it might be considered surprising that less than a third of provider respondents reported use of advertising for recruitment.

The next most common action (26%) was increased pay and this might also be seen in conjunction with the 12% who had introduced bonuses or other financial incentives and the 6% who reported improvements in terms and conditions. This reported action appears to demonstrate that purchaser pressure on charge rates in not universally constraining providers from improving pay and conditions.

While 15% of provider respondents had run job fairs, open days, etc, fewer than 0.3% of workers gave such events as the source of their information about their current job, that may suggest this is not an effective way to recruit.

In contrast, only 4% of provider respondents reported use of referral bonuses. Given the 35% of workers who were recruited as a result of 'word of mouth' it might be useful for this to be used more widely.

Despite frequent media assertions and anecdotal reporting, only 3% of provider respondents reported seeking to recruit from overseas.

Equally, only 3% reported offering guaranteed hours as a recruitment incentive. This figure may appear to conflict with other data from the provider survey and from the worker survey:

- 44% of providers said some or all of their workers had guaranteed hours;
- 54% of workers said they had guaranteed hours, averaging 29 hours per week.

The discrepancy may be that many providers do not consider guaranteed hours to be a 'special' recruitment measure.

Since payment for travel is thought to be an important problem in workers' terms and conditions for home care, the survey sought information on the issue from both employers and workers (see table 35).

	Worker respondents (Frequency / number of respondents)	Employer respondents (Frequency / number respondents)
Expenses paid for travel between clients	57% (1546 of 2712)	69% (354 of 513)
Travel time paid between clients	29% (788 of 2717)	38% (196 of 516)
Is travel time paid at the normal hourly rate?	Not asked	77% (144 of 187)

The discrepancy between the answers given by workers and employers may be due to employers including allowances for travel time and / or expenses, within the amount paid for service user contact time. Workers may not always identify this as such.

Whether or not this is the case, it is clear that two-thirds of workers do not receive pay specifically for travel time. It is hoped that allowance for this time is made, when calculating compliance with National Minimum Wage. For example, a worker on £5.50 per hour would have to average no more than 12 minutes of travel in every hour of service user contact time. One third of workers are paid below this level.

68% of providers said they offer a clearly defined career path.

61% of providers said their pay structure reflected achievement of qualifications, although this appears to be at odds with the analysis of pay rates against qualifications held.

Normal methodologies for describing turnover are difficult to apply to home care, since few organisations (in the independent sector, at least) have fixed 'establishment' numbers.

The average number of years in home care reported by care workers was 5.32, so 'turnover' of workers entering and leaving the sector as a whole (rather than for any individual employer) could be stated as 18.8%. Given that the sample of care worker respondents may have attracted those who were more 'engaged' with home care as a career, it is likely that this figure for turnover is an understatement, even on a 'sector' basis.

In addition, the figure inevitably hides far higher levels of turnover, recruitment activity and movement between individual employer organisations. 70% of worker respondents had worked in home care for another organisation, prior to their current job. One in twelve had worked for 10 or more previous home care organisations.

Figures reported by provider respondents for new recruitment and leavers should be treated with great caution.

- The responses ranged from 0 to 5000 recruits and 0 to 4000 leavers.
- The mean was 26 for new recruits and 21.5 for leavers.
- The most frequently reported number was 2 for new recruits and 3 for leavers

In addition to the wide ranges reported and the disproportionate effect of a very small number of providers reporting high numbers, some respondents answering this pair of questions had not given usable answers for their total number of care

workers, making the turnover rate calculation impossible. Among those provider organisations whose responses were usable:

- The number of workers recruited, over the preceding 12 months, as a proportion of their total workforce was reported as 35%.
- The number of workers leaving, over the preceding 12 months, as a proportion of their total workforce was reported as 29%.

It will be seen that respondents reported considerably more new recruits than workers lost, an apparent contradiction of the reduction in overall workforce. It is thought this may reflect the consolidation known to be occurring in the number of home care organisations. This consolidation is confirmed by the increased size of respondents, who reported an average 25% more hours per organisation than in 2000.

As organisations close or are taken over by larger competitors, many of their workers are likely to transfer to the new organisation. Organisations that had ceased providing home care were excluded from our survey and those about to do so are less likely to have responded.

Effectively, workers were leaving organisations that did not respond to our survey and joining those organisations that did respond, appearing in the survey as a disproportionate number of new recruits.

SECTION SEVEN
Qualifications and Training

The survey provides information about the qualifications and training of independent home care workforce. Over a quarter (27%) of home care workers who responded to the survey held an NVQ at level 2 and almost 50% of them were working towards this qualification. N.B. The choice of these workers was left up to the employer and may or may not have introduced some selection bias eg. giving it to their most qualified/longest serving staff.

However, this is in conflict with the providers' survey that gives care worker figures as just under 10% who hold NVQ 2 and 18% working towards it.

Organisations providing personal care must be registered with the Commission for Social Care Inspection. National Minimum Standards (ref. 2) relating to the training and qualifications of people working in the social care sector are central to the regulations under the Care Standards Act 2000 (ref. 12).

The NMS set high expectations of home care providers. A comprehensive review of the regulations and NMS is currently under way but the following reflects the requirements, at time of writing.

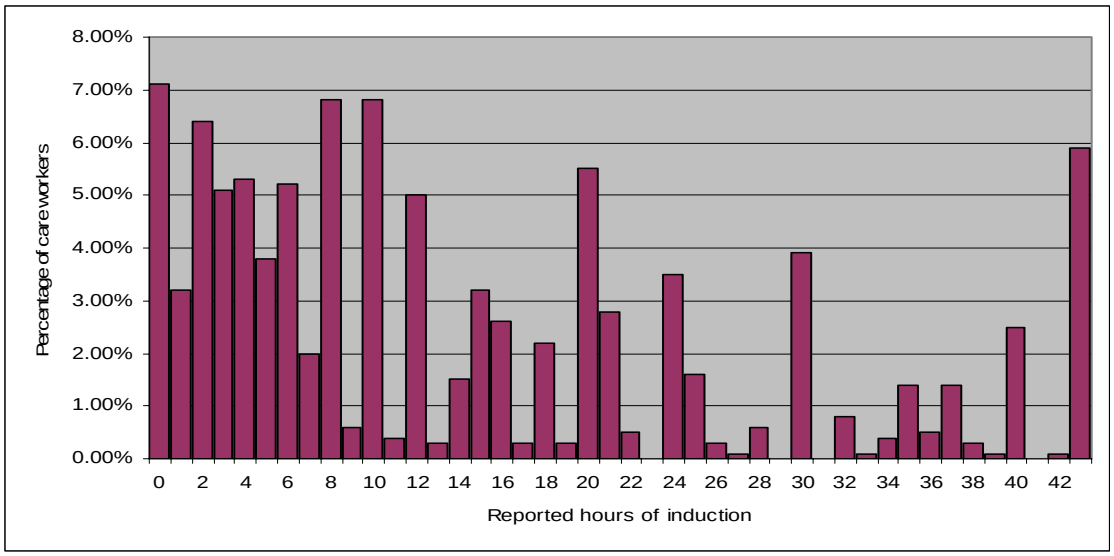
From April 2003, all new workers have been expected to have induction training that conforms to National Minimum Standards (ref. 2). Induction is seen as one of the critical measures for service user safety and a key issue is that workers are not permitted to work unsupervised until the programme is complete.

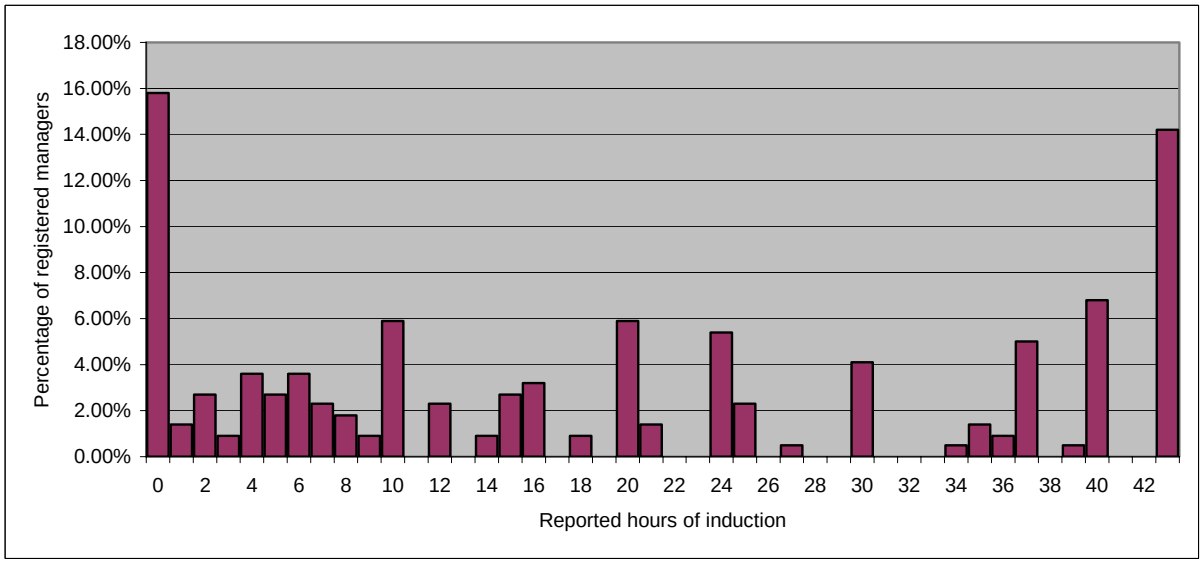
In home care the NMS requirement means delivering specified content through a minimum of 3 days learning. This may be done in an intensive burst or spread over the first 6 weeks in work.

