The TUC response to
the 'national debate' on Care and Support

1. Introduction

Social care covers all the services which aim to help people overcome difficulties related physical, mental, environmental or lifestyle problems, whether living in their own homes, in the community or in a care home.

In May the Prime Minister and Health Secretary launched a national debate about the long-term future of social care and support in England. The TUC is very pleased that the Government has opened the debate about the future of social care. Unions began life as part of the response of the working class to the insecurities of a modern industrial economy, and unions had important welfare functions as well as an industrial role well into the twentieth century. Several unions continue to offer their members important welfare services or include a charitable arm.

The TUC has long had a vital interest in the development of the welfare state – William Beveridge called us the 'godfathers of the Beveridge report'. Unions have been very engaged in the national debate, and sent representatives to discuss the TUC's policy at a special meeting on the subject, held in September. A broader discussion, involving speakers from the Government, took place at the TUC's third Social Policy Forum in November, which was wholly given over to the future of social care. The issue was also discussed at meetings of the TUC's Pensioners Committee, Disability Committee and Executive Committee.

Unions representing workers in all social care services have taken part in this discussion and workforce issues in social care form an important part of this submission. Our comments also represent the views of workers in all walks of life - we speak for nearly 6.5 million workers in our 58 affiliated unions; one worker in every four belongs to a TUC affiliated union. The whole trade union movement has an interest in the future of the welfare state because secure and prosperous employment and profitable enterprises rely on the strength and depth of our social infrastructure.

This document presents the TUC's written contribution to the national debate. Our central principle, on which this document is based, is that we regard social care as part of the welfare state. We are strong supporters of cradle-to-grave provision, and

we do not agree that social care has a future as merely one service industry among others.

2. Summary

This document begins by looking at the background to the policy debate –

- The social context, especially this country's distressingly high level of inequality.
- The likely effect of demographic change over the coming decades.
- What people expect from care and support services, the document focuses in particular on the shortcomings that most upset service users, carers and other citizens; we pay particular attention to the demand for free long-term care.

In the next section we set out the TUC's view of a care and support system fit for the future. Our vision of where we would like to be in a few years time has been heavily influenced by the *Disability Agenda* published by the former Disability Rights Commission and its emphasis on choice and control, dignity and respect. We argue for a funding system modelled on the NHS, funded from general taxation and free at the point of use.

We then look at the Government's personalisation agenda. This is a model of social care that has enthused many disabled people and, provided that personalised provision is chosen freely by service users, the TUC agrees that it has the potential to promote choice and control, dignity and respect. At present the personalisation agenda is lacking in detail, and this worries us. We insist that personalisation must not be confused with marketisation – reducing human contact to a service contract is not the way forward. We are also concerned that the strategic mistake that was made with 'care in the community' may be about to be repeated – introducing a progressive policy alongside funding restrictions. To be effective, personalisation is a *more expensive* way forward, not a way to save money.

The sixth section looks at managing change. At a time when social care services are going to change rapidly across England, greater coherence will be achieved if we have common principles and advice on best practice. This will provide some measure of security for individual workers dealing with change, and help make sure that staffing issues are integral to the change process, not an afterthought.

We conclude by looking at workforce issues. Too many social care occupations are characterised by low skill levels, low pay and very high staff turnover. We believe that social care needs an Agenda for Change, emphasising skills development as the visible expression of a new commitment to valuing staff.

3. Background

3a The Social Context of Social Care

It is increasingly clear that social care services attempt to deal with the chronic infirmities of an unequal society, and the best way to control the rising cost of social care is to attack the root cause: poverty and inequality. As the Social Care Institute for Excellence has reported, "it is accepted that families living in poverty are over represented as users of some children's and families' services, including those of an involuntary rather than voluntary nature."[1]

Over the last three decades inequality has grown rapidly in the United Kingdom. The chart below shows the rising income gaps between the poor and people in the middle (the lower dashed line) and between people in the middle and the rich (the unbroken line). The gap between the rich and the poor combines the first two, and shows that the gap between the top tenth of the population and the bottom has roughly doubled since 1979.

Inequality, 1979 – 2005/6[2]

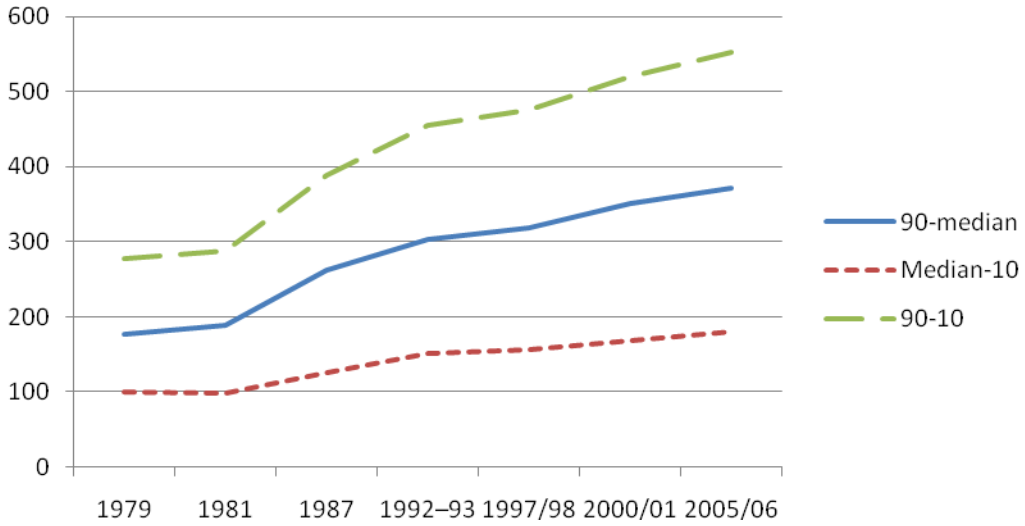
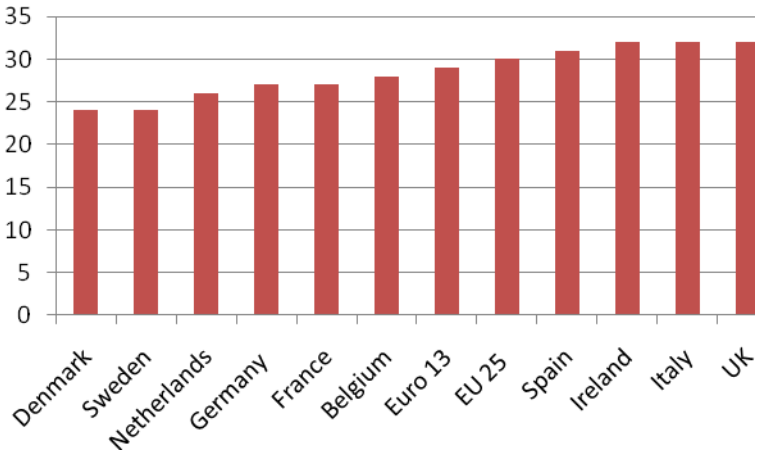


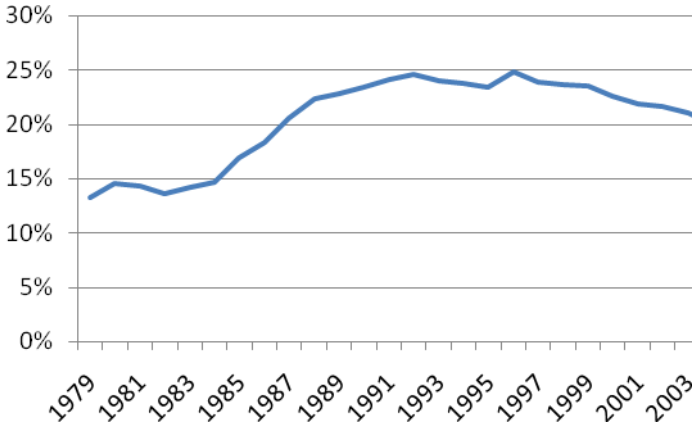
table below we present the Gini coefficients (a common measure of overall inequality in a society) for the European Union, the Eurozone and some individual European countries we often compare ourselves with: Ireland and Italy have the same level of inequality, Germany and France significantly lower – and none have a higher level.

