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Manchester Metropolitan University | Decent Work and Productivity Research Centre

Proud to Care CORNWALL

Delivering Better Care

Creating an adult social care workforce strategy for Cornwall

December 2023

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Foreword

We are delighted to introduce the Adult Social Care Independent Sector Workforce Strategy for Cornwall.

The strategy sets out an ambitious vision for our future and a route map to its achievement, based on a solid foundation of collaboration and commitment. It has been developed with the support of academic colleagues from Manchester Metropolitan University through engagement with stakeholders from across the sector. It reflects their views on how to create an environment in which excellent, high-quality care can continue to be provided.

Our workforce is our greatest strength and at the heart of all we do, working hard to provide the care needed by service users. We recognise the significant pressures faced by those delivering adult care services in our county and the necessity to change the model of care to meet the current and future needs of the Cornish population. This will require a sustainable, confident, skilled workforce who feel valued and are well supported both in respect of their own career development aspirations, their mental and physical health, and pay, terms and conditions. Building digital capability and the ability to embrace new technologies is also essential.

This workforce strategy outlines a number of actions which, when implemented, will support our people to experience good work and deliver excellent social care, with the right people with the right skills in the right place who are recognised and valued for their contribution within the wider health and care sector.

We are committed to developing and supporting our care workers and to attracting and retaining a workforce that reflects the community we serve.

Ass on ni lowen dhe gomendya an Strateji Gweythlu Ranngylgh Anserghek Gwith Socyal Tevesik rag Kernow.

An strateji a ragworr gwel ughelhwansek rag agan termyn a dheu ha mappa hyns dh'y gowlwrians, selys war fondyans soled a gesoberyans hag a omrians. Displegys veu gans skoodhyans kowethysi akademek dhyworth Pennskol a'n Worcita Manchester dre geskolm gans kevrenogyon dhyworth a-dreus an ranngylgh. Ev a dhastewyn aga gwel ow tochya an fordh dhe wruthyl kerghynnedh le may hyll pesya bos gwith kooth hag ughel y gwalita proviys ynno.

Agan gweythlu yw agan moyha nerth ha dhe gres a oll a wren, owth oberi yn tynn dhe brovia an gwith hwensys gans usyoryon a'n gonis. Ni a aswon an posow bras enebys gans an re a dhelirv gonisyow gwith tevesik y'gan konteth ha'n edhom dhe janjya an patron a with dhe gewera an edhommow a'n poblans a Gernow lemmyn hag y'n termyn a dheu. Hemma a wra erghi gweythlu konnyk, kyfyansek ha sostenadow a omglew talvesys ha bos skoodhys yn ta ow tochya gorvynnow displegyans aga resegva, aga yagh ha brysel ha fysygel, ha gober, termys ha studhyow. Drehevel gallos besyel ha'n gallos dhe vyrla teknegiethow nowydh yw essensek ynwedh.

An strateji gweythlu ma a linen niver a weythresow hag a wra, pan vons kowlwrys, skoodhya agan tus dhe brevi ober da ha delivra gwith socyal splann, gans an tus ewn gans an sleyneth ewn y'n le ewn neb yw aswonys ha talvesys rag aga hevro yn mysk an ranngylgh gwith ha yeghes ledanna.

Omres on dhe dhisplegya ha skoodhya agan oberoryon with ha dhe denna ha gwitha gweythlu a dhastewyn an kemeneth a wonedhyn.

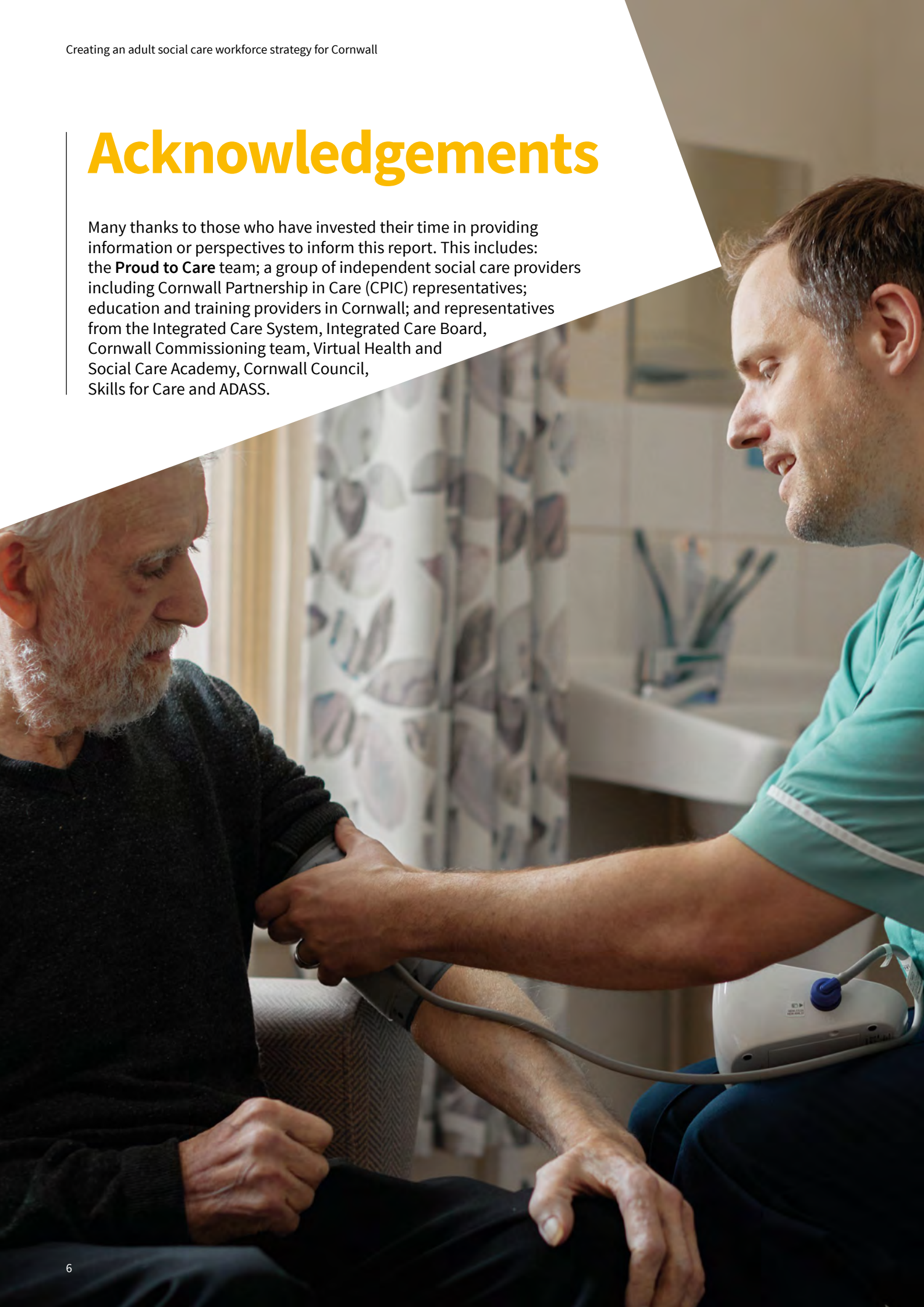
Cllr Dr Andy Virr
Portfolio holder for Adult Social Care and Health

Alison Bulman
Strategic Director Care and Wellbeing (DASS)

Rachael Rothero
Service Director People Commissioning

Acknowledgements

Many thanks to those who have invested their time in providing information or perspectives to inform this report. This includes: the **Proud to Care** team; a group of independent social care providers including Cornwall Partnership in Care (CPIC) representatives; education and training providers in Cornwall; and representatives from the Integrated Care System, Integrated Care Board, Cornwall Commissioning team, Virtual Health and Social Care Academy, Cornwall Council, Skills for Care and ADASS.



Executive summary

'Creating an adult social care strategy for Cornwall' presents a rapid evidence review of relevant policy and academic evidence, together with analyses of Cornwall's current adult social care workforce to inform an adult social care workforce strategy for the independent sector.

Adult social care makes a vital social and economic contribution in Cornwall. In social terms, the sector supports a large number of older or vulnerable people. In economic terms, in 2022-23, the sector contributed £606 million GVA to Cornwall's economy, an increase of 5.9% on 2021-2 and is one of the largest employers in the county. It experiences, however, similar workforce challenges to the rest of England, with the addition of some regionally specific challenges, including a high cost of living, expensive accommodation, lack of reliable public transport and hard to reach rural areas, and poor digital connectivity. These factors make recruitment into a low-paid sector difficult, especially against a backdrop of significant competition from other sectors and in particular seasonal demand in tourism and hospitality. Yet significant growth is required. Forecasts demonstrate that, to match the growing demand for adult social care in Cornwall, the independent sector workforce will need to grow in the region of 30-35% by 2035.

The underlying premise of the report is the need to create good work in the sector. This includes the offer of fair pay, secure employment, training, qualifications and career progression opportunities, worker recognition and involvement in decision making. Parity with the NHS for similar roles is essential, as are place-based solutions to the particular labour market challenges that Cornwall experiences. Good work will both attract workers to and retain them in the adult social care sector, but the scale of the task in achieving this should not be under-estimated.

Recruitment

Recruitment issues identified centre on increasing labour supply, establishing an optimal level of international recruitment and ensuring cross-local authority strategic collaboration.

Increasing labour supply

In Cornwall, vacancy rates exceeded 11% in 2022-23, which is problematic given the required growth in labour supply and an ageing workforce which means a large proportion of the social care workforce could retire in the next 10 years. It will be particularly important to attract young people into the sector and engagement with the education sector and improving the image of adult social care are central to this. It will also be important to identify other sources of labour. Engagement is needed with providers to address reluctance on the part of some to employ young people and/or non-traditional sources of labour. Supply of registered managers is also a concern, with a high proportion potentially due to retire in the next 10 years. Development programmes to support promotion into these roles are needed. **Proud to Care** will lead on addressing these issues.

International recruitment

International recruitment has had less uptake in Cornwall than in England, filling only 7.5% of posts, and consequently vacancy rates have not reduced to the same extent. Nevertheless, given the political volatility that surrounds international recruitment, together with well-documented ethical concerns, it should be used as only a short-term solution to building required workforce levels.

Cross-local authority working

Accommodation shortages and transport difficulties are critical issues in recruitment in Cornwall. Cross-local authority strategies are required and **Proud to Care** will work with the departments responsible for housing and transport to develop strategies to alleviate accommodation and transport difficulties for the adult social care workforce.

Training, qualifications and career progression

Robust induction focused on socialisation is critical to ensuring new workers have the required skills and confidence and improving retention. Completion of the Care Certificate, proportions of the workforce holding Level 2 and 3 qualifications and uptake of apprenticeships are all low, and growth here is needed. There is also an increasing need for specialist training provision in, for example, working with dementia. Career progression is lacking and implementing the DHSC's career pathways, and drawing on associated funding, both to be announced in early 2024 is vital. Importantly, this will establish not only adult social care pathways, but also integrated pathways across health and social care, for example, children's social care, nursing and Allied Health Professionals. **Proud to Care** will lead on addressing these issues.

There are various funding concerns. First, over funding distribution mechanisms; second, over funding sources as ESF monies disappear amidst lack of clarity over access to Shared Prosperity Fund monies; and third, over the extent to which transfer of apprenticeship levy monies to smaller providers will continue to be possible. Additionally, to support greater uptake of training and qualifications, fee levels must be high enough to allow care workers to be paid for their time when doing training. Fair Cost of Care exercises offer the opportunity to address this.

Professionalisation

Professionalisation, based on mandatory registration and regulation of care workers, offers a mechanism to increase the status of care work and address recruitment and retention challenges. The DHSC's anticipated career pathways offer an important starting point, but to be effective must be accompanied by improved pay and other terms and conditions. A co-ordinated package that creates parity with the NHS is needed. While registration must be actioned at national level, a care charter in Cornwall is an option, requiring training and development, alongside particular levels of terms and conditions of employment as a means to improve job quality and address workforce shortages. **Proud to Care** will facilitate exploration of establishing this.

Digital skills

Digital skills provision is currently somewhat uncoordinated, and training is needed for both registered managers, in for example analysis skills, and care workers in use of technologies. The DHSC's digital leadership qualification will also be an important development, as is support for its digital skills passport when launched in 2024. Various curricula, for example, the Care Certificate and Level 2-3 qualifications require review to ensure they adequately address digital matters. In Cornwall, a technology-enabled care strategy is in development and consideration of its workforce implications will be needed. **Proud to Care** will support with digital skills co-ordination, implementation of digital skills passports and digital leadership qualifications and the building of digital support networks.

Retention

Similar to elsewhere in England, Cornwall experiences high labour turnover rates and these stood at 27.4% in 2022-23. **Proud to Care** will offer provider/registered manager programmes on developing a strong workplace culture, understanding costs/benefits of reducing turnover and workforce planning to reduce turnover. Actions from elsewhere in this report will address other important causes of turnover e.g., low pay and limited career progression opportunities.

Pay, terms and conditions and contracted hours

Cornwall's current pay rates are competitive in the social care sector. However, recent increases to both the National Living Wage and Real Living Wage will require substantial increases to current rates and are likely to reduce/remove this competitive edge. Care worker/senior care worker pay differentials have significantly reduced in recent years and salary progression opportunities have thus worsened. Creating parity with the NHS is essential to building a skilled and stable adult social care workforce in Cornwall. Investment in pay is required as part of the government's reform agenda for social care and the benefits of this will include a more diverse workforce (particularly the recruitment of more men into the sector), reduced turnover and improved care quality.

Terms and conditions of employment such as sick pay and pension provision are also typically at statutory minimum levels. Parity with NHS terms and conditions is again required to address workforce shortages. Additionally, around 20% of the home care workforce in Cornwall is on zero hours contracts. While Cornwall's 2024 recommissioning of home care will encourage providers to consider different employment patterns including offering shift work, it does not address the fundamental need for a cohesive reform agenda that addresses the availability of capacity across the sector. and some pilots are in progress.

These issues are significant national policy questions and need to form a key part of the discussion around the next steps to reform the adult social care system. However, in the meantime local commissioning needs to ensure that it paying fees which are fair locally as well as seeking to influence the national policy agenda around fair pay and recognition for care workers.

Health and well-being

The adult social care workforce is under significant pressure, key factors being post pandemic burnout and the work intensification created by high vacancy rates and turnover. These are reflected in higher-than-average sickness absence rates. While many of the actions in this report will serve to improve this situation, direct forms of support are also required. Counselling is available for free, but perhaps not well known about. For many, there is limited access to occupational health services. Innovative working practices are also needed. **Proud to Care** will take action to address these issues.

Equality, diversity and inclusion

The adult social care workforce is female dominated and has an ageing profile. The recruitment section above offers some ways to address this and pay and career pathways are also important factors. While the workforce in Cornwall is not particularly diverse in terms of ethnicity and nationality, it is broadly reflective of its wider population. Neurodiversity and disability are increasingly prominent in the workforce. At local authority level, Cornwall is part of a pilot to improve workforce equality, diversity and inclusion, but this does not yet include the independent sector. Cornwall will roll out this assessment and action planning process to the independent sector.

Workforce strategy, planning and integration

Cornwall's Integrated Care System (ICS) will consider producing an integrated health and social care workforce plan that supports its adult social care workforce strategy. This should again work towards parity between the NHS and adult social care. Not all the data needed for workforce planning is currently available. Neither have the implications for increased use of digital technologies and technology enabled care or adoption of shift working for staffing ratios been identified. All are needed for detailed workforce modelling and the Integrated Care Partnership (ICP) will prioritise producing this data.

Workforce planning will also support capacity optimisation, promoting, for example, place-based strategies that create provider alliances for more efficient care delivery and developing skills so that workers can operate flexibly across different services. Integrated planning will also serve to support developments such as delegated health care. The ICP will drive these initiatives.

The need for increased funding has already been flagged. The ICP will explore an interim solution to funding challenges by driving greater budgetary integration, offering cross institutional leadership and investment in improvements for the adult social care workforce. The Integrated Care Board (ICB) also offers an opportunity for improved within and cross-sector communication and **Proud to Care**, the VCSE and providers will have representation on it. This offers a voice to social care and supports improved communications with independent providers to help them to understand their role in the ICS.

Commissioning and funding

Under-funding of the adult social care sector across England is widely acknowledged and implicated in issues already discussed such as low pay, poor uptake of training and use of zero hours contracts. While additional funding is regularly made available, it is fragmented and short-term in nature, making it difficult for providers to plan. Under-funding also underpins practices such as payment of fees to providers that do not fully cover the costs of care and the commissioning of care on a package-by package basis that creates income instability for providers.

While constrained by funding settlements and meeting statutory need within available resources, commissioners nevertheless have some capacity to influence terms and conditions in the sector.

The 2024 re-commissioning of home care provides such an opportunity. Contracts could require particular pay levels, training days, shift working and so on and thus enhance job quality. Commissioning is also currently highly fragmented across a large number of small providers. Re-commissioning across fewer, larger providers to create improved career structures will be explored. To enable the effectiveness of this workforce strategy, Cornwall will on an ongoing basis review funding levels and commissioning practices.

Delivering the strategy

Based on this report, Cornwall has created an ambitious adult social care workforce strategy. Central to its achievement will be collaboration, both within the local authority and more widely. Within the local authority, **Proud to Care** will require support from local partners, the ICB/ICP and other departments including those responsible for commissioning, housing and transport. Independent sector providers are also fundamental to the achievement of the strategy, and a strong communication and consultation programme will be launched to gain their commitment. SW ADASS will be an important partner, given the recent launch of its own strategy and streams of work that can support Cornwall in achieving its aims. Finally, partnerships with other local authorities will provide learning around workforce innovation.


FIRE EXIT
STAFF

Terms of reference

The Care and Wellbeing Directorate of Cornwall Council has commissioned Manchester Met researchers to provide a deep-dive study into the Cornwall adult social care workforce with the aim of producing a robust workforce strategy to cover the period 2023 – 2027. This will be a fit for purpose, modern, realistic workforce strategy that makes recommendations on priority actions. The strategy will have a detailed focus on activity for the next four years but will also set a direction of travel to 2033.

The study will:

- Analyse the current recruitment, availability and deployment of workforce; employment and socio-economic factors impacting on recruitment, retention and 'churn'.
- Identify where there are skills gaps and where investment and skills provision are needed to support the growth of the workforce to meet existing and predicted future need.
- Review and build on the workforce implications of the:
  i) new strategic commissioning intentions for maximizing independence and better lives.
  ii) the market position statement.
  iii) existing high level care sector workforce strategy for Cornwall and the Care and Wellbeing Directorate Workforce strategy (excluding Public Specification for Creation of a Workforce Strategy for Cornwall's commissioned adult social care workforce and the Cornwall Council Local Authority workforce delivering adult social care).
  iv) ADASS and Skills for Care collective workforce priorities and government direction, CQC reporting requirements and emergent CIoS ICS workforce priorities and identified best practice both nationally and internationally.
- Provide analysis of the economic benefits of the social care sector.
- Offer understanding of the emerging national policy context pre- and post-election to support the social care sector and how this will shape our requirements locally.

Deliverables

The key deliverables from undertaking research to inform a workforce strategy and associated action plan, are:

1. Introduction: Provide an overview of the care sector in Cornwall and its importance to the local economy. Explain the purpose and scope of the workforce strategy.
2. Current state analysis: Analyse the current state of the care sector workforce in Cornwall, including its size, composition and any challenges or issues it faces.
3. Goals and objectives: Set out the goals and objectives of the workforce strategy, such as increasing recruitment, improving retention, or enhancing training and development.
4. Strategies and actions: Outline the specific strategies and actions that can be taken to achieve the goals and objectives. This could include initiatives to attract new workers to the sector, programs to support career development or measures to improve working conditions.
5. Implementation plan: Develop a detailed plan for implementing the workforce strategy, including timelines, responsibilities and resources required.
6. Impact: outline how to measure workforce impact.

Introduction

Adult social care offers vital services to older and vulnerable people. In England in 2021-22, over one million people were supported and annual funding reached £26.9bn (Kings Fund, 2023). The majority of this was spent on workforce. In 2022-23, posts numbered nearly 1.8m, larger than the NHS workforce. In 2021, the sector had a Gross Value Added to the economy of £25.6bn. Adult social care is, therefore, an important sector both socially and economically and is set to grow ever more important as the population ages and demand for adult social care services increases. Its workforce matters are, however, well documented. Adult social care workers experience low pay, insecure work and have low levels of qualification. Resulting recruitment and retention difficulties create challenges of work intensification and in delivering high quality care.

These issues are reflected within Cornwall, with the addition of some regionally specific challenges including a high cost of living, expensive accommodation, lack of reliable public transport and hard to reach rural areas, and poor digital connectivity. Cornwall also has a super-ageing population, meaning larger growth in demand for adult social care than for England more generally, and a reducing working age population with higher-than-average levels of disability. All these make recruitment into a low-paid sector difficult, especially against a backdrop of significant competition from other sectors and in particular seasonal demand in tourism and hospitality.

Within this context, it is important to create a robust adult social care workforce strategy for Cornwall. Developing a successful strategy involves establishing a baseline of the current workforce, including its size, demographics, and skill sets. It also needs to align with commissioning intentions, considering changes in care and support services. It is important to note that, in Cornwall, only half of adult social care provision is local authority-funded, the other half being purchased by self-funding care recipients. There is then only a partial overview of the adult social care market.

To develop the strategy, this report presents a rapid evidence review of relevant policy and statistical analysis of both the economic contribution of adult social care to Cornwall's economy and its workforce. It also presents stakeholder perspectives on workforce matters and draws all this together into scenario modelling of future workforce needs. This informs conclusions and recommendations and an implementation and evaluation framework. These later sections inform a separate workforce strategy document.