- For convenience in this survey, a 'day' has been taken to equate to 7 hours
- The requirement for induction is therefore equated to 21 hours
- Responses measured in days have been recalculated into hours, on this basis
- Responses measured in weeks or months have also been incorporated in this way but it is acknowledged that such longer periods will not involve continuous learning.

In looking at responses from care workers and Registered Managers, about the amount of induction they had received, it must be remembered that two-thirds of respondents entered the sector before regulation was introduced.

Nevertheless, it is disturbing that three-quarters of care workers and half of managers reported duration below the legally required minimum and the most frequently cited period of induction for both managers and workers was zero (see figures 17 and 18). In contrast, 6% of care workers reported induction at more than twice the required period. In the figures below all responses in excess of 42 hours have been combined.



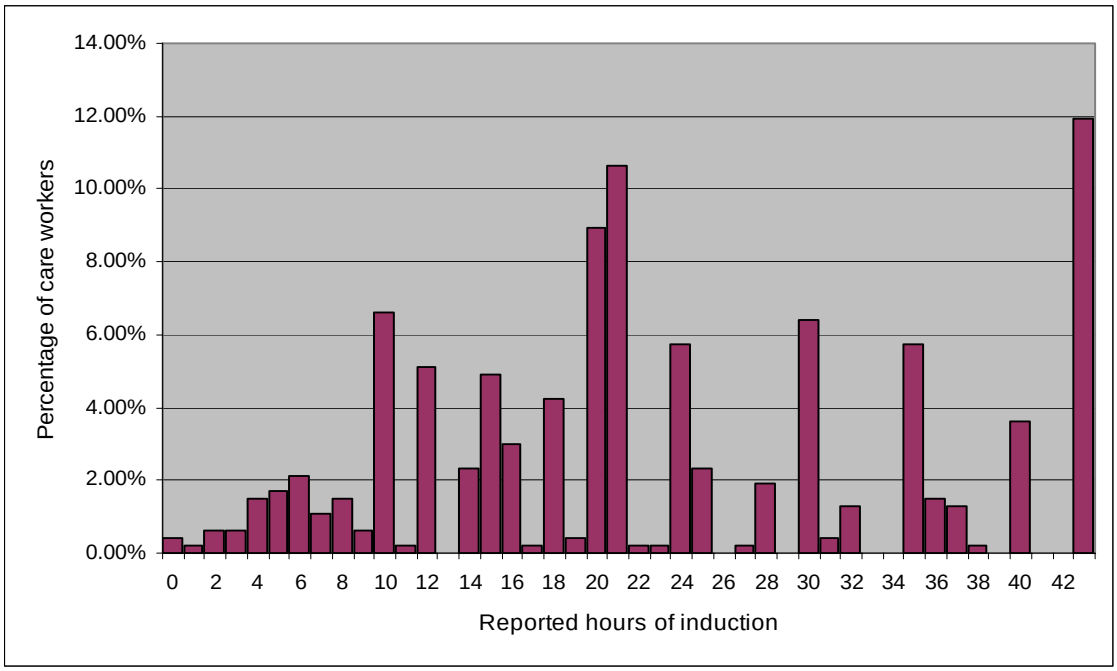


The data on which the figures above are based appear in Appendix 2.

The responses from employers might be expected to yield a more compliant picture, as they reflect current practice, where care workers and managers were often reporting on what they experienced before regulation.

The most commonly reported period was indeed 21 hours, closely followed by 20 hours, that may be considered close enough to 3 days to be acceptable. However, even giving the benefit of the doubt to those reporting 20 hours, one-third of providers reported periods of induction that were below the legally required minimum (see figure 19).

In contrast, 56 respondents (12%) reported induction at more than twice the required period. This included a number who cited 6 weeks – the period within which induction must be completed. This illustrates the caution that the calculation used to incorporate periods measured in weeks into this survey does not imply that such periods involve continuous learning. In figure 19 all responses in excess of 42 hours have been combined.



The data on which the figure above is based appear in Appendix 2.

The National Vocational Qualification (NVQ) in Care at level 2 is considered the minimum, and currently the main, qualification for all care workers. The intention of regulation is to reach a point where all home care workers either hold at least this level of qualification or are actively working towards it.

There is a target that by 1st April 2008, 50% of the care arranged by each provider will be delivered by a care worker who holds at least the NVQ2 in care. The target will be reviewed in 2006 (and then annually) to assess whether it should be increased or decreased in the light of experience. It is expected to be increased.

As required process measures to achieve this target:

- All new (unqualified) home care workers joining an organisation after 1st April 2003 must register for an NVQ within 6 months of starting work and must complete it within 3 years.
- All home care workers who joined an organisation between 1st April 2001 and 1st April 2003 must be registered for their NVQ before 1st April 2005 and must again complete within 3 years. They are expected to be 'phased in'.

These measures continue in force, even if the '50% of care' target has been reached.

The Care NVQ at level 2 currently consists of 9 Units. As a consequence of a fundamental review of National Occupational Standards in Care and their related qualifications (nearing completion at time of writing), this will be reduced to 6 Units. The new qualifications are likely to be available from 2005 and there will be special transitional arrangements for those who are already embarked on an existing programme.

The new smaller qualification will still meet the basic requirement of the National Minimum Standards but there may be more clarity about sets of knowledge and skills required for specialist care. There is also the possibility that new 'enhanced' or extended' qualifications may be awarded at level 2.

Two very different pictures emerge from the surveys of care workers and of care providers. It should be remembered that respondents to the care worker survey are likely to be the regular or more 'engaged', either through employers choosing which workers to give questionnaires or through the self-selection of which workers took the trouble to respond.

(see also the providers' story below)

Care workers were asked how many relevant qualifications they held or were 'working towards' (see table 36).

- The proportion of VQs held at level 2 or above in care had risen sharply to 26.6%, from 8.5% in 2000.
- The number 'working towards' had risen to almost 50% from 8.9%. *N.B.* *Please see warning on page 16.*

By the date of this survey:

- After one year, providers were already halfway toward the five year target for 50% of care to be delivered by workers with NVQ2 or above (assuming that workers with qualifications deliver as much care as those who do not)
- At least one-third more workers have started working towards NVQs than is required by NMS.

- Only 7% to 14% of the workforce is likely to have been required to start working towards an NVQ, under the NMS 'first 6 months' rule.
- Around 23% of the workforce fall within the group who are required to be 'phased in' to an NVQ, within 2 years, but this period had almost a year to run.

On the basis of the care workers' survey, the figures are extremely encouraging.

Qualification n = 2895	Hold (Frequency)		Working towards (Frequency)	
NVQ Care level 2	18.5%	(537)	30.3%	(878)
NVQ Care level 3	6.4%	(185)	14.0%	(406)
NVQ Care level 4	1.7%	(49)	5.3%	(154)
Registered Nurse Qualification	2.6%	(76)	1.1%	(32)
Social work qualification	1.3%	(21)	2.1%	(39)
SPA Homecare / enhanced	1.0%	(29)	1.1%	(31)
NVQ Assessor/Internal verifier	2.4%	(69)	3.0%	(87)
NVQ Mentor	0.4%	(13)	0.5%	(14)

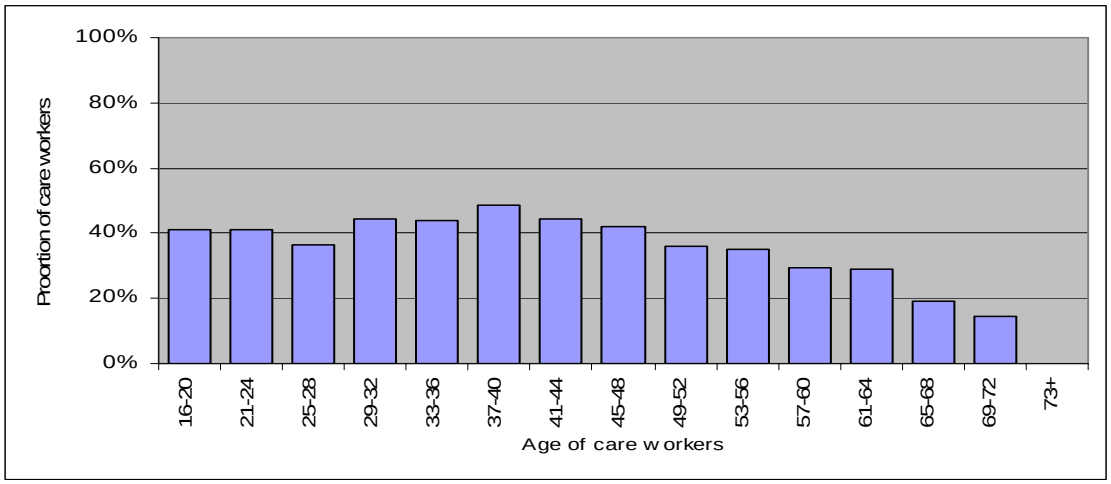
More than one qualification might have been reported by one individual worker. On a strict statistical analysis, the results should be considered as separate and will not perfectly offer an overall proportion of workers holding or studying qualifications.

The proportion of registered nurses working as home care workers was substantially reduced, probably reflecting the absence of a major nurse agency, whose responses were sizeable in the 2000 survey.

A variety of other qualifications were reported. The most noteworthy were unspecified degrees, that were held or being studied for by 3% of care workers, and Health and Safety reported at 2%.

The distribution of workers holding NVQs across the age bands was closely in line with the general age distribution (except that few workers under 20 held a qualification). Among those 'working towards, though, there was a rapid reduction in participation after the age of 50, evidence that this group may be resistant to 'going back to school'.

