Mapping the Wider Care Workforce:

Expert Paper

Nick Jagger

Published by:

INSTITUTE FOR EMPLOYMENT STUDIES
Mantell Building
University of Sussex
Falmer
Brighton BN1 9RF
UK

Tel. + 44 (0) 1273 686751
Fax + 44 (0) 1273 690430

http://www.employment-studies.co.uk

Printed in Great Britain

The Institute for Employment Studies

The Institute for Employment Studies is an independent, apolitical, international centre of research and consultancy in public employment policy and organisational human resource issues. It works closely with employers in the manufacturing, service and public sectors, government departments, agencies, and professional and employee bodies. For over 35 years the Institute has been a focus of knowledge and practical experience in employment and training policy, the operation of labour markets and human resource planning and development. IES is a not-for-profit organisation which has over 60 multidisciplinary staff and international associates. IES expertise is available to all organisations through research, consultancy, publications and the Internet.

IES aims to help bring about sustainable improvements in employment policy and human resource management. IES achieves this by increasing the understanding and improving the practice of key decision makers in policy bodies and employing organisations.

Acknowledgements

The author is indebted to Ian Barber of the NHS Widening Participation Unit for his helpful comments at the proposal stage of this project as well as Peter Bates and Georgios Loukas who provided data, and to Gill Stephens and Denise Hassany for their time and attention with the final manuscript.

Contents

1 Introduction and background 1

1.1 Introduction 1
1.2 Objectives 1
1.3 Background 1
1.4 User preference and policy 3
1.5 Potential double counting or synergy 4
1.6 Approach used 4
1.7 Structure of this paper 4

2 Definitions and usage of the term 6

2.1 Usage of the term 6
2.2 The working definition 7
2.3 Care sectors 7

3 Available forecasts 9

3.1 National forecasts 9

4 Data Sources 16

4.1 Labour Force Survey 16
4.2 2001 census 16
4.3 Social services data 18
4.4 NHS census 19

5 The LFS evidence 20

5.1 Care workforce in the LFS 20
5.2 SOC 2000 definition 20
5.3 SIC 2003 Definition 22
5.4 Age breakdowns 23
5.5 Gender breakdowns 24
5.6 Ethnicity breakdowns 25
5.7 Qualification breakdowns 26
5.8 Full-time or part-time 27

5.9 Country of birth breakdowns 27
5.10 Sector of employment breakdowns 28
5.11 Public or private breakdown 29
5.12 Type of non-private organisation 29

6 Reconciling the sources 31

6.1 First care sector 31
6.2 Second care sector 32
6.3 Third care sector 32
6.4 Fourth care sector 32
6.5 Fifth care sector 32

7 Conclusions and Recommendations 34

7.1 Conclusions 34
7.2 Recommendations 36

8 Bibliography 38

1 Introduction and Background

1.1 Introduction

This expert paper has been prepared in response to a series of discussions with the NHS Widening Participation Unit and a proposal prepared by the Institute for Employment Studies (IES).

1.2 Objectives

The main stated objective of this paper is the mapping of the wider care workforce. This will increasingly be responsible for the delivery of health and care as NHS services move closer to the community, and are integrated more closely with social care. To be included within the scope of the paper will be the expected expanded contribution by the voluntary sector, community organisations and charities, and social enterprises, alongside users and their carers. The paper looks particularly at issues of gender, age, ethnicity, qualifications and other background descriptors of the wider care workforce. Where available, the work incorporates forecasts and other projections, and emphasis is put on areas where there may be dangers of double counting.

1.3 Background

The Wanless review for HM Treasury (Wanless, 2002) recognised growing demand for NHS care, which necessarily would lead to a growth of the NHS. The review also estimated the future staffing and cost implications of this expansion. Critically, the review believed that the only way in which the need could be met was through a change in the staff mix and what they did. The review foresaw nurses taking on more of the roles of doctors, and health care assistants taking on more of the roles nurses.

Parallel with the Wanless review, a range of work was undertaken on the care of the elderly as the expansion of this group was seen as the main driver for increased demands on the NHS. The Audit Commission examined the provision of equipment

in the homes of the elderly and disabled to enable them to live independently (Audit Commission, 2000). The Standing Nursing and Midwifery Advisory Committee looked at best practice in terms of the care of the elderly (SNMAC, 2001). 2001 also saw the publication of a National Service Framework (NSF) for Older People (Department of Health, 2001a). The NSF introduced a ten-year programme of actions to ensure integrated health and social care for the elderly.

An important development towards the NSF was a report highlighting how housing strategies can be integrated into health, social care and other local strategies (Department of Health, 2003). A series of progress reports documenting the progress with the NSF have been published, most notably a report by Professor Ian Philip (Department of Health, 2004). The strategy of looking after the elderly in the own homes was reinforced with the publication of research into the sort of care that the elderly would like to receive (Opinion Leader Research, 2006). This process has culminated in the recent White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006).

The White Paper aims to:

- make community services more flexible and responsive to local and user needs
- provide a more tailored and individualised service
- give individuals more control over the treatment they receive
- develop local partnerships involving GPs, primary health care trusts, local authorities as well as private, voluntary and charitable organisations
- integrate more closely the planning, funding and evaluation processes of community health and social services provided care.

In part, the White Paper is also a response to the 'Living well in later life' report by three audit and inspection bodies (Healthcare Commission, 2006), which is the latest progress report on the NSF. This report was the first collaborative in depth review by the three bodies. These were the:

- Healthcare Commission – which promotes improvements in the quality of healthcare and public health in England and Wales.
- Audit Commission – audits, inspects and aims to promote good practice in the local government, housing, health and criminal justice.
- Commission for Social Care Inspection – responsible for regulating and inspection of all social care providers in the public and private sectors.

The report had three main areas where further improvements needed to be made:

- "Tackling discrimination through ageist attitudes and an increased awareness of other diversity issues.

- Ensuring that all the standards in the NSF are met, including further guidance on the next steps in implementing the NSF from the Department of Health due to be published in April 2006.
- Strengthening working in partnership between all the agencies that provide services for older people to ensure that they work together to improve the experiences of older people who use services." (Healthcare Commission, 2006)

It has also been recognised that movement of care out into the community will have implications for the role of the local acute hospitals (National Leadership Network, 2006). In particular, it is felt that the Practice Based Commissioning is likely to mean that the full range of services provided under the District General Hospital model are unlikely to be provided by a single institution. However, there is an urgent need to determine what is the minimum mix of acute care services that is needed for patient safety in association with an accident and emergency department.

The recently published Wanless review of social care, undertaken for the Kings Fund, (Wanless, 2006) examines future funding issues, part of which involves a workforce model. Importantly, this model recognised that the major constraint on future growth of the care workforce was the numbers of people willing to and capable of training new recruits. The conclusions of the workforce modelling section included the following comments

> *'Trends in recruitment and retention suggest that current policies and pay are not closing the gap between demand and supply. However, a range of circumstantial and anecdotal evidence is, on balance, positive about future supply. Overall, the evidence base is limited by the absence of definitive studies that would allow confident conclusions and predictions.'*

The conclusions and proposals put forward in the Wanless review of social care are likely to be influential over the next few years.

1.4 User preference and policy

The key policy theme running through many of the policy developments, in terms of the wider care area, has been an attempt to respond to the desire for care closer to, or preferably within, people's own homes. This demand for wider community care has been documented (Commission for Social Care and Inspection, 2004 and; Opinion Leader Research, 2006), but the true cost and workforce implications of this demand has not fully been examined (Wanless, 2006). The Wanless (2006) review also noted that despite this clear demand for domiciliary care, in practice the growth in delivery has been for residential care.

> *'For example, older people prefer to receive care in their own homes, yet local authority spending on care home placements has risen at a faster rate that on home care. In 2004/05 almost 60 per cent of local authority gross spending on older people's social care went on residential and nursing home placements. Furthermore, in directing resources to people*

with the most intensive needs, a substantial number of people with lesser but still significant needs are not being helped in many cases.'

(Wanless, 2006)

Another area linked to user views is that NHS care is free, but social services care is means-tested.

'It often comes as an unwelcome surprise to older people to discover that social care is means-tested and they are expected to rely on their own savings and income until their assets have fallen to the threshold set for stat- funded care. It is a common complaint that the existing system penalises those who have saved for their old age.'

(Wanless, 2006)

1.5 Potential double counting or synergy

In part, this paper is driven by a concern that different sectors may be counting the same staff and, more, importantly the same potential staff more than once, as each of the care sectors lays claim to those employed by other sectors. This is a real concern in an area where existing data and definitions remain unclear and no single agency or body is tasked with an overview. This means that traditionally data collection exercises and forecasts have been limited to single occupational groups. However, a more positive alternative exists whereby those recruited by one sector then become available to the other sectors and a synergy develops between the sectors. In a true partnership model staff from all agencies become the eyes and ears for specialist staff from their own and other agencies.

This paper attempts to examine the extent to which each of these positive and negative scenarios operates and what the data sources can tell us about the situation.

1.6 Approach used

This paper, as intended, has been based on desk research. The time frame within which this paper has been written means that the paper has almost entirely been based on secondary materials that are publicly available. However, extensive analysis of the Labour Force Survey has been undertaken specifically for the paper.