The underlying premise of this report, and associated strategy, is the need to create good work (Taylor, 2017) in the sector. This includes the offer of fair pay, secure employment, training, qualifications and career progression opportunities, worker recognition and involvement in decision making. Parity with the NHS for similar roles is essential. Good work will both attract workers to and retain them in the adult social care sector ((SfC, 2021a). As will be seen, there is a significant amount of change needed to deliver good employment for the adult social care workforce and this report sets out a roadmap to achieve this.

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Project data sources

The evidence that informs this report comes from a number of sources:

Rapid evidence review: a desk-based review was conducted to identify the current legislative and consultative framework on the future of adult social care. This included review of legislation, government policies and consultations and important health and social care infrastructure developments to establish the wider adult social care context. The review also included a small amount of academic literature relevant to the matters under consideration.

Analysis of the economic benefit of the adult social care sector to Cornwall's economy: Skills for Care's analysis team has, using methodologies adopted in its national reports[1], calculated the economic contribution of the adult social care sector to Cornwall's economy.

Analysis of the adult social care workforce in Cornwall: Skills for Care's (2023) analysis team has used data specific to Cornwall to present detailed statistics that have been interpreted by the ManMet team. Unless otherwise specified, all data is for the year 2022-23.

Stakeholder perspectives: facilitated group and one-to-one discussions were held as per Table 1. Ethical approval was provided via Manchester Metropolitan University's Research Ethics and Governance procedures. Informed consent was gained from all stakeholders involved and perspectives offered are all subject to the usual principles of confidentiality and anonymity.

Table 1: Stakeholder discussions

Facilitated group discussions
Independent social care providers
Education and training providers
Integrated Care System representatives
One- to one discussions
ICB workforce representative
Adult social care commissioning representatives
Health and Social Care Academy representative
Digital transformation representative
Council representative
Skills for Care representative
ADASS representative
Social value representative

Scenario planning: Skills for Care's (2023) analysis team used a range of data sources, as agreed with **Proud to Care** and the ManMet team, to provide a number of workforce forecasts. These were interpreted by the ManMet team.

Rapid evidence review

This rapid evidence review sets the national context against which Cornwall's adult social care workforce will be analysed. It starts with an overview of the adult social care workforce in England, before discussing relevant policy and legislation in the sector. It then covers evidence in relation to pay, professionalisation, integration of health and social care and the workforce implications of digital technologies.

The adult social care workforce in overview

A relatively brief overview is presented here of the adult social care workforce in England, drawn from Skills for Care's (SfC, 2023) **The State of Adult Social Care** annual report, where more detail can be found. The overview presents a backdrop against which issues in the sector are then discussed.

Size and structure of the workforce

The adult social care workforce is large, in fact bigger than the NHS workforce, with around 1.79m posts. The workforce thus constitutes a substantial proportion of the overall working population, more than 5%, of the circa 29 million people in employment in England (LFS, 2023). Of these posts, 1.635m are filled and 152,000 are vacant. Vacancies run at around 9% of total posts,

[1] Economic value of the adult social care sector (skillsforcare.org.uk)

creating significant pressure. While high vacancy rates have long beset the sector, these were exacerbated by the government's requirement, introduced in November 2021, that care home staff receive Covid-19 vaccinations. While withdrawn in March 2022, government estimates were that around 40,000 workers could leave as a result of this requirement, and DHSC research found that it could have been the second most common reason for staff leaving (Kings_Fund, 2023).

Vacancies, however, have fallen by around 11,000 (7%) in the past year. This is in large part due to international recruitment, which is discussed further below. More than three quarters of vacancies are in direct care, that is, care workers, senior care workers or similar. The remaining quarter are managers and supervisors (7%), regulated professions (5%) and other (13%).

The majority (88%) of the adult social care workforce is employed on permanent contracts, particularly managerial staff and senior care workers, with around half (52%) usually working full-time hours. Around a fifth of the workforce (22%) is employed on zero hours contracts (340,000 filled posts). The percentage of workers employed on zero hours contracts between 2016/17 and 2022/23 has remained relatively stable, decreasing by only 1% in this period. Care workers have the highest proportion of workers on zero hours contracts (32%) and half (50%) of those who work in home care are on these contracts, creating a high degree of insecurity for this section of the workforce.

Pay

Care work is low paid, with median independent sector care worker pay per hour of £10.11 in March 2023, a reduction of 35p per hour on the previous year (SfC, 2023), as compared to the National Living Wage of £9.50 at the same date. Independent sector senior care workers earn on average an extra 75p per hour. Other terms and conditions, such as pensions and sick pay, are typically at statutory minimum levels. Low pay can have a wide range of effects, including high vacancy and turnover rates, so it is argued that higher pay is needed in the sector. This is supported by Skills for Care's (2021a) research that showed better pay is associated with improved Care Quality Commission (CQC) ratings.

Recruitment and retention

The sector has long been beset by recruitment and retention difficulties, and recent data reflects little change in this situation. The 1.79m total posts is an increase of 0.5% over the previous year, and demand will grow further over coming years. Vacancies sit at 152,000, down from a peak of 164,000 in 2021/22 but still creating significant pressures in the sector.

Recruitment difficulties also vary by geography. Of particular significance to Cornwall are the rural issues identified by the recent House of Lords (2022) report. It noted challenges resulting from a smaller working age population and the availability of, possibly more attractive, jobs in the tourism sector. Lack of affordable housing is also often an issue. Further, large, remote, rural areas have increased time and cost for care delivery. Workers have longer than average travel distances to work or while at work, which, as noted below, is a significant cause of increased labour turnover.

Turnover rates also remain high, at approximately 28% per annum. This equates to approximately 390,000 leavers each year, although many of these (59%) remain within the sector, moving to other providers. Nevertheless, this comes at substantial costs given Skills for Care estimates of the cost of replacement per leaver of £2,500.

Turnover is highest for residential care (30.7%) and home care providers (28.2%). Cost of living pressures across 2023 may have impacted turnover, particularly in home care where increased fuel prices have created financial stress.

While the cost-of-living crisis is beyond providers' control, they can influence turnover rates in other ways. For example, recent Skill's for Care (2023) analysis demonstrates that higher pay, guaranteed hours and training and qualification opportunities are associated with better retention. Other factors that increase the likelihood of leaving an employer are: having a longer commute to work, being under 25, and having fewer contracted hours or a zero hours contract. Earlier work also showed that providers having turnover rates of under 10% was associated with investing in learning and development, embedding organisational values, recognising individual and organisational achievements and involving workers in decision making (SfC, 2021a)

Demographics

Women make up the overwhelming majority of the workforce, a proportion that has fallen slightly over the past year (from 82% to 81%). This is again related to international recruitment where a higher proportion (32%) of overseas recruits are men. This gender pattern is fairly consistent

across roles, although women make up a smaller proportion of senior management roles (69%).

The adult social care workforce is typically older, with 29% aged 55+, as compared to 21% of the overall working population. This has significant implications for workforce planning as approaching one third of the workforce could retire over the next decade.

Workers of ethnic minority origin constitute 14% of the total workforce, which is more diverse than the overall working population. Notably, there are large variations by region, with London having the most diverse workforce (29% with a White ethnic background) and the Northeast the least diverse workforce (93% with a White ethnic background). Over 80% of the workforce has British nationality, 6% hold EU nationality and 13% hold non-EU nationality. This is again more diverse than the wider working population.

Training and qualifications

The sector is beset by a 'low-skilled' label, and indeed over half (54%) of the workforce has no relevant social care qualification. 40% of staff providing direct care hold relevant Qualifications and Credit Framework (QCF) Level 2 and Level 3 qualifications, rising to 72% for senior care workers, while 67% of managers hold Level 3 and Level 4 qualifications.

Despite lack of qualifications, care workers may have completed relevant training. Of those care workers without a qualification, 61% had completed or were working towards the Care Certificate[2], a Skills for Care training programme for workers new to a provider, and 71% had completed some other form of training.

Workforce projections

Skills for Care (2023) estimates that, by 2035, workforce demand will grow from the current 1.79m to 2.3m. That is another 440,000 workers, a 25% increase. This is in a context where there are already workforce shortages, and a significant proportion of the workforce is due to retire. In response, there has been significant policy interest in how to build a fairly paid, highly skilled and diverse workforce. The next section discusses relevant policy in some detail.

Policy and legislative context

Concerns around the care workforce and care quality in a system under enormous pressure date back many years (see, for example, Kingsmill, 2014, Cavendish, 2013). More recent policy responses build on this and are discussed here. The wider legislative context, namely the Care Act (2014) and the Health and Social Care Act (2022), are discussed only in so far as they impact on the adult social care workforce.

Funding reform

It has been long recognised that the adult social care sector is under-funded, resulting in low pay and poor terms and conditions of employment (Rubery and Urwin, 2011). Funding flows mainly from central government to local authorities, although in recognition of funding pressures, local authorities can also set an adult social care precept. This allows for generation of local revenue, of up to 2% per year in 2023/24 and 2024/5 without a referendum[3]. However, areas with higher deprivation, such as Cornwall, generate less funding per capita, raising regional inequality (Foster, 2023). Other funding sources include, for example, the Market Sustainability and Improvement Fund (MSIF) Workforce Fund[4], with allocations of £365 million for 2023-24 and £205 million for 2024-25. This patchwork of funding sources has been criticised as being short-term and not allowing providers to take a longer-term strategic view towards workforce. It has also resulted in a situation where most local authorities pay below a sustainable rate for care delivery in fees to providers (Kings Fund, 2023)

Successive governments have committed to reform that addresses under-funding, but have failed to deliver. Recently, DHSC's (2022a) **Build Back Better** proposed charging reform, partially implementing the proposals from the Dilnot Commission's (2011) report on social care. A cap on care of £86,000 per annum was announced which, while higher than the Commission's original proposal, would nevertheless have reduced the financial burden for many requiring adult social care. This cap would have substantially increased the amount of government funding required, and a UK-wide 1.25% Health and Social Care Levy (the Levy) ringfenced for health and social care, was announced. Reforms were

[2] Care Certificate (skillsforcare.org.uk)
[3] Adult Social Care Funding (England) – House of Commons Library (parliament.uk)
[4] Market Sustainability and Improvement Fund – Workforce Fund: policy statement – GOV.UK (www.gov.uk)

also accompanied by a Fair Cost of Care exercise[5]. This was intended to address the practice noted above whereby local authorities pay fees that do not sustainably cover the cost of care to providers (Curry, 2022). It required local authorities and providers to calculate more realistic costs to inform sustainable fee levels.

Later in 2022, however, amidst political turmoil, the Levy was abandoned, the outcomes of the Fair Cost of Care exercise were not fully implemented and the cap on care costs has been delayed to October 2025. It is anticipated that it will be implemented at that point, although it will be preceded by a general election which creates some uncertainty. In the interim, it should be noted that it is more than a quarter of a century since a Labour government established the Royal Commission on Long Term Care in 1997 (Hoddinott, 2023) and uncertainty about policy implementation and funding decisions has discouraged investment by both local authorities and providers.

Build Back Better also sought to tackle the situation, using provisions in the Care Act (2014, section 18(3)), where those self-funding their care pay higher fees than paid for local authority-funded provision. The differential can be as high as 40% in care homes (Curry, 2022) and £3 per hour for home care (Kings Fund, 2023). Reform will mean that self-funders can ask their local authority to arrange care for them to benefit from lower fee rates. Implementation of this reform has again been deferred but is expected to be implemented in October 2025.

When implemented, these reforms could, in combination, mean many more people accessing social care via local authorities, which will clearly increase commissioned provision and the associated workforce. Combined with workforce demand that results from an ageing population, urgent attention to workforce matters is needed.

Workforce policy and strategy

The most significant recent adult social care workforce policy response is **People at the Heart of Care** (DHSC, 2022b), which presented the government's 10-year vision for adult social care and outlines funding commitments including:

- Committing at least £500m to training and qualifications and prioritising workforce well-being
- An additional £10m to drive greater adoption of technology
- £100m in various programmes to drive innovation in care delivery, which will have workforce implications

Building on this, **Next steps to put People at the Heart of Care** (DHSC, 2023) committed a further £15m to support international recruitment and £3m to support volunteering in adult social care, with The NHS Volunteer Responder Scheme[6] being opened to the care sector. However, it also announced a training and qualifications budget of only a minimum of £250m. While over a different time period, and so not a like for like comparison, this has generally been acknowledged to be a reduction in funding from that presented in **People at the Heart of Care**.

People at the Heart of Care also proposed a number of workforce initiatives. First, a Knowledge and Skills Framework (KSF), with career pathways and investment in learning and development to support progression for care workers and registered managers. Second, funding for Care Certificates against a recognised delivery standard so that the certificates would be portable when moving employer. Third, support for health and well-being. Fourth, a portable record of learning and development called a digital skills passport and a supporting digital hub and, finally, policies on best practice recruitment.

While these are welcome initiatives, **People at the Heart of Care** does not set out a clear strategy for the adult social care workforce (Hemmings et al., 2022). The Social Care Policy Group (SCPG), for example, call for an end to the piecemeal planning and a focus on the need for a long-term plan including a workforce strategy. This should address the most immediate concerns of improving pay, terms, training and career progression for the care workforce. A **Vision for a Future Workforce Strategy** (LGA, 2022) similarly suggests the need for: investment in training, qualifications and support; removing the need to repeat training for workers who move with the sector; ensuring that the workforce has access to career long learning and development

[5] Market Sustainability and Fair Cost of Care Fund 2022 to 2023: guidance - GOV.UK (www.gov.uk)

[6] https://nhscarevolunteerresponders.org/i-want-to-volunteer?gclid=CjwKCAiA04arBhAkEiwAuNOsIlWLN1MgtyC4UFDoM-r63hnEvbgjc1WncCZMQ5h6WR6_1-KtvkMklRoCBfQQAvD_BwE

opportunities including recognised qualifications and recognition and support for professional development at all levels. It also calls for training and support for commissioners so that they are better able to achieve the aims of the Care Act (2014). Hemmings et al. (2022) additionally raise concerns that the Care Certificate is no longer fit for purpose as it does not cover more specialised training, for example, dementia (see also Luijnenburg et al., 2022), nor address the delegated healthcare tasks that some care workers undertake.

While an important starting point, **People at the Heart of Care** and **Next steps to put People at the Heart of Care** leave many issues to be addressed. Further, while the workforce aspect of these white papers has the largest share of the reform budget, a recent NAO (2023) report noted that delivery has started on only two of the eight projects announced, international recruitment and the volunteers responders scheme. The others are still in development, including the career workforce pathways and training projects, planned for September 2023 and now scheduled for spring 2024. The NAO report additionally noted that these delays risk underspend against announced budgets.

Two of the key initiatives outlined in **People at the Heart of Care**, international recruitment and career pathways, are now discussed in more detail.

International recruitment

As noted above, **Next steps to put People at the Heart of Care** committed £15m to support international recruitment to address workforce shortages in adult social care. This was informed by the Migration Advisory Committee's (MAC, 2022) examination of the impact on the sector of the ending of Freedom of Movement between the UK and EEA in January 2021. MAC suggested that employers were unfamiliar with sponsorship processes for the Skilled Worker Visa route, the process was unknown and intimidating, and many providers were paying less than the minimum required by the visa scheme. Support was needed to encourage providers to engage with international recruitment.

In February 2022, care workers were added to the Shortage Occupation List and the Health and Social Care visa route, which mirrors the Skilled Worker Visa route but with lower fees and fast-tracked processing. This entitles overseas workers with a licenced sponsor to a visa to work in care in England, for a minimum salary of £20,960 or £10.75 per hour. This is less than the usual minimum pay requirement of £26,500 for a Skilled Worker visa and is set at a level that makes international recruitment a viable option for the sector. It is worth noting that not all migrants working in the care sector are on work visas sponsored by their employers. Many already have permission to be in the UK in other immigration categories, e.g., as family members of visa holders or as refugees.

In summer 2022, the government launched a programme to help local areas establish support arrangements for international recruitment. Associated guidance[7] requires a focus on ethical recruitment and employment practice and provision of pastoral care and affordable housing for overseas recruits. The impact on recruitment to the sector has been significant. SfC (2023) reports that around 70,000 overseas recruits have taken up direct care roles in 2022-23, an increase of 50,000 over the previous year. This may be an under-estimate as it includes only providers submitting to the Adult Social Care Workforce Dataset. Government figures suggest it is around 100,000 overseas recruits[8]. It should be noted, however, that workers on visas often need to have 3 years residence in England to be eligible for funding for training (LGA, 2023).

Despite easing of vacancies, concerns are emerging about international recruitment. First, that the increasing number of migrant workers in the sector has led to a rise in allegations of ill-treatment, poor working conditions, and exploitation, with even suggestions of modern slavery (McKinney and Sturge, 2023). For example, both UNISON and MAC have documented questionable employer practices and issues. Second, whether international recruitment is sustainable as a mechanism to address workforce shortages. In policy terms, the situation is uncertain. A consultation on international recruitment has recently closed and outcomes are

[7] https://www.gov.uk/government/publications/international-recruitment-fund-for-the-adult-social-care-sector/international-recruitment-fund-for-the-adult-social-care-sector-guidance-for-local-authorities

[8] Home Secretary unveils plan to cut net migration - GOV.UK (www.gov.uk)

awaited[9]. Meanwhile, a recent MAC (2023) report recommended scrapping the Shortage Occupation List, viewing it as a short-term solution that drives down wages and leaves workers vulnerable to exploitation. The minimum salary threshold for international recruitment could then revert to that of a Skilled Worker Visa, i.e., £26,500. This would be a significant barrier to international recruitment for the sector, being substantially more than the average £21,300 independent sector care worker salary (SfC, 2023).

November and December 2023 have also been a period of uncertainty. In response to higher-than-expected net migration figures, government ministers have indicated support for MAC's (2023) recommendation that the Shortage Occupation List be scrapped. The government has also issued a press release[10] which, in addition to increasing minimum salaries to £38,700 from spring 2024 (although social care workers are exempt from this), would prevent spouses and dependents arriving in the UK with overseas recruits. As 120,000 visas were issued for dependents last year, this is likely to be a significant deterrent for overseas recruits. The situation is thus volatile with the potential for international recruitment to be severely curtailed. Providers heavily reliant on international recruitment could be in a vulnerable position.

Career progression in adult social care

The proposed care workforce pathway announced in **People at the Heart of Care** was put out to consultation in 2023[11]. The call for evidence closed on 31st May 2023. At the time of writing, in December 2023, there has been no formal response from the Government. The NAO (2023) report suggests that it has been delayed from September 2023 to spring 2024.

The proposed pathway sets out four broad categories of role:

- Care and support practitioner
- Advanced care and support practitioner
- Senior care and support practitioner
- Practice leader or specialist practitioner

For each role category, the pathway will set out expected knowledge and skills; responsibilities; and opportunities to develop expertise to progress into other roles. It will also propose a universal set of values for the whole adult social care workforce. The pathway will be developed in stages, starting with those in direct care roles, typically described as 'care worker' (SfC, 2023) but termed 'care and support practitioner' in the proposed pathways. This is the largest category of job role in the adult social care workforce, with an estimated 860,000 roles, representing over half of all filled posts (SfC, 2023).

The pathway is also to be extended to reflect wider opportunities in adult social care, including in local authorities and the voluntary, community and social enterprise (VCSE) sector, as well as other models of care. For example, setting out integrated career pathways across adult social care and children's social care. Interaction with other professional frameworks will also be considered (e.g., nursing, social work). There is an ambition to bring together existing skills, competency frameworks and pathways for social care specialisms, as well as acknowledging the variety of roles and career pathways across the wider adult social care system, such as commissioning, finance and senior management and leadership development. Pathways will:

- Enable specialisation where appropriate in specific areas such as supporting people with learning disabilities, autism, dementia etc.
- Support developing new roles and hybrid roles (e.g., assistant/associate roles) that deliver transformed care and achieve the support articulated in Social Care Future's vision.
- Build and enhance social justice, equality, diversity and inclusion in the workforce.

The intention to develop a universal career pathway reflects the move towards more integrated health and care systems. The pathway aims to ensure parity between equivalent roles in health and adult social care to build a more agile workforce, with the skills and opportunities to work across the wider system. If implemented, the pathways will address many of the issues reported above with the current care certificate, for example, the gap in specialist skills training (Hemmings et al., 2022).

[9] Call for evidence: An inspection of the immigration system as it relates to the social care sector – GOV.UK (www.gov.uk)
[10] Home Secretary unveils plan to cut net migration – GOV.UK (www.gov.uk)
[11] Care workforce pathway for adult social care: call for evidence – GOV.UK (www.gov.uk)

Consultation responses
While the government's response to the consultation is pending, it is worth noting some sector reactions to the proposals. The Local Government Association (LGA, 2023), for example, submitted a response to the consultation. Issues it raises include: that workers typically have to do training in their own time or, if done in work time, providers have to fund backfill. Clear benefits to the training and/or additional funding will be needed if more providers are to support it. If career progression is to offer substantial change, it will need to be accompanied by pay progression (see later discussion on professionalisation). Similarly, the TUC (2023) noted that the pathway should be informed by, and support delivery of, a joined-up, comprehensive and fully funded social care workforce strategy, negotiated and agreed with trade unions and employers.

More generally, Hemmings et al. (2022) report that other countries offer more comprehensive career pathways containing, for example, worker rights to training, training targeted at under-represented groups, e.g. men and young people, and training integrated with the healthcare sector. There is clearly much work to do, and the government's final policy pathway will be an important matter for the sector.

