Eurofound

More and better jobs in home-care services

United Kingdom

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Introduction

This country report gives an overview of the labour market policy in community-based care for adults with disabilities and chronic health problems in the United Kingdom (UK). The main topics discussed are the context in which community care labour market instruments are implemented, the funding structure, the strategies used to recruit new employees and retain current workers in the sector, and the resulting impacts and outcomes. Three case studies were carried out into initiatives in the field of labour market policies in community-based care to support adults with disabilities: the Single Ticket Programme, Assistive Technology Norfolk and the Social Care Workforce Development Programme. Annex 1 to this report contains summaries of the three case studies and analyses the main outcomes and success factors.

'Community care' covers a wide range of health and social care services. The term is ambiguous in that it can refer to services *in* the community as well as services provided *by* the community. Nevertheless, community care includes services such as home care, recreational activities, day care, respite care, and supported housing and employment. Such services differ from institutional care provided in mental health institutions as well as nursing and residential homes. Employment in community care comprises a variety of service providers. This report focuses on home help workers, social care workers, social workers, activity workers, community nurses and other professionals such as therapists.

1 Policy background

Overview of the care sector in the UK

Following the devolution of powers in the UK in 1997, there has been a transformation in the organisation and delivery of health and social care services. In England, Scotland and Wales, local authorities are responsible for social care, although there are different systems; in Northern Ireland, a single health and social care board exists (Hocking, 2009). Despite the different systems, similar services are offered across the UK. Publicly funded community-based care services are now delivered mainly by independent providers (Francis, 2013). The provision of home care has transformed significantly with the introduction of direct payments – cash payments to service users – and personal budgets, enabling greater personalisation of care.

In 2010–2011, 1.6 million people in England received social care services: 1.3 million (81%) people received community-based services including home care or home help; 213,000 people received residential care and 88,000 nursing care. Of those service users receiving community-based care, 65% were aged 65 and over. In terms of the specific age cohorts, 92% of care service users aged between 18 and 64 received community care compared with 82% of service users aged 65 and over, who are more likely to use residential and nursing care. With regard to the care needs of service users, two thirds (65%) of community care service users had a physical disability, while 21% had mental health problems and 12% had a learning disability (Health and Social Care Information Centre, 2012).

Reasons for developing and maintaining community-based care services

In the UK, like in many European countries, there has been a commitment over the years to transform social care provision for the elderly and people with disabilities from institutional to community-based care (Mansell et al, 2007). The introduction of direct payments and personal budgets has enabled many people to live independently in their home, providing individuals with greater flexibility and control over their care requirements.

'Big Society' is the concept that has been adopted by the current coalition government to make a case for creating greater community cohesion, challenging and encouraging communities to take responsibility and empowering individuals. The provision of social care in this context is moving away from a structural and professionally-led service to a community-based system directed by users (Skills for Care, 2011a). Moreover, the government aims to reduce spending on long-term residential care to reinvest in other services in a community setting, such as supported housing. Community-based services are considered to provide better outcomes and lower costs for service users and their carers than traditional nursing and residential care (Department of Health, 2010).

Type of community care services available

Community-based care in the UK includes a range of adult social care services that can be grouped broadly into domiciliary (home care), day care and community services. Specifically, these include self-directed support such as direct payments and personal budgets, supported living services, extra care housing services, domestic services, home helps, meals on wheels, professional support, carers' support services, short breaks and respite care, community support and outreach services, disability adaptations and assistive technology services, occupational and employment-related services, and information and advice services. This range of social care services generates a great diversity of jobs in the UK.

In 2010–2011, most service users in England received home care. Those aged 18–64 were more likely to receive professional support and direct payments. There has been a sharp rise in self-directed support such as direct payments and personal budgets over the past few years – specifically, from 166,000 recipients in 2009–2010 to 377,000 in 2010–2011. The number of

service users in receipt of direct payments alone rose from 37,000 recipients in 2005–2006 to 125,000 in 2010–2011 (Health and Social Care Information Centre, 2012). This reflects the personalisation and community-based approach to social care developed in the UK. Such developments have implications for job creation and recruitment in the sector.

Personalisation of services is having a significant impact on the roles of social care professionals. Personal budgets have transformed the functions of care management. Service users are now expected to play a role in assessing their own needs, drawing up care plans and purchasing services. As a result, local authorities have created a range of new roles or commissioned external organisations to support service users in carrying out these tasks. There has also been a reduction in some areas in the use of qualified workers and a rise in the use of non-professional staff (Dunning, 2012).

Labour market situation

Historically, recruitment and retention in social work and social care in the UK has been an issue of concern. Several negative aspects are associated with the sector which have impacted adversely on recruitment. Social care suffers from a poor image, low status, lack of public recognition and low pay compared with other professions. At the same time, there is competition from more attractive career options. Moreover, there has been a lack of available career information and a clear career path to attract workers. Low levels of job retention have mainly been associated with a loss of job satisfaction. The sector is characterised by labour shortages, a reliance on overtime work and temporary or inexperienced staff, poor management and high levels of bureaucracy, a lack of flexible working arrangements, the need to work anti-social hours, and work of a stressful and demanding nature (Eborall and Garmeson, 2001).

As a result of population ageing and the increasing number of people with chronic illnesses and disabilities, the demand for social care services in the UK is projected to grow rapidly. It has been estimated that the number of jobs in adult social care in England will grow by between 24% and 82% between 2010 and 2025 (Skills for Care, 2012c).

Many employers in the social care sector employ migrant workers from the European Union (EU) and from non-EU countries. While some employers insist that they do not rely on migrant workers, others cannot fill gaps in their workforce from within the EU. The more recent proclamations by the UK government to reduce levels of immigration from outside the EU could impact on the recruitment practices of employers in the social care sector (Skills for Care, 2010a).

PESTLE analysis

The research used the ‘PESTLE’ model to identify the external factors influencing the development of the labour market. The six dimensions in the PESTLE model are the *political*, *economic*, *social*, *technological*, *legal* and *environmental* dimensions. The PESTLE approach was originally a business-study model used to describe a framework of relevant factors at the macro level, used mainly for analysing the business environment of organisations. It is a means of measuring strengths and weaknesses against external factors and can help organisations develop strategies. In the same way, a PESTLE analysis can also be used for a contextual analysis of sectoral labour markets.

These six dimensions can greatly influence the sectoral labour market, although some are obviously more important than others. In the context of the research into the care sector, particular consideration must be given to the political and economic dimensions, as these have direct effect on the possibility of creating attractive and useful jobs in the community-based care sector. The financial dimension is of special importance in this context since this is not a commercial sector, but one generally financed with public money.

Since the situation in the different countries included in the research is different, the labour

market discrepancy model connected to the PESTLE factors can identify where the issues lie in each country. The model provides, in a sense, a common language that describes the challenges faced by the different actors. As previous research has already shown that there is a general shortage of labour in the sector, and in some cases a shortage of jobs, it is to be expected that there are clear discrepancies. The model can swiftly record whether these are qualitative or quantitative, due to a lack of influx into the sector or too great an outflow than can be compensated for, or whether they are triggered by developments in one of the PESTLE dimensions. At the same time, the model offers a structured means of comparison.

Political and legal factors

The government seeks to cut spending on residential care to reinvest the finances in community-based care services, increasing the use of personal budgets and direct payments. Several initiatives have been undertaken to increase the attractiveness of careers in the care sector and to improve recruitment and retention in the sector.

Economic factors

The austerity measures of the current government and cutbacks in public spending will affect social care budgets and the independence of many people with disabilities who are in receipt of a disability living allowance. Social workers and carers employed by the local authorities will face pay cuts and pay freezes, as there is an expectation to deliver savings. The private providers of care services commissioned by the authorities will also be affected. There is a fear that cuts in social care spending and a lack of resources will undermine the government's agenda to transform social care from a crisis-response to a preventative service, along with its aim to empower service users. This may also have a direct influence on the workforce.

Social factors

The concept of 'Big Society' has been used by the government to present its vision of a society where individuals and communities have more power and responsibility, in an effort to create better neighbourhoods and local services. Their goal is to transform social care services by stimulating innovation in the sector and creating incentives for the development of new community-based providers such as small provider agencies and social enterprises. There are growing pressures on the health and social care services sector, particularly due to population ageing. More people are living longer and the number of people with dementia, chronic illnesses and disabilities is on the rise. An adequate supply of workers will be required to meet this demand.

Technological and environmental factors

The growing use of assistive living technology (ALT) (such as telecare and digital participation services) by individuals in need of social care will have implications for the social care workforce. The development of new skills will be required to assist people with the use of such technologies. Skills for Care, the skills council for social care in England, is working towards providing the social care workforce with comprehensive and practical guidance on the skills, knowledge and understanding that social care staff in a variety of community-based roles will need to have of ALT, at a variety of levels.

Recruitment and retention of care workers

The Commission on Funding of Care and Support, chaired by Andrew Dilnot, was set up in July 2010 to review the funding system for care and support in England. The Commission reported back to the government in July 2011, providing advice and recommendations on how to reform the system. The current system was found to be confusing, unfair and unsustainable. Planning for future care needs is difficult and assessments of needs are complex; there are differences in

eligibility criteria between local authorities and the provision of information and advice is generally poor. Under the current system, care and support services are disjointed. In addition, the cost of care is high and the choice of financial products that can support care costs is limited. This report makes several recommendations on how to reform the funding of care (see Chapter 3) to create a fairer system. The reformed system is also expected to deliver higher quality of services; people will be more certain of their future and will be able to spend their money more effectively. In order to develop higher quality services, local authorities will need to stimulate and shape the market for services that necessarily require adequate funding (Dilnot et al, 2011).