1.7 Structure of this paper

This paper consists of six more chapters that respectively deal with:

- concept and usage of the wider care workforce term
- available forecasts of the wider care workforce
- data sources that can inform about the wider care workforce

- the LFS evidence on the wider care workforce
- a reconciling the sources and data relating to the wider care workforce, and
- conclusions and recommendations.

2 Definitions and Usage of the Term

This chapter examines the usage of the 'wider care workforce' term and provides a working definition used by this paper. Additionally, this chapter introduces the concept of the five care providing sectors.

2.1 Usage of the term

As far as we can discover the term wider workforce has been used in two UK contexts. These are:

- within the Scottish health planning context, and
- within the disability care policy arena.

Both of these usages are described below.

2.1.1 Scottish usage

There has been limited usage of the wider workforce term in Scottish health and care policy documents. From the context of this usage there appears to be an understanding of the term that is similar to that used in this paper. Having said that the usage is limited, although this may be as much due to the common problem of a focus of service delivery rather than demand within the policy literature. This means that in Scotland, as elsewhere, the focus is on hospital and social services' demand. Although, there is a greater willingness within Scotland to examine and model the care workforce as a whole.

2.1.2 Disability policy usage

Another usage of the term wider workforce occurs in the disability policy literature. Here the term refers to the health and care workforce beyond that specifically working with the disabled. The usage reflects concern that the wider workforce needs to develop greater awareness of the needs of the disabled care group. This is a more

colloquial usage of the term and needs to be distinguished from the usage within this paper.

2.2 The working definition

This report uses a broad definition of the term wider care workforce. The term has been taken to encompass the health care and social care workforce, particularly that in the community, and includes statutory, private, voluntary and other provision. This broad definition has been used as it is felt that currently, and especially in the future, many policy potentials and dilemmas exist at the interfaces between these workforces and sectors. The policy potentials are in terms of greater, more targeted, more appropriate, more appreciated and often cheaper provision. The policy dilemmas range from possible double counting in terms of the workforce and the potential workforce. However, there are also issues of:

- inter-agency working
- budgeting across agencies
- training and staff development
- quality control and management
- recruitment and availability of staff.

This paper will at least ask these questions and hopes to provide some of the answers relating to the wider workforce.

2.3 Care sectors

A relatively recent categorisation of the sectors providing care into five sectors, which is an expansion of the more familiar three sectors is outlined below.

2.3.1 First sector

The term the first sector is usually used to describe the public sector. In this context we take this to include the directly employed National Health Service (NHS) and SSD (Social Services Department) staff, thus excluding any statutory services that may be provided by second or third sector staff under contract from the statutory sector.

2.3.2 Second sector

The second sector is usually used to describe the private sector. Private health care is important for all care groups. Care homes provide an important mechanism for looking after elderly people who are too dependent for independent living but not sufficiently dependent to require hospital or hospice care. Similarly, amongst other

age and care groups private options often supplement or co-exist alongside statutory provision.

2.3.3 Third sector

The third sector is also usually used to describe the voluntary, charity and otherwise not-for-profit sector provision. This sector is seen as increasing important in part due to its greater flexibility and, often, greater responsiveness to user needs. Increasingly, the provision by this third sector is funded by the state, or its agencies, to supplement or, indeed, replace statutory provision.

2.3.4 Fourth sector

The fourth sector recognises the massive care provision provided by unpaid carers for friends, neighbours and relatives. By its nature the extent of this care is difficult to quantify. However, it is estimated that if these care relationships broke down demand on the first, or statutory sector, could easily double. Therefore, increasing attention is provided to sustaining these care relationships via respite-care, advice, and other support mechanisms.

2.3.5 Fifth sector

The concept of a fifth care sector is recently new and may date from a recent newspaper article (Beresford, 2006). However, following on from the idea of the four sectors the fifth sector is seen as user group provided care. The numbers of carers may be small, but this sector is considered significant in terms of advocacy, support and advice.

2.3.6 Five sector model

This Five sector model is one way to examine and discuss those involved in providing care. This approach has been used in this paper as it provides relatively clear boundaries between providing sectors, and also maps relatively well onto existing data collection exercises and more general data classifications. It should be realised that in practice whatever structure is used to sub-divide the wider care workforce is going to have problems. The Five sector model is not a total panacea, but it does offer advantages over other classifications.

3 Available Forecasts

This chapter examines the available forecasts that might inform the future development of the wider care workforce. This includes a range of UK and English national forecasts and a separate section covers Scottish forecasts. The final section examines the increasing importance of local forecasts.

3.1 National forecasts

There are a range of national forecasts, either at the level of the UK or England, that provide important background to the wider care workforce. These are:

- Wanless 2002 review
- MWSAC forecasts
- Future demand for long term care
- Review of UK nursing labour markets
- National framework
- Working futures
- Employer Organisation's projections for England
- Scottish nursing and midwifery workforce
- Wanless 2006 review.

These forecasts and their implications are outlined individually below.

3.1.1 Wanless 2002 review

The most comprehensive forecasts of the NHS were undertaken as part of the Wanless Review (Wanless, 2002) for HM Treasury. A more recent Wanless review (Wanless, 2006), this time for the Kings Fund, has produced some forecasts for the social care

sector. However, although the main report has been published at the time of writing the appendix containing the forecasts has not.

Although, the costs involved in the three core scenarios used by the 2002 Wanless review differed greatly the numbers of extra staff over and above those currently required were pretty similar in each of the scenarios. However, within the 'solid progress' scenario the review forecast a requirement for an extra:

- Sixty-two thousand doctors
- One hundred and eight thousand nurses
- Forty-five thousand professionally qualified therapists and scientists, and
- Seventy-four thousand health care assistants.

The 2002 Wanless review also identified that it was very unlikely that the UK could produce that many additional doctors within the 20 years available. They suggested that up to 20 per cent of the workload of doctors could be taken over by nurses. This in turn would overload nurses, as they would have a ten per cent increase in demand. So in turn up to 12.5 per cent of the nurses' workload could be transferred to HCAs. This in turn would mean a need for an additional requirement for 70,000 HCAs. This work mix approach would allow current plans for doctor and nurse numbers to meet demand. The caution expressed by the review was due to the large increase in HCA numbers from the current 350,000 to 494,000 if the scenario and the work mix increases were added.

The BMA, in a recent submission to the Health Committee Inquiry into Workforce Planning (BMA, 2006), while praising the Wanless 2002 review implicitly criticised it for starting from current staff numbers rather than from current need. The assumption being that it is unlikely that the full demand is currently expressed and that the current staff mix is unlikely to be optimal.

> *'Successive reviews at the macro level have assessed the likely supply of doctors under certain assumptions and compared it with prospective NHS demand, the stepping off point being the existing position. As a result, no comprehensive needs-based evaluation of that position has been undertaken. This has cemented in a shortfall of doctors hidden by long hour of work and perverse incentives for substitution.'*
>
> (BMA, 2006)

However, establishing current need is exceptionally problematic and in practice there is always likely to be an element of unmet demand within any health and social care system.

3.1.2 MWSAC forecasts

The Medical Workforce Standing Advisory Committee (MWSAC), which has recently been wound-up, historically produced a series of forecasts of the demand for doctors. The most recent of which (MWSAC, 1997) was associated with the subsequent 50 per cent increase in medical student places. As the BMA (2006) suggests, these tended to examine demand for doctors in isolation and, unlike the Wanless 2002 review, rarely looked at doctors working hours or skill mix issues.

3.1.3 Future demand for long term care

An attempt to start forecasts from the basis of need rather than the current staffing situation has been undertaken by the Personal Social Services Unit (Comas-Herrera et al., 2003 and; Wittenberg et al., 2006). They produced the forecast in Table 3.1, which perhaps more importantly shows the importance of informal care and private domestic help. Importantly, Wittenberg et al. also show the sensitivity to a wide range of factors, most importantly the future disability rates and the availability of informal care.

Table 3.1: Future demand for long term care for older people in England

	2002 (1,000s)	2012 (1,000s)	2022 (1,000s)	2031 (1,000s)	2041 (1,000s)	Per cent growth 2002 to 2041
Disabled older people with informal care (in household)	1,710	1,950	2,380	2,900	3,340	95
Users of local authority home help services	340	380	470	580	680	100
Users of community nursing services	430	490	600	760	890	110
Users of private domestic help	820	960	1,180	1,420	1,630	100
In residential care homes	200	230	280	360	440	115
In nursing homes	120	140	170	220	260	115

Source: Witternberg et al., 2006

3.1.4 Review of UK nursing labour market

This report, produced by the Royal College of Nursing (Buchan and Seccombe, 2005),used past trends to examine the likely future pressures on nursing staff levels. They note that despite a 23 per cent increase in the NHS nursing workforce there remain staff shortages and nurses reporting heavy workloads. Nurses from overseas remain a critical source for the UK, with 45 per cent of new entrants to the UK Nursing Register coming from outside the UK. Another critical feature of the current nursing labour market is the age profile of nurses, with many about to retire. This appears to be a particular problem in the community and primary care sector. They conclude:

'The NHS is moving into a period of greater uncertainty about service configuration and associated workforce planning and policy. The continued rapid aging of the UK nursing population means that all these efforts must be regarded as necessary, but not sufficient to meet the nursing workforce replacement challenge of the next ten years.'