Possible policy developments
As a general election looms, it is worth considering policy developments that could result from the election of a Labour government. The Labour Party commissioned a report by the Fabian Society that forms the basis of its policy commitments to create a **National Care Service** (Cooper and Harrop, 2023). This would guarantee better pay and conditions for care workers and also commits to implementing the Dilnot Commission recommendations. The Labour Party has not yet, however, set out detailed plans for reform of social care funding (Helm and Savage, 2023).

Major implications for the workforce include:

- A Fair Pay agreement that covers the whole adult social care workforce with a minimum hourly pay rate of the lowest NHS pay point (£11.45 per hour in 2023/24)
- Minimum terms and conditions negotiated between worker representatives, employers and local authorities, including guaranteed hours, transparent pay slips, paid travel time and minimum mileage rates for home care workers, sleep-in pay, minimum sick pay, minimum holidays, and paid training time.
- Minimum induction and training standards and wider regulation of training and qualifications
- National employment terms, pay bands and minimum pension entitlements for care workers
- Role re-design to reward the complexity, responsibility and autonomy of jobs, including delegated healthcare tasks
- Integrated health and social care workforce plans

It should be noted that, in October 2023, the Real Living Wage increased to £12.00 per hour[12] meaning that the Fair Pay Agreement is likely to adopt a higher figure, as the minimum NHS pay point typically sits above the Real Living Wage level.

In addition, the Labour Party has set out **A New Deal for Working People**[13]. Of particular relevance to adult social care, this will ban use of zero hours contracts. In combination, the election of a Labour government and implementation of these policies could have significant implications for the adult social care workforce.

Pay and other terms and conditions

Low pay is an ongoing issue for the adult social care workforce (SfC, 2023). As at March 2023, the median hourly rate for independent sector care workers was only 61p per hour more than the National Living Wage and care workers with five or more years' experience are, on average, earning around only 6p more per hour than care workers with less than one years' experience. This differential has decreased from 33p per hour in March 2016. Independent sector senior care workers earn on average an extra 75p per hour.

Pay is often held out as a key reason for difficulties in recruitment into the sector, particularly given growing competition from the hospitality and retail sectors and decreasing differentials between social care and other low paying occupations. The Social Care Policy Group, for example, notes that sales and retail assistants earned 13p per hour less than care workers in 2012/13, but by 2020/21, on average, they earned 21p per hour more. It

[12] What is it? | Living Wage Foundation
[13] A New Deal for Working People – The Labour Party

also argues that pay is low when compared to similar healthcare worker roles in the NHS (LGA, 2023). ADASS (2023) has argued for pay reform, both increasing pay rates and introducing pay progression/scales to rebuild differentials.

In response, **People at the Heart of Care** points to increases in the National Living Wage. However, this is unlikely to address the competition point, as the National Living Wage is a common wage floor across the whole economy. Further, there are no other specific commitments to improve the terms and conditions of care staff or bring them in line with their NHS colleagues. This is important, as it carries the risk of unsustainable movement between health and care and other sectors.

Aspirations for increasing care worker pay ultimately depend on sustainable funding within the sector and this remains an important issue to address. The MAC (2022) report, for example, shows that care workers considered pay to be low and this was a cause of actively seeking opportunities in other sectors. SfC (2023) analysis shows that, on average, providers paying higher wages have better Care Quality Commission (CQC) ratings. Improved retention and care quality could thus result from increased pay.

Yet the current government has not demonstrated any intention to more actively drive pay increases. As noted earlier, a Labour government could adopt a very different position, which reflects practice in other countries. Hemmings et al. (2022) report on these in some detail, but in brief, Germany has a sector minimum wage, New Zealand has a national pay and progression framework, and Scotland and Wales are seeking to standardise pay and raise it above National Living Wage levels. International evidence also then suggests that pay increases have supported increased retention. Further, it has supported in recruiting a more diverse workforce, for example, more men or better qualified recruits.

Building on this, local practice has sought to improve care worker terms and conditions. Hemmings et al. (2022), for example, report that the local authority in Southwark has implemented a residential care charter. This requires payment of the London Living Wage, payment for time to handover between shifts, training to be paid and within working hours and guaranteed hours contracts, unless workers request otherwise (Cromar, 2022). This seeks to address the prevalence of zero hours contracts in the sector, as other countries have done. In New Zealand, for example, guaranteed hours contracts were introduced for home care workers in 2017. This does come at a cost, as around 2.6% of hours were estimated to be unfilled and there were substantial additional administration costs (Moore et al., 2019).

Generally, there remains much work to be done to address the low pay and poor terms and conditions in the sector.

Professionalisation of care work

Within **People at the Heart of Care**, there is substantial emphasis on workforce training, qualifications and career pathways. This reflects a wider, ongoing conversation about the need to professionalise the care workforce. The Nuffield Trust has recently published a comprehensive discussion of this for England and offers international examples of effective, and less effective, professionalisation interventions (Hemmings et al., 2022). Its relevant points are laid out in what follows.

Key aspects of professionalisation are registration and qualifications, which must lead to improved pay and career progression and higher status. While the discussion so far has placed significant emphasis on qualifications, pay and career progression, it has not addressed registration and status. Care work is considered to be low status, for a variety of reasons, including low pay and its labelling as low-skilled as a result of its female-dominated workforce (Atkinson and Lucas, 2013). Professionalisation could be a means to address this. It requires registration of care workers, typically with a minimum level of qualification, and that workers are regulated by an oversight body. This would place care workers in the same position as groups such as nurses, social workers and allied health professionals, their peers in the adult social care sector.

In the UK, England is the only country not to have implemented registration and professional regulation of care workers. This is despite evidence from Scotland and Wales that it can improve the workforce's confidence, drive up standards and improve outcomes for those receiving care. These same countries also show, however, that registration can be a barrier to entry to the sector and increase turnover of those currently in post if training is too rigid. It can also be expensive, although some costs could be offset as training can retain workers and care quality may improve.

Professionalisation might also standardise access to training and development and address pay and career progression inequalities, thus building a more diverse workforce.

Hemmings et al. (2022) suggest that professionalisation reform must devise and implement initiatives as a co-ordinated package. This suggests that **People at the Heart of Care's** measures which do not, for example, address pay, are unlikely to have the desired effect. Hence, there have been calls for more focused efforts to drive professionalisation. For example, in September 2023, Care England's roadmap for social care set out its call of the next government, whichever party comes to power, for mandatory registration[14]. The New Economics Foundation made a similar call in January of that year (Sandher and Button, 2023) and suggest that registration should be managed through a revised Care Certificate process.

Health and social care integration

There has long been recognition of the need to better integrate health and social care systems and a number of previous structural reforms including Primary Care Trusts and Clinical Commissioning Groups. Most recently, the Health and Social Care Act (2022) provided, amongst other things, for establishment of Integrated Care Systems (ICS). These comprise an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) that are tasked with driving system integration. The 42 ICS have been operational since July 2022 and are thus at relatively early stages of development. They are required to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area (Health Foundation, 2022). In autumn 2023, an **Accelerating Reform Fund**[15] was launched to encourage the adult social care sector to work with ICS partners to initiate and scale up innovation.

Workforce planning

A key aspect of effective integration is the health and social care workforces and a strategic approach to this is needed. The NHS has a People Plan[16] and a similar adult social care people plan is needed that moves beyond **People at the Heart of Care** (Hemmings et al., 2022). While these plans may be separate and distinct, they should align with and reflect each other. The House of Lords (2022) notes that England is the only UK nation not to have a clear national health and social care workforce strategy, citing those both of Scotland[17], backed by £1bn of funding, and Wales[18].

In England, integrated planning has been devolved to ICSs, which are tasked with developing workforce plans, collaboratively with providers and partner organisations, that set out the local vision, shared priorities, and strategies for achieving them. This seeks to address the absence, identified in a 2022 parliamentary report (HoCH&SC Committee, 2022), of national, or even regional, integrated workforce planning in adult social care. Workforce planning supports identification of required numbers of workers and their roles and skills. This is vital to address issues identified earlier, such as potential labour market exit of older workers and policy reforms that could substantially increase the amount of local authority-provided social care.

The HoCH&SC Committee (2022) identified that, in most cases, workforce plans for the independent sector workforce do not exist. While a co-ordinated ICS response is required, providers can in the interim conduct planning for their own organisation. Skills for Care[19] presents materials on workforce planning that outline the need to work across traditional boundaries and build supporting digital skills. Its guidance and tools help both providers and commissioners to shape, commission, plan and develop the workforce.

Delegated healthcare

Delegated healthcare is another aspect of health and social care integration relevant to the adult social care workforce. It refers to clinical tasks, typically undertaken by community nurses, being delegated under supervision to care workers. While this is relatively new, it is rapidly developing. On the one hand, it presents training and development opportunities to care workers. On the other, where it is not accompanied, for example, by additional pay it can be a source of

[14] Care For Our Future: The roadmap to a sustainable future for adult social care – Care England
[15] Accelerating Reform Fund | SCIE
[16] Accelerating Reform Fund | SCIE
[17] National Workforce Strategy for Health and Social Care in Scotland (www.gov.scot)
[18] A healthier Wales (nhs.wales)
[19] Workforce planning, transformation and commissioning (skillsforcare.org.uk)

tension and work intensification. Indeed, Labour's **National Care Service** framework undertakes to regularise delegated healthcare activity. In the meantime, Skills for Care has presented material on delegated healthcare[20] and examples of successful pilots are available, particularly in Tameside[21].

Technology and digital

People at the Heart of Care includes proposals for increasing the use of technology in the sector and these were developed in **Next steps to put people at the heart of care**. Priorities are to drive a rapid adoption of digital and social care records and to test, evaluate and scale technologies based on local priorities. A further priority is to support providers to boost their digital readiness, including digital skills, connectivity and cyber security. A number of initiatives support achievement of these priorities.

Digital working in adult social care: what good looks like[22] provides a guide for local authorities and providers that covers both system and workforce issues. The **Digitising Social Care Fund**[23] (DISC) is a national programme with grants for providers to develop their digital offer and a team has been established in the NHS Transformation Directorate that brings together NHS and DHSC staff to lead the digital transformation agenda. Their current priorities include: digital systems, such as digital social care records, technology-enabled care to support people at home/ independent living; care home connectivity/digital migration and digital skills. In what follows, their workforce implications are considered.

Digital systems

Next steps to put people at the heart of care outlined proposals to increase the uptake of digital social care records by 2025 and the testing and scaling of new technologies through 2023-2025 to improve care quality and safety. DISC supports the implementation of digital social care records, with providers moving away from paper-based systems. This will eventually support shared health and social care records with a national target of 80% of providers using digital records by March 2024. However, a recent NAO (2023) report indicates that this target is not expected to be met. DISC also provides a data security and protection toolkit (DSPT)[24] to support a minimum level of security.

While these are important developments, Kings Fund (2021) research found that providers working with these systems often lacked the capacity to benefit from their analytical potential. Provider training will be needed to maximise the benefits of digital systems.

Digital skills

One of the seven planks of **Digital working in adult social care: what good looks like** is workforce support to ensure that the workforce is skilled, capable and can confidently use the required technology. Around half of providers have expressed concern that their workforce lacks the required digital skills and yet there is some evidence that digital skills training can improve worker retention and satisfaction (Hemmings et al., 2022). Workforce training is thus vital and, going further, **Next steps to put people at the heart of care** proposes development of a digital leadership qualification[25]. Digital skills are clearly an area of significance for all levels of the care workforce.

Technology-enabled care

The Kings Fund (2021) has published a useful overview of the potential of digital technologies to transform health and social care systems. It presents a rapid review of how emerging technologies such as AI, smart phones and wearable devices are being used in care settings around the world. It concludes that there is evidence that these tools have potential and can be used to support staff and patients with specific tasks, e.g., personable wearables for measuring risk of fall in older people. However, research is at an early stage and work is ongoing. For example, Health Innovation Manchester, one of a number of regional academic health science and innovation hubs working on transformation of the health and care systems, is undertaking research into wearable devices, telehealth and telemedicine[26].

[20] Data Security and Protection Toolkit (DSPT) (skillsforcare.org.uk)
[21] Data Security and Protection Toolkit (DSPT) (skillsforcare.org.uk)
[22] Data Security and Protection Toolkit (DSPT) (skillsforcare.org.uk)
[23] Data Security and Protection Toolkit (DSPT) (skillsforcare.org.uk)
[24] Data Security and Protection Toolkit (DSPT) (skillsforcare.org.uk)
[25] Essential digital skills framework - GOV.UK (www.gov.uk)
[26] Digital Transformation - Health Innovation Manchester

The Kings Fund (2021) has again considered workforce implications, noting that staff roles and work processes will need to be re-designed and must consider, for example, whether technology replaces or supports care tasks. SW ADASS's social care workforce strategy suggests that uptake of digital technologies will reduce workforce demand. Again, care workers will require training to develop the skills required to work with these technologies.

Key points

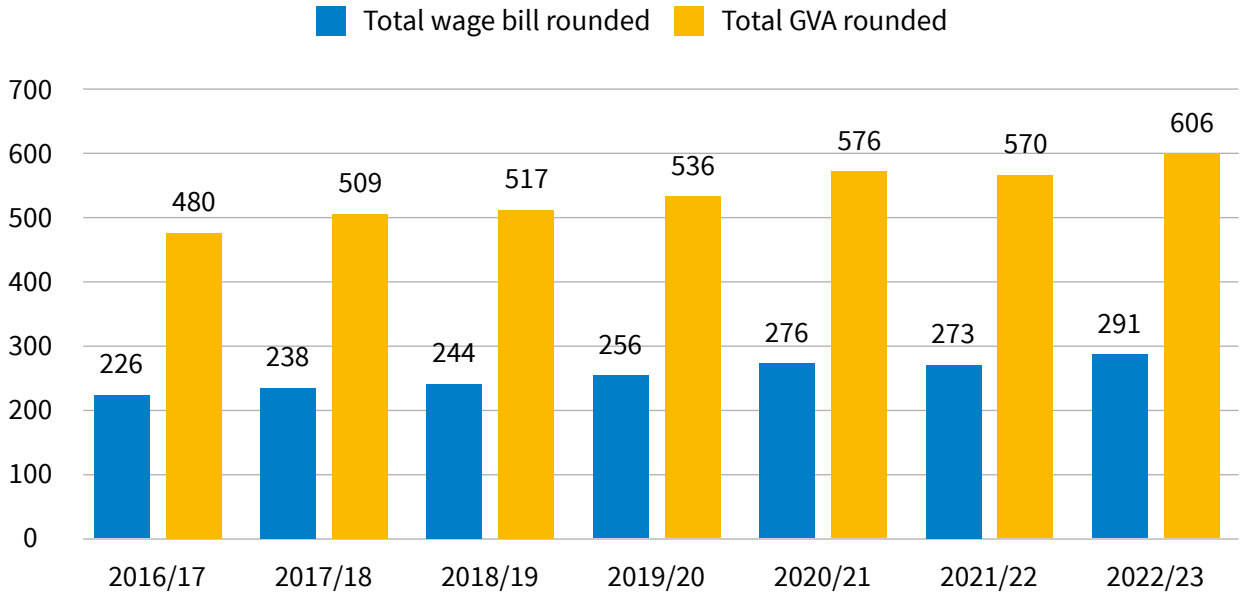
This evidence review has set out the context of the adult social care sector and its workforce in England. It demonstrates that the sector is under-funded and that the workforce is large, low-qualified, low-paid, predominantly older women and is beset by recruitment and retention difficulties. While national policy responses seek to address issues such as training, qualifications and career pathways, they are largely silent on pay and other terms and conditions of employment and the need for registration and regulation. Predicted workforce growth combined with policy developments, including a possible change of government, introduction of charging reforms, change to international recruitment programmes, health and social care integration and digital developments, present significant workforce challenges. This is the backdrop against which Cornwall is developing its adult social care workforce strategy, and analysis of it position and possible responses are presented in subsequent sections.

The economic contribution of the adult social care sector to Cornwall's economy

Skills for Care's analysis team has calculated the economic contribution of the adult social care sector to Cornwall's economy. The detail of this is laid out in the four charts that follow.

In 2022-23, the sector is estimated to have contributed £606 million gross value added (GVA) per annum to Cornwall's economy, an increase of 5.9% on 2021/2 (Figure 1).

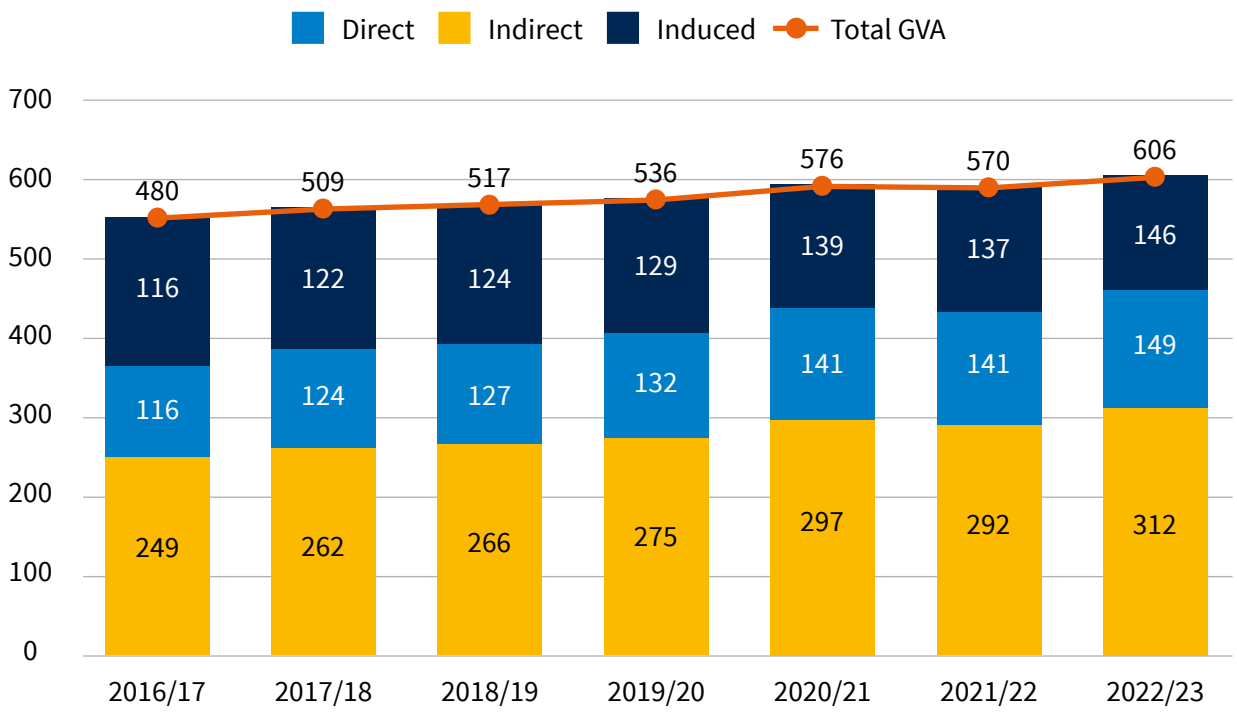
Figure 1: Adult social care wage bill and GVA in Cornwall 2016-17 to 2022-23 (£million)



Source: Skills for Care estimates

The total wage bill of the sector, calculated using ASC-WDS data, accounted for just less than half of this amount, at £291 million in 2022-3, an increase of 6.2% on 2021-22 (Figure 2). This economic contribution estimate also includes private sector profits, indirect effects (the adult social care sector's supply chain) and induced effects (money spent by people working in the adult social care sector).

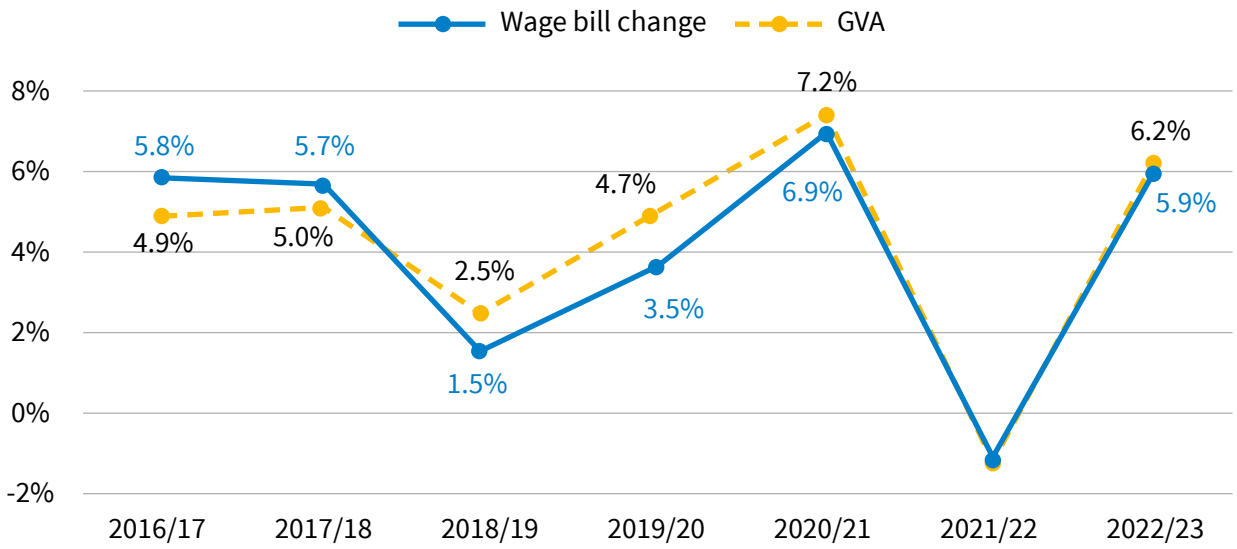
Figure 2: Direct, indirect, induced and total GVA in Cornwall 2016-17to 2022-23 (£million)



Source: Skills for Care estimates

Figure 3 shows the year-on year percentage change in wage bill and GVA from 2016-17 to 2022-23. There was a decrease in the wage bill and GVA between 2020-21 to 2021-22.