2 Political and legal frameworks

Regulations and policies on recruitment in community care services

Over the past two decades, a number of important pieces of legislation have significantly affected the development of community-based care services for adults with disabilities in the UK.

1. The Disability Discrimination Act (1995) and the Human Rights Act (1998) – these sought to promote the equal rights of people with disabilities in different areas of public life.
2. Modernising Social Services (Department of Health, 1998) – this measure sought to promote independence, improve protection and raise standards in the provision of social services. The Community Care (Direct Payments) Act (Department of Health, 1996) – this Act introduced self-directed support payments (direct payments and personal budgets), which enable service users to exercise greater choice and control over their individual care needs. People with disabilities in receipt of direct payments are in control of their own care budget and can recruit personal assistants of their choice or arrange day care in the community. Direct payments can also be used to purchase equipment and adaptive technology.
3. The Equality Act (2010) – this legislation replaced the earlier anti-discrimination laws with a single Act, making it easier for people to understand and comply with the law. It strengthens the law in terms of tackling discrimination and inequality. The Act has implications for community-based care: it provides a legal framework which can support personalisation in adult social care. Care providers from all sectors need to ensure that individuals receive services that are respectful, effective and accessible.

Recruitment strategies for community care workers

Government policy for the development of the workforce in social care involves several instruments, namely:

- a recruitment and retention strategy for adult social care;
- a workforce development strategy;
- a workforce innovation programme;
- the principles of workforce redesign;
- workforce development for those working in the field of ALT;
- international recruitment;
- neighbourhood workforce planning and community skills development;
- a sector qualification strategy;
- a sector skills agreement;
- workforce commissioning (Skills for Care ‘Workforce Strategy’).

The government recognises that the demographic and social changes, along with greater emphasis on personalisation and funding issues necessarily shape the demand for and supply of care services. Improving the image of social care and transforming it into a career of positive choice are at the heart of the recruitment and retention strategy; the sector requires a skilled, capable and confident workforce (Skills for Care, 2011a). The ‘Adult social care workforce – recruitment and retention strategy’ (Skills for Care, 2011a) has a number of key themes, each consisting of several elements, as outlined under the following sub-headings.

Promoting social care

- Better explaining social care
- Improving public awareness
- Selling the value, rewards and longevity of a career in social care
- Promoting career opportunities
- Elevating the status of social care work and affirming professionalism

Attracting a diverse workforce

- Facilitating career transitions
- Encouraging older workers
- Encouraging volunteering and community capacity building
- Addressing equalities and gender balance
- Ensuring an appropriate workforce

Managing new interests and recruits

- Nurturing new recruits
- Ensuring direct employers are given targeted information to support their recruitment and retention needs
- Developing new career pathways that recognise developing specialities
- Developing incentives for retention and career progression
- Supporting a community-based approach to care and support

Retention

- Encouraging personal development and growth
- Encouraging organisational development and growth

Research and intelligence

- Informing and influencing national policy development, local initiatives, individual businesses, and service and workforce development

Standards, learning and qualifications

- Providing clear information about training and funding support
- Implementing quality assurance
- Providing effective and consistent induction
- Ensuring that qualifications are fit for purpose and represent value for money, using an employer and sector-led approach based on the new qualifications (Qualifications Credit Framework (QCF)).
- Engaging with the supply side to ensure what it offers meets the needs of employers and the new agenda

3 Structural framework, funding and actors involved

Employment in the care sector

The social services sector employs about 1.87 million people across the UK. This includes people providing social work, social care and children's services.[1] In terms of adult social care, the analysis by Skills for Care makes a distinction between the number of jobs in adult social care and the number of people working in the sector, recognising that some people may hold more than one job. As shown in Tables 1 and 2, there were an estimated 1.85 million jobs in adult social care in England in 2011 (an increase of 4.5% on 2010), while the actual workforce in social care stood at 1.63 million workers (Skills for Care, 2012c).

Table 1: Total number of adult social care jobs, by sector and service type, 2011

Job role group	Type of service	All sectors	Local authority	All independent	National Health Service (NHS)	Direct payment recipients
All job roles	Residential	674,900	38,100	636,800	0	0
	Domiciliary (Home)	830,700	23,100	387,600	0	420,000
	Day	95,600	16,300	79,300	0	0
	Community	251,500	82,000	95,300	74,200	0
	Total workforce jobs	**1,852,760**	**159,540**	**1,199,100**	**74,200**	**420,000**

Source: Skills for Care, 2012c. Note: Rows may not add up to totals due to rounding.

Table 2: Total number of people working in adult social care jobs, by sector and service type, 2011

Job role group	Type of service	All sectors	Local authority	All independent	NHS	Direct payment recipients
All job roles	Residential	652,000	36,000	630,000	0	0
	Domiciliary (Home)	650,000	23,000	383,000	0	262,000
	Day	88,000	15,000	75,000	0	0
	Community	243,000	78,000	94,000	74,000	0
	Total workers	**1,633,000**	**152,000**	**1,183,000**	**74,000**	**262,000**

Source: Skills for Care, 2012c

The community-based services relevant to this study are the non-residential services regulated by the Care Quality Commission (CQC), the health and social care regulator for England. These include home-care services, supported living, extra care housing services, nursing agencies and other types of services. They also include non-regulated services such as day care, domiciliary

[1] See Skills for Care and Development (SfC&D) workforce, available at http://www.skillsforcareanddevelopment.org.uk/Aboutus/SfCandD_workforce.aspx.

or home care, meals on wheels and community services. The split between residential and non-residential establishments is 48% and 52% respectively. Most jobs in social care (65%) are for independent employers, followed by the direct payment recipient workforce (23%), local authorities (9%) and the NHS (4%) (Skills for Care, 2012c).

In 2009, there was a total of 4,720 registered businesses (public, commercial and voluntary or charitable) providing social work activities without accommodation for the elderly and people with disabilities (NACE 88.1) across the UK. Altogether, these businesses employed approximately 960,000 workers (3% increase on 2008 and 9% increase on 2005). The average annual employment growth in non-residential services has been 2.4% (Skills for Care and Development, 2011).

Funding structure

Spending on social care will need to increase in the future, and the funds will have to come from both individuals and the state (Dilnot et al, 2011).

Most funding for social care in the UK comes from central government through the Revenue Support Grant. The government also allocates specific grants for the local authorities. A large proportion of the social care budget comes from funds that the local authorities raise themselves, mostly from levying council tax.[2] The local authorities are also expected to achieve significant savings in their budgets for social services in addition to undertaking commercial activities to generate income.

Total gross current expenditure on personal social services in 2009–2010 amounted to GBP 16.8 billion (about €19.5 billion as at 11 August 2013), an increase from the previous year (GBP 16.1 billion or €18.7 billion). Most of the expenditure covered the cost of care for older people (GBP 9.4 billion or €10.9 billion); around GBP 6.9 billion (€8 billion) was spent on services for adults with physical and learning disabilities or mental health needs (Health and Social Care Information Centre, 2011).

Social care funding is provided on a means-tested basis. This means that people who are able to pay for their own care must do so; others receive financial support from local authorities (HM Government, 2012). The means test takes into account the income and assets of individuals, with some differences across the nation states. The current system is funded in the following way.

- People with assets of less than GBP 14,250 (€16,562) in England or GBP 15,250 (€17,727) in Scotland or GBP 23,250 (€27,026) in Wales are not expected to use their assets to pay for care. They pay a proportion of their income and their local authority pays the remaining cost.
- People with assets between the previous thresholds and GBP 23,250 in England and Wales or GBP 24,750 (€28,770) in Scotland are required to make some contribution beyond their income, contributing a 'tariff income' based on their wealth.
- People in England and Wales with assets above GBP 23,250 (including their home for people in residential care) or GBP 24,750 in Scotland are rated as 'self-funders'.

In Wales, compared with the rest of the UK, people are allowed to retain more savings and capital without having to spend it on care costs. Public funding of social care in Scotland also differs in that people over the age of 65 who are assessed as needing care at home will receive it for free; however, they still need to pay for non-personal care services such as cleaning or meals

[2] See overview of the 'present social care system', UK parliament Health Committee, available at http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/22/2205.htm.

on wheels. The care needs of people under the age of 65 are means tested. The Scottish government provides a flat rate contribution towards care in a care home.[3] Northern Ireland has social care arrangements similar to England.

From April 2017, the current system will be replaced by new measures, following the recommendations of the Dilnot Commission. The key change will be the proposed cap on the contribution individuals are expected to make in meeting the cost of their care needs. This will protect individuals from incurring very high costs so that once they have reached the cap, the state will step in and provide financial support. The UK government introduced a cap of GBP 61,000 (€70,908) in 2010–2011, which is above the GBP 25,000–GBP 50,000 (€29,060–€58,122) cap recommended by Andrew Dilnot. Means-tested support will continue for people of lower means and the asset threshold for those in residential care beyond which no means-tested help is given will increase from GBP 23,250 (€27,027) to GBP 100,000 (€116,243) (Department of Health, 2013).

Organisations, actors and stakeholders involved

The main organisations involved in social care and community care in the UK are as follows.