(Buchan and Seccombe, 2005)

3.1.5 National framework

Much of the responsibility for NHS and Social Services workforce planning has been devolved to the local level. In order to support this devolved activity a suggested national framework has been developed and provided to the local bodies to assist the process. The documentation (Department of Health, 2005d) outlines a range of issues and approaches that can be used for local workforce planning and the development of local workforce strategies. There is also encouragement for these to be integrated at the local level between health and social services.

3.1.6 Working futures

The Sector Skills Development Agency, which is responsible for co-ordinating employers' views about skills and training, has commissioned a series of employment forecasts. These forecasts are based on past trends and a range of assumptions about the pattern of economic development. They have recently been published (Wilson et al., 2006) and provide detailed forecasts at the level of two digit SIC (Standard Industrial Classification) at the UK level. The relevant SIC code is SIC 85 which covers health and social work. Table 3.2 shows overall 9.7 per cent employment growth is forecast for the sector. Particular, growth is expected in male part-time work and in part-time work in general.

Table 3.2: Working Futures forecasts for the health and social work sector

	Full-time (1,000s)	Part-time (1,000s)	Total (1,000s)	Percentage
2004 Male	367	136	594	18.4
2004 Female	1,125	1,323	2,629	81.6
2004 Both	1,492	1,459	3,224	100.0
2014 Male	420	197	703	19.9
2014 Female	1,199	1,456	2,833	80.1
2014 Both	1,618	1,654	3,536	100.0
Percentage growth 2004 to 2014 Male	14.4	44.9	18.4	–
Percentage growth 2004 to 2014 Female	6.6	10.1	7.8	–
Percentage growth 2004 to 2014 Both	8.4	13.4	9.7	–

Source: Wilson et al. (2006), Working Futures, table 6.24.2

Table 3.3 examines the occupational make-up of the forecast expansion of numbers within the health and social services sector. Importantly, the table also shows the expected levels of expansion demand and replacement demand. This shows the greatest expansion in overall numbers is expected to be amongst the Personal service occupations, with an increase from 356,000 to 1,067,000. However, given the age structure of the Associate professional and technical occupations their replacement demand is almost as big as that from the Personal service occupations.

Table 3.3: Forecast occupational change within the health and social work sector

	1984 (1,000s)	1994 (1,000s)	2004 (1,000s)	2009 (1,000s)	2014 (1,000s)	Net change 2004-2014	Replace-ment demand (1,000s)	Total require-ment (1,000)
Managers and Senior Officials	184	283	377	434	469	92	148	240
Professional Occupations	199	303	420	477	526	106	181	286
Associate Professional & Technical Occupations	598	765	916	964	973	58	357	414
Personal Service Occupations	356	608	896	960	1,067	171	362	533
Other Occupations	747	788	615	572	501	-115	249	136
Total	*2,084*	*2,747*	*3,224*	*3,407*	*3,536*	*312*	*1,297*	*1,609*

Source: Wilson et al. (2006), Working Futures, table 6.24.3

Overall, the total requirement of 1,609,000 is about 50 per cent of the current workforce of about 3,224,000.

3.1.7 Employers organisation projections for England

The Local Authority Employers' Organisation has produced what they call trends and projections of demand for local government staff (EO, 2005). Unfortunately, this report is far more an analysis of recent trends, and the continuation of these trends, rather than projections based on demographics and other demand factors.

Table 3.4: contains details of the current trends for numbers of social care staff numbers which shows headcount numbers falling between 1998 and 2003.

Table 3.4: Social care current trends for social care in England

Year	Headcount	FTE
1996	n/a	233,656
1997	n/a	229,443
1998	299,281	223,515
1999	295,680	221,742
2000	291,857	217,184
2001	284,445	211,990
2002	277,320	209,695
2003	276,960	211,970

Source: EO (2005), Table 1.9

Table 3.5: Social care workforce with recruitment and retention difficulties, England, 2004

	Headcount	FTE	% of authorities reporting recruitment difficulties in this area	% of authorities reporting retention difficulties in this area
Social Worker Children and Families	22,830	20,520	88.6	39.5
Community Care Social Work	22,325	20,015	75.0	30.2
Residential Social Work	13,920	12,335	61.4	26.2
Community Social Work	50,325	42,895	51.1	19.2
Occupational Therapist	4,425	3,430	72.7	29.1
Home Care Staff	55,540	34,975	47.7	37.5
Care Assistant	42,960	29,910	44.3	37.5

Source: EO (2005) Table 3.3

Table 3.5 provides more detail of the social care workforce in England for 2004 and indicates the groups with recruitment and retention difficulties. The most problematic in terms of both recruitment and retention are socials workers working with children and families. However, community care social work and occupational therapists are almost as difficult to recruit. Importantly, especially given the relative size of the groups retention was particularly a problem with home care staff and care assistants.

3.1.8 Scottish nursing and midwifery workforce

The Scottish Executive has funded a series of modelling exercises which aim to forecast over the relatively short term, in 2004 the forecasts were for 2007, demand for nurses and midwives. This exercise by the National Workforce Unit (2004) is regularly undertaken to determine the number of nursing and midwifery places that need to be offered to maintain staff levels and meet rising demand.

Table 3.6: Average growth assumptions nursing and midwifery Scottish scenarios

	Stock at start of 2002/03	Stock at start of 2007/08	Leavers	Joiners/re-joiners	Number of NQNs required
Best case	39,128	42,412	2,986	1,997	1,705
Likely case	39,128	41,974	2,995	1,806	1,815
Worse case	39,128	41,539	2,998	1,794	1,922

Source: National Workforce Unit (2004)

3.1.9 Wanless 2006 review

The Wanless review of social care produced for the Kings Fund (Wanless, 2006) has been recently published. Table 3.7 provides the reviews estimate of the social care workforce, broken down by sector. This indicates the importance of the Independent sector in the employment in the Domiciliary care services area as well as in the Care homes area. This shows the Independent sector employing two-thirds of the domiciliary care staff and about 85 per cent of the care home staff. Equally, sixty per cent of the Day care staff are considered to be employed by the independent sector and 63 per cent of the Agency staff.

Table 3.7: Social care workforce, broken down by sector

	Local Authority	Independent sector	NHS	Total
Social services departments (central, area, filed, other)	112,000	–	–	112,000
Domiciliary care services	56,000	107,000		162,000
Day care services	38,000	57,000		95,000
Care homes	72,000	390,000		462,000
Agency staff	11,000	19,000	Not known	30,000
NHS (narrow definition)	–	–	62,000	62,000
Core workforce total	*288,000*	*572,000*	*62,000*	*922,000*

Source: Wanless (2006) based on Eborall 2005

The chapter of the review covering workforce issues concludes:

> *'In the context of expected increases in demand for care in the future, there is a very real issue of whether it is possible to realistically to expect supply to increase in response. There are mixed signals about supply responsiveness and about what factors might bring about increases in supply. Trends in recruitment and retention suggest that the current policies and pay are not closing the gap between demand and supply. But, there is a range of circumstantial and anecdotal evidence that is, on balance, positive about future supply. Overall, the problem is not having definitive studies to be able to confidentially decide this issue.'*
>
> (Wanless, 2006)

4 Data Sources

This chapter introduces a range of data sources and examines the headline data they can provide about the wider care workforce. These sources include the:

- Labour Force Survey
- 2001 Census
- NHS Census, and
- Social Services data.

Each of these is covered in turn below.

4.1 Labour Force Survey

The Labour Force Survey is a sample survey of about 60,000 UK households where the individuals in the households are interviewed five times every three months. A fifth of the sample is refreshed every quarter, producing a rolling sample. The data is released quarterly and weighted up to produce population estimates. As it is a sample survey, small groups are unreliable and population estimates below 10,000 have to be suppressed. Therefore, we have used a dataset made up from the four quarters of 2004. This allows the publication of estimates as small as 6,000. A further benefit is that the currently available NHS and Social Services data is also for 2004, and this allows more direct comparability.

As this source is very flexible, and has universal coverage, the lessons learnt about the wider care workforce are dealt with in the next chapter (Chapter 5).

4.2 2001 Census

The 2001 Census included a question about caring responsibilities. The census form asked:

'Do you look after, or give any help or support to family members, friends, neighbours or others because of:

- long-term physical of mental ill-health or disability, or
- problems related to old age?'

This is the largest sample where this sort of question has been asked, and allows an examination of the fourth sector in more detail than before.

4.2.1 Standard census reports

Table 4.1 examines the pattern of informal care by age of provider and the number of hours of care provided each week. This shows that about two thirds of the informal carers provide between one and 19 hours a week. This level of care is mainly provided by people aged 35 to 49, with 30.7 per cent of all care of one to 19 hours per week provided by this age range, although those aged 50 to 59 also provide 28.6 per cent of this intensity of care. Interestingly, almost the same proportion of those aged under 16 provide this level of care than those aged between 16 and 34. This pattern suggests that the main providers of this level of care are the children of adults and the elderly. A similar pattern of ages of carers are involved providing between 20 and 49 hours of care a week. The most intensive levels of care, of 50 or more hours a week, are most likely to be provided by those aged 60 to 74 (28.3 per cent of the total), with those aged over 75 also providing 13.2 per cent of this level of care 75. This suggests that this intensive level of care is mainly provided by the partners of infirm, elderly people.