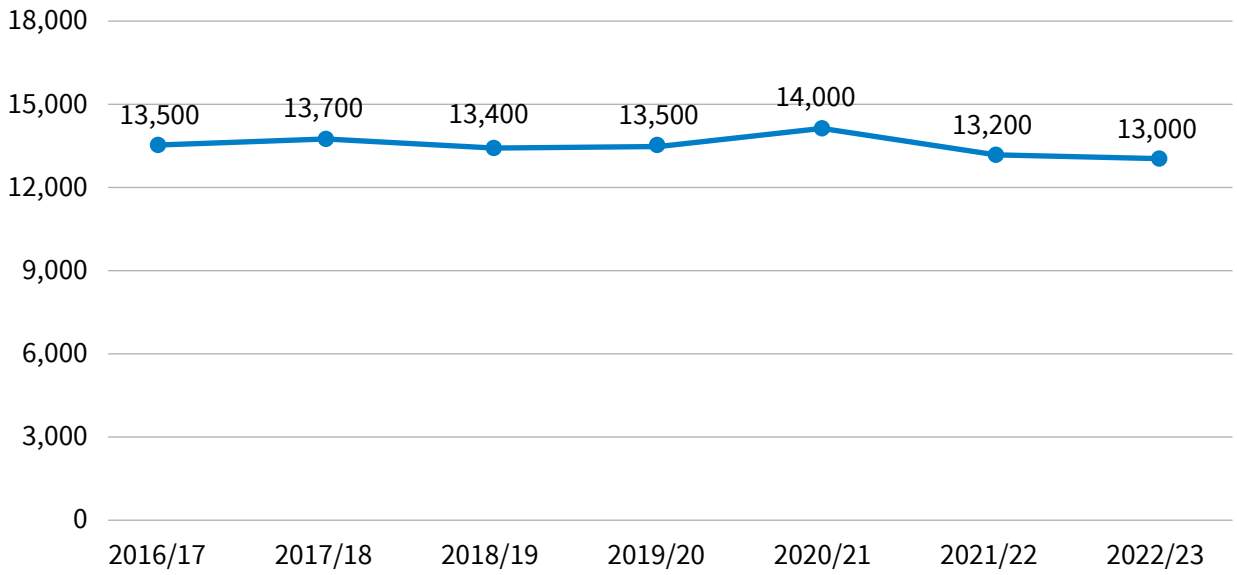
Figure 3: Change in adult social care wage bill and GVA in Cornwall 2016-17 to 2022-23 (£million)



Source: Skills for Care estimates

There was also a decrease in filled posts in this period, from 14,000 to 13,200 which may have contributed to this decrease (Figure 4). However, despite another decrease in filled posts between 2021-22 and 2022-23, GVA increased. This may result from pay increases in that period.

Figure 4: Filled posts in the adult social care sector in Cornwall 2016-17 to 2022-23 (£million)



Source: Skills for Care estimates

In November 2023, the ONS[27] calculated the UK's GVA at £614,304m and £9,850m for Cornwall, with the Strategic Economic Plan[28] reporting a similar figure. Skills for Care's (2021b) figure for GVA for the adult social care sector in England in 2021 was £25.6bn. With a GVA of £606m, the adult social care sector makes approximately 6% of Cornwall's GVA and is thus a significant economic contributor.

[27] Gross Value Added (GVA) – Office for National Statistics (ons.gov.uk)
[28] Vision-30.pdf (cioslep.com)

Overview of the adult social care workforce in Cornwall

This section presents a subset of Skills for Care (2023) data specific to the adult social care workforce in Cornwall. Unless otherwise specified, all data is for the year 2022-3. Data are presented on: size and structure of the workforce; pay; recruitment and retention; demographics; and training and qualifications. Cornwall has specified some statistical neighbours for comparison purposes, and these comprise Shropshire, Telford and Wrekin, Somerset and Devon.

Size and structure of the workforce

This section presents data on posts, vacancies and contract type.

Posts and vacancies

For the overall adult social care workforce in Cornwall, there was a total of 19,500 posts (Table 2) and filled posts stood at 17,500 (Table 3). Of these, 10,500 were care worker posts, of which 9,000 were filled. There were 1,200 bank and agency posts, of which were 800 care workers.

Table 2: Total posts by job role 2022-23

	All job roles	Care Workers	Senior Care Workers	Registered Managers
Total posts	19500	10500	1100	275

Cornwall has a bigger workforce than Shropshire and Telford and Wrekin, is equal to Somerset and smaller than Devon (Table 3). Despite being equal to Somerset for total workforce, it has more care workers and is second in size only to Devon for this section of the workforce.

Table 3: Total posts, filled posts, and vacancies by job role for statistical neighbours

		All job roles	Care Workers	Senior Care Workers	Registered Managers
Cornwall	Total posts	19,500	10,500	1,100	325
	Filled posts	17,500	9,000	1,000	275
	Vacancies	1,900	1,400	50	50
Shropshire	Total posts	12,500	6,700	700	200
	Filled posts	11,500	6,100	650	175
	Vacancies	1,000	700	25	25
Telford & Wrekin	Total posts	6,700	4,200	275	100
	Filled posts	6,100	3,600	250	100
	Vacancies	650	550	10	10
Somerset	Total posts	19,500	9,700	1,100	300
	Filled posts	18,000	8,800	1,000	250
	Vacancies	1,300	850	50	25
Devon	Total posts	29,000	14,000	1,500	475
	Filled posts	27,000	12,500	1,500	425
	Vacancies	2,400	1,500	50	50

In 2020-2021, 1,300 (7.9%) of Cornwall's total posts were vacant, which increased to 1,800 (11.3%) in 2021-23 (Table 4). This is slightly higher than the figure for England, which was 9%. The largest number of vacant posts was for care workers, increasing from 900 (9.2%) to 1,400 (14.6%) from 2020-23. This is again somewhat higher than for England, where care worker vacancies stood at 11.8% in 2022-23. Registered manager vacancies also increased across the period, standing at 50 (17.2%), which is higher than the equivalent figure for England of 10.6%. Comparatively, there were modest levels of senior care worker vacancies, which was similar to the position in England.

Table 4: Vacant posts 2020-23

	All job roles	Care Workers	Senior Care Workers	Registered Managers
2020/21	1300	900	25	25
	7.9%	9.2%	2.6%	11.2%
2021/22	1800	1200	75	50
	11.2%	12.8%	7.7%	15.2%
2022/23	1800	1400	50	50
	11.3%	14.6%	5.0%	17.2%

The increase in care worker vacancies stands in contrast to England where, as noted earlier, vacancies have fallen as a result of increased international recruitment. In Cornwall, there were 300 (7.5% of total posts) overseas recruits in 2022-23, of which 225 were care workers and 25 senior care workers (see below for further discussion of this). This constitutes a significant proportion of the direct care workforce. Given these overseas recruits, the increase in vacancies suggests an ongoing departure of domestic workers from the sector.

Contract type

For all job roles, there was an even split between those working full and part time, around 56% of care workers working part time (Table 5). Only around one third of senior care workers and 6% of registered managers worked part-time. These patterns were fairly stable across 2020-23.

Table 5: Working patterns 2022-23

	All job roles	Care Workers	Senior Care Workers	Registered Managers
Full time	50.0%	44.4%	66.2%	93.6%
Part time	50.0%	55.6%	33.8%	6.4%

14.8% of the total workforce in Cornwall was employed on zero hours contracts. These numbers were again fairly stable, increasing by around 1.5% over a three-year period. By group, nearly one fifth of care workers were on zero hours contracts (18.7%), as compared to 32% in England, and this was slightly higher for home care (21.9%), as compared to 50% in England. There were no registered managers in bank and agency roles, and 8% of care workers and 7% of senior care workers. While zero hours contracts are lower than the figures for England (32% on these contracts, and 42% of home care workers), there remains a fair degree of insecurity, particularly for home care workers.

Pay

Independent sector pay rates for care workers were £10.53 per hour (Table 6), which was higher than those working for local authorities (£10.42) and higher than England's average of £10.11. These rates might reflect both that Cornwall requires its commissioned providers to pay the Real Living Wage, and that recruitment and retention difficulties have driven pay rates above national averages. This might also explain the smaller differential between independent sector care workers and senior care workers, only 52p per hour as opposed to a national average of 75p. Independent sector care workers also have a higher annual salary than those in the local authority, although the differential here may be skewed by very small numbers. In the independent sector, there were also differences by service. For example, average annual pay in home care was £24,209, while residential, day and domiciliary care were similar at £21,562, £21,563 and £21,636 respectively.

Table 6: Average hourly and annual pay 2022-23

	Local authority		Independent sector	
	Annual	Hourly	Annual	Hourly
Care Workers	£20,100	£10.42	£20,300	£10.53
Senior Care Workers	£23,200	£12.08	£21,300	£11.05
Registered Managers	£35,400	£18.38	£37,000	£19.25

Upwards pressures on pay can also be seen in trends over the last three years which have increased year on year for both sectors and all roles (Table 7). For example, independent sector care workers have seen increases from £9.35 per hour to £10.53 per hour, an increase of nearly 13%. The equivalent increase was also 13% for senior care workers and for registered managers it was just over 20%.

Table 7: Pay trends by job role and sector 2020-23

		Local authority				Independent sector			
		All job roles	Care workers	Senior Care Workers	Registered Managers	All job roles	Care workers	Senior Care Workers	Registered Managers
2020/21	**Annual**	£26,459.62	£18,993.34	£22,404.88	£29,919.51	£19,209.44	£17,986.51	£18,892.30	£30,719.07
	Hourly	£13.74	£9.87	£11.65	£15.55	£9.98	£9.35	£9.82	£15.97
2021/22	**Annual**	£28,514.72	£19,413.04	£22,703.35	£31,732.71	£19,980.16	£18,666.83	£19,563.69	£31,640.99
	Hourly	£14.81	£10.09	£11.80	£16.49	£10.38	£9.70	£10.17	£16.45
2022/23	**Annual**	£29,857.34	£20,051.56	£23,232.69	£35,355.75	£21,731.37	£20,255.02	£21,262.55	£37,035.48
	Hourly	£15.52	£10.42	£12.08	£18.38	£11.29	£10.53	£11.05	£19.25

Recruitment and retention pressures may also be reflected when comparing Cornwall's figures to the National Living Wage (Table 8). While this has increased by 7% from 2021-23, and those working for the local authority have had only a 3% rise, independent sector care workers have had an increase of 9%. It should also be noted that, while Cornwall's average for care workers compares favourably with both England and its statistical neighbours, it sits some way below the increased Real Living Wage of £12 per hour from October 2023.

When compared to statistical neighbours, independent sector care workers in Cornwall have the highest pay rates (Table 9). This is also the case for senior care workers, other than for Devon, where the pay rate is 17p per hour higher. For registered managers, Cornwall has the second highest pay rates behind Somerset. On balance, pay rates in Cornwall appear to be competitive when compared to statistical neighbours.

Table 8: Care worker pay increases compared to the National Living Wage

	Local authority		Independent sector		NLW	
	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23
Hourly	£10.09	£10.42	£9.70	£10.53	£8.91	£9.50
% increase	3%		9%		7%	

Table 9: Mean hourly and annual pay by job role and sector by job role

		Local authority		Independent sector	
		Annual	Hourly	Annual	Hourly
Care Workers	Cornwall	£20,100	£10.42	£20,300	£10.53
	Shropshire	£19,500	£10.15	£19,700	£10.26
	Telford & Wrekin	£19,600	£10.18	£19,500	£10.15
	Somerset	*	*	£20,200	£10.50
	Devon	£22,500	£11.72	£19,900	£10.37
Senior Care Workers	Cornwall	£23,200	£12.08	£21,300	£11.05
	Shropshire	*	*	£20,900	£10.87
	Telford & Wrekin	*	*	£20,500	£10.66
	Somerset	-	-	£21,100	£10.98
	Devon	-	-	£21,600	£11.22
Registered Managers	Cornwall	*	*	£37,000	£19.25
	Shropshire	*	*	£30,800	£15.99
	Telford & Wrekin	*	*	£33,200	£17.23
	Somerset	-	-	£39,100	£20.30
	Devon	*	*	£35,500	£18.46

Recruitment and retention

This section presents data on new starters, turnover and length of service, and sickness absence.

New starters

Across all job roles, there were 5,200 new starters in 2020/21, dropping to 4,200 in 2022/2023. In the same period, care worker new starters fell from 4,000 to 3,100, and for senior care workers from 200 to 175. For registered managers, the new starter figure was static across the period at 75 per annum. 39.8% of recruits were new to the sector. The figures for new starters include the overseas recruits outlined above, namely 300 (7.5% of total posts) overseas recruits in 2022-23, of which 225 were care workers and 25 senior care workers. By service, more than two thirds of overseas recruits went to residential care, with just under one third to home care.

There are large variations across the statistical neighbours' group for overseas recruits. Despite having the second highest number of care workers, Cornwall had fewest overseas recruits other than Telford and Wrekin. While Cornwall has more care workers overall than Somerset, it has less than one quarter of its overseas recruits. This indicates that Cornwall could make greater use of international recruitment opportunities, although, as has already been noted, this is not necessarily a sustainable labour supply and could be a short-term measure.

Table 10: New starters arriving from outside the UK by job

		All job roles	Care workers
Cornwall	International recruits	300	225
	% of all starters	7.5%	7.4%
Shropshire	International recruits	500	400
	% of total posts	18.4%	19.1%
Telford & Wrekin	International recruits	150	150
	% of total posts	14.2%	14.5%
Somerset	International recruits	1,200	1,000
	% of total posts	25.4%	27.1%
Devon	International recruits	1,100	900
	% of total posts	17.0%	16.0%

Refers to the adult social care sector as posts in the independent sector only

Turnover

In 2022-23, turnover for all posts was 3,800 leavers or 27.4% (Table 11), which is broadly similar to turnover for England as a whole. Of this, 2,900 were care workers, 200 senior care workers, and 75 registered managers. Many leavers (60.9%) remained within the sector, moving from one provider to another. Turnover rates in absolute numbers appear to have dropped slightly over the last three years, for all roles including care workers, although for the latter group there has been a small percentage increase on 2020-21.

Turnover rates were highest in residential care (30.8%) and domiciliary care (27%), again broadly similar to England, and they ran at 28.1% in the independent sector. Turnover was also around 35% for care workers. These figures again evidence significant workforce pressures in Cornwall.

Table 11: Turnover by job role 2020-23

	All job roles	Care Workers	Senior Care Workers	Registered Managers
2020/21	4300	3100	200	50
	28.7%	34.2%	20.2%	20.8%
2021/22	4300	3200	175	75
	31.0%	37.8%	19.7%	30.4%
2022/23	3800	2900	200	75
	27.4%	35.3%	20.8%	29.0%

Other important matters include length of service and sickness absence. Average length of service in the sector is 9.2 years, with 6 years in role. The equivalent figures for care workers are 8.1 and 4.2. Senior care workers have an average of 13 years in the sector and 7.2 years in role, and for registered managers the figures are 21 and 10.5 years. As noted in turnover, much movement is within the sector, hence care workers spend around 8 years in the sector, but only 4 years in role. It is widely recognised that the majority of turnover occurs within the first 6 months in role, so effective induction could significantly reduce this. This is a point that is returned to in the stakeholder perspectives section. On sickness absence, care workers had an average of 6.3 days and senior care workers had 5.5 days. These figures are broadly similar to the UK average of 5.7 days per worker[29].

[29] Sickness absence in the UK labour market – Office for National Statistics (ons.gov.uk)

Demographics

This section presents data on protected workforce characteristics including gender, age, ethnicity and nationality, and disability.

Gender

The gender profile of the workforce in Cornwall is similar to England as a whole, with 79% of filled posts being held by women and 80.7% of care workers being female (Table 12). The figures for senior care workers and registered managers are slightly higher (82.7% and 81.2% respectively). These proportions have been broadly similar over the past three years and are reflected across most services, with day care being slightly lower (69.6%). Men are better represented in local authority employment, where they hold over one quarter of filled posts (26.8%).

Table 12: Gender profile by job role 2022-23

	All job roles	Care Workers	Senior Care Workers	Registered Managers
Male	3200	1700	175	50
	21.0%	19.3%	17.3%	18.8%
Female	12000	7200	900	225
	79.0%	80.7%	82.7%	81.2%

Age

Average age across filled posts was 44.6, with care workers being slightly younger (42.8) and senior care workers and managers slightly older (45 and 49.2 respectively, Table 13). The average age in home care was 48.2 years. Nearly one third (32%) of all posts is, however, filled by those aged 55+, slightly higher than the proportion for England (29%). Over one quarter (27%) of care workers are aged 55+, as are 30% of senior care workers and 37% of registered managers. Only 12% of care workers are aged under 25.

Table 13: Average age of workers 2022-23

	All job roles	Care Workers	Senior Care Workers	Registered Managers
Mean	44.6	42.8	45.0	49.2
Under 18	1%	0%	0%	0%
18 – 19	2%	2%	0%	0%
20 – 24	7%	10%	4%	1%
25 – 29	10%	11%	12%	3%
30 – 34	10%	12%	12%	6%
35 – 39	10%	10%	12%	13%
40 – 44	9%	8%	10%	16%
45 – 49	9%	9%	10%	10%
50 – 54	11%	10%	11%	14%
55 – 59	14%	13%	12%	13%
60 – 64	11%	9%	11%	15%
65 – 69	5%	4%	6%	6%
70 and over	2%	1%	1%	3%

These figures reflect an ageing workforce, with the potential for over a quarter of care workers and over one third of registered managers to retire in the next decade. As currently smaller numbers of younger workers are coming into the sector, this creates the prospect of serious labour shortages. This point is returned to in the scenario planning section.

Ethnicity and nationality

Despite recent international recruitment, the adult social care workforce in Cornwall is overwhelmingly White (96.4%), which is less diverse than England where the equivalent figure is 86% (Table 14). This figure rises to 98.6% for registered managers. This is broadly the same across sectors and services.

Table 14: Workforce ethnicity 2022-23

	All job roles	Care Workers	Senior Care Workers	Registered Managers
White	14600	8600	1000	275
	96.4%	96.0%	95.1%	98.6%
Mixed	100	50	<10	<10
	0.6%	0.6%	*	*
Asian	275	175	50	<10
	1.9%	2.1%	3.8%	*
Black	125	75	<10	<10
	0.8%	0.9%	*	*
Other	50	25	<10	<10
	0.4%	0.4%	*	*

In terms of nationality, most of the adult social care workforce in Cornwall is British (93.7%), with 3.4% holding EU nationality and 2.9% being non-EU. This is again higher than for England, where 80% of the care workforce has British nationality. Proportions are, however, largely reflective of Cornwall's population, ONS (2023) data indicating that 96.8% identified as White British in 2021.

The proportion of the social care workforce being British in Cornwall has fallen slightly over 3 years (from 95.2% in 2020-21) as the proportion of the workforce that is non-EU has grown (from 1.4% in 2020-21), again presumably due to international recruitment. The registered manager proportions that are British are again slightly higher at 96.6% when compared to care workers (92.9%) and senior care workers (92.6%). These proportions are again broadly similar across sector and service.

Disability

2.5% of the adult social care workforce in Cornwall has a declared disability, the figures falling to 1.7% for care workers and 1.2% for senior care workers. This is low, compared to the 24% of the UK population that declares itself to have a disability, over half of whom are in employment[30]. This is a potentially untapped labour source for the adult social care sector.

[30] CBP-7540.pdf (parliament.uk)

Training and qualifications

This section presents data for training, qualifications and apprenticeships for the adult social care workforce in Cornwall.

Training

Since 2015, 5,400 care workers have completed or are in the process of completing the Care Certificate (Table 15). As current care workers number 10,500, that is a maximum of just over half of care workers, as compared to 63% in England. Of course, some of those who have completed the certificate since 2015 may have left the sector, meaning in fact less than half of care workers are likely to have completed it. Moreover, these figures have been largely static over the 2020-23 period, suggesting that numbers taking the certificate are only replacing those leaving the sector.

Table 15: Workers who have completed/are in progress with the Care Certificate since 2015

	All job roles	Care Workers	Senior Care Workers	Registered Managers
Filled posts	7300	5400	600	100

Data on other forms of training are more positive, although there is limited detail on this, that is, it could be largely statutory training. Nevertheless, around 67% of workers had over 12 instances of training, and 77% of senior care workers had 22 instances. For registered managers, around 76% had 20 instances (Table 16). The average for the sector in England is 71%.

Table 16: Workers and % of workers with training recorded, and mean instances of training

	Care Workers	Senior Care Workers	Registered Managers
ASCWDS base	1900	275	75
%	66.9%	77.1%	75.9%
Mean training instances	12.2	22.4	20.0

Qualifications

Half of the social care workforce in Cornwall holds no relevant social care qualification, compared to 54% in England. This rises to 52% for care workers but falls to 27.7% for senior care workers and 8.6% for registered managers (Table 17).

Table 17: Proportion of workers by highest level of relevant social care qualification in Cornwall

No relevant qualification	50%
Entry/Level 1	1%
Level 2	18%
Level 3	20%
Level 4+	10%

Just under one quarter of care workers and senior care workers hold a Level 2 qualification. The proportions are 20% for care workers and 40% for senior care workers at Level 3. Very few care workers (2%) and senior care workers (8%) hold a Level 4 qualification, as compared to 87% of registered managers.