- The Department of Health – the government department that provides leadership for social care in England.
- The Health and Social Care Directorates of the Scottish government – a set of directorates that includes the Health and Social Care Integration Directorate.
- The Welsh government – responsible for funding, policy making, reviewing, inspecting and regulating of social services in Wales. Social services in Wales are delivered by 22 local authorities and around 1,800 private and independent organisations.
- The Department of Health, Social Services and Public Safety in Northern Ireland – responsible for social care in Northern Ireland.
- National employer-led organisations – these include the National Skills Academy for Social Care and various sector skills councils (SSCs). The Skills for Care and Development (SfC&D) body is licensed by the government to be the SSC for the social care sector in the UK. The SSCs are independent employer-led organisations that work to ensure that the development of skills in the UK is driven by employers' needs. The organisation works with its delivery partners – the Care Council for Wales (CCW), the Northern Ireland Social Care Council (NISCC), the Scottish Social Services Council (SSSC) and Skills for Care (SfC) in England – to help employers and workers in social care improve skills, career prospects, and standards across the sector.
- The social care councils in Scotland, Wales and Northern Ireland – SSSC, CCW and NISCC are the relevant social care regulators. The Health and Care Professions Council (HCPC) is the regulator for England.
- Trade unions – they include Unison and the British Association of Social Workers (BASW). The latter is the largest professional association for social work in the UK, with offices in England, Northern Ireland, Scotland and Wales.

[3] See 'paying for care in Scotland', Advice on Care, available at http://www.adviceoncare.co.uk/scotland-care.htm.

4 Strategies for recruiting and retaining employees

Skills for Care, the skills council for social care in England, has been given the task of developing a 'workforce strategy'. This strategy consists of several measures and initiatives with implications for recruiting and retaining workers, as outlined under the following sub-headings.

Targeting labour reserves

- The 'Sector Route-Way' is a new scheme developed by Skills for Care in collaboration with Jobcentre Plus and other partners. The scheme seeks to support unemployed people by giving them the skills and confidence to move into entry-level jobs in the adult social care sector.
- The National Care Association, a lobby group for the independent care sector, launched the 'Adult social care workforce – recruitment and retention strategy' (Skills for Care, 2011a), developed by employers for employers. The strategy aims to tackle one of the biggest obstacles to effective workforce development across all parts of the sector – that is, recruitment and retention.
- International recruitment – Skills for Care has been working with employer representatives, the Migration Advisory Committee and other stakeholders to produce evidence to shape the government's policy on migration.

Promoting education and training

- Skills for Care plays a leading role in determining the structure and content of vocational qualifications in the adult social care sector in England.
- Skill for Care, in partnership with the Department of Health, promotes social care apprenticeship programmes that combine job training and learning. Examples include the Higher Apprenticeship (level 5) in social care – Care Leadership and Management. Its aim is to double the number of apprentices in social care to 100,000 over the next five years.
- Skills for Care, in collaboration with Skills for Health, has been commissioned by the Department of Health to jointly develop a code of conduct and standards – 'Minimum training standards and code of conduct for adult social care workers and healthcare support workers in England' – setting out expectations for roles in the sector.

Improving the situation of current employees as well as operational management and labour productivity

- The 'Workforce Development Strategy' was launched in May 2011 in partnership with employers, key partners and the Department of Health to help create a capable, confident and skilled adult social care workforce across England (Skills for Care, 2011b). As part of the strategy, the Workforce Development Fund was set up to help frontline employers train their staff to meet the deliverables in the strategy.
- The 'Workforce Innovation Programme', formerly the 'New Types of Worker Programme', explores how people's care and support needs change and how the workforce has to adapt to meet these challenges. The programme has been implemented through several small-scale sites, including the Assistive Technology Norfolk project. It has also involved micro and small employers as well as large national employers. Due to the changes in care and support needs, new roles have emerged in the care sector, either replacing more traditional roles or complementing core roles.

- 'The Principles of Workforce Redesign' were developed to support the transformation of services in adult social care and support, setting out the key issues that need to be taken into account when changing the way staff work in order to meet the challenges of personalisation.
- 'Integrated local area workforce strategies (InLAWS)' aim to bring together strategic financial planning, service planning and workforce planning to support the development of a programme of action for commissioning the workers.
- 'Sector Skills Agreements' (SSAs) map out the skills employers require from their workforce and how these skills will be developed. Linked to this is the 'Sector Qualifications Strategy' (SQS), which determines how SSAs will be delivered.
- 'Neighbourhood workforce planning' and 'community skills development' are models that can empower local people to understand how the skills they have can be enhanced and shared to ensure that those who need care and support in their neighbourhood can continue to be active and empowered local citizens.
- Skills for Care is undertaking a project to help people who work in assistive living services to develop their skills in using ALT.
- The Personal Assistant (PA) Framework has been devised by the Department of Health as part of its vision to create more personalised social care services in England. Specifically, this framework supports the development of the PA workforce and their employers. The framework sets out the action that is required to achieve this goal. This includes the promotion of wider understanding of PA working, improvement of recruitment and retention of PAs, learning and development.
- The Healthcare Quality Improvement Partnership (HQIP) was established to promote quality in health and social care services in the UK. In particular, it seeks to increase the impact of clinical audits. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. HQIP is contracted by the Department of Health in England to deliver outcome-focused quality improvement programmes structured around the collection of clinical data, including clinical audits, registers and confidential enquiries. It also works under contract in areas related to national clinical audits and confidential enquiries in Scotland, Wales, Northern Ireland and Ireland to promote and develop other areas of quality improvement in health and social care in addition to these contracts. In 2011, HQIP extended its work to promote quality improvement within social care.

5 Outcomes, results and impact of policies

The number of jobs in adult social care in England was estimated to have increased by 7% between 2009 and 2010 and by a further 4.5% between 2010 and 2011 (Skills for Care, 2011c, 2012c). In both instances, most of the increase came from jobs for direct payment recipients. There was a rise in the number of personal assistants by 35% (92,000 posts) between 2009 and 2010 (Skills for Care, 2011c), reflecting the advancement of the personalisation agenda in social care across the UK.

On the other hand, the number of local authority jobs decreased by almost 10% between 2010 and 2011. This reflects the fall in local authority spending on adult social care and a move towards more direct service provision contracted out to independent providers (Skills for Care, 2012c).

Overall, the increase in the number of adult social care jobs in England between 2009 and 2011 was estimated at 216,000 jobs (13% increase). The majority (around 70%) of these came from new jobs for direct payment recipients, while around 65,000 came from elsewhere (5% increase) (Skills for Care, 2012c).

Effectiveness of current instruments and policies

Many of the instruments that have been developed to improve recruitment and retention in the social care sector are relatively new and their impact has not been fully evaluated. Preliminary findings are available for some of the initiatives. The research and evaluation that has been carried out focused primarily on the effectiveness and impact of instruments in terms of workforce development, rather than investigating the impact of policies on the number of jobs created or retained. Preliminary findings for some of the initiatives are as follows.

- An online survey was conducted in the summer of 2012 to examine the implications of ALT and assisted living services (ALS) for workforce development. The way ALT was delivered varied across the different types of organisations. The study found that some progress was made towards making ALT mainstream, but further progress was still required.[4]
- Skills for Care is building on its learning from the Workforce Innovation Programme, creating new and innovative solutions such as: the Common Core Principles to Support Self Care; its work in end of life care; the principles of workforce redesign; InLAWS; and community skills development ('Only a Footstep Away').[5]
- An evaluation of the Principles of Workforce Redesign (Skill for Care, 2012b), carried out in January 2012, showed that the principles have been welcomed by employers and that the materials have assisted in boosting confidence and, to a lesser extent, competence in relation to undertaking workforce remodelling. They have also helped to inform practice in a range of settings.
- The Care Ambassadors is a nationwide scheme that has been recognised for raising the profile of careers in social care. There are around 1,300 Care Ambassadors nationally.[6]
- Research has been carried out into support provided by local authorities to people who employ personal assistants. Findings suggest that local authorities play a significant role in developing the market of personal assistants to meet the demand for personalised care in their local areas (Skills for Care, 2012a).

[4] http://www.skillsforcare.org.uk/workforce_strategy/assistedlivingtechnology/assisted_living_technology.aspx.

[5] http://www.skillsforcare.org.uk/workforce_strategy/workforce_innovation_programme/workforce_innovation_introduction.aspx.

[6] http://www.skillsforcare.org.uk/entry_to_social_care/ICareAmbassadors/I_Care_Ambassadors.aspx.

6 Analysis of key trends, issues and policy pointers

This report gave a brief overview of the UK's labour market policy in community-based care for adults with disabilities and chronic health problems. The three case studies presented in Annex 1 will further illustrate the labour market policies underway in this sector.

National context

The provision of social care in the UK has increasingly moved away from institutional to mainly community-based care since the 1970s. The ideas of independent living and assistive living emerged as a new benchmark for social care provision, recognising that, with the right support, people with disabilities and the elderly can be in control of their care needs, leading independent and dignified lives. Self-directed support, such as direct payments and personal budgets, is now common across the UK and most adults with disabilities live in their own home. Community care comprises a range of services including assistive technology services, equipment and adaptation services, home helps, domestic services, social care workers, extra care housing services and meals on wheels.

Since 2011, government cuts to public spending have led to widespread budget reductions for social care. At the same time, the number of adults with disabilities and older people continues to grow. The social care sector is characterised by labour shortages and there is a high level of staff turnover in the sector. In England alone, the number of jobs in adult social care is predicted to grow by 24% to 82% between 2010 and 2025. The current trends indicate that most of these jobs will be in community-based care.

Policy and legal frameworks

Several pieces of legislation are relevant to or have been instrumental in developing community-based care in the UK. The Disability Discrimination Act (1995), the Human Rights Act (1998) and the Equality Act (2010) all sought to promote the equal rights of people with disabilities in various areas of public life, with implications for social care providers in all sectors and the workforce. The legislation that is more specific to community care includes Modernising Social Services (Department of Health, 1998) and the Community Care (Direct Payments) Act (Department of Health, 1996), which aimed to improve the independence, protection and quality of care in the community. The Community Care (Direct Payments) Act has been particularly influential, as it introduced self-directed support payments – direct payments and personal budgets. This has enabled service users to exercise greater choice and control over their individual care needs.