This resistance is illustrated in figure 20, that shows a steady decline, after the age of 40, in the proportion of care workers identifying a need for training.



The data on which the figure above is based appear in Appendix 2.

(see also the care workers' story above)

Provider organisations were asked how many relevant qualifications were held by their care workers or were being 'worked towards'.

- The proportion of NVQs reported as held at level 2 or above in care was 9.9%, only slightly above the 8.5% reported by care workers in 2000.
- The number reported as 'working towards' was 18.0%, a large rise from the 8.9% reported by care workers in 2000.

N.B. Please see warning on page 16.

By the date of this survey:

- After one year, providers had reached around one-fifth of the five year target for 50% of care to be delivered by workers with NVQ2 or above (assuming that workers with qualifications deliver as much care as those who do not)
- At least 17% fewer workers have started working towards NVQs than might have been expected under NMS.
- 7% to 14% of the workforce is likely to have been required to start working towards an NVQ, under the NMS 'first 6 months' rule.
- Around 23% of the workforce fall within the group who are required to be 'phased in' to an NVQ, within 2 years, but this period had almost a year to run.

On the basis of the providers' survey, the figures are barely keeping up with NMS expectations and, given that some workers already held or were working towards qualifications when regulation was introduced, the recent activity rate is wholly inadequate to achieve compliance with targets (see table 37).

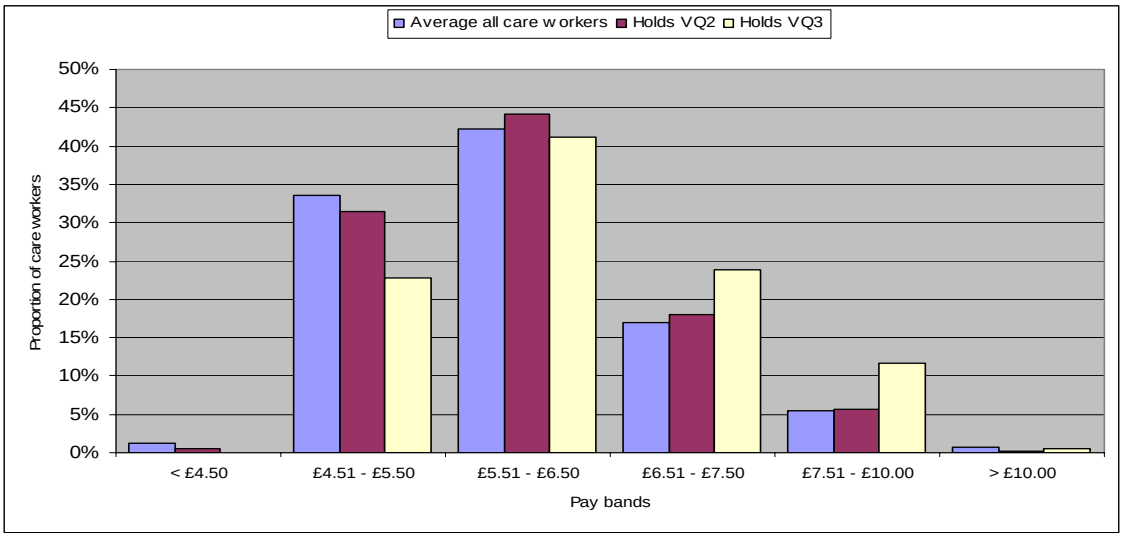
Qualification n = 36,104	Hold (Frequency)	Working towards (Frequency)
NVQ Care level 2/3/4	9.9% (3,586)	18.0% (6.670)
Social work qualification	0.1% (21)	0.1% (22)
Registered Nurse Qualification	0.6% (209)	0.3% (104)
Others (mostly BTec in care)	0.5% (161)	0.5% (140)

Number of respondents 538

More than one qualification might have been reported by one individual worker. On a strict statistical analysis, the results should be considered as separate and will not perfectly offer an overall proportion of workers holding or studying qualifications.

The care workers' survey sought to establish whether there was a link between qualifications and higher rates of pay.

- For workers holding the most common qualification, the NVQ at level 2, there was only a very slight improvement in the likelihood of being paid more (see figure 21).
- Those working towards NVQ2 were likely to have much lower pay than the average.
- For those holding NVQ3s, the rewards were slightly better. 36% were paid over £6.50 compared to the all workers' average of 23% (see figure 21).
- Those working towards NVQ3 received slightly above the all workers' average.
- For those holding professional nursing or social work qualifications there was a very surprising picture. Although most of these respondents had higher than average pay, there was a substantial number of each (50% of DipSW holders and 40% of RNs) who appeared in the £4.50 - £5.50 band.
- In contrast, people working towards DipSW or RN qualifications were substantially more likely to be paid above the all worker average.
- Those holding NVQ assessor, verifier or mentor awards were far more likely to be paid in the upper bands, although those 'working towards' appeared to be paid well below the all workers' average.
- Among the best rewarded qualifications appeared to be those in counselling, mental health and learning difficulties.
- A small group cited holding or working towards 'Personal Care' but did not say to which form of qualification they referred. It would be valuable to know, since 64% of this group were paid over £6.50 and almost none were paid less than £5.50.



The data on which the figure above is based appear in Appendix 2.

There are no specific targets in the National Minimum Standards for the NVQ in Care at level 3. The level 3 is considered appropriate for senior care workers, field supervisors, workers in childcare or specialist learning difficulties and those expected to perform more complex duties e.g. health related tasks.

Level 3 is also intended for those people who work independently. As a consequence, some providers consider NVQ3 to be their own minimum standard for home care and there may be pressure in the longer term to raise the National Minimum Standards requirement to this level.

The care workers' survey results reported above suggest that 8% of care workers already hold a NVQ at level 3 or above and a further 20% are working towards this level. The cautions on the tendency to self-selection of these respondents should be recalled however.

The National Minimum Standards require all 'managers' in home care appointed before 1st April 2003 to hold a nationally recognised qualification in management at level 4 or above by 1st April 2008. Managers appointed after 1st April 2008 will need to achieve their qualification within 3 years after their appointment to the position.

For the purposes of regulation, the NCSC indicated that they interpret the word 'manager' in this context to mean either the Registered Manager or the Responsible Individual, if they are in day to day control.

There is currently no specific requirement for managers in home care to hold any qualification in care but it should be noted that there is a requirement for the appropriate range of skills and experience to exist in the staff group as a whole. For example, where the 'Manager' does not hold a qualification that enables them adequately to undertake care needs assessments and reviews, this skill should be available from another member of staff.

The most relevant qualification available now is the Registered Managers Award (RMA). This was created for managers of care homes, is at level 4 and consists of 10 NVQ Units. In most RMA programmes, it is necessary for candidates to 'contextualise' the learning to fit home care. The assessors used also have to be prepared to adjust what they expect from candidates to fit the very different setting. Experience of home care managers who have done RMA suggests this is not difficult to achieve.

As a consequence of the review of National Occupational Standards in Care and their related qualifications (now nearing completion), it is anticipated that the Care NVQ at level 4 will be reduced to 8 Units and will be adjusted to incorporate more explicit management content.

Once the new qualification is available, it is possible that Government may reconsider the current NMS and require the new 'management oriented' Care NVQ instead of the current requirement for a management qualification. The new qualification is likely to be available from 2005 and there would be special transitional arrangements for those who are already embarked on an existing programme.

Provider organisations were asked how many relevant qualifications were held by their Managers or were being 'worked towards' (see table 38). More than one qualification might have been reported, in relation to one individual manager. The results should therefore be considered separately and do not show the overall proportion of managers holding or studying qualifications.

Given that the deadline for managers' qualifications was 4 years after the survey date, it is encouraging that 12% of managers already hold the NMS required qualification and that almost one-third are already studying for it.

However, these figures appear very different among respondents to the Registered Managers' survey, with just 3% known to be holding the required qualification and 6% studying towards it (see table 39).

We should note that a further 5 managers (1%) cited the RMA but did not specify whether they already held it or were still 'working towards'. Similarly, 31 other management qualifications (6%) were cited without specifying whether or not they had yet been achieved.

A possible explanation for this difference lies in the relatively high numbers of Registered Managers reporting that they hold or are working towards the NVQ4 in Care. It is possible that respondents have been confused between the required Management NVQ4 and the Care NVQ4, that is not required by National Minimum Standards. Whether any confusion has been simply in the answering of this survey or whether large numbers of Registered Managers have undertaken the 'wrong' qualification cannot be determined.

The difference may also reflect the fact that providers' responses may have included managers who were not Registered Managers.

It is encouraging for overall training capacity that large proportions of managers hold or are undertaking NVQ assessment and verification qualifications.

As in 2000, one-third of managers were identified as registered nurses. An interesting difference, though, is that nurses constituted only one in seven Registered Managers. This suggests that nurses are often engaged as care managers, while others run the business side of the organisation.

Workers must receive specialist advice, training and information if they are expected to provide specialist types of care or care to groups of clients with specialist care needs.

The list of types of care and client groups for which this requirement applies appears in NMS Appendix E (ref. 2). This is a long list and most clients could be said to fall within one or more of the groups described. The scope and depth of specialist training is not specified. It may depend on the extent to which the service actually provided is general in nature or is specifically targeted at the client group in question.

Care workers and Registered Managers were asked whether they undertook study or training in their own time or in paid work time. This produced a mixed response but one in which the image of home care workers and managers having to study entirely in their own time appears not to be supported (see table 40).