There are declining qualification trends, with 800 fewer workers, 700 care workers, holding a relevant Level 2 qualification in 2022-23 than in 2020-21. Numbers at Level 3 were largely static for care workers across the same period, indicating that qualification levels are not increasing. In combination with the Care Certificate data, this suggests training and qualification levels are at a lower than optimal level.

Apprenticeships
The number of adult social care workforce apprenticeship starts is also modest. While registrations at Level 2-3 increased from 323 to 401 from 2019-21, by 2021-22 they had fallen back to only 290. More positively, while small numbers, there was an upward trend over the same period for Level 4-5 apprenticeship starts. Nevertheless, small numbers of the direct care workforce are engaged in apprenticeships.

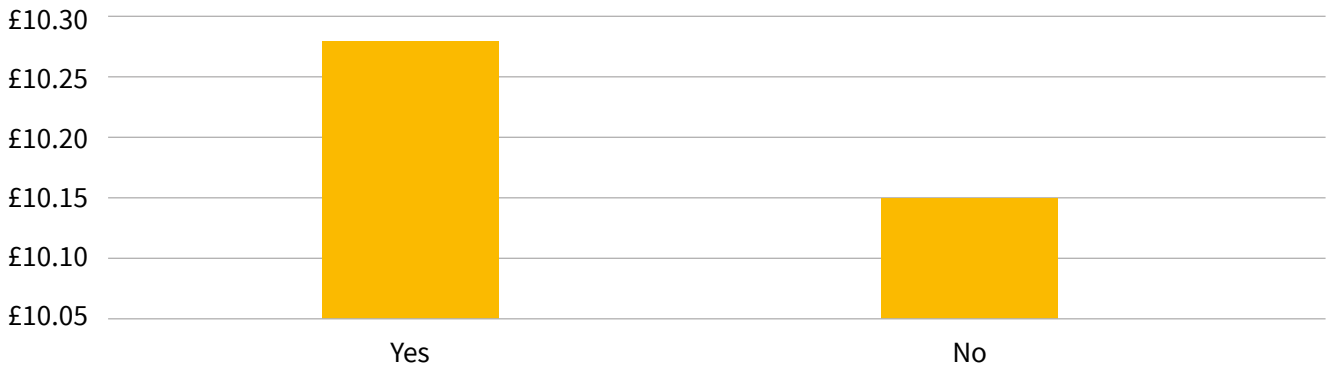
Table 18: Number of workers starting an adult social care apprenticeship 2019-2022

	2019/20	2020/21	2021/22
Level 2-3	323	401	290
Level 4-5	61	78	106

Source: Analysis of data from DfE

Pay and qualifications.
It is interesting to examine patterns of pay by qualification level (Table 19). A pay premium of 13p per hour accrues to those who hold a relevant qualification as compared to those who do not.

Table 19: Care worker pay by whether they hold a relevant qualification



Key points
The adult social care workforce patterns in Cornwall evidenced in this section mirror, to a large extent, those in England. The workforce is large, low paid and has low qualification rates. Recruitment and retention difficulties are reflected in high vacancy and turnover rates. It is worth noting, however, that pay rates for care workers in Cornwall have seen substantial rises since 2020 and are higher than for both its statistical neighbours and for England. Vacancy rates are somewhat higher than for England and use of zero hours contracts is lower. These factors perhaps reflect the competitive nature of the labour market, particularly the tourism sector. International recruitment has not had the effect of substantially reducing vacancies that it has had across England. Overseas recruits' numbers are particularly small when compared to statistical neighbours. While this may present a recruitment opportunity, it is unlikely to be a sustainable one given the volatility of international recruitment discussed throughout this report. Finally, the workforce is female dominated and older, with potentially one third retiring over the next decade. The workforce challenges in Cornwall are acute and require an effective strategic response.

Stakeholder perspectives on the adult social care workforce in Cornwall

This section presents stakeholder perspectives on the adult social care workforce in Cornwall. It picks up on issues raised in previous sections, including: recruitment and retention; workforce planning; and pay, benefits and contracted hours. It also discusses training qualifications, career progression and professionalisation, together with important issues such as health and well-being and equality diversity and inclusion. Finally, it considers the integration of health and social care, commissioning and digital developments in the sector.

Recruitment

As noted earlier, Skills for Care data show around 1,400 care worker and 50 senior care worker vacancies (14.6% and 4.6 of total posts respectively) and a further 50 registered manager vacancies (17.1% of total posts). 1,200 bank and agency staff are used to address these labour shortages, of which 800 are care workers and 75 are senior care workers. These figures demonstrate substantial workforce pressures, and this section presents stakeholder views on increasing workforce supply, international recruitment, the image of the adult social care sector and the need for cross-local authority working to address some of the inherent recruitment challenges. It should also be noted that Skills for Care plans to invest in supporting recruitment, including appointing a commissioning lead, and this will be a resource for Cornwall to draw upon.

Increasing workforce supply

Recruitment into adult social care is challenging. Vacancies lead to the use of agency staff and stakeholders noted that this an inefficient use of budget, plus it creates instability for the workforce who often work across agencies. There is an urgent need to increase workforce supply. **Proud to Care** initiatives, such as recruitment events in local towns, were noted to have had positive impact through media coverage and bringing people into employment. Discussions then centred on other ways to increase labour supply.

Engaging with schools and colleges

Maximising the recruitment of young people was seen to be vital. Initiatives are needed across the education spectrum, from visits to primary schools to improve the image of care as an occupation, through to secondary schools and colleges, to present training and qualification options and ensure that care work is seen as a career of choice. Stakeholders questioned whether Skills for Care's Care Ambassador role[31] still existed and argued for its more widespread use.

Establishing clear pathways from education into the care sector is essential. Examples of this included offering work placements for those doing relevant qualifications, as too often there is a disconnect between doing health and social qualifications and having an ambition to work in social care, as opposed to healthcare. Offering placements to those doing NHS qualifications, such as nursing or paramedics, was also seen as a positive step to open social care to a wider range of applicants. It was noted that providers are sometimes reluctant to employ people under the age of 18. Again placements, or part-time work opportunities for those studying, could often lead into employment and were proposed as a way to both make young people aware of opportunities in social care and reassure providers that young people were suited to the work.

Engaging with unemployed people

Numerous stakeholders suggested that unemployed people are an untapped resource and that neighbourhoods with high unemployment could be targeted. A place-based, more localised recruitment model, for example, on particular estates with high unemployment levels, could be very effective in attracting people into care and

[31] I Care... Ambassadors (skillsforcare.org.uk)

delivering care close to home. This could create a walk to care model, addressing the concern that many in deprived neighbourhoods do not have access to a car. It would have a 'double bottom line' as it would also target poverty in deprived areas. Work would, in some instances, need to be designed in ways that accounted, for example, for health conditions. Nevertheless, bringing unemployed people into care work could substantially increase workforce supply.

Discussing why this was not already being done, some stakeholders suggested that it was seen as 'too hard' but that various voluntary organisations have had success in other sectors with supported back to work placements. With flexibility on hours and location of work, unemployed people could offer an important form of workforce supply.

Other demographic groups
Other potential workforce groups were also identified.

Care leavers: the NHS is currently undertaking work, via the Care Leaver Covenant[32], to support care leavers into employment. A similar programme of work could be beneficial in social care.

Men: in Cornwall, over 80% of care workers are female, reflecting the pattern across England. There is an opportunity to recruit more men into care and, while many of the matters discussed below such as increased pay and better care pathways will support this, there are also other mechanisms. For example, Norway's bespoke programme to recruit and train men in social care which has been very successful. Men entering care in this way have also adopted a 'snowballing' approach where they recruit other men they know into the sector.

Refugees: targeting refugees who do not wish to return to their countries of origin and who are seeking jobs with visa sponsorship offers another source of labour supply, especially as many are well-qualified in relevant areas.

Former care workers: stakeholders suggested that many care workers had left the sector either as a result of the requirement to be vaccinated against Covid-19, or subsequent to that, due to the stress and burnout of having worked through the pandemic. Programmes to attract these workers back into care could now be very fruitful.

Volunteers: loneliness and its association with poor health was noted and here the ageing population was seen as a potential supply of resource to the care system, as well as a demand upon it. Encouraging unemployed and retired people to volunteer to offer companionship was a clear opportunity. This could create space for care workers to focus on other forms of care. The NHS Volunteer Responder Scheme[33] has also been opened to the care sector and offers another form of support.

Personalisation
A strategic emphasis on personalisation and direct payments was noted, with an aspiration to increase the proportion of care being delivered through this route from around 20% to 35-40%. While personal assistants employed via direct payments are not within the scope of this work, it is raised here as it has workforce implications. Personal assistants could, for example, be drawn from the existing care worker population, making it harder for providers to recruit and retain staff. It was, however, also presented as a mechanism for drawing new people into the workforce, where someone receiving direct payments recruited family or friends into that role.

Values-based recruitment
Values-based recruitment emphasises personal attributes and values in recruitment as opposed to experience and qualifications. Resources are available via Skills for Care[34]. While it was not a matter raised by stakeholders, it is likely that many providers use values-based recruitment, and this can be an effective mechanism for increasing labour supply. That said, it sits in tension with later discussions on training, qualifications and the need to professionalise the workforce.

International recruitment
As noted in the evidence review, the Government has included care work on its Shortage Occupation List, which has opened up international recruitment as a means to increase labour supply. In Cornwall, 225 care workers and 25 senior care worker appointments have been made (7.4% and 16.3% of total posts respectively). While some

[32] About the CLC - Care Leaver Covenant (mycovenant.org.uk)
[33] Sign up today to become a volunteer | NHS and Care Volunteer Responders (nhscarevolunteerresponders.org)
[34] Values-based recruitment (skillsforcare.org.uk)

viewed it positively, there were also significant concerns raised, both in terms of the ethics of international recruitment and its sustainability as a mechanism to increase workforce supply.

Ethical concerns were twofold, with instances being given of the practices of agencies charging migrants for visas and the potential for modern slavery. This could result in the revoking of licences to issue visas and reduced numbers of overseas recruits. There were also concerns over the implications of recruitment for the countries of worker origin and the compromising of care systems in less developed parts of the world.

In relation to sustainability, international recruitment was suggested to be a 'short term' fix that does not address the broader issues of why adult social care work is not a more attractive occupation. Its substantial cost was seen as an inhibitor to it being a long-term workforce strategy. Further, it was questioned how long overseas care workers would remain in their roles, particularly if they were qualified as nurses etc. Where over-qualified, they are under-employed and may experience low job satisfaction with an attendant risk that they move to the healthcare system. A second issue was the political volatility associated with the current visa system outlined in the evidence review. International recruitment was seen to be a significant risk for providers heavily reliant on overseas recruits.

Other concerns around international recruitment included: the challenges of finding suitable accommodation for care workers, particularly in Cornwall; the complexity and length of the visa process; and the demands of the pastoral support required particularly around cultural differences. There were examples of some community agencies supporting with accommodation and integration into the country, but for the bulk of providers, these were demanding requirements.

In sum, international recruitment was suggested to be a relatively short-term solution and did not remove the need to diversify sources of workforce supply.

Image and status of adult social care work
One significant barrier to recruitment was identified as the image of adult social care and adult social care work. The pandemic's recognition of its value quickly faded and now, given NHS pressures, adult social care was suggested to be often more negatively seen as a blocker to effective discharge. Similarly care work was argued to have a negative image as low skilled and low status work. Yet in a post-pandemic era where many are re-evaluating their lives, stakeholders suggested that care work could be positioned as a meaningful role and fulfilling work. Mechanisms to raise awareness and recognition of the sector, building on the work that **Proud to Care** and local partners have already done are needed.

Later sections discuss pay, training and qualifications and professionalisation, which could also serve to enhance the image and status of care work.

Cross-local authority working
Stakeholders were clear that some of the more intractable issues related to recruitment, particularly accommodation and transport, would require cross-local authority working and solutions.

Taking first accommodation, both rental and purchase prices are high, and availability is limited. There is also a shortage of social housing. Many, especially younger people, find it difficult to secure accommodation, at all and particularly on adult social care pay rates (see later for detailed discussion of pay). Accommodation constraints were seen to limit recruitment for both those currently based in Cornwall and for overseas workers.

Stakeholders suggested various solutions to this, centring mainly on key worker housing schemes and provision of houses of multiple occupancy. Some projects were identified that involved international recruits and community agencies attempting to provide short-term accommodation solutions.

Second, transport created various challenges. Public transport is limited, particularly in rural areas, which creates a heavy reliance on private vehicles. This results in increased costs and time for care providers traveling to remote areas, making care provision more expensive in rural locations as compared to urban areas. Again, there were various solutions, such as offering pool cars, running minibuses and having an NHS-type salary sacrifice scheme to support purchase of vehicles. These recommendations would require policy and resource considerations as part of any budget process. This has implications for other local authority strategies.. Taking, for example, the carbon neutral strategy, there is a need to reduce carbon usage of home care workers. The electric bikes and vehicles needed

will be out of the affordability range of many, without an NHS-type salary sacrifice scheme that supports their cost-efficient purchase. A further consideration around this, however, is that home care workers often rely on work mileage to fund their private vehicles, plus they often run older cars that are less carbon-efficient, again compromising the carbon neutral strategy. This is clearly a complex issue.

Retention

Labour turnover rates stand at 2,900 for care workers and 200 for senior care workers (35.3% and 20.8% of total posts respectively). Approximately 60% of leavers move to another care provider and 40% leave the sector. This level of turnover clearly creates significant pressures within the sector, and also comes at significant cost. Skills for Care estimates that the average cost of filling a vacancy (including recruitment costs, loss of productivity, agency staff and so on) is around £2,500 per worker, meaning that current turnover costs c.£7.25m per annum.

Stakeholders offered various reflections on the reasons for turnover, and how it could be reduced. Tourism was suggested to be a key driver of turnover, with care workers often leaving for better paid roles in that sector in peak season. Some providers were able to offer increase pay rates, which was often effective in improving retention in these periods, but this was not possible for all providers. Better understanding of the often-hidden costs of turnover might, however, create understanding of the benefit of offering higher pay to prevent it.

Guaranteed hours and shift working were also suggested as mechanisms to improve retention, particularly in home care. This supports Skills for Care analysis and was seen to increase employment stability and income. While there is currently no requirement in local authority contracts for providers to offer shift work, the contracts offered in Cornwall's recommissioning exercise in 2024 will encourage this. While there was some resistance to guaranteed hours on the grounds that care workers often preferred zero hours arrangements, the debate around professionalising the workforce presented below might mean that new entrants to the sector are more open to guaranteed hours contracts. These mechanisms come at increased cost, as outlined in the evidence review, but again reducing labour turnover might offset at least some of these.

Work pressures and intensification and lone working at unsocial hours for home care workers were also argued to be reasons for turnover. Finally, some suggested that not feeling valued and a poor workplace culture led workers to leave. Evidence more generally suggests that managers are a key determinant of labour turnover and work with managers to improve workplace culture might serve to reduce turnover.

Workforce planning

Stakeholders noted that work is taking place to produce a workforce plan at the Integrated Care System (ICS) level. There were suggestions, however, that the ICB and ICP are health-focused and more attention to social care is needed. Reflecting the national situation, Cornwall does not currently have a workforce plan for the independent sector and there is very little local authority/independent provider workforce planning. Better mechanisms are needed to support this planning, and care providers need to have a clearer understanding of what workforce planning entails. Skills for Care provider toolkits that could support with this[35].

Workforce demand and supply

Cornwall's current workforce modelling is discussed in detail in the following scenario planning. It is, however, worth noting here that changes in care delivery will have substantial workforce implications. For example, growth in supported and specialist housing will require significant workforce growth, as will an increased offer of home care.

Stakeholders expressed concern that there was a risk that the proposed new build care homes will attract staff from current provision, as older care homes may seem less attractive, meaning those providers will face even greater recruitment challenges. Proposed growth in extra care and supported housing may also attract the home care workforce. While there may be workforce efficiencies in concentrating the offer of care in fewer buildings, workforce shortages may still result given anticipated increases in levels of home care.

[35] Workforce planning, transformation and commissioning (skillsforcare.org.uk)

Other delivery changes, including predicted increased levels of dementia and higher use of digital technologies (discussed further below), will both increase workforce demand and require higher-level skills. Shift working could also increase demand for labour if less productive.

Workforce planning will also need to consider issues of workforce supply. These are again discussed in more detail in the scenario planning section but include an over-reliance on women, older workers and international recruits. Some provider stakeholders noted that those receiving care, particularly in their own homes, preferred a female care worker so there is clearly a need for sensitivity around gender. These attitudes were, however, noted to be reducing as social norms change. Stakeholders also noted, however, that many care workers were in receipt of Universal Credit benefits and suggested that this limited them to 16 hours work per week before their benefits were negatively affected. This cap has in fact been removed with a taper system in place[36] and better understanding of this might translate into some increasing the hours they work each week.

Capacity optimisation strategies

Various strategies were suggested to optimise current workforce capacity. Place-based working was central to these. For example, the contracts issued in the 2024 recommissioning exercise will encourage alliances of providers in a geographical zone and permit any provider in that alliance to deliver a care package. This could reduce waiting time in home care worker runs, optimising resource and perhaps support pay increases. As workers could have to travel less distance, it could also reduce difficulties with transport, public and private.

Support was also suggested to be needed so that workers could move across home care and care homes and not be limited to one service. This would also enable workers to support those receiving care in moves to different forms of care delivery e.g., when moving from home to residential care

Pay, benefits and contracted hours

In this section, pay, benefits and contract types and their role in care worker recruitment and retention are discussed.

Pay

In Cornwall, Skills for Care data shows that independent sector care worker average hourly rates to October 2023 were £10.53 (as compared to £10.42 for those who are local authority employed) and £11.05 for independent sector senior care workers (as compared to £12.08 when local authority employed). This compares to a National Living Wage rate of £10.42 (increasing to £11.44 from April 2024) and a Real Living Wage rate of £10.90 (increased to £12 per hour from October 2023). An ongoing theme from stakeholders was the need for parity with the NHS, where current Band 2 rates are £11.45, with Band 3 ranging from £11.67 to £12.45. There is clearly a way to go to bridge this gap. Should there be a change of government, implementation of sector-wide Fair Wage Agreements, as proposed in the Labour Party's **National Care Service** paper, would require even larger pay increases.

Cornwall's contracts require providers to pay the Real Living Wage, although stakeholders noted that monitoring locally authority-contracted providers to ensure its payment was challenging. As noted in the analysis of SfC's ASC-WDS data, Cornwall's hourly pay rates compare favourably across the sector. Despite this, provider stakeholders argued the need to pay more and that the funding received from the local authority did not support this (see later section on commissioning). While stakeholders recognised the need to increase pay rates, they also noted that the required funding was not available at local authority level and that the Council was paying comparatively more than most Councils. For example, in October 2023, the authority's Scrutiny Committee reported previous estimates that an increase in pay to £13.50 per hour would cost approximately £39m for the commissioned workforce alone, not including the self-funded workforce. This was simply unaffordable given current central government funding levels.

Stakeholders further argued that pay rates do not reflect the responsible nature of the job, delivering personal care, sometimes medication, and requiring the building of strong relationships. Home care workers particularly were argued to have more responsibility than many NHS-based healthcare assistants given the lone working and unsupervised nature of their roles. This

[36] Universal Credit and you - GOV.UK (www.gov.uk)

undervaluing was partly historic, embedded in the 'home help' origins of the role, and partly due to the gendered nature of the sector, where care is positioned as 'women's work' and thus de-valued.

Low pay gave rise to stark financial pressures, particularly given the cost-of-living crisis and, for example, increases in fuel costs for home care workers. Perhaps unsurprisingly then, the workforce was noted to be highly transient, willing to move providers for just a few pence more per hour. A move to the NHS, given the above rates for Band 2 health care assistants, was also noted. Pay levels did not attract workers into the sector and were a leading cause of labour turnover.

Benefits
Stakeholders also argued that care worker benefits were at statutory minimum levels for, for example, pensions, sick pay and annual leave, again noting a lack of parity with the NHS. They suggested that a better terms and conditions package is needed to attract and retain care workers.

Contracted hours
In Cornwall, a little over half of care workers and around one third of senior care workers work part-time. Approaching 20% of care workers, some 2,000, and just over 10% of senior care workers, more than 100, work on zero-hours contracts. Provider stakeholders argued that use of these contracts resulted from local authority commissioning of care on a package-by-package basis and funding ceasing if a person in receipt of care goes into hospital or dies. This instability of funding for providers transfers to care workers and results in zero hours contracts that were argued to be problematic for recruitment and retention. It should, however, be noted that some stakeholders argued that many care workers had a preference for zero hours contracts. Despite this, the election of a Labour Government could lead to the ban of zero hours contracts. Given the numbers outlined above, this could have significant cost implications.

Some provider stakeholders noted that they offered guaranteed contracts to reduce instability of care worker income and improve recruitment and retention. There was, however, associated risk in having to pay care workers for time they did not spend working. There seemed to be limited appreciation, however, of the reduced recruitment and labour turnover costs that this could deliver as outlined above.

Guaranteed hours do not, however, resolve all issues with working patterns, particularly in home care. Care workers might be guaranteed 30 hours of paid work, but this could be spread over 50-60 hours as they are often not paid for waiting time between visits. One solution to this is shift working, where care workers are paid in blocks of time e.g., 7am-2pm and not dependent on number of visits. Elsewhere in England, some local authority providers offer shift work, and as noted above, Cornwall is exploring the potential for this in its recommissioning exercise. It will re-commission contracts next year and, while the re-commissioning exercise will not fund shift working, the local authority will be encouraging providers to offer shifts to care workers. It will be running some pilots in collaboration with providers which might, for example, involve providers sharing or swapping care packages to enable them to more easily fill care worker runs and minimise non-contact time.