Inequality across Europe, 2006[3]

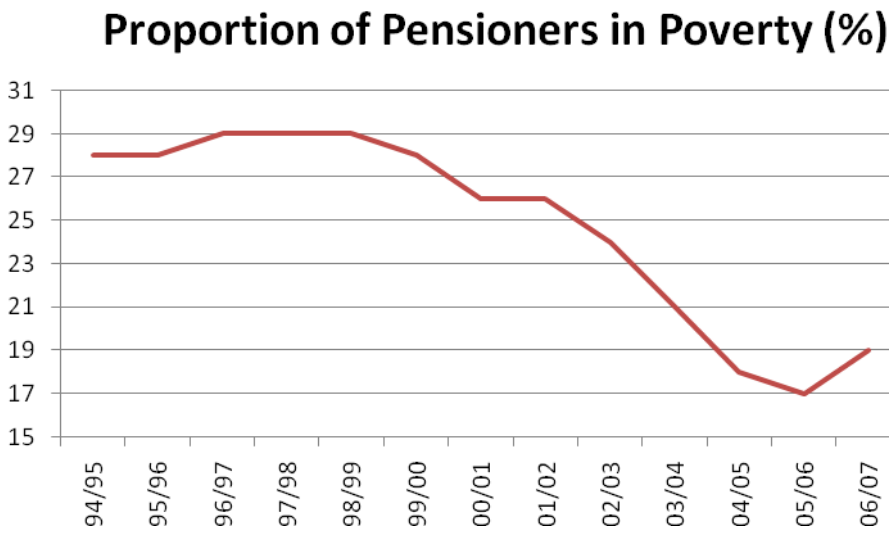


As a result, the number of people afflicted by income poverty grew, though it has fallen back somewhat since 1997:

Proportion of people in poverty, 1979 – 2004[4]



Older people account for a majority of adult social care service users. After several years in which the number of pensioners in poverty has fallen, Britain is entering the recession with pensioner poverty growing again. The most recent figures show that, in the most recent year for which we have data, there was a sharp increase – 200,000 if we measure poverty on an after housing costs basis. There are now 2.1 million pensioners in poverty, nearly one pensioner in five:[5]



Although this discussion is primarily concerned with adult social services, the trade union movement would emphasise the fact that poor health and social exclusion, which later in life give rise to the need for social services, frequently have their roots in child poverty.

A study using the well-known UNICEF index of child wellbeing found that it was significantly correlated to a country's level of income inequality and the percentage of children in relative poverty, but not to a country's or state's average income, suggesting that reducing inequality would do more to promote children's well-being than further increases in economic growth. A parallel exercising, using equivalent US data to make the same comparison for US states found the same results. The dimensions of wellbeing covered material wellbeing, health and safety, educational wellbeing, family and peer relationships, behaviours and risks and subjective wellbeing – all important for likely later use of social services.[6]

3b Demographic change

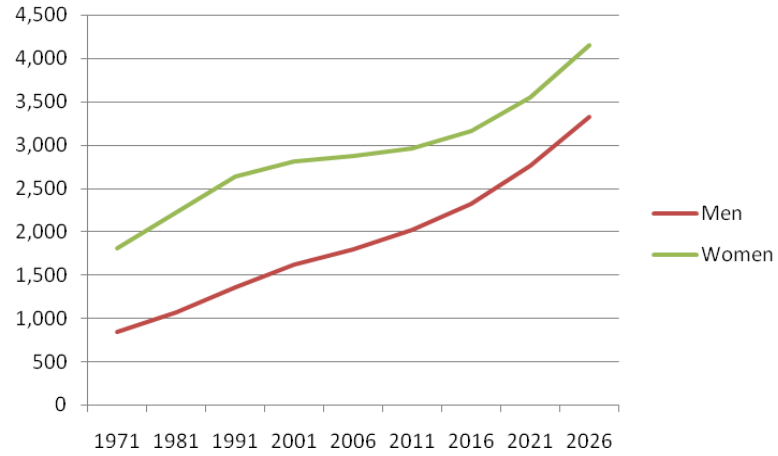
When it launched the national debate the Government published *The case for change – Why England needs a new care and support system,* arguing that fundamental reforms are necessary for two reasons:

- Demographic changes (especially the impact of an ageing population) and
- To meet people's expectations of social care services.

The TUC believes that it is not melodramatic to talk about a 'crisis' in social care that calls for fundamental reform. The population of older people (who are much more

likely to need social care) is growing; as the latest edition of *Social Trends* revealed, by 2021 the number of people aged over 65 will, for the first time, exceed the number aged under 16. In 1971 there were two-and-a-half million people aged over 75; by 2026, this will have risen to seven-and-a-half million:

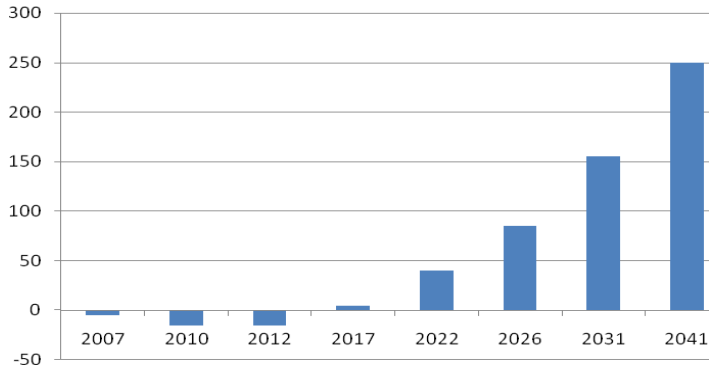
Population aged 75 and over, UK, 1971 – 2026[7]



Projections by the Personal Social Services Research Unit (PSSRU) confirm that demand for care is likely to grow substantially. This will create a crisis of informal care: the demographic changes that present a challenge for pension policy will also mean that there will be growing numbers of older people who need informal care but fewer younger people able to provide it. This will create a significant problem of unmet need in less than ten years' time:

"Demand for informal care by disabled older people is projected to exceed supply by 2017, with the 'care gap' widening over the ensuing years. By 2041, the gap between the numbers of people projected to provide informal care and the numbers needed to provide care if projected demand is to be met amounts to nearly 250 thousand care-providers."[8]

Care providers shortfall, England, 2007 - 2041[9]



This will have implications for formal social care for disabled elderly people. The PSSRU projections are:

"The numbers of users of non-residential formal services would need to rise by 102%, from 1.5 million to 3.1 million, to keep pace with demographic pressures; and the numbers of older people in care homes (and long-stay hospital care) would need to rise by 139%, from 345,000 to 825,000.

"Projected public expenditure on social care and disability benefits would grow by 226%, from £13.1 billion in 2005 to over £42.7 billion in 2041 in constant 2005 prices. If Gross Domestic Product rose in line with HM Treasury assumptions**,** long-term care expenditure would grow from 1.2% of GDP in 2005 to 2.0% in 2041. Within these totals, public expenditure on social care, net of income from user charges, is projected to rise by 329% from £6.6 billion in 2005 to £28.4 billion in 2041. Public expenditure on disability benefits is projected to rise by 121% from £6.5 billion in 2005 to £14.3 billion in 2041."[10]

The PSSRU has also projected the likely increase in the number of younger disabled adults (aged 18 – 64), with the number of assessments rising 17.7 per cent, from 585,000 in 2005, to 685,000 in 2041. Given the demographic pressures we can expect, the following increases in the numbers of younger adult service users, staffing and spending:[11]

- Local authority home care services, from 75,000 in 2005 to 90,000, in 2041 (18%);
- Day care services, from 95,000 in 2005 to over 110,000 in 2041 (19%).
- Local authority funded residential care, from just under 60,000 in 2041 to over 70,000 in 2041 (21%).