	NVQs		Other qualifications	
	Registered Managers (Frequency)	Care workers (Frequency)	Registered Managers (Frequency)	Care workers (Frequency)
All in own time	14% (76)	17% (497)	6% (36)	9% (251)
Some paid / some own time	40% (227)	28% (815)	12% (103)	19% (342)
All in paid time	22% (117)	18% (514)	20% (103)	18% (577)

N.B. This table is taken from 6 separate questions from within the Care Worker and Registered Manager surveys' therefore an overall number of respondents cannot be given.

Respondents to the providers' survey appeared to describe a rather more generous position for care worker training (see table 41).

	Skills training (Frequency)	Statutory training (Frequency)	CPD/LLL (Frequency)
All in own time	14% (74)	17% (91)	14% (74)
Some paid / some own time	31% (166)	24% (128)	29% (155)
All in paid time	39% (212)	51% (274)	27% (144)

N.B. This table is taken from 6 separate questions from within the Provider survey therefore an overall number of respondents cannot be given.

Care workers and Registered Managers were asked who paid for their qualifications and training. Once again, the concern that workers and managers have to fully fund their own development appears unsupported (see table 42).

A notable feature was that external funding, from sources such as Topss, local councils, ESF etc, was identified across the range of qualifications by only 2% of respondents to either survey. It could be expected that care workers might not know the source of their funding but this seems unlikely for the Registered Managers. The implication may be that such funding is not reaching independent sector providers to any substantial degree.

	NVQs				Other qualifications			
	Registered Managers (Frequency)		Care workers (Frequency)		Registered Managers (Frequency)		Care workers (Frequency)	
Self-paid	6.0%	(35)	5.5%	(159)	4.5%	(25)	4.5%	(130)
Part self paid	6.0%	(35)	5.5%	(161)	4.0%	(30)	5.0%	(111)
Paid by employer	48.0%	(271)	39.0%	(1,133)	33.0%	(185)	26.0%	(756)

N.B. This table is taken from 6 separate questions from within the Care Worker and Registered Manager surveys' therefore a number of respondents cannot be given.

Once again, respondents to the providers' survey described taking a more generous position on payment for care worker training (see table 43).

External funding was reported by only a small fraction of the 538 organisations responding to this question, confirming the picture reported by care workers (see table 43). The most common sources quoted were local councils and Topss (6% each). Business Link and LSCs were mentioned by 2% each. The evidence is, therefore, that such funding is not reaching independent sector providers to any considerable degree.

	Skills training (Frequency)		Statutory training (Frequency)		CPD/LLL (Frequency)	
Self-paid	9%	(47)	9%	(46)	5%	(29)
Part self paid	9%	(47)	7%	(40)	10%	(53)
Paid by employer	64%	(345)	69%	(372)	46%	(247)
External funding received	6%	(32)	12%	(65)	4%	(22)

Care workers were asked whether they provided home care services of a variety of types and whether they had received specific training for each. The responses were as shown in table 44.

	Provide (Frequency)		Had specific training (Frequency)	
Older people	81%	(2,350)	38%	(1,086)
Personal care	78%	(2,261)	35%	(999)
People with a physical disability	75%	(2,170)	31%	(884)
People with dementia	69%	(2,005)	30%	(879)
People with Health Needs	68%	(1,981)	33%	(953)
People who are elderly mentally infirm	62%	(1,809)	28%	(804)
Domestic services	56%	(1,616)	15%	(439)
People with mental health problems	48%	(1,396)	18%	(515)
People with a learning disability	46%	(1,333)	19%	(562)
People with a sensory impairment	41%	(1,194)	15%	(435)
Social & emotional support	34%	(986)	13%	(384)
People with infectious / contagious diseases	31%	(905)	17%	(489)
Hospital Discharge	31%	(894)	9%	(266)
People from minority ethnic groups	29%	(845)	9%	(257)
Night sleeping service	26%	(757)	7%	(212)
Respite Care	23%	(679)	9%	(249)
People who abuse drugs or alcohol	22%	(634)	8%	(218)
Night waking service	18%	(514)	5%	(155)
Children	15%	(432)	7%	(207)
Intermediate care	12%	(343)	5%	(133)
Rapid response	10%	(290)	4%	(109)
Live-in care	10%	(284)	4%	(114)
Prevention of admission	8%	(221)	3%	(90)
Young Offenders	1%	(41)	1%	(35)

Number of respondents 2895

40% of care workers and 47% of the Registered Managers felt that they themselves needed further training to carry out their current work. This is somewhat at odds with the importance placed on training generally, where over 90% of care workers and Registered Managers described it as 'important' or 'very important'.

When asked to identify what kind of training they felt they needed, respondents volunteered the list in table 45. Of course, in drawing conclusions from this table, it needs to be borne in mind that, where a person has already received training on a particular topic, it may be less likely that they will identify a need for further training.

Description of training	Care Workers (Frequency) n=1054		Registered Managers (Frequency) n=240	
NVQ qualification	25.8%	(271)	1.9%	(5)
Updating care skills/personal care	21.5%	(226)	18.3%	(48)
Health and Safety	17.9%	(188)	2.7%	(7)
Any/all training	12.1%	(127)	10.3%	(27)
Mental health/dementia /learning difficulties	7.0%	(73)	2.3%	(6)
Management Skills/RMA/NVQ4	4.5%	(47)	38.8%	(102)
Other	3.0%	(3)	3.8%	(10)
Food Hygiene	2.4%	(25)	0.4%	(1)
NVQ assessor/verifier	2.3%	(24)	4.6%	(12)
Protection of vulnerable adults/children	0.9%	(9)	0.8%	(2)
Communication/listening skills/advocacy	0.8%	(8)	1.1%	(3)
IT training	0.6%	(6)	3.4%	(9)
Legal Skills	0.3%	(3)	5.7%	(15)
Degree/other course	0.3%	(3)	2.3%	(6)
Personnel Skills	0.2%	(2)	2.7%	(7)
Don't know	0.2%	(2)	0.4%	(1)
Induction	0.2%	(2)	0.0%	(0)
Team work/development	0.1%	(1)	0.8%	(2)
Basic training	0.1%	(1)	0.0%	(0)

N.B. Some of the respondents to this question may have included more than one of the above in their answer.

When asked what training already undertaken had been most useful, care workers and Registered Managers volunteered the list in table 46. The opposite caution in drawing conclusions from this table needs to be borne in mind. Where a person has never received training on a particular topic, they will not have been able to identify it as useful.

Despite the caveats offered here the low frequency with which some key topics appear in either table might suggest that there is still considerable work needed to convince this workforce of the need for qualifications or for specific, topic related training.

For example, only 1% of respondents identified training in protection of vulnerable adults either as being needed or as having been received and found useful. Even the most commonly cited training (Health & Safety and Food Hygiene) was suggested by only 56% as being of either past or future value.

Description of training	Care Workers (Frequency) n=1669		Registered Managers (Frequency) n=373	
Health and Safety / food hygiene	35.0%	(595)	11.6%	(43)
NVQ training/ASET training	17.4%	(296)	10.2%	(38)
All of them	14.8%	(252)	8.6%	(32)
Specific care /mental health/personal care	12.1%	(205)	14.0%	(52)
Learning 'on the job'	5.5%	(93)	9.1%	(34)
Induction	4.1%	(70)	1.6%	(6)
Supervision/mentoring/accompanying	1.9%	(32)	2.2%	(8)
Protection of vulnerable adults/children	1.4%	(24)	1.1%	(4)
Communication/listening skills	0.6%	(11)	0.5%	(2)
Registered Manager/RMA/NVQ4	0.5%	(9)	28.0%	(104)
Provision of client care	0.4%	(7)	1.6%	(6)
NVQ assessor/verifier	0.4%	(6)	1.1%	(4)
Equal opportunities/cultural needs and issues	0.4%	(6)	0.3%	(1)
Legal issues	0.3%	(5)	0.8%	(3)
Basic training	0.2%	(4)	0.8%	(3)
House related training	0.2%	(3)	0.0%	(0)
IT training	0.1%	(1)	0.3%	(1)

N.B. Some of the respondents to this question may have included more than one of the above in their answer.

Since 2002, individual home care workers and their employers have been required to comply with Codes of Practice issued by the General Social Care Council (GSCC). Compliance by employers is enforced by CSCI, as part of their regulation of home care services.

Over time, it is expected that all care workers will be required to register with the GSCC and may be subject to formal proceedings to investigate complaints of misconduct. This could result in the worker being disbarred from working in the care sector.

Until registration is introduced, employers are expected to enforce the code on their workers and, to do so, many have chosen to incorporate the code into their terms and conditions of contract with the workers.

The codes of practice for social care workers and employers of social care workers describe the standards of conduct and practice within which they should work. The two codes for workers and employers are complementary and mirror the joint responsibilities of employers and workers in ensuring high standards.

Example:

- There is an obligation on the employer to offer training and development opportunities to all.

- There is an obligation on the worker to become and remain competent.

The Code of Practice for Employers of Social Care Workers sets down the responsibilities of employers in the regulation of social care workers. The code requires that employers adhere to the standards set out in their code, support social care workers in meeting their code and take appropriate action when workers do not meet expected standards of conduct.

The Code of Practice for Social Care Workers is a list of statements that describe the standards of professional conduct and practice required of social care workers as they go about their daily work. The codes are intended to reflect existing good practice and it is anticipated that workers and employers will recognise in the codes the shared standards to which they already aspire.

The survey sought to establish to what extent the GSCC codes had been disseminated and were being adopted (see table 47). The high levels reported by care workers and Registered Managers is very encouraging, although it is perhaps anomalous that more care workers reported having the code incorporated in to their terms and conditions than reported having been given information on them.