Structural framework and funding structure

The estimated number of adult social care workers in England in 2011 stood at 1.63 million, while the actual number of jobs in the sector amounted to 1.85 million. The community-based care sector in the UK comprises non-residential services, some of which are regulated while others are not. More than half of adult social care is provided within non-residential establishments, and the majority of adults with disabilities receive non-residential care and support. Most jobs in social care are provided by independent service providers (65%), followed by direct payment recipient workers (23%), local authorities (9%) and the NHS (4%).

The majority of funding for social care in the UK comes from central government. The local authorities are allocated grants that cover the cost of social care in their area. In addition, some social care spending comes from funds raised by the local authorities themselves. The total gross current expenditure on personal social services for adults with disabilities stood at GBP 6.9 billion (€8 billion) in 2009–2010. Unlike healthcare, social care funding in the UK is means tested.

The key stakeholders involved in labour market management of community care in the UK are: the Department of Health, England; the Scottish Government Health and Social Care Directorates; the Welsh Government; the Department of Health, Social Services and Public Safety, Northern Ireland; national employer-led organisations; and trade unions.

Strategies used to recruit and retain employees

The government's policy on recruitment and retention of social care workers consists of six broad themes:

1. promoting social care;
2. attracting a diverse workforce;
3. managing new interests and recruits;
4. retention;
5. research and intelligence;
6. standards, learning and qualifications.

Outcome and impact of policies

Most of the measures described in this report aimed at improving the recruitment and retention of workers have been developed by Skills for Care, the skills council for social care in England. As part of the workforce development strategy, Skills for Care has a programme of research activities aimed at informing its recruitment and retention initiatives. Moreover, it is committed to evaluating the outcomes and impact of its projects and programmes. Findings from the available evaluation reports suggest that progress has been made in skills development, workforce re-design (such as ALT), and promoting and raising the profile of social care.

Case studies for the UK

The case studies presented as part of this report describe three labour market initiatives that seek to address the issue of social care workforce development in the UK. Each of the initiatives reflects the changing nature of social care in the face of demographic, economic and technological developments. The case studies describe three programmes that developed either locally, regionally or at national level.

- The Single Ticket Programme (STP), Manchester – this is a local initiative developed by the Manchester College to address high unemployment rates in the most deprived areas of Manchester City. STP is essentially an apprenticeship; it offers a training course, qualification, and five work placements with health and social care providers.
- Assistive Technology Norfolk (ATN) – this pilot project was undertaken by Norfolk Council with the aim of creating a new type of worker – the Assistive Technology Support Worker – and of developing assistive technology services for older people and people with disabilities.
- The Social Care Workforce Development Programme (SCWDP), Wales – this is a national scheme that operates across Wales. The aim is to increase the training uptake of staff working in social care, to increase the number of staff with qualifications and, ultimately, to improve the quality of care, with implications for staff retention.

Each of the three initiatives has been successful in achieving its aims. However, the measures of success have been limited by the availability of data and resources to effectively evaluate their impact. The evaluations have been either quantitative in some cases or mostly qualitative in others. Some of the advantages of the initiatives are described briefly below.

Training new workers and tackling labour reserves

The Single Ticket Programme offers a unique approach to recruiting and retaining staff in health and social care. People who are long-term unemployed and without qualifications or work experience have an opportunity to embark on the programme, on the grounds that they show enthusiasm and commitment, through a simplified recruitment process. The programme participants undertake an intensive four-week induction course and five work placements – 12 weeks each – in health and social care. Through this, they are given the chance to obtain a nationally recognised BTEC Level 2 Health and Social Care qualification. The programme benefits the participants as well as the employers. In particular, the programme participants referred to the advantages of undertaking five work placements. This gave them a taste of what it was like to work in different areas of health and social care. Many participants completed the programme with a clear idea of where they would like to work and felt positive about being able to find work.

Creating a new type of (assistive technology) worker

On completion of the Assistive Technology Norfolk pilot project, Norfolk Council has successfully mainstreamed the ATN service across Norfolk county. Furthermore, they have retained the newly created ATN worker positions and recruited new staff to support their activities. Important lessons have been learnt during the process of mainstreaming. Before ATN became a core service within the social services department, the council considered making assistive technology a part of the day-to-day activities of all social services professionals, rather than maintaining ATN as a separate core team. The council invested heavily in the assistive technology training of its existing staff; however, assistive technology support was viewed as a peripheral task, an undesirable addition to their workload. As a result, the referrals to the service plummeted and the decision was made to maintain the ATN team, which has become a mainstream service funded by the council. There are plans to commercialise this service.

Training and personal development of existing workers

The Social Care Workforce Development Programme benefits the workers of social care services by offering financial support for their training and personal development needs. The social care providers can offer training courses to their staff and release them to attend the courses at no personal cost. The programme also benefits service users by increasing the standards and quality of care across Wales. Moreover, providing workers with opportunities for personal and professional growth, as well as recognising their achievements, can improve workforce retention. In terms of the programme's outcomes, over 82,100 people attended community care training events and 5,300 qualifications were attained by community care staff in 2010–2011.

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Links

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Healthcare Quality Improvement Partnership (HQIP): http://www.hqip.org.uk

Skills for Care: http://www.skillsforcare.org.uk

Skills for Care 'Workforce Strategy': http://www.skillsforcare.org.uk/workforce_strategy/workforce_strategy.aspx

Workforce Development Fund: www.skillsforcare.org.uk/wdf

Annex 1 Case studies

This annex presents the results of the three UK case studies on initiatives in the field of labour market policies in community-based care to support adults with disabilities and chronic health problems. The three case studies are:

Case study 1: The Single Ticket Programme

Case study 2: Assistive Technology Norfolk

Case study 3: The Social Care Workforce Development Programme

Each case study includes a description of the initiative, definition of the problem and overview of the approach used, implementation and contextual factors. This is followed by an analysis of the outcomes and results of the initiative. Finally, the lessons learnt and factors regarding the sustainability and transferability of the initiatives are presented.

Case study 1: Single Ticket Programme

Description of the initiative

The 'Single Ticket Programme' (STP) is an initiative launched in Manchester with the aim of helping people in local communities who are long-term unemployed to get into a career in health and social care.

The STP is a local programme, initiated and developed by the Manchester College in collaboration with a range of partners from public, private and charity sectors. The programme initially started as a pilot project, called 'Learning Works Wonders' (LWW). It lasted for six months (October 2009–March 2010) and was funded by Manchester City Council. For the next two phases of the programme, renamed the STP, the Manchester College secured funding from the government's Future Jobs Fund. In addition, funding from various sources, including the Manchester College (GBP 200,000 (€232,486) as part of its corporate citizenship) and other organisations, was secured to fund participants' wages. The fourth phase of the programme is funded by the partners, who contribute in different ways and cover the wages of programme participants.

Overall objectives

The objectives of the LWW pilot scheme were threefold (Bennett, 2010):

1. to help a group of people who are long-term unemployed in Manchester to become more employable;
2. to offer a strategy for developing and, where possible, offering employment to those capable of working with vulnerable people in the community;
3. to offer a potential blueprint for further cohorts of people who are unemployed to take part in the programme and have the same opportunity of work experience.

The STP addresses the gap in the health and social care labour market. It is a response to the government's policy changes to commissioning healthcare services and the integration of healthcare and social care. Currently, there are many agencies providing services to one or two individuals or a family. The aim is to reduce the number of agencies as well as people involved and to increase the number of people with a wide range of skills, so they can operate in health or care settings and have the confidence to make a decision rather than seeking specialist advice.

Definition of the problem

Policy background

In 2007, Manchester City was recognised as one of the most deprived local authority areas in England. Manchester City Council aims to address the social and economic issues in the city through its Community Strategy. To improve the situation of local residents, one of the key goals is to enable people to reach their full potential in education, skills acquisition and employment. Hence, its aim is to tackle inequality and promote greater social inclusion, in line with the values of the Manchester College (Bennett, 2010).

Role of the social partners

The STP is implemented by a small team at the Manchester College, led by Paul Haunch, Basil Curley and Cheryl Bates. The STP team works in partnership with different public, third sector and private sector organisations. These include Manchester City Council, Salford City Council, North Manchester General Hospital, Salford General Hospital and Greater Manchester Police.

Issue at stake

The STP is a response to the increasing demand by the government for closer integration and cooperation between health and social care. The concept of the Single Ticket emerged when Dr Haunch was involved in opening a new campus of Health and Social Care at the Manchester College in the city centre. As part of that process, he suggested that there needed to be a new approach to training people in health and social care, whereby instead of sticking to rigid disciplines, people would be allowed to develop core skills and choose from a wide variety of careers. To enable them to do this, people would have a 'single ticket', as coined by Dr Haunch.

Approach and implementation

Overall approach

The STP is considered to be a new initiative, developed from several years of experience gained by the STP team at the Manchester College working in the area of health, social care and employability. The programme offers a simplified recruitment process, whereby the main criteria for participants' selection are commitment and willingness to work, rather than previous experience or academic qualification in health or social care. Securing a job through the formal recruitment process might be difficult for the target group of participants. People from disadvantaged groups who are unemployed and who are on the wrong side of the digital divide, also lacking formal qualifications, often do not have the work experience or social capital needed to secure employment. The STP acts as a sponsor and a mentor, providing the necessary social capital as well as an environment that is flexible and supportive.