- The number of staff in social care services for younger adults would need to increase from 310,000 in 2005 to 370,000 in 2041 (20.5%).

- In 2005 prices, public spending on social care would need to rise from £5.4bn in 2005 to £12.9bn in 2041 (140%).

3c What people expect from social care

It is important to in any discussion of these issues to acknowledge the tremendous efforts the current Government has made to rationalise the administration of social care and create a unified guiding policy. The Government has an objective of achieving equality for disabled people by 2025 and a five year Independent Living Strategy for promoting the autonomy of disabled people. The *Lifetime Homes, Lifetime Neighbourhoods* strategy aims to link housing, health and care services to create a barrier-free environment for older people, so we can all remain active in our own homes and neighbourhoods. *Putting People First* highlights the importance of information and advocacy, autonomy and personalisation and the prevention of social exclusion.

These policies have, to some extent, been supported with cash, notably the £100 million extra funding for disabled children and their parents announced in December 2007 and the Social Care Reform Grant, worth £520 million over the next three years. But social care has not experienced anything like the tripling of funding that has benefitted the NHS, and funding increases have lagged way behind what would be necessary to raise standards and keep up with increasing needs due to demographic and other changes. As the Institute for Public Policy Research has noted, at a time when the public sector generally has been expanding, social services have been remarkable in that the number of employees has actually fallen – from 229,000 in 1997 to 216,000 in 2005. They also note that 'care and development' – which includes child and social care professionals – stands out as a sector where vacancy rates are almost twice the national average.[12]

There is an entirely justified demand that the quality of services needs to be raised and service users and their families increasingly demand services that are not so tightly rationed that access disappears. Social care and health are two sides of the same coin, but spending on social care has historically lagged well behind health expenditure.

Counsel and Care's most recent national survey of local authority care charging and eligibility criteria found that "only those older people with the highest dependency

needs, without any available family support and on low incomes, will get council services."

When local authorities assess service users' needs, they put them in one of four categories: low, moderate, substantial and critical. In more than two-thirds of local authorities, only those people assessed as having "critical" or "substantial" needs are judged to be eligible for services. Three councils only provide services for those whose needs are "critical." This problem is worsening, and the Commission for Social Care Inspection has predicted that the proportion of local authorities limiting provision to people with at least "substantial" needs will rise to 73 per cent by March 2008.[13]

While local authorities are not required to charge for services for older people, Counsel and Care report that "the vast majority" do. Only two of the local authorities they surveyed did not charge for home care services, with others charging up to £18 an hour.[14]

Councils are supposed only to levy "reasonable" charges, but this guidance seems to have little effect on what they actually do. A survey by the Coalition on Charging revealed that local authority charges for social care services could increase substantially and unpredictably, with little information being provided by Councils about these changes. Some people had had to stop using or cut back on the services they received and a majority said that charging policies had had a negative effect on their income and lifestyle.[15]

The Commission on Social Care Inspection's 2006-7 report on *The State of Social Care in England* found "an increasingly sharp divide" between people who are covered by the formal social care system and those outside the system. This latter group includes both people who fund their own care and those who are "lost to the system" because they do not qualify but cannot purchase care privately. People covered by the system "are seeing improvements and, in some areas, early steps towards a redesigned system offering personalised care" while those outside are disadvantaged and those lost to the system "often struggle with fragile informal support arrangements and a poor quality of life."[16]

3d What people expect: long-term care

Since 2002 all the countries of the UK have provided free nursing care for elderly people in care homes; Scotland has also provided free *personal* care for older people in care homes *and* at home. This is not quite the bonanza some envious commentators in England have suggested; while these services are provided without

a means-test by local authorities, there is a cap on the amount paid: £149 per week for personal care, £67 per week for nursing care, or £216 per week for personal and nursing care (in England and Wales the highest rate currently payable for nursing care is over £130 a week). Furthermore, in Scotland, people in residential care no longer receive Attendance Allowance.

Despite these provisos, the impact of the free personal care policy has been broadly positive. An evaluation by the Joseph Rowntree Foundation found that:

- Although the policy has been more expensive than was originally predicted it is affordable, currently costing just 0.2 per cent of Scottish GDP. Although demographic changes will increase the costs further it will remain a relatively small proportion of GDP.
- The policy has encouraged a move towards "person-centred care sensitive to individual needs" and towards providing more care within service users' own homes.
- It has promoted a more integrated, across-Government approach.
- Free personal care has reduced the incidence of means-testing, made provision fairer for poorer individuals (especially women) and helped informal carers to continue caring.

This is an extremely emotive issue. A great deal of media coverage has concentrated on the position of elderly people who have to sell their homes to pay for long-term care. Having to rely on means-tested benefits to pay the costs of personal care has led to real hardship which has seemed to be unjust, even random in its incidence. As the Royal Commission on long-term care put it:

"If a person is in residential care for up to three years, and owns a house worth say £40,000, over those three years the system (by assuming that the house is sold and the proceeds are used to pay for care) will bring him or her to a level where it judges there is sufficient impoverishment to warrant state help. Someone with more assets is less likely to become impoverished in this way. The system at the moment helps people who are poor, demands that people of modest means make themselves poor before it will help, and affects people to a lesser degree the richer they are and better able to afford the sums required."

We agree with the Royal Commission that "this seems strangely inconsistent".[17]

Ken Mack, an independent campaigner, has pointed out that people who sell their homes to pay for a place in a care home are giving up a home in which they had security of tenure in return for accommodation from which they can be evicted with

no redress. Several newspapers have reported the distress of frail elderly people summarily evicted, some of whom have died shortly afterwards. Regrettably, the Government has told Mr Mack that it "has no intention to introduce legislation to ensure that care home residents are never required to move."

This is probably correct if we continue to rely on a wholly privatised system of care home provision – if providing such homes is a business, should the business fail, the homes will close. Most small businesses do fail, and the consequence is inevitable. To unions this seems to make a strong case for avoiding over-reliance on the private sector; as Peter Scourfield has argued:

"It is in the nature of a marketized and privatized care system that homes will periodically close or change ownership. The physical and mental well-being of elderly residents experiencing eviction and relocation can be seriously damaged by the experience."[18]

3e The current funding system

The TUC believes that our current social care system is complex, the funding levels are seriously inadequate and the UK is facing demographic changes with serious consequences. Funding shortages impact on and limit the type of services available and exclude tens of thousands of people. Means-testing produces serious injustices and increases the UK's already shameful level of poverty and inequality; a radical overhaul is badly needed.

This view chimes with that of service users and others with direct experience of the current means-tested system, as surveyed for the Caring Choices report. It found widespread demand for change, though without producing a clear way forward; the key findings included:[19]

- 90% rejected the present means-tested system, preferring a stronger 'universal' element determined by care need rather than income or wealth;
- The vast majority wanted a simpler system with clearer entitlements so people are able to plan ahead with greater understanding of the services on offer;
- 99% wanted more money spent on long-term social care irrespective of the funding system or where the money comes from.

4. Care and Support for the Future

4a The Disability Agenda

The TUC's views of what social care should like in the future have been greatly influenced by the *Disability Agenda* published in 2007 by the Disability Rights Commission (since merged into the Equality and Human Rights Commission). This agenda included a section on "Developing a Social Care System Fit for the Future" that argued that limiting services to those with the highest needs and relying on families to fill the gaps risked undermining the well-being of individuals and the prosperity of the country.