Table 4.1: Provision of care by age range in England 2001

	Provides 1 to 19 hours of care		Provides 20 to 49 hours of care		Provides 50 or more hours of care	
	(N)	(%)	(N)	(%)	(N)	(%)
Aged under 16	76,685	2.3	7,026	1.3	6,720	0.7
Aged 16 to 19	78,479	2.4	11,311	2.1	8,033	0.8
Aged 20 to 34	440,153	13.2	74,109.0	14.0	112,017	11.2
Aged 35 to 49	1,021,329	30.7	156,789.0	29.7	247,906	24.9
Aged 50 to 59	954,108	28.6	135,860	25.7	208,185	20.9
Aged 60 to 74	625,784	18.8	109,149	20.7	281,557	28.3
Aged 75 plus	134,074	4.0	34,018	6.4	131,439	13.2
All carers	3,330,612	100.0	528,262	100.0	995,857	100.0

Source: Census 2001 Standard Table S25 for England

Table 4.2: Health of care providers by gender England 2001

	Male		Female		All	
	(N)	(%)	(N)	(%)	(N)	(%)
Total - Good Health	16,844,836	50.6	16,477,798	49.4	33,322,634	100
Provides no care - Good Health	15,676,633	51.2	14,940,151	48.8	30,616,784	100
1 to 19 hours - Provides care - Good Health	901,888	44.3	1,131,723	55.7	2,033,611	100
20 to 49 hours - Provides care - Good Health	105,801	40.6	154,693	59.4	260,494	100
50+ hours - Provides care - Good Health	160,514	39.0	251,231	61.0	411,745	100
Total - Fairly Good Health	4,736,065	44.4	5,939,592	55.6	10,675,657	100
Provides no care - Fairly Good Health	4,104,949	45.1	4,987,683	54.9	9,092,632	100
1 to 19 hours - Provides care - Fairly Good Health	416,183	41.2	594,325	58.8	1,010,508	100
20 to 49 hours - Provides care - Fairly Good Health	73,368	38.1	118,960	61.9	192,328	100
50+ hours - Provides care - Fairly Good Health	141,565	37.2	238,624	62.8	380,189	100

Source: Census 2001 Standard Table S25 for England

Table 4.2 examines the health status of those providing different levels of care. This shows that women who are in good health themselves are the main providers of care. Women are also more likely to providing care overall, especially at the higher levels of dependency. The numbers providing care compared with those employed by the formal care system, many of whom work part-time, emphasises the importance of informal care in relieving the burden of the formal system.

4.3 Social services data

The Department of Health collects data on social services staff from local authorities. Data from this data collection exercise is presented in Table 4.3. This shows that area office and field work staff represent the majority of social services staff, and that the majority (83.2 per cent) of this group is female.

Table 4.4 shows that the bulk of the social services workforce is white, with slightly higher proportions of black and ethnic minority staff in area offices and field work. Of the ethnic minorities the blacks are the most important group followed by Asians.

Table 4.3: Social services staff by category and gender England 2004

	Total (N)	Male (%)	Female (%)
Area office/field work staff	113,500	16.8	83.2
Residential care staff	48,900	18.0	82.0
Day care staff	28,600	25.4	74.6
Central/strategic/HQ staff	20,400	27.3	72.7
Other staff	1,900	40.9	59.1
Total	*213,300*	*19.5*	*80.5*

Source: Personal Social Services staff of Social Services Depts at 30 Sept 2004 England: Table 1a & 1b

Table 4.4: Social services staff by ethnic category England 2004

	Ethnic origin unknown	White	Black and ethnic minority	Mixed origin	Asian	Black	Other ethnic origin
	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Area office/field work staff	8.1	81.9	10.1	0.9	2.8	5.7	0.7
Residential care staff	8.9	82.9	9.0	0.7	1.6	6.1	0.7
Day care staff	8.3	83.0	8.7	0.9	2.5	4.7	0.6
Central/strategic/HQ staff	6.9	83.2	9.9	0.8	3.7	4.6	0.7
Other staff	9.3	80.7	10.0	0.5	4.3	4.7	0.5
Total	*8.2*	*82.2*	*9.6*	*0.8*	*2.6*	*5.6*	*0.7*

Source: Personal Social Services staff of Social Services Departments at 30 September 2004 England: Table 1b

4.4 NHS census

The NHS Census is an annual data collection exercise that collects data on all those employed in the health service. Unfortunately, the standard published breakdowns of this data do not include a hospital/community breakdown. This means that this data is off little use in examining the wider care workforce.

Table 4.5 shows that about half of all NHS staff are professionally qualified clinical staff of which about two-thirds are qualified nurses.

Table 4.5: NHS staff from the NHS census 2004

	Headcount
Professionally qualified clinical staff	660,706
All doctors	117,806
All qualified nurses (including practice nurses)	397,515
Qualified nursing, midwifery and HV staff	375,371
Practice nurses	22,144
Total qualified scientific, therapeutic & technical staff	128,883
Qualified allied health professionals	58,959
Other qualified st&t staff	69,924
Qualified ambulance staff	17,272
Support to Clinical Staff	368,285
Support to doctors and nursing staff	303,630
Support to ST&T staff	55,025
Support to ambulance staff	9,630
NHS infrastructure support	211,489
Central functions	99,831
Hotel, property & estates	73,932
Manager & senior manager	37,726
Other non-medical staff and those with unknown classification	497
Practice staff other than nurses	90,110
Total	*1,331,857*

Source: NHS Census 2004

5 The LFS Evidence

This chapter specifically examines the rich data that the Labour Force Survey can provide covering the wider care workforce.

5.1 Care workforce in the LFS

The care workforce has had many definitions and descriptions that make comparisons difficult. People in employment can usually be described in terms of their occupation and the sector within which they work. Using this approach, there follows a definition of the wider care workforce, in occupational terms and in sectoral terms.

5.2 SOC 2000 definition

The LFS is the Standard Classification of Occupations used to define occupations. Using grouping of four-digit SOC codes it is possible to describe the wider care workforce. For ease of analysis this workforce has been broken down into three groups. This three way grouping, and the component four digit SOC occupations, is given below:

- Care professionals consisting of: SOC 2211, Medical practitioners; SOC 2212, Psychologists; SOC 2213, Pharmacists/pharmacologists; SOC 2214, Ophthalmic opticians, and; SOC 2215, Dental practitioners.
- Care associate professional and technical occupations consisting of: SOC 3211, Nurses; SOC 3212, Midwives; SOC 3213, Paramedics; SOC 3214, Medical radiographers; SOC 3215, Chiropodists; SOC 3216, Dispensing opticians; SOC 3217, Pharmaceutical dispensers; SOC 3218, Medical and dental technicians; SOC 3221 Physiotherapists; SOC 3222 Occupational therapists; SOC 3223 Speech and language therapists, and; SOC 3229 Therapists not elsewhere classified.
- Care personal service occupations consisting of: SOC 6111, Nursing auxiliaries and assistants; SOC 6112, Ambulance staff (excluding paramedics); SOC 6113, Dental nurses; SOC 6114, House parents and residential wardens, and; SOC 6115, Care assistants and home carers.

In order to generate data which is comparable to the currently available NHS Census and Social Services data this report uses a data set constructed by merging the four available LFS quarters for 2004. This gives us a minimum usable cell size of 6,000 rather than the 10,000 if only one-quarter was used. Table 5.1 provides an estimate of each on the component occupation, in this LFS occupation based care workforce.

Table 5.1: Detailed headcount occupational breakdown of wider care workforce in England, 2004

SOC code	Description	Number	Per cent
2211	Medical practitioners	144,204	9.3
2212	Psychologists	17,247	1.1
2213	Pharmacists/pharmacologists	28,004	1.8
2214	Ophthalmic opticians	13,612	0.9
2215	Dental practitioners	21,562	1.4
3211	Nurses	391,138	25.2
3212	Midwives	33,015	2.1
3213	Paramedics	11,338	0.7
3214	Medical radiographers	16,380	1.1
3215	Chiropodists	11,915	0.8
3216	Dispensing opticians	10,014	0.6
3217	Pharmaceutical dispensers	23,268	1.5
3218	Medical and dental technicians	29,624	1.9
3221	Physiotherapists	32,404	2.1
3222	Occupational therapists	20,630	1.3
3223	Speech and language therapists	11,738	0.8
3229	Therapists n.e.c.	41,065	2.6
6111	Nursing auxiliaries and assistants	170,765	11.0
6112	Ambulance staff (excluding paramedics)	12,526	0.8
6113	Dental nurses	27,741	1.8
6114	House parents and residential wardens	30,043	1.9
6115	Care assistants and home carers	453,740	29.2
	The care workforce	1,551,969	100.0

Source: IES analysis of all four 2004 LFS quarters

The LFS allows this SOC 2000 defined care workforce to be analysed using a range of break variables. Those used for this paper are:

- Age bands (see Section 5.4)
- Gender (see Section 5.5)
- Ethnicity (see Section 5.6)
- Highest qualification (see Section 5.7)
- Full-time or part-time (see Section 5.8)

- Country of birth (see Section 5.9)
- Sector (see Section 5.3 and Section 5.10)
- Public or private sector (see Section 5.11).