Aim of initiative

Recruitment versus retention

The programme aims to create a new type of health and social care worker who is confident to work in a variety of settings. In that sense, the STP is a recruitment rather than job retention programme. The STP also seeks to create a more flexible workforce, which is able to take advantage of various opportunities, thus potentially increasing job satisfaction and retention of staff in the sector.

Specific target groups

The programme targets people who are long-term unemployed, particularly those from disadvantaged communities. It selects people on the basis of their ability to demonstrate commitment and passion for work in health and social care settings.

Formal versus non-formal employment

The programme is not aimed at a transfer from non-formal to formal employment.

Project implementation

Programme level

The STP recruits people over 18 years of age who have the right to work in the UK. Those without any qualifications are eligible to apply. In this way, the programme recognises that everyone has skills that can be developed further through commitment and hard work. The programme is also free of charge. The STP consists of the following four core elements.

1. A unique recruitment process – the aim is to recruit people through a different process (not paper based, electronic based or qualification based). Individuals on the programme must demonstrate commitment as well as a willingness and ability to work. The recruitment

process involves a systematic screening of people. If they cannot pass this initial stage, they will not be interviewed. The interview is carried out by the programme partners (employers) on a one-to-one basis and consists of only five questions. The final question is the crucial question – people who cannot demonstrate commitment and ability to travel to various locations where work placements are available will not get onto the programme.

2. An intensive four-week induction process – this is delivered by the Manchester College and provides participants with key skills and understanding of what it is like to work in social care – for example, skills in confidentiality, moving and handling, food hygiene and infection control. It also imparts skills in and understanding of various socioeconomic factors that influence health – for instance, drug and alcohol abuse, sexual health, domestic violence and housing. The programme partners contribute during the induction stage.
3. Five separate work placement modules in the area of health and social care – each work placement lasts for approximately 12 weeks. The work placements could be with any of the programme partners (employers) in the areas of adult care, childcare, general health, mental health or learning disabilities. The range of placements provides comprehensive exposure to issues common to health and social care, also providing participants with the skills, competences and confidence to respond to the needs of individuals and families receiving care services. The programme participants are expected to work full time (35 hours a week) and must be prepared to work unsocial hours, depending on the placement. Participants receive at least the national minimum wage. As part of their corporate social responsibility, partners provide support and mentoring in the workplace. This is important, as many of the participants need to know and learn how to work, provide a quality service and be proud of what they do. At the same time, participants need to be able to look after their families as well as undertake their academic study.
4. A nationally recognised qualification – as part of the programme, participants undertake academic study at the Manchester College. Successful completion of these studies leads to a formal, nationally recognised BTEC Level 2 Health and Social Care qualification.

Project level

While details of the programme have been outlined above, it should be highlighted that the programme is continuously evolving in response to monitoring and observed trends. A number of changes have been made as the STP has progressed, including the following three changes.

1. Changes to funding – funding for the six-month pilot scheme was provided by Manchester City Council. At the end of this period, the programme secured funding from the government's Future Jobs Fund for the next two phases of the STP (six months each); further funding was also made available by the Manchester College. Moreover, some of the partner organisations have since become sponsors of the programme participants by covering their wages.
2. Changes to the recruitment process – in the first phase of the STP, the Manchester College had no say in the selection and recruitment process. As a result, some of the candidates were not motivated enough for the programme and dropped out. When the Future Jobs funding ended and the programme received funding from various other sources, the college could recruit according to its own criteria of commitment, willingness and ability to work.
3. Changes to the duration of the programme – the duration of the programme increased from 6 months in the pilot and first two phases to the current 15 months, as the programme gained an apprenticeship status.

Monitoring and evaluation

An independent evaluation of the LWW pilot scheme was carried out by Sheffield Business School in 2010 (Bennett, 2010). The Manchester College carries out its own internal monitoring

through data collection from participants, their family and friends. The college has started recording destinations of the programme participants and would like to contact former participants to see where they are 6 months or 12 months after completing the programme. However, the monitoring team is very small and has limited resources.

Contextual factors

The STP was partly influenced by the Better Life Chances initiative, which started in Greater Manchester in 2010. The aim of the latter initiative was to develop and test approaches to delivering integrated public services and reform in the areas of Broughton and Cheetham. The Better Life Chances initiative targeted areas of high unemployment, low incomes, poor health and poor skills, where public services were in high demand. The Manchester College decided to contribute and managed to approach some of the disadvantaged groups from that area, placing them onto the second phase of the STP, which started in March 2011.

The STP is also influenced by the partners funding the programme, as the programme participants essentially undertake work placements in the locations of the STP partners. Consequently, the programme participants need to travel to areas where the work placements are available. The STP organisers would welcome more sufficient resources allowing them to systematically plan how they would like to roll out the programme. The programme participants have to be prepared to and commit to travel to the work placements. However, more placement opportunities are being created, enabling the Manchester College to reduce the amount of travel and increase the spectrum of opportunities available. In the future, the programme organisers would like to be able to offer the last module on the programme as an elective module. This is not possible at the moment, because there are not enough work placement opportunities. However, as there are more partners coming on board, this may be a possibility in the coming 12–18 months.

Outcomes and results

Type and number of jobs created

Taking part in the STP does not automatically guarantee a job; however, the participants are more likely to find employment. The intensive nature of the programme means that the numbers of people who participate in the STP are quite small. However, the success rate of the programme is high. Around 70 people have participated in the programme since 2009. On completion of the programme, about 70% of the participants have gone on to secure work in health and social care settings. Some of the participants have been offered jobs with their placement organisations or have found work through the council bank (Manchester City Council's own work agency). Those who can demonstrate experience of working for an organisation will be in a far better position if a permanent post arises. A number of people have reported that health and social care work is not for them and have gone on to find work elsewhere. Five of the participants from the latest cohort (commenced in March 2012) are applying for a place at university.

There were a number of dropouts and dismissals from the programme. According to the organisers, these were mainly applicants from the previous recruitment process. At the same time, the programme is demanding and not suitable for everyone. Out of the 18 participants who started in March 2012, 7 dropped out. Some people decided it was not for them, while others had to leave because they were not prepared to commit to the work placements.

Other relevant outcomes

As a result of taking part in the programme, participants' independence, confidence and self-esteem have increased, their physical and mental health has improved and they now have better career prospects. The participants valued the knowledge and skills they were able to gain during the programme.

The participants found that the STP was hard work due to the amount of coursework involved and the fact that they had to work full time as well. Working in health and social care is physically and emotionally demanding. However, the participants recognised that this was the nature of the work and the STP prepared them for this.

Monitoring data show that participants and their families are benefiting physically, mentally and socially. Some of the analysis shows that the interventions of the STP may be seen as expensive, but overall the STP is a cost-effective model. The benefits of giving people the opportunity to gain work experience and the difference that it makes to them, their families and society are hard to capture and quantify.

Main results

Table 3: Summary of key aspects of the STP and its results

Total number of:	Pilot 2009–2010	Phase 1 2010–2011	Phase 2 2011–2012	Phase 3 2012–2013	Phase 4 2013–2014
Partners	1	3	5	11	14
Participants	16	20	8	18***	8
Completions	16	8	5	11	-
Drop-outs or dismissals	-	12	1	7****	-
Jobs created	8	-	7*	5**	-

** Two of the participants who did not complete the programme were offered jobs before the end of the programme.*

*** Five participants have been asked to apply for posts in their existing placements and are likely to secure them. If successful, the college will seek agreement with that employer to honour their release for college one day a week.*

**** Five participants have applied for a place at university.*

***** Of these, one person left on maternity leave, one left through injury sustained away from the programme during induction and one left to take up a job elsewhere.*

Lessons learnt

Success and failure factors

The STP is regarded positively by the programme organisers, the participants and the partner organisations. Several factors have contributed to the success of the programme, as follows.

- The STP is offered free of charge, making it available to people from disadvantaged groups who may not be able to afford a college course.
- Through a simplified recruitment process, the programme organisers target potential participants based on their interest, commitment and willingness to work in health and social care. This means that people who are long-term unemployed and those who lack a formal qualification are eligible to apply.
- The four-week induction stage of the STP equips participants with the necessary knowledge and confidence to work in health and social care.
- The five work placements provide invaluable experience; while the placements are challenging at times, this reportedly teaches participants how to deal with different situations and to be patient and professional. In addition, five work placements provide five

different references, putting participants in a stronger position when applying for a permanent job.

Conversely, some of the negative factors or potential fail factors include the following.

- The programme participants have to be willing to travel to various locations, depending on where the work placements are available. The commuting time could be an hour or an hour and a half each way. This can be demanding for some, especially if they are not used to long hours commuting and working. The Manchester College is addressing this issue by trying to expand the number of work placements available.
- Another challenge is trying to secure enough funding and work placements to ensure the sustainability of the programme.
- Finding suitable people in partner organisations who understand the need to help participants by showing them the right approach at work can be problematic; there must be a common understanding of the STP ethos.
- Some employees from partner organisations resist change and the STP team must establish how best to overcome these difficulties.

Sustainability and transferability

Support from partners is the key factor for making the programme effective and sustainable. The STP team needs to convince partners to contribute by widening participation opportunities for people. Equally, if the model proves successful, the state will have to come in at some point and support the model. In order to scale it up, funding from central government will be required, but also a change in approach from the traditional route taken by agencies. More tailor-made support is needed for helping people from disadvantaged groups to enter employment. For example, all NHS jobs are currently advertised online; this means that those without internet or computer access are automatically excluded from these opportunities.