The DRC suggested that the objectives of reform should be to:

- *Extend the choice and control that individuals can exert over their support services.*
- *Set national frameworks of minimum entitlements to social care.*
- *Incentivise services that support people to live in their own homes and participate in public life.*
- *Ensure that everyone is treated with dignity and respect.*

4b The Wanless Proposals

An important benchmark for progressive approaches to social care has been set by the Wanless Review*;* its report, *Securing Good Care for Older People,* was published in 2006. Wanless looked at how much should be spent on social care for older people in England over the next 20 years and the funding arrangements that would be needed.

Wanless reported widespread dissatisfaction with the funding system, budgets largely based on historical patterns, and no attempt to calculate the right amount to spend. He predicted growing demand for care services and added to this the need to address shortcomings in the system as it stands, which together would probably raise the cost of social care from the 2002 level of 1.1% of GDP to 2% by 2026 to provide "the highest levels of personal care and safety outcomes justifiable given their cost".

The review rejected free personal care, as it would entail a higher level of service than society seemed willing to support, but also argued that a means-tested system would lead to under-spending. Instead Wanless recommended a partnership funding model, in which everyone would be entitled to a minimum amount of free care, set

in this case at 66% of a benchmark care package. Individuals would be able to top this up to the benchmark level, with the state paying £1 for every £1 the individual paid (the benefits system would help people on low incomes.) The TUC and affiliated unions have had an important discussion about the merits of this proposal, which is reflected in the views set out below.

4c Dignity and respect

The TUC has been very influenced by the Disability Agenda, which we believe establishes principles that can be applied for all users of social care services, not just disabled people.

Every citizen has a right to dignity and respect. Disabled trades unionists have told the TUC about grown men and women who are told when they must go to bed by their local authority; this is at the very least contrary to the spirit of human rights legislation. Sometimes eligibility for support that is vital for maintaining human decency is so tightly rationed that people are abandoned to deteriorating circumstances until they fall below the 'critical' threshold;[20] this is cruel and inhuman. Human beings have a right to integrity and dignity.

Self-respect and dignity are intimately bound up with self-actualisation. We cannot claim to respect the dignity of users of social care services if we do not allow them the choice and control that are the mark of an adult's life in our society. Living in your own home and contributing to your community are marks of citizenship, and social services should make this possible, not take away the possibility.

Choice and control are also about the ability to make *informed* choices, so information about services should be clear, understandable and as accessible as possible.

That is why we applaud the Government's intention of creating "a society where everybody is treated with dignity and respect and has the chance to fulfil their potential and unlock their talent."[21]

We do not believe that it would be consistent with this approach to treat people differently on the basis of when they become disabled, even if their care costs are more predictable – the degree of support should be determined by the level of need. Similarly, the 'post code lottery' is inconsistent with respect for service users: respect means that everyone should be treated fairly and equally, regardless of where they live. The TUC is committed, of course, to the recognition of diversity as a positive value and believes that everyone should be guaranteed an equal right to care,

regardless of whether or not they are disabled and regardless of their community, gender, race, age or sexuality.

4d Funding social care

In large measure the vision we have just described is of independent living. It is worth emphasising that independent living is not just better for service users, it can be the cheaper option as well. As the Office for Disability Issues' investigation of the implications for health and social care budgets of investment in housing adaptations, improvements and equipment noted, such investments could reduce the need for residential care, cut the cost of home-care and achieve savings through extending healthy life.[22]

Independent living can lead to lower benefits expenditure, a higher employment rate and a reduction in the costs of inequality. A literature survey carried out for the Department for Work and Pensions found that, although there is a lack of cost-benefit data relating to independent living, it is clear that "the delivery of independent living support to disabled people and older people is more cost effective, or at least no more expensive than traditional care provision."[23]

Every public service has a role to play in achieving the vision we have for social care. The equality and independence of disabled and older people are not only – or, in an egalitarian society, even primarily – to be achieved through social care services. The equality of disabled people, for instance, depends upon effective anti-discrimination legislation, accessible public transport, integrated education, the elimination of barriers in the workplace and concerted efforts to counter stigma, prejudice and discrimination.

After a sustained reform effort a lot of social care would disappear from view as a separate sphere of activity, to be merged into the normal running of society. As housing became more accessible, designed to meet *everyone's* needs, so housing interventions by social services would become less frequent. A barrier free environment would need fewer services to help people maintain their mobility.

The reform of social care should be undertaken as part of a general assault on poverty and inequality. A more equal society would have less need for social care services, and the nature of those services would help promote equality and the elimination of poverty.

The TUC therefore believes that social care should follow an NHS model: free at the point of delivery and funded from general taxation. We have seen, in the discussion

of what people expect, the problems currently being caused by means-testing and rationing. Requiring people to sell their homes to pay for personal care is tremendously unpopular and can leave people in an extremely vulnerable and exposed position. Means-testing and rationing inevitably leaves gaps, with the people 'lost to the system' falling through.

Caroline Glendinning has pointed out that, in most non-English speaking countries, "access to social care is based on universal principles – it is the level of impairment, incapacity or support needed that determines access, not the level of income or assets. While co-payments, based on income levels, may subsequently also be required, an individual's financial situation is not a criterion that determines initial eligibility for social care. Countries as diverse as Austria, Germany, Japan and the Netherlands all provide social care according to universalist principles that avoid means testing as a condition of access."[24]

In our view the experience of free personal care in Scotland illustrates the strengths of our preferred model, but we would wish to go further, and make a broader range of social care services free to the user. A supplementary consultation on the services that should be covered in this way would be needed; in line with our vision for social care, we would suggest that those services promoting independence, choice and control and which make it easier for people to continue to live in their own homes should be prioritised.

The model of social care a country chooses will tend to bear a strong family resemblance to the rest of its welfare state. The trade union movement's strong preference is for a universalist and inclusive system. As the World Health Organisation has noted:

"Generous universal social protection systems are associated with better population health, including lower excess mortality among the old and lower mortality levels among socially disadvantaged groups. Budgets for social protection tend to be larger, and perhaps more sustainable, in countries with universal protection systems; poverty and income inequality tend to be smaller in these countries compared to countries with systems that target the poor."[25]

Unfortunately, the Government has already indicated its reluctance to introduce a universalist system of social care. Given this, we believe that the Wanless proposals are the next best option for funding these services – providing there is adequate support and protection for those who might be unfairly disadvantaged or seriously deprived as a result of the contributory requirement. Subject to this proviso, Wanless is the only report in recent years to face up to the scale of expenditure that

is needed to provide a decent level of service, and if implemented would eliminate many inconsistencies and injustices. The Wanless report also has the virtue of recognising that funding should be aimed at those who are most disadvantaged through poverty or disability. The attraction of the Wanless proposals depends, however, on the extent to which they would meet the needs of the poorest people and prevent families from being pushed into poverty by service charges and means-testing of services; our support for this option would depend upon how the "safety net" element worked out in detail.

The worst option would be to rely on private insurance. As the Royal Commission noted in 1999:

"Left to grow without intervention, there seems little reason to think that private insurance will become more important in the UK than it has become over a 14-year period of development in America. At present only 4% - 5% of Americans have taken out LTCI, while 10% - 20% could afford to do so and 80% - 90% could not afford the cost in any event. Marketing through employers and partnership schemes with State Governments have been introduced in America and equity release products are available. According to expert witnesses, and the evidence cited earlier to a Senate committee, private insurance is not now, and is unlikely to become, the major way of funding long-term care in America. …

"The Commission conclude that private sector solutions do not and in the foreseeable future, will not offer a universal solution. Even schemes for partnership can make only a limited contribution. Inevitably, of course, people may consider one of the many schemes available from the private sector to be worthwhile for them provided they can pay the premiums. Overall however, the funding problem cannot therefore be solved by the private sector."[26]

4e Health and social care

The boundary between health and social care is one of the most frequently discussed subjects in social care. The need for local authorities and primary care trusts to integrate social care and health in planning and provision is recognised by the Local Government and Public Involvement in Health Act 2007, and the statutory guidance on "Creating Strong, Safe and prosperous Communities", issued in July. The Act requires Councils and PCTs to produce Joint Strategic Needs Assessments of the health and wellbeing of their local communities, which should be consulted during local commissioning. The statutory guidance is very strong on involving local communities and service users in the delivery of care services, and taken with the

public sector disability duty should give disabled people a much more powerful voice in planning services.