Offering guaranteed hours could be important to care worker recruitment and retention but could come at significant cost, as noted in the evidence review. In England, one NHS Trust has established its own home care service and care workers are wholly employed on a shift basis. The evaluation of this service will take place in 2024 and will offer a better sense of cost implications.

Training, qualifications and career progression

The importance of training, qualifications and career opportunities in delivering high quality care and valuing staff was widely noted and positioned as a means to attract workers into the sector. A strong offer here could also serve to resist the low skilled label often attached to the sector. In this section, stakeholder perspectives are presented on funding, induction, and training and qualifications.

Funding
Stakeholders noted that the former coordinating entity, CAHSC, which focused on professional development and guidance for health and social care learning, had ceased to operate. There were concerns that this left a gap in coordination and support for workforce development and, as CAHSC had managed the Workforce Development Fund, an open question as to how providing professional development guidance, advice, signposting, and coordination for the care sector will now operate. Questions around the apprenticeship levy also arose as, while Cornwall has managed to transfer levies from the local authority and some NHS trusts to support training, there was concern that

the Cornwall Partnership Trust may not have such a capability due to its own levy expenditure.

Further, Cornwall has historically been successful in securing European Structural Fund (ESF) monies to support training for the care workforce, but these projects are now ending. A potential gap with other funding, such as the Shared Prosperity Fund, has created difficulties in maintaining a consistent delivery skill set and retaining experienced education professionals. It was also noted that, while the Shared Prosperity Fund and Good Growth initiatives had provided opportunities for training, their short-term nature is a concern. Additionally, some care providers have struggled to bridge the gap between their investments and receiving funding, sometimes experiencing delays of up to a year.

Induction

Stakeholders suggested that workforce pressures meant that care workers sometimes started to deliver care without robust induction. Yet effective induction was also noted as critical to retention, with turnover rates at their highest within the first 6 months of service and a lack of support for new care workers being central to this. Particularly for home care workers, the confidence and assurance that comes from induction is essential. Indeed, provider pilots in other areas of England that have focused on organisational socialisation and making the first 90 days of employment a positive experience have evidenced significantly improved retention rates.

Training and qualifications

There was a wide range of training and qualification provision in the sector, ranging from the Care Certificate to QCF Level 2-5 adult social care education and apprenticeship. These are discussed here, together with challenges around uptake.

Training

When starting to work for a provider, care workers are encouraged to complete the Care Certificate that focuses on technical aspects of the role. Skills for Care data indicates that in Cornwall, since 2015 when it was introduced, 5,400 care workers have completed, or are in the process of completing, the certificate. Some will have of course been in post prior to its introduction, but it still seems that many have missed the opportunity to get this introduction to their work. SfC (2023) data shows that 67% of care workers and 77% of senior care workers had had other forms of training, although there is limited detail on the content of this.

Stakeholders raised concerns about the Care Certificate, importantly that it is training only and not linked to the QCF and so does not lead to a qualification. This means that it is not portable and has to be redone when moving provider, which is a significant burden given the level of turnover in the sector. Also, new entrants to the sector need to complete it, despite having potentially transferable skills. Stakeholders suggested that QCF-based training that recognises prior skills and is portable is much needed. The need for the certificate to include digital skills as part of a general skills set, in the same way, for example, as health and safety was also noted.

Stakeholders also suggested an urgent need for more advanced training, especially in home care given the increasingly complex needs of people in receipt of care. This includes training on dementia, identifying deteriorating patients, sepsis, managing diabetes and neurological conditions. Developing these skills is important in supporting people in their own homes/residential homes and avoiding hospital admission. It can also be important in improving retention. While there were some examples of this skills training being offered, not all providers are able to do this. Additionally, ESF monies that have previously funded events such as a dementia conference and pain management training are now coming to an end, and it is unclear how this training will now be funded.

A number of concerns were raised about training delivery. First that care workers are frequently unpaid for the training that they attend and thus restricted in gaining the development they desire, which constrains their career progression. Care providers indicated that this came from them not having sufficient budgetary capacity to backfill for care workers when they are absent for training. Some training programmes that have seen strong uptake in primary care, e.g., Skills Bootcamps, have had very limited uptake in social care for this reason. Funding is thus a constraint on both training and qualifications (see following section). Second, that care providers, especially small ones, lack the in-house skills to deliver or support training. Here, use of NHS e-learning or partnering with larger providers that have training teams were suggested as mechanisms to support providers in training delivery.

Qualifications

There is no current requirement on care workers to gain any particular social care qualification. Skills

for Care data shows that, in Cornwall, over half of care workers and more than a quarter of senior care workers do not hold a relevant qualification. Approaching a quarter of both groups hold a Level 2 qualification, 20% of care workers and 40% of care workers hold a Level 3 qualification and only 2% of care workers and 8% of senior care workers hold a Level 4 qualification. Given the role of qualifications noted earlier in reducing retention and improving care quality, a focus on building the qualifications base in the care workforce is much needed.

That said, there is a strong offer of both education and work-place based qualification routes in Cornwall. Stakeholders noted that both routes were needed, as some people needed to stay in education as a result of the household benefits situation. This is particularly significant in areas with high levels of deprivation, where individuals may not have the option to move out of their parental homes and secure affordable housing.

Education-based qualifications: T levels
At Level 3, T levels are replacing BTec qualifications, which will cease to exist in 2025. A number of concerns were raised around this change. First, that T levels are too academically based, akin to A levels and will be less popular than BTecs, thus potentially reducing the supply of students. Second, the current T level has health but not social care in its title. Many students take to qualification as a precursor to entering health roles, and it is important that the social care options are also obvious. Third, that the required placements can be difficult to source due to infrastructure limitations in Cornwall. Earlier discussions on establishing partnerships between providers and educational establishments would again seem to be very important.

Work-place based qualifications: apprenticeships
In Cornwall, there were 290 people in the care sector taking Level 2 and 3 apprenticeships in 2021/22, which is a fall from both 2019/20 (323) an 2020/21 (401). Conversely, Level 4 and 5 registrations grew to 106 in 2021/22 from 61 in 2019/2020. As Level 2 and 3 apprentices are likely to be care workers or senior care workers, as opposed to registered managers at Level 4 and 5, this is a small percentage of the overall workforce.

While apprenticeship curricula were suggested to be robust, difficulties with encouraging care workers to take them were noted. Firstly, there was a perceived reluctance amongst providers to advertise apprenticeships because of an inaccurate perception that apprenticeships were for young people and the concerns discussed earlier about recruiting young people into care worker roles. Second, it could be challenging to convince existing care workers to enrol on apprenticeships because of the required maths and English literacy levels; these can also create difficulties with completing the apprenticeship and dropout rates are often high. Third, provider stakeholders again noted challenges with funding staff backfill when releasing care workers for the off-the-job elements of the apprenticeship. While some requirements could be met in the workplace, there is still a substantial amount of time required out of it. Better take up in the healthcare sector was again suggested to be due to better funding. Finally, concerns were raised that international recruits may not be eligible for funding until they have spent three years in the UK, depending on their visa status, which excluded them from apprenticeship routes.

In sum, while stakeholders argued the need for a continuous professional development approach for care workers, there is somewhat limited uptake of qualifications and apprenticeships in Cornwall. Changing patterns of care delivery create a clear requirement for flexible training and qualifications, emphasizing the shift towards home-based care and addressing the challenges associated with potentially peripatetic working between care homes and home care. Commissioning contracts currently set standards on, for example, the number of days training a worker should receive and the re-commissioning exercise offers the opportunity to further influence this. Cornwall's Virtual Health and Social Care Academy can also contribute to developing an outline for the workforce skills and qualifications profile needed in social care.

Career progression
There has long been recognition of the need for clearer career pathways in adult social care and stakeholders also argued for the importance of this. As noted in the earlier evidence review, the government's proposed career pathways have been delayed but it will be important to build these into the workforce strategy once available. Ensuring that pathways are implemented, and providers supported to access funding will be essential. Meanwhile, broader issues around careers in the sector are discussed in the Professionalisation section that follows.

Professionalisation

Stakeholders argued that the adult social care sector has a poor reputation, particularly post-pandemic where the narrative is focused on its role in delayed discharges, or 'bed-blocking', in the NHS. There is limited portrayal of the valuable work done in the sector. This is accompanied by a lack of occupational status and esteem, where care work can be seen as an occupation of last resort. Both points reflect the low value placed on care and caring roles in the sector, in stark contrast to the NHS.

There is a need to change the narrative to one in which care work is seen as important, valued and positioned as an occupation of choice. Professionalisation was seen by some as a means to achieve this. As noted in the earlier evidence review, registration is a means to build a professional and skilled workforce. Care workers would be qualified, their skills recognised and have clear career pathways. Stakeholders suggested that this would attract a different type of worker into the care sector, potentially increasing workforce supply. Concerns were raised, however, around registration as a barrier to entry or even as a driver for exit based on the profile of the current workforce. Thought is needed as how to manage the changing workforce profile that professionalisation could bring so that, alongside improved recruitment, retention of those already in the sector is supported. Some will welcome the opportunities that professionalisation brings, but others may not aspire to career progression and, in the medium term, catering to the needs of this group will be important.

While many stakeholders supported a drive for professionalisation and mandatory registration, there was recognition that it must be addressed at national level and cannot be tackled at local authority level. In the interim, actions such as implementing the NHS's Higher development award[37] in social care, as other local authorities have done, could pave the way to a more professional employment offer in social care. Local initiatives like a charter, similar to that implemented in Southwark, were also possibilities.

Health and Well-being

There was widespread concern as to the health and well-being of care workers. This resulted in part from an ongoing level of stress and burnout from the pandemic and a sense that the sector had not yet recovered from this. It was also related to the intensity of work experienced by care workers, exacerbated in many instances by high vacancy levels and labour shortages. As shown earlier, care workers had on average 6.3 days absence in the year. Stakeholders suggested that stress and poor mental health were the main causes of sickness absence. Mechanisms outlined earlier to improve recruitment, retention and work scheduling will be important in reducing the burdens on the workforce.

In the interim, stakeholders suggested that support was available for care workers. For example, care workers have access to referral systems that offer access to counselling and 'Care Coins'[38] offers free mental health support for social care staff in Cornwall. However, not all stakeholders were aware of this provision and there was limited occupational health provision. More locally, some providers were considering adopting practices such as a 4-day working week to ease the burden on their workers, though others were of the view that this would not be workable in their organisations.

Equality, Diversity and Inclusion

The care workforce is highly gendered, over 80% of care workers in Cornwall are female, and to an extent older women, as 35% of care workers and 41% of senior care workers are aged over 50. Ensuring inclusive and fair employment practice is important, plus additional support may be needed as the workforce ages to retain workers in employment.

In addition to gender and age, other protected characteristics referred to included:

- Religion: both that workers can be very distant from places of worship and that there can be tensions across different care worker/care recipient religions that need to be managed. A need for cultural sensitivity was noted.

[37] The Higher Development Award | Health Education England (hee.nhs.uk)
[38] cornwallwellbeingincare.org

- Neurodiversity: an increased number of workers were noted to need support together with the importance of addressing this.
- Disability: stakeholders argued that it is important that opportunities are made available for people with disabilities to enter and progress within the sector.

At local authority level, Cornwall is working with ADASS/ LGA as one of four pilot sites in a 'Diversity by Design' project and is committed to being an inclusive and fair employer. There is an aspiration to ensure that principles within the project are extended to the independent care workforce.

Integrated health and social care

The ICS was argued to offer a local level opportunity to improve conditions in the adult social care sector. Stakeholders suggested that, as a budget holder, the ICS can engineer meaningful integration of health and social care in a way that serves to deliver innovation and create parity with the NHS. There was, however, agreement the ICS was at an early stage of development and these opportunities are not yet being realised, although work is beginning. The Integrated Care Board's (ICB) Terms of Reference have been revised and greater emphasis will be placed in future meetings on social care matters, alongside the NHS, ensuring that **Proud to Care** and representatives of the independent Care sector and the voluntary sector are involved. They were felt to be under-represented.

Further, it was argued that cross-institution leadership is needed and that this could come through the Integrated Care Partnership (ICP). Recruitment was given as an example. While the ICB/ICP recognise the over-riding priority of recruitment into social care, NHS recruitment campaigns, into Allied Health Professions for example, have taken workers from the sector. While data on the implications of this is not yet available, stakeholders suggested that it was developed so that the 'bigger picture' ICP can be seen rather a very local view being taken. A second example of a somewhat silo-ed approach was commissioning, which could create unwelcome competition across H&SC services. Generally, better integration of health and social care e.g., GPs and residential/home care, was seen to be needed. There were some instances of good practice. One example was the care home support team, where a lead NHS consultant nurse and a number of clinical nurse specialists work with care homes to address clinical needs. A second example was in local authority-led provision, where closer links were being forged with community health colleagues e.g., AHPs in reablement.

More generally, stakeholders noted the need to bring teams together to meet care needs in a more joined up way. Delegated healthcare offers an opportunity to create greater health and social care integration[39]. In Cornwall, stakeholders suggested that there has been limited progress in implementing delegated healthcare. Southwest ADASS is partnering with other ADASS regions to learn more about delegated healthcare, and this type of knowledge sharing could also be promoted by Cornwall partnering with other local authorities. Provider stakeholders expressed concern, however, following experiences during the pandemic, over placing further pressures on an already over-burdened workforce and lack of funding to backfill for care workers taking on delegated healthcare tasks. While undoubtedly complex, other local authorities have experienced some benefits from delegated healthcare, and it provides an opportunity for much needed development and improved esteem for care workers. Budgetary integration has been important, for example, the Better Care Fund has been used in some places to fund increases in care worker pay for those taking on delegated tasks. Other forms of budgetary integration could also support these kinds of initiatives.

An ongoing theme from provider stakeholders was the need for better communication with them from both the local authority and the NHS. Clear lines of communication were argued to be needed, both generally and to support improved integration. Skills for Care also offers materials to help providers to understand their roles in ICS[40]. Education stakeholders echoed the need for enhanced communication so that their programmes could reflect changing needs. Better communication across Cornwall was a recurrent theme and is an important point to address.

[39] Delegated healthcare activities (skillsforcare.org.uk)
[40] https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Integration/Integration.aspx

Commissioning of adult social care

Stakeholders noted the important role of commissioning in addressing workforce matters. For example, commissioners can influence care worker employment via the contracts that they offer to providers. In Cornwall, contracts specify: payment of the Real Living Wage, which compares favourably with the rest of the sector; a number of paid training days; and an expectation that mileage and travel time is paid. These are factored into the fees paid to providers. It was also argued that the provider market is quite fragmented with around 130 care home and 100 home care providers, together with around 60 providers of supported living. Stakeholders questioned whether a smaller number of larger providers might, for example, offer better career structures. They also questioned whether there should be greater reliance on the voluntary sector to reduce profit element of care funding, potentially supporting increased pay for care workers. It was noted that great care was needed as this would complicate an already intricate commissioning environment. The re-commissioning exercise due in 2024 will provide the opportunity to reflect on these matters.

System-wide charging reforms were also raised in relation to commissioning and may have important workforce implications. First, some stakeholders suggested that the cap on the cost of care, currently due to be implemented from October 2025, could have significant implications for commissioning. Raising the cap will mean there are fewer self-funders and more people seeking to access care via the local authority. There was also discussion of implementation of legislation (Care Act 2014, S18(3)) that would mean self-funders were able to purchase care through the local authority prices at their rates, again increasing local authority-commissioned provision. A review of the current approach of externally commissioning services was argued to be needed and stakeholders questioned whether it might be more efficient to bring some care services in-house. This could have significant workforce implications, with the local authority directly employing a significant proportion of the workforce. Even if services are not brought back in-house, there could be a significant shift from self-funded to local authority-funded care provision, again meaning a much larger commissioned workforce will be needed.

In summary, system pressures were evidenced in inadequate and insecure funding given insufficient central government settlements which have not kept pace with inflation. These factors play a central role in the low pay, insecure employment and poor terms and conditions experienced by care workers.

Digital

Cornwall is at a relatively early stage of its digital journey having recently made an appointment to the ICB to develop better digital insights. The appointee sits on the ICB Workforce Committee and will support workforce modelling around implications of technology, which as noted earlier does not currently exist.

As outlined in the evidence review, the government has recently set out its position on what good digital practice looks like in adult social care, and supporting the workforce is a core element of this. In particular, the challenges of an ageing workforce and its motivation/ confidence around digital skills were noted as requiring action. Concerns around connectivity were also raised, although this was suggested to be more of an issue for home than residential care and stakeholders noted that there is a government-funded programme is underway to improve connectivity in Cornwall for hard-to-reach areas[41].

Stakeholders raised three other important aspects of digital provision that have workforce implications: digital management of care, technology-enabled care and digital skills.

Digital management of care

Three main issues emerged in discussions, namely digital social care records, digital rostering systems and data security and protection.

The digitising social care (DISC) programme is a national programme with funding/grants for providers to develop their digital offer[42]. A key element of this is implementation of digital social care records, in Cornwall so far, there has been a 60% uptake of digital records usage against a national target of 80% by 2024. While

[41] Project Gigabit | Wildanet
[42] Digitising Social Care | Digitising Social Care

training is offered by software providers, there does not appear to be any co-ordination of this for providers or the care workforce. Providers are also expected to fund training, although some grants are available. DISC also provides a data security and protection toolkit (DSPT, Data Security and Protection Toolkit (dsptoolkit.nhs.uk)) to support a minimum level of security. Both Care Partners in Cornwall[43] and Skills for Care offer support with this and also cyber security and data protection training[44]. A plan for workforce training, particularly for registered managers, is again important here.

Stakeholders also discussed digital rostering systems as a means to facilitate easier rostering and support more productive work, in for example, maximising capacity on home care worker runs. Cornwall has explored systems from other countries as potential options, alongside some being developed by providers elsewhere in England that may in due course be sold on a commercial basis to providers. There has, however, been limited progress made on implementation of these systems. In other contexts, digital rostering has significantly changed workplace practices and it is important that care workers are consulted on implementation of digital rostering. This is particularly so to ensure that improved productivity does not result from work intensification.

Stakeholders suggested that digital innovation in care management will create significant change and that support will be needed, particularly for many small- and medium-sized enterprises that lack the digital literacy skills needed to make most of technology, for example, creating and interpreting reports to inform management decision making. The local authority-run digital inclusion programme already provides a network of digital champions to support providers with training. These digital skills sharing networks will become very important and consideration of how to develop them was suggested to be essential.

Technology-enabled care: delivery and planning

Discussions also covered the implications of technology-enabled care, which was again noted to be in its early stages with a strategy in development. Examples given included digital monitoring, wearable technologies and the use of fall mats. Nine residential care providers had received DISC grants for pilot studies in prevention technologies and there has thus far been limited uptake in home care. As noted in the evidence review, this is an area of significant innovation and one which the workforce strategy will need to revisit on a regular basis given the likely pace of change.

There were divided opinions as to the implications for workforce. Some suggested that it would have limited impact, with technology simply delaying the demand for care or enabling improved care quality through creating, for example, time for conversations, rather than leading to any reduction in workforce numbers. Others suggested that technologies, such as digital monitoring, could make care more time efficient and reduce labour demand. SW ADASS's recent social care workforce strategy adopts this position. Modelling of the impact of technology-enabled care on the workforce does not currently exist and is needed. There seemed widespread agreement that different skills will be needed to use this technology. Responsibility for training currently sits with providers and stakeholders noted that system wide planning here could be of benefit.

While possibly beyond the scope of a workforce strategy, it is worth noting that concerns were also raised around resourcing of required investment. In healthcare, there is a clear infrastructure for investing in digital technologies, but this is absent in social care with progress at the discretion of individual providers and their propensity, or otherwise, to engage with such technology. To move the digital agenda forward, a system-wide investment infrastructure will be needed.

Digital skills

As noted in the earlier discussion of training, there is a need to build digital skills in the workforce. While some of this could be supported by the local authority's wider work on digital inclusion[45], a workforce-specific offer will also be needed. Stakeholders suggested that digital skills should be embedded in training and qualifications, from including them in the Care Certificate, to adapting

[43] Cornwall Partners in Care – For all care providers in Cornwall
[44] Data Security and Protection Toolkit (DSPT) (skillsforcare.org.uk)
[45] Digital Inclusion - Cornwall Council

Level 2 and 3 qualifications curricula to ensure that they are adequately addressed. Stakeholders could not offer evidence that this work is currently taking place and it will be important to review this. This is particularly important given the ageing workforce and suggested lack of digital literacy and potential resistance to its uptake. Examples were given from other local authorities of projects that focus on hard-to-reach populations with an inter-generational approach to developing digital skills. These kind of projects may be of benefit in Cornwall's digital skills plans.

Key points

Stakeholder perspectives presented here indicate that the adult social care workforce in Cornwall is subject to issues experienced across England more widely. Its geographical backdrop does, however, create additional challenges in accommodation and housing and its ageing workforce is of concern, particularly for registered managers. While some of the issues discussed need to be tackled at national level, there are also more local levers for some. These include ICS action to better integrate health and social care and the re-commissioning of home care which creates the opportunity for innovation in workforce practices. The next section deals with scenario planning for the workforce and is followed by the conclusions and recommendations section which addresses national versus local level actions.

Workforce scenario planning

This section discusses both workforce demand, given changing population demographics and changing patterns of care delivery, and workforce supply, given changing workforce demographics and potential policy and regulatory change. All data is drawn from Skills for Care's Adult Workforce data for the period 2022-23 unless otherwise specified.