	93.4% (499 of 534 respondents)	87.7% (2334 of 2662 respondents)
	86.1% (445 of 517 respondents)	94.8% (2455 of 2589 respondents)

CONCLUSION

Enabling people who require support to remain at home has now become a major policy area for Government. Although independent sector home care workers provide the majority of this support, there has been little research undertaken in this field. This survey adds to the limited information available and provides updated figures on home care worker establishments and, for the first time, presents information on Registered Manager activity.

One of the most worrying aspect of the results of this survey is that although the volumes of publicly funded domiciliary care have risen the private domiciliary care market appears to be falling rapidly by comparison. There appears to have been a large decline over the last four years.

First reported by Mathew (2000) (ref. 1) the figure stood at 40% of the care delivered by independent providers. This figure, however, had dropped by the time of her next survey Mathew (2003) (ref.7) down to 27%. Only one year later this figure now appears to have dropped yet again to 18% (see table 48).

	2000	2003	2004
Private purchase as a percentage of all home care delivered by independent providers	40%	27%	18%
Private purchase as a percentage of total home care delivered by all sectors	25%	No estimate	13%

There may be a number of reasons for this fall including a change in the balance of respondents, however it is unlikely this would account for such a large shift. This could have a major effect on the future market stability and therefore further research is required urgently to verify these figures and establish the cause. *N.B. Please see warning on page 16.*

Problems of recruitment and retention remain high despite recent Government efforts to raise awareness through high profile recruitment campaigns. Although employers have been using more sophisticated recruitment methods to attract staff there has been consolidation in the workforce with fewer care staff now working than previously identified.

However, although there are fewer staff the survey shows that care staff are now working longer hours than before to compensate for this, in addition more staff are being offered guaranteed hours, financial incentives and better terms and conditions as a mechanism to ensure they remain with the provider.

Another area of concern is the reduction of the over 50 workforce (However, it must be remembered that the choice of these workers was left up to the employer and may or may not have introduced some selection bias eg. giving it to their most qualified/longest serving staff).

Traditionally the mainstay of the service, the loss of these workers will be felt particularly by older people who have long expressed a desire to be cared for by someone from this age group. This may well be linked to the reported antipathy by this group towards undertaking vocational qualifications or short course training.

There are important discrepancies within the survey between the responses of home care workers and their employers on the level of training and qualifications being undertaken or held. This may be due to selection bias with providers ensuring that their most qualified / most able care staff received the questionnaire to complete. However, both care workers and providers have identified that more training has been undertaken or commenced than previously reported.

More worrying are the low levels of reported induction. Although two thirds of the respondents entered the sector prior to regulation, three quarters of care workers and half of the managers reported induction periods of less than the required three days or 21 hours.

The survey provides an interesting analysis of the ethnicity of the workforce. It reports a large proportion of Black and Black British workers that is three times the national average. There was a lower response rate to the survey from London and other metropolitan areas where the proportion for black and minority ethnic communities are known to be higher, but 60% of all respondents identifying themselves from a black and minority ethnic background were from the London region alone.

Although the survey identifies some worrying trends that will need further analysis to confirm these and to explain the reasoning behind them there are also some positive elements. Although recruitment and retention problems remain high, providers have become more sophisticated in their recruitment techniques and in the packages they are offering to entice people to work within the sector.

More care staff are working towards or have completed NVQ2 training that is now a requirement of the National Minimum Standards (ref. 2). Although there are less workers than previously identified these workers are now working longer hours, for which a number of these are guaranteed, meaning that workers have a more stable job and therefore less likely to work for a number of different agencies with the conflict that could arise from this.

Finally, this survey shows an urgent need for routine collection of data about this important sector of the social care workforce. The absence of such information as a basis for policy is a major gap in our understanding of the dynamics of an increasingly large part of the total care workforce.

GLOSSARY OF TERMS

The Commission for Healthcare Audit and Inspection exists to promote improvement in the quality of healthcare in England and Wales. In England only this includes regulation of the independent healthcare sector.

The Criminal Records Bureau is an executive agency of the Home Office It was set up to help organisations make safer recruitment decisions. By providing wider access to criminal record information, the CRB helps employers in the public, private and voluntary sectors identify candidates who may be unsuitable for certain work, especially that involving contact with children or other vulnerable members of society.

The Commission for Social Care Inspection is the new independent inspectorate for all social care services in England.

Following an assessment of need, a local authority, with the agreement of the service user, provides cash to enable the user to purchase for themselves the services that will meet those needs.

The General Social Care Council is the social care workforce regulator. It registers social care workers and regulates their conduct and training.

is used to describe the workers who responded to the survey, although the job titles of respondents were varied. They included home carer, domiciliary care worker, support worker, independent living assistant and care auxiliary.

includes for-profit, not-for-profit, voluntary sector organisations and co-operatives.

are used interchangeably when describing the role of local government in purchasing home care from independent providers.

The National Care Standards Commission was the previous inspector of care standards. This has now been superseded by CSCI (above).

National Minimum standards for domiciliary care services.

An employer must pay their employees a minimum amount as defined by law. This is called the National Minimum wage.

National Vocational Qualifications are work-related, competence based qualifications that reflect the skills and knowledge needed to do a job effectively. They represent national standards recognised by employers throughout the country

: This describes assistance with activities that involve physical and/or intimate touching eg. bathing, dressing, toileting. Respite, overnight, live-in and 24 hour care are included in this category.

There has been a phased introduction of the Protection of Vulnerable Adults scheme. At the heart of the POVA scheme is the POVA list. Care workers who have harmed vulnerable adults in their care should be referred to the list, and the list should be checked when care providers wish to appoint individuals to care positions working with vulnerable adults. There is a statutory requirement on registered care providers to check if a care worker is included on the POVA list.

: This describes routine household tasks e.g. cooking, cleaning, and shopping.

is used to describe the home care organisations that responded to the survey. The provider may operate as a single outlet or be a branch of a larger organisation. Questionnaires were sent to each branch of larger organisations. In one case a central office supplied information on all their branches.

is used to describe a senior member of staff who is responsible for managing the provision of domiciliary care on a daily basis. They must be registered with the Commission for Social Care Inspection to do so.

Services for which special training or skills are required e.g. services for people with learning disabilities or dementia.

This is the Training Organisation for Personal Social Services (soon to be renamed 'Skills for Care').

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APPENDIX ONE: THE RESPONDENTS

A database of independent sector home care organisations was assembled from a variety of sources, including membership lists of representative bodies and the website listing of the CSCI. After purging duplicate entries the database stood at 4,515 entries.

Early in May 2004 a pre survey letter was sent out to 4,515 organisations alerting them to the imminent arrival of the survey, explaining the purpose of the survey and to ask whether the organisation did actually provide home care or housing support services. If organisations were not providing the above services they were asked to complete a slip at the bottom of the letter and return it to a freepost address.

Three questionnaires were distributed in May 2004 with a letter instructing the organisation what to do with the questionnaires. The questionnaires were sent as follows:

1) Organisational Questionnaire
This asked the organisation to provide information about hours of provision, the size of the workforce, training of workers and management qualifications. This questionnaire was coded so that reminders to return the questionnaire could be sent to the organisation.

2) Home Care Worker Questionnaire
Nine of these questionnaires were sent to each organisation with an instruction to give them to nine of their care workers to complete. This questionnaire asked about the skills and experience of the workers, hours of work, qualifications obtained, and training undertaken. The choice of these workers was left up to the employer and may or may not have introduced some selection bias eg. giving it to their most qualified/longest serving staff. To preserve anonymity, care worker questionnaires were not made identifiable to provider organisations.

3) Registered Manager Questionnaire
A third questionnaire (similar in content to the home care worker questionnaire) was to be given to the Registered Manager to complete. To preserve anonymity, Registered Manager questionnaires were not made identifiable to provider organisations. While it is likely, therefore, that the 561 responses received correspond closely with the 538 organisational responses, this is not certain.

Questionnaires were colour coded to make it easier for home care staff to differentiate between each of them.

After purging duplicate entries, organisations that had ceased trading and those who responded stating that they do not provide home care, the list consisted of 3,584 service outlets. In the absence of a definitive list, this was taken as the statistical universe of service outlets for the survey. However, there may still be organisations on this list who do not provide home care and who did not respond at all.

538 Responses were received from organisations representing 727 of these outlets, a response rate of just over 20%.
2895 responses were received from care workers.
561 responses were received from Registered Managers.

In all 49,665 questionnaires were distributed, of which 39,424 were sent to the 3,584 organisations who were on the final purged list. Table 49 gives a breakdown of the questionnaires sent out and returned.

	Numbers sent out	After purging	Numbers returned	Outlets	Percent return
Organisational questionnaire	4,515	3,584	538	727	20%
Home Care Worker Questionnaire	40,635	32,256	2,895	n/a	9%
Registered Manager Questionnaire	4,515	3,584	561	n/a	16%
Totals	49,665	39,424	3,994	727	n/a

Respondents did not always complete all the questions or did not complete them fully. As a consequence, although care has been taken to ensure the data presented for each question is valid, caution should be exercised in comparing data between tables.

The respondents

Because relatively little is still known about the industry, it is not possible to know how representative the providers and workers that responded to the survey are of independent home care. Nevertheless, it is hoped that this report will contribute to the understanding of a little-known area of social care and will assist policy makers identify further research that is required.

The hours of home care purchased by local authorities in one week from the providers in the surveys was 607,961 (missing data 125 respondents). This represents 29% of total hours purchased from the independent sector by local authorities based on figures from the 2003 statistical return for the September survey week.