This is a very good foundation for future policy, but there remain important areas of uncertainty. Unions hope that the opportunity of the Department of Health "national debate" running at the same time as the consultation on the welfare reform Green Paper will not be missed. In particular, one issue has bedevilled provision for decades: health care is free but social care is means-tested.

Unions wish to see an NHS model adopted for social care provision (as we explain above) and this would address this problem. If the Government decides not to go down the universalist route it will need to explain the basis for means-tested provision running alongside free healthcare – at present it is simply experienced as an injustice.

- When is care medical and when is it social? Scholastic distinctions between the two can determine whether vital provision is free or charged for, and it will be difficult to persuade the public that the distinction is not completely arbitrary.
- This is particularly an issue for many people with long-term conditions, who will need health care, personal care and support for everyday living. For many people in this position early access to high quality social care will delay or reduce their need for more expensive health care. The current funding model gives local authorities a perverse incentive to raise the threshold for eligibility for this support, throwing the burden onto the NHS.

4f The role of the public sector

The TUC believes that the shortcomings of the current social care system are closely tied up with the rapid collapse of in-house and public sector provision. As recently as the early 1990s the public sector directly provided more than 90 per cent of social care with the independent sector playing a supporting supplementary role, but today that ratio has almost reversed. The percentage of home care hours provided by the independent sector increased from 2 per cent to more than 73 per cent between 1992 and 1995. These trends continue apace – in 2006-07 the number of places in council care homes fell by 1,599 and the number of home care agencies run by councils also fell.[27]

No one would argue that traditional council-provided social care services were perfect, or indeed, adequate – they were severely underfunded and often unresponsive. But the rapid withdrawal of the public sector from provision, and exposure of the sector to market forces, has unleashed a process of fierce

competitive cost-cutting that has undermined quality and continuity and has exposed care users to unacceptable levels of insecurity and risk.

Despite the pressure placed on remaining council services it is still generally the case that terms and conditions offered to staff are significantly worse in the independent sector, [28] and there are examples of companies seeking to increase margins by undermining agreements previously secured by staff who have been transferred from the public sector.[29] The Commission for Social Care Inspection consistently finds council care homes more likely than private care homes to meet or exceed National Minimum Standards in areas such as privacy and dignity, autonomy and choice, protection, hygiene and infection control, staff qualifications, recruitment, staff training, day to day operations, ethos, quality assurance, staff supervision and safe working practices.[30] The large scale privatisation of domiciliary care left us with a 'cottage industry', 'struggling already to provide services of sufficiently high quality' and 'failing to recruit, train and develop care workers … to meet new demands and ways of working'.[31] Surveys of home care users have revealed lower levels of satisfaction and perceptions of quality for independent providers, and that 'characteristics associated with positive perceptions of quality were more prevalent among in-house providers'.[32]

These concerns are exacerbated by the risk to care users arising from the instability in the private market and consequent danger of disruption resulting from private providers changing hands or going bust. In 2008 a number of care home providers faced severe financial difficulties as a result of highly leveraged business strategies coming to grief in the new conditions of falling asset prices and the declining availability of credit.[33]

The TUC believes that the role of in-house and public sector provision needs to be rebuilt. Publicly provided care homes and care services, based in high levels of training and workforce development, could play an essential role as guarantors of service continuity and stability, and leading innovators and standard setter, driving quality improvements throughout the sector.

5. The personalisation agenda

The TUC remains committed to responsive public services that put users and their families at the centre of the services they receive. We support all initiatives and proposals which allow people more involvement and control over their lives and the services they receive. We also support the need for flexibility in the way services are delivered to fully meet the needs of service users.

However, we remain concerned about the large claims that have been made about the potential of personalisation and the pressure on both organisations and service users to undertake radical changes.

Personalisation entails a long continuum, starting with the redesign of services to better reflect the way people live their lives, such as the increased use of the internet or changed opening hours. Midway along the spectrum sees a balance of collective with individual needs, with the development of stronger relationship between professionals and service users to receive tailored care and support. At the far end lie developments such as personal budgets which transfer control from provider to service user. Having control of money to pay for services is only one aspect of personalised care; information, communication and innovation are also equal elements of the personalisation agenda.

Personalised services can often improve service quality and make services more appropriate to people's needs. However, as explained above, personalisation is a long continuum along which some options may not be appropriate for all users or local circumstances. In some situations, it could create inequalities of service, while in others people may be unable to unwilling to engage in this agenda. The responsibility therefore rests with the government and public service organisations to establish where personalisation is appropriate and in what form. This echoes the conclusions of the following section on managing organisational change where we advocate an approach which is responsive to local circumstances and builds on the experience and views of staff, users and their carers and families.

The TUC is also concerned that person-centred care is not used as a disguise for cutting costs. Person-centred care and personal budgets should never be used as a cheap option.

5a Personalised care and the workforce

The TUC strongly supports the conclusions made by the Public Administration Select Committee report *The Public Service Ethos.*[34] The report recommended that public service workers and users should be treated fairly and equitably, and involved as much as possible in service issues. It goes on to argue that as part of their adherence to an overall ethos of public service, workers should give due importance to involving and engaging with service users.

The Select Committee report also states that the Government should actively promote principles of public service that recognise the value of involving users and should ensure that an understanding of service user involvement is reflected in

programmes designed to develop public service skills. The TUC strongly supports its recommendation around the need for investment in skills and training. As relationships between workers and service users change, workers must be supported in skills and career development. Person-centred services can only be achieved with a highly skilled, well rewarded workforce, who are given the time to develop relationships and trusts with service users and their families.

5b Personal budgets

It is perhaps the development of policy around individual and personal budget where the TUC is most concerned. The TUC broadly supports current plans for personal budgets for anyone eligible for publicly funded adult social care support, except for emergency care. We have been alarmed that, in the confusion over funding for health care and social care, services once provided by the NHS are now treated as means-tested social care. In the short-term eligibility criteria should be reformed to ensure that healthcare needs are not shifted into personal budgets for social care, and that personal budgets in health threaten the concept of care free at the point of need through spending caps. In the long-term, it is vital that personal budgets are part of a general shift from rationing of services towards a transparent system of rights and entitlements.

There have been many reports citing positive feedback from service users from direct and personal budgets. They offer the potential for service users and providers to work together to help shape service to best suit the individual. Designed well, service users can become direct participants in the design and delivery of their care and offer control over the support they need to live independently.

However, studies such as the IBSEN report on individual budgets make it clear that such programmes work differently for different groups of service users, and notably not so well for older people.[35] These programmes place a great deal of responsibility on services users, their carers and families to navigate the system, and often entail looking after budgets and acting as a direct employer.

We also have concerns that personal budgets may be set at a level which is inadequate to meet people's needs, then individuals could top up their budgets from their own resources. This is neither sustainable nor fair.

Above all, we are worried that the transformational potential of personal budgets is being over hyped. A change in the way financial transactions are made will not transform health and social care services in itself. Person-centred services can only

be achieved through investment in services, the workforce and their skills – not through restructuring.