Workforce demand

The 65+ age population in Cornwall currently numbers 151,600, which is 32% of its population. Cornwall has a super-ageing population which is set to grow to 187,300 by 2033[46]. This is an increase of 36,000 or 24% over the next 10 years. The number of people aged 75+ is expected to increase by 22%[47]. In what follows, implications of this growth in demand for workforce are estimated.

Using established Skills for Care workforce forecasting methodologies, total posts will grow from 19,500 to 26,445 by 2035 to reflect the growth in the 65+ population[48], an increase of around 35% (Table 20). This is much higher than the 25% growth forecast in England and indicates the scale of the challenge facing Cornwall.

Table 20: Increase in population 65+ and workforce forecast (total posts)

Population aged 65+				Workforce forecast			
2022/23	**2025**	**2030**	**2035**	**2022/23**	**2025**	**2030**	**2035**
151,600	160,900	180,000	197,600	19,500	20,903	23,787	26,445

In 2022-23, 8,485 (6%) people accessed long term support that was local authority funded (Table 21).

Table 21: Number of people in Cornwall accessing long term local authority-funded support in year by support setting, 2022-23

	Total	**Nursing**	**Residential**	**Non-Residential**
Number of clients	8,485	835	1,875	5,775

Source: Adult Social Care Activity and Finance Report, England, 2022-23

Using POPPI[49] data indicates that 44% of long-term care in Cornwall in residential homes was self-funded, and assuming a similar proportion for home care, a total number of just over 14,000 people received long-term care in Cornwall in 2022-23 (Table 22).

Table 22: Estimated total number of people receiving care accessing long term support during the year by support setting, 2022-23

	Total	**Nursing**	**Residential**	**Non-Residential**	**Individual employers**
Number of clients	14,052	1,482	3,329	9,241	600

[46] Drawn from the Delivering Better Care: Supported and Specialist Housing, summary document 2023 which will shortly be published.
[47] Drawn from the CIOS Dementia Strategy and Delivery Plan 2023 which will shortly be published.
[48] This model is based on the number of people aged 65+ in the population, which is robust as other Skills for Care modelling has shown that, for example, adding the number of people aged 16-64 with a learning disability into the model does not improve the quality of the estimate. For that reasons, the simpler model is adopted.
[49] Projecting Older People Population Information System (poppi.org.uk)

Different forms of provision have different support requirements and Table 23 sets out support ratios for filled posts to people receiving care in England. It can be seen that care home with nursing is most intensive, at 1.63 posts per person in receipt of care, with ratios reducing to 1.24 in care homes without nursing and 0.71 in home care. The ratio for individual employers is 1.87, but directly employed personal assistants often support more than one person.

Table 23: Filled posts per person receiving care by service provided in England

	Care home with nursing	Care home without nursing	Domiciliary	Individual employers
Support ratio	1.63	1.24	0.86	1.87

Source: Skills for Care unweighted national workforce estimates, March 2023, and CQC data

Combining the total number of people receiving care (Table 22) with staffing ratios (Table 23) provides an estimated number of filled posts of 15,613 (Table 24). These figures represent filled posts in the independent sector, local authority and direct payments. This is similar to estimates using Skills for Care's official methodologies of 16,381. This official estimate is not used here, as it does not allow for breakdown by service, which is needed to present more detailed workforce estimates. As the two estimates are broadly similar, there is confidence in using the more detailed estimate based on staffing ratios and people receiving care in the scenario planning that follows.

Table 24: Estimated filled posts compared to Skills for Care official estimates in 2022-23

	Total	Nursing	Residential	Non-Residential	Individual employers
Estimated filled posts (SfC official estimate)	16,381	2,936	4,247	8,010	1,188
Estimated filled posts (based on staffing ratios and people in receipt of care estimates)	15,613	2,409	4,134	7,947	1,122

The base case estimate of people in receipt of care, established at a general level in Table 22, can then be detailed by service (Table 25). This assumes no changes in care delivery patterns and suggests a growth of around 36%. This in itself is a substantial growth but is likely to be an under-estimate. For example, the CIoS Dementia Strategy and Delivery Plan indicates that the number of people 65+ living with dementia is expected to increase from 9,862 in 2020 to c13,00 by 2030 and to c14 700 by 2035. Similar estimates are made in the CIoS Integrated Care Strategy. These increases in dementia are likely to increase both demand for care and more specialist, labour intensive care. Similarly, Southwest ADASS's Adult Social Care Workforce Strategy (2023) notes that, as people enter the care system at a later age, they are likely to have more complex needs.

Table 25: Base Case estimated total number people in receipt of care in Cornwall 2023-2035

	Total	Nursing	Residential	Non-Residential	Individual employers
Number of clients 2023	14,052	1,482	3,329	9,241	600
projected clients in 2025	15,551	1,573	3,533	9,808	637
projected clients in 2030	17,397	1,760	3,952	10,972	712
projected clients in 2035	19,098	1,932	4,339	12,045	782

Using the more detailed estimate based on staffing ratios/people in receipt of care presents a likely increase from 15,613 to 20, 350 filled posts, around 30% (Table 26). This compares to the Skills for Care official estimate of 35%. As these figures are similar, there is again confidence in proceeding with this more detailed estimate for scenario planning.

Table 26: Base case workforce forecasts based on staffing ratios people in receipt of care estimates in Cornwall 2023-2035

	Total	Nursing	Residential	Non-Residential	Individual employers
2022/23	15,613	2,409	4,134	7,947	1,122
2025	16,571	2,557	4,388	8,435	1,191
2030	18,538	2,861	4,909	9,436	1,332
2035	20,350	3,141	5,389	10,359	1,462

The base case workforce forecasts do not, however, reflect planned changes to care delivery. For example, Cornwall's Supported and Specialist Housing Strategy outlines significant planned increases in all forms of housing by 2033 including: retirement/sheltered housing units to grow to 2,644 units; extra care units to 1,842; residential units to 857; and working age adult units to 280. There will be 750 extra units by 2030 alone. An increase in people receiving care in care homes with nursing will lead to greater demand, given more intensive staffing ratios.

Care demands also may change, becoming more complex given the predicted increase in dementia levels noted above. The Dementia Strategy and Delivery Plan sets out increases in supported living. It has as a measure of success that, by 2030, there will be at least 750 units of extra care, plus 7 new care homes and 4 refurbished care homes that, by 2033 will increase care home beds by 2000. Cornwall's dementia strategy outlines an NHS-led support service for training for complex dementia, presenting recommendations on Level 2 and 3 training and qualifications. It does not, however, consider the implications of increased workforce intensity, nor model any reward for higher skill levels, for example, increased pay.

These increases in residential care sit alongside predicted growth in home care, as strategies are implemented to support people to live well at home for longer. Southwest ADASS is undertaking work, currently at an early stage, to transform the home care market and will model an optimum level of home care hours throughout a year, including peak and troughs. The workforce implications of this will also be considered. These data will be important for more accurate workforce modelling.

Workforce demand modelling, therefore, needs to understand not just absolute growth in services, but how distribution across services will change. For example, if people receiving care were moved from nursing to residential services, the types of job roles required would differ. As Cornwall does not currently have

the required data, Skills for Care has, for illustrative purposes, produced a scenario based upon a number of assumptions (Table 27). It is emphasised here that these assumptions are not predictions, simply illustrations of the scenario planning that can take place once required data are produced. With that in mind, the assumptions are based on keeping people out of higher intensity care for longer and preventing people requiring care as soon, in more detail:

- 50% of the growth projected in nursing care receive residential care instead
- 50% of the growth projected in residential care receive non-residential care instead
- 50% of the growth projected to be in non-residential care do not receive formal care
- 50% of the growth projected to be in individual employers don't receive formal

Using these assumptions, the forecast number of people receiving care falls from a little over 19,000 in the base case to around 17,700 in the scenario, a drop of nearly 1,500. Forecast workforce demand falls from 20,350 in the base case to 18,870 in the scenario. To re-iterate, this is not a prediction; rather it illustrates changes in workforce demand that can result from changing care delivery patterns and the importance of modelling these.

Table 27: People kept out of higher intensity care for longer and preventing people requiring care as soon

People in receipt of care	Total	Nursing	Residential	Non-Residential	Individual employers
2022/23	14,052	1,482	3,329	9,241	600
2025	15,277	1,528	3,505	9,627	618
2030	16,562	1,621	3,866	10,418	656
2035	17,746	1,707	4,199	11,148	691

Not receiving care
0
302
922
1,493

Workforce	Total	Nursing	Residential	Non-Residential	Individual employers
2022/23	15,613	2,409	4,134	7,947	1,122
2025	16,271	2,483	4,353	8,279	1,156
2030	17,624	2,635	4,802	8,960	1,227
2035	18,870	2,775	5,215	9,587	1,292

Difference from base case	Total	Nursing	Residential	Non-Residential	Individual employers
2022/23	0	0	0	0	0
2025	-299	-74	-35	-156	-34
2030	-914	-226	-107	-476	-105
2035	-1,480	-366	-173	-771	-170

Skills for Care has also forecast how job role demand may vary across the base to scenario cases as a result of changing patterns of service demand. Again, this is illustrative only and not a prediction. For example, in the base case, care worker demand grows to 11,106 but falls to 10,353 in the scenario. While for care workers demand still grows, but by less, this is not the situation for all roles. Demand for senior care workers, for example, is static and demand for registered nurses falls.

Table 28: Job role breakdown, filled posts

Job role	Current	Base Case (2035)	Scenario (2035)
All job roles	**16,200**	**20,350**	**18,870**
Senior Management	177	232	217
Registered Manager	266	340	320
Social Worker	200	273	253
Occupational Therapist	35	47	43
Registered Nurse	348	381	337
Allied Health Professional	3	4	4
Senior Care Worker	1,029	1,294	1,209
Care Worker	8,840	11,106	10,353
Community Support and Outreach Work	527	696	645
Personal assistants	1,200	1,462	1,292
Other managers	864	1,116	1,042
Other professional	4	5	4
Other direct care	237	307	284
All others	2,471	3,088	2,867

Assuming the job role mix per service type remains the same as current and the service types change as projected

Other factors should also be built into workforce modelling. First, digital developments in both care management and technology-enabled care may alter the ratios presented in Table 23. For example, ratios may fall in certain cases if digital care is more efficient. Southwest ADASS's workforce strategy adopts this position but as noted in the stakeholder perspectives section, there is not as of yet general agreement on this. Second, changes in working patterns may affect workforce productivity. For example, adopting shift working for home care workers, as discussed in the stakeholder perspectives section, may be less productive and thus alter ratios. The implications of these developments for workforce demand are also needed to inform robust scenario planning.

The scenarios presented here are illustrative only, but the underlying assumptions will inform production of realistic scenarios once the data required are available.

Workforce supply

This section presents data on workforce demographics, unemployment rates and qualifications.

Workforce demographics

As Cornwall's population ages, so does it workforce. This has implications both in terms of proportions that are 55+ and the availability of younger workers, noted earlier as an important source of labour.

Taking first older workers, an increasing proportion of the workforce, 31%, is aged 55+ (Table 29). This situation is even more acute for registered managers, where 37% are aged 55+. A substantial proportion of the workforce could thus retire in the next 10 years.

Table 29: Filled posts, workers aged 55 and over as proportion of filled posts in Cornwall

Filled posts	15,000
Workers aged 55 and over	4,700
% of filled posts	31.0%

To compound this, analysis by Cornwall's Public Health team suggests that the working 16-64 age population will reduce from 57.3% of the overall population in 2025, to 54.6 by 2035[50]. Relatively small proportions, only around 14%, of the working age population will be aged under 30 by 2035 (Table 30). This will make the strong partnerships with education, discussed by stakeholders, crucial to ensuring an adequate supply of younger workers into the adult social care workforce.

Table 30: population aged under 30 by 2035

16-18			**19-24**			**25-29**		
2025	**2030**	**2035**	**2025**	**2030**	**2035**	**2025**	**2030**	**2035**
19,666	21,217	20,533	34,300	37,579	40,596	27,857	27,033	29,727
3.3	**3.4**	**3.1**	**5.7**	**6.0**	**6.2**	**4.6**	**4.3**	**4.5**
9,447	10,345	9,974	16,458	17,565	19,023	14,179	13,454	14,481
10,219	10,871	10,559	17,842	20,014	21,572	13,678	13,579	15,246

Source: 2011-2022 Revised MYE Estimates, ONS (2023) and Housing Led Population Projections (2025, 2030,2035), Cornwall Council and Edge Analytics (2023)

Stakeholders also suggested targeting the unemployed population. As of November 2023, Cornwall had an unemployment rate of those looking for work of 3.1%, which had increased over the previous 12 months[51]. This constitutes 8,800 people, some of whom maybe well-suited to work in adult social care with appropriate into work support.

Qualifications

Previous sections have noted policy emphasis on career pathways, and even the possibility of registration and regulation, which is typically linked to holding relevant qualifications. The discussion immediately above also notes the need for more highly skilled staff as care becomes more complex. Both place substantial emphasis on qualifications.

As shown earlier, 50% of the workforce in Cornwall has no relevant social care qualification and this rises to 52% for care workers. The figure is 27.7% for senior care workers. Workforce forecasts demonstrate that those holding no relevant qualification will increase to around 13,000 by 2035 (Table 31).

[50] 2011-2022 Revised MYE Estimates, ONS (2023) and Housing Led Population Projections (2025, 2030,2035), Cornwall Council and Edge Analytics (2023)
[51] Cornwall's employment, unemployment and economic inactivity - ONS

Table 31: Current and projected number of workers by highest level of relevant social care qualification in Cornwall

	2022/23	2025	2030	2035
Workforce forecast	15,000	20,903	23,787	26,445
No relevant qualification	7,600	10,500	12,000	13,000
Entry/Level 1	200	300	325	375
Level 2	2,800	3,900	4,400	4,900
Level 3	3,000	4,200	4,800	5,300
Level 4+	1,600	2,200	2,500	2,800

Projections include posts in local authority, independent, direct payment, and NHS sectors.

Seeking to build a more highly qualified workforce has significant implications. If there were, for example, an aim of 75% of workers to have at least a Level 2 qualification, this would mean that around 6,700 additional workers would need to be qualified by 2035 (Table 32). Should registration linked to qualifications be introduced, and mean that all the workforce must have a relevant social care qualification, this figure would be even higher.

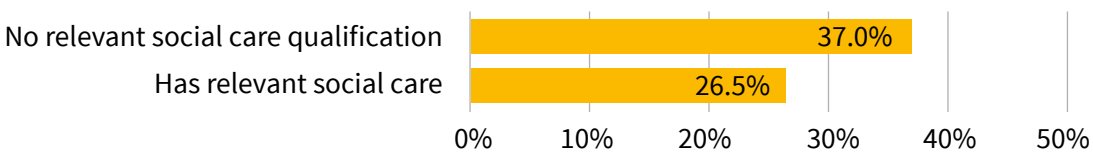
Table 32: Current and projected number of workers by highest level of relevant social care qualification in Cornwall to obtain 75% of workforce with Level 2+ qualification

	2022/23	2025	2030	2035
Workforce forecast	15,000	20,903	23,787	26,445
No relevant qualification/ Entry/Level 1	3,800	5,200	5,900	6,600
Level 2+	11,500	15,500	18,000	20,000

Projections include posts in local authority, independent, direct payment, and NHS sectors.

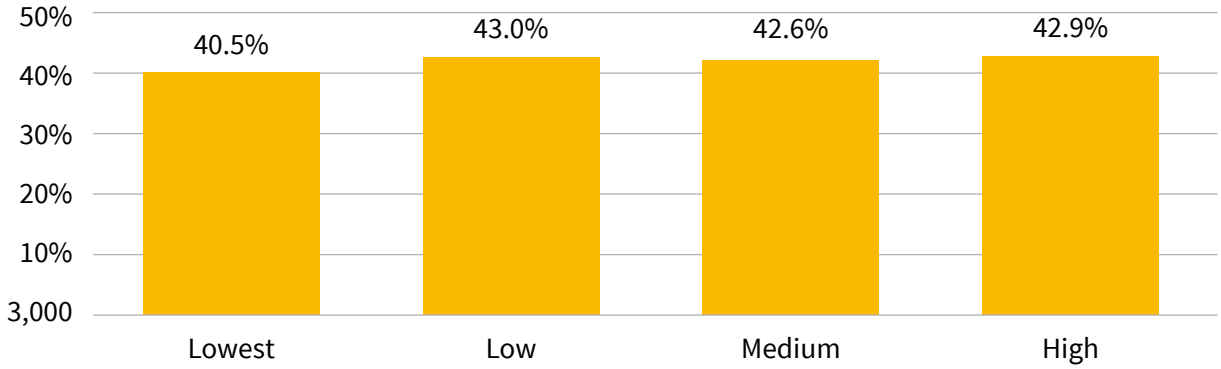
Supporting more of the workforce to gain Level 2 qualifications would come at significant cost. However, this cost could be offset by the reduced costs of labour turnover. For example, in 2022-23 in England, turnover in care workers who had a relevant qualification was 10.5% lower than for those who had no qualification (Figure 5). There were 2,900 leavers in Cornwall in that period; increased qualification could reduce that to around 2,600, a reduction of around 300. At an average cost of replacement per head of £2,500, as Skills for Care estimates, having a better qualified workforce could create cost savings of around three quarters of a million pounds.

Figure 5: Care worker turnover by social care qualification in England March 2022-23



Holding relevant qualifications has also been linked to increases in care quality (Figure 6). Here, providers with the highest CQC inspection ratings had 42.9% of the workforce with a relevant qualification, as compared to only 40.5% for those with the lowest ratings.

Figure 6: Proportion of care workers who had a qualification relevant to social care by CQC score in England



Source: ASC-WDS unweighted data October 2022 and CQC inspection ratings

Key points

Increased demand for adult social care workers of between 30-35% as Cornwall's population ages is of particular concern given the ageing demographic of its workforce and small numbers of workers under 30 by 2035. While modelling is needed to identify the specifics of this in more detail, recruitment and retention challenges over the next decade are likely to be significant as many retire and there is fierce competition for the younger workers needed to replace them.

This will be accompanied by a need to upskill the workforce, given policy imperatives and changing care demands. While increasing the proportion of the workforce that is qualified may come at significant cost, this could be offset by reduced costs of labour turnover and improved care quality. More broadly, it could also support recruitment and retention by tackling the low skill image that besets the sector and increasing the status of care work.

Conclusions and recommendations

This report has demonstrated the social and economic value of the adult social care sector in Cornwall. In social terms, it supports the large and growing number of older or vulnerable people in Cornwall and is one of the largest employers. In economic terms, in 2022-23, the sector contributed £606 million GVA to Cornwall's economy, an increase of 5.9% on 2021-2. It is thus a hugely important sector, and its workforce is critical. Yet it faces many challenges, not least the scale of growth required. Forecasts demonstrate that, to match the growing demand for adult social care in Cornwall, the workforce will need to grow in the region of 30-35% by 2035. This is challenging when set in the context of an ageing workforce, small numbers of younger workers and the entrenched recruitment and retention difficulties in the sector. It is also against a backdrop in Cornwall of acute accommodation pressures, insufficient public transport and intense competition, particularly in peak season, from the tourism and hospitality sectors.

Southwest ADASS has recently published its adult social care workforce priorities that, unsurprisingly, has identified many similar issues. Aligning to this, Cornwall's strategy aims to create:

- **A well-trained and developed workforce**
- **A healthy and supported workforce**
- **A sustainable and recognised workforce**

The central tenet of this report is that good employment is needed to build the required adult social care workforce. This will offer: fairly paid, secure work; training, development and career progression opportunities; and worker recognition and involvement in decision making. This will create a 'virtuous' circle of improved recruitment and retention and a more stable workforce. Parity with equivalent NHS roles is essential, as are place-based solutions to the particular labour market challenges that Cornwall experiences.

Bringing together the analyses presented, this section draws conclusions and offers recommendations to inform the adult social care workforce strategy. It covers both matters that Cornwall as a local authority can address and matters that will require national policy attention. The former are outlined in more detail in the following implementation and evaluation framework. For national policy matters, this report forms part of the evidence base required to lobby for required change.

Recruitment

Recommendations here centre on increasing labour supply, international recruitment and cross-local authority strategic collaboration.

Increasing labour supply

Recruitment challenges are evident in vacancy rates, which are higher than for England. Given the growth needed in labour supply and the proportion of the social care workforce that could retire in the next 10 years, both again higher than for England, it will be particularly important to attract young people into the sector. Engagement with the education sector and improving the image of adult social care are central to this. It will also be important to identify other sources of labour. These could include: unemployed and non-working disabled people, care leavers, men, refugees, and return to care for those who have left the sector. Volunteers, including retired people, are a resource to mobilise for companionship which could address the significant problem of loneliness. Attracting many of these groups will have the 'double bottom line' of increasing labour supply and reducing, for example, unemployment. Engagement is needed with providers to address reluctance on the part of some to employ young people and/or non-traditional sources of labour. Supply of registered managers is also a concern, with a high proportion potentially due to retire in the next 10 years. Development programmes to support promotion into these roles are needed. **The Accelerating Reform Fund**, despite having a primary emphasis on unpaid carers, could support some of the required programmes.

Recommendation: Local partnerships including **Proud to Care** to lead engagement with the primary, secondary and tertiary education sectors to:

- Deliver programmes in schools to build understanding of the value of and

opportunities in care work. The Skills for Care's Care Ambassador role could be re-invigorated to support this.
- Awareness raising and reputation building programmes in education providers and more widely
- Support providers to establish partnerships with schools and colleges to support structured pathways from education into employment, e.g., work placements, part-time work for students

Recommendation: Local partnerships including **Proud to Care** to work with organisations, e.g., DWP, SW ADASS and VCSE sector, to develop programmes to offer pathways into employment for non-traditional sources of labour, e.g., the unemployed, return to care people, care leavers

Recommendation: Local partners to develop/ co-ordinate training programmes that offer development pathways into Registered Manager roles

International recruitment
While international recruitment has had less uptake in Cornwall than in England, and vacancy rates have not then reduced in the same way, overseas recruits nevertheless constitute a fair proportion of the workforce. Given the political volatility that surrounds international recruitment, together with well-documented ethical concerns, it is recommended that it is used as only a short-term solution.