The programme is based on a model that is highly transferable and, with care, it can be applied to any other setting or discipline. The STP team are currently talking to colleagues at the Manchester College about introducing a ‘single ticket’ module in construction. The college is not looking to make a profit, but its reputation is critically enhanced. It wants to encourage others to copy its model and is working with partners in Merseyside, Liverpool to transfer the model. Salford College contributed to the induction stage in one of the STP phases, and the Manchester College is discussing further collaboration with this college. Liverpool Community College also expressed interest in collaborating in 2013. Moreover, a work exchange is being organised with colleagues in Sweden; in 2013, colleagues in Sweden will see if the skills that people bring are right for them. The Manchester College is hoping to cooperate with colleagues in other countries as well. It is critical to find the right people and the right partners to make the programme work.

Conclusions

This case study described a local initiative that has the potential to provide an effective model for creating and retaining jobs in community-based care for adults with disabilities. The STP offers training and work experience placements within the health and social care sector to people who are unemployed and who have little or no work experience or qualifications. This is achieved through a unique recruitment process, where enthusiasm and commitment are the key selection criteria. On completion, the programme participants are more employable and ready to take up employment across a range of settings within health and social care. Furthermore, the range of work experience gained during the programme enables participants to make a more informed decision about their preferred area of employment in the sector. This arguably contributes to job satisfaction and therefore staff retention.

The STP addresses a number of social and economic issues. Firstly, it tackles social exclusion in the local area by providing employment opportunities to people from disadvantaged communities in Manchester. Secondly, it targets labour reserves of people who are long-term unemployed. Thirdly, it fills a gap in the health and social care labour market, where the demand for skilled and experienced workers is likely to rise in the future.

The STP is a small-scale initiative that has proven to be highly effective. The programme has developed from a pilot project that lasted six months, developing into a 15-month apprenticeship within four years. Between 2009 and 2012, 70 people took part in the programme and an estimated 70% secured employment in health or social care or went on to higher education.

This programme offers a model that is highly sustainable and transferable. Establishing an effective collaboration with multiple partners from public, private and voluntary sectors is a prerequisite to its success.

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Case study 2: Assistive Technology Norfolk

Description of the initiative

This case study describes the Assistive Technology Norfolk (ATN) initiative. Norfolk County Council has undertaken several projects to develop assistive technology (AT) services within its social services department since 2003. Initially, a small grant was used to provide innovative services for older people with dementia and adults with disabilities. In 2005, Norfolk County Council received funding of GBP 265,000 (€308,045) from Skills for Care under the New Type of Workers (NToW) programme, funded by the Department of Health, to develop new worker roles within social care. The council's social services department used the funding to undertake a pilot project – Assistive Technology Norfolk – to develop specialists in the field of AT. Further funding became available through the government's Preventative Technology Grant, which provided GBP 80 million (€92.9 million) to all local authorities with social services responsibilities to invest in AT and telecare services. Norfolk received GBP 542,000 (€630,040) in 2006–2007 and a further GBP 913,000 (€1.06 million) in 2007–2008.

Overall objectives

The aim of the ATN pilot project was to design a new type of worker – the Assistive Technology Support Worker – as part of the NToW programme. The aim of NToW was to foster innovative work redesign in adult social care, exploring how the workforce needs to be developed and adapted in order to meet the challenges of social care provision. The programme had a number of targets:

- to identify and trial innovative types of working that are central to the government's vision of a service-user commissioned service;
- to embed sustainable new types of working in the sector through information, the development of career pathways, performance management, National Occupational Standards (NOS) and qualifications;
- to ensure that new types of working in social care make a full contribution to community regeneration.

Definition of the problem

Policy background

The growing demand for social care services is a challenge for many local authorities in the UK. Norfolk County has a higher ratio of older people than the average across the UK, as many older people retire in the county. Due to cuts in public spending and budget restrictions, Norfolk's social services had to re-evaluate ways of delivering services in the most cost-efficient and effective way. Norfolk County is also experiencing difficulties in recruiting enough staff to meet the health and social care needs of its existing service users and patients.

Initially, a small grant was used to provide innovative services for older people with dementia and adults with disabilities. This proved very successful and the department looked at ways to develop the service. It started to link up with community alarm providers (CAPs) around the county and invested money into telecare equipment, such as smoke detectors linked to community alarms.

Role of the social partners

Several stakeholders are involved in providing AT services in Norfolk, as follows.

- AT workers – the Assistive Technology Practitioners (ATPs) are the core of the service. There are also two AT Assistants, a Service Coordinator and a Manager of the AT team.
- Service users – these consist mainly of elderly people and those with dementia, adults with learning and physical disabilities, and children.
- Social services department – this includes Social Workers, Occupational Therapists and Support Workers.
- Community alarm providers (CAPs).
- Others – other stakeholders involved in this area include manufacturers and distributors of equipment, the emergency services (fire, police, ambulance), home improvement agencies, voluntary organisations, the independent sector, housing (District Councils and Registered Social Landlords) and regulators.

Issue at stake

AT is a means of supporting people with disabilities and older people at home, enabling them to retain independence and control over their lives. It also saves money by preventing expensive hospital admissions and residential care. Norfolk County Council has explored the benefits of using AT and telecare services, investing significantly in the development of such services in recent years.

Approach and implementation

Overall approach

The AT service is not a new concept and is available all over the country. While it is not an innovative service, Norfolk County Council was one of its earliest adopters. When Norfolk started the initiative in 2004–2005, there were only a few places in the country offering AT to service users.

Aim of the initiative

By providing technological and innovative support systems at home, people with disabilities and elderly people can live in a supported way while still living at home. Technological solutions tend to be more cost-efficient and are also effective ways of providing social and health support. In addition, there is less need for the presence of relatively scarce health and social care workers.

Recruitment versus retention

The ATN pilot project sought to create a new type of worker – a specialist in AT. This initiative may involve recruiting new individuals or training existing health and social care workers.

Specific target groups

Initially, the AT service workers were deployed from within the social services department; these workers were existing Assistant Practitioners rather than qualified Social Workers or Occupational Therapists. They all had assessment experience, but their task was to learn more about the AT equipment and to develop the range of equipment provided by the service.

Formal versus non-formal employment

The project was not aimed at the transfer of non-formal to formal employment.

Project implementation

Programme level

The AT services are provided in conjunction with CAPs. There are six CAPs around Norfolk County, all part of the district councils. Some of the providers were initially attached to the housing provision unit, but when housing provision moved over to housing associations, the CAPs moved with them.

The AT practitioners (ATPs) go out and assess the service users. If the service users require only simple standalone items of equipment that do not need to link outside the house, the AT service provides them. If, however, they need telecare items, and if the person already has a community alarm, ATPs will liaise with CAPs to swap the community alarm for a telecare enabled one and install the additional equipment. If the person does not have an alarm, ATPs will arrange with CAPs to provide them with one.

The ATPs are not only assessors for AT; they provide training and awareness-raising sessions, as well as talks and clinics around the county to various groups. They also research and trial the equipment. The scope of their work goes beyond what Assistant Practitioners would generally do.

There are different ways of delivering the AT service. Some providers try to incorporate AT into the everyday work of other professionals; others contract out companies to do this for them; there are also providers that have specialist teams, such as Norfolk County Council. The way the service is delivered depends on the demographics and geography of the area. Different models work in different contexts. The AT service in Norfolk is different from other services that offer packages of services, such as dementia or falls packages. According to the AT service manager, they have a very person-centred approach, providing equipment that is tailored to individual needs.

Project level

The method of implementing this initiative is described in the section above. However, there have been several adjustments to the AT service since the initial pilot stage. The service is constantly evolving. This section describes some of the changes to the initiative that have taken place in practice.

Consolidating AT workers: Initially, the AT workers were based in localities around Norfolk county and were managed by different team managers, rather than being part of a standalone AT service. It was then decided that, to move the service forward, the AT workers needed to be a discrete team. Under the new management, a team of AT workers was formed in 2006.

Mainstreaming AT services: Before the ATN project became the mainstream service within the social services department, the management had to explore different options. One of the options was training all social care assessment staff to carry out AT assessments as part of their job to save time and money in hiring specialists. The department organised training for about 450 assessment staff across the county in January 2007. However, this did not work in practice, as the workload of assessors was already demanding and the workers were not coming into contact with AT often enough to remember the different equipment. They continued with awareness raising and training, but in the end it was agreed in the same year that AT would become a mainstream service. The department decided to keep and fund the AT team through the annual budget system. At the same time, all this training did not go to waste because the assessment staff are able to order some of the simple equipment directly, rather than coming to the AT team who carry out the more complex assessments.

Expanding AT services and reacting to austerity measures: The AT service is very organic; it is constantly adapting and adjusting, as it needs to be reactive to what is happening. The budget available for the AT service within the department is limited and this restricts the scope

of the service. In 2009, the AT team was looking to expand the service, putting its expansion plans forward for the next budget round. However, following the strategic spending review in 2010, departmental budgets were cut and it was unlikely that the AT service would get more money.

Creating commercially minded AT services: As a result of changes to the local authorities' budgets, Norfolk County Council is looking at ways to generate money through commercial activities to revive the services that it is legally required to provide. This has implications for the AT team, who are not going to be part of the council anymore and are currently (January 2013) moving out. One of the ways in which the council is trying to generate money is by operating AT services through its trading company. The AT team will be a part of this trading company but will continue providing the same free service for eligible people and with the same staff. The team aims to develop a market in which to sell its services, equipment and consultancy to generate income. Ultimately, the council will be able to provide AT services at no cost, because income will be generated through the marketplace.