These start in Section 5.4.

5.3 SIC 2003 Definition

An alternative approach to defining the care workforce is to use a sectoral classification. The UK currently uses the Standard Industrial Classification 2003 (SIC 2003) which is a minor variation to SIC 1992. Using this classification the care workforce can be defined as those working in SIC category 85.1 and SIC category 85.3. These are defined below along with their component four digit sectors:

- SIC 85.1 Human health activities
  - SIC 85.11 Hospital activities
  - SIC 85.12 Medical practice activities
  - SIC 85.13 Dental practice activities
  - SIC 85.14 Other human health activities
- SIC 85.3 Social work activities
  - SIC 85.31 Social work activities without accommodation
  - SIC 85.32 Social work activities with accommodation.

Again, using the 2004 LFS, Table 5.2 provides a basic headcount breakdown of the Care sector as defined by the SIC codes. This shows that the bulk, (42.2 per cent of the sectorally defined wider care workforce), are included under 'hospital activities'. The next largest group, with over a quarter of the total sectorally defined wider care work force, are employed in 'Social work activities without accommodation'.

Table 5.2: Detailed headcount sectoral breakdown of the wider care workforce England, 2004

	Headcount	Per cent
85.11:Hospital activities	1,142,209	42.2
85.12:Medical practice activities	179,398	6.6
85.13:Dental practice activities	60,585	2.2
85.14:Other human health activities	211,336	7.8
85.31:Social work with accommodation	383,051	14.2
85.32:Social work without accommodation	727,539	26.9
Care sector	2,704,117	100.0

Source: IES analysis of all four 2004 LFS quarters

5.4 Age breakdowns

Overall, using the occupational definition, roughly half of the wider care workforce are aged 40 and under. Broadly, this pattern is sustained at the detailed occupational level (see Table 5.3). The notable exception is amongst Dental practitioners where 71.5 per cent are aged 41 and over. Other older than the norm occupations include: House parents and residential wardens (71.0 per cent over 40); as well as Midwives (61.0 per cent) and unspecified Therapists (61.8 per cent). A range of occupations are younger than the norm. These include:

- Psychologists with 63.2 per cent aged 40 and under
- Pharmaceutical dispenser with 62.3 per cent aged 40 and under, and
- Dental nurses with 74.1 per cent aged 40 and under.

Table 5.4 provides a more detailed age breakdown for the broad occupational groups within the wider care workforce. This shows that Care personal service occupations have the most in the 16 to 24 year old age range, and the 50 to retirement age range. Both the Care professionals and the Care associate professionals are clustered in the 35 to 49 year old age range, with about 45 per cent of each group in that age range.

Table 5.3: Age breakdown of the detailed occupation breakdown England, 2004

SOC code	Description	16 to 40		41 to 65		Total
		(N)	(%)	(N)	(%)	(N)
2211	Medical practitioners	72,139	50.0	72,065	50.0	144,204
2212	Psychologists	10,892	63.2	6,355	36.8	17,247
2213	Pharmacists/pharmacologists	13,569	48.5	14,435	51.5	28,004
2214	Ophthalmic opticians	**	**	8,158	59.9	13,613
2215	Dental practitioners	6,155	28.5	15,408	71.5	21,563
3211	Nurses	183,106	46.8	208,033	53.2	391,139
3212	Midwives	12,886	39.0	20,129	61.0	33,015
3213	Paramedics	6,887	60.7	**	**	11,338
3214	Medical radiographers	9,559	58.4	6,822	41.6	16,381
3215	Chiropodists	**	**	6,579	55.2	11,915
3216	Dispensing opticians	**	**	**	**	10,013
3217	Pharmaceutical dispensers	14,507	62.3	8,761	37.7	23,268
3218	Medical and dental technicians	14,871	50.2	14,753	49.8	29,624
3221	Physiotherapists	18,251	56.3	14,153	43.7	32,404
3222	Occupational therapists	11,008	53.4	9,622	46.6	20,630
3223	Speech and language therapists	6,808	58.0	**	**	11,739
3229	Therapists n.e.c.	15,688	38.2	25,378	61.8	41,066
6111	Nursing auxiliaries and assistants	74,619	43.7	96,146	56.3	170,765
6112	Ambulance staff (excluding paramedics)	6,085	48.6	6,441	51.4	12,526
6113	Dental nurses	20,557	74.1	7,184	25.9	27,741
6114	House parents and residential wardens	8,721	29.0	21,322	71.0	30,043
6115	Care assistants and home carers	215,064	47.4	238,676	52.6	453,740
	Care workforce	*737,935*	*47.5*	*814,043*	*52.5*	*1,551,978*

Source: IES analysis of all four 2004 LFS quarters

Table 5.4: Detailed age bands of the broad occupational breakdown England, 2004

	Care professionals		Care associate professionals		Care personal services		Total
	(N)	(%)	(N)	(%)	(N)	(%)	(N)
16 to 24	7,235	3.2	33,988	5.4	86,070	12.4	127,293
25 to 34	59,931	26.7	169,327	26.8	153,252	22.1	382,510
35 to 49	100,479	44.7	292,645	46.3	259,207	37.3	652,331
50 to 59 or 64	56,984	25.4	136,567	21.6	196,286	28.3	389,837
All ages	224,629	100.0	632,527	100.0	694,815	100.0	1,551,971

Source: IES analysis of all four 2004 LFS quarters

5.5 Gender breakdowns

Table 5.5 provides a gender breakdown of the broad occupational groups. This shows that overall the Care workforce is overwhelmingly female (79.1 per cent). However, this is despite a male majority amongst the Care professionals, as 84.0 and 86.1 per cent respectively of the Care associate professionals, and Care personal services, occupations are female.

A more detailed gender by occupation breakdown is contained in Table 5.6. This shows that some groups are almost totally female, such as dental nurses, as well as Speech and language therapists. Paramedics and Dental practitioners are more likely to be male 77.8 per cent and 69.3 per cent respectively.

Table 5.5: Gender breakdown of the broad occupational groups England, 2004

	Male		Female		Total	
	(N)	(%)	(N)	(%)	(N)	(%)
Care professionals	126,396	56.3	98,233	43.7	224,629	100.0
Care associate professionals	101,167	16.0	531,361	84.0	632,528	100.0
Care personal services	96,771	13.9	598,043	86.1	694,814	100.0
Care workforce	324,334	20.9	1,227,637	79.1	1,551,971	100.0

Source: IES analysis of all four 2004 LFS quarters

Table 5.6: Gender breakdown of the detailed occupational groups England, 2004

SOC Code	Description	Male (N)	Male (%)	Female (N)	Female (%)	Total (N)	Total (%)
2211	Medical practitioners	86,434	59.9	57,770	40.1	144,204	100.0
2212	Psychologists	**	**	12,567	72.9	17,247	100.0
2213	Pharmacists/pharmacologists	12,986	46.4	15,018	53.6	28,004	100.0
2214	Ophthalmic opticians	7,346	54.0	6,266	46.0	13,612	100.0
2215	Dental practitioners	14,950	69.3	6,612	30.7	21,562	100.0
3211	Nurses	46,122	11.8	345,017	88.2	391,139	100.0
3212	Midwives	**	**	33,015	100.0	33,015	100.0
3213	Paramedics	8,818	77.8	**	**	11,338	100.0
3214	Medical radiographers	3,799	23.2	12,581	76.8	16,380	100.0
3215	Chiropodists	**	**	6,404	53.7	11,915	100.0
3216	Dispensing opticians	**	**	6,425	64.2	10,014	100.0
3217	Pharmaceutical dispensers	**	**	21,128	90.8	23,268	100.0
3218	Medical and dental technicians	14,485	48.9	15,139	51.1	29,624	100.0
3221	Physiotherapists	-	-	26,528	81.9	32,404	100.0
3222	Occupational therapists	-	-	18,451	89.4	20,630	100.0
3223	Speech and language therapists	-	-	11,356	96.7	11,738	100.0
3229	Therapists n.e.c.	8,267	20.1	32,798	79.9	41,065	100.0
6111	Nursing auxiliaries and assistants	24,631	14.4	146,134	85.6	170,765	100.0
6112	Ambulance staff (excluding paramedics)	8,599	68.6	-	-	12,526	100.0
6113	Dental nurses	-	-	27,741	100.0	27,741	100.0
6114	House parents and residential wardens	-	-	26,097	86.9	30,043	100.0
6115	Care assistants and home carers	59,594	13.1	394,146	86.9	453,740	100.0
	The care workforce	324,334	20.9	1,227,640	79.1	1,551,974	100.0

Source: IES analysis of all four 2004 LFS quarters

5.6 Ethnicity breakdowns

When Ethnicity is examined in Table 5.7 this shows the importance of Asians or British Asians amongst the Care professionals where they represent 15.5 per cent of the workforce. Overall, 5.0 per cent of the care workforce is Asian or British Asian, 4.8 per cent Black or Black British and 3.8 per cent Chinese, mixed and other non-white ethnic groups. Asian or Asian British and Chinese, mixed and other non-white groups are relatively under-represented in the Care personal services occupations.