Table 50 gives an indication of how representative the respondents are of regions in England. As in the 2000 survey the North East has a high response rate as does the South West. The Eastern region also has a fairly high response rate. Although the East Midlands have the lowest response rate, they have all improved from the last report. Workers in the North East and, again, the South West have responded in higher numbers than other regions; there are far fewer worker responses in London and Yorkshire and Humber.

	Population* (000s)	Respondent UKHCA members (per 100,000 population)	Respondent organisations (per 100,000 population)*	Respondent care workers (per 100,000 population)	Respondent Registered Managers (per 100,000 population)
South West	4928	45 (0.91)	70 (1.42)	303 (6.14)	78 (1.58)
Greater London	7172	25 (0.35)	47 (0.66)	247 (3.44)	55 (0.77)
South East	8000	52 (0.65)	91 (1.14)	406 (5.08)	77 (0.96)
East of England	5388	33 (0.61)	50 (0.93)	254 (4.71)	57 (1.05)
East Midlands	4172	18 (0.43)	26 (0.62)	174 (4.17)	39 (0.93)
West Midlands	5267	25 (0.47)	43 (0.82)	227 (4.30)	50 (0.95)
North West	6729	29 (0.43)	57 (0.85)	327 (4.86)	70 (1.04)
North East	2515	18 (0.72)	26 (1.03)	229 (9.11)	38 (1.51)
Yorkshire and Humberside	4964	13 (0.26)	32 (0.64)	154 (3.10)	35 (0.71)
Base numbers	49135	258	442	2321	502

* Source: Census 2001

N.B. This table excludes information from 4 organisations (head offices) who completed the survey on behalf of 157 outlets and who operated on a national basis and those who did not respond to the question identifying region.

Sixty-three percent of the respondents were UKHCA members. All 11 organisations that were replying on behalf of other organisations were UKHCA members. This produces a total outlet UKHCA membership figure of seventy-three percent.

Voluntary sector/not-for-profit organisations make up 32% of respondents as opposed to 14% in 2000. The voluntary sector provided 33% of independent hours purchased by local authorities as opposed to the figure of 15% quoted in the last Who Cares report. In the last report it stated that many housing associations were developing home care services. Although we included housing organisations who were providing home care services on the database as taken from CSCI, those who had not yet completed their registration may not have been included. 19% of organisations taking part in the survey stated that they provided housing support services. *N.B. Please see warning on page 16.*

70% of respondents were single outlet organisations (counting all 727 outlets) as opposed to 51% in the last report. This is contrary to the expectation of a fall in the number of smaller providers due to consolidation within the industry.

The people, who completed the questionnaires, as with any postal survey, could be expected to find the topic of the survey salient to them. If this was the case, the level of training provided by organisations and the level of qualifications of the home care workers who responded is likely to be higher than the total population.

APPENDIX TWO: MISCELLANEOUS DETAILED DATA

See figures 11-13

Enjoy helping people	68.2%	19.9%	5.0%	2.8%	4.1%	2768
Like care work	68.0%	20.0%	5.0%	3.0%	4.0%	2777
Flexibility	49.6%	18.4%	18.1%	7.0%	6.9%	2770
Easy application process / rapid start	37.6%	27.5%	23.2%	6.0%	5.7%	2718
Pay	31.2%	30.3%	26.0%	7.7%	4.7%	2721
Convenience	25.3%	23.4%	24.1%	12.5%	14.7%	2634
Pathway to nursing	16.3%	11.7%	18.6%	14.0%	39.5%	2588
Just needed a job	9.2%	7.0%	14.6%	17.7%	51.6%	2570
Relationship with clients	83.6%	9.9%	1.5%	1.0%	4.0%	2835
Good managers	82.2%	10.8%	1.9%	1.0%	4.1%	2818
Accessible managers	72.6%	17.1%	4.8%	1.7%	3.8%	2796
Training	70.7%	17.2%	6.3%	2.1%	3.7%	2821
Being trained before starting work	66.8%	18.3%	8.9%	2.5%	3.5%	2792
Flexibility to meet client needs	65.4%	23.1%	6.2%	1.8%	3.5%	2797
Clear, simple contract	59.3%	22.7%	11.8%	2.9%	3.2%	2792
Opportunity to do NVQ	53.5%	20.7%	12.7%	4.7%	8.3%	2781
Involvement in decisions about clients	50.9%	27.8%	14.4%	3.2%	3.7%	2783
Staying with same clients	42.3%	26.9%	20.8%	4.6%	5.4%	2801
Able to refuse work	40.6%	24.9%	23.0%	6.0%	5.5%	2742
Opportunity for promotion	39.8%	21.2%	20.0%	8.3%	10.8%	2745
Clearly defined career path	35.6%	23.7%	23.5%	8.1%	9.0%	2793

See figures 14-16

Enjoy helping people	67.0%	21.0%	4.0%	3.0%	5.0%	497
Like care work	60.4%	22.8%	8.2%	3.1%	5.5%	513
Easy application process / rapid start	37.8%	27.2%	21.1%	5.9%	7.9%	477
Flexibility	27.4%	17.6%	26.8%	12.3%	16.0%	489
Pay	17.6%	32.6%	31.8%	11.7%	6.3%	494
Convenience	10.8%	16.5%	28.8%	18.1%	25.8%	480
Pathway to nursing	8.4%	5.1%	11.0%	8.8%	66.8%	455
Just needed a job	6.3%	3.0%	11.1%	11.7%	67.9%	461
Good managers	88.3%	6.3%	0.2%	0.8%	4.4%	522
Relationship with clients	82.7%	10.2%	1.7%	1.2%	4.2%	521
Training	78.0%	13.6%	3.4%	0.6%	4.4%	523
Accessible managers	71.5%	17.9%	4.5%	2.0%	4.1%	509
Being trained before starting work	70.3%	16.3%	7.9%	1.6%	3.9%	509
Involvement in decisions about clients	69.7%	20.7%	4.2%	1.7%	3.6%	521
Flexibility to meet client needs	68.4%	23.4%	3.3%	1.2%	3.7%	513
Clear, simple contract	61.4%	22.3%	9.9%	1.7%	4.7%	515
Opportunity to do NVQ	58.2%	21.0%	11.1%	2.7%	7.0%	514
Opportunity for promotion	56.1%	23.6%	10.5%	3.1%	6.6%	512
Clearly defined career path	45.4%	25.9%	16.9%	6.3%	5.5%	509
Staying with same clients	45.2%	27.1%	18.1%	4.6%	5.0%	498
Able to refuse work	35.3%	30.2%	22.2%	5.3%	6.9%	490

See figure 17

Hours	Frequency	Percent
0	111	7.10%
1	50	3.20%
2	100	6.40%
3	80	5.10%
4	82	5.30%
5	59	3.80%
6	81	5.20%
7	31	2.00%
8	105	6.80%
9	9	0.60%
10	106	6.80%
11	6	0.40%
12	77	5.00%
13	5	0.30%
14	24	1.50%
15	50	3.20%
16	40	2.60%
17	5	0.30%
18	34	2.20%
19	4	0.30%
20	85	5.50%
21	44	2.80%

Hours	Frequency	Percent
22	8	0.50%
23		0.00%
24	54	3.50%
25	25	1.60%
26	4	0.30%
27	1	0.10%
28	9	0.60%
29		0.00%
30	61	3.90%
31		0.00%
32	12	0.80%
33	1	0.10%
34	6	0.40%
35	22	1.40%
36	8	0.50%
37	21	1.40%
38	4	0.30%
39	1	0.10%
40	39	2.50%
41		0.00%
42	1	0.10%
More	89	5.90%
Total respondents	1554	

See figure 18

Hours	Frequency	Percent
0	35	15.80%
1	3	1.40%
2	6	2.70%
3	2	0.90%
4	8	3.60%
5	6	2.70%
6	8	3.60%
7	5	2.30%
8	4	1.80%
9	2	0.90%
10	13	5.90%
11	0	0.00%
12	5	2.30%
13	0	0.00%
14	2	0.90%
15	6	2.70%
16	7	3.20%
17	0	0.00%
18	2	0.90%
19	0	0.00%
20	13	5.90%
21	3	1.40%

Hours	Frequency	Percent
22	0	0.00%
23	0	0.00%
24	12	5.40%
25	5	2.30%
26	0	0.00%
27	1	0.50%
28	0	0.00%
29	0	0.00%
30	9	4.10%
31	0	0.00%
32	0	0.00%
33	0	0.00%
34	1	0.50%
35	3	1.40%
36	2	0.90%
37	11	5.00%
38	0	0.00%
39	1	0.50%
40	15	6.80%
41	0	0.00%
42	0	0.00%
More	31	14.20%
Total respondents	221	

See figure 19

Hours	Frequency	Percent
0	2	0.43%
1	1	0.21%
2	3	0.64%
3	3	0.64%
4	7	1.49%
5	8	1.70%
6	10	2.13%
7	5	1.06%
8	7	1.49%
9	3	0.64%
10	31	6.60%
11	1	0.21%
12	24	5.11%
13	0	0.00%
14	11	2.34%
15	23	4.89%
16	14	2.98%
17	1	0.21%
18	20	4.26%
19	2	0.43%
20	42	8.94%
21	50	10.64%

Hours	Frequency	Percent
22	1	0.21%
23	1	0.21%
24	27	5.74%
25	11	2.34%
26	0	0.00%
27	1	0.21%
28	9	1.91%
29	0	0.00%
30	30	6.38%
31	2	0.43%
32	6	1.28%
33	0	0.00%
34	0	0.00%
35	27	5.74%
36	7	1.49%
37	6	1.28%
38	1	0.21%
39	0	0.00%
40	17	3.62%
41	0	0.00%
42	0	0.00%
More	56	11.91%
Total respondents	1698	

See figure 20

	30	41%
	69	41%
	64	37%
	108	44%
	108	44%
	146	49%
	137	44%
	115	42%
	93	36%
	79	35%
	53	30%
	24	29%
	6	19%
	1	14%
	0	0%

See figure 21

	0.0%	0	0.6%	3	1.3%	35
	22.8%	41	31.4%	161	33.5%	920
	41.1%	74	44.1%	226	42.3%	1160
	23.9%	43	18.0%	92	16.9%	465
	11.7%	21	5.7%	29	5.4%	147
	0.6%	1	0.2%	1	0.7%	18
		180		512		2745

APPENDIX THREE: THE QUESTIONNAIRES

se tick an

YOUR

How d

Newsp

Job Ce

Alread

homec

2. In cho Please circle 1 – 5, where 1 = 've

Flexib	2	3	4	5
Pay	2	3	4	5
Enjoy	2	3	4	5
Like ca	2	3	4	5
It is co	1	2	3	4	5
Just ne	1	2	3	4	5
It prov	1	2	3	4	5
Other	1	2	3	4	5

3. Which y work in?

4. Do yo er? (✓ one) Yes ☐ No ☐

5. How n k as a home care worker in the last seven days? ☐

6. Do yo an one home care organisation? (✓ one) Yes ☐ No ☐

If yes, ome care organisations do you work for? (Please enter a number beside of organisation you work for).