5c Personal budgets and the workforce

The TUC is highly concerned that increased use of personal budgets and personal assistants risks impacting heavily on the workforce. For example, Janet Leece has warned that:

"Many care workers providing homecare support funded by local authorities are now employed by voluntary or private agencies that are not unionised and offer minimal employment rights. Increasing user-controlled support may result in women losing jobs in the public sector where they have pension provision, union representation and safe working environments for casual employment as personal assistants with less beneficial terms and conditions."[36]

Giving evidence to all-party parliamentary group on social care, Sue Bott, director National Centre for Independent Living, said personal assistants will be a fast-growing workforce, given the government's promotion of individual budgets. However, she said they were currently "very low paid, given the level of direct payments, had little access to training and were thus unable to demonstrate their skills to new employers, hampering recruitment and retention."[37]

James Churchill from the Association for Real Change has pointed out that local authorities are cutting the hourly rates they are paying under direct payments "to the point where good providers pull out because they cannot cover their costs or recruit staff at the rock-bottom level wages that the local authorities' rates requires."

He warned that: "Working in social care will be on a par with casual jobs in the fast-food sector – unsocial hours, low pay, little or no training, no prospects of career development, no recognition of the skills and understanding it takes to do the job well, and poor job security. Since your employer is totally dependent on local authority funding, if this is cut you lose pay, or perhaps even your whole job… We can already see the consequences in the workforce, characterised by high rates of migrant workers, part-time female workers, and low pay rates… Who can afford to be a PA?"[38]

There are also important implications for personal assistants' training needs and aspirations. Research carried out on behalf of Skills for Care highlighted a general reluctance on the part of employers to arrange or fund training for their PAs, with

only 7% of the employers surveyed having arranged any training for their assistants.[39]

Asked what attributes they considered very important for recruiting a PA, 89% of employers said a friendly attitude and 77% an ability to adapt to their needs, but only 60% said good references, 32% a willingness to learn and engage in training, and 28% having experience in health or social care. Only a third of PAs had been given a job description and almost half had been known to their employer before being taken on.

Andrea Rowe, the chief executive of Skills for Care said: "My feeling is that the stock answer of employers who struggle with the complexity of training and qualifications is to hide behind 'we don't think they need it'. There is some responsibility on us to make sure that the framework and supply of training and skills development is simple for them and is affordable."[40] It is vital that Skills for Care and other agencies work together address this reluctance and ensure that a framework is put in place in order to ensure sufficient and effective training for all social care workers.

With regard to registration the same survey found that 79% of employers said registration of PAs would be either very or quite useful, but only 46% thought it should be compulsory. While 71% wanted to retain the right to employ somebody who was not registered, 87% of personal assistants thought registration would be a very good or fairly good idea.

Research undertaken in Scotland for UNISON and Scottish Personal Assistants Employers Network (SPAEN) found that among those people interviewed with personal support systems, there was a lack of awareness amongst employers of where to access support on such matters as training and funding for training. This includes training for themselves as employers and their employees. It also found that while most employers complied with most areas of employment law, there was a significant minority who failed in one or more area. As a result of these failings a significant number of employees did not enjoy their minimum employment rights, with a significant number of employers at risk of having awards given against them at Employment Tribunal. In addition, most employees did not pay into a pension fund. [41]

Other findings included a lack of awareness amongst employers of equality issues, with most failing to have an equal opportunities policy. A significant number of employers expressed difficulties in dealing with employee competency and capability. This raised concerns about potential risk in relation to the weakness of effective disciplinary procedures.

The survey revealed concerns in relation to bullying, harassment or violence experienced by a number of employers from their employees, agency workers, social work staff or family members. A number of employees also reported bullying, harassment or violence from their employer, or the employers' family or friends.

Finally, the survey found that a large number of employers did not make arrangements for "contingency" including staff sickness, holiday cover and unusual circumstances. Those who retain a contingency fund found that, often, the local authority "clawed back" monies which were "unused" in the employers account.

This research highlights the problems and tensions inherent in personal budgets agenda. A system in which employment is so fragmented and devolved down to the individual places risks on both service users and their personal assistants. There exist very important responsibilities with regard to training, registration and employment relationships, yet there are very real dangers that if these responsibilities are not fully addressed, safety and quality in service provision will be threatened. It is vital that the Department of Health, local authorities and regulatory bodies work with trade unions to set up a framework to ensure that personal assistants are employed under contracts which protect their legal rights and ensure they gain access to good employment conditions including fair pay, sick pay, maternity pay and leave, annual leave and training.

5d Personal budgets and choice

Personal budgets are often presented as providing choice for services users and their families and carers. Yet people may opt for individual budgets not because of a positive choice, but because of criticisms of their existing care. The answer may well, therefore, lie with improving existing care, rather than opting out altogether. In fact, giving the "right" to purchase individualised care may present a loss of choice to keep state provided social and health care.

Neither is choice in itself a "magic bullet" to achieving improved services. The TUC believes that priority should be given to improving the quality of services over offering choice. Personal budgets are so claimed to offer the potential of cultural change. The TUC believes that cultural change can be achieved by allowing and enabling professionals to focus on the individual needs of service users rather than any focus on choice of provider. It is deeply concerning that personal budgets are presented as a solution or challenge to professionals' inappropriate or outdated outlooks or working practices. In reality, the problem is more likely to lie rather with the market for social care or lack of resources.

Investment in the workforce and their skills allied to a sharper focus on individual needs may be a more appropriate and cost effective option than wholesale reform that threatens to do erect a barrier between individuals and collective provision. This is particularly concerning since public service professionals are making efforts to develop a "whole systems" approach to health and social care, linking them to housing, education and leisure services. These reforms therefore threaten to unduly fragment the public sector by disrupting collective provision and risk-pooling.

The reforms also threaten to substitute group for individual contact, breaking down opportunities for human interaction as the emphasis on group activities and settings is removed. There is therefore a risk of isolation as the relationship between user and service is reduced to an individual, transactional one. We perceive these risks to be associated particularly with the use of personal budgets and not necessarily with person-centred support.

6. Managing organisational change

The Green Paper - allied to other significant policy developments such as the NHS Next Stage Review, *Independence, Well-being and Choice* (the social care Green Paper), and the *Putting People First* concordat - has the potential to lead to far-reaching organisational change through the health and social care system. The TUC believes it is important that principles applying to managing change are set out and understood in order to ensure that organisations are equipped to undertake the change processes required to improve services and to provide support and re-assurance to individuals facing a time of great uncertainty and change.

The TUC is clear that principles of best practice should be set out to assist organisations within the health and social care system. These principles should allow organisations to review policies and procedures, to ensure that the arrangements which they have in place are based on sound practice and to amend their policies and procedures as necessary.

Some of these principles are included in guidance around commissioning and service restructuring, but the TUC is concerned that insufficient attention is paid to workforce matters to ensure that staff are fully involved in the process of change, that their employment conditions are protected and that service quality is supported through the provision of leadership, training and development, and attention to workforce planning, recruitment and retention.

6a Organisational Change

As a result of the Green Paper or other health and social care policies, organisations are likely to consider different aspects of organisational change, such as service reviews, restructuring of services and service commissioning. Services may be contracted out of the public sector or to other parts of the public sector. New models of service provision may also be established.

All of these possibilities will have an impact on service design, work organisation, funding arrangements and staff contractual arrangements.

6b Purpose

The TUC believes it is necessary to set out a framework for organisational change to ensure that:

- Disruption to service users is minimised
- There is a consistent approach to improving health and social care services addressing local needs and priorities within a clear national framework
- Staff and users know how change will be managed and how this may affect them personally.
- The timescales, processes and policies involved in any organisational change are explained and transparent.
- There is a managed process of change which meets both the need to support staff during the transition and the need to maintain services to the public.

6c Principles of Change

The TUC supports the pledges at the heart of the Next Stage Review and believes these could be modified and adopted for all health and social care services. These pledges provide a strong foundation which can be built on.

1. Change will always be to the benefit of patients
2. Change will be clinically driven
3. All change will be locally-led
4. You will be involved
5. You will see the difference first (existing services will not be withdrawn until new and better services are available to patients so they can see the difference).