Monitoring and evaluation

The AT team measures the quality of its service in several ways, collecting qualitative and quantitative data. Feedback is regularly received from service users and their primary workers. ATPs speak to service users and give them their telephone number in case anything happens with the equipment. Records are kept of the number of referrals, the number of people on the waiting list, how quickly the team responds to referrals and how quickly it delivers equipment to the service users.

Contextual factors

The key factor contributing to successful implementation of the AT service in Norfolk has been the support received from senior management, who have been very much in favour of the AT service. This had a big impact from the very beginning. Ironically, the cuts imposed by central government have also helped, because the council is more focused on saving money and the AT service contributes to this goal.

Outcomes and results

Type and number of jobs created

The new AT workers have been successful at developing the service, providing innovative solutions for the needs of service users. There have been no staff reductions as a result of introducing the AT service. From the original team of six AT service workers, only one person left due to ill health. The AT team has grown from 6 to 13 people in the past few years.

Other relevant outcomes

The AT service provides a cost-effective solution to the growing pressures on social services by enabling people to live independently at home. The referrals for the AT service have risen since first introduced, currently standing at around 1,800–2,000 referrals a year. In addition, many people receive AT directly through other social services professionals. The AT initiative benefits service users in many ways. Most people want to remain in their home and providing AT can help them to do that, particularly in the case of people with dementia. A person with fairly advanced dementia can still function well at home with the help of equipment that can monitor their daily routine, ensuring that they eat and sleep properly. As well as helping people to remain in their own home rather than going into a residential home, AT helps carers. It also improves people's lives by not restricting them to the house – for instance, the use of simple location devices can track people if they get lost.

Main results

(See previous two sub-sections)

Lessons learnt

Success and fail factors

In the initial stages of the ATN pilot project, there were several problems in terms of service design and organisation. As it was a new service, the AT workers and their managers were unsure about what was expected of them; there was no clear direction. According to the present manager, the service started from the wrong end. Rather than looking at what equipment was available and how it could help, they should have started by looking at what was needed. Another issue was the fact that the team members were distributed around the county and rarely met each other. As a result, there was a feeling of isolation and uncertainty about expectations for the service. In the current format, however, the ATPs can discuss their work as a team, sharing their experiences and ensuring consistency across the service.

The AT service manager identified several factors for success that can be taken from their experiences in Norfolk, as follows.

1. To get a new initiative up and running, support from the top down is needed.
2. To get people involved, correct and regular awareness raising and training is required. This is crucial because of staff turnover.
3. It is important to get the right people who are enthusiastic about providing the service. These people can help to develop the service further.
4. To ensure sustainability, the service must be mainstreamed. It has to be centrally funded rather than financed through grants, because once the service is introduced, people expect it to continue.

A number of barriers to implementation arose in the case of Norfolk. The following challenges should be borne in mind for future reference.

1. One of the biggest challenges for the Norfolk AT team was overcoming the attitudes of social services professionals within the department and being recognised as a core service. AT was initially seen as an ‘add-on’ rather than a core service; however, after a lot of training and awareness raising, referral numbers have been steadily increasing.
2. Another challenge was the assumption within the department that older people do not understand technology.
3. The AT team experienced similar barriers when they initiated telehealth services in Norfolk. As part of this service, they started a small innovative project around monitoring people’s vital signs at home so they do not have to come to clinics and hospitals regularly. However, clinicians viewed this development as a threat to their jobs.
4. A final difficulty for the ATPs was the lack of a recognised formal qualification in this area. Initially, no training was available for ATPs and they had to just learn themselves and experiment. However, the service developed once the workers became familiar with the equipment and started to see its potential and benefits.

Sustainability and transferability

The AT service is funded centrally. It is part of a larger group of services – the Prevention Services Group. In 2009, all prevention services had to go through a financial evaluation and impact assessment to determine the impact of these services on the department and to assess savings in terms of residential care, police time and healthcare time. The evaluation showed that

for every GBP 1 (€1.16) spent on direct AT service provision, there was a cost diversion elsewhere of about GBP 3.75 (€4.36). This meant that for every GBP 1 worth of AT equipment put to use, the department saved GBP 3.75 elsewhere. The AT service has therefore proved to be highly economical.

The AT service in Norfolk has grown organically, but the model is transferable and expandable. The service is restricted to Norfolk because the initial team was still part of Norfolk County Council. However, once the service becomes a commercial provider, it will not be restricted by boundaries. In addition, there are other areas, such as telehealth, where there is potential for the service to expand. There is also a range of new equipment that could be introduced to meet the demand.

Conclusions

The development of a new type of worker – the Assistive Technology Support Worker – and essentially a new assistive technology service for older people and people with disabilities in Norfolk has not been a smooth process. As with many new initiatives, there were several problems and obstacles concerning its implementation, including a lack of a clearly defined job description. One of the main barriers, however, has been the attitudes to and assumptions about assistive technology. Many people feel threatened by advances in technology, as they are often perceived to have an impact on human resources. In this case, no staff reductions have been made as a result of introducing AT services. On the contrary, five new positions have been created since the beginning of the project and the service continues to expand. In terms of sustainability, the AT service has become a mainstream service within Norfolk County Council. Moreover, there is the potential to benefit commercially from AT products and services. To this end, the council is looking to sell its services, equipment and consultancy in the marketplace in order to generate income.

This case study has illustrated that AT has the potential to benefit service users and cares alike, enabling people who need support to continue living in their own home. AT offers a cost-effective alternative to residential care, substantially reducing the cost of care services for local authorities. In times of austerity and growing demand for health and social care services, cost-saving alternatives such as the AT service will be welcome.

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Case study 3: Social Care Workforce Development Programme

Description of the initiative

This case study describes the Social Care Workforce Development Programme (SCWDP). The SCWDP is a national programme, funded by a grant given by the Welsh Assembly Government (hereafter 'the Welsh government') to local authorities in Wales to develop a Social Care Workforce Development Partnership for their area. Each year, the local authorities are invited to apply for funding. The planned expenditure on the SCWDP for 2012–2013 will total GBP 12,015,714 (€13,967,449). The grant provides 70% of the cost of the programme and is intended as a supplement to employers' own training resources. The remaining 30% is funded by the local authorities.

Overall objectives

The broad aim of the programme is to improve the quality and management of social services provision through training and staff development and by increasing the take-up of training across the social care sector. The objectives of the SCWDP are:

- to increase the proportion of staff across the whole social care sector with the necessary qualifications, skills and knowledge required for the work they do;
- to achieve the previous objective through assistance and support from Social Care Workforce Development Partnerships led by local authorities and informed by the commissioners of services within local authorities.

At the local level, partnerships are expected to deliver the following:

- to plan and develop SCWDP funded training across the whole social care workforce;
- to monitor progress in relation to those plans;
- to evaluate the impact of those plans on services and the workforce.

Definition of the problem

Policy background

The number of people in need of social services in Wales is increasing and this reflects the growing demand for social care workers. In the UK, the number of workers in both residential and non-residential care has increased between 2005 and 2009. In terms of the community-based workforce, it was estimated that the number of workers in social work activities without accommodation (NACE 88) increased by around 8,000 workers, suggesting that the annual average employment growth in non-residential services has been 2.4% (Skills for Care and Development, 2011).

In Wales and nationally throughout the UK, there are concerns about the instances of serious misconduct, bad practice and abuse by a minority of staff in social care. It has been shown that employment in social care is not suitable for everyone (Welsh Government, 1999). In *Building for the future; A White Paper for Wales 1999*, the Welsh government committed itself to raising standards of conduct and practice for everyone working in social care. It was emphasised that the quality of social care services depends very much on the workforce having the right knowledge, skills and attributes. It was also recognised that many workers in services such as children's homes, residential care for adults and day care were not qualified.

The SCWDP was developed in 2003 as an initiative of the Welsh government, which was seeking to support improvements in the quality of care services for adults and children. The programme has been rolled out across 22 local authorities in Wales. When the initial SCWDP

expired, it was updated with a five-year plan, but the partnerships are essentially renewed on a yearly basis and informed by the strategic vision of each council as a whole. Every year, the local authorities have to produce a report and an application for funding to the Welsh government to continue their funding. The budget varies for different local authorities.

Role of the social partners

The key stakeholders within the partnerships include commissioners, commissioned service providers, statutory, third sector and private sector employers, service users, carers and training providers. Membership of the partnerships varies from one local authority to another. The membership should include members from regulated and non-regulated settings providing social work and social care services for children, family services and adult services. These could include providers of adult care, home care, children's care, foster care, further and higher education, as well as service users and carers. Thus, there is a mix of social and other partners.

Issue at stake

The programme seeks to support improvement in the quality and standard of social care services delivered by the local authorities and through commissioned services.

Approach and implementation

Overall approach

The SCWDP is a distinct form of financial support granted to independent sector providers. It enables employers to provide their staff with training as well as personal and professional development at a low cost or backfill cost only. Some providers may incur no cost to themselves, depending on the terms and conditions of the contract they hold with individual care workers. The funding for the programme comes from the Welsh government and covers 70% of the cost of training. The remaining 30% is funded by the local authorities. Employers themselves should take responsibility for supporting their staff with their professional development needs. While the SCWDP partnership can offer a programme that includes a whole range of training activities, the employers would be implementing the training that is mandatory, such as moving and handling training. The employers maintain the responsibility for training their staff, while the local SCWDP partnerships provide an additional resource to them that would not otherwise be available. This gives social care workers an opportunity for further development. The SCWDP partnerships are required to make adequate provision for training in three main groups: childcare, community care and management training (Welsh Government, 2011).