Priva tary home care or		Local authority home care service	
g. Trust, GP, PCT)		Any other home care organisation	
ed/very sheltered sing		**Total number of home care organisations**	

7. e you other paid work at present, other than a home care worker? Yes ☐ No ☐

, please specify

8. Are you paid for time spent travelling between clients? (✓ one) Yes ☐ No ☐

9. Are you paid expenses for travelling between clients? (✓one) Yes ☐ No ☐

10. Are your working hours guaranteed? Yes ☐ No ☐

If yes, what is the average number of hours guaranteed? ☐

11. What is your normal hourly rate of pay? (✓ one)

Less than £4.50	☐	£4.51 - £5.50	☐
£6.51 - £7.50	☐	£7.51 - £10.00	☐

YOUR EXPERIENCE

12. How many years in total have you worked as a home care worker? If less than one year, how many months have you worked?

Years ☐ Months ☐

13. In the past how many home care organisations have you worked for in ☐

14. Please indicate any current or past work or other experience you have which is relevant to home care (please tick ✓all that apply and indicate for each one how long you worked for them)

	✓	How long?
Care assistant (including residential/nursing home)		
Auxiliary work in hospitals		
Registered nurse		
Caring for a relative/friend		
Child minder		
Nanny		
Au Pair		
House-keeper		
Cook		

Other work or experience relevant to home care (please state)

15. Now you are working in social care what are the following things to you? (Please circle 1 – 5, where 1 = 'very important' and 5 = 'not at all important'.

Good managers	1	2	3	4	5
Being able to get hold of manager	1	2	3	4	5
Being able to say 'no' to work	1	2	3	4	5
Your relationship with clients	1	2	3	4	5
Flexibility to change your need	1	2	3	4	5
Staying with the same client	1	2	3	4	5
Training	1	2	3	4	5
A clear and easily understood contract	1	2	3	4	5
Being trained before you start work	1	2	3	4	5
An opportunity to undertake NVQ/SVQ qualification	1	2	3	4	5
Opportunity to progress to senior careworker or higher	1	2	3	4	5
Simple, quick recruitment process and rapid start to work	1	2	3	4	5
Being informed about clients or work	1	2	3	4	5
Supported career development	1	2	3	4	5

YOUR TRAINING

16. How many hours of induction training did you receive for this employment? ☐

17. Do you have any of the following qualifications in care or are you working towards any of them? (please tick ✓all that apply)

	Working towards	Hold
NVQ/SVQ Care level 4,		
Certificate in Social Services (CSS)		
Certificate in Qualification in Social Work (CQSW)		
Diploma in Social Work (DipSW)		
Registered Nursing Qualification (or equivalent)		
NVQ/SVQ Care level 3		
NVQ/SVQ Care level 2		
NVQ/SVQ assessor		
NVQ/SVQ internal verifier		
NVQ/SVQ mentor awards		
SPA Enhanced home care practice award		
SPA Home care practice award		
Other (please state)		

18. Do you do any of the following? (✓all that apply). **If yo… …the… …r to any of these questions please put 'don't know'.**

	NVQ/…	OTHER
Undertake **all** work related training in your …		
Undertake **some** work related training in y… …wn time and some in paid time?		
Undertake **all** work related training in p…		
Pay for **all** your work related training course…		
Pay for **some** of your work related t… …g course…		
Have **all** your work related trainin… …id for by your organisation?		
Have **all** your work related training … …s p… another organisation? (Please state org… …on)		
Have **some** of your work re… …ining … …paid for by another organisatio… …ion)		

19. Do you feel there is any furth… …you nee… …carry out your current work. (✓ one)

Yes ☐
No ☐

If yes, please spec…

---

20. Are you involved i… …ping … …ming personal plans/care diaries?

Yes ☐
No ☐

If yes, hav… …ou had train… …ist you with this? Yes ☐ No ☐

21. Whi… …g/… …expe… …e have you found most useful/relevant to your work?

---

22. Hav… …ven inf… …ion on your responsibilities to work in accord… …th the Ge… …Social Care Council/Scottish Social Care Council Codes of … (✓ one)

Yes ☐
No ☐

23. Is the Code of Practice incorporated into your terms and conditions of employment?

Yes ☐
No ☐

24. Do you provide home care services for any of the groups below and have you had specific training to care for them? (✓all that apply)

	Provide services	Specific training
Older people		
People who are elderly, mentally infirm		
People with dementia		
People with a physical disability		
People with a learning disability		
People with mental health problems		
People who abuse drugs, alcohol etc.		
People with infectious/contagious diseases		
People with health needs i.e continence aids, medication, dressings etc.		
Children		
Young offenders		
People who have a sensory impairment		
People from minority ethnic groups		
Personal care		
Respite care		
Hospital discharge		
Prevention of admission		
Live-in care		
Domestic services		
Night sleeping service		
Rapid response		
Social & emotional support		
Night waking service		
Intermediate care		

ABOUT YOURSELF

25. How old are you? (years) ☐

26. What is your gender? (✓ one) Male ☐ Female ☐

27. Do you consider yourself disabled? (✓ one) Yes ☐ No ☐
If yes, please describe your disability

Workforce Survey of Home Care Organisations 20

Please tick (✓) answers that apply where necessary or provide information where requ

YOUR ORGANISATION

1. Does your organisation provide home care services? (✓ on — Yes ☐ No ☐

2. Does your organisation provide Housing Support? (✓ one) — Yes ☐ No ☐

If yes to one or both of the above please complete t… g questi…
If no to both, please state what service you d… return the …estionnaires in the freepost envelope provided.

3. Which Local Authority area is your principal …

4. Is your organisation? (✓ one)
Private/for-profit ☐
Volu…/Charity/Not for Profit ☐

5. Are you part of a larger home care organisa… ✓ o… Yes ☐ No ☐

6. **If yes**, how many branches are t… ☐

7. Are you completing this question… …ingle b… as a head office? (✓ one)
As a single branch ☐ …head office ☐

8. Is your organisation a m…r of UKHCA? (✓ o… Yes ☐ No ☐

9. Is your organisation a … …sociation? (✓one) Yes ☐ No ☐
If yes, please state

YOUR SERVICES

10. Does your organisation provide … …rvices in addition to home care? (✓ one) Yes ☐ No ☐

If no, go t… …n 11
If yes, w… …ther s… …provide? (✓all that apply)

… …y ☐ Meals on wheels service ☐
… …ome ☐ Short breaks/respite ☐
Care home with nursi… Sheltered/very sheltered housing/extra care ☐
Day care ser… ☐ Other (please specify) …

11. Please indicate the type of service users your home care organisation cares for. (✓all that apply)

As a generic service		**As a specialist service**	
Older people		Older people	
People who are elderly, mentally infirm		People wh… elderly, mentally infirm	
People with dementia		P…le with dementia	
People with a physical disability		…e wit… …ysical disability	
People with a learning disability		…le w… …earnin… …ility	
People with mental health problems		…al hea… …olems	
People who abuse drugs, alcohol etc.		Peop… …dru… …hol etc.	
People with infectious/contagious diseases		People with ini… …s diseases	
Children		Children	
Young offenders		Young offenders	
People who have a sensory impairment		…ople who hav… …ory impairment	
People from minority ethnic groups		…le fro… …ity ethnic groups	

12. How many service users did you arrange ca… during t… – 22nd May 2004?
(N.B. If the actual figures are not availabl… estimate…

Actual figures ☐ Esti…tes ☐

13. Estimate the number of hou… you a…ed/provided in the week of 16th – 22nd May 2004 within each of these categories.

Practical care	Personal care	…cialist care	**Total**

14. Please enter the total numbe… …urs purch…d from your organisation during the week of 16th – 22nd May 2004? …care as 10 hours of service per day)

Local Authorities	Pr… …urch…	National health service (e.g. Primary Care Trusts)
Other (please state)		
Total Hours Of Home … …hased		

INFORMATION ABOUT STA…

15. How many p… …orked in home car… …anged by your organisation in the following categories during the … …y 2004? (Please give the number and the total hours employed in each categ… …

	Numbers (head count)		Total hours employed
	Full-time	Part-time	
Managers and dep… …rs			
Senior/specialist/en… …are workers (who may su… …others)			
…are …			
…min st…			

16. …eople … …rovided home care in your organisation during the week of 16th – 22nd May … …npaid vo… …ers?