The modification and adoption of these pledges would ensure that any organisational change process has the user at the centre and driven by an evidence-based approach. All too often, we have seen new initiatives and restructuring implemented in the public sector without a clear understanding of the long-term impact on local services. This means that changes are sometimes made contrary to local needs and circumstances and are directed at fulfilling other - perhaps competing - priorities such pressure to make financial savings, or to outsource services.

The TUC believes it is vital that any organisation commits to undertaking a thorough evaluation of the service with the full cooperation of users and staff, before embarking on any change programme. A task-oriented approach to organisational change can have a negative impact on service quality and staff and user morale. Any options for change should also be discussed fully with users and staff and reviewed to fully understand the impact on:

- **Service users** – users and the public are meaningfully involved and engaged
- **Service quality and sustainability** – services are provided according to clear standards, within a safe environment, by competent staff. Services meet immediate needs without comprising the needs of future generations
- **Equality** – services are provided in a way which promotes diversity and allows universal access
- **Value for money** – consideration of long-term outcomes rather than short-term costs
- **Strategic and operational partnerships** – consideration of the knock on effects for other services and partners, and their shared values
- **Accountability** – services are provided in a transparent manner, open to scrutiny and according to best practice.
- **Workforce planning** – comprehensive planning to ensure a competent and sufficient future workforce
- **Workforce skills** – staff receive training and development opportunities to match their aspirations and meet the needs of the local community
- **Employment conditions** – staff are employed on policies and procedures which meet best employment standards.

6d Employment Issues

It is particularly important to put in place an employment framework for managing organisational change, since delivery relies on current and future frontline and support staff. A framework would be vital in providing support and re-assurance to individuals facing uncertainty and change. It will also help underpin certain standards

around employment and staffing and future proof any changes which may be adopted.

The TUC would support the development of an employment and staffing framework to underpin the management of change containing the following principles:

- All staff should be fully informed and involved in the change process.
- All reasonable steps should be taken to avoid redundancies in order to ensure that valuable skills and experience are not lost.
- There should be partnership working with trade unions at national and local level. The views of trade unions should be taken into account in managing the change process.
- Consultation should begin at the earliest opportunity and be on-going through the change process.
- All HR processes will comply with relevant employment legislation and be underpinned by equality and diversity principles
- An assessment should be made on the impact on job satisfaction, career development, training and skills, cross-organisational working and recruitment and retention.
- All social legislation such as TUPE, the two-tier workforce agreement and the public sector duties should be made a condition of all contracts.

6e A Framework for Change

Reflecting on recent experience of organisational change in the public sector, the TUC strongly believes that a framework for managing change is vital for the future of health and social care. Such a framework would give organisations and individuals the confidence that changes to structures and services are carried out in a systematic, thoughtful and fair manner. The TUC would be pleased to assist in the development of a framework and consider how best it should be implemented.

7. Workforce issues

This debate presents an invaluable opportunity to take stock of the current situation in social care and examine not only the way in which it is structured and funded, but how it is delivered. As a labour intensive service, the key employment aspects of the sector tell us a great deal about how social care is both run and valued. Questions about how people are paid, trained, regulated and employed have been addressed by the Department of Health, Skills for Care and the Social Care Institute for Excellence and have led to valuable initiatives such as the national recruitment campaign and the forthcoming National Skills Academy for Social Care. The Adult

Social Care Workforce Strategy, due for launch later this year will also address some of these issues. The TUC believes that it is impossible to take forward a debate about the future of care and support without examining the current workforce situation and planning for a future workforce which is fairly rewarded, well motivated and able to respond to future demands.

7a Social work as a career

While the social work degree has certainly helped raise the status of social work as a profession in recent years, there are still recruitment and retention problems across the country. A survey by the Local Government Employers cited social workers as the main profession facing recruitment problems in English and Welsh councils.[42] Retention problems are generally linked to heavy and increasingly complex workloads, while the lack of a national framework on pay has led to large discrepancies in pay levels across the country.

In comparison with other parts of the social care workforce, however, some aspects compare more favourably. Progression, for example is better, with social workers having the chance to study for post-qualifying awards and move up into management positions.

The Social Care Workforce - at a glance

- Around 1.6 million people in wider social care workforce (in adult and children's services)
- 87% work in adult services
- 76,000 people are professionally qualified social workers
- 30,000 employers of which 150 are local authorities
- 30% of the total workforce are employed by local authorities
- Only 30,000 social care staff have a relevant qualification
- Within 30 years there will be a 180% increase in the numbers of people over 85, and double the number of people suffering from dementia
- 12% of workforce born outside of UK
- Around 80% of the social care workforce is female, with many working part-time

Turning to social care, this sector acts as a reception area of employment for certain groups of people, including migrants, young people and individuals returning to the workforce. Social care is seen as an entry point to the workforce because the jobs are viewed as low-skilled and often involve part-time or shift work, so can be compatible with other responsibilities. The fact that social care work is available locally also makes it attractive to this group of workers, but the low pay in the sector results in a high level of turnover.

Low-skill jobs in the UK can present an opportunity as a first step on a ladder to better paid jobs, in which experience and tacit skills are developed. However, according to a study by the Institute for Employment Research,[43] low skills jobs provide "little or no basis for substantial advancement through the labour market." The report goes on to state that short-term mobility in the wage distribution is limited and that individuals who do progress do not generally progress very far. "The concentration of people without qualifications in such jobs, and the lack of training derived from them, further constrains movement. Consequently, people who enter low-skill jobs without significant qualifications are unlikely to gain them during, or more particularly as a result of, their occupancy."

For this reason, it states that opportunities for advancement are largely restricted to either similar jobs with 'better' employers elsewhere in the local labour market or promotion opportunities with the existing employer that do not call for better formal qualifications and are not the prerogative of better-qualified external entrants. UK employers report that such openings are often simply not recognised by many new entrants to their sectors, who conclude that prospects are poor and so quit to look elsewhere.

Substantial progress has been made recently to upskill the workforce, but there are significant barriers including training capacity constraints, funding problems in the independent sector and reservations amongst experienced staff to qualify for a job they have done for years. Qualification requirements will go a long way to professionalise the sector, yet employees consistently voice concerns that these qualifications do not translate into better pay.

An EOC report found that stereotypical ideas of women's caring roles are driving low pay and high staff turnover in the female-dominated caring professions, and particularly in social care.[44] It said many care staff received "pocket money pay" as if the job were a labour of love, leading to unacceptably high levels of staff turnover, particularly in services for children and older people. It found turnover was 14% for care workers in residential homes for older people and 13% for home care staff working with older people. The EOC went on to call for a modernisation of the Equal Pay Act 1970, to enable equal pay laws to apply to employment practices including the contracting out of public services.

7b Pay, Recruitment and Retention

The social care sector is experiencing major recruitment and retention problems with low pay, lack of career progression opportunities and image problems playing a key role. Particular problems are found in occupational therapist and social worker posts.

The Skills for Care National Minimum Data Set (NMDS-SC)[45] shows the following turnover and vacancy rates in adult social care (all job roles):

Turnover and vacancy rates

Care Setting	Turnover Rate	Vacancy Rate
The adult care sector	19.3%	3.8%
Care only homes	18.6%	3.2%
Care homes with nursing	19.0%	2.6%
Domiciliary care	24.9%	5.9%

The report by Skills for Care states that high turnover rates are not a result of high levels of temporary and casual employment. Of the 120,000 employees that had been recorded at April 2007, over 112,000 (95%) were permanent and yet 22,900 employees had left in the previous 12 months. It goes on to show that at least half of all workers that leave are lost to the sector completely.

In the private sector, employers are more likely to cite pay as a reason for people leaving than the voluntary sector (6% as opposed to 3%). Staff in the voluntary sector are more likely to leave for reasons of career development (12% as opposed to 9% in the private sector).