Table 5.7: Ethnicity breakdown of the broad occupational groups England, 2004

	White		Asian or Asian British		Black or Black British		Chinese/mixed and other		Total
	(N)	(%)	(N)	(%)	(N)	(%)	(N)	(%)	(N)
Care professionals	168,891	75.2	34,773	15.5	6,794	3.0	14,172	6.3	224,630
Care associate professionals	550,249	87.1	26,159	4.1	29,388	4.7	25,993	4.1	631,789
Care personal services	619,532	89.2	17,245	2.5	38,829	5.6	19,207	2.8	694,813
Care workforce	1,338,672	86.3	78,177	5.0	75,011	4.8	59,372	3.8	1,551,232

Source: IES analysis of all four 2004 LFS quarters

5.7 Qualification breakdowns

As would be expected a large proportion (85.8 per cent) of the Care professionals have a degree or equivalent qualification (see Table 5.8). The more detailed breakdown in Table 5.9.

Table 5.8: Highest level of qualification by broad occupational group England, 2004

	Degree or equivalent		Higher education		Other qualifications		No qualification and don't know		Total
	(N)	(%)	(N)	(%)	(N)	(%)	(N)	(%)	(N)
Care professionals	192,747	85.8	11,302	5.0	20,307	9.0	273	0.1	224,629
Care associate professionals	179,548	28.4	332,554	52.6	116,281	18.4	4,016	0.6	632,399
Care personal services	36,205	5.2	69,187	10.0	511,822	73.7	77,470	11.2	694,684
Care workforce	408,500	26.3	413,043	26.6	648,410	41.8	81,759	5.3	1,551,712

Source: IES analysis of all four 2004 LFS quarters

Table 5.9: More detailed highest qualification and broad care occupations England, 2004

	Care professionals		Care associate professionals		Care personal services	
	(N)	(%)	(N)	(%)	(N)	(%)
Higher degree or NVQ level 5	83,652	37.2	32,388	5.1	5,060	0.7
First/Foundation degree	88,458	39.4	137,110	21.7	29,489	4.2
Nursing etc	7,888	3.5	252,524	39.9	39,302	5.7
Other NVQ level 4 or equivalent	24,052	10.7	90,083	14.2	31,542	4.5
NVQ level 3 or equivalent	4,077	1.8	45,853	7.3	150,905	21.7
Other qualifications	16,232	7.2	70,432	11.1	360,919	52.0
No qualifications or don’t know	273	0.1	4,016	0.6	77,470	11.2
Total	*224,632*	*100.0*	*632,406*	*100.0*	*694,687*	*100.0*

Source: IES analysis of all four 2004 LFS quarters

5.8 Full-time or part-time

Table 5.10 shows that the majority of Care professionals work full-time, although over one in five (21.7 per cent), even of this groups of staff, work part-time. Over a third of Care associate professionals (35.5 per cent) work part-time, and nearly a half of those in Care personal service occupations work part-time. All of these are higher levels of part-time work that comparable staff groups. In part, this may reflect more female staff than in other sectors and the success of family friendly working practices in the care sector. However, this may also reflect potential for persuading more staff to move to full-time working.

Table 5.10: Broad occupational groups by full-time and part-time work

	Full-time		Part-time		Total	
	(N)	(%)	(N)	(%)	(N)	(%)
Care professionals	207,013	78.3	57,209	21.7	264,222	100.0
Care associate professionals	498,489	64.5	274,077	35.5	772,566	100.0
Care personal services	492,382	56.5	379,217	43.5	871,599	100.0

Source: IES analysis of all four 2004 LFS quarters

5.9 Country of birth breakdowns

The dependence of the care workforce on those born outside the UK is shown in Table 5.11. It is striking that over three out of ten (30.9 per cent) of Care professionals were born outside of the UK. Overall, 16.9 per cent of the wider care workforce were born outside of the UK. This is a higher proportion than working population at large where 10.8 per cent of the workforce were born outside of the UK. This suggests that almost three times as many Care professionals than would be expected were born abroad. The Care personal services occupations are closer to the national picture with only 11.9 per cent of the workforce born outside of the UK. The Care associate professionals were midway between the Care professionals and those in Care personal service occupations with 17.4 per cent of the workforce born abroad.

Table 5.11: Country of birth breakdown by broad occupational group England, 2004

	UK born		Non UK born		Total	
	(N)	(%)	(N)	(%)	(N)	(%)
Care professionals	155,263	69.1	69,366	30.9	224,629	100.0
Care associate professionals	522,227	82.6	110,301	17.4	632,528	100.0
Care personal services	612,393	88.1	82,421	11.9	694,814	100.0
Care workforce	1,289,883	83.1	262,088	16.9	1,551,971	100.0

Source: IES analysis of all four 2004 LFS quarters

5.10 Sector of employment breakdowns

Another approach to looking at the wider care workforce is to use the sectoral classification. Essentially, this uses the most detailed available breakdown of the Health and Social care sector, as defined by the Standard Industrial Classification (SIC).

Table 5.12 provides the detailed breakdown of SIC 85 by the occupationally defined wider care workforce. This shows that the majority of Care professionals work within hospitals, with a sizeable other group within GP practices. Similarly, the bulk of Care associate professionals and those in Care personal service occupations work within hospitals. Amongst the care associate professionals, which contains the bulk of nurses, the second largest sector is 'Other human health activities' which would cover community nursing. Interestingly, a relatively large number of Care associate professionals work in sectors outside of the obvious care sectors.

In terms of the sectors, 15 per cent of the wider care workforce working in hospitals, are Care professionals. However, over half (55.4 per cent) of the wider care workforce in hospitals are Care associate professionals. Within GP practices there are approximately similar numbers of Care professionals and Care associate professionals. There are no reportable Care associate professionals working within dental practices. About half dental surgery staff are dental nurses and 40 per cent dentists. As we have excluded social workers from the occupational wider care workforce there are no Care professionals in social work. Importantly, for all of the broad wider care workforce occupations, substantial numbers work in sectors outside of Health and Social care.

Table 5.12: Sectoral breakdown by broad occupational group England, 2004

	Care professionals		Care associate professionals		Care personal services		Care workforce	
	(N)	(%)	(N)	(%)	(N)	(%)	(N)	(%)
85.11:Hospital activities	106,476	15.0	393,551	55.4	210,385	29.6	710,412	100.0
85.12:Medical practice activities	40,544	46.2	39,816	45.4	7,382	8.4	87,742	100.0
85.13:Dental practice activities	19,248	41.0	**	**	24,060	51.3	46,916	100.0
85.14:Other human health activities	7,998	5.6	95,867	67.6	37,975	26.8	141,840	100.0
85.31:Social work with accommodation	**	**	11,920	4.9	229,781	94.8	242,436	100.0
85.32:Social work without accommodation	**	**	8,773	6.1	134,829	93.7	143,963	100.0
Other Sectors	*49,267*	*27.6*	*78,729*	*44.1*	*50,402*	*28.3*	*178,398*	*100.0*

*Note ** values suppressed as below 6,000 reliability limit*
Source: IES analysis of all four 2004 LFS quarters

5.11 Public or private breakdown

Another, LFS variable, which is of interest, is based on the self -reported view of respondents, whether or not they are in the public or private sector. There tends to be more than usual non-responses to this question which explains why the totals of the broad wider care workforce occupational groups in Table 5.13 are smaller than in the other tables. This probably reflects some confusion over this question when people are working in some other public- private hybrid forms that are currently operated.

Table 5.13 shows that a larger proportion than might be expected (42.4 per cent) of the Care professionals consider themselves to work in the private sector. While the majority (54.5 per cent) of those in the Care personal services occupations consider themselves to be in the private sector. However, more than three-quarters (75.9 per cent) of the Care associate professionals consider themselves in the public sector.

Table 5.13: Public or private sector by broad occupational group England, 2004

	Private		Public		Total	
	(N)	(%)	(N)	(%)	(N)	(%)
Care professionals	95,276	42.4	129,353	57.6	224,629	100.0
Care associate professionals	152,612	24.1	479,808	75.9	632,420	100.0
Care personal services	377,764	54.5	315,125	45.5	692,889	100.0
Care workforce	625,652	40.4	924,286	59.6	1,549,938	100.0

Source: IES analysis of all four 2004 LFS quarters

5.12 Type of non-private organisation

In terms of matching up the NHS and Social Services data, perhaps the most useful breakdown is given in Table 5.14. It also allows the closest approximation to the third sector to be obtained. The breakdown examines the type of non-private body people work for. This question is only asked of people who do not identify themselves as working in the private sector. This shows that the bulk, (61.9 per cent), of Care professionals work for a Health authority or NHS trust. Similarly, the bulk (72.6 per cent) of Care associate professionals work for a Health authority or NHS trust. However, more of those in the Care personal services occupations work in the Private sector (43.8 per cent) than in Health authorities or NHS trusts (27.3) per cent. In part, this is because 19 per cent of those in Care personal services occupations work for local government, and a further 8.1 per cent work for the third sector of charities and voluntary organisations.