Cross-local authority working
Accommodation shortages and transport difficulties are critical issues in recruitment in Cornwall. Responses to accommodation shortages could include key worker housing schemes and provision of houses of multiple occupancy. Responses to transport difficulties could include NHS type salary sacrifice schemes to fund purchase of vehicles or, for home care workers, provision of pool cars. Where electric, these will also support Cornwall's carbon-neutral strategy. Cross-local authority strategies are required to develop appropriate responses.

Recommendation: Local partnerships work in conjunction with the departments responsible for housing and transport to develop strategies to alleviate accommodation and transport difficulties for the adult social care workforce

Training, qualifications and career progression

Robust induction, focused on socialisation rather than the more technical Care Certificate, is critical to ensuring new workers have the required skills and confidence and reducing the number of those who leave in the first six months of employment. Completion of the Care Certificate, proportions of the workforce holding Level 2 and 3 qualifications and uptake of apprenticeships are all low, although there is reasonable provision of other forms of training. There is, however, a growing need for specialist training provision in, for example, working with dementia. Career progression is also lacking and the DHSC's career pathways, and funding, to be announced in early 2024 will be critical to addressing this. Importantly, these will establish not only adult social care pathways, but also integrated pathways across health and social care, for example, children's social care, nursing and AHPs.

Digital skills provision is currently somewhat uncoordinated, and training is needed for both registered managers, in for example analysis skills, and care workers in use of technologies. The DHSC's digital leadership qualification will also be an important development, as is support for its digital skills passport when launched in 2024. Various curricula, for example, the Care Certificate and Level 2-3 qualifications require review to ensure they adequately address digital matters. Also, T level qualifications should include 'social care' in the title, as opposed to just 'health', to ensure that students see this as a career pathway.

There are various funding concerns. First, over funding distribution mechanisms; second, over funding sources as ESF monies disappear amidst lack of clarity over access to Shared Prosperity Fund monies; and third, over the extent to which transfer of apprenticeship levy monies to smaller providers will continue to be possible. Additionally, to support greater uptake of training and qualifications, fee levels must be high enough to allow care workers to be paid for their time when doing training and to pay for the backfill required in their absence. Fair Cost of Care and home care recommissioning exercises offer the opportunity to address this.

Recommendation: Local partners to promote access to and uptake of training:
- Design provider induction programmes –and promote uptake of the Care Certificate

- Lead on development of specialist training programmes
- Lead on communication and implementation of the career pathways, supporting providers to access the available funding
- Co-ordinate digital skills training programmes, including the proposed digital leadership qualification
- Co-ordinate and communicate training and training delivery and funding mechanisms

Recommendation: Local partners to work cross-local authority to lobby for national policy change to address fee levels that support uptake of qualifications. In addition, local partnerships to work cross local authority to develop

- Levy transfer availability
- Clarity around sources and distribution of funding

Recommendation: Cornwall to feedback nationally on T level title and need to include digital skills in various curricula

For many of the above, **Proud to Care** and other local partners will benefit from working with Cornwall's Health and Social Care Academy.

Retention

Labour turnover is high and has many causes, including low pay, insecure employment and poor training and qualification opportunities. As such, many of the other recommendations presented throughout this section will support improved retention. Another important influence on turnover is workplace culture, that is the extent to which workers feel valued, their voice is heard and that their contribution is appreciated. It is also the case that the costs of turnover often go unrecognised and that, for example, reducing turnover could facilitate higher pay rates and investment in training. Workforce planning to develop this understanding, and wider workforce demand and supply matters, is important.

Recommendation: Local and /or national partners to offer provider/registered manager programmes on

- Benefits of and practices to develop a strong workplace culture
- Understanding costs/benefits of reducing turnover
- Workforce planning

Pay, terms and conditions and contracted hours

Cornwall's current pay rates are competitive in the social care sector. However, recent increases to both the National Living Wage and Real Living Wage will require substantial increases to current rates and are likely to reduce/remove this competitive edge. Inflation has driven increases in care worker pay over the past two years, but funding increases have not kept pace. This has meant that care worker/senior care worker pay differentials have significantly reduced and that salary progression opportunities have worsened. This is an important matter to address to ensure adequate supply of senior care workers.

A potential change of government may also see a significant increase in pay rates, if Labour's **National Care Service** plans are implemented and a collectively bargained, sector-wide **Fair Wage Agreement** established. Such an agreement will provide for pay scales and salary/pay progression akin to those offered through Agenda for Change. This parity with the NHS is essential to building a skilled and stable adult social care workforce in Cornwall and should be worked towards, irrespective of the government in power. Investment in pay is required and outcomes will include a more diverse workforce (particularly the recruitment of more men into the sector), reduced turnover and improved care quality.

Terms and conditions of employment such as sick pay and pension provision are also typically at statutory minimum levels. Parity with NHS terms and conditions is again required to address current workforce shortages. Additionally, around 20% of the home care workforce is on zero hours contracts. While a more favourable position than for England, it nevertheless creates insecurity for a substantial section of the workforce. Election of a Labour government could lead to the banning of zero hours contracts, which creates substantial risk to Cornwall's use of these contracts. While Cornwall's 2024 recommissioning of home care will encourage providers to offer shift work, and some pilots are in progress, no funding will currently accompany this.

Recommendation: local authority commissioning teams to consider fee levels that

- Continue to demonstrate a fair cost of care to enable competitive pay rates and establishment of pay scales
- Lobby to seek to secure payment of terms and conditions that offer parity with NHS Agenda

for Change for similar roles as part of the government policy reforms for Adult Social Care.
- Enable shift working for those on zero hours contracts

Recommendation: local authority to lobby nationally for increased funding settlement to support the above, and other, recommendations

Health and well-being

The adult social care workforce is under significant pressure, key factors being post pandemic burnout and the work intensification created by high vacancy rates and turnover. These are reflected in sickness absence rates that are higher than the norms for the working population in England. While many of the measures recommended in this report will serve to improve this situation, including innovative working practices, direct forms of support are also required. Counselling is available for free, but perhaps not well known about. For many, there is limited access to occupational health services.

Recommendation: Local partners to

- Run a communications campaign to raise awareness of counselling support
- Run programmes to demonstrate to providers how innovative working practices can reduce workforce stress
- Explore with providers how they are supporting workforce well-being

Recommendation: local authority to explore options to offer occupational health services

Equality, diversity and inclusion

The adult social care workforce is female dominated and has an ageing profile. The recruitment section above offers some ways to address this and pay and career pathways are also important factors. While the workforce in Cornwall is not particularly diverse in terms of ethnicity and nationality, it is broadly reflective of its wider population. Neurodiversity and disability are increasingly prominent in the workforce. At local authority level, Cornwall is part of a pilot to improve workforce equality, diversity and inclusion, but this does not yet include the independent sector.

Recommendation: local authority to roll out local authority level assessment and action planning process to the independent sector.

Workforce strategy, planning and integration

There is currently no national workforce strategy, and Cornwall producing its own is an important step. There is similarly no national workforce plan for the independent sector, and this situation is reflected in Cornwall. This is despite the planned growth in and changes to care delivery, substantial predicted increases in workforce demand and current and future supply challenges. The potential workforce implications of increases in local authority commissioned care resulting from capping the costs of care and allowing self-funding care recipients to purchase at local authority rates also need to be considered.

Workforce planning is much needed, and the establishment of the ICS creates an opportunity to produce an integrated health and social care workforce plan. This should again support working towards parity between the NHS and adult social care. Not all the data needed for workforce planning is currently available. For example, the implications of care delivery changes for staffing demand have not been worked through. Neither have the implications for increased use of digital technologies and technology enabled care or adoption of shift working for staffing ratios. All are needed for detailed workforce modelling.

Workforce planning can also support capacity optimisation, promoting, for example, place-based strategies that create provider alliances for more efficient care delivery and developing skills so that workers can operate flexibly across different services. Integrated planning will also serve to support developments such as delegated health care.

The need for increased funding has already been flagged, and that lobbying at national level for improved settlements is needed. The ICS could, however, offer an interim solution to funding challenges in driving greater budgetary integration, offering cross institutional leadership and investment in improvements for the adult social care workforce. The ICB also offers an opportunity for improved within and cross-sector communication. For example, it is important that **Proud to Care**, the VCSE and providers have representation on the ICB. This offers a voice to social care and supports improved communications with independent providers to help them to understand their role in the ICS.

Recommendation: ICS to produce an integrated workforce plan and to

- Model workforce implications of changing patterns of care delivery, policy changes, changing workforce supply and demand, digital technologies and shift working
- Establish capacity optimisation strategies including delegated healthcare

Recommendation: ICS to address greater budgetary integration

Recommendation: ICB to invite representation from all sectors

Recommendation: local authority to lobby nationally for a workforce strategy and plan

Professionalisation

Professionalisation, based on mandatory registration and regulation of care workers, offers a mechanism to increase the status of care work and address recruitment and retention challenges. The anticipated career pathways offer an important starting point, but to be effective must be accompanied by improved pay and other terms and conditions. A co-ordinated package that creates parity with the NHS is needed. Registration has had some positive outcomes in, for example, Scotland and Wales, but any transition will need careful management to ensure retention of current workers as the workforce profile changes.

While registration must be actioned at national level, at least one local authority has its own care charter requiring training and development, alongside particular levels of terms and conditions of employment as a means to improve job quality and address workforce shortages. Cornwall could consider a similar charter, although it will only be effective if it offers a comprehensive package of measures, not simply an emphasis on training, qualifications and career progression.

Recommendation: local partnerships to co-ordinate cross-local authority discussions of a care charter

Recommendation: local authority to lobby nationally for care worker registration

Commissioning and funding

Under-funding of the adult social care sector is widely acknowledged and implicated in issues already discussed such as low pay and zero hours contracts. While additional funding is regularly made available, it is fragmented and short-term in nature, making it difficult for providers to plan. Under-funding also underpins practices such as payment of fees to providers that do not fully cover the costs of care and the commissioning of care on a package-by package basis that creates income instability for providers.

While constrained by funding settlements, commissioners nevertheless have the capacity to influence terms and conditions in the sector. The 2024 re-commissioning of home care provides such an opportunity. Contracts can require particular pay levels, training days, shift working and so on and thus enhance job quality. Commissioning is also currently highly fragmented across a large number of small providers. Re-commissioning across fewer, larger providers could create improved career structures.

Recommendation: local authority to seek to offer as stable fee mechanisms as possible that support improved terms and conditions in the sector

Recommendation: as above, local authority to lobby nationally for increased funding settlement to support increased fee levels

Digital skills

There are numerous national initiatives to drive uptake of digital technologies in the sector, including digital care records, digital skills passports, digital rostering, and technology-enabled care. DHSC will also launch a digital leadership qualification in 2024. In Cornwall, a technology-enabled care strategy is in development and consideration of its workforce implications will be needed. A co-ordinated digital skills training offer is currently lacking and recommendations on this were presented above. Building digital support networks will also offer important peer support.

Recommendation: local partners to support with implementation of digital skills passports and digital leadership qualifications

Recommendation: local partners to support building of digital support networks

Recommendation: C&WB to support uptake of digital tools that enable maximisation of care worker time in delivering care

Delivering the strategy

This report underpins the creation of an ambitious adult social care workforce strategy for Cornwall. Central to its achievement will be collaboration, both within the local authority and more widely. Within the local authority, local partners referenced in this document will require support from the ICB/ICP and other departments including those responsible for commissioning, housing and transport. Independent sector providers are also fundamental to the achievement of this strategy, and a strong communication and consultation programme will be needed to gain their commitment. SW ADASS will be an important partner, given the recent launch of its own strategy and streams of work that can support Cornwall in achieving its aims. Finally, partnerships with other local authorities could provide learning around workforce innovation. A detailed implementation and evaluation framework follows for recommendations that are for local partnerships, including **Proud to Care**, or within the local authority and/or Integrated Care System.

Implementation and evaluation framework

Recommendations outlined above are detailed in the following implementation and evaluation framework, where they are for action by local partners including **Proud to Care** (Table 33) or the local authority/ICS (Table 34). The framework draws on priorities from Cornwall's social value measures[52], which use a selection of National Themes, Outcomes and Measures (TOMs)[53]) that are aligned to the Gyllyn Warbarth strategic themes 2020 – 2050. Where appropriate, targets are specified for three times points, 2025, 2028 and 2033. The adult social care sector is a highly dynamic context and TOMs will require regular review.

Table 33: Targets, outcomes and measures for the adult social care workforce strategy – local partners including **Proud to Care**

Outcomes	Gyllyn Warbarth Priority	Why?	Measures
An adequate supply of skilled care workers: recruitment	**Work**	So no-one is unwillingly out of work	**Building labour supply** **Overall evaluation measures are vacancy levels, proportions of the workforce that are female, and average workforce age, all drawn from the ASC-WDS.** Each programme will establish its own measures of success, though possible measures are suggested here. This overall evaluation measure/ programme level measure approach is adopted where appropriate throughout this framework. Outreach programmes across primary, secondary and tertiary education sectors to improve image of care work, including use of Skills for Care's Care Ambassadors **Measures: numbers of programmes run; survey feedback to establish whether perceptions of care work are changing** Support providers to establish partnerships with education establishments to support work placements and employment opportunities and tackle provider reluctance to employ young people. **Measures: numbers of partnerships established; number of placements/jobs created** Programmes to target recruitment of particular sections of the population including: • Unemployed and non-working disabled people, partner with DWP • Care leavers, working with the Care Leavers Covenant • Men, running targeted training programmes • Refugees, working with VCSE groups • Return to care programmes, working with SW ADASS • Volunteers accessing £3m fund and working with NHS Care and Volunteer Responders programme **Measures: number of programmes run, and numbers involved; where possible, numbers converted to employment**
			International recruitment Engagement with international recruitment should be short-term only given policy volatility and ethical concerns. **Measure: 7.5% (2022-23): not to exceed 7.5% by 2028**
			Registered managers Development programmes to build the required supply of registered managers. **Measures: programmes run; number of managers promoted**

[52] Social Value in Council Procurements Guidance Document (March, 2023)
[53] The National TOMs - Social Value Portal

Table 33 (continued)

Outcomes	Gyllyn Warbarth Priority	Why?	Measures			
An adequate supply of skilled care workers: recruitment	**Work**	So no-one is unwillingly out of work	Baseline vacancies: 11.1%	2025: 9%[54]	2028: 7%	2033: 4.5%[55]
			Baseline gender: 79%	2025: 76%	2028: 73%	2033: 70%
			Baseline age: 44.6 years	2025: 43	2028: 42	2033: 41[56]
Improved skills	**Education**	So everyone can fulfil their potential	**Overall evaluation measures are Care Certificate completions, numbers holding Level 2 and 3 qualifications and apprenticeship starts, all drawn from the ASC-WDS.** **Induction** Develop induction programme and support providers with delivery. **Measure: delivery and uptake of induction programme**			
			Training Lead co-ordination of specialist training programmes and identify funding sources. Lead co-ordination to share training resources and experiences across providers. Registered manager programmes: detailed elsewhere in a number of sections of this framework. **Measures: number of programmes run; numbers of delegates**			
			Career pathways implementation[57] Programme to support providers to engage with career pathways when launched in 2024 and to access funding. **Measures: Care Certificate completions; numbers holding Level 2 and Level 3 qualifications; apprenticeship starts; amount of funding accessed**			
			Baseline Care Certificate: c50%	2025: 60%	2028: 80%	2033: 100%
			Baseline Level 2: 18%	2025: 25%	2028: 50%	2033: 75%
			Baseline Level 3: 20%	2025: 25%	2028: 35%	2033: 50%
			Baseline uptake of apprenticeships L2-3: 290	2025: 400	2028: 600	2033: 1,000
An adequate supply of skilled care workers: retention	**Work**	So no-one is unwillingly out of work	**The overall evaluation measure is turnover rates, drawn from the ASC-WDS** Actions throughout the framework will impact retention. Plus, programmes for providers/registered managers on: developing a positive workplace culture; understanding the costs/benefits of reducing turnover; workforce planning. **Measures: numbers of programmes run; numbers of delegates**			
			Baseline turnover: 27.4%	2025: 23%	2028: 18%	2033: 10%[58]
Improved staff wellbeing and mental health	**Equality**	So everyone can thrive in a diverse, inclusive and anti-racist Cornwall	**The overall evaluation measure is sickness absence rates, drawn from the ASC-WDS** Communications campaign to raise awareness of counselling support. **Measures: uptake of counselling support** Programmes to demonstrate to providers how innovative working practices can reduce workforce stress. **Measures: numbers of programmes run; numbers of delegates**			
			Baseline sickness absence: 6.3 days	2025: 5.7 days[59]	2028: 4.5 days	2033: 4 days

[54] Average vacancy rate for adult social care in England 2022-23
[55] Average UK vacancy rate for all jobs
[56] Average age of a UK employee
[57] Figures may need review when the DHSC career pathways are published
[58] Recommended turnover rate in England
[59] UK average in 2022 (though this was a record high in recent years) Sickness absence in the UK labour market 2022.pdf

Table 33 (continued)

Outcomes	Gyllyn Warbarth Priority	Why?	Measures
An adequate supply of skilled care workers: digital skills	**Work**	So no-one is unwillingly out of work	Lead co-ordination of digital skills training programmes, including the digital leadership qualification, support implementation of digital skills passports and development of digital support networks **Measures: numbers of programmes run; numbers of delegates; uptake of digital skills passports; support network established; number of members**

Table 34: Targets, outcomes and measures for the adult social care workforce strategy: Local authority/ Integrated Care System

Outcomes	Gyllyn Warbarth Priority	Why?	Measures
An adequate supply of skilled care workers	**Work**	So no-one is unwillingly out of work	**Cross-local authority working** The workforce strategy must be supported by strategies from other departments including: **Housing:** policies to support adult social care workers find accommodation where they want to live/work are urgently needed. These might include, for example, key worker housing schemes and provision of houses of multiple occupancy. **Measure: detailed in the strategy but provision of housing support** **Transport:** policies to support adult social care workers to travel to work and, for home care workers, to travel while at work. This should be integrated with Cornwall's carbon-neutral strategy and mirror the NHS's salary sacrifice scheme. **Measure: detailed in the strategies but likely to include provision of a salary sacrifice scheme to purchase electric pool cars and bicycles and pool schemes for use of these at work**
Improved skills	**Education**	So everyone can fulfil their potential	**Cross-local authority working** **Funding for training:** review of levy transfer and sources and distribution of funding; fee levels that support payment to staff undertaking training and backfill. **Measure: clarity on funding sources and availability; fee levels cover FCoC**
Pay, terms and conditions and contracted hours	**Income**	So no-one lives in poverty	**Local authority commissioners** Use re-commissioning/FCoC/lobbying exercises to influence fee levels, stability and employment practice. **Overall evaluation measures are pay rates, terms and conditions and % use of zero hours contracts, drawn from the ASC-WDS**
			Pay Rapidly changing hourly pay rates mean that it is difficult to set specific figures here. Rather, a narrative approach has been adopted that reflects the improvements required to absolute pay levels and pay progression.

Table 34 (continued)

Outcomes	Gyllyn Warbarth Priority	Why?	Measures			
Pay, terms and conditions and contracted hours	**Income**	So no-one lives in poverty	Baseline pay: £10.53ph	2025: % TBC agreed above RLW	2028: parity with NHS AfC scales	2033: parity with NHS AfC scales and linked to career progression
			Terms and conditions Terms and conditions: sick pay, pensions			
			Baseline: statutory minimum levels		2028: parity with NHS	
			Contracted hours Implementation of shift working and removal of zero hours contracts; measures have a particular focus on CWs[60]			
			Baseline CW on ZHC: 18.7%	2025: 15%	2028: 10%	2033: 5%
Improved staff wellbeing and mental health	**Equality**	So everyone can thrive in a diverse, inclusive and anti-racist Cornwall	**Local authority** to explore options to offer occupational health services. **Measure: decision taken on whether to offer occupational health services**			
Workforce EDI	**Equality**	So everyone can thrive in a diverse, inclusive and anti-racist Cornwall	**Local authority** to roll out local authority level assessment and action planning process to the independent sector. **Measure: roll out of EDI process**			
An adequate supply of skilled care workers: H&SC workforce strategy, planning and integration	**Work**	So no-one is unwillingly out of work	**Integrated Care Board/Partnership: integration** Produce an integrated health and social care workforce plan, building in greater budgetary integration. Establish capacity optimisation strategies, including delegated healthcare. Invite ICB representation from all sectors. **Measures: publication of workforce plan and capacity optimisation strategies; ICB membership is reflective of the health and social care sector**			
			Integrated Care Board/Partnership: workforce planning Model workforce implications of changes in care delivery, changing demographics, and digital developments. **Measures: workforce modelling data is available, and scenarios are produced**			
			Integrated Care Board/Partnership: delegated healthcare Explore opportunities for delegated healthcare, partnering with other local authorities that have adopted this. **Measures: to be determined as part of the exploration**			
An adequate supply of skilled care workers: profession-alisation	**Work**	So no-one is unwillingly out of work	**Integrated Care Board/Partnership** to evaluate the option of a care charter for Cornwall. **Measure: decision taken on whether to have a care charter**			

[60] Will require review if a Labour government implements its proposals on banning zero hours contracts

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