The NMDS-SC shows that care workers' gross median hourly rate is £5.87 (at February, 2007), only 9% more than the minimum wage of £5.35 for people aged over 22 in October 2006. A care worker in the average care home with nursing earns £5.54 per hour, just 19 pence over the minimum wage, for working with the most vulnerable clients. A senior care worker in the same setting earns just £6 per hour.

The ONS Annual Survey of Hours & Earnings 2006 shows that, for the group "Care Assistants and Home Carers" median gross hourly pay is £7.12 an hour - just £1 an hour more than check out operators (£6.03), and less than call centre agents (£7.20/hr) and far less than general office assistants (£8.03/hr). But the "Care Assistants and Home Carers" group also contains a wide range of care and support workers – for example in local authorities and the NHS. The NMDS-SC shows that

care workers are getting lower rates: median gross pay of £6.15 an hour for senior care workers and just £5.87 an hour for care workers.

The NMDS-SC Briefing shows that "the pay structure does not consistently correlate with qualifications, longevity, employment status and the vulnerability of service users." It goes on to pose the question: "With such pay rates and structure how can we recruit, retain and develop a skilled, committed and stable workforce?"

Qualifications and pay

Qualification level	Care Worker (£/hr)	Senior Care Worker (£/hr)
All Workers	£5.87	£6.15
Entry level or level 1	£5.70	n/a
NVQ Level 2	£5.80	£6.10
NVQ Level 3	£6.04	£6.25
NVQ Level 4 or above	n/a	£6.38

The figures show a slight increase in pay for senior care workers according to qualifications, with those on NVQ Level 4 or above getting an extra 5% more than those at entry level. This is repeated for care workers up to Level 3 though changes are small and the maximum gain is never more than 6%.

The briefing quotes research by the Social Care Institute for Excellence (SCIE) that in-service training has been shown to increase staff retention. Pay was the factor most likely to act as an incentive to stay with or move to a new employer in the survey of Welsh Social Workers.[46]

Employment Status and hourly pay

Employment Status	Care Worker (£/hr)	Senior Care Worker (£/hr)
All Workers	£5.87	£6.15
Permanent	£5.80	£6.15
Temporary	£6.09	n/a
Bank or Pool	£6.23	£6.60
Agency	£6.40	n/a

The NMDC-SC briefing shows that an interpretation of the data for care workers is clear: "To increase your pay, do not take qualifications, with a maximum benefit of 6%, but instead work for an agency and get an immediate increase of 10%. This is clearly not what employers or people who use services want to get the consistency of care they require."

The report concludes that: “Pay structure in terms of reward for longevity, qualifications and employment status, is conspiring against service users’ desire for stability. What it may do is confirm such work as low status that for some is a stepping stone to the job markets where pay is better related to responsibility and level of qualification.”

The debate on the future of care and support provides an opportunity to define and plan for the workforce we need to support the care and support services of the future. It is clear that the move to integrated services across health and care systems, and joint working across all public services also provides an impetus for examining pay and conditions in the social care sector. Practical and cultural barriers will continue to emerge and strengthen between different parts of the public sector, until we address both the divergent pay and conditions of its workers and the low pay of the social care workforce. It is only by describing the workforce we want to see in the future – how staff are employed rewarded and trained – that we can fully understand the true costs of any future plans for the future of care and support.

8. The Union Agenda on the Social Care Workforce

Below we set out our key concerns, along with recommendations and suggestions about how to address these issues. We strongly support a partnership approach, working with trade unions and the workforce, to address these issues.

8a Accountability

There are key questions related to accountability which require clarification. In particular, we are concerned that while “light touch” regulation is increasingly applied to social and health care providers, stricter regulation of individual workers is adding a disproportionate burden to the workforce. Unions are dealing with a growing number of cases where the conduct of members had been questioned, yet in reality the problem lies with failures of training or under-staffing. Even responsibility for training is being forced onto the shoulders of individual workers.

We strongly recommend that registration should be extended to personal assistants in order to protect both employer and personal assistant. We also believe that the registration process for all health and social care providers should require pay, conditions and employment practices which are of sufficient quality to recruit and retain competent staff.

8b Local Government

As local authorities move into a commissioning role and away from provision, it has a responsibility to set in place a framework to address workforce pay and conditions across the whole provider sector in each local care market. It is essential that the commissioning process ensures a well rewarded, well motivated workforce that will provide high quality services in the future. The TUC remains unconvinced that the solution lies in training public sector commissioners about their responsibilities. We would like to see a far more robust approach taken which builds in pay and employment conditions into the whole commissioning process.

We would also support the Low Pay Commission recommendation made in 2007 that the government continue to make clear that the commissioning policies of local authorities should reflect the costs of care provision. It also called for the government to monitor actively how far practice matches policy, to examine the reasons for any uneven provision, and, if appropriate, to provide further guidance.
An Agenda for Change for the Social Care Workforce

The TUC would advocate a similar approach to pay and workforce development adopted in the social care sector as Agenda for Change in the NHS, which was negotiated win partnership with trade unions. A key aspect of Agenda for Change is the Knowledge and Skills Framework which would provide a valuable template for the social care sector. The KSF would facilitate a systematic approach to skills development through the use of skills pathways and portable qualifications which recognise and develop core competencies. The adoption of a workforce framework such as this would also assist with recruitment and retention in local labour markets where the NHS offers a more attractive salary and employment conditions.

9 Notes

[1] *Poverty, Parenting and Social Exclusion: educator's guide*, SCIE, 2008, p 2.
[2] Calculated from data for *Social Trends* 38, ONS, 2008, fig 5.3. Data is for real, (£ p.w. at 2005/6 prices) disposable, equivalised (using OECD scale) household income. The comparisons are between the average incomes of those in the 90th and 10th percentiles of the income distribution and the median (the point in the distribution with half the population above and half below.) 1997/8 and 2000/01 are GB only, other years are United Kingdom.
[3] Eurostat data.
[4] Poverty = living in a household with an income below 60% of the median after taking housing costs into account. Data taken from *Poverty and Inequality,* Luke Sibieta, IFS, 2005.
[5] Calculated from *Households Below Average Income 1994/95 - 2006/07*, DWP, 2008, table 6.6ts. Poverty is defined as living in a household with less than 60 per cent of contemporary median household income, by age and gender; figures are for United Kingdom from 2002/03 onwards, earlier years are for Great Britain only.

[6] "Child wellbeing and income inequality in rich societies", Kate Pickett and Richard Wilkinson, *British Medical Journal,* 2007; 335:1080, (24 Nov 2007).
[7] *Social Trends* 38, ONS, 2008, table 1.2.
[8] *Informal Care for Older People Provided by Their Adult Children: Projections of Supply and Demand to 2041 in England*, Report to the Strategy Unit (Cabinet Office) and the Department of Health, Linda Pickard, PSSRU Discussion Paper 2515, 2008, p 15.
[9] Gap between numbers projected to provide care assuming constant probabilities of care provision and numbers needed to provide care if demand is to be met, op cit, table 7.
[10] *Future Demand for Social Care, 2005 to 2041: Projections of Demand for Social Care for Older People in England,* Report to the Strategy Unit (Cabinet Office) and the Department of Health, Raphael Wittenberg, Linda Pickard, Juliette Malley, Derek King, Adelina Comas-Herrera and Robin Darton, PSSRU Discussion Paper 2514, 2008, p 4.
[11] *Future Demand for Social Care, 2005 to 2041: Projections of Demand for Social Care and Disability Benefits for Younger People in England,* Report to the Cabinet Office Strategy Unit and the Department of Health, Raphael Wittenberg, Juliette Malley, Adelina Comas-Herrera, José-Luis Fernánadez, Derek King, Tom Snell and Linda Pickard, PSSRU Discussion Paper 2512, 2008, pp 10 – 11.
[12] *Public Services At the Crossroads,* Richard Brooks (ed), IPPR, 2007, pp. 63-5.
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