Table 5.14: Type of non-private organisation by broad care sector

	Care professionals		Care associate professionals		Care personal service	
	(N)	(%)	(N)	(%)	(N)	(%)
Local government or council (inc police etc)	**	**	18,243	2.4	165,177	19.0
Health authority or NHS trust	163,744	61.9	560,676	72.6	237,321	27.3
Charity voluntary org etc.	**	**	15,027	1.9	70,492	8.1
Other sort of non-private organisation	10,193	3.9	18,367	2.4	15,007	1.7
All non Private	180,638	68.3	612,313	79.3	487,997	56.1
Private	83,829	31.7	160,138	20.7	381,134	43.8
Total	*264,465*	*100.0*	*772,450*	*100.0*	*869,251*	*100.0*

Source: IES analysis of all four 2004 LFS quarters

6 Reconciling the Sources

The preceding chapters have provided a wide range of data from different sources, using an equally wide range of definitions, all approximating to the wider care workforce. This chapter attempts to reconcile the various data and also to allocate them to the Five sector model of care provision. Therefore, this chapter is structured into the five separate care providing sectors.

6.1 First care sector

The first care sector, or the public sector provision of care, is relatively simple to define and the best measured.

6.1.1 NHS

The NHS can be most clearly measured using the NHS census. This source, in Table 4.5, suggests that this part of the wider care workforce has about 1,332,000 employees. The LFS wider care occupational work force definition, in Table 5.14, suggests about 962,000. However, it should be realised that the LFS based- count excludes administrators, clerical staff as well as scientific and therapist staff. If these groups are excluded from the NHS census data then a more comparable figure of about 959,000 is arrived at.

6.1.2 Social services

The Social Services survey data, reported in Table 4.3, indicates a total social services staff of 213,300. The LFS based figure for local government employed, wider care workforce, in Table 5.14, suggests a much smaller workforce of 183,420. However, the wider care workforce LFS occupational definition excluded social workers, and if area office and field work staff are excluded a more comparable figure of 99,800 is derived from Table 4.3. Similarly, if only home care staff and care assistants are taken from Table 3.5 then another comparable figure of 98,500 is arrived at.

6.2 Second care sector

Private sector provision can only really be derived from the LFS, and a total figure of about 626,000 private sector carers in the wider care workforce is derived from Table 5.13.

6.3 Third care sector

The provision by the third sector or the charity and voluntary sector is not generally visible in the statistics. Their numbers only emerge briefly from the LFS data in Table 5.14. This suggests that the third sector of charities and voluntary organisations have about 85,000 workers in the wider care workforce. However, there is a further category with about 15,000 wider care workers from other non-private organisations. It is possible that in practice these are effectively also in the third care sector so this suggests a total for the third care of about 100,000 care workers.

6.4 Fourth care sector

It is not clear the extent to which any of the forecasts for future staff take account of any potential changes in the care provided by unpaid informal carers. The Wanless review used population projections as the basis for their modelling. However, future demand was based on the current demand for statutory services by each age range. This was moderated by assumptions about changes in the relative health and care seeking behaviour as health awareness grows. However, as **Error! Reference source not found.** shows, the bulk of informal care is provided by those in their fifties, and it is assumed that this is largely older adults caring for their even more elderly parents or other relatives. While the most intensive care of over 50 hours per week appears to be mainly provided by the partners of the elderly infirm. The population projections suggest a relative slight decline in the 50-year old population compared with a relative increase in the 75 to 95 year old population. This suggests that there may be fewer informal carers for the elderly in the future, and this in turn suggests a greater demand for statutory care. Given the current impact on the care system of the elderly, this issue may warrant further examination. The absence of the fourth sector, and the potentially large impact of any decline in its inputs from the forecasts of the wider care workforce, are potentially worrying.

6.5 Fifth care sector

User group provision, in part because of its nature, is very difficult to include within projections of the care workforce. However, as the primary role of this sector is in terms of information, provision and advocacy, the extent of direct care provided by this sector will be limited. Provision of support to such groups, when and if they emerge, will be important in term of the care groups quality of life and the

involvement of patients/clients in determining the nature and pattern of care provision.

6.6 Across the sectors

The Labour Force Survey provides the most consistent source of data for measuring the wider care workforce. The previous sections in this chapter show that the LFS based estimates are consistent with the other official sources for the NHS and Social Services. At the same time the LFS provides the only reliable measure for the care workforce in the private sector and the charitable sector. Therefore, in summary Table 6.1 shows the entire wider care workforce by sector of employment. This shows that the NHS only represents just over half of the total wider care workforce.

Table 6.1: LFS based wider care workforce by sector

	Care Workforce	Per cent of total
NHS	962,000	51.4
Social Services	183,420	9.8
Private sector	625,000	33.5
Charitable sector	100,000	5.3
Total wider care workforce	*1,871,000*	*100.0*

Source: IES analysis of all four 2004 LFS quarters

7 Conclusions and Recommendations

This chapter is simply divided into two sections; the first covers the conclusions arising from the paper and the second covers the subsequent recommendations.

7.1 Conclusions

7.1.1 No one data source provides an accurate picture

It is clear that no one source provides an accurate picture of the wider care workforce. However, probably the most useful source is the Labour Force Survey, using an occupational definition of the wider care workforce.

7.1.2 The wider care workforce is twice the size of the NHS care workforce

The total wider care workforce, using the LFS occupational definition, is about 1,871,000. Of this 1,871,000, about:

- 962,000 work for NHS health authorities or trusts as part of the first care sector
- 183,000 work as carers for social services as part of the first care sector
- 626,000 carers work in the private, or the second care sector, and
- a further 100,000 work in the charity and voluntary sector, or the third care sector.

Overall, this suggests that the wider care workforce is about twice the size of the NHS care workforce. This is of course without including the significant inputs of the fourth and fifth care sectors.

7.1.3 Most forecasts tend to be within service delivery silos

The Wanless 2002 review provided the only workforce forecast within England that linked demand for doctors, nurses and HCAs. Most existing workforce models only examine doctors or nurses in isolation and very few bother analysing HCAs.

However, even the Wanless 2002 review's forecast was limited to the impact on the NHS. It is clear that healthcare of the elderly, especially their heath-monitoring, will increasingly involve social services, housing bodies and other public and private bodies. Given the potential mobility of the less qualified care staff between sectors there is therefore an increasing need to model at the level of the wider care workforce.

7.1.4 Historically most forecasts concentrate on the higher skilled

Most of the workforce forecasts that have been undertaken within the wider care workforce tend to concentrate on the higher skilled. Most forecasts have looked at numbers of Doctors or Nurses. However, most of these forecasts assume much faster growth rates amongst the lower skilled such as HCAs. This makes it increasingly important to examine the future demand, and potential supply, of Care personal services personnel.

7.1.5 Training forecasts closest to the wider care workforce

Interestingly, the one group producing forecasts that relate most closely to the concept of the wider care workforce are those involved with training. The Working Futures projections, as they are simply based on a broad sectoral definition, map more closely than the various service -delivery based forecasts. The Working Futures forecasts also are the closest to those produced by the Wanless 2002 and Wanless 2006 reviews, and reveal the extent of the future training required by the sector.

7.1.6 Include the fourth sector in forecasts

Impact of any changes in the amount of care provided by the fourth sector need to be taken into account in any scenarios or forecasting of the wider care workforce. The decline in the size of the main caring age band, and an increase in the main cared for age bands, could lead to a significant increase in expressed demand for statutory services.

7.1.7 Heavy dependence on non-native care staff

The UK is heavily dependent on non-native care staff. It is not clear whether the successful overseas recruitment of doctors and nurses is sustainable. It is also not clear whether the countries from where the recruitment is occurring will be willing or able to provide a future supply.

7.1.8 The LFS provides useful baseline data

The Labour Force Survey (LFS) provides useful baseline data. This is especially the case when the wider care workforce is defined occupationally as this classification transcends issues of sector. This cross-sectoral data provides a basis for forecasting that goes beyond the traditional boundaries and traditional data collection exercises.

7.2 Recommendations

A range of recommendations, derived from the data presented in previous chapters, are made and conclusions in this chapter. These are briefly presented below.

7.2.1 Examine the impact of demographics and ethnicity on informal care

With the bulk of informal care provided by age groups that are forecast to decline, and those age groups normally receiving informal care forecast to grow, there is a need to better understand how this will influence the levels of care provided. A growing proportion of the elderly will come from ethnic minority groups. However, the pattern of informal care amongst these groups is less well understood. Any differences compared with whites will either lead to an increase or reduction in the forecast levels of informal care. This, is turn, will influence the levels of formal provision that will be required. Better understanding of these issues is important for forward planning.