Numbers ☐ Total hours worked ☐

17. Do any of your care workers have guaranteed hours? (✓ one) Yes ☐ No ☐

If yes, what is the average number of guaranteed hours? ☐

18. Do your care workers receive expenses for travel between clients? (✓ one)
Yes ☐
No ☐

19. Do your care workers receive pay for travel time between clients? (✓ on
Yes ☐
No ☐

20. **If yes**, is this paid at the normal hourly rate? (✓ one)
Yes ☐ ☐

TRAINING

21. How many of your workforce has a relevant qualification in care for their particular role or are working towards one?

		Hold
Managers/deputy managers		
NVQ/SVQ in Management or RMA (Registered Manage ward)		
NVQ/SVQ assessor		
NVQ/SVQ internal verifier		
NVQ/SVQ mentor awards		
NVQ/SVQ Care level 4,		
Certificate in Social Services (CSS)		
Certificate in Qualification in Social Work (CQ		
Diploma in Social Work (DipSW)		
Registered Nursing Qualification (or equiva		
Other (please state)		
Home care workers		
NVQ/SVQ Care level 4,		
Certificate in Social Services (CSS)		
Certificate in Qualification in Social Wor SW)		
Diploma in Social Work (DipSW		
Registered Nursing Qualificati len		
NVQ/SVQ Care level 3		
NVQ/SVQ Care level 2		
SPA Enhanced home care practice a tland)		
SPA Home care practice award (Scotland		
Other (please state)		

22. Do any of the follow y to ye e staff? Do they…(✓all that apply)

	Skills training	Statutory training	Continual Professional Development
Undertake related tra their own time?			
Undertal work related tra n their own time and so paid ti			
Under all w ing in paid time?			
Pay fo relate ning courses?			
Pay for ir work d training courses?			
Have **all** their work ning courses paid for by your organisation?			
Have **all** their work related training courses paid for by another organisation? (Please state organisation)			
Have **some** of their work related training courses paid for by another organisation? (Please state organisation)			

23. How is the training you provide funded?

24. Do you provide specific training within any of the following categ (✓all that apply)

Older people		Personal care	
People with dementia		Respite care	
People who are elderly, mentally infirm (EMI)		spital arge	
People with a physical disability		tion of sion	
People with a learning disability		n care	
People with mental health problems		ervices	
People who abuse drugs, alcohol etc.		g service	
People with infectious/contagious diseases		d response	
Children		Social & emotional support	
Young offenders		waking service	
People who have a sensory impairment		termediate care	
People from a black and minority ethnic group			

25. How many hours of induction do you provi ewly app ne care workers work on their own in a service user's hom

26. Does your induction include informati the wo responsibilities to work in accordance with the GSCC/SSCC C one) Yes / No

27. Is the Code of Practice incorpo your teri itions of employment? Yes / No

28. Does your induction provide train ide r prevention of abuse? Yes / No

RECRUITMENT AN ON

29. Do you offer a clearly ar Yes / No

30. Does your pay structure reflec ualifications? Yes / No

31. Has your orga n experienced any ulty with the recruitment or turnover of home care workers ? (✓ one) Yes / No

32. **If yes**, please g ils

33. Please estimate the ome care workers identified in 15 who started working for you in the last 12 months. (P er 0 if none)

Number of workers who started

34. se esti ber o home care workers who left your organisation in the last 12 months. se

Number of workers who left

35. Do the home rs identified in 15 have the skills/competencies to meet the needs of clients? (✓ o

Yes, fully / Partly / Not at all / Not known

36. Have you taken any special measures to tackle recruitment/retention problems? Yes / No
If yes, please specify

Thank you for your time in completing this questionnaire. Please be assured that your answers will remain totally confidential. **Please return this questionnaire in the freepost envelope provided.**

Survey of Registered Managers 2004

Please tick answers that apply where necessary or provide information where requested.

YOUR JOB

1. How did you find out about your job? (✓ one)

Newspaper		Other a	
Job Centre		eone to	
Already working for another homecare organisation		lease sta	

2. In choosing home care work, how importa the t below? (Please circle 1 – 5, where 1 = 'very important' and 5 = 'not at all im

Flexibility to fit around other commitments		2	3	4	5
Pay		2	3	4	5
Enjoy helping people		2	3	4	5
Like care work	1	2	3	4	5
It is convenient	1	2	3	4	5
Just needed a job		2	3	4	5
It provides a way into a care sing		2	3	4	5
Other (please state)	1	2	3	4	5

3. Which Local Authority area do ly work

4. Do you work as a li are worker? (✓ on Yes ☐ No ☐

5. How many hours manager in the last seven days? ☐

6. Do you work for more care organisation? (✓ one) Yes ☐ No ☐

If yes, how ny home ca sations do you work for? (Please enter a number beside of organisati work for).

Priva tar are orga ion		Local authority home care service	
Hea		Any other home care organisation	
Shel eltered housing		**Total number of home care organisations**	

7. Have you any ot work at present, other than a registered manager? (✓ one) Yes ☐ No ☐

If yes, please specify

8. Are you paid for time spent travelling between clients? (✓ one) Yes ☐ No ☐

9. Are you paid expenses for travelling between clients? (✓one) Yes ☐ No ☐

10. Are your working hours guaranteed? Yes ☐ ☐

If yes, what is the average number of hours guaranteed? ☐

11. What is your normal hourly rate of pay? (✓ one)

Less than £4.50	☐	£4.51 - £5.50	☐	£5.[illegible]	☐
£6.51 - £7.50	☐	£7.51 - £10.00	☐	More than £[illegible]	☐

YOUR EXPERIENCE

12. How many years in total have you worked in home care? [illegible]an 1 year, how [illegible] months have you worked?

Years ☐ [illegible] ☐

13. In the past how many home care organisations have you worked for in t[illegible] ☐

14. Please indicate any current or past work or other [illegible]rience [illegible]ave had which is relevant to home care (please tick ✓all that apply and indi[illegible]each [illegible]ow long you worked for them)

	✓	How long?
Care assistant (including residential/nursing home		
Auxiliary work in hospitals		
Registered nurse		
Caring for a relative/friend		
Child minder		
Nanny		
Au Pair		
House-keeper		
Cook		

Other work or experience relevant [illegible]are (plea[illegible]tate)

15. Now you are working in home care, how im[illegible]e the following things to you? (Please circle 1 – 5, where 1 = [illegible]ortant' and 5 = [illegible]at all important'.

Good managers	1	2	3	4	5
Being able to get ho[illegible]nag	1	2	3	4	5
Being able to say 'no' t[illegible]	1	2	3	4	5
Your relationship with yo[illegible]t	1	2	3	4	5
Flexibility to do what your [illegible]t or need	1	2	3	4	5
Staying with t[illegible]me clients	1	2	3	4	5
Training	1	2	3	4	5
A clear a[illegible]un[illegible]contr	1	2	3	4	5
Being t[illegible]d bef[illegible]ork	1	2	3	4	5
An opp[illegible]tai[illegible]VQ/SVQ qualification	1	2	3	4	5
Opportu[illegible]ess	1	2	3	4	5
Easy, quick [illegible]ation pro[illegible]nd rapid start to work	1	2	3	4	5
Being involved in de[illegible]ut clients or work	1	2	3	4	5
A clearly defined ca[illegible]	1	2	3	4	5

YOUR TRAINING

16. How many hours of induction training did you receive for this employment? ☐

17. Do you have any of the following qualifications in care or are you working towards any of them? (please tick ✓all that apply)

	Working towards	Hold
NVQ/SVQ Care level 4,		
Certificate in Social Services (CSS)		
Certificate in Qualification in Social Work (CQSW)		
Diploma in Social Work (DipSW)		
Registered Nursing Qualification (or equivalent)		
NVQ/SVQ Care level 3		
NVQ/SVQ Care level 2		
NVQ/SVQ assessor		
NVQ/SVQ internal verifier		
NVQ/SVQ mentor awards		
SPA Enhanced home care practice award		
SPA Home care practice award		
Other (please state)		

18. Do you do any of the following? (✓all that apply). **[illegible]t know [illegible]r to any of these questions please put 'don't know'.**

	[illegible]SVQ	OTHER
Undertake **all** work related training in your [illegible]e?		
Undertake **some** work related training in yo[illegible] time and some in paid time?		
Undertake **all** work related training in p[illegible]time?		
Pay for **all** your work related training		
Pay for **some** of your work related tr[illegible]		
Have **all** your work related training cou[illegible]id [illegible] your organisation?		
Have **all** your work related trai[illegible]es pa[illegible]by another organisation? (Please		
Have **some** of your work rela[illegible]r co[illegible] for by another organisation? (Plea[illegible]ranisatio[illegible]		

19. Do you feel there is any further training yo[illegible]carry out your current work. (✓ one)

Yes ☐
No ☐

If yes, please specify

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20. Are you involved in develop[illegible]aintaining personal plans/care diaries?

Yes ☐
No ☐

If yes, h[illegible]ad[illegible]o ass[illegible]you with this? Yes ☐ No ☐

21. Which [illegible]g e[illegible]nce have you found most useful/relevant to your work?

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22. Have you been give[illegible]on on your responsibilities to work in accordance with th[illegible] Social Care Council/Scottish Social Care Council Codes of Practice? (✓ one)

Yes ☐
No ☐

23. Is the Code of Practice incorporated into your terms and conditions of employment?

Yes ☐
No ☐

24. Do you provide home care services for any of the groups below and have you had specific training to care for them? (✓all that apply)

	Provide services	Specific training
Older people		