Recruitment versus retention

The primary purpose of the programme is to improve the standards of social services through training and staff development. This is achieved by increasing the take-up of training and the number of staff with qualifications. It is anticipated that the programme will improve retention rates among the social care workforce.

Specific target groups

The programme aims to target all workers who are employed in organisations providing social care services through a contract for care services with the local authorities, as well as community care workers.

Formal versus non-formal employment

This measure does not specifically aim to transfer non-formal to formal employment.

Project implementation

Programme level

The aim of the SCWDP is to develop the social care workforce through the development of training programmes. The SCWDP in Wales is not a new initiative; there are similar models under different guises in the UK. Every year, local authorities are invited to apply for the grant and to submit their training plans for the coming year.

Project level

Local partnerships, on a whole, are implemented through coordinating various training events. The partnership coordinator looks at the needs of social care providers in their local areas to determine how the partnership can meet this demand.

Every care provider with a formal contract to provide care services receives communication through a distribution list of the partnership. The partnership provides them with information about the programme and invites them to engage in any activities that are offered by the partnership. Participating on the programme is a voluntary arrangement. The funding is available to support people and care providers with their training programmes, but the ultimate responsibility for providing training for their care staff remains with the care providers.

The partnership undertakes a substantial data collection exercise every year. A standard form is sent out to all care providers requesting information regarding the level of qualification that their staff members hold and the specific training needs that they are looking to meet in the next 12 months. The training needs are then assessed on the basis of the funding available. A report is produced and this is then reviewed by the Steering Board group, which advises the coordinating team on the steps to be taken next.

The role of the partnership is to offer different avenues to support care workers' training. This training is done at low or no cost to the care providers, including the cost of releasing their staff for the training. Due to the huge staff turnover in the care sector, particularly in home care and community care services, the ultimate aim is to try to improve the quality of care services.

One of the key elements of partnership is to create effective communication between different stakeholders, particularly the social care providers and the contract and commissioning staff at the local authorities. This is important in terms of understanding which direction the partnership needs to take strategically in planning care services. The strategic issues are dealt with by the Steering Board group. The Steering Board of Partnerships is led by different people in different roles within each local authority area; however, the local authority maintains the overall responsibility for the programme. Each local authority operates its SCWDP slightly differently based on the regulations set out by the Welsh government. Steering boards have a fairly standard representation in each area, which can include members from children's and adult services, service providers including residential care providers and home-care providers of adult and children's services, service users, carers and training providers. Each local authority sets its own meeting schedule, usually quarterly with extraordinary meetings set as required. Other working and sub-groups, including task and finish groups, exist to oversee the operational side of the programme.

The SCWDP has changed significantly over the years. Most recently, in 2011, the National Vocational Framework (NVF) qualifications were replaced by new types of qualifications under the Qualifications and Credit Framework (QCF). QCF is a new credit transfer system, which applies in England, Northern Ireland and Wales. QCF qualifications are much more robust and targeted at particular client groups. This will have an impact on the SCWDP in terms of providing much more measureable improvement in the quality and standards of care services.

Major changes occur each year with regard to the groups of care staff and their managers registering with the Care Council for Wales. The aim of registration is to try to produce a

reliable workforce and to eliminate the problems arising from employing the wrong people for the job in terms of their past histories and behaviours towards vulnerable people.

Monitoring and evaluation

Each local authority is required to monitor and evaluate the progress of the SCWDP partnership. Monitoring and evaluation of the authorities' use of the SCWDP grant is also carried out by the Welsh government. It is recommended that the local authorities develop a range of evaluation projects. These should include evaluations of short-term action as well as the longer-term benefits of training and its contribution to the objectives of the five-year plan. It is also essential to evaluate the impact and any benefits of training to service users and carers (Welsh Government, 2003).

In practice, measuring the quality of the programme involves a constant evaluation and review process. This includes inviting formal and informal feedback from all participants at the end of each training session and from their managers. The information is then gathered by the SCWDP coordinators and evaluated to determine what efforts have been made to make improvements for the following year. All of the information from different sources is collated and presented at the meetings of the Steering Board group and in the yearly reports submitted to the Welsh government.

Contextual factors

The Care Council for Wales, as a regulatory body for the social care workforce, plays a significant role in achieving the goals of the SCWDP. The Register of Social Care Workers, established under the Care Standards Act 2000, requires the council to register social workers and social care workers. The aim of the register is to ensure workers' suitability for work in social care in terms of their health condition, character and the necessary qualifications held. Without the registration and regulation role of the council, the number of companies supporting staff to take up qualifications and training would be much lower.

The success of the SCWDP partnerships has been furthered by the change of structure in the required qualifications for care workers, as mentioned earlier. Moreover, significantly improved communications with health and social care providers have had a positive impact on their working relationships.

On the other hand, one of the main difficulties encountered in this area is in relation to staff retention and training new staff. This is more of a problem in the city than in rural areas; in the principal cities in Wales, there are many other industries that compete for the same pool of staff, for example, hospitality, retail and customer services. There is a lot of employment in these areas and care staff are traditionally the same pool of workers who are attracted to these professions. Moreover, some people may migrate to the cities, start working in the care sector and go through training, but then move on to other professions. Therefore, despite the investment in these people's training and professional development, they have moved on to another sector. As there is a significant level of turnover of care staff, the workforce overall has to be retrained constantly; however, it is known that staff also 'move around' within the sector, working for different companies. There has not been any evaluation conducted on how the SCWDP may improve retention rates. However, it is expected that the initiative will address this issue to some extent through the objective of increasing training and personal and professional development of social care workers, as well as increasing the number of staff with qualifications.

Outcomes and results

Type and number of jobs created

Overall, the impact of the SCWDP is vast in terms of developing the social care workforce in Wales. However, the programme is not compulsory and from the large number of staff employed in care services, only a fraction of people undertake the training. While the programme has likely implications for workforce recruitment and retention, data on the impact of the SCWDP on job creation and retention in the sector is not available.

Other relevant outcomes

The programme benefits the social care staff, service providers, service users, as well as the care sector and society as a whole. The benefit to staff is that every element of training can be added to their portfolio of learning, which goes towards qualification or continuing professional development. The programme enables service providers to train and develop their staff at no cost. From the service user point of view, they should experience an improved quality of service as the standards of the social care sector generally improve.

Main results

According to the progress report for 2010–2011, the key outcomes of the SCWDP for all services across Wales were as follows.

- In 2010–2011, there were up to 127,000 attendances at SCWDP funded events – this represents a decrease of 3.8% on the previous year.
- Some 6,500 qualifications were gained during the year – this constitutes a decrease of 2.9% on the previous year.
- Across Wales, the number of 'specified qualifications' obtained decreased slightly in the training areas of management and community care (6% and 4% respectively); conversely, there was a 14% increase in childcare qualifications.

Specific information on community care training and qualifications reveals the following.

- The total number of attendances at SCWDP funded community care training events was slightly over 82,100, representing a decrease of nearly 5% on the previous year; there were over 76,200 attendances at SCWDP funded community care training events by Social Services Department (SSD) staff, constituting a decrease of 7% on the last year.
- Of the 76,200 training attendances by SSD staff, fewer than 52,500 (or 69%) were from local authority staff; there were just under 23,800 attendances at SCWDP funded community care training events by staff from 'other employers', representing an increase of 7% on the previous year; and across Wales, the total number of qualifications gained by all community care staff was just over 5,300, constituting a decrease of 5% on the previous year.
- Of the total number of qualifications gained, nearly all (99%) awards were gained by SSD staff. The number of qualifications awarded to SSD staff (5,300) represents a decrease of 4% on the previous year.
- Of the qualifications awarded to SSD staff, just over 3,700 (or 70%) were awarded to staff from 'other employers' – this was more than double the number awarded to local authority staff (just over 1,600). Of the total qualifications gained, the majority (89%) were National Vocational Qualifications.

Lessons learnt

Success and fail factors

One of the key lessons learnt during the course of the programme was the importance of ensuring that all the key stakeholders are firmly on board from the outset. This is a huge and difficult task; it requires that people understand the intention of the programme and are committed to its aims. The possibilities of the programme improved significantly when people became fully involved.

Some potential fail factors that should be borne in mind include the fact that combining profit organisations and care services might cause resistance. The role of the SCWDP and its support of private providers were slightly controversial at the start. Many people questioned the direction that the development of the sector may take, along with the impact on the quality of services and how it was going to be monitored. However, there are various bodies in place that are involved in contract monitoring and in care inspection. The attitudes towards privately provided care services have changed over the years, as the majority of these services are now contracted out to independent sector providers and few services remain internally directly provided.

Sustainability and transferability

The programme is fully transferable in that its principles can be taken forward into other contexts. The programme's implementation in practice would depend on various other factors. There is a commitment to funding the programme in the future.

Conclusions

Evidence from the National Minimum Data Set for Social Care suggests that there is a correlation between high levels of staff retention and qualification levels held (Skills for Care, 2011). The overall aim of the SCWDP is to improve the quality and management of social services provision through training and staff development. Furthermore, the SCWDP develops the recruitment and retention strategies of employers by offering their management staff training on recruitment and retention matters. Although data on the SCWDP's impact on recruitment and retention rates are not available, by increasing the standards in the sector, the programme has likely implications for workforce recruitment and retention in social care.

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Link

Register of Social Care Workers: http://www.ccwales.org.uk/registration/

Annex 2 Interviewees

Case study 1

Paul Haunch

Participants of the Single Ticket Programme

Case study 2

Jonathan Langman, Assistive Technology Service Manager

Community Services, Norfolk County Council

Case study 3

Coordinator of the Social Care Workforce Development Programme (SCWDP)

Eva Kasperova, Kingston University

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