7.2.2 Examine the potential to move part-time staff to full-time

Many personal care services staff work part-time. A relatively simple way to expand the workforce, with minimal training implications, would be to persuade those working part-time to work full-time. A better understanding of why part-timers work part-time, and what the barriers to working longer hours are, could allow policy initiatives to encourage full-time work in this important care group.

7.2.3 Examine ethnicity and care personal service occupations

Ethnic minorities are not equally distributed in terms of the care occupations, and appear to be relatively under represented amongst the care personal services occupations. As larger numbers of ethnic minorities reach dependent ages there may be an opportunity to recruit more care personal services staff from these groups.

7.2.4 Model at the level of the wider care workforce

There is a case for building some workforce models that project the wider care workforce based on LFS data. It is only by using this data, that is collected from outside of the main institutional settings, that the true size and nature of the wider care workforce can be grasped and forecast.

7.2.5 Expand training of care personal service occupations

The social services data suggest significant retention problems amongst care personal services staff. This group is also the least well qualified. As appropriate training is know to be an important retention tool, training can serve both improve the service the staff provide and work to maintain staff levels.

7.2.6 Cross train social services and health service care workers

As health, social services and other agencies' staff increasingly provide care in the community it will be important that information provided to workers of one agency reach appropriate staff in other agencies. For instance, if a home help is told about, or notices, a health problem they should know whom to tell within the health service. Likewise, community health staff will need to know what services are available from social services and how to mobilise them. Dependent people often do not distinguish between the agencies, and should be able to expect a co-ordinated response at the individual level as well as at a planning level.

7.2.7 Cross train social services and health service care workers

As health, social services and other agencies staff increasingly provide care in the community it will be important that information provided to workers of one agency reach appropriate staff in other agencies. For instance if a home help is told about, or notices, a health problem they should know who to tell within the health service. Likewise community health staff need to know what services are available from social services and how to mobilise them. Dependent people often do not distinguish between the agencies and should be able to expect a co-ordinated response at the individual level as well as at a planning level.

8 Bibliography

Almond S, Kendall J (2000), *Paid Employment in the Self-defined Voluntary Sector in the Late 1990s: An initial description of patterns and trends*, Civil Society Working Paper No. 7

Appleby J, Harrison A (2006), *Spending on Health Care: How Much is Enough?*, Kings Fund

Audit Commission (2000), *Fully Equipped: The provision of equipment to older or disabled people by the NHS and social services in England and Wales*, Audit Commission

Audit Commission (2004), *Older People – Building a strategic approach*, Audit Commission

Audit Commission (2005), *Supporting People*: Housing National Report, Audit Commission

Beresford P (2006), *Fifth element will help to form the future*, Society Guardian, 15 February

BMA (2006), *British Medical Association Memorandum of Evidence to the Health Committee Inquiry into Workforce Planning*, March 2006, British Medical Association

Buchan J, Seccombe J (2005), Past *Trends, Future Imperfect? A review of the UK nursing labour market in 2004/2005*, Royal College of Nursing

Comas-Herrera A, Pickard L, Wittenberg R, Davies B, Darton R (2003), Future Demand for Long-Term Care, 2001 to 2031: Projections of demand for long-term care for older people in England, PSSRU Discussion Paper No. 1980

Commission for Social Care Inspection (2004), *When I Get Older: What people want from social care services and inspections as they get older*, Commission for Social Care Inspection

Commission for Social Care Inspection (2005), *The State of Social Care in England 2004-05,* Commission for Social Care Inspection

Department of Health (2001a), *National Service Framework for Older People*, Department of Health

Department of Health (2001b), *Building Capacity and Partnership in Care: An agreement between the statutory and independent social care, health care and housing sectors,* Department of Health

Department of Health (2003), *Preparing Older People's Strategies: Linking Housing to Health, Social Care and Other Local Services*, Department of Health

Department of Health (2004), *Better Health in Old Age*, Department of Health

Department of Health (2005a), *Creating a Patient-led NHS: Delivering the NHS Improvement Plan,* Department of Health

Department of Health (2005b), *Detailed Results: NHS Hospital, Public Health Medicine and Community Health Service Medical and Dental Workforce Census England at 30 September 2004,* Department of Health

Department of Health (2005c), *Staff in the NHS 2004*, Department of Health

Department of Health (2005d), *A National Framework to Support Local Workforce Strategy Development: A Guide for HR Directors in the NHS and Social Care,* Department of Health

Department of Health (2005e), *Personal Social Services Staff of Social Services Departments at 30th September 2004 England*, Bulletin 2005/09, Department of Health

Department of Health (2006), *Our Health, Our Care, Our Say: A new direction for community services*, Department of Health

DWP (2005*), Opportunity Age: Meeting the Challenges of ageing in the 21st century*, Department of Work and Pensions

Eborall C (2005), *The State of the Social Care Workforce 2004: The second Skills Research & Intelligence annual report*, Skills for Care

Eborall C, Gameson K (2001), *Desk Research on Recruitment and Retention in Social Care and Social Work,* Department of Health

EO (2004), *Demographics and the Workforce in England and Wales: trends and projections*, Employers Organisation

EO (2005), *Local Government Workforce in England: trends and projections*, Employers Organisation

Francis J, Netten A (2003), *Home Care Workers: Careers, commitments and motivations,* PSSRU Discussion Paper No. 2053

Healthcare Commission (2006), *Living Well in Later Life: A review of progress against the National Service Framework for Older People*, Healthcare Commission, Audit Commission and Commission for Social Care Inspection

Heitmueller A, Michaud, P-C (2006), *Informal Care and Employment in England: Evidence from the British Household Panel Survey*, IZA Discussion Paper No. 2010

Henwood M (2006), *NHS Continuing Care in England*, Kings Fund

HSCIC (2005), *Community Care Statistics 2004*, Health and Social Care Information Centre

JRF (2002), *Informal Care and Work After Fifty*, Joseph Rowntree Foundation Findings

JRF (2003), *Nurses over 50: options, decisions and outcomes*, Joseph Rowntree Foundation Findings

Kendall J (2000), *The Third Sector and Social Care for Older People in England: Towards and explanation of its contrasting contribution in residential care, domiciliary care and day care,* Civil Society Working Paper No. 8

Kendall J (2001), *The Third Sector and the Development of European Public Policy: Frameworks for Analysis*, Civil Society Working Paper No. 19

Kendall J, Knapp M (2000), *The Third Sector and Welfare State Modernisation: Inputs, Activities and Comparative Performance,* Civil Society Working Paper No. 14

Laing W (2005), *Trends in the London Care Market 1994-2024*, Kings Fund

Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B (2006), *Substitution of Doctors by Nurses in Primary Care (Review),* Cochrane Library 2006 No. 1

Maher J, Green H (2002), *Carers 2000*, Office for National Statistics

MWSAC (1997), *Planning the Medical Workforce: Third Report*, Medical Workforce Standing Advisory Committee

NAO (2005), *Working with the Third Sector*, National Audit Office

National Leadership Network (2006), *Strengthening Local Services: The Future of the Acute Hospital*, The Report of the National Leadership Network Local Hospital Project

National Workforce Unit (2004), *Developing the Nursing and Midwifery Workforce 2003*, The Report of the Student Nurse Intake Planning Exercise 2003, Scottish Executive

Office for National Statistics (2000), *Standard Occupational Classification 2000: Volumes 1 and 2*, TSO

Opinion Leader Research (2006), *Your Health, Your Care, Your Say: Research Report*, Department of Health

Pickard L (2004a), *Caring for Older People and Employment: A Review of the literature prepared for the Audit Commission*, PSSRU

Pickard L (2004b), *The Effectiveness and cost-effectiveness of support and services to informal carers of older people*, PSSRU

Research Works (2001), *Perceptions of Social Work and Social Care: Report of Findings*, Department of Health

Scottish Executive (2002), *Future Practice: A Review of the Scottish Medical Workforce*, Scottish Executive

SNMAC (2001), *Caring for Older People: A Nursing Priority: Integrating knowledge, practice and values*, Standing Nursing and Midwifery Advisory Committee, Department of Health

SSIW (2004), *Overview Report on the Social Care Workforce Development Programme Applications and Training Plans the year 2003-04 by 22 Welsh Social Services Departments*, Social Services Inspectorate for Wales.

Towse A, Sussex J (2000), 'Getting UK Health Care Expenditure up to the European Union mean – what does that mean?', *British Medical Journal*, Vol. 320, pp. 640-642

Wanles D (2006), *Securing Good Care for Older People: Taking a Long Term View*, Kings Fund

Wanless D (2002), *Securing Our Future Health: Taking A Long-Term View, Final Report*, HM Treasury

Wanless Social Care Review (2005), *Social Care Needs and Outcomes: A background paper for the Wanless Social Care Review*, Kings Fund

Whittington C (1999), *Modernising the Social Care Workforce – the first national training strategy for England*, Training Organisation for the Personal Social Services

Wilson R, Homenidou K, Dickerson A (2006), *Working Futures 2004-2014: National Report*, Sector Skills Development Agency

Wittenberg R, Comas-Herrera A, King D, Malley J, Pickard L, Darton R (2006), *Future Demand for Long-Term Care, 2002 to 2041: Projections of demand for long-term care for older people in England*, PSSRU Discussion Paper No. 2330.